Leicestershire Partnership NHS Trust

LPT Domestic Abuse Policy

This policy sets out how LPT staff should respond to disclosures and incidents of domestic abuse.

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Contents

Summary and aim 3
Target audience 3
Training 3
Key requirements 4
Introduction and Purpose 4
1. Policy Requirements and Objectives 5
1.1 Identification of victims of domestic abuse 5
1.1.1 Responding to a disclosure of domestic abuse from a patient 6
1.1.2 Routine Enquiry 7
1.1.3 Young people in abusive relationships 9
1.1.4 Child to parent abuse 9
1.1.5 Older person's abuse 9
1.1.6 Domestic abuse and the Care Act 2014 10
1.1.7 LPT Employees and Domestic Abuse 10
1.2 Identification of perpetrators of domestic abuse 11
1.3 Responding to a disclosure of sexual violence 12
1.4 Honour based abuse, Forced marriage and Female genital mutilation 14
1.5 Risk assessments and onward referrals 17
1.5.1 Understanding the risk of domestic abuse and the homicide timeline 17
1.5.2 Non-fatal strangulation 19
1.5.3 MARAC 19
1.6 Record Keeping 20
1.7 Information sharing 21
1.8 Domestic Abuse Related Death Reviews / Domestic Homicide Reviews 21
2.0 Roles and Responsibilities 22
3.0 Consent 25
4.0 References and Bibliography 26
Appendix 1 – Definitions 29
Appendix 2 – Governance 33
Appendix 3 – Domestic Abuse Flowchart 35
Appendix 4 – LPT Safeguarding Adults Flowchart 36

Policy On a Page

Summary and aim

This policy is intended as a resource for all staff working within LPT. It outlines the duties, roles and responsibilities, that LPT staff have in responding to domestic abuse in relation to patients and service users, including where the alleged perpetrator is an LPT patient or service user. Domestic abuse experienced by LPT staff and colleagues is explored, however a separate process is available for in depth guidance.

The policy has been developed with the benefit of learning from local Domestic Abuse Related Death Reviews (formally called Domestic Homicide Reviews or DHRs), national policy recommendations and guidance such as NICE guidance. This policy outlines the commitment of LPT to identify, support, and protect patients who may be experiencing domestic abuse. Domestic abuse is a serious issue that can have a profound impact on an individual's health and well-being. This policy ensures that staff understand their role in recognising, responding to, and referring patients who may be victims of domestic abuse, in a safe and supportive manner.

Target audience

This policy applies to all staff, volunteers, and contractors working in LPT who interact with patients. This includes medical staff, nursing staff, social workers, mental health professionals, allied health professionals, and administrative staff.

Domestic abuse is highly prevalent and can be experienced by anyone. It happens in all communities, regardless of gender, age, disability, gender identity, race, religion or belief, sexual orientation, marriage or civil partnership and pregnancy.

Some people will find it harder to report domestic abuse or access support because of systemic, societal barriers linked to their identity. This policy outlines the steps practice staff will take to create equity.

Anyone within LPT irrespective of job role, may have opportunities to identify and respond to a patient or colleague needing support.

All staff should be aware of this policy and act accordingly through the management structure to respond to suspicions of, or actual domestic abuse experienced or perpetrated, whether in relation to patients or colleagues.

Training

All staff should undertake training in recognising and responding to domestic abuse.

In accordance with the NICE guidelines for domestic violence and abuse (https://www.nice.org.uk/guidance/ph50), clinical staff should be,
"trained to ask about domestic violence and abuse in a way that makes it easier for people to disclose it. This involves an understanding of the epidemiology of domestic violence and abuse, how it affects people's lives and the role of professionals in

intervening safely. Staff should also be able to respond with empathy and understanding, assess someone's immediate safety and offer referral to specialist services".

All staff should receive regular training on the signs of domestic abuse, how to respond to disclosures, and how to refer patients to appropriate support services.

The training should include:
- Understanding the dynamics of domestic abuse.
- Knowing how to recognise the signs of abuse.
- Learning how to engage in supportive, non-judgemental conversations with patients.
- Being familiar with local and national domestic abuse resources.
- Understanding the legal framework surrounding domestic abuse.
- Understand high risk.

Key requirements

Objectives
- To ensure that staff are trained to recognise signs of domestic abuse in patients.
- To provide guidance on how to respond appropriately and sensitively to disclosures of domestic abuse
- To create a safe environment for victims to disclose domestic abuse without fear of further harm or judgement.
- To ensure that patients are informed about available support services and resources.
- To develop a clear procedure for referral to specialist support services, such as domestic abuse charities, social services, or the police.

Introduction and Purpose

This policy reflects local, national, strategic and operational guidance produced in response to the growing recognition of the detrimental effects that domestic abuse has on adults, children and society as a whole.

Research has shown that people who have experienced abuse are high users of NHS services.

Surgical procedures, GP visits, hospital stays, visits to pharmacies and mental health consultations are all higher amongst victims of domestic abuse.

Physical injuries, chronic pain, neurological symptoms, gastrointestinal disorders, gynaecological problems, increased cardiovascular risk, depression, self-harm, PTSD, anxiety, insomnia, increased alcohol and drug use and suicidal ideation are all more common in those who have experienced domestic abuse than in individuals who have not.

Research also demonstrates that victims consider health practitioners, as one of the people they are most likely to disclose to.

It demonstrates the principle that domestic abuse and violence is unacceptable behaviour and that everyone has a right to live free from fear and abuse.

It recognises the need to share information and work in partnership with other agencies with greater experience of domestic abuse in order to reduce the risk of harm to victims.

LPT endorses that domestic abuse is a fundamental breach of trust and human rights, and contravenes an individual's right to feel safe, both within their home and within a personal relationship (Human Rights Act (1998).

LPT recognises the serious adverse impacts that domestic abuse has on individuals who live in a violent abusive household, and the short- and long-term damage to their physical and mental health; this also includes the significant harm caused to children in such households and due regard must be given to the wellbeing and escalation of such situations to appropriate agencies in order to safeguard children.

LPT recognises domestic abuse is not only an issue for service users, and that there is a need to address domestic abuse issues for staff when they themselves may be current or past victims of domestic abuse or are perpetrators of domestic abuse

1. Policy Requirements and Objectives

1.1 Identification of victims of domestic abuse

Staff should be aware of potential signs of domestic abuse, which may include:

Physical signs: Unexplained injuries, frequent visits for treatment of injuries, or a history of chronic health problems that do not have a clear medical explanation, substance dependency.

Psychological signs: Anxiety, depression, PTSD, or other mental health issues that may be related to trauma.

Behavioural signs: Isolation from friends and family, a history of missed appointments, or over-dependence on an abusive partner for decisions.

Verbal signs: Inconsistent explanations for injuries, a partner accompanying the patient in a controlling manner, or reluctance to speak freely.

Staff are encouraged to remember that success is enquiring in a safe way, no matter what the response or what help is accepted by the patient. This sends a strong message to the patient that domestic abuse and sexual violence are serious. Just asking may change the patient's thinking about what is happening to them. It also sends the message that there is help available. The patient may not accept help on the day but may keep the local resource numbers and call for help in the future.

When enquiring, staff should be aware of how to respond to disclosures and what steps to take, including the safeguarding considerations.

1.1.1 Responding to a disclosure of domestic abuse from a patient

If a patient discloses domestic abuse, it is vital that health professionals respond in a way that is sensitive, empathetic, and non-judgemental. The following steps should be taken:

Listen and acknowledge: Provide the patient with time and space to share their experience. Listen carefully and express empathy for their situation.

Reassure confidentiality: Explain that any information shared will be treated with respect and confidentiality, but note the limits of confidentiality (e.g., if there is a risk of serious harm to the patient or others utilising NHS code of practice supplementary guidance on public interest disclosures as linked below.

Ensure safety: Assess the immediate safety of the patient. If necessary, make arrangements for them to leave the premises in a safe manner, ensuring their safety from the abuser.

Avoid victim-blaming: Refrain from blaming the victim or suggesting that they could have done more to prevent the abuse.

