Cumbria Partnership NHS
NHS Foundation Trust

DOMESTIC ABUSE POLICY

Document Summary

To provide clear guidance on the action to identify when an inpatient should be classified as missing from an inpatient unit in the Trust and the action to be taken when this occurs.

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ACCOUNTABLE DIRECTOR	Director of Quality & Nursing
POLICY AUTHOR	Safeguarding Team

Important Note:

The Intranet version of this document is the only version that is maintained.

Any printed copies should therefore be viewed as “uncontrolled” and, as such, may not necessarily contain the latest updates and amendments.

Here for you

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1 SCOPE

This policy applies to all Trust services and to all Trust-employed staff, staff working in integrated teams, full-time and part-time clinical, students, Locums, Bank staff, non-clinical staff, volunteers, patients, visitors and others who may be subject to domestic abuse and related safeguarding procedures. This policy should be always used alongside the Cumbria Local Safeguarding Children Board and Cumbria Safeguarding Adults Board Multi-agency policy and procedures, accessible via the following website addresses:
Children's : http://www.cumbrialscb.com/
Adults: http://www.cumbria.gov.uk/healthandsocialcare/adultsocialcare/safe

2 INTRODUCTION

The cross-government definition of domestic violence and abuse is 'any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality'.

The abuse can include, but is not limited to, psychological, physical, sexual, financial and emotional abuse. The main characteristic of domestic abuse is that the behaviour is intentional and is calculated to exercise power and control within a relationship. Since 2004 the definition of domestic abuse has also extended to include acts perpetrated by extended family members as well as intimate partners. This means that acts such as forced marriage and 'honour based' crimes now are included under the definition of domestic abuse.

At least 1.4 million women and 700,000 men aged between 16 and 59 experienced domestic abuse in England and Wales in 2013/14, (Office for National Statistics Crime Survey England and Wales. 2013-14). These figures are likely to be an underestimate, because all types of domestic abuse are under reported in health and social research, to the police and to other services, (NICE '16).

Both men and women perpetrate and experience domestic abuse but it is more common for men to perpetrate violence and abuse against women. This is particularly true for severe and repeated violence and sexual assault.

Note that the terms domestic violence and domestic abuse are interchangeable. The term domestic abuse will be used throughout this policy as this represents the full range of abusive behaviours.

Domestic abuse encompasses a wide range of abuse and discriminates against no one. It includes all people from all cultures, backgrounds and beliefs and can take place between partners, ex partners, siblings and between generations.

This policy applies to all individuals, including those who have been assessed as lacking capacity. (Please see the MCA policy and Safeguarding policy-Incorporating information sharing guidance CPFT policy for further guidance if needed).

This policy sets out Cumbria Partnership Foundation Trust's guidance in the identification and response to potential or actual domestic abuse whilst safeguarding children, young people and adults effectively and supporting individuals who may be experiencing domestic abuse.

This policy aims to create a framework of action within the Trust to ensure a consistent and effective multi-professional response to the Government's drive in tackling domestic abuse. The NHS has a particular contribution to make because it is the one service that almost all victims of domestic abuse will come into contact with at some point in their lives.. This policy acknowledges that domestic abuse can both affect men, women and those in same sex relationships. Please note the terms Domestic abuse and domestic violence are interchangeable. One is not lesser or greater than the other.

To help professionals work within a multi-disciplinary approach this policy should be used alongside the Cumbria Safeguarding Board Multi-Agency (CSAB) and the Local Safeguarding Children's Board (LSCB) policy and procedures.

CPFT is committed to developing strategy for reducing and preventing incidents of domestic abuse, improving the safety and welfare of all victims and increasing the awareness and understanding of domestic violence across the whole organisation. CPFT will ensure that a consistent, measurable and effective approach to all incidents involving domestic abuse is developed and will ensure all departments are clear to their various roles in tackling and responding to the associated problems of domestic abuse.

All CPFT staff should empower people to make their own decision and not make a decision on their behalf. This will ensure a holistic approach aimed at empowering abused individuals to make informed decisions regarding their health and safety and that of their dependants.

This policy directs staff to the appropriate services, organisations and processes to support service users who may be the victim of domestic abuse.

