Medevent Limited

In Partnership with the NHS

SAFEGUARDING POLICY

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Contents

1.0 SAFEGUARDING

1.1 Safeguarding is the protection of members of society who may be more vulnerable due to age, illness, capacity or position in society. It incorporates children, vulnerable adults, those with mental health issues and those suffering domestic violence.

1.2 Medevent Limited supports the rights of all to be protected from harm and recognises that safety and welfare are paramount.

1.3 All employees and contractors, regardless of their position within the company, carry a responsibility to safeguard those who are vulnerable. Work with those that require safeguarding can be sensitive and difficult, good practice in these situations calls for:-

- Effective co-operation between different agencies and professionals, alongside a thorough knowledge of local Trust guidelines, policies and referral pathways;
- Sensitivity between professionals and carers in the best interests of the patient;
- Careful exercise of professional judgement; based on thorough assessment and critical analysis of available information;
- Information sharing in the best interests of the patient.

1.4 To demonstrate Medevent Limited's commitment to safeguarding, this policy seeks to: -

- Inform employees and contractors of the indicators of safeguarding issues;
- Provide procedures for employees and contractors to identify and report issues of possible vulnerability;
- Promote inter-agency working;
- Highlight the need for employees and contractors to be aware of Trust guidelines, policies and referral pathways relevant to their area of work.

1.5 This policy complements the requirements and guidance contained in local and national policies and procedures.

1.6 Employees and contractors are reminded that as in all areas of clinical practice, record keeping is vital to supporting actions taken. Record keeping should be contemporaneous and using company documentation. This is particularly important in areas of work where records are likely to be scrutinised for reviews, enquiries and court cases.

1.7 Medevent Limited recognise that robust recruitment and selection arrangements are crucial to the protection of the public. Recruitment at all times will follow best practise guidelines in this area.

1.8 In the event of a complaint or allegation being made about a member of staff or contractor in relation to safeguarding, the Medevent Limited Disciplinary Policy will be enforced, with recognition and compliance for any relevant Trust's disciplinary policies also being upheld.

1.9 The procedure for responding to an Allegation of Abuse or Neglect against a Child or Young Person made against a member of staff working with children or young

people is based on the framework for dealing with allegations of abuse made against a person who works with children, as detailed in Chapter 6 and Appendix 5 of Working Together 2010. Our procedure is incorporated within our disciplinary policy.

1.10 This procedure should be applied when an allegation or concern has been made against any member of staff who works with, or might come into contact with children or young people, and in doing so may have:

- Behaved in a way that has harmed, or may have harmed a child or young person;
- Possibly committed a criminal offence against or related to a child or young person;
- Behaved in a way that indicates that they may be unsuitable to work or have contact with children or young people.

The scope of this procedure is not just limited to allegations involving significant harm, or risk of significant harm to a child or young person. It should also be followed in other situations, such as concerns/allegations relating to 'inappropriate' behaviour that might include physical punishment, abuse of trust and grooming, all of which should be followed in an objective manner.

1.11 The Safeguard Manager must be informed of any complaints involving safeguarding issues.

1.12 The Quality Governance Patient Safety & Risk Committee will monitor the policy.

2.0 SAFEGUARDING CHILDREN

2.1 Safeguarding children includes the following key areas: -

- Being healthy – the clinical care of children & their families;
- Staying safe – child protection;
- Enjoying & achieving;
- Making a positive contribution;
- Achieving economic well-being.

2.2 Section 11 of the Children's Act 2004, gave all healthcare providers a statutory responsibility to safeguard children – all NHS bodies must make arrangements to ensure that their function is discharged having regard to the need to safeguard and promote the welfare of children.

2.3 It is recognised that any formal notification of a child at risk under this policy will contribute to the assessment of need for the child and their family. It is not intended as a punitive action.

