

**STANDARD OPERATING PROCEDURE FOR
RESPONDING TO DOMESTIC ABUSE**

Version:	1.1
Ratified by:	Leadership Committee
Date Ratified:	10.5.23
Name of Originator/Author:	Julia Mason/Louise Smailes
Name of Responsible Committee/Individual:	Shelagh Meldrum, Leadership Committee
Date issued:	May 2023 amended Feb 2024
Review date:	May 2025
Target audience:	All ICB staff, Primary Care, POD services

**STANDARD OPERATING PROCEDURE FOR RESPONDING
TO DOMESTIC ABUSE**

CONTENTS

		Page
	VERSION CONTROL	i
SECTION 1	IDENTIFYING INDIVIDUALS AT RISK	1
SECTION 2	FRAMEWORK FOR CLINICAL ENQUIRY	4
SECTION 3	DOMESTIC ABUSE STALKING AND HARASSMENT (DASH) RISK ASSESSMENT	8
SECTION 4	RESPONDING / SAFEGUARDING AND INDIVIDUAL AT RISK OF DOMESTIC ABUSE	8
SECTION 5	INDEPENDENT DOMESTIC VIOLENCE ADVISOR (IDVA)	9
SECTION 6	MULTI AGENCY RISK ASSESSMENT CONFERENCE (MARAC)	10
SECTION 7	PERSON CAUSING HARM (PCH)	11
SECTION 8	RECORD KEEPING	16
Appendix 1	SNOMED CODES FOR USE IN PRIMARY CARE	19
Appendix 2	GUIDANCE FOR RECORDING AND STORING OF SAFEGUARDING INFORMATION IN PRIMARY CARE	22

STANDARD OPERATING PROCEDURE FOR RESPONDING TO DOMESTIC ABUSE

1 IDENTIFYING INDIVIDUALS AT RISK

- 1.1 Practitioners need to be aware that [Domestic Abuse Act 2021 - GOV.UK \(www.gov.uk\)](http://www.gov.uk) describes Domestic Abuse as the behaviour towards another person who are “personally contacted”. People are personally connected if the following applies:
- they are, or have been, married to each other
 - they are, or have been, civil partners of each other
 - they have agreed to marry one another (whether or not the agreement has been terminated)
 - they have entered into a civil partnership agreement (whether or not the agreement has been terminated)
 - they are, or have been, in an intimate personal relationship with each other
 - they each have, or there has been a time when they each have had, a parental relationship in relation to the same child
 - they are relatives.
- 1.2 Services should ensure that they can provide a safe and private environment in which people feel able to disclose that they are experiencing domestic abuse. In some healthcare settings (for example, emergency departments, maternity services, mental health, sexual health and drug or alcohol services), it is recommended that routine or selective clinical enquiry be adopted.
- 1.3 NICE guidance recommends other health care settings including primary care should use targeted clinical enquiry, which sets the threshold for asking about domestic abuse low and uses the information from the interaction with the patient to make an assessment. ([Overview | Domestic violence and abuse | Quality standards | NICE](#))
- 1.4 Some physical and mental health issues, such as anxiety, depression, chronic pain, difficulty sleeping, facial or dental injuries, chronic fatigue and pregnancy and miscarriage have a strong link to being a victim/survivor of domestic abuse. Patients who present with such symptoms should always be asked about domestic abuse.
- 1.5 If a patient is a known informal carer for someone with mental health issues targeted clinical enquiry should be used at contacts.
- 1.6 Targeted enquiry needs to be considered in relation to older people the issue can often be hidden making victims hidden. It can be hard for older people to speak out about abuse and services need to be aware that domestic abuse affects people of all ages. Save lives ([Spotlight #1: Older people and domestic abuse](#)) [Safe Lives](#) highlight that older victims are:

- less likely to attempt to leave in the year before accessing help, and more likely to be living with the perpetrator after getting support
- are much more likely to experience abuse from an adult family member or current intimate partner than those 60 and under
- are significantly more likely to have a disability – for a third, this is physical (34%).

Patients Presenting with Indicators of Domestic Violence and Abuse

1.7 In response to prolonged abuse, people may have complex needs and multiple disadvantages. The term multiple disadvantage refers to those people who face multiple and intersecting inequalities including gender based violence and abuse, substance use, mental ill health, homelessness, being involved in the criminal justice system and children having been taken in local authority foster care.

1.8 Example Indicators of Domestic Violence and Abuse:

- Symptoms of depression, anxiety, post-traumatic stress disorder, sleep disorders
- Suicidal tendencies or self-harming
- “Stranger” assault / “Falls”
- Alcohol or other substance misuse
- Unexplained chronic gastrointestinal symptoms
- Unexplained gynaecological symptoms, including pelvic pain and sexual dysfunction
- Adverse reproductive outcomes, including multiple unintended pregnancies or terminations
- Delayed pregnancy care, miscarriage, premature labour and stillbirth
- Genitourinary symptoms, including frequent bladder or kidney infections / Recurrent UTIs
- Vaginal bleeding or sexually transmitted infections
- Chronic unexplained pain
- Traumatic injury, particularly if repeated and with vague or implausible explanations
- High risk injury: mid-arm injuries (defensive), strangulation marks, weapon injuries or marks, injuries to areas not prone to injury by falls, old as well as new injuries, bites and burns (scalding and cigarettes), injuries to multiple sites, symmetrical injuries, poor nutrition
- Common injury: mid face injury, black eyes, dental injuries, breast/abdominal injuries, injuries hidden by clothing, internal injuries.
- Problems with central nervous system – headaches, cognitive problems, hearing loss

- Repeated health consultations with no clear diagnosis
- Intrusive 'other person' in consultations, including partner or spouse, parent, grandparent or an adult child (for elder abuse)
- Injuries inconsistent with explanation of cause, patient tries to hide injuries or minimise their extent
- Frequent missed appointments, early self-discharge.

