SLHD Policy Compliance Procedure

Domestic Violence – Serious Threat	
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Domestic Violence – Serious Threat

Contents

1. Introduction 3
2. The Aims / Expected Outcome of this PCP 4
3. Risk Statement 4
4. Scope 4
5. Resources 5
6. Implementation 5
7. Key Performance Indicators and Service Measures 5
8. Procedures 5
8.1 Contacting NSW Police 5
8.2 Legal and policy context in support of making a report to NSW Police 5
8.3 Obtaining a Medical History 7
8.4 Clinical indications and presentations which require a report to NSW Police 7
8.5 Advising the client/patient of the report 9
8.6 Reporting to Police – Sexual assault 9
8.7 Additional situations which require a report to NSW Police 9
8.8 Significant predictors of serious harm or lethality requiring a response 10
8.9 Assessing safety and developing safety plans 11
8.10 Managing safety following discharge 11
8.11 Documentation of domestic violence in the medical record 12
8.11.1 Documenting Domestic Violence where there is a child in the household 12
8.11.2 Documenting a report to Police 12
8.11.3 Medical records - additional security considerations 13
8.12 Reviewing Next of Kin 13
8.13 Protecting the privacy of patients – phone inquiries 13
8.14 Apprehended Violence Orders 13
8.15 Staff affected by domestic violence in the workplace 14
8.16 Safety of staff and other patients 14
8.17 Referral pathway and response to individuals at serious threat due to Domestic Violence 16
9. Definitions 17
10. Consultation 17
11. Links and tools 18
12. References 18
13. National Safety and Quality Standard/s v.2 19

Domestic Violence – Serious Threat

1. Introduction

Domestic violence seriously impacts on people's physical, psychological, emotional and sexual health, contributing to a range of negative health consequences in the immediate and longer term (see: The Case for Change: integrated prevention and response to violence, abuse and neglect in NSW Health). These include:

- physical injury
- poor mental health
- difficulties during pregnancy and birth
- problems with sexual and reproductive health
- alcohol and other drug misuse
- self-harm and other behaviours associated with risk.

In May 2018, the Australian Domestic and Family Violence Death Review Network released its first report which analysed intimate partner homicides in Australia between 2010 and 2014.

The findings identified that between 1 July 2010 and 30 June 2014 there were 152 intimate partner homicides in Australia which followed an identifiable history of domestic violence (including a reported and/or anecdotal history of violence). The review demonstrates that:

- A significant proportion of all homicide victims are killed by a person with whom they share or have shared a domestic relationship, that is, a current or former intimate partner or family member
- Women are significantly over represented in this category of homicide
- Domestic and family violence deaths rarely occur without warning, with many fatal cases characterised by repeated episodes of abuse and identifiable risk indicators
- There have typically also been potential missed opportunities for individuals or agencies to intervene before the death
- **When viewed as the escalation of a predictable pattern of behaviour, domestic and family violence deaths can be seen as largely preventable.**

Given the evidence, SLHD has identified the need for a formal response to domestic violence where there are clear indications the individual is at serious threat of further harm or potential lethality. This PCP recognises that there are situations where the SLHD duty of care to patients may require staff to report to police, with or without consent. This should be accompanied by a comprehensive assessment and a safety planning response by a social worker.

It is acknowledged that not all people who experience domestic violence will be at serious threat, and in these cases, SLHD staff are to be guided by the NSW Health Policy and Procedures, Domestic Violence – Identifying and Responding (PD2006_084) Moreover, best practice responses to domestic violence are trauma-informed and client-centred, maximising the victim's choices and empowerment. Effective safety planning is based on a combination of the victim's assessment of risk, evidence based risk factors and the clinician's judgement.

This PCP acknowledges that people always resist and respond to domestic violence, even in ways that do not seem obvious, and that this resistance is an important part in upholding dignity. Listening for the ways in which the victim is already building safety and managing risk needs to be part of our response, as well as prioritising the safety needs the individual identifies.

This Policy Compliance Procedure (PCP) operationalises and clarifies the requirements under the relevant NSW Health Policy, Domestic Violence - Identifying and Responding (PD2006_084)

