Mid Essex Hospital Services NHS
NHS Trust

THE MANAGEMENT OF DOMESTIC ABUSE IN MATERNITY PATIENTS	CLINICAL GUIDELINES Register No: 06040 Status: Public

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Review No	Reviewed by	Review Date
1.0	Theresa Clark	February 2006
2.0	Diane Roberts	January 2010
3.0	Tracey Samuels, Specialist Midwife Safeguarding	January 2014

It is the personal responsibility of the individual referring to this document to ensure that they are viewing the latest version which will always be the document on the intranet

INDEX

1.0 Purpose

1.1 Domestic Abuse is a priority which the Government has made a firm commitment to tackle. All statutory agencies are expected to provide resources to ensure that effective single and multiagency responses are developed and maintained. The aim of this policy is to address domestic abuse in all contexts of the service.

1.2 This guidance is drawn from The Confidential Enquiry into Maternal Deaths (DoH 2001, 2004), Domestic Abuse: A report from the BMA board of science (2007); Safety and Justice: The Government's proposals on Domestic Violence (2003), Responding to domestic abuse: A handbook for health professionals (2005) and a variety of other research and guidance papers published nationally. The guidelines are intended to assist maternity health care professionals in the management and support of antenatal and postnatal women suffering domestic abuse.

1.3 This guideline is an addition to and should be read in conjunction with the Trust's policies for 'Drugs Alcohol and Substance Misuse'; register number 04045; and section 15 of the Trust's 'Domestic Violence Policy'.

2.0 Equality and Diversity

2.1 The Trust is committed to provision of a service that is fair, accessible, and meets the needs of all individuals.

3.0 Scope

3.1 This guidance covers six areas:

- Recognition of domestic abuse
- Provision of a quiet and private environment
- Routine Enquiry; Identification and confidentiality
- Documenting abuse - information sharing
- Provision of information and resources - support and follow up
- Information sharing and public interest referral guidance

4.0 Definition of Domestic Abuse

4.1 Home Office (HO) defines domestic abuse as "Any incident of threatening behaviour or abuse (psychological, physical, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality" (HO 2005). This incorporates issues such as forced marriages, female genital mutilation and so named 'honour killings', it also encompasses elder abuse when committed within the family.

4.2 Domestic abuse in pregnancy is a major public health issue that has been shown to have profound consequences for the mother's and infant's health. Domestic abuse has been defined by the government and includes issues of concern to black and minority ethnic communities such as so-called honour based violence, female genital mutilation and forced marriage. An adult is defined as any person aged 18 years or over. Family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in laws or stepfamily.

4.3 In 90% of cases children are very aware of domestic abuse and often witness the abuse within their home. Domestic abuse is an important indicator that a child may be at risk.

4.4 Domestic abuse is not limited to any particular class, ethnic or social group - however the experience of domestic abuse may differ as a result of these different contexts

4.5 Although domestic abuse can take place in any intimate relationship, including gay and lesbian partnerships, and abuse of men by female partners does occur, the great majority of domestic violence and the most severe and chronic incidents are perpetrated by men against women and their children.

4.6 Domestic abuse is a pattern of coercive and abusive behaviour used by the perpetrator to gain control over the victim. It is rarely a one off and escalates over time (more frequent and more severe).

4.7 When working with pregnant patients it is important to recognise that domestic abuse can take many forms, and is not limited to acts of physical violence.

4.8 All concerns about or disclosures of domestic abuse should be dealt with in a sensitive manner. Any woman who makes a disclosure of abuse requires clear messages about the action you will take, ongoing support and accurate information on local domestic violence support. Health professionals have a unique opportunity and responsibility to provide information and advice on domestic abuse to patients.

4.9 In all contacts with those who have disclosed domestic abuse, or where it is suspected that they may be experiencing domestic abuse, health professionals should always ask themselves 'will my intervention leave this patient and her children in greater safety or greater danger?' – for example never ask or discuss domestic abuse in the company of the partner or other family member.