1.9 It should of course be recognised that a patient displaying one or more of the above symptoms may not be a victim of domestic abuse.

The Role of the Healthcare Professional

1.10 Health Professionals may be the first people that patients confide in about their experience. These individuals are most at risk of increased life threatening abuse when they start to disclose abuse or try to leave an abusive relationship.

1.11 Any conversation and questions should be phrased sensitively and responded to with empathy and understanding. Response to disclosure should be; non-judgemental, non-victim blaming and include an acknowledgement of the cause when talking about symptoms.

1.12 The Health Professional should:

- Be aware that the patient's family member or intimate partner may not allow them to have a consultation alone. Abusers may also attempt to control the situation by dominating consultations and making decisions for the patient.
- Make every effort to speak with the person in private, ensuring that any visitors are asked to leave. A person may have multiple abusers and friends or family members may be colluding in the abuse.
- facilitate disclosure in private without any third parties present. If a patient discloses abuse in front of a friend or family member, the professional should use their professional authority and ask the accompanying person to leave the room, or take the patient for a treatment alone (e.g. urine sample, blood test, x-ray).
- If a patient requires an interpreter, call a language interpretation service. Do not use the patient's family or friends to interpret regarding abuse or the internet such as google translate. Be aware when using an interpreter that the definition of abuse may change according to the language. Be aware of gender when requesting an interpreter, female patients may prefer a female interpreter.
- If the patient is accompanied by an adult or a child above the age of 18months, it is recommended that staff create an opportunity to speak with the patient alone.

- 1.13 DO NOT ask a patient about domestic violence and abuse if:
- The patient is accompanied by another adult
 - The patient is accompanied by children above the age of 18months
- 1.14 Always consider the risk if a child can communicate verbally and inadvertently reveal to the abuser what was discussed.

Understanding The Barriers To Disclosure

- 1.15 Evidence Suggests That Patients Who Are Being Subjected to violence and abuse want to be asked, and that patients who are not, do not mind being asked (Friedman et al; 1992).Potential barriers include:

- Patient's experiencing abuse are often afraid to talk about what is happening to them
 - Do not identify that their experience is classified as domestic abuse, or unaware of the services and support available.
 - They may feel unsure of how to start the conversation, fearful of being judged, ashamed, embarrassed, or not feel worthy of help and support.
 - They are also likely to feel that they are betraying their partner; afraid of what will happen next, worried about how they will cope, and what they may have to do to leave the relationship.
 - language and communication difficulties
 - insecure immigration status or previous experiences of discrimination based on race, gender, religion, sex, marital status, pregnancy status, sexuality, disability and age.
 - Intersectionality; namely how aspects of one's social identities might combine to create unique modes of discrimination and thus prevent further barriers to disclosure must also be considered.
- 1.16 They may have previously encountered a negative experience of disclosure. It is important to remember that the health professional's response is key to the survivor accessing help and support.

2 FRAMEWORK FOR TARGETED CLINICAL ENQUIRY

1. Ask (Disclosure)
2. Validate
3. Assess
4. Action

How to Ask about Domestic Violence and Abuse

- 2.1 Use a generic line of enquiry to open up the conversation before advancing to a more directed question, for example:

- How are things at home?
- Are you getting the support that you need at home?
- Do you have concerns about your partner/family?

2.2 Direct questioning has been found to lead to disclosure of domestic violence and abuse. Proactive enquiry informs the patient that professionals are listening, available and confident in their response to violence and abuse at home. Many victims explain their previous non-disclosure due to the fact that they were never directly asked.

2.3 Framing and directing is the recommended style of questioning, for example:

- “Given the widespread nature of violence and abuse, we routinely screen for risks at home”, “Is there anyone at home that has threatened to hurt you or someone that you care about?”
- “Violence and abuse at home is common”, is there anyone that makes you feel unsafe or that you are frightened of?
- “Women exposed to abuse at home are particularly vulnerable to pre and post-natal stress”, “Is there anyone at home that makes you feel unsafe? Anyone who’s behaviour concerns you”?
- “Not everyone recognises that they are in an abusive relationship”, Does anyone consistency put you down / belittle you? Threaten or intimidate you?
- “I am concerned about your symptoms, is there someone at home hurting you?”
- “How are you coping at home”? Is there anything that you are worried about? Is there anyone that makes you feel unsafe?
- What happens when you and your partner / ex-partner / family member argue? What sort of things do you argue about?
- Who makes the rules in your household? What happens if you don’t obey?
- Do you ever change your behaviour because you are worried about how someone at home might react?

Explain the parameters of confidentiality

2.4 It is essential to ensure transparency around information sharing parameters. Advise patients of your duty to safeguard individuals and the parameters of confidentiality. For example, ‘Everything you tell me is confidential; I do not routinely share information without your consent. However, if I do feel that there is a risk of harm to yourself or someone else, I may have to share that information with other professionals’.

2.5 Remember that a survivor may be fearful about the implications of information sharing. For example, they may have had previous negative experiences with services, or the person causing harm may be using the threat of the involvement of services to control them. Staff must emphasise that actions offered, and information sharing is a supportive measure to reduce harm. They must offer support around the outcome of information sharing.