2. The Aims / Expected Outcome of this PCP

- Embed client-centred safety as the first priority in any response to domestic, family and sexual violence
- Implement system improvements to effectively identify client/patients at serious threat of domestic violence
- Establish a common organisation-wide understanding of what constitutes a serious threat due to domestic violence
- Client's at high risk of severe violence or potential lethality as a result of domestic and family violence are consistently and relevantly identified within the Medical Record and system
- Information relevant to the client/patient's clinical management is consistently available to responding services along the course of the client/patient journey
- Services are aware of the safety needs of clients and their dependents ,which are changeable over time
- Services are aware, document and adhere to any legal orders such as Apprehended Violence Orders or Apprehended Domestic Violence Orders (AVO/ADVOs)
- When making a report to the NSW Police in cases of domestic violence, SLHD staff:
    - Ensure the presentation is escalated for senior review by the Consultant or Staff Specialist/MUM/NUM/Line Manager as relevant;
    - Refer to Social Work within SLHD Hospital-based settings requiring an out of hours response where available;
    - The decision to report is always taken as a multi-disciplinary team comprising relevant Medical, Nursing, Social Work and other Allied Health staff.
- There is consistency of practice and policy compliance in relation to contacting the Police in the following circumstances, as required by NSW Health policy Domestic Violence - Identifying and Responding (PD2006_084) (the 'DV Policy') to ensure clinicians are clear of the parameters by which matters are escalated to Police, referral pathways and roles and responsibilities of SLHD staff.

3. Risk Statement

SLHD Enterprise Risk Management System (ERMS) Risk #1 Unwarranted Deviation from standards of clinical care.

This PCP aims to mitigate against the following risks:

- Staff fail to make reports to NSW Police as required by the NSW Health DV Policy;
- Staff fail to make reports to the Department of Community and Justice (formerly FACS) as required by NSW Health Policy and Legislation;
- Client/patients are not appropriately identified as being at serious threat due to domestic violence and experience harm or lethality;
- Relevant clinical information is not documented in the medical record;
- Client/patients do not receive referrals to social work services;
- Police reports are made without consent that did not meet serious threat threshold, as described in this document.

4. Scope

This PCP applies to all SLHD staff, with a particular focus on:

- SLHD Emergency Departments and General Practice Clinics;
- Child and Family Health (CFH), Drug Health, Mental Health, Aged Care, and Maternity services where the prevalence and incidence of domestic violence is high.

5. Resources

Within existing resources.

6. Implementation

- The aims and objectives of this PCP is to be integrated into all future training concerning domestic violence.
- A Safety Planning Guide will be developed to within 6 months of publication and published to the SLHD intranet.

7. Key Performance Indicators and Service Measures

- Training is delivered to all EDs, CFH, Drug Health, Mental Health and Maternity services within 6 months post publication.
- There is a reduction in IIMs reports over 12 months where the incident is recorded as domestic violence identified with serious injuries and/or threat and:
    - No referral to social work was actioned and/or;
    - No referral to NSW Police was made.

8. Procedures

The NSW Health DV Policy requires that NSW Health workers must make a report to NSW Police where there are individuals at serious threat of harm or lethality, even where this is against the victim's wishes.

This PCP provides clarity and direction on the:

- Legal and policy context by which NSW Health workers are able to make a report to Police without an individual's consent;
- Clinical indications and characteristics of presentations which require a report to Police;
- Other situations that give rise to the requirement to report to Police;
- The referral pathway and response to individuals identified as at serious threat.

This procedure is summarised in a one-page flowchart at section 8.10.

8.1 Contacting NSW Police

NSW Police can be contacted on:

- Via 131 444 for non-Emergency matters, or use the local Station search tool provided at: https://www.police.nsw.gov.au/about_us/regions_commands_districts
- Dialling the emergency phone number 0-000 (internal) or 000 (external) in the community.

Where an emergency occurs within an SLHD facility, escalate as a Code Black by ringing 2222, following the procedure outlined in SLHD, Duress Response - Code Black Policy (SLHD_PD2016_008).

8.2 Legal and policy context in support of making a report to NSW Police

NSW Health staff are supported in making a report to the NSW Police, and/or to the Department Community and Justice where the individual has already been a victim of a serious assault, or is at serious threat of harm or lethality, by a range of legal frameworks, as follows:

Legislation or Policy	How does this support a report being made?
Section 316 of the Crimes Act 1900 Privacy Manual for Health Information, section 11	When a serious crime has **been committed** – there is a duty on NSW Health staff to report to Police information that is of 'material assistance' to the apprehension or conviction of the perpetrator: - A serious assault in the context of domestic, family or interpersonal relationships or sexual assault would constitute a serious crime, noting that Health clinicians are not required to report a sexual assault to police where this is against the client's wishes (see also: Reporting to Police – Sexual assault) - This applies retrospectively, i.e. after a crime is committed (or the reporter believes it has been committed).

Part 13A of the Crimes (Domestic and Personal Violence) Act 2007
 	
Domestic Violence Information Sharing Protocol
	Where a health professional suspects there is a serious risk to the life, health or safety of a patient/victim Part 13A of the Crimes (Domestic and Personal Violence) Act 2007 permits the disclosure of the information without consent:
	- **the risk does not need to be imminent**
	- the individual's safety is paramount in decision-making
	- seeking informed consent is recommended
	- However, without consent information can be shared, including to Police when there is a serious threat and it is:
	  o unreasonable or impractical to gain consent,
	  o the victim does not consent to information sharing.

