

County of San Diego
Health and Human Services Agency (HHSA)

Chapter: Policy, Strategy and Program Development
Key Words: Domestic Violence, Intimate Partner Violence

**SUBJECT: Domestic Violence/Intimate Partner
Violence Reporting**

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REFERENCES: Business and Professional Code Sections 2089, 2191, 2736.1, 2811.5, 2914, 2915, 4980.57, 4997; Family Code Section 6211; Health and Safety Code Sections 1233.5, 242.50 (a) (1), 1259.5; Penal Code Sections 11160-1163.2, 11165.8, 13700.

PURPOSE: This policy describes who must report, and how and when to report suspected domestic violence/intimate partner violence identified in the course of providing medical services for an injury or wound.

BACKGROUND:

Domestic Violence is a pattern of coercive behaviors that involves physical abuse or the threat of physical abuse. It also may include repeated psychological abuse, sexual assault, progressive social isolation, deprivation, intimidation or economic coercion. It is violence perpetrated by adults or adolescents against their intimate partners in current or former dating, married or cohabiting relationships including heterosexual, gay men, lesbian, bisexual and transgender individuals.

POLICY: California State law requires that **any health practitioner** (see Appendix A for definition of Health Practitioner) employed in a health facility, clinic, physician's office, local or State public health department, or a clinic or other type of facility operated by a local or state public health department who, in his or her professional capacity or within the scope of his or her employment, provides medical services for a **physical condition** to a patient who he or she knows or reasonably suspects is a person who:

1. is suffering from any wound or other physical injury inflicted by his or her own act or inflicted by another where the injury is by means of a firearm, and/or
2. is suffering from any wound or other physical injury inflicted upon the person where the injury is the result of assaultive or abusive conduct (see Appendix A for the definition of "assaultive or abusive conduct").

All HHSA employees whose professional duties **mandate** them in the Act as reporters of domestic violence/intimate partner violence will receive annual updates on current legislation, identification and reporting of domestic violence/intimate partner violence, as part of their training. (See page 5 under Training Procedures).

HHSA employees whose professional duties **do not** mandate them, as reporters of domestic violence/intimate partner violence in the Act will receive annual updates on current legislation, identification and reporting of domestic violence/intimate partner violence, and do one of the following: 1) refer the patient to appropriate resources (see Attachment #3 for a list of HHSA approved resources, 2) report to law enforcement, and/or 3) bring the suspected abuse to the attention of a mandated reporter. Document in patient's chart which action was taken. (See page 5 under Training Procedures).

REPORTING PROCEDURES: After assessing and interviewing a patient, and the health practitioner knows or reasonably suspects domestic violence, she or he is required to report the suspected abuse, according to the following procedures:

1. Inform the patient of the health care provider's duty to report.

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REPORTING PROCEDURES- continued

2. Inform the patient of the likely response(s) by law enforcement and what will happen to the report (see page 5).
3. Make a telephone report to the local law enforcement agency **where the incident occurred**, immediately, or as soon as practically possible, regarding the person (see page 2 of the Suspected Intentional Injury Reporting Form).
4. Complete a Suspected Intentional Injury Reporting Form (see Attachment #2), and send within 48 hours of receiving information about the person to the law enforcement agency **where the incident occurred**, or the local law enforcement agency with jurisdiction over the medical facility.
5. When two or more HHS employees suspect a domestic violence incident that requires a report, only one person needs to submit the report. However, chief reporting responsibilities remain with the highest-ranking health practitioner who has knowledge of the event.
6. **All** health care providers involved are equally responsible to see that the report is made and completed, according to State requirements.
7. The report must be kept confidential (See Appendix B).
8. A report must still be made even if the person has died, regardless of whether or not the injury contributed to the death, and even if evidence of the conduct of the perpetrator was discovered during an autopsy.
9. The health practitioner is to enter into the patient's chart, in addition to the routine medical record notes and entries, the following information:
 - a) Any comments by the patient, regarding past domestic violence/intimate partner violence or the name of any person suspected of inflicting the injuries or wounds by their abusive actions.
 - b) A completed "Body Diagram Map", including the front and back of the body, identifying their injuries, wounds, bruises and painful locations on to the diagram (see Attachment #1 - Body Diagram Map).
 - c) A copy of the Suspected Intentional Injury Reporting Form.
10. The health practitioner must refer the patient and other involved individuals to local domestic violence services and other appropriate resources (see Attachment #3 for the approved Office of Violence Prevention Resource List).
11. See Appendix B for Doctor/patient privilege, liability and failure to report issues.

