Worcestershire Acute Hospitals NHS Trust

Domestic abuse guidelines

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Key Amendments

Date	Amendments	Approved by

Introduction
Domestic violence is defined as: 'any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality' (Home Office 2005)

It is suggested that abuse in pregnancy may be more common than placenta praevia, pregnancy induced hypertension or gestational diabetes. Therefore suggesting that women are at greater risk of domestic abuse and its ill-effects than other conditions that they are regularly screened for, making domestic abuse a major concern of midwives.

In Britain over the last decade, there has been a significant societal shift in the public perception of domestic abuse. Domestic abuse is now the subject of increasing public concern and condemnation and there is a much greater understanding of the nature of abuse and its serious long-lasting consequences. Research suggests at least one in four women will experience domestic abuse at some time in their lives irrespective of their age, ethnicity or social class. These figures are likely to be under-estimated as many women will not willingly disclose abuse.

One third of women who experience domestic violence are hit for the first time whilst pregnant (Duxbury 2014). Woman are known to be at higher risk of domestic abuse leading to homicide whilst pregnant or postpartum (World Health Organisation 2011). It is recognised that women who are experiencing domestic abuse already may be at a higher risk of abuse during pregnancy and of adverse pregnancy outcome, because they may be prevented from attending antenatal appointments, may be concerned that disclosure of their abuse may worsen their situation and anxious about the reaction of health professionals. (NICE 2010).
Female genital mutilation is also recognised internationally as a violation of the human rights of girls and women (World Health Organisation 2014. It is thus considered in the context of domestic abuse. It is known to be associated with increased obstetric complications including postpartum haemorrhage, perineal trauma and perinatal death (Creighton 2014)

An incident of domestic abuse occurs in the United Kingdom every six to twenty seconds and on average two women are murdered a week due to domestic abuse. Four in five women who are murdered are killed by a current or ex-partner and approximately thirty per cent of domestic abuse starts during pregnancy. There is increasing evidence suggesting that the abuse of women may begin, or increase in severity, during pregnancy.

Pregnant women in abusive situations are at an increased risk of drug and alcohol abuse, smoking, self-harm and depression. There are documented cases of fetal injury and death in-utero and so during pregnancy, domestic abuse may be seen as a contributory factor to maternal and fetal morbidity and mortality.
Domestic Abuse is a matter of public health and social concern and as such falls well within the remit of the British midwife. Pregnancy is the only time in a healthy woman's life that she has regular, scheduled

contact with health care providers, therefore providing an opportunity for identification and intervention of abuse.

The Royal College of Midwives has recommended that midwives should assume a greater role in its detection and management (RCM, 1999). . The MBRRACE-UK report (2015) recommends that

- Health Care Professionals need to be alert to the symptoms and signs of domestic abuse and women should be given the opportunity to disclose domestic abuse in an environment that they feel secure.
- Provide women with an interpreter which should not be a member of the womans family, her partner or her legal guardian.
- Ensure staff regularly ask service users whether they have experienced domestic violence and abuse.
- All staff should be aware of the pathway of care once domestic abuse is disclosed and escalate following appendix 1.