2.4 Medevent Limited recognises that the law permits the disclosure of confidential information necessary to safeguard children in the public interest, with or without the permission of the child's parents. Medevent Limited also recognises that children are entitled to the same duty of confidence as adults provided that in the case of those under 16 years of age, they have the ability to understand the choices and the consequences relating to any treatment. Confidentiality may be breached, following discussion with the child, in exceptional circumstances where it is believed that the child is being exploited or abused.

2.5 Child Protection procedure definition – A person may abuse or neglect a child by inflicting harm, or by failing to act prevent harm. Harm may take the form of physical abuse, emotional abuse, sexual abuse or neglect.

2.6 Operational staff will often be the first professionals on scene and their actions and recording of information may be crucial to subsequent enquires.

2.7 Operational staff should follow the normal history taking routine, taking particular note of any inconsistency in history and any delay in calling for assistance. They should limit any questions to those of routine history taking asking questions only in relation to the injury or clarification. Personnel should not question the child, but should listen and react appropriately to install confidence. Leading questions should always be avoided.

2.8 If Operational staff attend a child and are concerned that the child may have been physically, sexually, emotionally abused or neglected it is imperative that:-

- Presenting clinical conditions is assessed & treated;
- The appropriate emergency services are contacted without delay;
- Concerns and actions are fully recorded, dated and signed;
- **Suspicions are followed through, if necessary by immediate referral to social services and police as appropriate using the local safeguarding Boards/Local authorities notification documentation; please contact the Manager on call for a copy. This is a legal requirement.**
- Referrals are followed up in writing, using the appropriate forms;
- Advice and support is sought where necessary, from a line or safeguarding manager.

2.9 If an employee or contractor believe a child to be at immediate risk, an urgent referral should be made to social services or the police by phone, both these agencies have statutory powers to protect children where necessary. Trusts may have slightly varied approaches to the referral process. The appendices contained within this policy contain policy and guideline information relevant to individual Trusts. The appropriate pathway relevant to the Trust in question should always be followed in the event of a referral being required. If a staff member or contractor has any doubts as to what actions they should take in such circumstances, they should urgently seek clarification through communication with a representative of the relevant Trust. The information shared should include:-

- Identify of referrer and professional role;
- Clinical presentation and clinical outcome;
- As much demographic information as is possible to obtain about the child/children at risk;
- The name and relationship to the child of any adults present;
- The child's GP if that is known;
- A brief summary of the concerns and any immediate actions taken.

The verbal referral should be followed up in writing using a standard referral form containing the above information. For non-urgent referrals, the above information should be included on a referral form and sent to the Huddersfield office, unless this contravenes the requirements placed upon a staff member or contractor by a relevant Trust policy/guideline. If the incidents results in no-one being conveyed to hospital, staff should be absolutely confident that a child is not at immediate risk.

2.10 **Case Conferences/Court Appearances** – Staff should be prepared, following a referral, to attend a case conference or for their evidence to be called to court. Staff will be supported in these processes by a member of Medevent Limited.

3.0 SAFEGUARDING ADULTS

3.1 The legal framework for protecting vulnerable adults from abuse is garmented; however in some cases a criminal offence may have been committed. The key legislation underpinning the protection of vulnerable adults is the National Health Service and Community Care Act 1990. The Domestic Violence, Crime and Victims Act 2004 aim to improve the legal protection for those who are victims of domestic violence, and are included in the overall safeguarding of adults. The Mental Capacity Act 2005 (enactment April 2007) provides a statutory framework to protect vulnerable people who are not able to make their own decisions. It aims to enshrine in law what has been best practice with regards to consent. No Secrets was police guidance issued by the Department of Health in 2000, this set out standards for developing policies and procedures to protect vulnerable adults.

3.2 Medevent Limited acknowledges that adults have the right to take risks as long as they have the capacity to make an informed decision. The trust also acknowledges that it is every adult's right to live free from abuse in accordance with their human rights.

3.3 Medevent Limited recognises that the law permits the disclosure of confidential information in order to safeguard a vulnerable adult, in the public interest.

