## 1. Introduction and Who Guideline applies to

The Government's aim is to eliminate health inequalities and to improve the health of the population. Those who experience domestic abuse, the majority of whom are women and children, are at considerable health disadvantage, and may be at life threatening risk (DoH 2009).

In order to support this, the Government has published National Guidance for NHS staff to assist in management of cases of domestic abuse. The National Guidelines (DoH 2009) are designed to meet the needs of women, children and men, and to offer a framework for supporting good practice for health professionals in recognising possible indications and challenging domestic abuse.

- In the year ending March 2018, approximately 2 million adults aged between 16-59yrs, experienced Domestic Abuse – 1.3 million women and 695,000 men. (Office for national statistics 2018)
- Approximately 1 million women a year experience at least one incident of domestic violence. This equates to almost 20,000 women a week. (DoH, 2013) Domestic violence often starts or intensifies during pregnancy and postpartum.
- In 2014/15 81 women were killed by a current or previous partner (DVDS Guidance 2016).3.7 million women have reported being sexually abused since the age of 16 in England and Wales.
- In 2018 the Forced Marriage Unit gave help and advice to 1764 cases on suspected incidences of forced marriage. This was a 47% increase from 2017 (HO, 2018)
- In 2018 The UK Modern day slavery helpline supported 3280 men and 1476 women (HMG, 2018)
- One in four lesbian, gay, bisexual and transgender people have experienced domestic abuse in their relationships.
- Disabled women are twice likely to experience domestic abuse.
- Research suggests that women between the ages of 16 and 25 are at the greatest risk of domestic abuse. Domestic violence in teen relationships is increasingly recognised as a serious issue (DoH, 2013).
- All figures relating to domestic violence are likely to be underestimated, as all types of domestic violence and abuse are under-reported to healthcare, police and other agencies. (NICE 2016)

## Definitions

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to the following types of abuse:

- Psychological
- Physical
- Sexual
- Financial
- Emotional

“Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.”

“Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.”

Domestic violence is a systematic pattern of behaviour on the part of the abuser to control and dominate another.

A domestic violence incident which results in the death of the victim is rarely a first attack and is likely to have been preceded by psychological and emotional abuse.

Domestic Abuse also includes forced marriage and honour based violence and female genital mutilation.

Domestic abuse can be experienced by anyone but women and their children are at particular risk. Some groups face additional barriers to disclosing domestic abuse, including those from Black Minority Ethnicities (BME) communities, those in same sex relationships, older women, disabled individuals, LGBT (lesbian gay, bisexual and transgender) community and men. This is compounded by discrimination or fear of discrimination. Domestic abuse features in a high proportion of child protection cases and cases involving adults in need of safeguarding.

## Purpose

This document aims to support staff to help to screen women for domestic abuse. It also provides information on the referral pathways and support services

## Scope

This guideline applies to all members of medical, midwifery and nursing staff within the Maternity Service.

## Legal Liability (standard UHL statement)

Guidelines issued and approved by the Trust are considered to represent best practice. Staff may only exceptionally depart from any relevant Trust guidance providing always that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgment of the responsible health professional it is fully appropriate and justifiable – such decision to be fully recorded in the patient's notes.

## 2. Guideline Standards and Procedures

### Roles and Responsibilities

### Midwives

To ensure routine questioning of all antenatal women when seen alone in a department

- Routinely ask pregnant women if they suffer domestic abuse using questions from appendix 1.
- To attend Child protection case conferences for the women they are the named midwife for

### Action to be taken by all Staff

Roles and Responsibilities Midwives
To ensure routine questioning of all antenatal women when seen alone in a department
• Routinely ask pregnant women if they suffer domestic abuse using questions from appendix 1.
• To attend Child protection case conferences for the women they are the named midwife for

Action to be taken by all Staff

Have a conversation with the woman alone and in a quiet, private and safe environment wherever possible, as the presence of a partner or discussion of domestic abuse could place the person in greater danger (see Appendix VII Flow Chart). If the woman does not speak English as a first or preferred language an interpreter must be used. The individual interpreting should not be a family member or friend.