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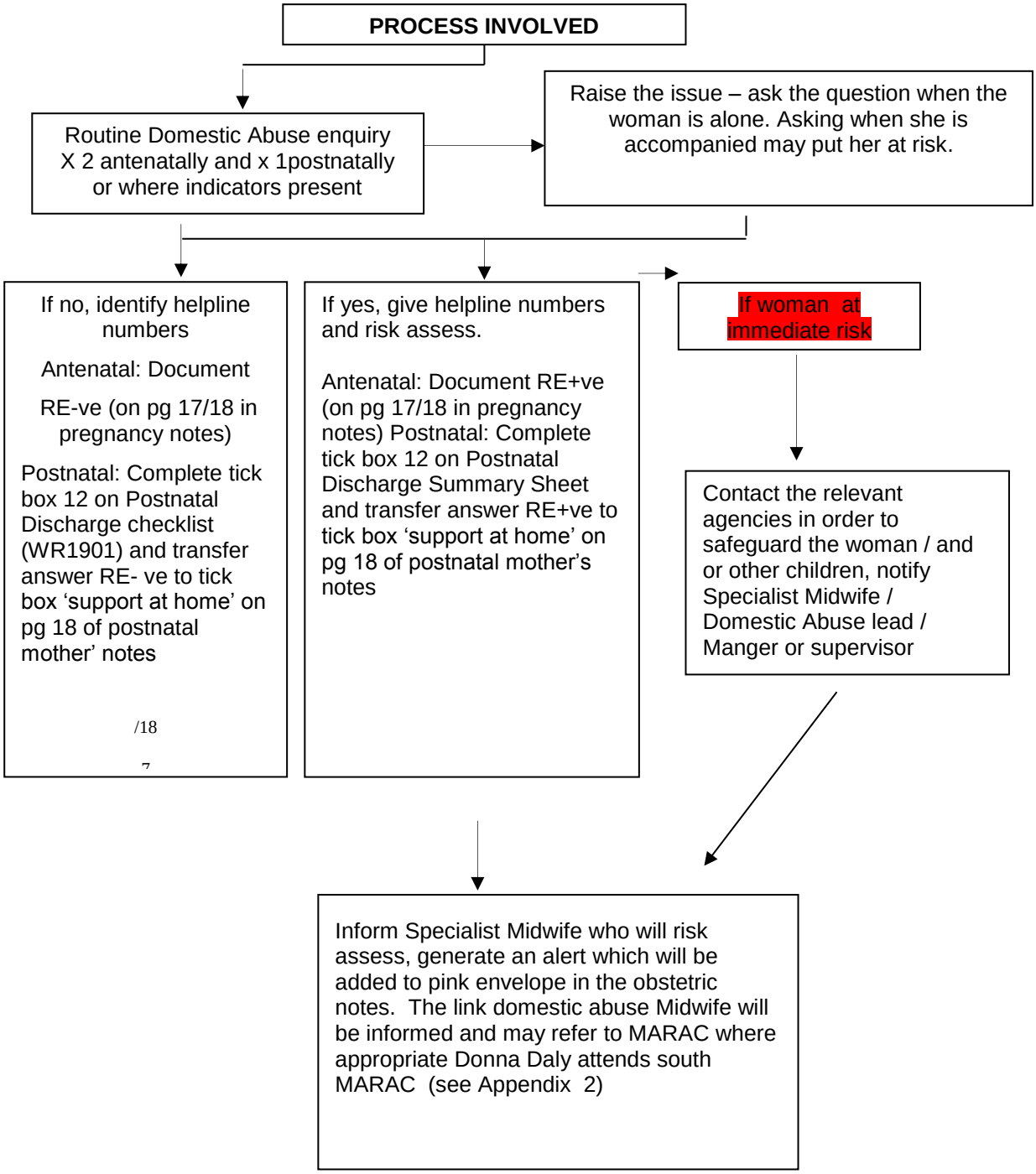
Appendix 1



Stage One – Recognition of abuse

1.1 Investigation of abuse is applicable to every woman who attends for a maternity booking/ antenatal appointment or who has an emergency admission. Women should be asked about domestic abuse at least 3 times; twice during pregnancy and at least once postnatally whenever the opportunity arises.

1.2 Staff should make themselves aware of the indicators of domestic abuse (see appendix 1).

1.3 If any of the possible indicators of abuse are present and/or if staff suspect abuse, staff should investigate the possibility of domestic abuse using stages 2 and 3 of the guideline detailed below It is vital that staff take any suspicion of domestic abuse seriously as abuse rarely happens in isolation and usually increases with severity over time.[12]

2. Stage Two – Provision of a safe and quiet environment

2.1 When staff are screening for domestic abuse or abuse is suspected, it should be ensured that the woman is interviewed in a private, quiet, safe environment.

2.2 Routine enquiry should only be made if the woman is alone. This may necessitate the midwife being creative about enabling this to happen without further endangering the woman. One way of doing this may be to ask her partner to wait outside whilst the midwife examines the client.

If the midwife is unable to see the woman alone on any occasion, it should be documented in the Pregnancy notes p.17 accompanied by…" or "with…". This will indicate that the woman was not seen alone and that a question regarding domestic abuse was not asked.