3.4 **Adult Protection Procedure**

3.4.1 **Definition** – Adults who are in need of safeguarding, are defined as any person over 18 years of age who is or may be in need of community care services by reason of mental or other disability, age or illness and who is or may be unable to take care of him or herself or is unable to protect him or herself against significant harm or exploitation. Abuse may include:

- Physical abuse.
- Psychological abuse.
- Sexual abuse.
- Financial abuse.
- Institutional abuse.
- Neglect and acts of omission.
- Discriminatory abuse.

3.4.2: Abuse may occur in a number of settings:

- Within the patients' home.
- Within a friends' home.
- Within a residential or nursing home.
- Within a hospital.
- Within a day centre or supported living scheme.
- Within an educational establishment.

3.4.3: Perpetrators of abuse may include:

- Family members.
- Neighbours and friends.

- Paid of volunteer carers.
- Professional staff.
- Strangers.
- Other patients or service users.

3.4.4 There are a number of ways that staff may become aware that a vulnerable adult may be in need of protection. The main way is by observing the circumstances of an incident, as well as the presentation. Patients may disclose abuse to a trusted healthcare professional, or staff may receive an allegation from a third party. In all these cases, the information must be taken seriously and documented. Care should be taken not to alert a possible perpetrator to the concerns.

3.4.5 If personnel attend an incident where they are concerned about a vulnerable adult, it is imperative that:

- Presenting clinical condition is assessed and treated;
- Call for Transport so that patient is transported to the appropriate medical facility if clinically indicated;
- Concerns and actions are fully recorded, dated and signed;
- Suspicions are followed through, if necessary by immediate referral to social service and police as appropriate and by referring the case to the local authority's Local Safeguarding Board. These referrals are a legal requirement and the on call manager must be informed as this is a statutory notifiable incident to CQC;
- Referrals are followed up in writing, using the appropriate form;
- Advice and support is sought where necessary, from line managers or members of the safeguarding team.

3.4.6 **Referrals** – If personnel believe a vulnerable adult to be at immediate risk, they should request police attendance. An urgent verbal referral should also be made to the appropriate Social Services department. Trusts may have slightly varied approaches to the referral process. The appendices contained within this policy contain policy and guideline information relevant to individual Trusts. The appropriate pathway relevant to the Trust in question should always be followed in the event of a referral being required. If a staff member or contractor has any doubts as to what actions they should take in such circumstances, they should urgently seek clarification through communication with a representative of the relevant Trust. Information shared should include:

- Identify or referrer and professional role.
- Clinical presentation and clinical outcome.
- As much demographic information as is possible to obtain about the adult at risk.
- The name and relationship to the patient of any adults present.
- The GP if that is known.
- A brief summary of the concerns and any immediate action taken.

The verbal referral must be followed up in writing using a standard referral form containing the above information. For non-urgent referrals, the above information should be included on a referral form and sent to the

Huddersfield office, unless this contravenes the requirements placed upon a staff member or contractor by a relevant Trust policy/guideline. If the incident results in no-one being conveyed to hospital, staff should confident that the patient is not at immediate risk.

4.0 DOMESTIC VIOLENCE

4.1 Domestic violence is a serious crime that has a major impact on the primary victim as well as members of the extended family. It costs society and the health service millions of pounds and has long lasting effects on the mental and physical health of all victims.

4.2 **Definition** – The Home Office have defined domestic violence as 'Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

4.3 Extent of the problem:

- 20% of women report having been physically assaulted by a partner at some point;
- Although 90% of reported domestic abuse is perpetrated by men or women, it is recognised that there is an under reporting of abuse, particularly by men who are victims of abuse by women, and by those in same sex relationships;
- Victims of domestic violence are assaulted on average 35 times before reporting it to the police;
- 30% of cases of domestic violence start during pregnancy;
- 52% of child protection cases involve domestic violence.

