Clinical Practice Guidelines: Other/Understanding and Responding to Domestic and Family Violence

Policy code	CPG_OT_UDFV_0722
Date	July, 2022
Purpose	To ensure a consistent appproach to understanding and responding to domestic and family violence.
Scope	Applies to Queensland Ambulance Service (QAS) clinical staff.
Health care setting	Pre-hospital assessment and treatment.
Population	Applies to all ages unless stated otherwise.
Source of funding	Internal – 100%
Author	Clinical Quality & Patient Safety Unit, QAS
Review date	July, 2025
Information security	UNCLASSIFIED – Queensland Government Information Security Classification Framework.
URL	https://ambulance.qld.gov.au/clinical.html

While the QAS has attempted to contact all copyright owners, this has not always been possible. The QAS would welcome notification from any copyright holder who has been omitted or incorrectly acknowledged.

All feedback and suggestions are welcome. Please forward to: Clinical.Guidelines@ambulance.qld.gov.au

Disclaimer

The Digital Clinical Practice Manual is expressly intended for use by appropriately qualified QAS clinicians when performing duties and delivering ambulance services for, and on behalf of, the QAS.

The QAS disclaims, to the maximum extent permitted by law, all responsibility and all liability (including without limitation, liability in negligence) for all expenses, losses, damages and costs incurred for any reason associated with the use of this manual, including the materials within or referred to throughout this document being in any way inaccurate, out of context, incomplete or unavailable.