All staff who come into contact with children, young people and their families have a duty to ask about and respond to domestic abuse and to consider this in the wider sphere of safeguarding.

This policy applies to all staff and services with the Cumbria Partnership NHS Foundation Trust. Its purpose is to provide guidance which will enable the health care professional to ensure that all patients subject to, or affected by domestic violence receives appropriate support, advice and guidance. All staff should be familiar with the trust policies and procedures for safeguarding .

3 STATEMENT OF INTENT

Domestic abuse is part of safeguarding. Safeguarding involves a range of activities aimed at upholding an adult's, child's or young person's right to be safe and free from harm. It incorporates the concepts of prevention, empowerment and protection, and involves all agencies taking all appropriate actions to address potential concerns, working to agreed local policies and procedures in full partnership with other local agencies. People at risk from domestic abuse in Cumbria should have the right to choice and be able to have control of their lives, free from discrimination, harassment, violence and abuse. That right is underpinned by the duty on public agencies under the Human Rights Act (1988), which places a duty on public organisations to enable persons at risk of abuse to access the advice, support and interventions they need to minimise the risk of further abuse. This Policy has been developed to ensure that staff working for

Cumbria Partnership NHS Foundation Trust will meet the fundamental requirements for effective safeguarding in the delivery of NHS care and will:

• Clearly understand the Trust's expectation of staff and their role and responsibilities for matters relating to domestic abuse. It can also be used in conjunction with the trust Safeguarding policy,(Safeguarding Framework Policy POL/001/006)

• Promote good practice and work in a way that reduces the risk of harm, abuse and coercion occurring through the provision of high quality care with dignity as a core requisite.

• Ensure that any allegations of abuse or suspicions are responded to and reported appropriately. The person experiencing abuse is supported and we consider the whole family. All staff that come into contact with children and young people have a responsibility to safeguard and promote their welfare and should know what to do if they have concerns about safeguarding issues. This responsibility also applies to staff working primarily with adults who have dependent children that may be at risk because of their parent/carers health or behaviour.

• Ensure that all concerns are acted upon and investigated.

• Ensure staff have access to support and supervision alongside undertaking regular safeguarding training/updates.

4 DEFINITIONS

- **Adult** – Any person aged 18 years and over.
- **Teenage relationship abuse** – this term incudes young people aged between 16 and 17 years old who experience domestic abuse.
- **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.
- **Coercive behaviour** - 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.
- **Domestic Abuse** - any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality.
- **IDVA** (Independent Domestic Violence Advocate): These people are specialised in providing support and guidance and assist high risk victims to access services to help diminish the risk and enhance the safety of themselves and any children.
- **Family member** – includes relationships across all generations and includes step families and those adopted into a family.
- **MARAC** (Multi Agency risk Assessment Conference) – the MARAC is part of a co-ordinated local community response to domestic abuse, incorporating representatives from statutory, community alleged perpetrator.
- **MAPPA** (Multi-Agency Public Protection Arrangements)- Support the assessment and management of the most serious sexual and violent offenders. The aim of MAPPA is to

ensure that a risk management plan drawn up for the most serious offenders. MAPPA's were introduced in 2001 and bring together the police, probation and prison services.

5 DUTIES

CPFT have responsibility to safeguard children, young people and adults effectively and support individuals who may be experiencing domestic abuse. This includes all staff and patients.
CPFT also has a responsibility to share information in the (MARAC) Multi Agency Risk Assessment Conferences and (MAPPA) the Multi Agency Public Protection Arrangements and to implement safety plans as appropriate to the organisation.

All managers have a responsibility to ensure their staff are aware and comply with the local domestic abuse procedures and that their staff receives the level of training appropriate to their role. Managers also have a responsibility to support staff who are working with victims of domestic abuse or are personally affect by domestic abuse themselves.

Individual staff have a duty to follow local policy and procedures when they have a concern about an individual who is or may be a victim of domestic abuse.

All staff have a duty to respect confidentiality, however they also have a duty to share information in order to protect the safety of individuals.

All staff have a duty to treat adult patients, children and young people, relatives and carers with respect and dignity at all times and to ensure that modesty of patients is preserved.

5.1 Legal Remedies

There are number of laws and legal documents that help support the drive against Domestic abuse.