Health Records and Information Privacy Act 2002	Section 11(1)(c)(i) of HRIPA provides for disclosure *to lessen or prevent a serious and imminent threat to the life, health or safety of the individual or another person*. Section 11(1)(c)(j) the disclosure of the information for the secondary purpose is reasonably necessary for the exercise of law enforcement functions by law enforcement agencies in circumstances where there are reasonable grounds to believe that an offence may have been, or may be, committed
Children and Young Persons (Care and Protection) Act 1998 (NSW)	If a child is involved or **exposed** to the domestic violence, or is at serious threat of it, there is a mandatory obligation on the health professional to report the concern to the Department of Communities and Justice under Sections 23 and 27 of the *Children and Young Persons (Care and Protection) Act 1998 (NSW).* Pre-natal reports should be made where staff form a belief there is a risk of harm to the child following their birth. It is not mandatory to make a report if it is an unborn child, or a young person aged 16 to 17. However, for unborn children, SLHD recommends reporting as an early intervention strategy and staff should be guided by the risk and circumstances of each individual presentation.

When making a report to Police, SLHD staff (including VMOs) are covered by the Treasury Managed Fund for civil liability claims arising from acts undertaken within the scope of their employment in the terms of that policy and when employees acted reasonably in the circumstances.

This requires that staff comply with the steps outlined within this PCP to ensure that there is no inadvertent breach of confidentiality. Where staff are unclear about whether a report to Police is required, escalate matters to your local manager or Executive on-call as appropriate.

8.3 Obtaining a Medical History

Taking a detailed medical history is essential to assess the seriousness of the presentation for all client/patients where domestic violence **is either suspected or confirmed**.

SLHD recognises that whilst domestic violence disproportionately impacts women, all genders can be affected.

In taking a medical history, the clinician must:

Describe	• How did the injury happen? • Record the client/patient's responses in their own words wherever possible
Review	• Previous presentations – are there patterns to presentations, or increasing presentations? • Are there previous disclosures/suspicions of domestic violence or other abuse?
Record	• The anatomical site of injuries and their size (diameter with measured length recorded and depth), shape, colour, texture, tenderness/pain on palpation, etc. (think Lumps&Bumps). • Use local processs to record/draw each injury, describe injury as featured in image. • Use clear terms: Abrasion, Laceration, Incision, Bruise, Petechiae, Burn
Assess	• If the client/patient has not disclosed (or has specifically denied) domestic violence – is the explanation for their presentation reasonable and medically indicated? • Clearly articulate any inconsistencies and your reason for reaching a decision that this client/patient may be experiencing domestic violence.
Ask	Ask direct questions – • Has somebody hurt you? • Do you feel safe to go home today? • Ask about children and their safety – **report concerns to Department of Communities and Justice** via Child Protection Helpline 132 111, the Child Wellbeing Unit 1300 480 420 or online via 'Child Story'

8.4 Clinical indications and presentations which require a report to NSW Police

When making a report to the NSW Police in cases of domestic violence, always ensure:

- The presentation is to escalated for senior review by the Consultant or Staff Specialist/MUM/NUM/Line Manager as relevant;

- Referred to Social Work within SLHD Hospital-based settings requiring an out of hours response where available;
- The **decision to report** is taken as a multi-disciplinary team, i.e. Medical, Nursing, Social Work and others as relevant.

The clinical indications that require a report to the Police are:

Non-consensual strangulation , non-lethal strangulation - staff to be aware that this injury presentation:

- Constitutes a serious offence (see Crimes Act 1900 - Sect 37)
- May not present with visible injuries
- Must be reported to Police (see also Reporting to Police – Sexual assault)
- For this presentation, domestic violence does not need to be identified or suspected before reporting to the Police occurs.

The following must also be reported to Police in cases where the cause is identified or reasonably suspected to the result of domestic violence:

- Serious injuries that suggest the deprivation of liberty through non-consensual restraint
- A serious injury that requires a surgical intervention and follow-up, including but not limited to broken bones
- A fracture to the face
- Serious penetrating injuries, regardless of what implement is used to cause the injury, that require a surgical intervention
- A serious injury where an object has been used
- Ruptured eardrums

Presentations that involve the clinical indications listed above must also be:

- Tabled for discussion at Case Review where available.
- For presentations involving an injury to a pregnant woman, hospital admission should be arranged once medically stable, if coming from the Emergency Department. Referrals to Social Work and Department of Communities and Justice are to be made.
- Referred to a Safety Action Meeting by contacting the SLHD Safer Pathway Senior Clinician.