Understanding and Responding to Domestic and Family Violence

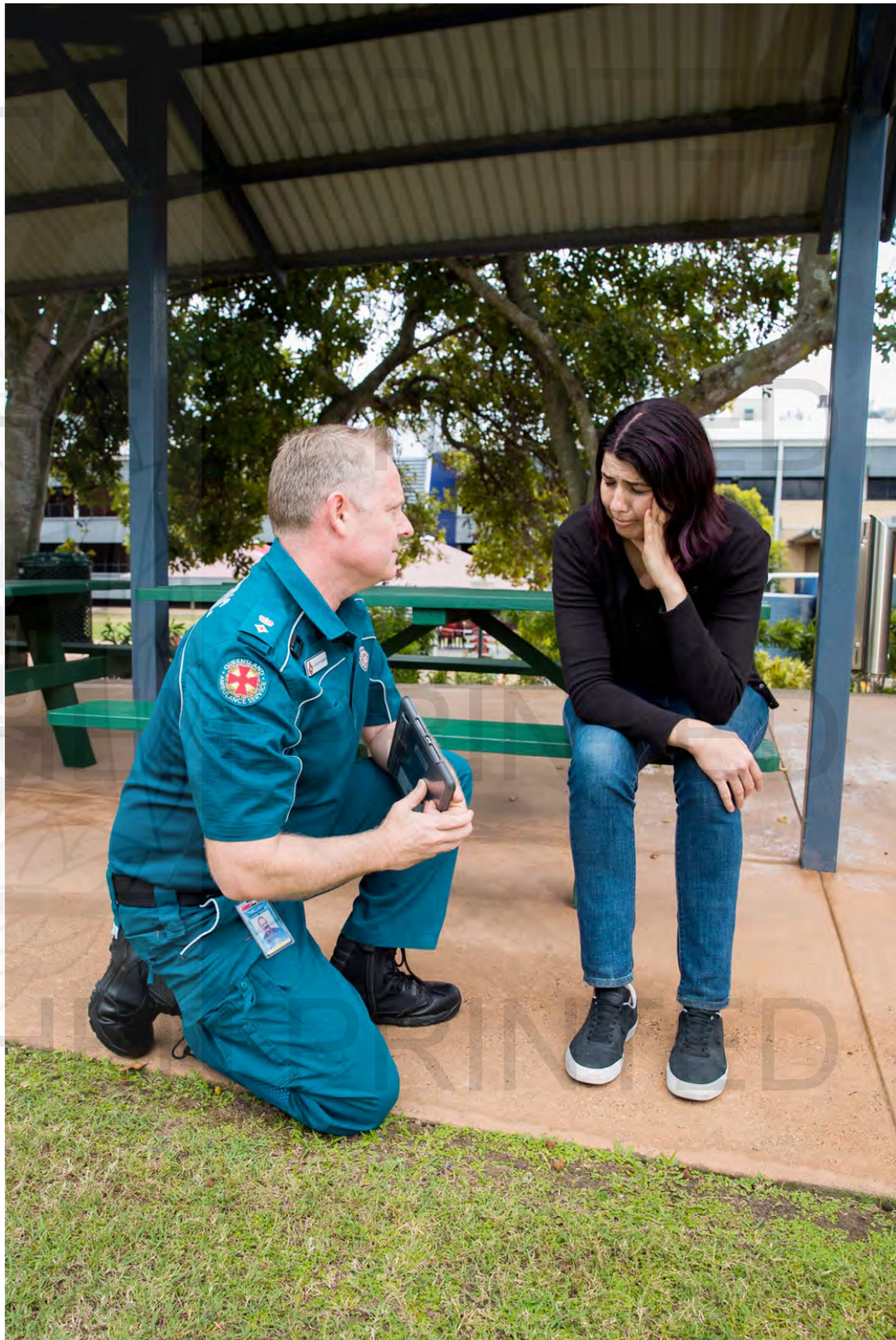
July, 2022

> *It is possible that the information contained in this section may cause some personnel to feel uneasy and trigger personal experiences, reactions and feelings. If this is the case, the reader is encouraged to seek assistance from QAS Priority One, or other applicable specialist services. Further information on support services can be found in the DFV Support Services section of this guideline.*

Domestic and family violence (DFV) is defined in Queensland as behaviour by a person (the first person) towards another person (the second person) with whom the first person is in a relevant relationship, such as a former or existing intimate personal relationship, a family relationship, or an informal carer relationship.[1]

DFV can occur in the family home, a person's workplace, a public place or any location in the community.[2]

The health system is often the first point of contact for individuals who have experienced DFV.[3] The circumstances resulting in that contact will not be limited to physical injuries. It can include a patient that has been threatened, coerced or has witnessed DFV and whose mental wellbeing has been significantly compromised. It is therefore important that ambulance clinicians understand DFV; recognise the signs of DFV; identify the circumstances in which individuals may be exposed to increased clinical risk associated with DFV; and are equipped with the knowledge and skill to respond to cases involving DFV.



In this CPG, the following topics relating to DFV will be addressed:

- Myths, attitudes and facts regarding DFV
- What is DFV
- Categories of abuse and violence that is perpetrated in DFV
- Children exposed to DFV
- Recognising clinical indicators of DFV
- Recognising the clinical indicators of DFV involving children and children exposed to DFV
- Ambulance response to a victim/survivor of DFV
- Ambulance response to a perpetrator of DFV
- DFV support services and referral
- Reporting of DFV and child abuse

Myths, attitudes and facts regarding DFV

Attitudes of community members can often reinforce behaviours that are related to DFV, and in some circumstances, can even excuse DFV. Victim blaming is one such attitude, where it shifts the focus of accountability from the person who commits DFV, to the victim/survivor of DFV. In these circumstances, it is the conduct of the victim/survivor that is questioned. For example: 'why is the person electing to stay in a violent relationship'?

Attitudes about gender roles and behaviours is another factor that may emphasise DFV behaviours as acceptable. For example: comments that 'boys will be boys'; 'men should take control and make decisions in a relationship'; 'boys don't cry'; and 'woman's work is around the home'.

There are also misconceptions that a person's level of education and socio-economic status can be a determinant of DFV. This is far from the case. DFV can affect any person regardless of gender, age, level of education, socio-economic status or cultural background.[3]

While both men and women can be victims of DFV, or in the alternative, use behaviours associated with DFV, the majority of people who experience DFV in Queensland, are women. Understanding the gendered nature of DFV is vital when determining appropriate responses to victims/survivors and providing necessary support.[4]

In addition to gender, there are certain groups that are identified as more vulnerable and at greater risk of being abused in a domestic or family situation. Aboriginal and Torres Strait Island Australians; the elderly; people with a disability; people in rural and remote communities; people from culturally and linguistically diverse (CALD) background; people that identify as lesbian, gay, bisexual, transgender and intersex; and children are all at significantly higher risk of DFV.[4]

What is Domestic and Family Violence?

Domestic violence and family violence have been variably defined in legislation, Government policy and reports. The common thread in the published definitions is that domestic and family violence involves violence that occurs within an existing or former intimate relationship.

The definition that is applied in Queensland is provided in the *Domestic and Family Violence Protection Act 2012* (Qld) (the Act) as:[5]

Behaviour by a person (the first person) **towards another** person (the second person) with whom the first person is in a **relevant relationship** that –

- is physically or sexually abusive; or
- is emotionally or psychologically abusive; or
- is economically abusive; or
- is coercive; or
- in any other way controls or dominates the second person and causes the person to fear for their safety or wellbeing or that of someone else.

There are many types or categories of DFV, all of which are characterised by behaviours that are intended to intimidate, dominate, control, coerce or oppress, causing fear for the person's own safety, or that of another, such as a child or other family member. The two key elements of DFV involve the type or category of behaviour that is directed towards another, and the relationship that exists between the parties (relevant relationship). Both elements are addressed below.

What are relevant relationships in DFV?