4.10 The aim of these guidelines is to raise awareness and encourage good practice. Pregnant patients who experience domestic abuse will not all manifest similar signs, symptoms and patterns of behaviour. They are often very resourceful and show great courage when protecting themselves and their children. A patient seeking help and support may only do so at the end of a process which has involved calculated decision making thereby enabling her to keep control of the home situation.
(Refer to Appendix A)

5.0 Recognition of Domestic Abuse

5.1 There are a number of indicators of domestic abuse, of which health professionals should be aware. None of these are absolute evidence that abuse has definitely occurred, but all maternity health care professionals need to know the recognised physical, emotional and behavioural indicators that can raise concerns that a patient may be experiencing domestic abuse.
(Refer to Appendices B, C, D and E)

5.2 Maternity health care professionals should make appropriate assessments of all patients attending for health care using the above indicators as a framework.

5.3 Guidance for maternity health care professionals working within the day assessment unit (DAU).
(Refer to Appendix H)

5.4 Guidance for managers if staff disclose personal domestic abuse.(Refer to Appendix I)

6.0 The Provision of a Quiet and Private Environment

6.1 Whenever domestic abuse is either suspected or known an opportunity should be provided for discussions about individual circumstance in a **quiet** and **private environment**, and where a **patient** can be **seen alone.** The presence of a partner or a relative during such conversations will place her at increased risk of harm. The professional limitations of confidentiality in relation to safeguarding and child protection should be clearly explained at the outset of the discussion.

6.2 Where a patient has a hearing impairment, or her first language is not English, arrangements should be made for an interpreter to be present. Wherever possible it should be ascertained from the woman whether the interpreter is suitable. Family members and friends should **not** be used to interpret interviews of this kind.
(Refer to the guideline for 'Interpreting and translation policy'; register number 09127)

7.0 Routine Enquiry - Asking the Question

7.1 Maternity based routine enquiry for domestic abuse is an excellent opportunity for proactive early intervention. It creates a culture where domestic abuse is named and discussed and therefore helps generate disclosure from pregnant patients. They can then access specialist support where they may not have been able to in the past or may have been previously unaware of the support available. It is recognised that patient welcome being asked about domestic abuse.

7.2 Routine enquiry should be undertaken in the antenatal period (at booking or before 28 weeks gestation) and in the postnatal period (by the tenth postnatal day).

7.3 Maternity health care professionals should initially ask all patients basic framing questions about domestic abuse. This helps in establishing a relationship with a patient and developing empathy.
(Refer to Appendix F)

7.4 If a patient states that she is experiencing domestic abuse you should ask her direct questions about the abuse. If you are unsure about any explanations given (for injuries for example) it is crucial that direct questions are asked rather than letting an improbable explanation pass without saying anything.
(Appendix F)

7.5 It is important to be honest and explain why you are asking the questions. This gives a sense of focus to the discussions and should avoid a patient feeling that she is being judged or targeted. It is important to listen carefully as a patient may talk around the subject before feeling able to openly discuss her experience of domestic abuse. Antenatal contacts provide an opportunity for repeated enquiry, which may further increase the likelihood of disclosure.

7.6 The maternity health care professional may need to remind a patient that anything she chooses to say will be confidential but there are limits to confidentiality i.e. if there are any concerns regarding child protection.

7.7 If a patient does make a disclosure and talks with the health professional about domestic abuse, she should always be offered accurate information on local groups or agencies (See appendix J)

7.8 The patient who is experiencing the abuse is ultimately the only one who can reliably predict the risks she faces and the likelihood of further abuse. In considering the likely risks the principal responsibility of the maternity health care professional is to support the patient in the decisions and choices she wishes to make.

7.9 Every maternity health care professional should ensure their own safety and has the right to withdraw where they feel their own personal safety is being compromised. This should always be discussed with a manager, and an assessment made of risks to a patient and her children, including the need to refer to other statutory agencies.

8.0 Documentation of Domestic Abuse

8.1 When routine enquiry has been undertaken during the antenatal period, the enquiry should be entered into the hospital maternity notes. In addition, at each antenatal appointment the midwife should undertake routine enquiry, denoted by the initials 'RE' recorded in the right hand corner of the antenatal care comments' section of the woman's handheld record. The importance of documented information about domestic abuse should be explained; records can provide concrete evidence of abuse and may prove to be crucial in influencing the outcome of any legal case.

8.2 Maternity health care professionals should document information clearly and accurately in the patient's hospital notes. This information should include a woman's history, including all physical, emotional and behavioural indicators. A body map may be useful to indicate physical injuries. Any direct disclosure must be documented using a patient's own words in inverted commas and records must be maintained in strict confidence.