These figures related to reported cases of domestic violence and therefore are an underestimation.

4.4 If Medevent Ltd staff witness an incident where they are concerned that domestic violence is a contributing factor, it is imperative that:

- Presenting clinical condition is assessed and treated;
- The patient is transported to the appropriate medical facility if clinically indicated;
- Concerns and actions are fully recorded, dated and signed;
- Any assault is notified to the police;
- If children are present, refer through the child protection procedure;
- If no children present, refer the adult via the vulnerable adult route;
- Advice and support is sought where necessary, from line managers or members of the safeguarding team.

4.5 **Referrals** - If Medevent Limited personnel believe a vulnerable adult or children to be at immediate risk as a result of the domestic violence, they should request police attendance. An urgent verbal referral should also be made to the appropriate Social Services department. Information shared should include:

- Identify or referrer and professional role;
- Clinical presentation and clinical outcome;
- As much demographic information as is possible to obtain about the adult at risk;

- The name and relationship to the patient of any adults present;
- The GP if that is known;
- A brief summary of the concerns and any immediate actions taken.

The verbal referral must be followed up in writing using a standard referral form containing the above information. For non-urgent referrals, the above information should be included on a referral form and sent to the Huddersfield office.

4.6 **Record Keeping** – Any observations of injuries and verbal abuse must be carefully documented. The service records may form a vital evidence base for prosecution of domestic violence cases.

5.0 MENTAL HEALTH

5.1 **Definition** – Mental health may be defined as how we feel, behave and think. Mental health problems arise when there are difficulties with these areas that affect the way we live our daily lives, how we conduct relationships and out physical health. Mental health problems are common, affecting one in four of us at some point in our lives, they cross all ages, genders, races and social background. The causes of mental health problems relate to individual response to particular circumstances. The circumstances that may trigger a mental health problem are common, such as house moves, loss of a job, a personal relationship difficulty or the death of a person close to you. Some people may be more vulnerable than others to developing a mental health problem, either due to their personality or due to their circumstances.

5.2 Risk factors for vulnerability to mental health problems:

- Poor living conditions;
- Drug and alcohol addiction;
- Homelessness;
- Disability;
- Ethnicity;
- Previous life circumstances (such as abuse or neglect in childhood).

Without treatment and support, mental health problems can become worse and longer lasting.

5.3 Treatment options include:

- Medication;
- Counselling;
- Psychotherapy;
- Psychiatric help;
- Specialist services such as eating disorder teams;
- Complementary therapies;
- Self Help strategies.

Some patients who come to the attention of the service suffer from severe mental illness that is recurrent and enduring, and exacerbated by alcohol and substance use.

5.4 **Referrals** – In many cases patients with mental health problems will require taking to A&E due to the nature of the presentation which will tend to be acute. However in some cases the patient's condition may not warrant conveyance to hospital or the

patient may refuse treatment. In these cases, serious consideration should be given to the sharing of information with the patient's GP or mental health worker, in order to ensure continuity of care that those involved in their care are aware of the incident. For patients who contact the urgent care service regarding mental health issues, the normal information sharing process will ensure that their own GP is aware of the contact.

5.5 Services for those with mental health problems are locally defined and will vary in their access criteria. Referral pathways for staff may exist in a particular locality. Please seek advice from the Clinical Supervisors in Control as to whether such an agreement exists.

5.6 Attention is drawn to the assessment tool in JRCALC, for the assessment of suicide risk.

5.7 Consideration should also be given to the effect that the patients' mental health is having on those for whom they have caring responsibility. Consideration should be given to a child protection or vulnerable adult referral if the patient is unable to care for their children or another person for whom they are the prime carer.

5.8 **Induction Training Delivery** - Consider the Mental Capacity Act and also the Mental Health Act.