Presentations that involve an injury to a pregnant women must also be:

- Where the injured woman has other children in the home or their care, a mandatory report to Department of Communities and Justice is also required
- Where there are no other children in the household, a report to Department of Communities and Justice is recommended as an early intervention strategy and to support referral to processes such as Pregnancy Family Conferencing.

For Services/Facilities without an out of hours Social Work service, refer the next business day.

The person who has the **most relevant information is responsible for making the report**. This may be the responding doctor, midwife, nurse, social worker or other staff member. Reports should be timely so that information is relayed as accurately as possible. Where multiple clinicians have seen the client, agreement about who will report is to be reached and then documented in the medical record.

8.5 Advising the client/patient of the report

Decision making by the multidisciplinary team is be inclusive of the individual. The clinician should be responsive to any client/patient apprehensions about reporting. The patient/client should be informed about the duty of care to report and the rationale for police reporting as soon as practicable. The views of the patient should be sought and the clinicians should take all steps to address patient concerns about police reporting.

Clinicians must be sensitive that a decision to report to police may increase psychological distress for the patient particularly when reporting occurs against patient wishes. The multidisciplinary team must consider and discuss the potential for police reports, which occur without client consent, to increase the risk of harm to the client and document how this has impacted the plan for action (see also Section 8.9 and Section 8.10).

Health clinicians have a duty of care to respond to an escalation in client/patient distress which arises from a decision to report to police. Social Work services should be provided wherever possible. Staff should request support from senior colleagues or Social Work where they do not feel they have the skills to manage this conversation.

The decision to make a report without consent is likely to be a stressful experience for all parties involved in this process (see also 'Staff affected by domestic violence in the workplace').

8.6 Reporting to Police – Sexual assault

The NSW Health Sexual Assault Services Policy and Procedure Manual (Adult) supports an individual's right to report to Police where a Sexual Assault has occurred. For more information see section 1.9 of that Policy - 'Reporting to Police'.

SLHD has determined, given the significant evidence which clearly demonstrates the severe escalation of risk and risk of lethality where **strangulation has occurred within the context of sexual assault**, that mandatory reporting to Police is required when the following two conditions are met:

- The client is in an **ongoing intimate relationship** with the perpetrator;

AND

- The client is **not engaged with specialist violence, abuse and neglect services** (these would include a Sexual Assault Service, the Domestic Violence Counselling team, or a specialist Domestic Violence NGO service) which can **actively support safety planning or therapeutic engagement**.

The SLHD Sexual Assault Service and Domestic Violence Counselling Team can be contacted on 9515 9040, during business hours. After hours referrals for recent sexual assaults within the last 7 days can be made to the Sexual Assault Service via RPA Switchboard 9515 6111 (See also - SLHD Policy Compliance Procedure: Transfer of Care to the Sexual Assault Service). Contact details are the same from all SLHD locations.

8.7 Additional situations which require a report to NSW Police

In addition to the clinical indications and presentations outlined above, some situations require that a report to NSW Police should be made, given the potential for serious harm or lethality, these include where the perpetrator:

- has access to a gun and is threatening to kill or cause physical injury to any person
    - Where there is reason to believe the perpetrator does not have a gun licence, or is not mentally fit to hold a gun licence, then this must be reported to Police.

- is using or carrying a weapon (including guns, knives or any other implement capable of injuring a person) in a manner likely to cause physical injury to any person or likely to cause a reasonable person to fear for their personal safety
- poses an immediate serious risk to individual/s or public safety exists
- has committed a serious offence on NSW Health premises, or in circumstances in which health workers are threatened because of their professional role.

In the result that any of the above scenarios occur at an SLHD facility or service, the SLHD, Duress Response - Code Black Policy (SLHD_PD2016_008) must be followed.

In any of the above situations, due to the potential for serious harm, domestic violence does not need to be confirmed to make a report to Police.

For staff working in the Community, a report should be made to the Police and immediately escalated through the appropriate channels.

8.8 Significant predictors of serious harm or lethality requiring a response

Evidence demonstrates that a range of factors are significant predictors, or 'red flags', for serious harm or lethality.

When ANY of the following are present in the context of **known or suspected domestic violence**, the following escalation must occur in order to determine whether the client/patient should be referred to Police:

- Refer to Social Work within **SLHD Hospital-based** settings requiring an out of hours response where available,
- Escalate for senior review by the Consultant or Staff Specialist/MUM/NUM/Line Manager as relevant,
- Discuss at Case Review where available,
- Contact the SLHD Safer Pathway Senior Clinician to determine if referral to the Safety Action Meeting is required.