8.3 An agreed plan of follow-up and action should also be documented to provide clarity around any decisions made and subsequent contact with a patient by a health professional. If an agreed action plan is not followed up a patient may feel that she has not been listened to. If a patient is unable to follow through with actions discussed this should be documented by a health professional and further follow-up and support offered.

9.0 Provision of Information and Resources

9.1 Maternity health care professionals should provide a patient with the opportunity to discuss her immediate and longer-term safety and what options she feels are available and appropriate for her, for example:

- Does she have family or friends who can provide her with emotionaland practical support?
- Does she require immediate access to a refuge?(Refer to Appendix G)
- Would she like you to make a referral for her to a specialist domestic violence (DV) service?

9.2 When a patient discloses domestic abuse you should encourage her to accept a referral to a specialist DV service for emergency housing, information support and advice. You can also encourage her to speak with the police to report the DV. Social Services can be contacted for assistance with accessing emergency temporary accommodation if she has children. If there are children present, Social Services must always be notified as set out in the Child Protection Policy.
(Refer to Section 0.3 Safeguarding Children Policy for medical, dental staff and nurses and professionals)

9.2 If a patient does not need immediate access to emergency accommodation, other safety options and information should be discussed. You may need to agree further appointments to undertake safety-planning work. If you are not suitably trained there are DV services that can undertake this, if the patient agrees to the referral. If her partner controls and closely monitors her movements think about and agree with her further maternity appointments so she can access this help.

9.3 This discussion should include what options are available for a patient i.e. legal advice and what specialist services are available in and out of her area. Information provided should be accurate and up-to-date and given in a format that is discrete.

9.3 Maternity health care professionals should give information in a way that is supportive to a patient, and reflects the seriousness of a patient's experience of domestic abuse. It is each individual patient's right to decide on what she wants to do. Each patient will use the information she is given in her own way and in her own time, and may be able or want to leave her abuser. Discounting concerns in relation to child protection, maternity health care professionals should respect and accept a patient's decision, whatever that may be.

9.4 Follow up care should be discussed and agreed by the maternity health care professional, this is vitally important for building up a trusting and supportive relationship.

9.5 Maternity health care professionals should access advice and professional support for any case where they have concerns from the safeguarding midwives as follows:

- Specialist Midwife Safeguarding - extension 3351
- Named Midwife for Safeguarding - extension 5167

10.0 Safeguarding and Public Interest Referral Guidance

10.1 Once disclosure of domestic abuse has been made the professional should consider the safeguarding aspects of the case. Follow-up questions are required enquiring as to the presence within the home of any children. Where domestic abuse is being perpetrated most children are either in the same room or an adjacent room and are not being safeguarded. There is risk of direct physical injury or indirect emotional harm from witnessing such activity and falls into the category of neglect.

10.2 When there are children involved all cases of DV must be referred to Social Care via the ECC999 referral form as per Trust Safeguarding Children Policy.

10.3 It is expected that the mother, will be informed about the referral, however, in the event she does not consent, the referral must still be made.

10.4 In the case where the mother is suspected of causing abuse herself, the professional may decide not to seek consent and in this case full documentation should be entered into the hospital records with the reasoning entered onto the ECC999.

10.5 The professional is responsible for following up the referral within 3 working days as per the Trust Safeguarding Children Policy.
(Refer to Section 0.3 Safeguarding Children Policy for medical, dental staff and nurses and professionals)

10.6 In addition, the yellow alert forms should be completed by the responsible professional and sent to the Specialist Midwife Safeguarding.

11.0 Staff and Training

11.1 The Trust should provide its key staff with sufficient information, mandatory training and support on the cause and prevention of domestic abuse and strategies for effective interventions. This training should be in line with the inter-collegiate document as per the training strategy. All Front line staff dealing with children and families should have level 1, 2 and 3 safeguarding training. Once level 3 has been achieved, level 3 supersedes level 2 and must be updated every 3 years; during this time staff must evidence at least 16 hours of continuing education within safeguarding. Midwives, Maternity Care Assistants and Obstetric staff must attend yearly mandatory training which includes an update on safeguarding supervision
(Refer to 'Mandatory training policy for Maternity Services (incorporating training needs analysis. Register number 09062)

11.2 All midwifery, nursing and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal.

11.3 The efficacy of the training and adherence to policy should be audited via safeguarding processes.

11.4 All frontline staff with safeguarding roles must access Safeguarding Supervision in line with Trust Safeguarding Supervision Policy, section 14.