RAPE OR SEXUAL ASSAULT PROCEDURES: Domestic violence comprised of sexual assault or rape may require special procedures. The health practitioner is required to check the "Sexual Assault" box on the Suspected Intentional Injury Reporting Form, and follow reporting procedures to the law enforcement agency **where the incident occurred**. Immediately call the Sexual Assault Unit of the law enforcement agency **where the incident occurred** to receive further instructions. Encourage the patient to stay until a law enforcement officer arrives. (See page 4 under "What Happens to the Report"). The domestic violence/intimate partner violence reporting duty remains, and the Suspected Intentional Injury Reporting Form must still be completed.

FACE-TO-FACE SCREENING: The following guidelines should be used for screening:

1. Screening should be in a safe and private environment.
2. If it is not possible to screen in a safe environment, postpone screening for a follow-up visit.

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FACE-TO-FACE SCREENING- continued

3. Use your own words in a non-threatening, non-judgmental manner.
4. Separate any accompanying person from the patient when screening for domestic violence.
5. Ask the patient about domestic violence in a private place.
6. Use questions that are direct, specific and easy to understand. (See Appendix C for suggested phrases.)
7. When unable to converse fluently in the patient's primary language:
 - a) Use a professional interpreter or another health care provider fluent in the patient's language.
 - b) The patient's spouse, partner, family, friends or children **should not** be used as interpreters when asking about domestic violence. Studies have shown a detrimental effect on children who act as interpreters in cases of domestic violence.
8. Children **must not** be present during screening.
9. Document that screening for domestic violence was done. Document in the patient's chart that domestic violence is or has been present, has not occurred or is suspected even though the patient may deny history of domestic violence.

ASSESSMENT: If the patient's screening suggests that domestic violence is or has been present or if it is suspected, even though the patient denies it. (See Appendix C under Initial Assessment for Abuse).

INTERVENTION:

1. Encourage the patient to contact the police.
2. Note this is not the same as mandated reporting.
3. Assist in the development of a safety plan, especially if the patient is returning home or to the previous living arrangement:
 - a) Suggest the patient gather important papers, (e.g., birth certificates and other documents of identification), some money and clothing for her/himself and children (if any).
 - b) Tell patient to keep these items in an accessible, hidden place or at a friend's home in case she/he has to leave home in a hurry.
 - c) Offer written information on safety plans if this will not endanger client (see Attachment #3 and Appendix D)

DOCUMENTATION:

1. Screening: document all screenings for domestic violence.
2. Suspected domestic violence: When domestic violence is suspected, health practitioners should make a complete legible record of any acute findings. The chart should include the following:
 - a) The patient's own words with the use of quotation marks, regarding the causes of the injuries or other important information.
 - b) A description of the patient's injuries: type, extent, age, and location to the level of expertise of the health practitioner. Location of injuries should be drawn on a body map (see Attachment #1). This map may be photocopied if needed.
 - c) Photographs of the patient's injuries if possible.
 - d) Past history of physical and sexual abuse.
 - e) Documentation regarding intervention and follow-up plans (see section on intervention, pg 3).

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PHYSICAL EXAMINATION: Some mandated reporters have the level of training where they are able to do a full physical exam (See Appendix E). In the event that the health practitioner is not able to do a full physical exam within their job description, the patient must be referred to a health department, facility or clinic for a complete exam of injuries.

MANDATORY REPORTING: It is the responsibility of the Health Practitioner to report if any medical services (including assessment, diagnosis or treatment for an injury) are provided for an injury resulting from domestic violence. Refer to the matrix below for determining under which conditions to report.

REPORTING MATRIX

	Patient Has Injury or Condition Caused by Domestic Violence	Patient Has No Current Injury or Condition Caused by Domestic Violence
Patient Admits Abuse	Refer and report	Refer only
Patient Denies Abuse/Abuse Suspected by Practitioner	Refer and report	Refer only
Patient Denies Abuse/None Suspected	N/A	Do not report

Source: Sharp Chula Vista Social Services Domestic Violence Reporting Policy

REPORTING WHEN THE INJURED PATIENT IS A MINOR: Whenever the Child Abuse and Neglect Reporting Act applies, that reporting act **supersedes** the Domestic Violence Reporting Act detailed above. (See the Child Abuse Reporting Policy HHSa-H-1).

The Child Abuse Reporting Hotline can be reached at: (858) 560-2191 or 1-800-344-6000.

REPORTING WHEN THE INJURED PATIENT IS AN ELDER OR DEPENDENT ADULT: Whenever the Elder and Dependent Adult Abuse Reporting Act applies, that reporting act **supersedes** the Domestic Violence Reporting Act detailed above. (See the Elder Abuse and Dependent Adult Abuse Reporting Policy HHSa-J-1). Reports should be made pursuant to the Welfare and Institutions Code Section 15630 (a). Health practitioners must report the suspicion of elder or dependent adult abuse to Adult Protective Services (APS). They should report the suspected abuse by phone as soon as practically possible, and then follow up with a written SOC 341 (Report of Suspected Dependent Adult/Elder Abuse). (See Appendix A for definition of "Dependent Adult").