For Services/Facilities without an out of hours Social Work service, refer the next business day.

Staff should exercise clinical judgement and escalate matters where they have formed a belief the client/patient is at serious threat due to domestic violence.

Predictors of serious harm or lethality requiring a response	
Assessment of victim/survivor	• Individual fears for life and/or fears further violence • Threats to kill the individual have been made
Patterns of behaviour/violence	• Recent violent incident – disclosed or identified • Escalation of violence – frequency or severity • Current Apprehended Domestic Violence Order or Apprehended Violence Orders (ADVO/AVO) – cross allegations (i.e. both parties are making allegations of violence against each other) • Sexual coercion, humiliation, violence/assault • Stalking • Access to weapons • Substance misuse - increased risk if recent cessation/withdrawal from substance misuse and perpetrator not engaged with recovery/rehabilitation • Suicide threats/attempts • Abuse of pets and other animals

Health presentations	• Repeat presentations or presentations of increasing frequency • Presentations with a known dynamic of domestic violence where there is unexplained or inconsistent explanation for current injuries
Coercive control	• Control of employment and financial security • No or controlled access to finances • Restricting or monitoring social activity and movement
Significant events	• Planned or recent separation • Pregnancy or new birth • Court orders or parenting proceedings
The following factors should also be considered where relevant:	
Lesbian, Gay, Bi-sexual, Transgender or Intersex	• Threats to 'out' to family/community • Forced commencement or cessation of gender transition
Refugee or migrant	• Threats to remove support or jeopardise temporary or permanent visa status • Threats to remove children and return overseas
Disability	• Withholding of care or medication • Limiting access to support

8.9 Assessing safety and developing safety plans

Evidence demonstrates that best practice responses to domestic violence are focussed on working collaboratively with clients to support them to establish safety. Assessing safety and developing a safety plan with clients/patients who present to our services is essential. Safety planning is not a 'one off' event. It recognises that risk and safety fluctuates and assessment must be undertaken regularly. This therefore requires that safety planning be conducted for each presentation to SLHD services/facilities where the client is found to be at serious threat due to domestic violence.

Within a hospital based setting, all patients identified at serious threat will be referred to Social Work services to conduct a full safety assessment. Assessing safety draws on a Social Worker's clinical skill and experience and there is no standard form or process. Where there is a risk of Patient/visitor aggression within the facility, refer to the SLHD Policy on Safety Huddles (SLHD_PD2017_012) for management strategies, including how to develop an individualised management plan.

It is acknowledged that staff will have mixed levels of skill and confidence in assessing safety, therefore seek support and escalate to your Manager as needed.

8.10 Managing safety following discharge

Discharge of patients **where a serious threat** has been identified should be guided, in the first instance, by ensuring the safety of the patient and any children in their care. Evidence demonstrates that separation, or the intention to separate, is an extremely high risk time for individuals and the children in their care.

Where immediately locating alternate accommodation is key to safety planning, due to acute risks of serious injury or lethality, and there is no refuge or safe accommodation available, a

social admission is to be offered until suitable accommodation is identified. This requirement also requires an admission to an SLHD in-patient facility where the patient is under the care of Community Health and no alternative accommodation can be identified.

When an individual refuses alternative accommodation or a social admission to an SLHD facility and intends to return to their home address:

- Police are to be made aware;
- All action taken is to be documented in the medical record.

8.11 Documentation of domestic violence in the medical record

The identification of people at serious threat of lethality is enabled and supported by clinical and administrative staff maintaining appropriate and relevant medical records.

All presentations with a known or confirmed dynamic of domestic violence should:

- Be explicitly recorded as domestic violence/abuse in the medical record: avoid use of terms such as 'relationship problems';
- If domestic violence was disclosed or otherwise confirmed, or the reasons for forming a belief the presentation was as a result of domestic violence;
- Document all known clinical and social concerns, with reference to section 8.3 through to section 8.7;
- Where there is a belief that the client/patient is at serious threat of further harm or lethality, this should be clearly documented:
    - e.g. 'in consideration of the medical presentation of attempted strangulation, it is my clinical assessment that this client/patient is at serious threat from domestic violence'.
    - Any additional reasons for forming this belief should also be noted.
- List all actions taken as a result of disclosure/identification, i.e. referral to social work, mandatory reporting.
- Document the client's assessment of their safety and the actions they have taken to support their own and their children's safety, i.e. 'Patient has recently changed their mobile phone number to prevent contact', 'Patient has organised children to be in care of maternal Grandparent during current hospital admission'.