One of the two key elements of DFV is the relationship that exists between the perpetrator and the victim/survivor. Relevant relationships include one that involves or has involved an intimate personal relationship; a family relationship; or an informal care relationship.[6]

An **intimate personal relationship** involves one of the following three relationships:[7]

- A **spousal relationship** which includes a couple that are currently, or have previously been married or in a de facto relationship, or a parent or former parent of a child of the person.[8]
- An **engagement relationship** includes a couple that are currently, or were previously engaged to be married to each other, or a betrothal under a cultural or religious tradition.[9]
- A **couple relationship** involves two people that are presently, or have previously been in a relationship as a couple. Factors that are relevant when determining if two people are or were a couple, include the degree of trust; the level of dependency; the duration of the relationship; the frequency of contact; and the degree of intimacy.[10] A couple does not exist merely because two people date or have dated on a number of occasions.[11]

A **family relationship** exists between two people if one of them is, or was, the relative of the other, either by blood or marriage. The concept of a relative may be wider than ordinarily understood. A relative, for the purposes of DFV will also include someone that the person regards as a relative.[12]

Examples of people who may have a wider concept of those that may be relatives, include aboriginal people; Torres Strait Islanders; members of certain communities; and people that may hold specific religious beliefs.

An **informal care relationship** is one in which a person is or was, dependent upon the other for help with one or more activities of daily living, for example, a carer.[13] However, an informal care relationship does not exist between a child and a parent of the child, or a relationship that is commercial in nature, both those that are provided on a fee for service basis, and those that are provided on a voluntary basis.[14]

Categories of abuse and violence that is perpetrated in DFV

There are many types of behaviour that fall within the definition of DFV, all of which are characterised by an intent to intimidate, control and cause fear. The following is a non-exhaustive list of common categories of DFV:[15]

- Physical violence
- Sexual violence
- Psychological and emotional abuse
- Financial or economical abuse
- Coercive control
- Threatening
- Social violence
- Deprivation of liberty
- Stalking and surveillance
- Cultural or spiritual violence
- Technology-facilitated abuse

Physical violence: involves a physical act that results in a personal injury to another, either directly or indirectly by hitting, slapping, shaking, punching, pushing, kicking; choking, burning, biting, smothering, throwing, poisoning, misuse of medication, or use of weapons.

Injuries from physical violence may range from minor trauma, which may or may not be visible, to fractured bones, lacerations, head injuries; and injuries to internal organs. Injuries can also be inflicted by weapons or household items such as a kitchen knife, cooking implement, a hot iron, cigarettes, or a length of rubber hose.[16]

Sexual violence: involves any type of sexual activity for which there is no consent. This may involve rape or penetration of the vagina or anus by penis, digit, or other object, sexual assault, sexual harassment, forced prostitution, and reproductive coercion such as controlling contraception.

Child sexual violence can involve any of the above and can also involve forcing or enticing a child to take part in sexual activities, whether or not the child is aware of what is happening. These activities may involve physical contact, with or without penetration. It can also include non-contact activities such as involving children as observers of sexual activities or encouraging children in a sexually inappropriate way.

Psychological or emotional violence: can be subtle or overt. It can include verbal abuse, intimidation, harassment, bullying and tormenting. The verbal abuse may involve jealous control, ridicule, name calling and humiliation that may be focused on the victim/survivor's intellect, sexuality, physical appearance, or capacity as a parent or partner.[16]

Other acts of psychological or emotional violence can involve threatening harm to the victim/survivor or other family members and family pets, threatening to commit suicide if the victim leaves the relationship, monitoring the victim/survivor's whereabouts and stalking the victim/survivor, restricting the victim/survivor's freedom, and threatening to destroy or damage the victim/survivor's personal property.[17]

Financial or economic violence: can include any behaviour that excludes the victim/survivor from decisions about finances that directly affects them. It can also involve controlling the victim/survivor's access to, and use of, funds to which the victim/survivor is legally entitled. Financial abuse can involve coercing a person to relinquish control over assets and income; disposing of property owned by a victim/survivor or owned jointly with another person against their wishes; theft of welfare funds; and preventing the victim/survivor from seeking employment.[16]

Coercive control: includes social isolation, financial abuse, monitoring the victim/survivor's movements, and monitoring the victim's telephone and online activity.[16]

Threatening behaviour: A perpetrator can make threats to exert control and induce fear. Threats can involve physical threats directed at the victim/survivor or someone that is close to the victim/survivor. Other threats can include threats to harm family pets or assistance animals, damage property, or to inflict physical injuries including threats to kill. A perpetrator can also threaten to harm themselves, or threaten to commit suicide.

Social violence: involves controlling a person's social activities and relationships with friends and family and preventing a victim/survivor from accessing support.

Spiritual and cultural violence: involves exerting dominance, control or coercion over a victim/survivor who is vulnerable due to their spirituality or cultural identity. A perpetrator may ridicule the victim/survivor's faith and prevent the victim/survivor from practicing their faith or observing their culture.

Technology-facilitated abuse: using text messages, email, social media, or telephone to monitor the victim/survivor and to abuse, humiliate, intimidate, and make threats.