Some suggested questions (see also suggested questions in appendix 1)

"Are you safe at home?"

"Have you ever been kicked/slapped/pinched or verbally abused?" "Have you been forced to do something sexual you didn't want to?"

If the woman answers "Yes" to any of these questions then you refer the woman to Children's Social Care and the maternity safeguarding team.. The rationale for the decision must be recorded.

Number must be given to the woman for UAVA (0800 802 0028)
Clare's Law also to be discussed with the woman

Named Midwife for Safeguarding/Specialist Midwife for Safeguarding/Safeguarding Link Midwife will provide advice and support to staff in relation to domestic abuse that places an unborn baby / child at risk.

The named professionals will ensure that all safeguarding children training include a link between domestic abuse and safeguarding

**Confidentiality**

- Extreme care should be taken to protect the safety of victims, and no information should be disclosed which might breach their safety, i.e. a third party trying to use the whereabouts of children to trace the mother.

- Staff need to make clear that there are limits to the extent of confidentiality, and that in cases where unborn children/ and or children are living in a violent household; information will be passed on to other agencies in line with Safeguarding Children Policy. These policies are congruent with the legislation and identifying that the welfare of the child is paramount (Children Act 2004).

- In the case of a serious assault, it would be best practice to have the person's consent to share information with another agency, but as with child protection and vulnerable adults, the welfare of the victim is paramount.

- If you reasonably believe that there is a risk to life or safety, then information may need to be disclosed, with or without consent.

- To ensure confidentiality, patient's addresses can be protected by producing labels with restricted data, contact medical records for assistance.

**Information Sharing**

If a practitioner has concerns regarding the welfare of an existing or unborn child a referral to the Children and Family Services must be made. If the practitioner has significant concern for the welfare of a child, then the local authority must be called immediately by the practitioner. The safeguarding midwifery team must be notified by phone and completion of an 'A Form'.

**Domestic Abuse in Pregnancy**

Risk factors indicating there maybe domestic abuse in the context of Midwifery and Obstetric Practice

- Booking after 20 weeks gestation
- Poor/non attendance at antenatal clinics.
- Repeat attendance at antenatal clinics, GP's surgery or accident and Emergency department for minor injuries or trivial or non-existent complaints.
- Repeat presentation with depression, anxiety, self-harm and psychosomatic symptoms.
- Minimalisation of signs of violence on the body.
- Poor obstetric history e.g. placental abruption, antepartum haemorrhage, abdominal pain
- Unexplained admissions
- Non-compliance with treatment regimens/ early self-discharge from the hospital.
- Constant presence of partner at examinations, who may answer all the 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.

- Repeated Self discharge particularly if there are other children

**Physical Manifestations of domestic abuse in the context of obstetric and midwifery practice.**

- Physical manifestations during pregnancy and postnatally include;
- Gynaecological problems, such as frequent urinary tract infections, dyspareunia and pelvic pain.
- Repeated self-referral to health professionals with vague complaints or symptoms without apparent physiological cause and recurring admissions for abdominal pain/reduced fetal movements or suspected Urinary tract infection
- Injuries that are untreated and of several different ages, especially to the neck, head, breasts, abdomen and genitals.
- Repeated or chronic injuries.

There may also be a history of:

- Repeated miscarriage or terminations of pregnancy
- Stillbirth or preterm labour
- Prematurity, intrauterine growth restriction/ low birth weight
- Unwanted or unplanned pregnancy.
- Repeated pregnancies within short time frame

**Routine Questioning and Documentation**

Women should be advised that asking about domestic abuse is a routine question in pregnancy because of the high incidence and to raise general awareness.

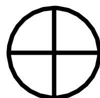
Aim to ask women if they are experiencing domestic abuse at the booking visit or later if the woman is not alone. At each contact with the woman (including admission to hospital) check that the question has been asked. If suspicious and an opportunity arises ask the question again.