Following a disclosure all patients should be offered safety planning advice.
Safety planning should involve:

- discussing with the patient the options available to them to increase their immediate safety, and that of their children.
- encourage the patient to call 999 if they are threatened or feel in danger
- discuss storing domestic abuse helpline numbers on their phone discreetly under a false name.
- ask whether they feel safe to return home or whether they can stay somewhere else
- discuss whether they have access to a mobile phone with good signal and battery
- ask if there are times when the abuse or violence is more severe, for example when their abuser has been drinking. Explore what options they have to avoid being alone with that person at that time.
- check that they know how to delete their browser history and phone messages if they are concerned that their abuser may be checking their devices.
- ask if there are trusted family/friends/neighbours they could tell about the abuse and could go to in an emergency?
- ask if they are considering leaving. This is a high-risk time. Stress to the patient that it's important to get the support of a domestic abuse professional who can help them make a plan to leave safely.
- ask if it would be useful to have additional appointments or calls with the service so that they have contact with someone until longer term support is put in place.

Action Following Disclosure (See flowchart Appendix 3)

1. Offer to complete a domestic abuse, stalking and honour based abuse risk assessment (DASH) this can be found within the safeguarding template on SystmOne of the victim's record, or within the Safeguarding section of Staffnet.

2. The LPT Safeguarding Team to be notified that a DASH has been completed within the patient's records.

3. Discuss safety planning (see safety planning advice).

4. Consider immediate safety (see safety planning advice).

5. Consider police reporting – with patient's consent or using NHS Code of practice for public interest disclosures: https://assets.publishing.service.gov.uk/media/5a757267ed915d6faf2b30d6/Confidentiality_-_NHS_Code_of_Practice_Supplementary_Guidance_on_Public_Interest_Disclosures.pdf

6. Referral to local domestic abuse services https://freeva.org.uk/make-a-referral/ or 0808 802 0028

7. Consider referral to National Centre for Domestic Violence (for legal support) https://www.ncdv.org.uk/third-party-injunction-referral/ or 0800 970 2070

8. Consider referral to Domestic Violence Disclosure Scheme (Clare's Law) https://www.leics.police.uk/rqo/request/ri/request-information/cl/triage/v2/request-information-under-clares-law/

9. Complete eIRF

10. A conversation with the safeguarding team to discuss next steps and to ensure DASH has been quality assured.

All steps should be recorded within the safeguarding template of the VICTIM's electronic patient records only.

1.1.2 Routine Enquiry

Some presentations may be indicative of a patient experiencing domestic abuse or sexual violence. These signs can help staff identify specific patients to ask about domestic abuse. However, in many cases the indicators are subtle or ambiguous.

All clinical staff should therefore set a low threshold for enquiry, asking a broad range of patients and consider asking all patients routinely.

Research shows that survivors of domestic abuse and sexual violence do want to be asked.

Starting the conversation

It is good practice to raise the general subject of domestic abuse at every contact and regardless of who is present. An example of this might be:

“I will ask you questions about abuse from time to time, just to reassure you that I talk about this to everyone I meet, and not because I have any specific concerns about you. You might want to talk to me about something that is happening, and when you feel comfortable to do so”
“We ask everyone about domestic abuse and whether families feel frightened or worried about something that is happening to them. If you ever want to talk to me about anything, we can make sure we have the time to do so.”
Starting conversations in this broader manner, allows individuals to see that we can help, when they are ready to disclose.
These sorts of statements can be made in front of others, but there should be no specific questioning unless the patient is alone.

Patients should only be asked directly about domestic abuse when they are on their own for safety reasons.

This includes not asking in front of children over the age of 2 and family members.
For video or telephone consultations, it’s important that you check with the patient that they are alone.
Family and friends should not be used for translation where this is required, doing so can create risk. Professional translation services should be used.
When speaking to a patient alone in an appropriate environment simple, sensitive but direct questions can be asked to enable disclosures. There is strong evidence to support the policy of asking about domestic abuse and sexual violence within all health settings.
Patients should be asked both:

- whether they are currently experiencing domestic abuse.
- whether they have in the past experienced domestic abuse.

There are many ways in which to enquire, and the most appropriate wording will depend on the patient and the circumstances. Examples include:
Does anyone make you feel scared?
It’s not uncommon for patients with these symptoms to be experiencing abuse from someone, does that sound familiar?
Because domestic abuse & sexual violence are common, I like to ask my patients if that’s something that’s happened to them…
Sometimes patients who have these injuries have been hurt by someone, has that happened to you?
Has anyone hurt you or threatened to?
Do you feel controlled or isolated?
Is anyone controlling or belittling you?
Are there times when sex is unpleasant or painful?
Has anyone ever forced or pressured you into doing things that you weren't comfortable with? What were they?
Do you ever feel you have to have sex when you don't want to?
Have any of these things happened to you previously?
Past experiences of trauma are associated with some health conditions and the patient may need ongoing support.
Your clinical teams may have their own standard operating procedures which provide service specific guidance, please refer to this where applicable alongside this policy.

1.1.3 Young people in abusive relationships

Young people are particularly at risk of intimate partner abuse. The cross-Government definition of domestic violence and abuse was changed in 2013 to encompass 16- and 17-year-olds, in recognition that 16-19-year-olds were the group most likely to suffer abuse from a partner. Additionally, young people in abusive intimate relationships have been shown to experience particularly high levels of sexual violence from their partners.

A Domestic Abuse, Stalking, Harassment and Honour Based Violence (DASH) checklist should be completed with young people, age 13 and above who disclose that they are in an abusive intimate relationship

You can use the standard version of the DASH, however there is also a young person's version with added guidance for responding to this age group.

Young Person's DASH Dash risk checklist: young people - SafeLives

1.1.4 Child to parent abuse

Child and Adolescent to parent violence and abuse (CAPVA) may be referred to as 'adolescent to parent violence (APV)' 'adolescent violence in the home (AVITH)', 'parent abuse', 'child to parent abuse', 'child to parent violence (CPV)', or 'battered parent syndrome'

Exposure to CAPVA can have a serious, long-lasting emotional and psychological impact on children and their parents.

The emotional responses of children who abuse adults may include fear, guilt, shame, sleep disturbances, sadness, depression, and anger.
Practitioners should also be aware of the impact on other children in the family such as stress-induced aches and pains, bedwetting, and inability to concentrate. Some children are the direct victims of other types of abuse or are injured while trying to intervene on behalf of their parent or sibling.

They may also display behavioural responses typical of children who witness domestic abuse such as acting out, withdrawal, or anxiousness to please. A change in achievement or behaviour at school can be an indicator of problems at home.

There are current multi agency workstreams within in LLR to strengthen the response and awareness of CAPVA. The current procedures can be found here: https://llrscb.trixonline.co.uk/chapter/child-and-adolescent-to-parent-violence-and-abuse-capva

1.1.5 Older Person's Abuse

On average, victims aged over 60 experience abuse for twice as long as younger victims before seeking help. There are many reasons why it can be difficult for older victims to speak out. And these barriers don't go away when someone has disclosed.

There are current multi agency workstreams within LLR to strengthen the response and awareness of older person's abuse. Further updates will be provided.

More information can be found here for additional reading: https://www.ageuk.org.uk/discover/2022/december/new-data-on-domestic-abuse-in-older-people/

1.1.6 Domestic Abuse and the Care Act 2014

The Care Act 2014 stipulates the right of all adults with care and support needs to live free from abuse and neglect with this being a key aspect of mental and physical wellbeing.

It is essential for all practitioners to recognise the interface between the Domestic Abuse Act 2021 and the Care Act 2014.

Where an adult is at risk of domestic abuse, consideration should be made for the following:

- Does the adult have care and support needs, and
- Is experiencing, or is at risk of domestic abuse, including neglect, and
- Is unable to protect themselves from this abuse due to their care and support needs.

Practitioners have a duty to raise a Safeguarding alert with the local authority under section 42 of the Care act 2014, alongside completing the Domestic Abuse protection and prevention duties.

Please refer to the LPT Safeguarding Adults' Flowchart (Appendix 4).

1.1.7 LPT Employees and Domestic Abuse

LPT is committed to reducing the impact of domestic abuse on staff, understanding the risks and consequences in the workplace, fully supporting colleagues and taking action against perpetrators of domestic abuse.