6.0 DISCRIMINATORY ABUSE AND HATE CRIME

6.1 The Equality Act 2010 provides a new crosscutting legislative framework to protect the rights of individuals and advance equality of opportunity for all; to update, simplify and strengthen the previous legislation; and to deliver a simple, modern and accessible framework of discrimination law that protects individuals from unfair treatment and promotes a fair and more equal society.

6.2 Discriminatory abuse includes the ill treatment of individuals motivated by racism, sexism, and homophobia or on the basis of religion or disability. This can include; harassment, denying people their rights, belittling or humiliating people, not providing appropriate food, and preventing access to places of worship or from carrying out cultural or religious beliefs.

6.3 Hate crime is the targeting of individuals, groups and communities because of who they are. Hate crime targets people because of elements which go to the core of their identities – their race, their religious beliefs (or lack of them) their disability, sexual orientation or that they are transgender. Hate crime is also a crime against the groups and communities to which these people belong.

6.4 Hate crime instils fear in victims, groups and communities. It significantly impacts on the quality of people's lives and leads them to change their habits and lifestyle as they seek to avoid becoming victims, including being forced to move home, changing the route to work, altering their daily routines and even breaking off relationships or limiting meeting friends and relatives. Those who fear they will be a target of hate crime may even seek to hide their own identity, for example someone who is gay may change their appearance and how they interact with people.

6.5 Discriminatory abuse encompasses racist, sexist, homophobic and other remarks or behaviour, including those related to age, disability or illness. This can include:

- Harassment;
- Denying people their rights;

- Belittling or humiliating people;
- Not providing appropriate food;
- Preventing access to places of worship;
- Preventing people from carrying out cultural or religious practices;
- Regarding someone as being intrinsically different from other human beings

6.6 Some indicators of neglect can include:

- Lack of self-esteem;
- Emotional withdrawal and symptoms of depression;
- Self-harm.

7.0 MIGRANT ABUSE AND HUMAN TRAFFICKING

7.1 Each year a number of migrants enter the UK legally to work in agriculture and other areas. Whilst visas are granted to allow this to happen, and regulations in relation to 'gang master' activity is more stringent than ever, they are particularly open to abuse, specifically around accommodation, pay, terms and conditions and their health needs. Every effort should be made to support these people to ensure they are not abused.

7.2 More complex are the migrants who enter the country illegally, or those who stay in the country after their visas expire, quite often these people become invisible on the authorities radars. All too often these people enter the UK and become involved in a life of abuse centred around the sex trade and drugs. There are more people enslaved worldwide today than there were 200 years ago. The modern slave trade is the fastest growing form of international crime with an estimated 600,000-800,000 people trafficked across international borders each year. In the UK many enslaved victims are unable to speak English, therefore they are unable to speak out about their suffering.

7.3 In relation to children, a benchmark example of migrant abuse was that of Victoria Climbe, she was given the opportunity to have better prospects, but was systematically abused from the time she left Africa. The number of migrant children has increased in recent years and they are highly susceptible to abuse. Many children are moved illegally and/or against their will.

8.0 INTERNET ABUSE

8.1 Sadly, Internet abuse is now a widespread problem, the Internet providing a useful medium for those wishing to exploit vulnerable adults and children. At the same time other information communication technology (ICT) mediums are increasingly becoming used by perpetrators to prey on their victims. For example using webcams, texting and other mobile information technologies.

8.2 Internet chat rooms, discussion forums and bulletin boards are known to be used by perpetrators as a means of contacting vulnerable people, and as a way of establishing deceptive relationships with them. They then 'groom' the victims, either psychologically on the Internet itself, or by arranging to actually meet them. The perpetrators may ask the victim to transmit pornographic images of themselves, or to perform sexual acts live in front of a webcam.

8.3 Abusers are very adept at manipulating their victims and particularly in the case of children it is known that girls are more at risk than boys.

9.0 INSTITUTIONAL ABUSE

9.1 Involves the collective failure of an organisation to provide an appropriate and professional service to vulnerable people. It can be seen or detected in processes, attitudes and behaviour that amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and stereotyping.