Make sure you have an opportunity to see the woman alone at least once during antenatal period.

NEVER USE THE PARTNER, RELATIVE OR FRIEND TO INTERPRET AND WHEN ASKING THE QUESTION ENUSRE THE WOMAN IS SEEN ON HER OWN.

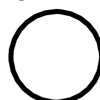
If abuse is suspected, to ensure confidentiality, a quiet, private area should be provided, away from the alleged or suspected perpetrator.

If Domestic Abuse **is disclosed** then this is recorded as in the Maternity Hand Held Notes, by ticking the box and crossing the circle, dating and signing.



Document details of the disclosure by using the symbols in the Antenatal Notes The aim of using this symbol is to provide front-line staff with a simple, clear and consistent way of recording disclosures of DA made to them.

If Domestic Abuse **is not disclosed** then this should be recorded as in the Maternity Hand Held Notes by ticking the box beside the circle, dating and signing.



The woman should be informed of the referral, unless it is considered that it would be unsafe to do so. Decisions must be discussed with the individual and an explanation of the reason for sharing information should be given. The child/children's interests are paramount and therefore confidentiality will not override the need to make a child protection referral.

Concise records must be kept; the staff must ensure that care is taken to maintain confidentiality in order to protect the abused person from further abuse. Records of domestic abuse should be held separately from records which may be held or seen by the perpetrator e.g. client held notes, notes at hospital bed ends, notes on a computer screen.

Where the victim of domestic abuse is believed to be at risk of serious harm and it is in the best interest of her children, other disciplines of staff should be informed Health visitors /School Nurse/General practitioner so as to safeguard other children.

## Physical, emotional and behavioural indicators

There are five main types of abuse: physical, psychological, sexual, financial or omission of care/neglect. It is important to remember that each individual will respond differently to domestic abuse. A checklist approach is inappropriate; however, some common presentations that suggest domestic abuse are shown in appendix 1

## The Multi Agency Risk Assessment Conference (MARAC)

The MARAC is chaired by the Police Detective Inspector who has overall responsibility for Domestic Abuse, Safeguarding Adults, Honor Based Violence and Forced Marriage (DASH). The police based MARAC support officer and the IDVAs (Independent domestic violence advisors) will be administering the referrals and reports. (For further information see appendix 8)

If the cases involve pregnant women then a representative from the midwifery safeguarding team will attend the meeting and inform the community midwife of the MARAC information and safety plan.

Where very high levels of risk around domestic abuse are identified the Specialist Midwife for Safeguarding should be contacted and an assessment made to consider referral to the MARAC. It may be necessary to contact the police, security etc because of the immediate danger presented by the perpetrator(s) to the victim, other family members, especially children, staff and/or the public.

## Safeguarding

Refer all cases to Children's Social Care and the maternity safeguarding team. Remember the overlap between Domestic Abuse and child protection and where there are child protection concerns the safety of the baby and other children is paramount. If you are uncertain about the need to refer to Children and Young People Services discuss with the Named Midwife/Specialist Midwife for Safeguarding.

Determine if the woman fears for her life and /or serious injury to herself or her children. Establish if she feels able to continue to live in the family home.

Establish if any other child/children in the family have suffered direct injury as a consequence of the domestic abuse. If a child has suffered direct injury a referral to Children and Young People's Service **must be made immediately** and an investigation with the Police can be instigated by them. The mother's consent is **not** required for such referrals, but the woman should be informed of the referral unless you have reason to believe the child may be at further risk if you do so, please discuss the case with the Senior Midwife/Specialist Midwife for Safeguarding as liaison with the Health Visitor/Named Nurse for the City/County is essential.

In particular discuss risk issues if the woman has left the perpetrator as the risk of serious harm increases at the point of or just after leaving.