Managers should:

- Provide a sympathetic and supportive response to staff who are victims of domestic abuse and take action to improve their safety at work.
- To take responsibility to enquire when concerned about an employee's personal home life.
- To give space, time and a degree of openness for individuals to feel able to talk at the time or at a later date and to create an environment in which employees feel able to come forward for support.
- To listen, reassure and support employees and respond in a sensitive and non-judgmental manner, referring them for appropriate support.
- To seek support and guidance from the domestic abuse lead if consent is given.
- To consider the impact of domestic abuse on the staff members ability to recognize and respond to domestic abuse if disclosed by patients.
- Encourage and reassure that disclosure or referral to services does not mean that they have to leave the relationship. However, if there is a risk of significant harm to individuals or children this will result in the relevant referrals being made.
- Recognise that the abuse by it's nature is cyclical and the survivor may leave and return to the relationship many times. It is critical that the organisation's

responses are trauma informed and makes a commitment to support the victim/survivor during this time.

Employees affected by domestic abuse can expect:

- A positive and sympathetic response.
- A meeting to explore what the trust can do to support you.
- Time and space to make choices and to be supported, whatever decision you make. This can include paid leave.
- Practical support depending on what you need. For example, being escorted to your car after work if you're feeling at risk or a block on calls being put through to you if you're being harassed.
- It is appreciated that you may choose not to share your situation with other colleagues. Disclosures will be handled with the upmost sensitivity and confidentiality whilst following any appropriate safeguarding steps that may apply.

Further information can be found in the additional guidance:
Domestic abuse support process for staff – Guidance for managers.

The LPT health and wellbeing page also have additional resources.
Where there is suspected Organised Drug-Facilitated Sexual Abuse for a member of staff, please contact the safeguarding leadership team only, rather than the safeguarding advice line. See further information on this area in 3.3 of this policy.

1.2 Identification of perpetrators of domestic abuse

Health professionals have opportunity to identify patients perpetrating domestic abuse. Local Domestic abuse related death reviews (DARDRs) have shown that some patients perpetrating abuse have approached health services for support. It is important that staff act when there are concerns.

Clinicians should consider indicators including:

- patients disclosing 'anger management problems' or 'arguments' at home which may be an indirect way of seeking help for abusive behaviours.
- patients disclosing feelings of jealousy, paranoia, low mood or anxiety.
- patients saying that their partner, friends or family have encouraged them to seek help from a health organisation because of their moods or behaviour.

Clinicians should ask gentle, exploratory questions about the patient's relationships, their mental wellbeing and how they manage conflict. These can lead to more direct questions about whether they are concerned about their own behaviour to others.

If the patient disclosing has a partner notify the partner's GP that a clinical enquiry for domestic abuse would be appropriate with that patient. This gives opportunity for the patient at risk to disclose and to seek support. It is essential that patient confidentiality is protected. The partner thought to be at risk should not be told that the clinical enquiry is linked to disclosures received.

In circumstances where there are concerns that the person presents a serious risk to themselves or others, information may need to be shared in order to safeguard the patient or others. Contact the LPT Safeguarding team for support and guidance in this situation.

If a member of LPT staff is alleged, arrested, cautioned or prosecuted for an offence related to domestic abuse or sexual violence, please contact the LPT safeguarding team for advice and support.

1.3 Responding to a disclosure of sexual violence

This policy adopts the World Health Organisation definition of sexual violence.

"Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.

Coercion can encompass varying degrees of force; psychological intimidation, blackmail; or threats (of physical harm or of not obtaining a job/grade etc.). In addition, sexual violence may also take place when someone is not able to give consent – for instance, while intoxicated, drugged, asleep or mentally incapacitated".

Sexual violence can occur both within and outside of the context of domestic abuse.

It is important that this is responded to promptly and that patients are referred to the correct services. They are likely to have physical as well as emotional trauma. There is a short forensic window within which evidence can be secured. Whilst patients may not want to consider or discuss criminal proceedings in the immediacy of a sexual assault, securing the evidence provides them with more options at a later stage.

The Sexual Assault Referral Centres (SARC) are specifically designed to meet the needs of children and adults who have experienced rape and sexual assault.

Sexual Assault of Adults:
If the assault happened in the last 10 days, refer to the Sexual Assault Referral Centre (SARC).

This must be done immediately. See https://juniperlodge.org.uk/ for information on the SARC and how to refer.

Sexual Assault of Children:
East Midlands Children and Young People's Sexual Assault Service - East Midlands Children and Young People's Sexual Assault Service
Nottingham: 0115 8754 595.

The SARC's offer medical, practical and emotional support.

They have specially trained NHS doctors, nurses and support workers who will explain to the patient the options available and who will work at their pace. Patients can also self-refer. They will be offered a forensic medical examination (if applicable), assessment, medical treatment, sexual health advice and emergency contraception to prevent pregnancy.

They can also arrange for the patient to speak informally with a specially trained police officer to help them consider options for reporting to the police. Independent Sexual Violence Advisors (ISVA) will offer support and access to counselling.

The SARC can be called for advice on 0116 273 3330
If the assault happened recently, but more than 10 days ago, the SARC can still offer support, but will be unable to gather forensic evidence.

Organised Drug-Facilitated Sexual Abuse (ODFSA)
Organised Drug-Facilitated Sexual Abuse (ODFSA) is an emerging form of sexual violence and domestic abuse in which an individual is deliberately incapacitated through drugs, alcohol, medication, or other substances to remove their capacity to consent to sexual activity. Recent investigations by the National Crime Agency (NCA) have highlighted that this offending is increasingly organised, involving networks of perpetrators who may connect online, share abuse material, exchange methods, and facilitate assaults against victims.

Unlike traditional perceptions of "spiking", ODFSA frequently occurs:
- Within intimate or long-term relationships.
- In domestic settings.
- Over months or years.
- Without the victim's knowledge.
- Sometimes involving multiple perpetrators.
- With images or videos shared online among offender networks.

Victims can often:
- Have little or no memory of events.
- Do not initially identify themselves as victims.
- Present with physical, psychological, or behavioural symptoms rather than a disclosure.
- May have been subjected to abuse for prolonged periods before concerns emerge.
- Frequently know and trust the perpetrator.
- Be accompanied to health appointments by their partner who dominates and steers the conversation with the health professional.

A person may report:
- Unexplained injuries which may include bruising, particularly genital, breast, inner thigh or unusual body areas.
- Recurrent urinary tract infections and unexplained sexually transmitted infections.
- Sudden onset of dizziness, nausea or confusion.
- Blackouts or memory gaps inconsistent with alcohol intake.
- Anxiety or panic attacks. Post-traumatic stress symptoms. Hypervigilance.
- A sense that "something isn't right" but inability to describe why.

Be curious where a person reports repeated memory loss.

Examples include:
- Waking up in a different room.
- Not remembering events from the previous evening.

- Finding messages, photographs, or purchases they cannot recall making.

LPT staff can play a vital role in early recognition, support and safeguarding for those affected. This includes:

- Listening without judgment; patients may be unsure or lack clear memories
- Responding with care, dignity, and trauma-informed approaches, using the appropriate safeguarding, clinical and forensic processes
- Sharing, where appropriate, information about Sexual assault referral centres (above)

Helpful responses:
"I believe what you are telling me."
"You do not need proof for us to take your concerns seriously."
Due to the rate of changing and emerging information and research, please contact the LPT Safeguarding Team for support for every case of suspected ODFSA to allow us to use the most up to date evidence-based guidance.

1.4 Honour' Based Violence, Forced Marriage and Female Genital Mutilation

There are several abuses that sit under the definition of domestic abuse, but which require a particular response. It is good practice to seek support from the LPT Safeguarding team early due to the often complex situations.

3.4.1 'Honour' Based abuse and violence.

Honour based abuse is an umbrella term for a range of abuses perpetrated in the name of 'honour'. Victims are perceived by the perpetrators to have done something which dishonours their family & the wider community.

Possible indicators of 'honour' dynamics may include:

- Disclosure of a planned marriage that the person is unhappy about
- Threats or pressure from family, extended family or others in the person's community
- Anxiety that disclosures made will not be relayed back to family
- Patients always being accompanied by family members

Disclosures related to HBV need to be responded to quickly and robustly. 'Honour' dynamics can escalate to 'honour' killings rapidly without indicators of worsening violence. You should take the following steps:

1. Establish the wishes of the person at risk and explore what they think may happen.
2. Connect the person with a specialist domestic abuse service or national HBV charity such as Karma Nirvana (https://karmanirvana.org.uk/) immediately. If you are able, offer them a side room to speak with a support worker there and then.
3. Assure them of confidentiality and make sure patient files are properly protected.
4. Establish a code word for communicating by phone so as to prevent others trying to gain information by posing as your patient.