Validation: Response and Assessment

- Listen
- I believe you
- You have the right to live free from violence and abuse
- Abuse is not your fault
- You are not alone
- We can help you to access support

2.6 Reassure the person that their disclosure is confidential and will not be shared with the abuser, that the abuse is not their fault and that they can access help and support. This may be the first time the patient is talking about their experience of domestic violence and abuse, how health professionals respond is key to the survivor accessing appropriate services and support.

Assessment

2.7 Determine if there is an immediate risk to the victim/child? Who they are at risk from, if there is a risk of multiple person causing harm and who else may potentially be at risk? (Consider risk to children, unborn baby and vulnerable adult). Check:

- A. Is the person causing harm with them?
- B. Where are the children?
- C. Is it safe for them to return home today?
- D. Do they have immediate concerns
- E. Do they have a place of safety?

2.8 Consider the actuarial risk, the indicators highlighted in the disclosure that may denote the probability of serious harm or homicide. If there is a risk of immediate harm the healthcare professionals should speak with their clinical or safeguarding lead prior to initiating immediate safety action in accordance with the organisational policy and departmental procedure.

2.9 Safety plans should be secured before assessing for ongoing risk, for example requesting security, the police or a duty social worker. Further questions which may prompt disclosure and inform healthcare professionals about the severity and frequency of abuse may be utilised.

- When was the last escalated incident, what happened?
- Is this the first injury that the patient has sustained? How does it compare to previous injuries?
- Does the abuser intimidate or threaten the patient?
- Would the patient describe their abuser as controlling or psychologically abusive?

- Is the abusers behaviours getting worse, are the incidents of conflict happening more frequently?
- Identify the location of the alleged abuser, and if the patient is frightened of them?
- What is it that the patient is frightened of?

Awareness of Key Risk Factors: SPECSSS

2.10 SPECSSS references six high risk indicators that have been identified from Domestic Homicide Reviews:

- Separation
- Pregnancy
- Escalation
- Community / Additional Factors
- Stalking
- Sexual Abuse
- Strangulation / Threats to Kill

2.11 SPECSSS is designed to strengthen professional judgement and understanding of the risks associated with domestic violence and abuse, whilst also acting as an alert to prompt referrals to the organisations Safeguarding Service / lead. If any one of the indicators are present within the initial assessment/disclosure immediate action must be considered.

In the event of Non-Disclosure

2.12 If indicators of domestic abuse have been identified, and opportunities to create a safe environment have been exhausted but not achieved staff must safely document their concerns and make plans to ensure that domestic abuse enquiry is safely followed up as a matter of urgency. For example:

- Sharing concerns internally with staff supporting the patient if they remain within the organisation and creating a plan for how enquiry may be facilitated.
- Making a follow up appointment with the patient as a matter of urgency and consider arranging this appointment at a time/location where a safeguarding practitioner or domestic violence specialist will be available.

2.13 Further information on clinical enquiry can be found via this link:
[Pathfinder GP practice briefing.pdf \(safelives.org.uk\)](#)

3 DOMESTIC ABUSE STALKING AND HARRASSMENT RISK ASSESSMENT (DASH)

3.1 If domestic abuse is identified a Domestic Abuse Stalking and Harassment Risk Identification Checklist (DASH) should be completed. The identification of high risk domestic abuse is everyone's business. The completion of a domestic abuse risk assessment (DASH) helps identify and assess the severity of the presenting risk, identify high risk cases of domestic abuse, stalking and 'honour'-based violence. This starts the process towards a MARAC where the aim is to ensure effective support to the right people without delay.

3.2 The DASH risk assessment helps to:

- Inform professionals of which cases should be referred to MARAC and what other support might be required.
- Offer a common tool to agencies that are part of the MARAC process and provide a shared understanding of risk in relation to domestic abuse, stalking and 'honour'-based violence.
- Enable agencies to make defensible decisions based on the evidence from extensive research of cases, including domestic homicides and 'near misses', which underpins most recognised models of risk assessment.

3.3 In the event of the DASH not being completed, professional judgement must inform all risk assessments, SPECSSS, with the patient's own perception of risk remaining central to the assessment. The DASH can be found on the Somerset Survivors website [www.sometsurvivors.org.uk](http://www.somerset survivors.org.uk) [How to make a referral \(sometsurvivors.org.uk\)](#)

4 RESPONDING / SAFEGUARDING AN INDIVIDUAL AT RISK OF DOMESTIC ABUSE

4.1 It is important that people who disclose that they are experiencing domestic violence or abuse can access appropriate support. This should include support for any children in their family who are affected. Specialist support services can help to address the emotional, psychological, physical and sexual harms arising from domestic violence and abuse.

4.2 Somerset Integrated Domestic Abuse Service is Somerset's main specialist service to provide support to men, women and children who are affected by domestic abuse. They offer a variety of services including support to adult victims/survivors in the community, emergency accommodation (e.g. refuge or safe-house), children affected by domestic abuse, and support to those who cause harm and want to change their behaviour. If you require more information, please telephone the Somerset Domestic Abuse Helpline on 0800 69 49 999. Opening Hours - 8am to 8pm Monday to Friday and 9am to 1pm Saturday / Sunday. To make a victim referral to the Somerset Integrated Domestic Abuse Service <http://www.sometsurvivors.org.uk/how-to-make-a-referral> www.sometsurvivors.org.uk email: SIDAS@somerset.gov.uk.