12.0 Supervisor of Midwives

12.1 The supervision of midwives is a statutory responsibility that provides a mechanism for support and guidance to every midwife practising in the UK. The purpose of supervision is to protect women and babies, while supporting midwives to be fit for practice'. This role is carried out on our behalf by local supervising authorities. Advice should be sought from the supervisors of midwives who are experienced practising midwives who have undertaken further education in order to supervise midwifery services. A 24 hour on call rota operates to ensure that a Supervisor of Midwives is available to advise and support midwives and women in their care choices.

13.0 Infection Prevention

13.1 All staff should follow Trust guidelines on infection prevention by ensuring that they effectively 'decontaminate their hands' before and after each procedure.

14.0 Audit and Monitoring

14.1 Audit of compliance with this guideline will be undertaken on an annual audit basis in accordance with the Clinical Audit Strategy and Policy, the Maternity annual audit work plan and the NHSLA/CNST requirements. The Audit Lead in liaison with the Risk Management Group will identify a lead for the audit. .

14.2 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

14.3 The audit report will be reported to the monthly Directorate Governance Meeting (DGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

14.4 Key findings and learning points from the audit will be submitted to the Patient Quality and Safety Committee (PSQC) within the integrated learning report.

14.5 Key findings and learning points will be disseminated to relevant staff.

15.0 Guideline Management

15.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.

15.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

15.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. 'Spot checks' are performed on all clinical guidelines quarterly.

15.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for further training; possibly involving 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

16.0 Communication

16.1 A quarterly 'maternity newsletter' is issued and available to all staff including an update on the latest 'guidelines' information such as a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly.

16.2 Approved guidelines are published monthly in the Trust's Focus Magazine that is sent via email to all staff.

16.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.

16.4 Regular memos are posted on the guideline notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

16.0 References

British Medical Association. (2007) Domestic abuse: A report from the BMA Board of Science. BMA.

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

Southend Essex &Thurrock Child Protection Procedures (2007) 10.4.3

National Domestic Violence Reduction Plan (2006) spara (Home Office)

Department of Health (2005) Responding to Domestic Abuse. A handbook for health professionals DH.

Home Office (2007) Domestic Violence and Children

Domestic Violence, Crime and Victims Act 2004

Department of Health (2008) Delivering Safer Communities Home Office and DH.

Appendix A

Responding to Abuse

When considering your responses to patients who are experiencing domestic abuse it is important to recognise that:

- A patient may have been experiencing violence and abuse over a long period of time. The violence may be a mixture of physical, sexual and emotional abuse
- She may have been limited in her movements
- She may have had no access to her own money or excluded from dealing with finances.
- She will probably have done a whole range of different things already to try and stop or manage the violence
- You may be the first person she has spoken to or the twentieth. She may have had previous bad experiences of disclosing domestic violence, so she may be fearful about what may happen if she tells you
- She will want to stop or escape the violence, but she may also want to try and save the relationship
- It is likely that she will blame herself for the violence, be lacking in confidence and be sensitive to your views
- She may be very frightened of him and possibly you
- Patients are most at risk of life-threatening or fatal violence when they attempt to leave, or have recently left the violent partner
- Do not be despondent if the patient chooses not to leave or returns to an abusive relationship

Appendix B

Physical Symptoms of Abuse

Common types of injury include:

- Abrasions and minor lacerations, including burns and bites, as well as fractures or sprains
- Injuries that are untended and are of several different ages to the head, neck, chest, breast and abdomen and genital area
- Multiple sites of injury
- Repeated or chronic injuries
- Injuries that are inconsistent with the given history

Physical symptoms related to stress. Examples are:

- Sleep and appetite disturbances
- Fatigue
- Chronic headaches
- Abdominal and gastrointestinal complaints
- Palpitations, dizziness and dyspnoea
- Chest pain
- Deliberate self harm

A History of:

- A high incidence of miscarriage and terminations of pregnancies
- Stillbirth
- Preterm labour
- Intrauterine growth retardation/low birth weight
- Unplanned or unwanted pregnancy
- Frequent visits with vague complaints or symptoms without evidence of physiological abnormality (i.e. recurring admissions for abdominal pain/reduced fetal movement)

Gynaecological Problems

- Frequent urinary tract infections
- Dyspareunia
- Pelvic pain

Frequent use of Prescribed Minor Tranquillisers or Pain Medications (also frequent attendance at health services)