Karma Nirvana have launched the first ever honour based abuse identification tool for us by professionals, to assist in recognising and responding to case of honour based abuse. The tool can be accessed online here:

https://karmanirvana.org.uk/news-item/launching-our-hba-identification-tool/ and professional guidance is also provided.

1.4.2 Forced Marriage

Victims of forced marriage may be taken out the country and forceable married. Young people, particularly women, may be taken overseas under the guise of a 'holiday'. Resisting a marriage can lead to abuse, violence, and 'honour' killings. Additional awareness of the signs of forced marriage for nurses offering travel vaccinations is beneficial.

One serious consequence of forced marriage is the increased likelihood of domestic abuse and sexual abuse. Anyone forced into marriage faces an increased risk of rape and sexual abuse as they may not consent, or may not be the legal age to consent, to a sexual relationship. This in turn may result in unwanted pregnancies or enforced abortions.

Warning signs that a child or young person may be at risk of forced marriage or may have been forced to marry may include:

- Extended absences from school/college, truancy, drop in performance, low motivation, excessive parental restriction and control of movements and history of siblings leaving education early to marry;
- A child talking about an upcoming family holiday that they are worried about, fears that they will be taken out of education and kept abroad;
- Evidence of self-harm, treatment for depression, attempted suicide, social isolation, eating disorders or substance abuse;
- Evidence of family disputes/conflict, domestic abuse or running away from home;
- Unreasonable restrictions such as being kept at home by their parents ('house arrest') or being unable to complete their education;
- A child being in conflict with their parents;
- A child going missing/running away;
- A child always being accompanied including to school and medical appointments;
- A child directly disclosing that they are worried they will be forced to marry;
- Contradictions in the child's account of events.

If there are concerns that a patient may be at risk of a forced marriage, they should be spoken to on their own.

Please seek advice and support from the LPT Safeguarding team if you suspect a potential forced marriage.

LLR procedures and further reading can be found here:
https://llrscb.trixonline.co.uk/chapter/forced-marriage

1.4.3 Female Genital Mutilation

Female Genital Mutilation (FGM) is a serious health threat to girls and women. It is the cut, removal or change of female genitalia for no medical reason.

Female Genital Mutilation of young girls is child abuse.
Regulated health and social care professionals and teachers in England and Wales have a **statutory duty** to report to the police 'known' cases of FGM in under 18s which they identify in the course of their professional work.

'Known' cases are those where either a girl informs the person that an act of FGM – however described – has been carried out on her, or where the person observes physical signs on a girl appearing to show that an act of FGM has been carried out and the person has no reason to believe that the act was necessary for the girl's physical or mental health or for purposes connected with labour or birth.

Reports under the duty should be made as soon as possible after a case is discovered, and best practice is for reports to be made by the close of the next working day.

LLR Safeguarding procedures can be found here:
https://llrscb.trixonline.co.uk/chapter/female-genital-mutilation

Please contact the LPT Safeguarding team for support where required.

FGM Information Sharing Service (FGM IS) : FGM Indicators ensure that clinical systems are 'flagged' where there is a family history of FGM.
FGM-IS is for healthcare professionals and administrative staff who have a responsibility to safeguard girls and provide early intervention of FGM.

Where there is a family history of FGM, authorised health professionals should ensure information is made available via the NHS Digital FGM Information Sharing Service.

Authorised health professionals include:
- GPs
- GP practice nurses
- midwives
- health visitors
- school nurses (NHS)
- local safeguarding leads

The service supports the sharing of FGM information, and allows authorised healthcare professionals and administrative staff throughout England to view information about girls with a family history of FGM, regardless of care setting:
The exact number of girls and women alive today who have undergone FGM is unknown; however, UNICEF estimates that over 200 million girls and women worldwide have had FGM procedures.

Girls are at risk from around the ages of 4 to 14, with the school summer holidays being a particularly high-risk time.

Health professionals are in a strong position to identify victims of FGM and girls at risk. Health Education England have created a short e-learning module including examples of sensitively addressing the issue with patients. https://www.e-lfh.org.uk/programmes/female-genital-mutilation/

FGM is illegal in England and Wales, and professionals should act if they have concerns in relation to women who may be at risk of FGM or have been affected by it. The type of safeguarding intervention needed will depend on how immediate the risk of harm is thought to be. The most appropriate course of action should be decided on a case-by-case basis, with input from all relevant agencies. The wishes of the woman should always be respected.

Action should include:

- making sure the woman receives the care and support she needs, for example by offering referral to community groups for support, clinical intervention or other services as appropriate, such as a referral to an NHS FGM clinic;
- making enquiries about other female family members who may need to be safeguarded from harm. This should include considering the needs of any unborn child if the woman is pregnant.
- considering criminal investigations into the perpetrators, including those who carry out the procedure, to prosecute those who have broken the law and to protect others from harm.
- Adult women who have had FGM should not be automatically referred to adult social care or the police. All cases must individually assessed.
- Professionals should be aware that any disclosure may be the first time that a woman has ever discussed her FGM with anyone, so conversations should always be handed sensitively and the woman's wishes respected. She should be given the time to speak, receive a non-judgemental response and be offered details of local and national support groups.
- When a woman with care and support needs is identified as having had or being at risk of FGM, adult safeguarding procedures should be followed.
- Where there is an immediate or serious risk, an urgent response may be needed, either an urgent referral to adult social care or contacting the police; a FGM Protection Order and / or an Emergency Protection Order may be necessary.
-

For more information see the RCGP page on FGM which includes guidance on reporting. https://www.rcgp.org.uk/policy/rcgp-policy-areas/female-genital-mutilation.aspx.

The NSPCC operate a free FGM helpline Female Genital Mutilation - Prevent & Protect | NSPCC

1.5 Risk assessments and onward referrals

1.5.1 Understanding the risk of domestic abuse and the homicide timeline

Domestic abuse can lead to homicide. On average 2 women a week in England and Wales are killed by a partner or ex-partner.

There are a number of indicators that someone is at high risk of domestic homicide.

These are captured in the Domestic Abuse, Stalking, Harassment and Honour Based Violence (DASH) checklist which can be found within the patient's record, or within the safeguarding section of StaffNet.

It is also important that staff are familiar with the domestic homicide timeline in order to make links with high-risk high harm behaviours.

The Homicide timeline clearly identifies patterns of behaviour that can, in some cases, lead to homicide. Professionals should be aware of high-risk factors.

As well as **Coercive controlling behaviour**, these include:

Separation
Leaving an abusive partner is extremely risky; in London 76% of domestic abuse murder victims had recently ended the relationship. Recent separation with harassment and stalking is a particular high risk.

Pregnancy (pre-birth and under 1s)
30% of domestic violence and abuse starts in pregnancy

Escalation of violence:
Previous domestic abuse is the most effective indicator that further domestic abuse will occur. 35% of households have a second incident within five weeks of the first.

Access to firearms

Non fatal strangulation
Threats to kill. This can include threats to kill the victim, family members, pets or that the alleged perpetrator makes a threat to end their own life.

Stalking and Harassment Research finds that intimate relationship stalkers use more dangerous stalking behaviours than non-intimate relationship stalkers.

Sexual assault and Strangulation
Where abusers use both physical and sexual violence victim/survivors are at an elevated risk. This can sometimes be minimised due to shame or embarrassment, or these behaviours have been normalised as part of the relationship.

Completing a DASH will give staff an indication of the risks to the patient.

Steps to address those risks must also be taken. These will include:
- Safety planning discussion with the patient
- Referral to a specialist support service
- Support from LPT Safeguarding team
- Referral to MARAC if threshold reached
- Referrals to children's social care and adult social care if appropriate

For support with high-risk domestic abuse cases, please contact the LPT Safeguarding Team as early as possible.

More information about the homicide timeline can be found here: https://www.homicidetimeline.co.uk/what-is-the-homicide-timeline.php

1.5.2 Non-fatal strangulation

Non-fatal strangulation (NFS) is common, especially in domestic and sexual abuse/rape and suicide attempts and is a red flag for future lethality. NFS poses significant health risks including strokes, nerve damage and psychological harm. Strangulation may result in acquired brain injury (hypoxic-ischaemic), and this may lead to neuropsychological difficulties.

The Institute for Addressing Strangulation (IFAS) was established in October 2022, following the introduction of new legislation on strangulation and suffocation as a stand-alone offence.