Assessment / Action – Further Guidance

- 4.3 People are at greater risk of domestic homicide at the point of separation or after leaving a violent partner. Be aware that the patient is more likely to feel in a heightened state of risk post disclosure, breaching the established power and control mechanisms will likely aggravate their abuser and conflict may escalate.
- 4.4 The person is likely to feel exposed and concerned about what is going to happen. Be clear about what support can be offered and what actions you have agreed. Do not suggest that the patient leave the relationship. Staff should not offer their personal views or make comments that could be perceived as judgemental. Domestic abuse is complex in nature. There are many barriers to disclosure and many reasons why a person experiencing abuse may feel isolated and powerless to leave.
- 4.5 The patient's rights should be respected. The patient may not yet be ready to engage with support but will feel reassured by your support which may indeed prompt them to engage at a later date. If you feel there may be a risk of serious harm or threat to life you should contact your line manager to explore the risk and agree appropriate actions. Disclosures and concerns should be recorded and documented in a factual/neutral manner.
- 4.6 Do not override the patient's decision of not contacting the police unless there is a threat to their life or to their children. Calling the police against the patients wish can increase the risk and severity of the abuse. In most instances the patient is the best gauge of their risk.

Where a patient is assessed to be at High Risk

- 4.7 Gain consent to share information and process appropriate referrals. You may still share information without consent, if in your professional judgement, that lack of consent can be overridden in the public interest.
- 4.8 Where a patient is assessed to be at high-risk of serious harm or homicide or there is a risk to a child, unborn or vulnerable adult, action will need to be taken regardless of whether the survivor consents. However when safe to do so, the patient must always be made aware of the action being taken.
- 4.9 There may be instances where informing the survivor of action being taken may increase their risk of harm, including, but not exclusively, a risk that the person causing harm will be made aware of action being taken. If this is the case, the patient must not be informed until safe to do so.

5 INDEPENDENT DOMESTIC VIOLENCE ADVISOR (IDVA)

- 5.1 An IDVA is an accredited Domestic Violence Advisor whose main purpose is to address the safety and wellbeing of victims at high risk of harm from intimate partners, ex-partners or family members.

- 5.2 Only 1 in 5 survivors of abuse are ready to report their concerns to the police, therefore it is important that you take the opportunity to encourage engagement with domestic abuse professionals (e.g. Independent Domestic Violence Advisors) who work independently from the police and can offer specialist advice and support.

6 MULTI AGENCY RISK ASSESSMENT CONFERENCE (MARAC)

- 6.1 MARAC is a partnership approach with a core objective to share information about domestic abuse victims, person causing harm and families. This involves a number of agencies including Children's Social Care, Adult Social Care, Police, Housing, Education, Specialist Domestic Abuse Services and Health.
- 6.2 The MARAC is designed to enhance existing agency arrangements rather than replace them, the Somerset MARAC protocol identifies how the MARAC will link with other processes to safeguard children and adults and manage the behaviour of the person causing harm. Further information can be found within the Somerset MARAC operating protocol [Somerset-MARAC-Protocol-2020-Oct-v2.docx \(live.com\)](#)
- 6.3 Each agency signed up to MARAC has a MARAC representative who attends meetings and is responsible for the actions of their agency. MARAC runs alongside other multi-agency assessment processes and so must link appropriately to avoid duplication (i.e. MASH, Channel).
- 6.4 Recommended referral criteria to a MARAC:

Professional judgement: if a professional has serious concerns about a victim's situation, they should refer the case to MARAC. There will be occasions where the particular context of a case gives rise to serious concerns even if the victim has been unable to disclose the information that might highlight their risk more clearly. This could reflect extreme levels of fear, cultural barriers to disclosure, immigration issues or language barriers particularly in cases of 'honour'-based violence. This judgement would be based on the professional's experience and/or the victim's perception of their risk even if they do not meet the threshold criteria.

'Visible High Risk': the number of 'ticks' on the DASH. If you have ticked 14 or more 'yes' boxes the case would normally meet the MARAC referral criteria.

Potential Escalation: the number of police callouts to the victim as a result of domestic violence in the past 12 months. This criterion can be used to identify cases where there is not a positive identification of a majority of the risk factors on the list, but where abuse appears to be escalating and where it is appropriate to assess the situation more fully by sharing information at MARAC. It is common practice to start with 3 or more police callouts in a 12 month period but this will need to be reviewed depending on local volume and level of police reporting.

6.5 If the completed DASH risk assessment indicates that a child / adult / family is at 'Visible High Risk' - 14 or more 'yes' boxes or the case meets the criteria on the grounds of professional judgement or escalation then a referral to Somerset MARAC <http://www.somersetsurvivors.org.uk/how-to-make> a-referral / should be actioned.

6.6 The DASH must be sent with a Somerset Integrated Domestic Abuse Service (SIDAS) intake form to the Somerset Domestic Abuse Service, for further guidance refer to the 'how to make a referral' page on <http://www.somersetsurvivors.org.uk/how-to-make-a-referral/>

6.7 Once the referral and DASH is received the Somerset Domestic Abuse Service will assess risk and if appropriate a dedicated Independent Domestic Violence Advisor (IDVA) will establish contact with the person and represent them at a MARAC.

Does the victim have to consent to share their information?

6.8 It is always advised to gain consent from the person as safety planning will be more effective if s/he agrees to work with the Independent Domestic Violence Advisor (IDVA). However, when considering the safety of patients who are at high risk of harm, gaining consent is not always necessary. Professionals are advised to seek guidance from their safeguarding lead.