5.1.2 Domestic Violence Disclosure Scheme (Clare's Law).

The Domestic Violence Disclosure System (DVDS) also known as 'Clare's Law' started in England and Wales in March 2014. The DVDS gives members of the public a formal mechanism to make enquiries about an individual who they are in a relationship with, or who is in a relationship with someone they know, where there is concern that the individual may be violent towards their partner. Members of the public can make an application for disclosure, known as 'the right to ask'. Anybody can make an enquiry, but information will only be given to someone at risk or a person in a position to safeguard the victim. This scheme is for anyone regardless of gender or sexuality.

Partner agencies can also request disclosure is made of an offender's past history when it is believed someone is at risk of harm.

If a potentially violent individual is identified as having convictions for violent offences or information is held about their behaviour which reasonably leads the police and other agencies to believe they pose a risk of harm to their partner, the police will consider disclosing the information which can be made legal if the risk is proportionate.

5.1.3 Domestic Violence Protection Orders

Domestic violence protection orders (DVPO's) were introduced by the Crime and Security Act 2010 and enable the police to put in place protection for the victim in the immediate aftermath of a domestic violence incident. Under DVPOs, the perpetrator can be prevented from returning to a residence and from having contact with the victim for up to 28 days, allowing the victim some space and time to consider their options, with the help of a support agency. This provides the victim with immediate protection. These orders can be requested by the Police. The victim stays in their own home and the perpetrator has to go elsewhere.

5.1.4 Enquiring about domestic abuse.

Asking about domestic abuse in the presence of a partner, family members or children should **NOT** be done. The only exception to this is when a professional interpreter is present and needed or if the potential victim is deemed not to have capacity. Also when interpreters are needed these should always be professional interpreters with no personal link to the family.

The individual should be listened to with respect and dignity and without judgement.

As part of routine good clinical practice, NICE (2014) recommend that trained staff ask service users whether they have experienced domestic abuse even where there are no indicators of such violence and abuse. This is called routine enquiry. It should be incorporated, appropriately, into general consultations and assessments.

5.1.5 Selective enquiry

Selective enquiry should be used when a health care professional is with a person and suspects from their presentation that domestic abuse may be an issue. Selective enquiry can also occur when the professional receives information from another source that domestic abuse is occurring.

When undertaking selective enquiry it is important that interruptions are avoided as the individual must be made to feel important. Patience is needed and support should be given.

All health care professionals should also acknowledge their own professional limitations. The use of an Independent Domestic Violence Advocate (IDVA) should be considered if specialist advice is needed. The health professional should always check to see if any children live with the perpetrator or victim as the needs and safety of any child is paramount. It should be made clear from the start that if any concerns are raised regarding the welfare of the children this information would need to be shared in order to protect them. Advice from a Health Visitor, School Nurse or the Safeguarding Children Team may be needed. Information on support services should be given including leaflets and contact details.

5.1.6 Possible signs of Domestic Abuse.

The following symptoms or conditions are possible indicators of domestic abuse. They should raise suspicion and prompt further action including selective enquiry:

- Symptoms of depression, anxiety, post- traumatic stress disorder, sleep disorders.
- Suicidal tendencies or self -harming.

- Alcohol or other substance misuse.
- Unexplained chronic gastrointestinal symptoms.
- Unexplained gynaecological symptoms.
- Adverse reproductive outcomes, including multiple unintended pregnancies or terminations.
- Delayed pregnancy care, miscarriage, premature labour and stillbirth.
- Genitourinary symptoms.
- Vaginal bleeding or sexually transmitted infections.
- Chronic unexplained pain.
- Traumatic injury with vague or implausible explanations.
- Problems with the Central Nervous System – headaches, cognitive problems, hearing loss.
- Repeated health consultations with no clear diagnosis.
- Intrusive 'other person' in consultations.
- Frequent missed appointments.
- Person frightened to speak in front of partner/family member.
- Early self- discharge from hospital.
- Non- compliance with treatment.
- Hidden injuries.

  This is not an exhaustive list. Staff should always be aware of the possibilities of domestic abuse.