The Elder and Dependent Adult Abuse Reporting Line can be reached at: 1-800-510-2020

WHAT HAPPENS TO THE REPORT: The law enforcement agency where the report is made assumes responsibility for the report. That law enforcement agency will process the report and proceed with an investigation. If a complaint was issued and it went to trial, the person reporting the abuse may be called as a witness.

TRAINING PROCEDURES: The HHSa's Office of Violence Prevention will update reporting and legislative issues related to domestic violence/intimate partner violence, and HHSa's Training and Development Department will incorporate these changes into the domestic violence/intimate partner violence-training curriculum.

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QUESTIONS/INFORMATION: County of San Diego HHSa Office of Violence Prevention, MS N510; Phone (858) 490-1670, Fax (858) 490-1677

ATTACHMENTS:

1. Suspected Intentional Injury Reporting Form
2. Body Diagram Map
3. Office of Violence Prevention Approved Resource List and Safety Plan
4. Safety and Resource Card
5. County Law Enforcement Jurisdictional Map

SUNSET REVIEW DATE: This policy will be reviewed for continuance on or before 2/03.

Approved **Betty A. Morell,**
Deputy Director
Betty A. Morell, Deputy Director

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Appendix A

DEFINITION OF HEALTH PRACTITIONER: “Health Practitioner” as defined in California Penal Code Section 11165.8 means any of the following: “a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist, marriage, family and child counselor (MFCC), MFCC trainee, unlicensed MFCC counselor intern, (licensed) clinical social worker (LCSW), emergency medical technician I or II, psychological assistant, state or county public health employee who treats a minor for venereal disease or any other condition, coroner, medical examiner or any other person who performs autopsies, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code”. However, psychiatrists, psychologists, MFCC’s, MFCC trainees, unlicensed MFCC counselor interns, and LCSW’s **are not** subject to the injury reporting requirements of Penal Code Section 11160, even though they are called “health practitioners” in section 11165.8. **They are not licensed to provide medical services for a physical condition.** They are licensed to provide psychological services, psychotherapy, counseling and psychosocial services.

Additionally, the chief Health Practitioner in that facility, which is ultimately responsible for the physical well being of the patient, is ultimately in charge of assuring that a report is filed.

DEFINITION OF ASSAULTIVE OR ABUSIVE CONDUCT: “Assaultive or abusive conduct” as defined in Penal Code Section 11160 to include a list of 24 criminal offenses, among which are murder, manslaughter, torture, battery, sexual battery, incest, assault with a deadly weapon, rape, spousal rape, abuse of a spouse or cohabitant, and an attempt to commit any of these crimes. Domestic violence that is comprised of sexual assault or rape requires that additional and specific procedures be carried out.

DEFINITION OF DEPENDENT ADULT: “Dependent Adult” is defined as any person residing in the State between the ages of 18 and 64 years, who has physical or mental limitations that restrict his/her ability to carry out normal activities or to protect his/her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age.

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Appendix B

CONFIDENTIALITY OF REPORT: The domestic violence/intimate partner violence report is to be kept confidential. Friends, family or other third parties without the patient's consent cannot access the report. However, health facilities, clinics, Public Health offices, physicians' offices and law enforcement may disclose a report to those involved in the investigation of the report, or to those involved in the enforcement of a criminal law related to the report. **In no case shall the person suspected or accused of inflicting the wound, other injury, or assaultive or abusive conduct upon the injured person or his or her attorney be allowed access to the injured person's whereabouts.**

DOCTOR-PATIENT PRIVILEGE: In any court proceeding or administrative hearing, the doctor-patient privilege does not apply to the information required to be reported.

LIABILITY: Civil and criminal immunity is provided to health practitioners who make required or authorized reports pursuant to Welfare and Institutions Code 11161.9, "for persons required or authorized to report pursuant to this article, that immunity does not eliminate the possibility that actions may be brought against those persons based upon required reports of abuse pursuant to other laws".

PENALTY: Violation of this law, such as failure to report, is a misdemeanor, punishable by imprisonment in a county jail not exceeding six months, or by a fine not exceeding one thousand dollars (\$1,000) or by both that fine and imprisonment. Additionally, HHSa employees may be subject to county disciplinary action for failure to report.