What If The Case Does Not Reach The Criteria For MARAC?

6.9 If a patient does not meet the criteria for MARAC they can still be referred to Somerset Integrated Domestic Abuse Service as support/ advice and guidance can still be provided.

What Happens After The MARAC?

6.10 The IDVA will inform the victim about the agreed safety measures and support offered by the MARAC partners.

What Happens If The Abuse Continues?

6.11 If a victim whose case has already been considered at a MARAC later reports an incident to any agency, that agency must refer the case back to the MARAC as a repeat case. This allows the MARAC to re-design the safety plan, taking the new information into account.

7 PERSON CAUSING HARM (PCH)

Who are patients

7.1 The primary aim of identifying a responding to patients who disclose that they are perpetrating abuse is to ensure the safety and wellbeing of the victim/survivor and their children.

7.2 Some person causing harm may identify their abusive behaviour directly and ask for help to deal with their violence. This is likely to have been prompted by a crisis such as a particularly bad assault, an arrest or ultimatum from the survivor. Such patients – even though they have come voluntarily –are unlikely to admit responsibility for the seriousness or extent of the abuse and may try to “explain” the abuse or blame other people or factors. Even those who are concerned enough about the abuse to approach an agency may present with other related

problems such as alcohol, stress or depression, and may not refer directly to the abuse.

- 7.3 Engaging with person causing harm about their abusive behaviour in order to refer them to specialist services should not take place as part of any form of 'couples' or 'joint family' work. The model is about aiding the person causing harm to address abusive behaviours and should be carried out independently from the victim/survivor.

As partners of patients

- 7.4 People who insist on accompanying their partners to appointments or who want to talk for their partners may appear to be caring and protective of their partners and very plausible. Direct engagement with an abusive person who is not the health professionals' patient may be difficult. However, being aware of the indicators of domestic abuse is important for any dealings with the person causing harm.

Abusing men as fathers of children who are patients

- 7.5 There are clear links between domestic abuse and child abuse. Health professionals may know children affected by domestic abuse and may come across the person causing harm/abusive father. Flags for possible concern include:

- I've got a problem with drink
- I need anger management
- I'm not handling stress at work
- My partner says I need to see you
- My partner and I are fighting a lot
- My partner and I need counselling
- My partner is not coping and taking it out on me
- The kids are out of control and she's not firm enough
- I'm depressed/anxious/stressed/not sleeping/not coping/not myself
- I feel suicidal (or have threatened or attempted suicide)
- I'm worried about my rage at work, in the car, in the street, at the football.

- 7.6 Additional behaviours/indicators to be aware of:

- Attempts to accompany or speak for partners
- Sexual jealousy or possessiveness
- Recent mental ill-health relating to violence
- Substance use/dependence
- Excessive telephoning or texting
- Checking on the person's whereabouts

7.7 Although rare, an abuser might present with a physical injury such as a hand injury caused by punching, or you might notice injuries caused by the victim defending themselves such as scratch marks.

Guidance on how to speak to suspected person causing harm

7.8 A health professional's response to any disclosure, however indirect, could be significant for encouraging responsibility and motivating a person causing harm towards change.

7.9 If a person causing harm presents with a problem such as drinking, stress or depression, for example, but does not refer to their abusive behaviour, these are useful questions to ask:

- "How is this drinking/stress at work/depression affecting how you are with your family?"
- "When you feel like that what do you do?"
- "When you feel like that, how do you behave?"
- "Do you find yourself shouting/smashing things.....?"
- "Do you ever feel violent towards a particular person?"
- "It sounds like you want to make some changes for your benefit and for your partner/children. What choices do you have? What can you do about it? What help would you like to assist you to make these changes?"

7.10 If the person causing harm has stated that domestic abuse is an issue, these are useful questions to ask:

- "It sounds like your behaviour can be frightening; does your partner say she is frightened of you?"
- "How are the children affected?"
- "Have the police ever been called to the house because of your behaviour?"
- "Are you aware of any patterns – is the abuse getting worse or more frequent?"
- "How do you think alcohol or drugs affect your behaviour?"
- "What worries you most about your behaviour?"

7.11 If a person causing harm responds openly to these prompting questions, more direct questions relating to heightened risk factors may be appropriate:

- "Do you feel unhappy about your partner seeing friends or family - do you ever try to stop her?"
- "Have you assaulted your partner in front of the children?"
- "Did/has your behaviour changed towards your partner during pregnancy?"

7.12 The information gathered will be the basis for a decision about how best to engage and what kind of specialist help is required - either for the person causing harm or to manage risk.

Good practice in dealing with person causing harm

7.13 RESPECT Guidelines:

- Be clear that abuse is always unacceptable
- Be clear that abusive behaviour is a choice
- Affirm any accountability shown by the abuser
- Be respectful and empathic but do not collude
- Be positive, abusers can change
- Do not allow your feelings about the abusers behaviour to interfere with your provision of a supportive service
- Be straight-forward; avoid jargon
- Be clear that you might have to speak to other agencies and that there is no entitlement to confidentiality if children are at physical or emotional risk.
- Whatever the person says, be aware that, on some level they are unhappy about their behaviour.
- Be aware, and tell the person, that children are always affected by living with domestic abuse, whether or not they witness it directly.
- Be aware, and convey to the person, that domestic abuse is about a range of behaviours, not just physical violence (see definition)
- Do not back them into a corner or expect an early full and honest disclosure about the extent of the abuse;
- Be aware of the barriers to them acknowledging their abuse and seeking help (such as shame, fear of child protection process, self-justifying anger).
- Be aware of the likely costs to the person themselves of continued abuse and assist them to see this
- If you are in contact with both partners, always see them separately if you are discussing abuse.