Prior to this strangulation and suffocation did not have the focus required given the dangers of the offence and tended either to be not charged at all or charged as a generic offence such as common assault, or sometimes actual bodily harm.

By recognising strangulation as a standalone offence highlights the severity of strangulation and the deep impact on the victim/ survivor.

Specific guidance for health staff is being developed nationally and is currently available for professionals working within acute and emergency care settings.

More information can be found here: https://ifas.org.uk/

1.5.3 MARAC

When notified that a DASH has been completed by a practitioner, the LPT Safeguarding team will review the assessment, and make contact to arrange a discussion about next steps.

The LPT Senior Safeguarding practitioner, in collaboration with whoever completed the DASH will work together to identify what level of risk is identified and whether a referral to Multi-Agency Risk Assessment Conference (MARAC)is required.

Patients and staff identified to be at risk of domestic homicide must be referred to the local MARAC.

MARAC is a process through which information on families at risk of domestic homicide is shared amongst professionals and an action plan to mitigate those risks is produced.

The primary focus of the MARAC process is to safeguard the adult victim and to prevent domestic homicide. The MARAC will also make links with others to safeguard children and manage the behaviour of the perpetrator. MARAC is based on the principle that no single agency or individual can see the complete picture risk to a family, but all may have insights that are crucial to safety. The family does not attend the meeting, but the adult victim is represented by an Independent Domestic Violence Advisor (IDVA) who speaks on their behalf.

Intervention by a MARAC and an IDVA service has been shown to be highly effective in increasing safety for people experiencing domestic abuse.

It is important that practitioners are comfortable explaining to a patient or member of staff why they are making a referral to MARAC and what the process will mean for them.

It is best practice wherever possible to obtain the patient's support to make a referral to MARAC, however because MARAC is a process for imminent risk of serious harm, it is not a consent-based process.

The thresholds for MARAC referral are:

- high risk identified through a DASH assessment – 14 or more risk indicators identified.
- Professional or clinical judgement that there is serious risk of harm.
- Escalation – indications that the abuse is escalating in severity or frequency
- Repeat – any person previously discussed at MARAC should be rereferred if a repeat incident occurs within 12 months of the original MARAC discussion. Incident means any disclosure of continued abuse.

If referring on the basis of professional judgement, it is important to detail this judgement on the referral form e.g. describing that the abuse is escalating quickly, is very severe, the patient is extremely frightened etc.

If the DASH score is lower than 14, refer to a local domestic abuse service.

More information about MARAC processes can be explained by members of the MARAC team, is discussed within the level 3 safeguarding training sessions, and can be found here:
Short training films on MARAC: https://safelives.org.uk/resources-for-professionals/marac-resources/video-resources-on-the-marac-process/
More information on MARAC: https://safelives.org.uk/resources-for-professionals/marac-resources/

1.6 Record Keeping

It is important that information about domestic abuse disclosures are recorded within the LPT Safeguarding templates on SystmOne.

The DASH risk assessment is included in this template, to avoid the necessity of attaching scanned documents onto the records.

It is important that progress notes are not used to capture safeguarding information, and the correct templates applied, along with saving the information as 'safeguarding relevant'.

Where a domestic abuse disclosure is acted upon, and the LPT patient is NOT the victim (for example the patient is the perpetrator) DASH risk assessments should NOT be completed within the LPT patient records and advice sought from the LPT Safeguarding Team about how best to access the records of the Victim.

Further information about recording keeping and safeguarding can be found on StaffNet and is presented at each Link Practitioner training day.

The LPT Safeguarding Team are always happy to assist with queries about recordkeeping.
Information relating to the changes in access to patient records can be found here Supporting victims and survivors of domestic or sexual abuse - NHS England Digital

1.7 Information Sharing

Health services will adhere to data protection laws (e.g., GDPR in the UK) when managing patient data related to domestic abuse. It is important that any information shared by a patient about domestic abuse is stored securely and only shared with those who need to know (e.g., relevant health professionals, social services, law enforcement, or domestic violence support agencies) with the patient's consent, where possible.

In situations where there is a risk of serious harm, confidentiality may need to be breached to ensure the safety of the patient or others. In such cases, the patient should be informed about this decision as soon as possible.

Using the department of health supplementary guidance is useful in these circumstances to guide decisions about sharing information without consent.
The guide can be found here:
https://assets.publishing.service.gov.uk/media/5a757267ed915d6faf2b30d6/Confidentiality_-_NHS_Code_of_Practice_Supplementary_Guidance_on_Public_Interest_Disclosures.pdf

1.8 Domestic Abuse Related Death Reviews (DARDRs) / Domestic Homicide Reviews (DHRs)

A Domestic Abuse Related Death Review (DARDR) also known as Domestic Homicide Review (DHR) is a multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves.

Since 13 April 2011 there has been a statutory requirement for local areas to conduct a DARDR following a domestic homicide that meets the criteria.

The purpose of a DARDR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

- Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
- Contribute to a better understanding of the nature of domestic violence and abuse.
- Highlight good practice.

It is often the case that people experiencing domestic abuse and/or people perpetrating domestic abuse are known to health services. Organisations may be called upon to provide an Individual Management Review (IMR). For LPT these are completed and submitted by the LPT Safeguarding Team.

It is important that this is provided to the review panel with a comprehensive chronology of involvement with the victim and others that may be the subject of the review. This will allow the review panel and chair to fully analyse events leading up to the death.

For more information see: the Home Office Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) DHR-Statutory-Guidance-161206.pdf (publishing.service.gov.uk)

2. Roles and Responsibilities

2.1 The Chief Nurse/Executive Director of Nursing, Allied Health Professionals & Quality and the **Trust Board** have a duty to ensure that it has policies and procedures in place to effectively safeguard; children and young people, adults; including domestic abuse and those at risk of radicalisation as well as the management of high-risk offenders. The Board will publish an annual safeguarding report and safeguarding assurance declaration on the public website.

2.2 The **Quality and Safety Committee** have a responsibility for approval, development, implementation, review and monitoring effectiveness of these policy and procedures on behalf of the Board, receiving assurance via the Trust Safeguarding Committee bi-monthly update, exception, and annual reports & annual safeguarding declaration.

2.3 The Chief Nurse/Executive Director of Nursing, Allied Health Professionals and Quality is the Executive Safeguarding Lead and will champion safeguarding within the Trust and Is the executive lead portfolio holder for safeguarding and has Board level responsibilities for the requirements under Regulation 11 of the Care Standards Act 2001 and Care Act 2014, and Section 11 of the Children Act 2004.

2.4 The **Deputy Director of Nursing and Quality** will attend strategic Safeguarding Children and Adult Boards and identify a policy lead and ensure safeguarding practice and procedures are reviewed in line with policy. The Deputy Director will also Chair and manage the Safeguarding Committee.

2.5 A **Non-Executive Director** will be appointed to provide scrutiny and additional Board assurance, whilst championing safeguarding across the wider organisation.

2.6 The **LPT Safeguarding Committee** meets every 2 months and has the responsibility to recommend the safeguarding policy and procedures for approval, monitoring the compliance against these and training, safeguarding reporting, multi-agency reviews and audits. The committee will report after every meeting and on an exception basis to the Quality and Safety Committee and review safeguarding training annually.

2.7 It is the responsibility of the **Head of Safeguarding** to ensure that comprehensive arrangements are in place regarding adherence to this policy and that policies and procedures are reviewed in line with local and national guidance and good practice in relation to safeguarding adults, children, Prevent, Multi Agency Public Protection Arrangements (MAPPA) and Domestic Violence and Abuse. This role will also ensure that there are robust advice and training procedures in place in relation to safeguarding adults, children, Prevent, MAPPA and Domestic Violence and Abuse and that safeguarding and public protection are championed across the Trust. The Head of Safeguarding will attend strategic boards and panels to and ensure that the Trust complies with all safeguarding and public protection legislative requirements.