### Planning on-going care

- Ensure you attend to the woman's on-going health needs
- Don't try to make decisions for her
- Advise her she is not alone
- Provide the woman with information and signpost her to specialist agencies who support victims of domestic abuse. Phone numbers are given in the antenatal notes
- Support the woman in her decisions
- Give time for the woman to talk about options
- **NEVER** act as a mediator between the woman and abuser

**Postnatal**

The Community Midwife must ask about domestic abuse again, prior to completing the discharge to the Health Visitor. In cases where domestic abuse is not disclosed, detail should be recorded on the discharge summary for the Health Visitor. When domestic abuse is disclosed, record brief detail on the discharge summary for the woman's Health Visitor as long as it safe to do so. Also, discuss cases on an individual basis with the Health Visitor in person/by telephone.

If the woman is discharged out of area and domestic abuse is disclosed – communicate (by telephone) to midwifery team continuing care.

# Appendix I:

## Asking the Questions

Health professionals in direct contact with clients have to be aware that treating the presenting symptoms may not address the underlying causes of a problem. It is important that health professionals sympathetically ascertain whether their clients/children are affected by domestic abuse. Many health professionals undertake initial assessments of clients and children. This provides an ideal opportunity to routinely ask every client the question:

***"Does violence or fear of violence affect your health?"***

After the issue has initially been raised, you may find the following questions useful when dealing with victims of domestic violence. The questions refer to 'male' partners, but could be asked where the suspected perpetrator is female. Furthermore, they can be tailored to ask about violence between other family members, or between individuals and their carers, or between same sex couples.

- Do you get support at home?
- I noticed a number of bruises/cuts/scratches/burn marks. How did they happen?
- Do you ever/did you ever feel frightened/intimidated by your partner?
- Have you ever been afraid of your present or previous partner?
- Does/did you partner ever treat you badly, such as shout at you, constantly call you names, put you down, push you around or threaten you?
- Have you ever been in a relationship where you have been hit, punched, hurt in any way? Is that happening now?
- Many women tell me that their partners are cruel, sometimes emotionally and sometimes physically hurting them – is this happening to you?
- How are decisions reached within the family?
- We all have rows at home occasionally. What happens when you and your partner fight or disagree?
- Has your partner ever:
  - thrown things?
  - destroyed things you cared about?
  - threatened or abused your children?
  - forced sex on you/made you have sex in a way you are unhappy with?
  - With held sex/rejected you sexually in a punishing way?
  - used your personal fears to 'torture' you?
  - stalked you?

- What do/did your children do when (any of the above) happens/happened?
- How do/did your children feel when (any of the above) happens/happened?
- Does your partner get jealous of you seeing friends, talking to other people, going out? If so, how does he then act?
- Does your partner / you mentioned your partner used/uses drugs/alcohol. How did/does she/he behave when this happens?
- Your partner seems very concerned and anxious – that can mean she/he feels guilty. Was he responsible for your injuries?

# Appendix II: Domestic Abuse Records

These records will be kept separately from the person/client held records.

The content of the records will be shared with the abused person.

The health professional will obtain written permission from the abused person if there is a need to share information with other professionals or agencies.

**Name of Client;……………………… D.O.B:………………………………………**

**Post Code:…………………………… Religion:……………………………………**

**Preferred:……………………………… Ethnicity:……………..……………………**

**Language:…………………………...............................................................**

**Relationship to alleged perpetrator?…………………………………………….…….**

| | *Yes* | *No* |
|---|---|---|
| Is the woman pregnant? | [ ] | [ ] |
| Are there children in the house? | [ ] | [ ] |

If yes, ages of the children……………….……………………………………...

| | | |
|---|---|---|
| Has the individual defined themselves as disabled? | [ ] | [ ] |

If yes, what is the nature of their disability?……………………………………

| | | |
|---|---|---|
| Are there any other agencies involved with the family? | [ ] | [ ] |

If yes, which agency?……………………………………………………………

| | | |
|---|---|---|
| Does the client get support from family / friends? | [ ] | [ ] |

Nature of abuse?