Children exposed to DFV

Fifty percent of women who were caring for children at the time that they themselves were experiencing DFV, report that their children were exposed to the violence, in that they either heard or saw the violence take place.[16]

Child exposure to DFV (CEDV) is a recognised phenomenon and one that has become the subject of a growing body of research. In Queensland, exposure to DFV has been defined in the *Domestic and Family Violence Protection Act 2012* as:

> *A child is exposed to domestic violence if the child sees or hears domestic violence or otherwise experiences the effects of domestic violence.* [18]

Exposure to DFV can involve any one or more of the following:

- Overhearing threats of physical abuse
- Overhearing repeated derogatory taunts
- Experiencing financial stress arising from economic abuse
- Seeing or hearing an assault
- Comforting or providing assistance to a person who has been physically abused
- Observing bruising or other injuries that have been sustained by a person who has been physically abused
- Cleaning an area after property has been damaged during an incident of DFV
- Being present at a DFV incident that is attended by police officers. [5]

Children that are, or have been, exposed to DFV can suffer harm that is directly attributable to that exposure. The harm can include one or more of the following:

- *Behavioural issues* such as aggression, physical violence and anti-social behaviour at school and in the community
- *Emotional issues* such as depression, anxiety, low self-esteem, phobias, insomnia, bed wetting and suicidal behaviours
- *Social issues* such as poor social skills, inability to communicate socially, social awkwardness and low levels of empathy.
- *Decreased cognitive and academic functioning* resulting in an inability to concentrate, difficulty with schoolwork, poor problem-solving skills, and lower scores when verbal, motor and cognitive skills are measured
- *Long-term developmental problems* resulting in behavioural, emotional and social issues persisting into adulthood. [19]

There is also an increased risk that children and adolescents living with, and exposed to DFV, may themselves become direct victims of physical and sexual abuse.[20]

Recognising the clinical indicators of DFV

Ambulance clinicians are in a unique position to identify a situation in which a person may be exposed to, or at risk of DFV. Following is a non-exhaustive list of clinical indicators that are often associated with DFV. Clinicians should be alert to the presence of these indicators and the possibility of DFV.

Physical violence

The violence could include hitting, slapping, shaking, pushing, kicking, choking, burning, biting, smothering, throwing, poisoning, restraint and inappropriate sanctions. [20]

Indicators *of physical violence may include unexplained physical injuries such as:*

- Bruising that is both recent and old, particularly to head, neck, arms, wrists, throat or chest or in a parallel strip pattern consistent with that inflicted by a belt, cord or stick
- Injuries to forearms and back consistent with blows sustained while in a defensive pose
- Ligature marks around the neck
- Burns and scalds (including cigarette burns)
- Lacerations
- Human bite marks
- Fractures, both recent and old
- Joint dislocation
- Internal traumatic injuries
- Loss of hair
- Loss of teeth
- Injuries in obscure sites – behind the ears, neck, angle of jaw, inside of mouth/tongue, soles of feet, genital region or buttocks
- 'accidents' that have occurred during pregnancy
- Miscarriages and other pregnancy related complications.

Suspicion *of physical violence may include:*

- Delay in seeking medical aid for injuries sustained
- In cases of child physical abuse, a reluctance by the alleged perpetrator for the child to be examined
- Siblings are blamed for causing injuries to a child
- Alleged perpetrator may infer that the injuries were self-inflicted
- Injuries observed by the ambulance clinician are not consistent with the related history of events
- Continued questioning produces variations in the history of events
- Vague or no explanation is given for the injuries
- Patient may present with a minor complaint that does not correspond to their psychological state, they may be disproportionately distressed, anxious or fearful
- Obvious lack of empathy and concern or inappropriately defensive behaviour from the alleged perpetrator
- The victim and the alleged perpetrator provide markedly different explanations for how the injuries occurred

Emotional or psychological violence and coercive control includes threats of harm, humiliation, intimidation, coercion, harassment, bullying and verbal abuse.[21]

Indicators *of emotional or psychological violence (which may be difficult to identify) can include:*

- Emotional distress (anxiety, indecisiveness, confusion, tearfulness)
- Depression
- Shame
- Low self-esteem
- Submissive behaviour
- Sleeplessness
- Self-harm and suicide attempts
- Emotional distress and tearfulness.

Suspicion *of emotional or psychological violence may include:*

- Partner does most of the talking and insists on remaining with the patient
- Appearing anxious in front of partner
- Psychosomatic and emotional complaints
- Reluctance to follow advice
- Drug and alcohol abuse

Recognising the clinical indicators of DFV and exposure to DFV in children

Indicators of physical *violence may include:* [21]

- Unexplained bruising that is both recent and old, particularly to head, neck, arms, wrists, throat or chest or in a parallel strip pattern consistent with that inflicted by a belt, cord or stick
- Injuries to forearms and back consistent with blows sustained while in a defensive pose
- Burns and scalds (including cigarette burns)
- Lacerations
- Human bite marks
- Fractures, both recent and old
- Joint dislocation
- Internal traumatic injuries
- Loss of hair
- Loss of teeth
- Injuries in obscure sites – behind the ears, neck, angle of jaw, inside of mouth/tongue, soles of feet, genital region or buttocks
- Difficulty in eating/sleeping
- Underweight (in infants)
- Unexplained bruising and other injuries