Rape and Sexual Assault

- Injury to genitals

Appendix C

Emotional Symptoms of Abuse

- Feelings of isolation and inability to cope
- Suicide attempts or gestures of self harm, particularly those in context of relationship problems and seeking help
- Depression
- Panic attacks and other anxiety symptoms
- Alcohol and drug abuse
- Post traumatic stress reaction and/or disorder
- The patient may appear frightened, ashamed, evasive, embarrassed or be reluctant to speak or disagree in front of her partner
- Intense irrational jealousy or possessiveness expressed by partner or reported by the patient
- Denial or minimisation of violence by the patient (or her partner) with an exaggerated sense of personal responsibility for the relationship, including self blame for her partner's violence

Appendix D

Signs of Control within a Violent Relationship

- Limited access to routine and/or emergency medical care
- Non-compliance with treatment regimens
- Not being allowed to obtain or take medication
- Missed appointments
- Lack of independent transportation, escorted everywhere by partner or other family member, limited access to finances and ability to communicate by telephone

Appendix E

Behavioural Signs of Abuse

- The patient may appear frightened, ashamed, evasive or embarrassed
- Partner accompanies patient, insists on staying close and answers all questions directed to her
- Reluctance of the patient to speak or disagree in front of her partner.
- Intense irrational jealousy or possessiveness expressed by the partner
- Denial or minimisation of violence by partner or patient
- Exaggerated sense of personal responsibility for the relationship, including self-blame

Appendix F

Asking the Question

The following example opening statement, initial and follow-up questions may be helpful when asking women about domestic abuse.

These are suggestions you may wish to incorporate into your practice.

Always commence your discussion and approach the subject by using the standard opening statement as set out below. Then follow this with asking her a framing question and direct question as appropriate to the situation. If the patient discloses domestic abuse, you should ask her direct questions as set out below as appropriate to the disclosure and any presenting injuries.

Standard Opening Statement

- The NHS takes domestic abuse very seriously and because violence in the home is very common we ask all women we see about it, in case it's something they may be experiencing.

Examples of Framing Questions

- Is everything all right at home?
- Are you getting the support you need at home?
- Do you get on well with your partner?
- Do you ever feel frightened of your partner or other people at home?
- Are you currently in a relationship where this is happening to you?

Follow- Up - Direct Questions

- I notice that you have a number of bruises / cuts / burns (as appropriate).
- Could you tell me how you got those injuries?
- Have you ever been slapped, kicked or punched by your partner?
- Does your partner often lose their temper with you? If he/she does, what happens?
- Does your partner get jealous of you seeing friends, talking to other people or going out? If so, what happens?
- Your partner seems very concerned and anxious about you. Sometimes people react like that when they feel guilty, was he responsible for your injuries?
- Does your partner use drugs or alcohol excessively? If so, how does he behave at this time?

Appendix G

Assessment of Risk and Safety

DV risk assessment is a specialist skill. If you are not trained in DV risk assessment you should always encourage the patient to accept a referral to a specialist DV support service for this to be conducted.

There are several known risk factors in relation to domestic violence.

- Separation
- Pregnancy
- Escalation of abuse
- Cultural issues / isolation / lack of support
- Sexual Assault
- Stalking

If she is not willing/or ready to agree to a referral to a specialist DV service you may wish to complete the multi agency risk assessment conference (MARAC) risk assessment tool (Discuss with the lead midwife for Vulnerable Women or Safeguarding if you are unsure).

You can also ask her the following questions:

- What is the history of domestic abuse:
- How long has the abuse been happening and is it increasing in frequency and severity?
- Is the abuser making threats to the woman and any children?
- What is the woman's understanding of risks to herself and any children?
- Who else knows about the violence? - can the woman get emotional and practical support from extended family and friends?
- What help has the woman already sought e.g. police, legal advice?
- What is the emotional status of the woman - e.g. any suicide threats?
- Does she require specific treatment / referral?
- Does the woman have accurate information regarding local resources, including safe housing?

These responses should be documented separately to her hospital maternity notes. Discuss with the Safeguarding Team or your manager if you have any concerns.

You can access referral to the Multi Agency Risk Assessment Conference via the Lead Midwife Safeguarding on extension 3351.

