Recording

It is important that the perpetrator cannot read the notes if they are in the room.

RCGP Position statement
Accurate documentation, over time at successive consultations, may provide cumulative evidence of abuse, and is essential for use as evidence in court, should the need arise

Record clearly:

1. Date and time of incidents, if known
2. If patient states that abuse is the cause of injury, preface patient's explanation by writing: "Patient states .....". Use patients own words when possible.
3. Avoid subjective data that might be used against the patient (for example, "It was my fault he hit me because I didn't have the kids in bed on time.").
4. Describe the patients psychological state, without interpretation/judgement
5. Briefly describe types or nature of abuse
6. Note facts (including observations). If patient denies being assaulted, write: "The patient's explanation of the injuries is inconsistent with physical findings" and/or "The injuries are suggestive of battering."
7. Record size, pattern, age, description and location of all injuries. A record of "Multiple contusions and lacerations" will not convey a clear picture to a judge or jury, but "Contusions and lacerations of the throat" will back up allegations of attempted strangling. If possible, make a body map of injuries. Include signs of sexual abuse.
8. Record non-bodily evidence of abuse, such as damaged, torn or stained clothing
9. Document behaviour of partner, including spontaneous disclosures that may indicate abuse, but do not interview partner.
10. Record your action (e.g. information provided, referral to DV service)
11. Sign and date your record. Print your name and role.

Include a detailed physical record, including sketches of injury sites on a body map or photographs if possible. Photographs can convey the severity of injuries and, whenever possible, photographs should be taken of all patients with visible injuries. If this is not possible at general practice then patients can be advised to have photographs taken elsewhere.

1. Explain to the patient that photographs will become part of the patient's medical record and, as such, can only be released with the patient's permission.
2. Obtain written consent from patient to take photographs. (Written informed consent should include the statement, "These photographs will only be released if and when the undersigned gives written permission to release the medical records.").
3. The photographer should sign and date the back each photograph.
4. Place photographs in a sealed envelope and attach securely to the patient's record. Mark the envelope with the date and the notation "Photographs of patient’s injuries"