2. 8 It is the responsibility of the **Lead Practitioner for Safeguarding Adults, Mental Capacity, Prevent and MAPPA** and the **Named Professionals** (Named Doctor and Lead Nurse for Safeguarding Children and Domestic Violence) to:

- Act in accordance with the roles and competencies laid out within Working Together to Safeguard Children (HMGov, 2023), Care Act (2014), Prevent & Channel Duties (2015) the Local Safeguarding & Prevent Boards, Adult Safeguarding Roles and Competencies and the Intercollegiate Competencies (RCN, 2024).
- Be responsible for monitoring and auditing the safeguarding, Prevent and MAPP arrangements and activity within the Trust and will report to the Safeguarding Committee where appropriate.
- To provide specialist advice, training, support, guidance, escalation of individual cases and where necessary training and supervision to Safeguarding Link Practitioners and Trust staff. This does not absolve individual practitioners of their professional accountability and duties.

2.9 It is the responsibility of **Operational Directors, Heads of Nursing/Clinical Directors and Leads, Operational Managers and Heads of Service** to ensure that:

- Safeguarding policies and procedures are managed within their own Directorates or Services in line with the guidelines in this policy.
- Team managers and other management staff are given clear instructions about policy arrangements so that they in turn can instruct staff under their direction; this includes on call managers who are required to provide safeguarding advice outside of core working hours in the week and weekends. These arrangements will include:
- Keeping informed of any changes to policies via Communication updates.
- Ensuring that all staff have access to up-to-date policies, through the Trust website or StaffNet.

- Ensuring effective safeguarding assurance and governance processes within Directorates and areas of responsibility.

2.10 **Managers and Team Leaders** will be responsible for**:**

- Ensuring allegations against staff / volunteers / students & contractors, reports of abuse, neglect, risk of radicalisation and high risk to others are reported as per the Trust and multi-agency policy and procedures.
- Ensuring that policies and procedures are followed and understood as appropriate to each staff member's role and function. This information must be given to all new staff on induction.
- Provide safeguarding support and guidance as per the Safeguarding Policy, Trust's Supervision Policy and if an On-Call Manager.
- Promote the use and concept of professional curiosity from staff within team meetings and supervision.
- To ensure that staff seek advice from the LPT Safeguarding Team when indicated and ensure that the advice is followed in a timely way.
- Assess risk to and impact on alerter / referrer / reporter and plan supportive measures where indicated.
- Ensuring that staff within their responsibility know how and where to access current policies and procedures.
- Ensuring that a system is in place for their area of responsibility that keeps staff up to date with new policies and policy changes.
- To ensure staff complete appropriate reporting and recording of safeguarding and risk issues as per Trust procedures.
- To follow up on safeguarding actions via liaison with staff member and escalate matters according to the Trust's escalation procedure where concerns are not being appropriately acted upon by another Trust employee or external agency.
- To ensure staff training compliance is monitored and any non-compliance is addressed in a timely manner.

2.11 **Safeguarding Link Practitioners**

- Raise awareness of safeguarding and public protection within the organisation and wider community.
- To act as a forum for discussion of relevant issues – providing consistency in approach across the organisation and promoting the concept of professional curiosity.
- To robustly disseminate changes to legislation/guidance and practice throughout the organisation.
- Opportunity to share information/examples of best practice with colleagues.
- Provide a support network for colleagues in clinical practice.
- Involvement of frontline staff in decision making regarding safeguarding practice.
- Develop a framework of expertise within localities.
- To provide opportunities for learning, increase knowledge and confidence regarding safeguarding issues.
- To provide a framework for identifying areas in need of strengthening regarding safeguarding practice.
- To attend the Link Practitioner learning and development sessions.

2.12 **Trust Secretary**
On behalf of the approving committees, the Trust Secretary's Office is the central control point for administering the distribution of all policies and maintains a database of all Trust policies and procedures. The Trust Secretary will therefore be responsible for:

- Co-ordinating and managing the creation, consultation, approval, ratification, review and archiving processes for all Trust-wide policies.
- Ensuring that a master copy is kept of all Trust-wide policies and procedures for a minimum period of 10 years in line with the guidance set out in 'The Records Management: NHS Code of Practice' (2023)
- Maintaining a single register of all Trust- wide policies.
- Ensuring that policies follow the prescribed format.
- Ensuring that policies follow the prescribed format.
- Ensuring that policies are kept under review.
- Being the main authority in all but rare circumstances for the inclusion of new policies or procedures on the Internet (in the interests of continuity, version control and security).
- Ensuring that the dedicated Corporate Governance Documents, Policies & Procedures pages of the Internet are regularly kept up to date.
- Ensuring that staff are informed regarding any policy updates or new policies.

2.13 **All Staff** (including seconded staff, volunteers and those who have a roving role in the Trust) should be aware that despite the above responsibilities of senior staff, every staff member has an individual duty of responsibility to ensure that they:

- Know where to locate the safeguarding policy and procedures.
- Adhere to safeguarding processes and carry out their responsibility and duty to report actual or suspected abuse, neglect and risk of radicalisation or from high-risk offenders to their Line Manager.
- Report safeguarding information to the appropriate agency and record actions and outcomes on the Trust's safeguarding child and adult screening tool and/or incident recording system (as per procedure 1D).
- Attend the appropriate level of safeguarding training as per mandatory Training Matrix Section 1E.
- Practice with a mind-set that promotes professional curiosity and enquiry to promote and enable disclosures of abuse.

3. Consent

Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent if they understand the treatment or care about to take place. Consent must be voluntary and informed and the person consenting must have the capacity to make the decision.

In the event that the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following:

- Understand information about the decision.
- Remember that information.
- Use the information to make the decision.
- Communicate the decision.

4. References and Bibliography

College of Policing (COP) **College of Policing Authorised Practice (CPAP) Forced Marriage and Honour-Based Abuse**https://www.college.police.uk/app/major-investigation-and-public-protection/forced-marriage-and-honour-based-abuse

HM Government (2024) **Information sharing advice for practitioners providing safeguarding services to children, young people, parents and carers.** https://assets.publishing.service.gov.uk/media/66320b06c084007696fca731/Info_sharing_advice_content_May_2024.pdf

Department of Health (2010) **Confidentiality: NHS Code of Practice Supplementary Guidance: Public Interest Disclosures** https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216476/dh_122031.pdf

HM Government (2021) **Domestic Abuse Act.** https://www.legislation.gov.uk/ukpga/2021/17/contents/enacted

HM Government (2023) **Working Together to Safeguard Children** https://assets.publishing.service.gov.uk/media/669e7501ab418ab055592a7b/Working_together_to_safeguard_children_2023.pdf

HM government (2018) **Data Protection Act.** https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted

HM Government (2014) **Care Act** https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

Home Office (2015) **Mandatory Reporting of Female Genital Mutilation – procedural information.** https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/573782/FGM_Mandatory_Reporting_-_procedural_information_nov16_FINAL.pdf

Royal College Nursing (RCN) (2019) **Safeguarding Children and Young people: roles and competences for health care staff. Intercollegiate document. https://www.rcn.org.uk/professional-development/publications/pub-007366**

NHS England (2026) Briefing for NHS staff: Organised Drug-Facilitated Sexual Assault

College of Policing: National Centre for Violence Against Women & Girls and public protection (2026) Organised Drug-Facilitated Sexual Assault awareness briefing for stakeholders and partners

National Crime Agency (2026) Sexual offending, domestic abuse and online abuse networks uncovered as law enforcement and prosecutors launch coordinated national response.
https://www.nationalcrimeagency.gov.uk/news/sexual-offending-domestic-abuse-and-online-abuse-networks-uncovered-as-law-enforcement-and-prosecutors-launch-coordinated-national-response?highlight=WyJvZGZzYSJd

Links and resources used in the policy:

LLR Domestic abuse services https://freeva.org.uk/make-a-referral/

National Centre for Domestic Violence injunction service
https://www.ncdv.org.uk/third-party-injunction-referral/

LLR Clare's law application https://www.leics.police.uk/rqo/request/ri/request-information/cl/triage/v2/request-information-under-clares-law/

LLR Sexual assault referral centre (SARC) https://juniperlodge.org.uk/

Honour based abuse assessment tool: https://karmanirvana.org.uk/news-item/launching-our-hba-identification-tool/

LLR procedures links:
https://llrscb.trixonline.co.uk/chapter/forced-marriage
https://llrscb.trixonline.co.uk/chapter/female-genital-mutilation
https://llrscb.trixonline.co.uk/chapter/child-and-adolescent-to-parent-violence-and-abuse-capva

Further information
Homicide timeline
https://www.homicidetimeline.co.uk/what-is-the-homicide-timeline.php

Institute for addressing non fatal strangulation
https://ifas.org.uk/

FGM
https://www.e-lfh.org.uk/programmes/female-genital-mutilation/
https://www.rcgp.org.uk/policy/rcgp-policy-areas/female-genital-mutilation.aspx.