Physical [ ] Financial [ ] Neglect [ ] Emotional [ ] Sexual [ ]

Name of key person involved………………………………..……………………………………...

Referred onto / from……………………………………..………………………………………...

*Continued on next page…*

# Appendix III: Domestic Abuse Records

**Name of Client** ……………………………………………………..

**This Body Chart was Completed on** ……………………………………………………..

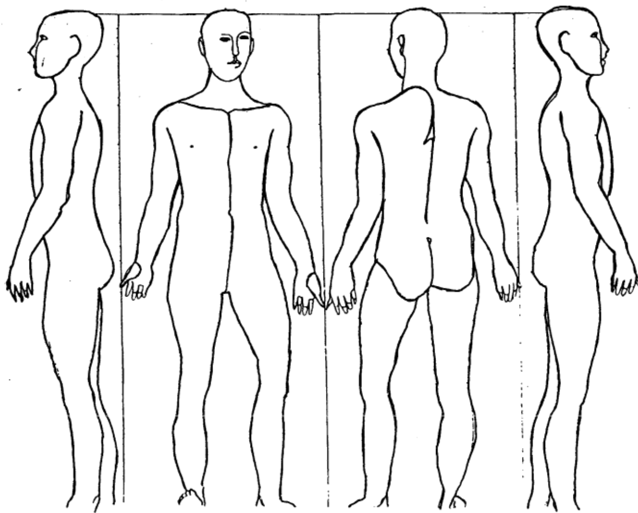
**Name of Professional Completing Record** ……………………………………………..

**Signed** ……………………………………………………..

**Witness if Applicable** ……………………………………………………..

***Diagram Code***

| | | |
|---|---|---|
| Bruise | = | B |
| Laceration | = | L |
| Rash | = | R |
| Scar | = | S |
| Burn | = | H |



## Appendix IIII: Domestic Abuse Records Continuation Sheet

| Date | Additional Information | Signature |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

# Appendix V: <u>Potential symptoms of abuse:</u>

1. **Physical**

- Injuries that are untended and of different ages:

  - Contusions, abrasions, lacerations, fractures, sprains
  - Injuries during pregnancy
  - Multiple sites of injury
  - Repeated or chronic injuries

- Chronic pain, or pain due to diffused trauma without physical evidence or with bruising where explanation does not fit with the description of the injury
- Physical symptoms related to stress, post- traumatic stress disorder, anxiety and depression.
- Frequent use of prescribed minor tranquillisers or pain medications.
- Frequent visits with vague complaints or symptoms, without evidence of physical abnormality
- A high incidence of miscarriage and termination of pregnancies.
- A history of stillbirth/pre-term labour/prematurely.
- Intrauterine growth retardation/low birth weight.
- Smoking, alcohol and drug use.
- Unplanned or unwanted pregnancy.
- Late attendance or poor attendance at antenatal clinic

2. **Psychological:**

- Feelings of isolation and inability to cope.
- Suicide attempts or gestures.
- Depression.
- Panic attacks and other anxiety symptoms.
- Alcohol and drug abuse.
- Post- traumatic stress reaction.

3. **Behavioural**

- Client may appear frightened, ashamed, evasive or embarrassed, generally with low self-esteem.
- Partner accompanies client, insists on staying close, and answers the questions directed at the client.
- Reluctance of a client to speak or disagree in front of the partner.

- Intense irrational jealousy or possessiveness expressed by partner or reported by client.
- Denial or minimisation of violence by partner or client.
- Exaggerated sense of personal responsibility for the relationship, including self-blame for partner's violence.
- Difficulty of gaining access to client or client – refusal of support services.
- Missed appointments and/or non-compliance with treatment regimes.
- Lack of independent transportation, access to finances and ability to communicate by telephone.