Indicators of exposure *to DFV* [22]

- Aggressive behaviour
- Anti-social behaviour
- Depression, anxiety and/or suicide attempts
- Abuse of siblings
- Exhibiting sexually abusive behaviour
- Alcohol and substance use
- Fighting with peers
- Stealing and social isolation
- 'Acting out', for example cruelty to animals
- Bedwetting
- Appearing nervous and withdrawn
- Difficulty adjusting to change
- Noticeable decline in school performance
- Regressive behaviour in toddlers
- Delays or problems with language development
- Overprotective or afraid to leave parent who is the victim/survivor of DFV
- Psychosomatic illness
- Restlessness and problems with concentration
- Feelings of worthlessness
- Insomnia
- Fear and phobias
- Inability to communicate

Note these are not exhaustive lists but may provide guidance when assessing the welfare of a patient and a child or adolescent that may be at the scene.

Ambulance response to a victim of DFV

A supportive response from the ambulance clinician can reinforce a victim/survivor's understanding that they are entitled to a healthy relationship, and a life free from violence. Focusing on the needs of the individual can be achieved through displaying empathy, a non-judgemental attitude and offering privacy and confidentiality.[19]

The first priority is the safety of the victim/survivor of DFV, and any children that may have been exposed to the DFV.

A victim of DFV may fear the potential consequences should he or she disclose the violence to the ambulance clinician. The ambulance clinician should therefore be alert to the indicators of DFV, and aware of the circumstances that may render a person vulnerable to further violence.

The following steps have been provided to assist the ambulance clinician responding to a victim/survivor of DFV or where DFV is suspected. The response however must take into account the diversity of the victim/survivor including the person's culture, language, disability, sexual orientation and age.[20]

It is also recommended that the ambulance clinician seek advice from a specialist clinician, such as the QAS Mental Health Liaison Clinician, in relation to patient assessment, risk analysis, safety planning and scene management. The QAS Mental Health Liaison Clinician can be accessed 24/7 via the *QAS Clinical Consultation and Advice Line*.

1. *Detection of Abuse/DFV*

The ambulance clinician should obtain a comprehensive social history and conduct a thorough clinical assessment to identify immediate safety needs and health needs.

2. *Provide emotional support*

Locate a private place in which to talk and allow the patient to tell their story and do so in their own time.

- Encourage the patient to talk using their own language
- Ask only enough questions to be clear about what the patient is saying
- Do not over interrogate the patient or ask leading questions
- Ensure the questions are medically pertinent and relevant to the ongoing treatment of the patient
- Do not make any promises to the patient about keeping any disclosed information secret
- Act on the basis that the information disclosed is true (other agencies will undertake appropriate investigation)
- Do not advise the alleged perpetrator of the allegations
- Non-judgemental and careful listening is critical during the conversations.
- Do not tell the patient what to do, rather help the patient to explore options that are available.
- Communicate belief in what you are being told – *'that must have been frightening for you …'*
- Validate the experience of DFV – *'it must have been difficult for you to talk about this …'*
- Affirm that violence is unacceptable behaviour – *'violence is unacceptable; you don't deserve to be treated in this way …'*
- Show support toward the patient by taking time to listen and provide information about who can further assist
- Respond to any concern about safety – offer referral to specialist support services such as **DV Connect, 1800 Respect** (only if safe to do so)

Never ask:

- Why don't you leave?
- What could you have done to avoid the situation?
- Why did he/she hit you?

3. Assess risk

*Determine the **degree of urgency** and the level of risk to which the patient is exposed:*

- Is there a significant risk to the patient's health?
- Is there a risk of serious physical harm or death?
- Is there the potential for self-harm?
- Are there children at risk of harm?

*The following factors may indicate that a person is at higher **risk of experiencing DFV:***

- The victim/survivor is pregnant or has recently delivered a baby
- The victim/s is isolated
- The victim/s engages in substance abuse
- There has been a recent separation or plans to separate
- Financial hardship or stress
- Escalation in severity and frequency of DFV

*The following factors may indicate that **DFV** inflicted by the alleged perpetrator* **could escalate:**

- Threats to kill
- Use of non-lethal strangulation/choking
- Access to/use of weapons
- Substance abuse
- Stalking
- Sexual violence
- Threats or direct harm to children
- Suicidality/threats to kill oneself
- Threats or harm to animals and pets
- Breach of intervention order
- Jealous, controlling behaviour
- Escalation in severity and frequency of DFV

4. Safety planning

If the ambulance clinician reasonably suspects that the patient is at risk of serious harm or death, the clinician should inform the patient (if appropriate) of those concerns and seek immediate advice from the QAS Mental Health Liaison Clinician *(QAS Clinical Consultation and Advice Line)* and report the matter to the Queensland Police Service (QPS).