8.11.1 Documenting Domestic Violence where there is a child in the household

All concerns about violence, abuse and neglect must be documented in the medical record, whether or not they meet the threshold for Risk of Significant Harm (ROSH), in order to build a clear and coherent picture, and assess the level risk and/or cumulative harm.

- Always seek advice from your medico-legal manager when you are unsure about your documentation requirements.
- Seek advice from the SLHD Child Protection Strategy Unit on 9378 1281, the Child Wellbeing Unit, or refer to the Mandatory Reporter Guide, to assess the level of risk and actions required in relation to concerns about a child, unborn child or their family.
- For staff seeking urgent advice after hours – escalate and consult with your HoD/MUM/NUM

SLHD is in the process of developing a related guideline to support SLHD staff in the effective documentation of domestic violence in the Medical Record. This will be updated here once published. In the interim, please seek advice from the Health Information Manager in your Service/Facility for guidance.

8.11.2 Documenting a report to Police

Where a report to Police has been made, the following additional fields must be documented:

- Name and contact details of who made the report if not the person documenting in the medical record
- Why the clinician determined serious domestic violence was a concern when domestic violence was not disclosed by the individual.
- Whether the client/patient provided consent. Patient/clients views and concerns about reporting to the Police should be sought and documented. Where consent for reporting to Police is declined, document how a decision was reached to report without consent and any consultation/escalation undertaken to support this decision making process.
- The client/patient was informed that Police were contacted, including for those instances where the patient did not provided their consent
- Referrals to Social Work and any action taken by them
- Escalation to HoD/MUM/NUM and any outcome from that escalation
- The perpetrators are identified and their relationship to the patient (if known)
- Details of to whom the report was made to as follows:
    - Name of Police station
    - Name of Police officer
    - Contact number of Police officer/station
    - Any case reference number – where provided/available.

8.11.3 Medical records - additional security considerations

Arrangements can be made for clients/patients who identify a need to have their identity restricted (i.e. use an alias), or to ensure that there is an alert on their file to ensure no information is released (i.e. physical location if admitted).

Contact your Facility/Service **Medical Records Department** for further information.

8.12 Reviewing Next of Kin

Following a presentation or disclosure of domestic violence, staff are to review next of kin arrangements. Offer patients the option of amending next of kin arrangements, i.e. to remove partner as next of kin.

Within the eMR PAS there are 2 fields – “Home Phone Call Instruction” and “Mobile Phone Call Instruction” which serves the purpose of providing call instructions to users. For those who are Powerchart users please note only texts entered in the “Home Phone Call Instructions’ field in the eMR PAS can be seen in Powerchart.

The NoK, Person To Contact, Carer fields are encounter level specific. Removing the details from one encounter will not remove the same details collected from an older encounter. Likewise the details collected can be different from each encounter. *Users should be viewing the latest encounter for the most up to date details.*

8.13 Protecting the privacy of patients – phone inquiries

SLHD staff should be guided by the NSW Health Privacy Manual for Health Information (see section 9.2.4.1) when providing information over the phone.

See also:

- Mental Health Services, Release of Information (Phone, Fax and Electronic) Policy (MH_SLHD_PD2018_001)

8.14 Apprehended Violence Orders

An **Apprehended Violence Order (AVO)** is an Order made by a court against a person who has caused an individual to fear for their safety, and to protect the individual from further violence, intimidation or harassment.

An **Apprehended Domestic Violence Order (ADVO)** is made where the people involved are related, living together or in an intimate relationship, or have previously been in this situation. This includes family members and non-intimate partners.

Apprehended Violence Orders made by the court prohibit the person who is causing these fears from assaulting, harassing, threatening, stalking, or intimidating the individual. Other conditions can be included.

- Where a serious threat due to domestic violence has been identified, staff are required to inquire about current AVO/ADVOs and document any contact conditions in the medical record.
- SLHD staff are encouraged to contact Police to obtain a copy of the AVO/ADVO, particularly where ongoing patient care/contact is likely.
- Unless otherwise stipulated, the victim and perpetrator may be able to maintain contact, therefore reference to the original document is important to ensure staff are aware of all conditions.
- Where contact (either in-person/by phone, or email) is prohibited, safety planning is to include a plan to manage attempts to contact/visits. This plan should be communicated to all relevant team members, including administrative staff.
- Staff must ensure that their service/facility is not potentially facilitating a breach of the AVO/ADVO through visits or contact, and should seek advice from their Manager as required.
- Where SLHD staff become aware that a person has breached the conditions of their AVO/ADVO, escalate to your HoD/NUM/MUM to review the facts and determine if the breach is to be reported to the Police. Where a breach gives rise to a concern that there is a **serious and imminent** threat to the client/patient (or a dependent child), a report should be made. In determining whether to report, be guided by the points outlined in the section, 'Advising the client/patient of the report'.