4. **Sexual:**
   - Injury to genitals.
   - Not being told by partners that they are infected with HIV or other sexually transmitted diseases.
   - Failure to use condoms and other contraceptive methods.
   - Non-consenting sexual acts including rape.

5. **Financial:**
   - Controlling money or access to money, stealing money, running up debts, taking away financial control.

6. **Neglect:**
   - Omission of care.
   - Physical neglect.

## Appendix VI: Safety Planning

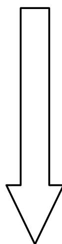
This should be discussed with the woman to give advice about what to do if the abuse continues/escalates

A safety plan should include:

- Identifying places to avoid when the abuse starts, i.e. the kitchen, where there are many potential weapons
- Identifying people the woman can turn to for help
- Identify neighbours, friends who can call the police if they hear anything that suggests the woman or her children are in danger
- Places to hide important telephone numbers such as help lines and personal documents
- Think about how to keep children safe when abuse starts
- Teach the children to call the police if the abuse starts
- Let someone know about the abuse so that it can be recorded - this is important for future prosecutions
- **If leaving in an emergency** - pack a bag including keys, documents, photo of the abuser (useful for serving court documents) and leave in a safe place in case she needs to leave the home quickly. Think about transport, debit & credit cards, money, access to a phone
- **If the woman has left the relationship** - contact details of professionals who can help and give advice, changing her mobile/land line number, keeping her location secret from the abuser, get legal help through a non-molestation order, exclusion or restraining order, talk to the children about staying safe, talk to employer about help with safety at work.

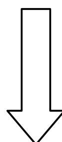
## Appendix VII:

**Domestic Violence disclosed.**
Discuss detail with woman, make safety plan (not in handheld notes).



Following discussion, provide the woman with the Domestic Violence Helpline number for Leicester, Leicestershire and Rutland-**0808 802 0028.**
Support from the helpline is offered to include a CARDA DASH assessment of risk to help identify a safety plan, give support and place of refuge if available and/or necessary.

Ask the woman if she wants to report the incident to the police. Discuss the importance of the woman being proactive in safeguarding herself, existing/unborn children.
'A' Form to be completed.



**If the woman is in immediate danger and is not prepared to safeguard herself and children despite support being offered, a referral will need to be made to social care.**
If the woman has existing children an immediate referral will need to be made to social care. The situation will need to be reported via telephone to the Children and Family Services local authority.

**County- 0116 305 0005**
**City- 0116 454 1004**
'A' form to be completed following telephone call.
Safeguarding midwifery team to be informed.

# Appendix VIII

## Contact numbers:

| | |
|---|---|
| SAFE Domestic Violence Helpline Project | 030 30 30 0112 |
| Police Domestic Abuse Incident Officers<br>**Dial 999 in an Emergency** | 0116 222 2222 |
| Living without Abuse (LWA) | 0300 365 0112 |
| The Jenkins Centre | 0116 254 0101 |
| Housing Options, Leicester City Council<br>*Access to City Council Hostels and other independent Refuges and Hostels* | 0116 454 1008 |
| National DV Helpline www.womensaid.org.uk | 0808 200 0247 |
| Domestic Violence Helpline for Leicester, Leicestershire and Rutland | 0808 802 0028 |
| Jasmine House (Leicester Rape Crisis) | 0116 255 8852 |
| NSPCC | 0808 800 5000 |
| | |
| **Social Care & Health:** | |
| County Duty & Assessment Team | 0116 305 0005 |
| City Duty & Assessment Team | 0116 454 1004 |
| Name Midwife for Safeguarding for the Trust | 0116 258 6087 |
| Specialist Midwife for Safeguarding | 07876 475 318/<br>0116 258 6432 |
| Safeguarding Midwives Office Fax Number<br>(to Fax completed 'A' Forms) | 0116 258 7774 |
| Forced Marriage Unit (HALO Project) | 0207 0080151 |

# APPENDIX VIIII

## What is the *MARAC?*

***Leicester, Leicestershire and Rutland are working in partnership*** Through Multi Agency Risk Assessment Conference – MARAC. The MARAC is a process which enables a group of representatives from a number of agencies to meet on a regular basis to share information on those victims and their children of domestic violence who are at the highest risk of homicide or serious harm. A unique support plan has been formulated, aimed at effectively managing and reducing the level of risk posed to them and their children.