If the patient is a child, the ambulance clinician should obtain consent to transport the patient to hospital (if required). If consent is not forthcoming, the clinician should refer to the guideline below as it relates to children who may be at risks of serious harm and in need of protection

DV support services and referral: There are a number of key services and service providers that may respond to an incident involving DFV and CEDV in the community. QPS officers and QAS clinicians are likely to be the first responders to such an incident. Ambulance clinicians are therefore in a unique position to recognise DFV, and children exposed to DFV, and have a vital role to play in responding to disclosures of DFV and referring victims/survivors and perpetrators to specialist support services.

When responding to disclosures of DFV and CEDV, the ambulance clinician should use the support networks available to assist them to provide the best possible outcome for the victim/survivor of DFV and their children.

*The ambulance clinician may **consult** with:*

Service	Contact details	Availability
QAS Mental Health Liaison Service	Via QAS Clinical Consultation and Advice Line	24 hours, 7 days a week
DVConnect – Womensline	1800 811 811	24 hours, 7 days a week
DVConnect – Mensline	1800 600 636	9 am to midnight, 7 days a week
1800 RESPECT	1800 737 732	24 hours, 7 days a week
Elder Abuse Helpline	1300 651 192	9 pm to 5 pm, Monday to Friday
Sexual Assault Helpline	1800 010 120	9 am to midnight, 7 days a week
National Disability Abuse and Neglect Hotline	1800 880 052	9 am to 7 pm, Monday to Friday
Lifeline	131114	24 hours, 7 days a week
Mensline Australia	1300 789 978	24 hours, 7 days a week
Policelink	131444	24 hours, 7 days a week
Legal Aid Queensland	1300 651 188	8 am to 5 pm, Monday to Friday

*The ambulance clinician may refer the victim/survivor, **with consent,** to any of the above listed support services plus that listed below.*

Service provider	Contact Details & Availability	Details of Service Provided
DVConnect	**1800 811 811** 24 hours, 7 days a week	DVConnect will contact the victim to provide further assistance. DVConnect can organise refuge, accommodation and transport for the victim/survivor along with ongoing assistance tailored to the person's specific situation, wants and needs
Victim Assist Queensland	https://www.qld.gov.au/law/crime-and-police/victim-assist-queensland	Victim Assist Queensland provides information and advice for victims of crime, including information about support services, victim's rights and financial assistance.
Queensland Police Service	**131 444** 24 hours, 7 days a week **000** 24 hours, 7 days a week	Reporting of non-urgent incidents or crimes. Reporting urgent incidents.

Ensure the victim/survivor is aware that clinicians are not authorised to provide legal advice or directly advocate on the patient's behalf.

Information Sharing

Provisions in the *Domestic and Family Violence Protection Act 2012* enable prescribed entities, which includes the QAS, to share **relevant information** with another prescribed entity, or a specialist DFV service provider, for the following purpose:

- to **assess** whether there is a *serious threat* to the life, health, or safety of a person/s because of DFV; and
- to **respond** to a *serious threat* to the life, health, or safety of a person because of DFV; and
- to **refer** people who fear or experience DFV, or those who commit DFV, to specialist DFV service providers.[23] (See '*Additional Information*' section for a complete list of prescribed entities)

A **serious DFV threat** may arise in circumstances where there is a pending or recent separation, non-lethal strangulation, threats to kill, an extended history of DFV, stalking, intimate partner sexual violence, an escalation in the intensity and frequency of DFV and/or coercive control, or where the perpetrator has access to a weapon.

Relevant information may include (but is not limited to) the patient's history relating to the attendance of the ambulance clinicians, the nature of the patient's injuries as assessed by the ambulance clinician, or any other information that may indicate a serious DFV threat.

Obtaining a patient's **consent to share** their information with another entity or service provider is preferable, and should be sought where it is safe, possible, and practical to do so. Circumstances may exist where it is not safe or practical to seek consent. In these circumstances, the safety, protection, and wellbeing of people who fear, or experience DFV, including children, is paramount.[24]

Sharing information **without consent** is permitted under the *Domestic and Family Violence Protection Act 1991*, and furthermore, is an exception to the duty of confidentiality in section 49 of the *Ambulance Service Act 1991*.

Before sharing information about a patient, the ambulance clinician must consider whether disclosing the information is likely to adversely affect the safety of the patient or another person.

Documentation is essential. Comprehensive details must be recorded in the eARF regarding any information that is shared, and the entity to which the information is shared. If a serious DFV threat exists and information is not shared, details regarding the factors which influenced that decision must also be recorded.