MARAC
https://safelives.org.uk/resources-for-professionals/marac-resources/video-resources-on-the-marac-process/
https://safelives.org.uk/resources-for-professionals/marac-resources/

Legislation

Legislation for all:
- The Crime and Disorder Act 1998
- Female Genital Mutilation Act 2003
- Sexual Offences Act 20023
- Mantal Capacity Act 2005

- UN Convention on the Rights of Persons with Disabilities 2006
- Mental Health Act 2007
- Children And Families Act 2014
- Modern Slavery Act 2015
- Serious Crime Act 2015
- Mental Capacity (Amendment) Act 2019
- NHS Constitution and Values (updated Jan 2021)
- Domestic Abuse Act 2021
- Serious Violence Duty 2023

Safeguarding Children and Young People
- United Nations Convention in the Rights of the Child 1989
- Children Act 1989 and Children Act 2004
- Promoting the Health of Looked After Children 2015
- Children and Social Work Act 2017
- Working Together to Safeguarding Children 2023
- Children Social Care Reforms
- Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff 2019

Safeguarding Adults
- European Convention on Human Rights
- The Care Act 2014
- Care and Support Statutory Guidance- Section 14 Safeguarding
- Adult Safeguarding: Roles and Competencies for Health Care Staff 2018

Trust Policies
- Incident/Serious Incident Reporting Policy.
- Safeguarding and public protection policy
- Data Protection and Information Sharing Policy.
- Mental Capacity Act (2005) Policy.
- Supervision Policy.

Appendix 1: Definitions

Terminology: Descriptor

Coercive and controlling behaviour	Dictating daily routines, restricting freedom. 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.
Consent	A patient's agreement for a health professional to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be valid, the patient must: • be competent to take the particular decision. • have received sufficient information to take it and not be acting under duress.
Controlling behaviour	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.
Due Regard	Having due regard for advancing equality involves: • Removing or minimising disadvantages suffered by people due to their protected characteristics. • Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.
Domestic Abuse	Is any incident 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 their gender or sexuality. (Domestic Abuse Act 2021). For the definition to apply, both parties must be aged 16 or over and 'personally connected'.
Domestic abuse related death review / Domestic Homicide Review	A Domestic Abuse Related Death Review (DARDR), formerly known as Domestic Homicide Reviews (DHR), is carried out where a person has died as a result of abuse, violence or neglect by a relative, intimate partner or member of the same household**.** DARDRs were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004).
Domestic abuse stalking and honour-based abuse risk assessment (DASH)	A risk assessment tool used to identify and understand the level of risk faced by victims of domestic abuse. The assessment categorises risks

	levels and recognises that abuse is multi-dimensional, encompassing various forms of abuse.
Economic Abuse	Controlling finances, preventing access to money, preventing benefit claims, not allowing access to mobile phone, transport, utilities.
Emotional Abuse	Belittling, isolating from friends and family.
Female Genital Mutilation	Comprises all procedures involving the partial or total removal of the external female genitalia or any other injury to the female genital organs for non-medical reasons.
Forced Marriage	Is a marriage in which either or both parties do not (or in the case of some adults with support needs, cannot) consent to the marriage and an element of duress is involved. • Duress can include physical, psychological, financial, sexual, emotional pressure. Consent is essential to all marriages in all religions. • Only a spouse will know if consent is given freely. If the prospective spouse has been placed under familial pressure to marry, then consent is not given freely and therefore it is a forced marriage. • An arranged marriage is very different from a forced marriage. In an arranged marriage, both parties enter the marriage freely. Families of each spouse take a leading role in arranging the marriage and this usually includes the choice of partner. However, the choice of whether to accept the arrangements remains with the prospective spouses. • Criminal activity relating to honour based violence and forced marriage may include: o False imprisonment or kidnap o ABH or GBH. o Threats to kill. o Harassment and stalking. o Sexual assault. o Rape. o Female genital mutilation. o Forced to commit suicide. o Murder.
Homicide Timeline	The Homicide Timeline™ is a new framework for tracking homicide risk in cases of coercive control and stalking.
Honour based abuse/ honour-based violence (HBV):	Honour based violence is a crime or incident, which has or may have been committed to protect or defend the honour of the family and /or community. • "Honour Based Violence" is a fundamental abuse of Human Rights.

	• There is no honour in the commission of murder, rape, kidnap, and the many other acts, behaviour and conduct which make up "violence in the name of so-called honour". • It is a collection of practices, which are used to control behaviour within families or other social groups to protect perceived cultural and religious beliefs and/or honour. • Such violence can occur when perpetrators perceive that a relative has shamed the family and / or community by breaking their honour code. • "Honour Based Violence" can be distinguished from other forms of violence, as it is often committed with some degree of approval and/or collusion from family and/or community members. • Examples may include murder, un-explained death (suicide), fear of or actual forced marriage, controlling sexual activity, domestic abuse (including psychological, physical, sexual, financial or emotional abuse), child abuse, rape, kidnapping, false imprisonment, threats to kill, assault, harassment, forced abortion. This list is not exhaustive.
Non–Fatal Strangulation (NFS)	Strangulation can be defined as obstruction or compression of blood vessels and/or airways by external pressure to the neck impeding normal breathing or circulation of the blood. Non- fatal strangulation is where such strangulation has not directly caused the death of the victims. Fatal strangulation is where death ensues.
Online/Digital Abuse	Taking over social media accounts surveillance. Controlling bank accounts.
Organised Drug-Facilitated Sexual Abuse (ODFSA)	Organised Drug-Facilitated Sexual Abuse (ODFSA) is an emerging form of sexual violence and domestic abuse in which an individual is deliberately incapacitated through drugs, alcohol, medication or other substances to remove their capacity to consent to sexual activity. The abuse is organised, can involve networks of perpetrators who may connect online, share abuse related material, as well as exchanging methods and facilitate assaults against victims.
Personally Connected	Is defined in the act as parties who are: • Intimate partners. • Ex partners. • Family members. • Individuals who share parental responsibility for a child.

Physical Abuse	Hitting, slapping, choking and /or physical force e.g. throwing objects punching walls smashing things.
Post separation abuse	Domestic abuse can continue after a relationship has ended including stalking or repeated control through the family courts.
Psychological abuse	Constant surveillance, threats of harm gaslighting.
Sexual Abuse	Rape, sexual coercion.
Stalking and harassment	GPS tracking surveillance turning up at work or home.

Appendix 2: Governance

Version control and summary of changes

Version number	Date	Description of key change
1	5 June 2025	
1.1	20 August 2025	Comments considered and changes made
2	10 July 2026	Clarification of routine enquiry. Addition or organised Drug-Facilitated Sexual Assault.

Responsibilities

Responsibility	Title
Executive Lead	*Michelle Churchard-Smith*
Policy Author	*Natalie Asser*
Advisors	*Members of the LPT Safeguarding Group*
Policy Expert Group	*LPT Safeguarding Group*

Governance

Governance Level	Name
Level 1 Assurance Oversight	*LPT Safeguarding Group*
Level 2 Delivery Group for policy approval and compliance monitoring	*LPT Safety Forum*

Compliance Measures

KPI	Where will this be reported and how often
Recording and assessment of safeguarding via incident report system or safeguarding screening tools.	LPT Safeguarding Group. Quarterly.
Systems in place to monitor safeguarding training & recording as identified in training matrix.	LPT Safeguarding Group. Monthly.

Training Requirements

There is a need for training identified within this policy. In accordance with the classification of training outlined in the Trust Learning and Development Strategy this training has been identified as mandatory. All Trust staff in a clinical role must attend a training session when current compliance is due to expire. Refresher training must be completed via e-learning every 3 years.

The Governance Group responsible for monitoring the training is the Trust Safeguarding Group.

Training is recognised as a critical control measure in minimising risks associated with healthcare delivery. Ensuring that staff possess the appropriate knowledge and skills significantly reduces the potential for errors, omissions, and unsafe practice.