Risk assessment

7.14 Although risk assessment is primarily informed by the survivor's experience and insights there may be other factors identified through contact with or knowledge of the person causing harm.

7.15 Research shows that these are significant indicators of heightened risk. Risk awareness should be a continuous process and risk assessments should be regularly reviewed.

7.16 Checklist: Risk Assessment

- Recent or imminent separation
- Past assault of family members
- Past assault of strangers or acquaintances
- Past breach or ignoring of injunctions, court orders or conditions
- Victim and/or witness of “family” violence as child or adolescent
- Substance misuse
- Recent mental ill-health relating to violence
- Past physical assault of partner
- Partner pregnant or recently given birth
- Sexual assault or sexual jealousy
- Past use of weapons or threats of death
- Recent escalation in frequency or severity of assaults
- Extreme minimisation or denial of domestic violence history
- Attitudes that support or condone domestic abuse

7.17 Research shows that these are significant indicators of heightened risk. These considerations should inform any decision making around undertaking multi-agency consultation or risk management measures, together with agencies such as children and families social work, police or other agencies.

Safety for the professional

7.18 Don't work on your own – utilise your agencies policies and procedures and maintain links with other colleagues / agencies to share relevant information for the purpose of assessing and managing risk.

7.19 Ensure that you have sufficient training for this work and seek specialist advice.

Referral for patients who disclose that they are Perpetrating abuse

7.20 It is important that Health professionals are aware of where to refer identified person causing harm: A referral should never be made to anger management courses. (This is a common misperception and needs to be highlighted in any policy document as it is dangerous practice).

7.21 The primary role of specialist services for person causing harm is to confront and tackle the violence. When men are convicted of domestic violence offences they may be referred to a Probation Service male person causing harm programme, depending on the severity of the offence and their suitability for this kind of intervention.

Respect National Helpline

- 7.22 The national Respect phone line is a confidential helpline, email and webchat service for person causing harm of domestic violence looking for help to stop. The service helps male and female person causing harm, in heterosexual or same-sex relationships. Partners or ex-partners of person causing harm, as well as concerned friends and family members and frontline workers are also welcome to make contact for information, advice and support.

Resources

- 7.23 www.respect.uk.net Phone Line: 0808 802 4040 (Monday-Friday 9am-5pm. Free from landlines and mobile phones, the call will not appear on your phone bill statement). Webchat available Tuesdays and Thursdays 10am – 4pm

Local provision

- 7.24 Somerset Integrated Domestic Abuse Service offers support to men and women who want to change their abusive behaviour in intimate relationships and victims who wish to break the cycle of abuse.
- 7.25 If you would like more information, please telephone the Somerset Domestic Abuse Helpline on 0800 69 49 999.
- 7.26 There are a range of useful resources and training videos on the Safe and Together website www.safeandtogetherinstitute.com

[Briefing-on-the-nature-and-impact-of-domestic-abuse-perpetrators.pdf \(somersetsurvivors.org.uk\)](http://www.somersetsurvivors.org.uk/Briefing-on-the-nature-and-impact-of-domestic-abuse-perpetrators.pdf)

8 RECORD KEEPING

- 8.1 The Department of Health states that ‘documentation and record keeping have an important role in responding to domestic violence’. Each service should consider the need for recording information and the value of monitoring data in order to reinforce good practice.
- 8.2 Staff should clearly explain to the victim the importance of documenting their experience. Records of injuries may prove vital at a later date if they choose to prosecute the abuser. Additionally clear and concise documentation of their abuse is a helpful way of validating their experiences and demonstrates that professionals have taken seriously their account of events.
- 8.3 However, in order to maintain confidentiality, extreme caution should be taken when documenting domestic abuse. Safety planning should be clearly documented in the clinical notes to enable staff to follow up at a later date. Staff must ensure that medical records are well documented for the purpose of monitoring the clients/patient’s care and incidences of abuse/suspected abuse.
- 8.4 Accurate documentation, over time at successive consultations, may provide cumulative evidence of abuse, and is essential for use as evidence in court, should the need arise.

8.5 Record clearly:

- Date and time of incidents, if known
- If patient states that abuse is the cause of injury, preface patient's explanation by writing: "Patient states". Use patient's own words when possible. Avoid subjective data that might be used against the patient (for example, "It was my fault he hit me because I didn't have the kids in bed on time".)
- Describe the patient's psychological state, without interpretation/judgement
- Briefly describe types or nature of abuse
- Note facts (including observations). If patient denies being assaulted, write: "The patient's explanation of the injuries is inconsistent with physical findings" and/or "The injuries are suggestive of battering."
- Record size, pattern, age, description and location of all injuries. A record of "Multiple contusions and lacerations" will not convey a clear picture to a judge or jury, but "Contusions and lacerations of the throat" will back up allegations of attempted strangling. If possible, make a body map of injuries. Include signs of sexual abuse.
- Record non-bodily evidence of abuse, such as damaged, torn or stained clothing.
- Document behaviour of partner, including spontaneous disclosures that may indicate abuse, do not interview partner.
- Record your action (e.g. information provided, referral to DV service).
- Sign and date your record. Print your name and role.
- Include a detailed physical record: Include sketches of injury sites on a body map or photographs if possible. Photographs can convey the severity of injuries and, whenever possible, photographs should be taken of all patients with visible injuries. If this is not possible at general practice then patients can be advised to have photographs taken elsewhere.
- Explain to the patient that photographs will become part of the patient's medical record and, as such, can only be released with the patient's permission.
- Obtain written consent from patient to take photographs. (Written informed consent should include the statement, "These photographs will only be released if and when the undersigned gives written permission to release the medical records.").
- The photographer should sign and date the back of each photograph.
- Place photographs in a sealed envelope and attach securely to the patient's record. Mark the envelope with the date and the notation "Photographs of patient's injuries" monitoring the client/patient's care and incidences of abuse / suspected abuse
- Disclosure or suspicion of domestic abuse should never be recorded in client or patient held records and staff should be vigilant in ensuring that records are not left unattended as this could place the abused person in serious danger.