5.1.7 Role of families , friends and carers.

The importance of family and friends supporting people who are experiencing domestic abuse is recognised as important but it is vital that health and social care practitioners need to speak to people alone to facilitate and support disclosures of domestic abuse. Also when interpreters are needed these should always be professional interpreters with no personal link to the family

5.1.8 Forced marriage

In 2012 Forced Marriage became a criminal offence. Forced marriage was included as part of the Anti-social Behaviour, Crime and Policing Act 2014.

A forced marriage is defined as one conducted without the valid consent of both people, where pressure or abuse is used.

Many people may assume that a health professional is unable to help them as a victim of forced marriage, for this reason it is unlikely that they will present with their story. During routine enquiry into domestic abuse it may be good practice to incorporate forced marriage into the routine questions.

In cases where there are concerns that a young person (under 18 years) or child may be at risk of forced marriage a referral must be made to Children's Social care. The family should not be informed of this referral in case this puts the person at further risk of abuse.

There is a national Forced Marriage Unit (FMU) available for advice and support. In 2014 the FMU reported 1267 cases of forced marriage in 2014.

If forced marriage is a concern staff should follow usual safeguarding procedures.

Further information can be accessed here.

5.1.9 Honour based violence.

Honour based violence (HBV) is an umbrella term that is used to describe a crime or incident which has or may have been committed to protect or defend the honour of the family and/or community. Such abuse can occur when perpetrators perceive that a relative has shamed the family and/or community by breaking their honour code.
HBV may include any type of abuse being used towards the victim.

Examples of why honour based violence might be committed against people who for example start a relationship with someone from a different culture or religion or want to get out of an arranged marriage.

Further information on Honour Based Violence can be found here on the metropolitan police website.

5.1.10 Female Genital Mutilation (FGM).

Female genital mutilation (FGM), refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. The practice is illegal in the UK.

It has been estimated that 137,000 women in the UK are affected by female genital mutilation (FGM). However, the true extent is unknown, due to the "hidden" nature of the crime.

FGM is usually carried out on young girls between infancy and the age of 15, most commonly before puberty starts.

The girls affected may be taken to their countries of origin so that FGM can be carried out during the summer holidays, allowing them time to "heal" before they return to school. There are also worries that some girls may have FGM performed in the UK.

The procedure is traditionally carried out by a woman with no medical training. Anesthetics and antiseptic treatments are not generally used, and the girls may have to be forcibly restrained.

There are four main types of FGM:

• Type 1 – clitoridectomy – removing part or the entire clitoris.

• Type 2 – excision – removing part or all of the clitoris and the inner labia (lips that surround the vagina), with or without removal of the labia majora (larger outer lips).

• Type 3 – infibulation – narrowing of the vaginal opening by creating a seal, formed by cutting and repositioning the labia.

• Other harmful procedures to the female genitals, which include pricking, piercing, cutting, scraping and burning the area.

If you are worried about someone who is at risk of FGM or has had FGM, you must share this information with social care or the police. It is then their responsibility to investigate and protect any girls or women involved. Please see the CPFT safeguarding policies for further guidance.

For further information on FGM you can click and read the 2015 Government declaration on female genital

mutilation

5.1.11 Responding to a disclosure

If domestic abuse is disclosed, as a health care professional your role is to;

- Provide support and information and refer to the relevant agencies.
- Always be non- judgemental.
- Encourage the individual to have a safety plan.
- Focus on the individual's safety and that of any children they have. Help assess the risk. Remember that the children's safety is paramount.

- NEVER advise anyone to leave their partner or to take any particular course of action. This could lead to problems including increased danger for the victim and their children. The risk of serious injury or murder escalates dramatically when the victim leaves an abusive relationship. Leaving immediately may not be the best option.

5.1.12 Assessing Risk.

It is important to determine the level of risk and danger faced by the victim and their children. The health care professional who witnesses the disclosure does not assume full responsibility for this but will play a vital role in assessing if someone is at immediate risk of harm. A health care professional should NEVER take on lone responsibility for dealing with high risk situations. Support and guidance can be sought from your line manager and the Safeguarding Team. Please refer to assessing risk flow chart later in this policy.

5.1.13 MARAC.

This policy outlines the CPFT's role as a contributing agency, to Multi Agency Risk Assessment Conference (MARAC), and provides guidance to those nominated to act on behalf of the Trust when involved in MARAC.

MARAC was established originally in Cardiff in 2003 and has been developed nationally with the safety of high risk victims of domestic abuse as its focus.