Managers

- Assess the training needs of staff to ensure they are equipped to meet the expectations set out within this policy.
- Facilitate staff access to all relevant training required for safe and effective compliance with this policy.
- Ensure all staff complete mandatory and role-essential training in line with Trust policy.
- Where gaps in available training are identified, collaborate with the policy author or subject matter expert to develop and agree a training or development plan.
-

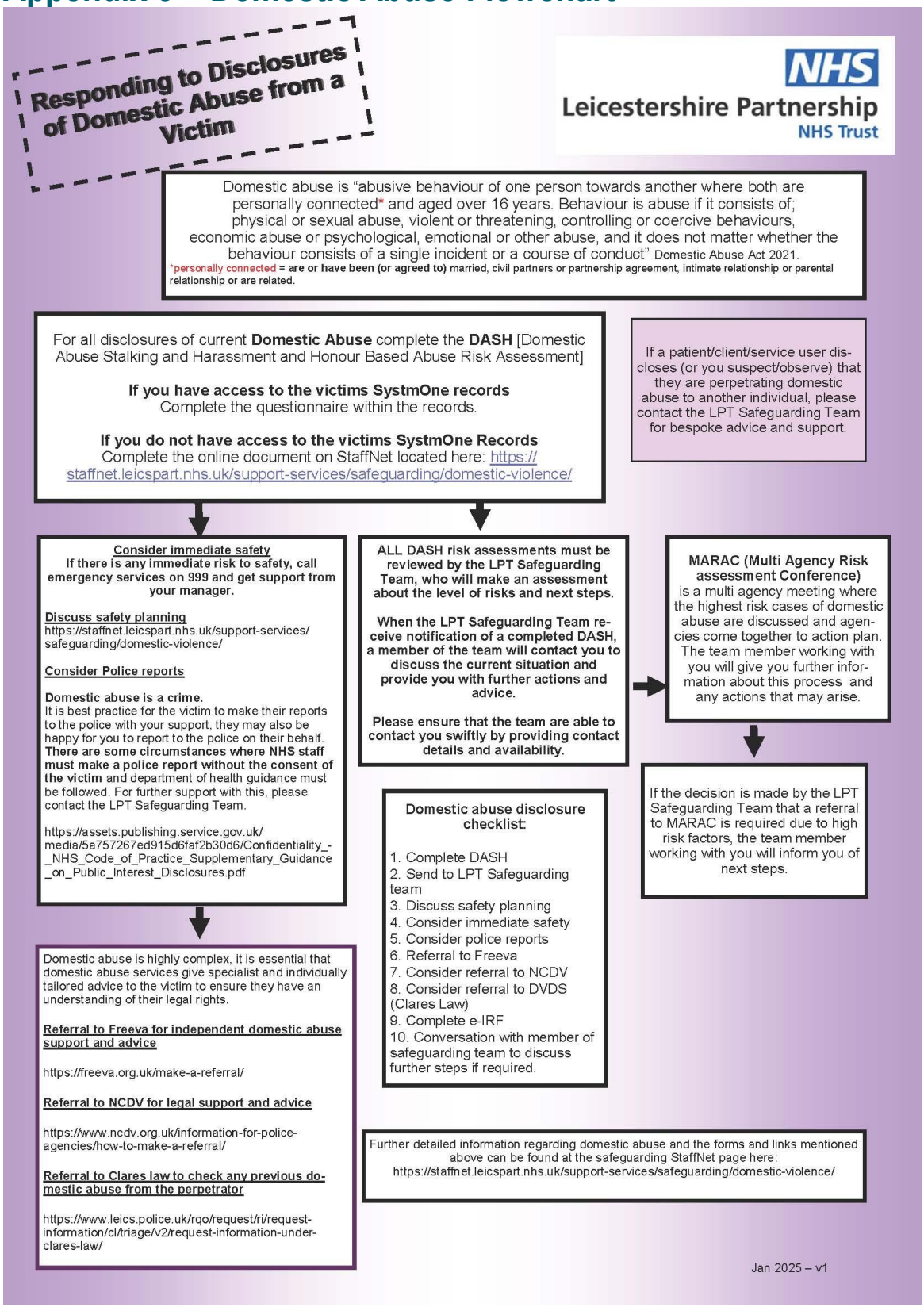
Staff

- Maintain compliance with all mandatory and role-essential training as required by Trust policy.
- Identify any personal learning needs necessary for the safe and effective implementation of this policy, and work with your manager to agree an appropriate training plan to meet these needs.

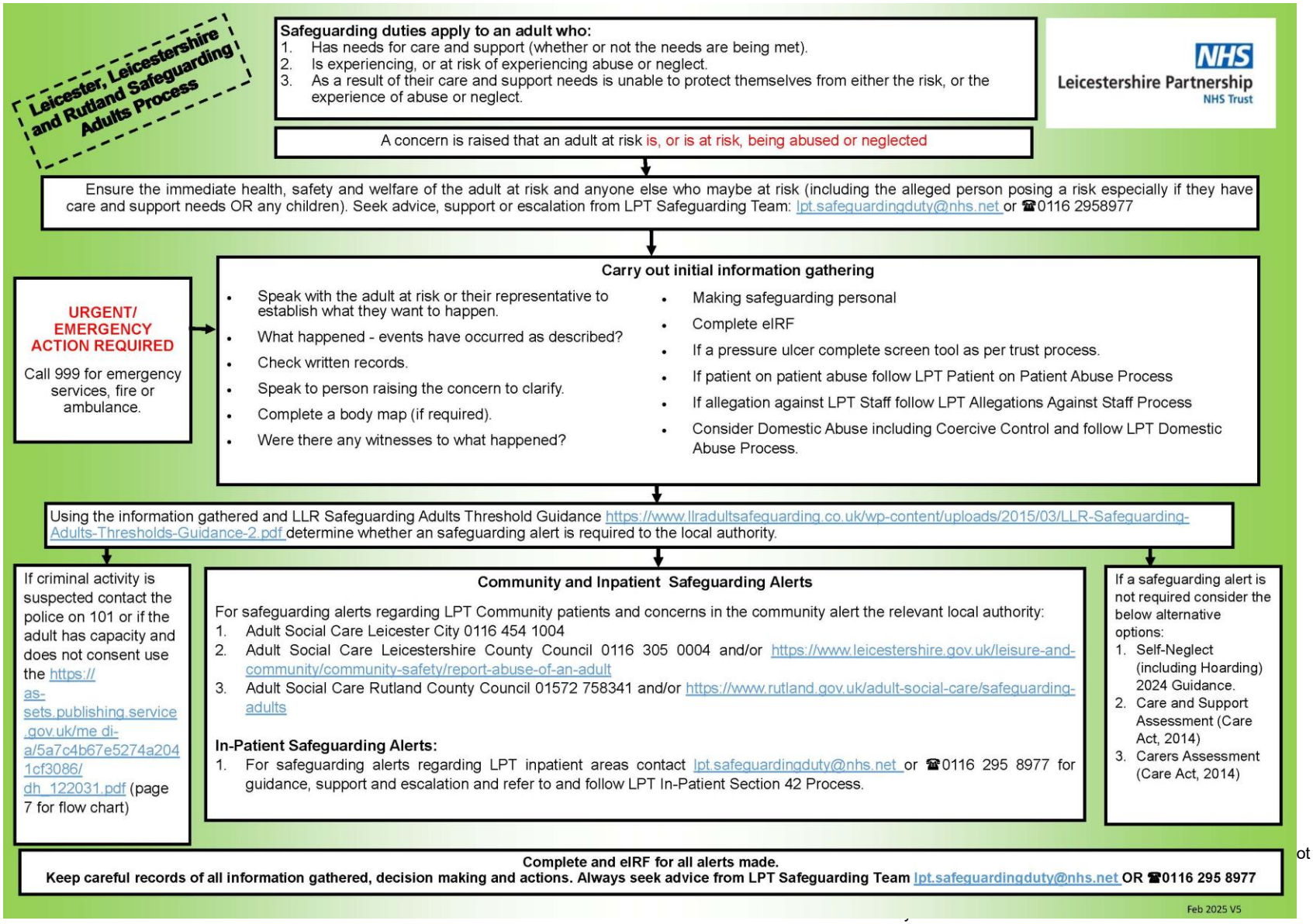
Relevant training currently available to equip staff to deliver the requirements of this policy

Training topic title	Source of training e.g. ulearn, CPD
Level 3 - Child and Adult Safeguarding Training (Whole Family Approach)	1 day training bookable on uLearn

Appendix 3 – Domestic Abuse Flowchart



Appendix 4 – Safeguarding Adults Flowchart



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