2.3 If the woman's first language is not English, or she is deaf, arrangements should be made for an interpreter to be present. **Contact PEARL Linguistics.**

3. Stage Three – Identification and asking the question

3.1 Staff should initially question the woman in an empathetic manner and be sensitive in their use of language – e.g.

"I am sorry if you have been asked this question before. According to research 1 in 4 women face abuse in their home during their lifetime so we are now routinely asking every woman about domestic abuse."

3.2 When staff suspect abuse a possible opening could be :

"I am sorry if you have been asked this question before and I don't want to cause you any offence but we know that 1 in 4 women experiences abuse at home at some point during their lifetime. I notice that you have a number of cuts / bruises/ burns. I was wondering if this was happening to you."

3.3 Staff should then go on to ask direct, non-threatening questions in an empathetic manner if the woman affirms there are problems at home, is hesitant, or gives an answer which does not seem plausible. It is essential to ask direct questions rather than let an improbable explanation pass without saying anything.

3.4 Be honest; explaining why you are asking the questions gives the woman a concrete focus and avoids her feeling judged. Listen carefully; the woman may talk around the subject before getting to the point.

3.5 Remind the woman of your position in terms of confidentiality; make your position with regards to child protection clear to her. Respect and validate what she tells you and remember that you may be the first person who has listened to her and taken her seriously.

3.6 If the woman makes a disclosure, she should always be offered accurate information of local support groups or agencies (see Appendix 2) and stages 4 and 5 of the guideline should be followed. Document the disclosure as 'RE+ve' on page 17 of the pregnancy notes.

3.7 If the woman does not make a disclosure, document this as 'RE-ve' on page 17 of the pregnancy notes in the antenatal section alongside 'Accompanied' and relevant information.

3.8 Following a POSITIVE response (RE+ve) at any stage the midwife should inform the Specialist Midwife for Vulnerable Groups. If the Specialist Midwife is off duty then a manager or Supervisor of Midwives should be informed.

4. Stage Four – Documentation of Abuse

4.1 Staff need to recognise that their response to a woman disclosing abuse is of great importance. Women have to access between 5 and 12 different agencies before they get an empathetic, supportive and appropriate response.

4.2 The importance of documentation of abuse should be explained with the woman. Records may prove to be critical to the outcome of any legal case and can provide concrete evidence. **Documentation of abuse should never be recorded in hand- held pregnancy notes, or in any document that the perpetrator may have access to.**

4.3 Information about the abuse must be recorded in her medical records, staff must document the information accurately and clearly. The woman's history should be documented including physical or psychological symptoms. A body map may be used to indicate physical injuries e.g. bite/ scratch marks and bruising. These records must be maintained in strict confidence.

4.4 The record should be stored in a 'pink envelope'. Where a 'pink envelope' is present in a woman's record, the notes should never be left unattended in a room, in clinic or delivery suite, where the contents could be read by the perpetrator of the abuse.

5. Stage 5 – Safety Assessment, Provision of Information and Responses

5.1 It is vital to let the woman know that she is believed and for her to be reassured that what she has experienced is not her fault.

5.2 Safety options should be discussed. Work with the woman to consider any immediate risks to her or her children. Going through a safety plan with the woman may help her to reflect about her situation and may have an impact on future decision making. **It is important to be empowering rather than prescriptive.**

5.3 If the woman wants immediate access to safe accommodation facilitate this wherever possible by contacting Women's Aid They may want to talk to the woman herself but it is important she knows she has your support. (See appendix 2)

5.4 If she is in immediate danger, offer to contact the police.

5.5 If any children are in immediate danger follow child protection procedures as a matter of urgency (refer to safeguarding children and young people policy WAHT-CG-455).

5.6 If the woman does not need immediate access to a refuge, discuss other safety options with her. The woman should be informed of her options and of the specialist services available to her. Information and leaflets should be given which will provide immediate help and long-term support. Women should be advised to prepare a bag of clothes, money, personal papers etc, in case they need to leave home at short notice. These belongings may be stored with a neighbour or friend, along with any information leaflets and relevant telephone numbers.