In a MARAC local agencies meet to discuss the highest risk victims of domestic abuse in their area. Information about the risks faced by those victims, the actions needed to ensure safety, and the provisions available locally is shared and used to create a risk management plan involving all agencies

The MARAC Process aims to:

- Identify and refer victims at high risk of harm.
- Share relevant information among those MARAC agencies involved in supporting the victim and their family.
- Identify actions on behalf of the Trust to support and increase the victim's safety
- Confirm when actions are completed to the MARAC

- Identify any risks from the perpetrator to the Trust and its Employees

Definitions of 'high risk' of harm are determined by the use of the DASH Risk Identification Checklist. The checklists for young people and in a range of languages can be found also. Dash stands for domestic abuse, stalking and 'honour'-based violence. It is based on research about the indicators of high-risk domestic abuse

The purpose of the Risk Identification Checklist is to give a consistent and simple tool for practitioners who work with adult victims of domestic abuse in order to help them identify cases of domestic abuse that are high risk and may warrant a referral to the MARAC to ensure all agencies share information in order to reduce the risk of repeat incidence of abuse.

MARAC referral forms can be found here on the Safe Lives website. Ensure that protective passwords are used when sending confidential information via email. The email address to send referrals is **MARAC@cumbria.pnn.police.uk**

The MARAC referral form is completed and shared with the patient and consent is sought to share information at the MARAC meeting. A copy of the referral is placed in the medical notes. Staff caring for the patient are notified of any risks identified and controls that should be put in place. The sharing of this information is on a need to know basis.

Any information in relation to MARAC provided to practitioners, is done so in confidence. Consent to share information should be obtained from the victim. However if the victim refuses to give consent the information can still be shared in high risk cases, under the Crime and Disorder Act, in order to prevent serious harm to the victim.

When a victim of domestic abuse lacks capacity to consent to a MARAC referral, a professional should always make the referral in their best interest.

The alleged perpetrator is not asked for their consent or informed about the MARAC referral as to do so might jeopardise the victims safety.

It should be noted that MARAC is not a legal entity in itself but a set of administrative arrangements with authority resting with each agency involved. CPFT recognises its responsibilities with regard to multi-agency working, the support and protection of victims, and its role in reducing serious harm. As such, the Trust embraces its statutory duty to co-operate in respect of Multi Agency Risk Assessment Conference work.

5.1.14 Safety Planning.

Domestic abuse is significant in that it occurs repeatedly and is cyclical in nature. It is encouraged that when a victim discloses abuse they are encouraged to have a safety plan of what to do when the abuse starts.

Safety planning needs to begin with the victim's view of the risks to themselves and their children and the strategies they have in place to address them.

It may be more appropriate for specialist domestic violence services to complete this with the victim. Please see your Domestic Violence Champion for further advice.

A list of Domestic Abuse contacts for organisations can be found at the end of this policy.

Examples of what a safety plan should cover include:

- Safety in the relationship.
- Places to avoid when the abuse starts e.g. kitchen due to potential weapons.
- People the victim can turn to for help or inform they are in danger.
- Asking friends or neighbours to call 999 if they hear/see anything that worries them.
- Places to hide important phone numbers.
- How to keep children safe when the abuse starts.
- Teaching children how to find safety or get help e.g. teaching them to call 999.
- Keeping important documents in one place so they can be taken together in case they need to leave suddenly.
- Leaving in an emergency.
- Packing an emergency bag and hiding it in a safe place.
- Plans for who to call and where to go.
- Remember to take documents, medication and keys.
- Access to a phone.
- Plans for transport.
- Plans for taking clothes, toiletries and toys for children.
- Taking proof of abuse.

5.1.15 <u>Responding to Police Domestic Violence Notification.</u>

The police will notify both Children's social care and the Safeguarding Team when they have been called out to a domestic violence incident and it is found to involve the following:

- The victim or perpetrator is known to be pregnant.
- There is a child abuse marker on the address irrespective of the severity of the incident.
- A child under the age of 18 years is living/present in the household and/or the child has made the call for assistance.
- It is the third reported incident within the previous 12 months.
- The incident is so serious and the domestic violence officer feels or believes a referral should be made.