Record keeping of person causing harm disclosure

- 8.6 It is paramount to keep detailed records if a person causing harm discloses abusive behaviour. This is important information which will enable continuity of care. Good records may also help in any future legal proceedings which the survivor or the police/Crown Prosecution Service may take.

- 8.7 Record keeping by health professionals around person causing harm has been highlighted as critical in the context of domestic homicide reviews. Often health professionals will be the only agency in contact with both survivor and person causing harm and will hold critical information.

- 8.8 It is crucial that the health professional is clear about recording the information. If an individual may be at risk of significant harm, this will override any requirement to keep information confidential.

APPENDIX 1: GUIDANCE FOR RECORDING AND STORING OF SAFEGUARDING INFORMATION IN PRIMARY CARE

Legal duty: All providers and local authorities have a (legal) duty under the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 to ensure that any personal data they process is handled and stored securely. Further information on data security is available from the [Information Commissioner's Office](#).

Where personal data is not properly safeguarded, it could compromise the safety of individuals and damage your reputation. Concerns and information about vulnerable children must be recorded in the child's records, and where appropriate the notes of siblings / other children in the same household, and parents / carers / significant adults.

The GMC guidance '[Protecting children and young people: The responsibilities of all doctors](#)' advises doctors 'to record minor concerns, as well as their decisions and the information given to parents/carers'. This guidance came into effect in 2012. It was updated in 2018 to reflect the requirements of the GDPR and Data Protection Act 2018.

Further information and eLearning training is provided by the RCGP that covers online access to GP records and coercion, identifying it in primary care, proxy access and coercion (produced April 2022) [Coercion v5.0.pdf \(rcgp.org.uk\)](#).

Safeguarding information: Safeguarding concerns and information from other agencies such as social care; education; the police, or other health colleagues, including Public Health Nurses and Midwives, should be recorded in the notes under the most appropriate SNOMED codes outlined in Appendix 2.

All contacts with any parties regarding any safeguarding children issues/concerns should be recorded on the patient's medical records and any necessary action taken immediately. This includes:

- Contact with staff from partner agencies as part of Child Protection / Section 47 investigations
- Attendance at multi-agency meetings i.e. Strategy meetings, Child Protection Conferences (CPC), Child In Need (CIN) meetings, Core Groups and Team Around the Family (TAF) meetings.
- Discussions held with staff from partner agencies at the Practice's Safeguarding / Child Protection meetings, where discussion of all children subject to child in need or child protection plans, or any other children/families where there are concerns are discussed. The record for each family member must highlight any agreed actions to be taken as a result of the discussion.

Safeguarding information received by the practice should be reviewed by the relevant GP and must be scanned and stored within the records of all people named within the documents. This can include but is not limited to the following:

- Child Protection Conference invites and minutes.
- MARAC referrals and information (on ALL named persons records)
- Police Domestic Abuse Incident Notifications (on ALL named persons records)
- Child Looked After health reviews
- Team Around the Family (TAF) invites and minutes
- A&E / MIU / Out of Hours reports
- Maternity Safeguarding Communication Form

These records are as important as those for serious physical illness and should be recorded in the same way, with the same degree of permanence and never kept separately from the main record. Consideration must always be given as to how Safeguarding information is stored within a patient's electronic record, and it may need to be saved in such a way that it cannot be seen online by the patient, particularly if to do so would increase the risks to the child(ren) and other adults in the household. Safeguarding information within a patient's electronic record may also need to be redacted if patients ask for a copy of their file.

SNOMED codes to be used on EMIS in relation to recording and storing of safeguarding information:

Records Management		
1077911000000105	Safeguarding (record artifact)	Use this code when receiving all safeguarding records related to a child: <ul style="list-style-type: none"> • Strategy meetings • Minutes from multi agency meeting regarding a child e.g. Child Protection Conference / CIN / CLA Review / core group • MARAC referrals • Police Domestic Abuse Incident Notifications (DAIT / Merlin / Form 72) (on all named persons records) • Child Looked After Health Assessment / Form C • Maternity Communication Form

Online visibility of Safeguarding information: In both SystmOne and EMIS, entries can be 'hidden' from online view both whilst writing your entry (before saving) and retrospectively after saving an entry. Entries become visible as soon as they are saved, if not hidden. If you think that an entry needs to be 'hidden', it is better to do this whilst creating the entry to prevent temporary visibility of the entry between saving it and retrospectively 'hiding' it. Please note: Hiding information from online visibility WILL NOT redact records when printed.

Safely managing and recording patient information is most relevant when considering how to store Domestic Abuse information on an individual's record, including the perpetrator. The challenges of managing and recording domestic abuse (DA) information in the electronic medical record (EMR) of people experiencing or perpetrating abuse and how to do this without increasing risk of harm to victims (adult and child) is addressed in the RCGP Guidance on recording domestic abuse in the EMR 2021.