Appendix H

Guidelines for Staff Working in Assessment Unit A&E and Day Assessment

Stage 1: **Silent triage assessment**
(Refer to Appendices B, C, D and E)

Stage 1

Negative
|
Abuse not suspected
|
Protocol ends

Stage 1 Positive
|
Abuse Suspected
|
If visitor present, they are asked to
Leave
|
Directly ask the patient
|
Stage 2

Stage 2: **Midwife/Doctor assessment**

- If the patient confirms that abuse has taken place, offer support, advice, and ascertain if She/he wants to report the incident to the police or referral to a specialist DV service

- Document your discussion, including disclosure and your actions and any injuries accurately into hospital held records – never into the patient's handheld records.

- If she denies that abuse has taken place, do not push the patient to admit to abuse if she is not ready to do so, but you can offer a leaflet for her to take if it is safe for her to do so. She will know if it is safe to take a leaflet home. Record your actions.

- If she denies that abuse has taken place and you are satisfied it is not a concern - protocol ends. Consider other family members, especially any children who may be witnessing violence and suffering emotionally or physically as a result. Referral to Children's Social Services is required in such cases.

Appendix I

Guidelines for Managers if Staff make Disclosure of Personal Domestic Abuse

- If a member of staff discloses that she/he is a victim of domestic abuse listen carefully and respond constructively without being judgemental

- Acknowledge fears and offer reassurance

- Give the message that domestic abuse is unacceptable

- Confidentiality is essential to enable a staff member to disclose her experiences. However the manager must be clear and honest that there are limits to confidentiality – for example in relation to child protection. Explain that a discussion with HR may be necessary.

- If there are concerns about child protection contact the Lead for Child Protection for advice.

- Provide encouragement to seek support from friends or family

- Provide a list of current agencies, encourage her to accept a referral

- Discuss any health and safety issues for her in relation to work – this may include her commute, location and current workplace. Does reception need to be informed regarding any visitors or phone calls?

- If there is evidence of, or the woman states that she has been physically abused, advise her of the necessity to seek medical attention from either her GP or an accident and emergency department

- Remember that the member of staff may not wish to take further action at this stage

- A member of staff is able to receive confidential counselling from occupational health

- A record of the interview should be made that is separate from the personnel file

Appendix J

Resources

Service	Contact numbers
DV Directory available on safeguarding intranet page	
Eaves Women's Aid	0800 980 1993
In an emergency always call the Police	**999**
National Domestic Violence Helpline	0808 2000 247 (freephone 24 hours)
Samaritans	08457 909090 (free phone 24 hours)
Victim Support Line	0845 30 30 900
Victim Support Essex	0845 45 65 995
Victim Support	01245 422660
National Centre for DV	0844 8044 999
Free legal advice & injunctions	**www.lcdv.co.uk**
Rights of Women (legal advice	0207 251 6577
Sexual Violence Advice Line	02072518887
Essex Police Child Protection and abuse investigation Team	01245502110
Safer Places Domestic Abuse Outreach Support Service	08450177668
Women's Aid Refuge Chelmsford	01245 493114
Women's Aid Refuge Braintree	01376 321720
National Woman's Aid	0808 2000 247
Women's Aid Chelmsford and Maldon Outreach Service	01245 493056
Women's Aid Braintree /Witham /Halstead Outreach Service	01376 321720
Essex Police Domestic Violence Unit Chelmsford/Maldon	01245 490840
Lead Midwife Vulnerable Women/Designated Midwife Safeguarding MEHT	07887 636751 01245513351

Named Nurse for Safeguarding MEHT	01245 514728 pager # 6400 896
Social Care (referrals)	0845 603 7627 – in hours
Social Services Essex Emergency Duty Team	0845 806 1212 – out of hours 0845 603 7634 - urgent
Relate	0845 909090/01245 258680
DHSS Benefits Agency	01245 214300
RELEASE	0207 729 9904
Families Anonymous	0207 498 4680
Chelmsford Borough Council (housing)	01245 606606
Chelmer Housing	01245 613000
Braintree District Council (housing)	01376 552525
Maldon District Council (housing)	01621 854477
Essex Young Peoples Drug & Alcohol Services (EYPDAS) (aged up to 18 years)	01245 493056
Community Drug & Alcohol Team (Changes)	01245 318580
National Drugs Helpline	0800 77 66 00
Citizens Advice Bureau Chelmsford	01245 257144
Citizens Advice Bureau Braintree/Witham/Halstead	01376 264065
Citizens Advice Bureau Maldon	01621 841195