5.1.16 Domestic Abuse and children.

In over half of known domestic abuse cases children were also directly abused. Nearly three quarters of children on child protection plans live in households where domestic violence occurs.

The safety of children is paramount. Advice and referral should be made for any child in danger. Please see Safeguarding policies regarding children and discuss any concerns with the Safeguarding Team or Safeguarding Hub as a matter of priority.

Teenagers suffer high levels of relationship abuse. It is now recognised that young people aged 16 years and above are included in the cross government's definition of domestic abuse. Therefore young people aged 16 years old and above can now be referred under the MARAC process and the adult domestic abuse pathway should be followed.

5.1.17 Digital Abuse.

Because of the technological world we live in there are now reports of 'Virtual Violence'.

This can include:

- Gifts of expensive smart phones which can be used in exchange for gang membership, sexual favours and abuse.
- Cyber bullying.
- Online grooming.
- Digital stalking
- Naming of rape victims online.
- Social location services whereby perpetrators can keep track of where victims are.
- Sexting – the exchange of sexual messages or images and creating, sharing and forwarding sexually suggestive nude or nearly nude images through mobile phones and the internet. (ref)

Please discuss any issues regarding this with the Safeguarding Team as a matter of priority.

More information on Digital Abuse can be found here.

5.1.18 Confidentiality.

How we treat information must align with the Data Protection act and professional guidelines that address confidentiality and information sharing within CPFT and the NHS.

Confidential information may need to be disclosed in the best interests of the patient or children at risk and it would be shared on a need to know basis.

The safety of the person experiencing domestic abuse is essential. The victim who has disclosed domestic abuse should be encouraged to seek help and information. However, unless the victim is a vulnerable adult, or a child is involved, the victims' decision on whether to do this should be respected. You should be aware that it may be risky to give the perpetrator any indication that the victim has reported domestic abuse. In the event of a request for access to records under the Data Protection Act (1989) the risk of the perpetrator viewing information recorded about domestic abuse should be considered by the Lead Health Professional.

Where appropriate the Trust Confidentiality Policy should be referred to. Advice can also be obtained from the Trust Caldicott Guardian or the Information Governance Officer.

If there are reasons to believe that children are at risk, their protection must take precedence over confidentiality and the parent/carer made fully aware of this and Safeguarding Children procedures followed.

5.1.19 Recording and documentation.

Health records play an important role in responding to domestic abuse. Health professionals have a duty of care to record domestic abuse and permission is not needed to document violence in records. Health records may be used in criminal proceedings, obtaining an injunction against a perpetrator, immigration/deportation cases, housing provision and civil procedures in family courts.

With this in mind records should always be clear, accurate and detailed of what has been discussed, even if any suspicions have not yet led to a disclosure. If documenting a disclosure then the victims own words should be used to describe what happened supported by the health care professional's assessment of the impact of abuse.

Documentation should be factual and concise. Record what the individual has said about the domestic abuse rather than your assumption of what happened.

Notes on domestic abuse should include;

- Ethnicity
- Has routine enquiry been undertaken?
- Response to routine or selective enquiry.
- Relationship to perpetrator and the name of perpetrator.
- Whether a woman is pregnant.
- Presence of children in the household.

- Nature of abuse (psychological, physical etc), and injuries.
- Documented and observed injuries.
- Description of all kinds of abuse experiences and reference to specific incidents.
- Is this the first incident? If not, how long has it been going on and how often?
- Presence of enhanced risk factors e.g. disabilities, drug and alcohol misuse etc.
- Indication if information provided to victim on advice and support.
- Referrals made to other services and any advice taken from others.

Explain to the person the importance of documenting the information for any future legal case. It may provide 'proof' of violence should they decide to prosecute now or in the future.

5.1.20 Caldicott principles.

Caldicott Guardians and those responsible for making decisions about the appropriateness of sharing information (including sensitive health information) about individuals involved in domestic violence. It identifies the underlying ethical considerations so that tensions between confidentiality and information sharing may be resolved.

Within CPFT the Medical Director is the Caldicott Guardian.

For further information please see CPFT Confidentiality policy.