### Aims of the *MARAC*

- To share information to increase the safety, health and wellbeing of victims and their children
- To determine the risk posed by a perpetrator to an individual or community
- To implement an integrated risk management plan
- To reduce repeat victimisation
- To improve agency accountability

### How do you complete the risk referral form?

All agencies dealing with a victim of domestic violence, who are under consideration for a referral to MARAC, must complete the agreed risk referral form. It will require you to ask the victim a set of victim focused questions to identify the risk that is posed to them.

It is advised that you complete a form of consent with the victim in order to share the information with other agencies. This is good practice and helps involve and empower victims in the process. If a victim refuses to consent, this **does not prevent you sharing the information** with the MARAC, but please indicate this on the referral form.

An Information Sharing Protocol has been agreed to give us all confidence in what information we must share and why.

**Who is the information shared with?**

The MARAC is made up of statutory and voluntary agencies that have a duty and responsibility to work with victims of domestic violence, their children or vulnerable adults affected by domestic violence, or where they work with the perpetrators of domestic violence and potential victims are identified.

Each agency has signed up to an information sharing protocol which allows the sharing of such confidential information under current law.

**What is the role of the IDVAs?**

IDVAs are Independent Domestic Violence Advisors. They are specially trained and responsible for working with the victims of domestic violence in order to reduce the risk that is posed to them. The IDVA team are greatly involved in the MARAC process. They have a large part to play in the support and advocacy for the cases which are brought to the MARAC and the Specialist Domestic Violence Court. The IDVA can be considered as the 'voice of the victim.'

**If you have any concerns**

| | |
|---|---|
| Specialist Midwife – Safeguarding | 0116 258 6432 |
| Forced Marriage Unit | 0845 607 0133 |
| Karma Nirvana | 0800 5999 247 |
| National Domestic Violence Helpline | 0808 2000 247 |
| Local Domestic Violence Helpline | 0116 255 0004 |

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<table>
<tr><th colspan="3">DEVELOPMENT AND APPROVAL RECORD FOR THIS DOCUMENT</th></tr>
<tr><td>Author / Lead Officer:</td><td>C Rogers and P Ryan</td><td>Job Title: Specialist Midwife for Vulnerable Groups and Senior Midwife for Safeguarding</td></tr>
<tr><td>Reviewed by:</td><td colspan="2">C Robinson</td></tr>
<tr><td>Approved by:</td><td>Guidelines Group and Maternity Service Governance Group</td><td>Date Approved: 30.06.14 and 9.09.14<br>19.04.17<br>18.03.20</td></tr>
</table>

| **REVIEW RECORD** | | | |
|---|---|---|---|
| **Date** | **Issue Number** | **Reviewed By** | **Description Of Changes (If Any)** |
| June 2014 | | As above | No change |
| April 2017 | V1 | R Smith | General update of stats, terminology and contact details. |
| February 2020 | V2 | C Robinson | Phone numbers and websites updated |

| **DISTRIBUTION RECORD:** | | | |
|---|---|---|---|
| **Date** | **Name** | **Dept** | **Received** |
| 10.14 | All Midwives and Obstetricians | Maternity | |
| 4.17 | All Midwives and Obstetricians | Maternity | |
| April 2020 | All Midwives and Obstetricians | Maternity | |
| | | | |

## 3. Education and Training

*None*

## 4. Monitoring Compliance

| What will be measured to monitor compliance | How will compliance be monitored | Monitoring Lead | Frequency | Reporting arrangements |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

## 5. Key Words

Domestic Violence, DV

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**The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.**
**As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.**