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Appendix C

INITIAL ASSESSMENT FOR ABUSE: When domestic violence is suspected or reported, the health practitioner should interview the patient alone in a private setting. The patient should be interviewed using a nonjudgmental manner, and avoid blaming the patient for what has happened. Minimally, the following issues should be addressed before the patient leaves the site:

1. Immediate risk: If you return home, will you be in immediate physical danger?
2. State of mind toward situation and possible changes: What type of assistance would you like? Are there any changes you would like to make? What steps would help you move towards those goals? What actions are you ready to take?
3. Suicidal/Homicidal: Have you had any suicidal/homicidal thoughts? What is your likelihood to act on these thoughts? If suicide is likely in the opinion of the health care provider, follow the protocol and reporting requirements for suicide/homicidal patients, in addition to protocol for domestic violence.
4. Substance abuse: Is there substance or alcohol abuse problems in the home?
5. Gun: Is there a gun in the home? Patient should be made aware of the dangers of guns in the home, and the risks of increased danger when domestic violence is occurring.
6. Children: Are there children in the home? Have they been abused? Have they witnessed domestic violence? Clarify visual, auditory, and frequency of children witnessing domestic violence in the home. If the children have witnessed domestic violence, follow protocol for mandated reporting of child abuse. Even if the child has not been in the same room where the abuse occurs, they can still be affected by the abuse that is overheard.

SUGGESTED PATIENT INTERVIEW QUESTIONS: Health care providers should be prepared to ask their patients some or all of the following questions to determine if they are the victims of domestic violence:

1. Do you ever feel afraid of or threatened by your partner?
2. Are you in a relationship in which you have been physically hurt, or threatened by your partner?
3. Are you in a relationship in which you are treated badly?
4. Have you been hit or battered in the last six months or since I last saw you?
5. Has your partner ever destroyed things that you cared about?
6. Has your partner ever threatened or abused your children or animals?
7. Does your partner ever force you to engage in sex that makes you feel uncomfortable or use coercion or threat of violence to have sex?
8. We all disagree sometimes. What happens when you and your partner fight or disagree?
9. Has your partner ever prevented you from leaving the house, seeing friends, getting a job or continuing your education?
10. Does your partner watch your every move? Call home or work multiple times a day? Accuse you of having affairs with everyone?

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Appendix D

PATIENT SAFETY: The patient's safety should be of utmost concern. If the batterer should find out the patient revealed the abuse, the patient may be in greater danger of further harm. **If the patient is in eminent danger, call 911 immediately.**

Leaving the relationship is often the most lethal time for a victim, and requires special attention to their safety. The health practitioner should address directly the risk of retaliation by the batterer, and discuss how the patient might protect her/himself from further abuse. For example, discuss with the patient a plan for her/his protection and safety. Indicate on the reporting form any special concerns regarding how the report should be handled, to maximize patient safety. (See the block titled "Special Instructions" found on page one of the Suspected Intentional Injury Reporting Form). Patient safety is a critical concern. However, it does not supersede the health practitioner's duty to report. The health care provider is required to report. In turn, effective treatment includes communicating with the patient regarding her or his concerns about the report being made. The health practitioner should advocate on behalf of the patient's needs and concerns for protection and safety.

The patient will be given the approved Office of Violence Prevention Approved Resource List and Safety Plan and/or the Safety and Resource Card, unless they refuse. (See attachment's #3 and 4).

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Appendix E

DOCUMENTATION DETAILS: Health practitioners should make a complete, legible record of their findings in the patient's chart, which should include the following:

1. A detailed description of the patient injuries: type, extent, age, location and the use of a body map when applicable.
2. Photographs of patient's injuries. **Be sure to obtain a signed release form from the patient.**
3. The maintenance of physical evidence.
4. The inclusion of relevant information such as:
 - a.) Past medical history: history of falls, "accident prone" injuries.
 - b.) Social history: overly concerned partner, history of substance abuse (including alcohol and drugs) by patient or partner.
 - c.) Sexual history: history of sexually transmitted diseases, rape.
5. All charts should include comments by the health practitioner as to whether the explanation offered for the injury adequately explains the injury.
6. The patient's own words, with the use of quotation marks, should be entered into the chart, in the chief complaint and history of present illness section(s) describing the abusive event.
7. Name of investigating officer and any action taken if the police were called.
8. Document every detail, even seemingly trivial ones, such as torn clothing, smeared make-up, broken fingernails, scratches and bruises.
9. Include names of all personnel who examined or talked with the patient about the injuries or abuse in the record.

Note that records are admissible as evidence if:

1. They were made during the "regular course of business".
2. They were made in accordance with routinely followed procedures.
3. They were stored properly and access to them is limited to staff only.

Even if a patient later decides that she/he does not want to pursue legal remedies, introducing the statements she/he made to people in the past about what happened can still prove a case. Include anything that might allow you to remember the patient's attitude, face and experience at a later date.