For general information please read "Striking the Balance" the government document for practical guidance on the application of Caldicott Guardian Principles to Domestic Violence and MARACs (Multi Agency Risk Assessment Conferences)

5.1.21 Employees experiencing Domestic Abuse.

If employers can create a safe environment that encourages people to reveal that they have been subjected to some form of domestic abuse, help them recognise that this is not acceptable and enable them to seek help and support, then they can make a real difference for their employees and their families.

NHS employers have a duty to protect their staff from violence and the NHS has taken a strong stance against verbal or physical assaults on staff by patients or relatives. The position with domestic abuse is more complex because in most cases the domestic abuse will occur away from the work environment.

Domestic abuse does not just impact on home life as abuse victims can be targeted at work by telephone calls and emails. People who have left an abusive partner are especially vulnerable at work as the workplace is easily identified as a place of contact by perpetrators.

Employees should be treated no different to anyone else. The Trust will not discriminate against anyone who has been or are a victim of domestic abuse, in terms of his or her existing employment or career development. Any concerns should be discussed with an appropriate line/senior manager. Confidentiality should be respected. The individual should be supported and referred to other agencies as appropriate. Please contact the Safeguarding Team for further information or discussion.

6. TRAINING

There are E-learning packages available under headings such as domestic violence and abuse, modern slavery and Female Genital Mutilation. Please visit the trust website for further information.

A champion's network has been set up in Cumbria to improve community and organisational responses to domestic abuse and sexual violence. For further information on how to become a champion and for information and booking onto the relevant courses please see the LSCB website.

7. MONITORING COMPLIANCE WITH THIS POLICY

Aspect of compliance or effectiveness being monitored	**Monitoring Method**	**Individual responsible for the monitoring**	**Frequency of the monitoring activity**	**Group / committee which will receive the findings / monitoring report**	**Group / committee / individual responsible for ensuring that the actions are**
The response of staff responding to suspected or disclosed domestic abuse incidents.	Analysis of the data collected via duty queries.	Named Nurse Safeguarding Adults	Annual – from 1 April to 31 March.	Adult Safeguarding Group	Named Nurse Safeguarding Adults
The compliance to policy when managing situations affected by domestic abuse.	Annual audit of MARAC referrals to ensure quality of process followed.	Named Nurse Safeguarding Adults	Annual – from 1 April to 31 March.		Named Nurse Safeguarding Adults

8 REFERENCES / BIBLIOGRAPHY

Domestic Abuse contacts.

Cumbria Local Safeguarding Childrens Board.
http://www.cumbrialscb.com/
Safeguarding Hub Telephone 0333 240 1727

Let Go
http://www.cumbriaadvicenetwork.org.uk/can/index.php?option=com_content&view=article&id=221&Itemid=229
The LetGoservice has a 24 hour on call element, this is for use by professionals who may need some advice surrounding domestic advice in a crisis. This call will be answered by a member of the LetGo team. To access this service the number is 07736275516
North Office (Carlisle) - 01228 633640
West Office (Workington) – 01900 842990
South Office (Ulverston) – 01229 582386

Safety Net
www.safetynetuk.org.uk
Telephone 01228 515859

West Cumbria Domestic Violence Support
http://www.freedom-project-west-cumbria.org.uk/
Telephone 07712117986

Cumbria Constabulary
www.cumbria.police.uk
Telephone 101for routine enquiries.
Telephone 999 in an emergency.

Victim Support
www.victimsupport.org.uk
Telephone 0300 303 0157

Womens Aid
www.womensaid.org.uk
24 Hour Helpline 08082000247

Mens Advice Line
www.mensadviceline.org.uk
Telephone 08088010327

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9 RELATED TRUST POLICIES / PROCEDURES

Visiting Dignitaries

Mental Capacity Act

Mental Health Act

MARE/MAPPA

Incident Reporting

Management Supervision

Learning & Development

Record Keeping

Information Sharing & Information Governance

Safeguarding

Confidentiality Policy

Cumbria Local Safeguarding Children Board and Cumbria Safeguarding Adults Board Multi-agency policy

and procedures, accessible via the following website addresses:
Children's : http://www.cumbrialscb.com/
Adults: http://www.cumbria.gov.uk/healthandsocialcare/adultsocialcare/safe

Cumbria Safeguarding Board Multi-Agency (CSAB) and the Local Safeguarding Children's Board (LSCB) policy and procedures.