Additional Information

A prescribed entity for the purposes of sharing information, means the following:

- The Chief Executive of a Department that is responsible for the following:
  - Adult corrective services;
  - Child protective services;
  - Community services;
  - Court services;
  - Disability services;
  - Education;
  - Housing services;
  - Public health services;
  - Youth justice services;
- The Chief Executive of another Department that provides services to person who fear or experience DFV, or who commit DFV;
- The Ambulance Commissioner;
- The Police Commissioner;
- The Chief Executive of Mater Misericordiae Ltd;
- A health service Chief Executive under the *Hospital and Health Boards Act 2011*; or
- The principal of a school;
- A specialist DFV service provider; or
- A support service provider (counselling, disability services, health services, housing and homelessness services, legal services, sexual assault services)

5. *Reporting*

DFV and Child Abuse (not sexual): Ambulance clinicians are encouraged to report a reasonable suspicion of harm associated with child abuse or neglect in the context of DFV or CDFV.

If the victim/survivor of DFV is a child (under the age of 18 years),[20] and the ambulance clinician forms a reasonable suspicion that the child has suffered significant harm, or is at risk of suffering harm and may be in need of protection, the clinician should inform the Department of Children, Youth Justice and Multicultural Affairs (Child Safety) and can do so in accordance with section 13A of the *Child Protection Act 1999* (Qld). This section also applies to an unborn child that may be in need of protection after he or she is born.[25]

The factors that the ambulance clinician may consider when deciding to inform Child Safety includes anything that the clinician views as relevant to forming his or her suspicion, including:

- the age of the child;
- whether there are detrimental effects on the child's body or the child's psychological or emotional state that are evident to the clinician, or the clinician considers are likely to become evident in the future;
- the nature and severity of the detrimental effects; and
- the likelihood that any detrimental effects will continue.[26]

Reporting a reasonable suspicion

The ambulance clinician can immediately inform Child Safety in writing and can do so on-line using a 'Report of suspected child in need of protection' form. A link to the form is provided below.

The **form can be completed and submitted** on-line, or completed, printed and forwarded to the relevant Child Safety Regional Intake Service (contact the relevant office to obtain an address for this purpose).

When completing the form, select the option that the report is made under 'section 13A of the *Child Protection Act 1999*', and select 'other health professional' when recording 'reporter type'.

Alternatively, the ambulance **clinician can telephone** a Child Safety Services' Regional Intake Service, the contact numbers for which are listed below. If this option is preferred, it is recommended that the clinician first access the *'Report of suspected child in need of protection'* form and provide verbal details in relation to that which is asked on the form.

Child Safety Services Regional Intake Service (Mon-Fri (0900 - 1700))	
Brisbane	[redacted]
Central Queensland	[redacted]
Far North Queensland	[redacted]
Ipswich	[redacted]
North Coast	[redacted]
North Queensland	[redacted]
South East Queensland	[redacted]
South West Queensland (Darling Downs)	[redacted]
Child Safety After Hours Service Centre for callers from QH/QAS	
All Queensland	[redacted]
Legal Aid Queensland	
All Queensland	1300 651 188
'Report of suspected child in need of protection' form	
[redacted]	

The ambulance clinician providing information to Child Safety is protected from liability arising from the provision of that information. Information provided to Child Safety, including the identity of the ambulance clinician who is providing the information, is subject to the provisions of the *Child Protection Act 1999* and the Information *Privacy Act 1999*. The information is to be kept confidential and only disclosed in accordance with that permitted under the Act.

Abuse of a child (sexual): If the ambulance clinician believes, on reasonable grounds, that:

- a child under the age of 16 years; or
- a child aged 16 years and under 18 years with an impairment of the mind *(see definition below)*,

has been sexually abused/assaulted, the clinician MUST REPORT the alleged abuse/assault to the QPS or Child Safety *(see above)* as soon as it is reasonably practical to do so.[27]

Reasonable grounds could include directly witnessing the abuse occurring; obtaining information that an abuse has occurred (e.g. a child states they have been sexually abused); or observing clinical signs consistent with sexual abuse.

Note:

- A *child* is a person under the age of 18 years[28]
- A *person with an impairment of mind* means a person (who is a child) who has a disability that is attributable to an intellectual, psychiatric, cognitive, or neurological impairment or a combination of any of the above, resulting in substantial reduction of the person's capacity for communication, social interaction or learning and the person needs support.[29]
- This *obligation to report is mandatory* and is not limited to the clinician's role as a QAS employee. The obligation extends outside the workplace as an adult within the Queensland community. A failure to report a reasonable belief of sexual abuse/assault will amount to a criminal offence, unless the clinician believes, on reasonable grounds that the information has already been reported.[27]

6. Documentation

In all cases of suspected or disclosed DFV, the ambulance clinician should record comprehensive details of the following:

- the clinical assessment findings;
- details of any information disclosed by the patient or others at the scene;
- details of any children at the scene who may be exposed to DFV;
- relevant details of the environment in which the patient was located;
- information provided to the patient regarding available support services;
- recommendations for management including transport to hospital;
- if suspicion that the DFV is escalating posing significant risk to victim/survivor and others, details and circumstances that resulted in the clinician reaching that conclusion;
- if suspicion reported to another agency, information regarding the time and the agency to which the suspicion was reported, including mandatory reporting of child sexual abuse/assault; and
- if mandatory reporting of child sexual abuse/assault has been reported by receiving hospital personnel, record the name of the person who reported the abuse/assault, the time at which it was reported, and the agency to which to it was reported.