In the event that **no AVO/ADVO is in place**, but the patient has expressed a preference to not have contact with the perpetrator, refer to the SLHD Warning Notices, Conditional Restricted Visiting Notices and Banning Notices: Restricting Access to SLHD Facilities/ Property (SLHD_PD2019_017).

8.15 Staff affected by domestic violence in the workplace

Responding to domestic violence can be a highly traumatic experience for staff. Staff may have their own current or past experience of domestic violence, or by hearing stories of trauma can experience vicarious trauma (for more information, see Blue Knot Foundation 'Vicarious Trauma').

The SLHD Employee Assistance Program (EAP) is staffed by highly trained clinicians who can provide counselling for employees who have either an experience of domestic violence in the workplace or in their own relationships. The EAP is a free, professional and strictly confidential counselling and support service for all SLHD staff and their families.

Whilst uncommon, there are situations where staff who provide responses to client/patient's at serious threat of domestic violence, may themselves become subject to violence from the perpetrator. Staff who are fearful for their safety as a result of their professional interaction with a client, should raise these concerns with their direct line manage and may seek to take out an Apprehended Personal Violence Order (APVO). Refer to the SLHD Guideline Apprehended Personal Violence Orders (APVO) SLHD_GL2013_002

8.16 Safety of staff and other patients

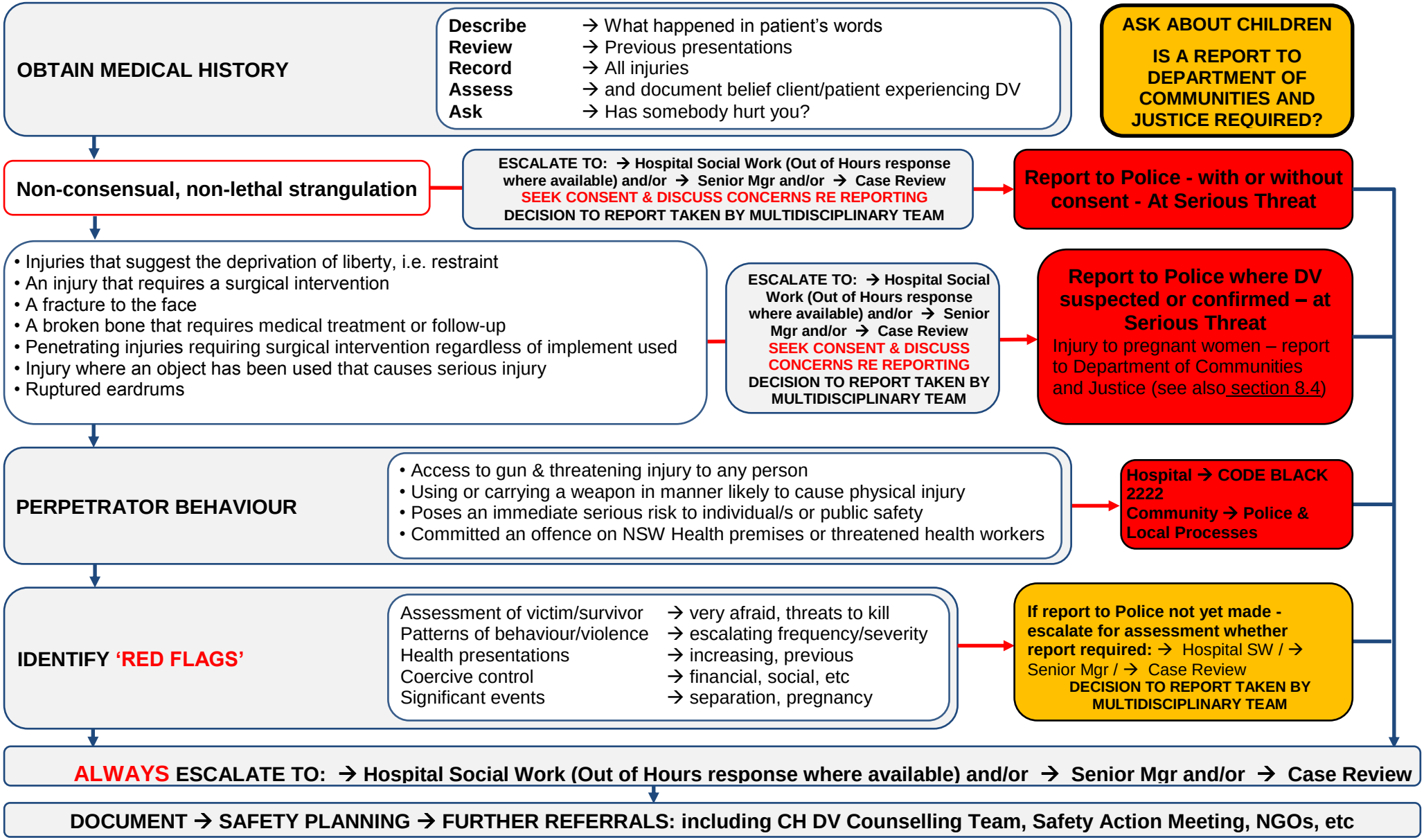
Where the domestic violence presents a risk to SLHD staff and other patients, a safety plan is to be developed in consultation with clinical staff, security and hospital management. This plan should document all known safety issues, agreed mitigation strategies and escalation