5.7 Staff should encourage the woman to consent to specific interventions e.g. does she want a referral to a local domestic abuse organisation for further support and information. All interventions should give assurances of safety and confidentiality. However, it is up to the woman to decide on the appropriate course of action. Staff must respect and accept the woman's decision, whatever that may be.

5.8 It is important to remember when considering asking women directly about their experiences that safety is the most important consideration. Any intervention should be considered as to whether the intervention will increase safety for the client or place her in more danger. Staff should be clear with the woman about their responsibilities with regard to confidentiality. Consent must be obtained from the woman in order to share information with other healthcare professionals or other agencies unless there are concerns about her safety or the safety of her children.

5.9 Midwives should inform the Supervisor of Midwives of any complicated cases or where he/she is finding it difficult to deal with the situation. The Supervisor of Midwives can act as an independent advisor to the midwife.

N.B. It should be remembered that women working within the NHS may also be in need of help from Domestic Abuse agencies. Staff offering support to work colleagues should follow the same basic principals within the protocol, ensuring confidentiality.

6. Multi Agency Risk Assessment Conference (MARAC) and other referrals

6.1 The Link Midwife for Domestic Abuse will discuss the referral with the relevant MARAC co-ordinator (see Appendix 2). The MARAC co-ordinator will decide whether the threshold for a MARAC has been reached. Only high risk cases are referred to MARAC.

6.2 The Link Midwives for Domestic Abuse will feedback to the Specialist Midwife, the GP and Health Visitor within 24-48 hours following a MARAC. A written summary of the MARAC findings will be put in a pink envelope and placed in the hospital records and copies forwarded to the GP and Health Visitor.

6.3 A referral to Children's Services will be made if there are any Child Protection/ Safeguarding issues.

6.4 Women who disclose domestic abuse should be provided with details of support available as appropriate (see appendix 2).

APPENDIX 1

Indicators of Domestic Abuse in Pregnancy

- Poor/non attendance at antenatal clinics.
- Late booking.
- Minimisation of signs of abuse on the body.
- Poor obstetric history.
- Repeat attendance at antenatal clinics/GP's surgery/ accident and emergency department for minor injuries or trivial or non-existent complaints.
- Repeat presentation with depression, anxiety, self-harm and psychosomatic symptoms.
- Unexplained admissions.
- Non compliance with treatment regimes/early discharge from hospital
- Constant presence of partner at examinations, who may answer all questions for her and be unwilling to leave the room.
- The woman appears evasive or reluctant to speak or disagree in front of her partner.

Social indicators of women who suffer domestic abuse

- 3 times more likely to be diagnosed depressed or psychotic.
- 15 times more likely to abuse alcohol.
- 9 times more likely to abuse drugs.
- 5 times more likely to attempt suicide than women generally.

Physical Manifestations of domestic abuse during pregnancy

- Gynaecological problems e.g. frequent vaginal and urinary tract infections (UTI), dsyparunia, and pelvic floor pain.
- Frequent visits with vague complaints or symptoms with out apparent physiological cause and recurring admissions for abdominal pain/reduced fetal movements or ? urinary tract infections.
- Repeated or chronic injuries.
- Injuries that are untended and of several different ages, especially to the neck, head, breasts, abdomen and genitals.

There may also be a history of:

- Repeated miscarriage or terminations of pregnancy.

- Unwanted or unplanned pregnancy.
- Stillbirth or preterm labour.
- Prematurity, intrauterine growth restriction/low birth weight.

APPENDIX 2

DOMESTIC ABUSE LINK MIDWIVES

Donna Daly Malvern, Worcester, Droitwich, Evesham

SPECIALIST MIDWIVES FOR VULNERABLE GROUPS

Kidderminster	07786963414
Droitwich-Evesham	07919598304
Worcester-Malvern	07786431798
Bromsgrove-Redditch	07717530360

INFORMATION AND SUPPORT SERVICES

National Domestic Abuse Helpline	0808 200 0247
County Domestic Abuse Helpline (Women's Aid)	0800 980 3331

Police	From hospital	via Switchboard
	From community	999