The eARF must record 'DFV' in the pre-existing/social situation/risk factors section of the document. If children were present at the scene and exposed to 'DFV', this must be recorded in the same section.

Ambulance response to a perpetrator of DFV

In some circumstances, the ambulance clinician may engage with an alleged perpetrator of DFV. Perpetrators come from all socioeconomic, cultural and social groups. They will often attempt to minimise their responsibility for their violent behaviours and convince themselves and others that they are not responsible.

If a person discloses that they are responsible for committing violence, the ambulance clinician should reinforce that violence is not acceptable and refer the person to an appropriate support service *(see below)*.

Tips for ambulance clinicians

Never ask:

Questions of the person who commits DFV in the presence of a victim/survivor or a victim/survivor in the presence of a someone who commits DFV.

The ambulance clinician should not ask questions of the perpetrator of DFV. Asking questions about the perpetrator's alleged behaviours is the role of specialist clinicians.[19]

Additional Information

When responding to a case of DFV as the initial responding service, your primary responsibility is your own personal safety and the immediate medical assessment and treatment of the victim. If a risk assessment returns a high likelihood of immediate danger for any involved parties, including QAS staff, immediate QPS involvement must be requested.

UNCONTROLLED WHEN PRINTED
UNCONTROLLED WHEN PRINTED
UNCONTROLLED WHEN PRINTED

Information Sharing – Domestic and Family Violence (DFV) and Children Exposed to DFV

Discretionary information sharing with a prescribed entity
Domestic & Family Violence Protection Act 2012, S169DE

- **to ASSESS if there is a serious threat to the life, health, or safety of a person**
- **to RESPOND to a serious threat**
- **to REFER people to specialist DFV providers who fear or experience DFV OR commit DFV**

Does the patient consent for information disclosure with a prescribed entity?

Y

Consider:

- **Encourage the patient to contact a specialist DFV provider, and assist patient to do this if required.**
- **Sharing this information with a prescribed entity such as:**
  - **DV Connect (1800 811 811)**
  - **1800 RESPECT (1800 737 732)**
  - **QPS via Policelink (131 444)**
- **Document within your eARF the patient's consent and any information that was shared, and the entity to which it was shared.**

N

Is the disclosure likely to adversely affect the safety of the patient or another?

N

Consider:

- **Sharing this information with a prescribed entity such as:**
  - **QPS via Policelink (131 444)**
- **Document within your eARF any information that was shared and the entity to which it was shared.**

Y

Consider:

- **Contact the *QAS Clinical Consultation & Advice Line* (ambulance medical officer) for case specific management guidance and advice.**
- **If information is NOT shared, document within your eARF the factors that influenced your decision not to share information with a prescribed entity.**

Mandatory Reporting – Sexual Abuse of a Child or Person with Impairment of Mind

Indicators of sexual abuse of a child < 16 years OR a child aged 16 years and under 18 years who has an impairment of mind identified.

Mandatory reporting required
Criminal Code Act 1899, S229BC

Patient transported to hospital?

Y

Must:

- Contact the *QAS Clinical Consultation and Advice Line* for case specific management guidance and advice.
- Provide a verbal handover at hospital detailing the sexual abuse.
- Report all relevant information regarding the sexual abuse to QPS via Policelink (131 444) OR confirm the receiving hospital personnel HAVE REPORTED the sexual abuse to either QPS or Child Safety.
- Document within your eARF all relevant information regarding the sexual abuse that was reported. Also include details regarding the name of the hospital employee that reported the sexual abuse, the time at which it was reported, and the agency to which it was reported.

N

Must:

- Report all relevant information regarding the sexual abuse to QPS via Policelink (131 444)
- Document within your eARF all relevant information regarding the sexual abuse that was reported. Also include information confirming that the abuse was reported to QPS and the time at which it was reported.

Discretionary Reporting – Child Abuse (Not Sexual)

Reasonable suspicion of abuse of a child (< 18 years) in need of protection (not sexual) OR an unborn child in need of protection once born.

↓

Discretionary reporting to Child Safety
Child Protection Act 1999, S13A

↓

Consider:

- **Completing a 'report of a suspected child in need of protection form' using the link below:**
  [redacted]

  OR
- **Contact the Child Safety Services Regional Intake Service in your area (Mon–Fri 09:00–17:00)**

  OR
- **The Child Safety After Hours Service Centre at all other times ([redacted])**
- **Document within your eARF all relevant information regarding the abuse that was reported.**