processes. The plan is to be communicated to relevant staff across clinical, clerical, executive and security.

See also:

- SLHD Guideline - Aggressive Behaviour: Identification, Escalation and Management for Inpatients (excluding Mental Health Units) (SLHD_GL2018_034)
- SLHD Policy - Safety Huddles (SLHD_PD2017_012).
- SLHD Policy - Duress Response - Code Black Policy (SLHD_PD2016_008

8.17 Referral pathway and response to individuals at serious threat due to Domestic Violence



9. Definitions

AVO/ADVO	Apprehended Violence Order, Apprehended Domestic Violence Order
Department of Communities and Justice	Under changes to the machinery of government, the former Department of Family and Community Services (FACS), has become the Department of Communities and Justice.
Domestic Violence	In NSW, the definition of domestic and family violence commonly used in Government is: …any behaviour in a domestic relationship, which is violent, threatening, coercive or controlling and causing a person to fear for their own or someone else's safety. It is usually manifested as part of a pattern of controlling or coercive behaviour. (NSW Department of Justice 2014)
Perpetrator	A perpetrator of domestic violence is an adult who carries out violent, abusive or intimidating behaviour against a partner or ex-partner to control and dominate that person. NSW Health Policy, Domestic Violence – Identifying and Responding (PD2006_084)
Serious Threat	In this document, this refers to a serious threat to the life, health or safety of a victim, any children or other persons due to domestic violence. The threat does not need to be imminent to be serious.
Vicarious Trauma	Vicarious trauma (VT) is 'the negative transformation in the helper that results (across time) from empathic engagement with trauma survivors and their traumatic material, combined with a commitment or responsibility to help them' (Pearlman and Caringi, 2009, 202-203). The greater the exposure to traumatic material, the greater the risk of vicarious trauma. People who work in services to which people with traumatic histories present seeking help, or who work with traumatic material are at particular risk.
Choking	Choking is often used interchangeably by patients and non-medical staff to refer to the act of strangulation. However, in a medical sense, choking refers to an internal blockage of the airways, whereas strangulation is the act of compression around the neck. For that reason, the term 'strangulation' is used in this document rather than choking. Staff should be aware that patients may use the term 'choking' to describe strangulation.

10. Consultation

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- Emergency Department Clinician, RPA Hospital
- ED Social Worker, RPA Hospital
- VAN Clinical Redesign Project Manager

11. Links and tools

Section 316 of the Crimes Act 1900

Privacy Manual for Health Information, section 11

Part 13A of the Crimes (Domestic and Personal Violence) Act 2007

Domestic Violence Information Sharing Protocol

Children and Young Persons (Care and Protection) Act 1998 (NSW)

Health Records and Information Privacy Act 2002

Child Story Reporter – Department of Communities and Justice Mandatory Reporter Guide

Child Wellbeing Unit and Child Wellbeing Coordinators

Domestic Violence Safety Assessment Tool (DVSAT)

12. References

Toivonen, C., & Backhouse, C. (2018). National Risk Assessment Principles for domestic and family violence (ANROWS Insights 07/2018). Sydney, NSW: ANROWS

NSW Health, Domestic Violence – Identifying and Responding (PD2006_084)

SLHD, Duress Response - Code Black Policy (SLHD_PD2016_008)

Child Wellbeing and Child Protection Policies and Procedures for NSW Health (PD2013_007)

Safe Start Strategic Policy (PD2010_016)

Australian Domestic and Family Violence Death Review Network – Data Report (2018)

NSW Health, The Case for Change: integrated prevention and response to violence, abuse and neglect in NSW Health (2019)

Pearlman, L. & Caringi, J. (2009) Living and working self-reflectively to address vicarious trauma. Treating complex traumatic stress disorders: An evidence based guide (pp. 202-224), New York, U.S.

13. National Safety and Quality Standard/s v.2

Clinical Governance Standard

Comprehensive Care Standard

Communicating for Safety Standard