Principles relevant to all recording of domestic abuse information include the following:

- ALL information in the EMR (Electronic Medical Record) about domestic abuse MUST be hidden from patient online access.
- Family records should be linked in practices where possible.
- The name of anyone accompanying a patient in a consultation should be documented
- The name of any alleged perpetrator/s should be included when documenting disclosure of Domestic Abuse (DA).
- Ensure that any reference to DA on a victim's records is not accidentally visible to the perpetrator during appointments. The computer screen showing the medical record should never be seen by third parties (i.e. family or friends accompanying a patient). When providing a summary printout for a hospital admission for example, care should be taken that information about DA is not inappropriately included when printing out these summaries to give to patients, as the perpetrator may see this.
- Never disclose any allegation to the perpetrator or other family members.
- Ensure that any decision to record the information in the perpetrator's EMR is made with due regard to the associated risks.
- Ensure that any reference to DA in a perpetrator's record is redacted if provided to the perpetrator unless you are certain it is information that the perpetrator already knows. For example, the perpetrator has disclosed this information themselves to you, or there is a relevant conviction which the perpetrator has disclosed or is aware has been disclosed to you such as in Child Protection Conference minutes, when the perpetrator has been present at the conference and is aware this information is being shared.
- Be aware of the potential danger of the perpetrator having access to information about their abuse and to information in children's EMRs; this includes via online access to their own information and their children's information, as well as coercive access to the victim's EMR.

APPENDIX 2: SNOMED CODES FOR USE IN PRIMARY CARE

When to use the code	Snomed Name of code	Snomed number
Child Safeguarding		
Referral to Child Safeguarding Team	Referral to Child Safeguarding Team	514341000000108
Child has been discussed at a Strategy	Discussion meeting Child Protection Strategy Meeting	762931000000105
Child is on a Child Protection Plan (CPP)	Subject to Child Protection Plan	342191000000101
Unborn Child Subject to Child Protection Plan	Unborn Child Subject to Child Protection Plan	818901000000100
A family member of the patient is on a Child Protection Plan	Family member subject of child protection plan	375041000000100
Child is on a Child in Need Plan (ChIN)	Subject of Child in Need Plan	836931000000102
Child Protection Report Submitted	Child Protection Conference Report Submitted	1036511000000100
Child Protection Conference Minutes received	Child Protection Conference Minutes received	1659091000000102
Child was not brought to appointment	Child was not brought to appointment	901441000000108
History of Adverse Childhood Experiences	History of Childhood Adverse Experiences	747531000000108
Abusive head trauma	Traumatic injury to head and/or neck due to physical abuse	1659241000000103
Information about infant crying and how to manage this has been given to patient	Provision of information about infant crying	150091000000106
Adult Safeguarding		
Referral to Safeguarding Adults Team	Referral to Safeguarding Adults Team	514331000000104
Adult is subject to Section 42 enquiry	Subject to safeguarding enquiry under section 42 of Care Act 2014	1659071000000101
Subject to Adult Safeguarding Plan	Subject to Adult Safeguarding Plan	1659081000000104
Adult was not brought to appointment	Adult was not brought to appointment	1323481000000100
Referral to social services for care needs assessment	Referral made to adult social services for care needs assessment	150141000000100

Domestic Abuse		
History of Domestic Abuse	History of Domestic Abuse	429746005
Family has been discussed at MARAC	Subject of Multi-Agency Risk Assessment Conference	758941000000108
DASH risk assessment completed	Assessment using DASH (Domestic Abuse, Stalking and Harassment and Honour Based Violence) 2009 Risk Checklist	886191000000108
Referral to Domestic Abuse Agency	Referral to Domestic Abuse Agency	758599003
Referral to Multi-Agency Domestic Abuse Conference (MARAC)	Referral to Multi-Agency risk assessment conference	978091000000105
Children Looked After		
Child is a Looked After Child	Looked After Child	764841000000100
Care Leaver	Care leaver	770347003
Adult has become an "Approved Foster Parent"	Approved Foster Parent	314381008
Codes which apply to both adults and children		
Subject of Multi-Agency Public Protection Arrangements	Subject of Multi-Agency Public Protection Arrangements	495021000000105
Notification received that subject of record is missing	Notification received that subject of record is missing	1659211000000104
Referral to Prevent	Referral to Prevent Programme	1659101000000105
Information requested by council for safeguarding purposes	Safeguarding-relevant information requested by council	1659221000000105
Information Shared with council for safeguarding purposes	Provision of safeguarding-relevant information to council	1659231000000107
Patient declined online record access	Online access to own health record declined by patient	1290331000000103
Patient online access granted	Online access to own health record granted following enhanced health record review	1290311000000106

Patient online access withheld	Online access to own health record withheld following enhanced health record review	1290301000000109
Capacity Decisions		
Has the mental capacity to make this decision	Has the mental capacity to make decision (Mental Capacity Act 2005)	1136641000000105
Lacks the mental capacity to make this decision	Lack of Mental Capacity to make decision (Mental Capacity Act 2005)	787381000000106
Power of Attorney in place for this patient for personal welfare	Has appointed person with personal welfare lasting power of attorney (Mental Capacity Act 2005)	816361000000101
Best Interests Decision made for patient	Best Interest Decision made on behalf of patient (Mental Capacity Act 2005)	765141000000105