9.2 Institutional abuse includes a failure to ensure the necessary safeguards are in place to protect vulnerable adults/ children and maintain good standards of care in accordance with individual needs, including training of staff, supervision and management, record keeping and liaising with other providers of care. In the case of institutional abuse being discovered, the police should be notified to ensure that a criminal investigation is undertaken.

10.0 UNFORESEEN VULNERABILITY

10.1 This is a significant type of vulnerability that could be argued to be comparatively common when measured against the areas mention above.
There will be situations where a person becomes vulnerable because the support that they rely on is no longer available. Examples of this might include where a person can no longer look after themselves because:-

- A carer is taken ill, or to hospital;
- A couple living independently where one is taken ill.

In these situations we have a duty of care not only to the patient, but also to anybody that suddenly becomes vulnerable, specifically because of these circumstances. Consider whether the care provision for them is adequate. Are urgent arrangements such as immediate contact with Social Care required?

10.2 Many 'vulnerability' referrals are due to acopia – a failure or inability to cope. Acopia covers a multitude of reasons which might include the following:-

- General ill health or worsening of their health making them unable to cope;
- Medication issues;
- Alcohol issues;
- Where they are in need of a care plan, or where it is clear that modifications need to be made to their current plan;
- General deterioration;
- Sensory problems (deteriorating eyesight/hearing etc);
- Financial concerns resulting in poor health (i.e. lack of warmth);
- Stress;
- Inability to cope with dependant spouse / relatives any longer;
- Repeated falls.

10.3 In these and similar situations it is probably more appropriate to refer to the patients GP. Out of hours this can be an issue and with a professional duty of care the safeguarding route is often seen as an appropriate alternative.

11.0 FORCED MARRIAGE

11.1 A marriage must be entered into with the full and free consent of both people. Everyone involved should feel that they have a choice. An arranged marriage is not the same as a forced marriage. In arranged marriages the families take a leading role in choosing the marriage partner. Both people enter into the marriage freely.

11.2 However, in some cases, one or both people are forced into a marriage their families want. A forced marriage is a marriage conducted without valid consent of both people. The victims may encounter both physical and / or emotional pressure to get married.

11.3 Hundreds of young people (particularly girls and young women) are forced into marriage each year. Some are taken overseas to marry whilst others may be married in the UK. Forced marriage can involve child abuse, including abduction, violence, rape, enforced pregnancy and enforced abortion. Refusing to marry can place a young person at the risk of murder; this is sometimes referred to as "honour killing".

11.4 Children as young as 7 or 8 can be victims of forced marriage. Forced marriage is recognised in the UK as a form of domestic abuse and as serious abuse of human rights. The Department of Health has joined forces with the Forced Marriage Unit to raise awareness of the problem.

12.0 FEMALE GENITAL MUTILATION

12.1 Female Genital Mutilation (FGM) is a collective term for procedures that include the removal of part or all of the external female genitalia for cultural or non-therapeutic reasons.

12.2 In the UK FGM is a criminal offence under the Prohibition of Female Circumcision Act 2003. This act also makes it an offence for UK residents or nationals to carry it out, or knowingly allow it to happen abroad – even in countries where it is legal.

12.3 FGM has potentially serious health implications, it is unnecessary and can be extremely painful, both at the time and later on in life. It is typically carried out between the ages of 4 and 13. It remains relatively common across the world. In the UK alone it is estimated that up to 24,000 girls under the age of 15 are at risk of FGM.

13.0 DANGEROUS DOGS AND SAFEGUARDING CHILDREN

13.1 The NSPCC document, Understanding the Links; Information for Professionals; child abuse, animal abuse, and domestic violence says, 'There is increasing research and clinical evidence which suggests that there are sometimes inter-relationships, commonly referred to as 'links', between the abuse of children, vulnerable adults and animals. A better understanding of these links can help to protect victims, both human and animal, and promote their welfare'.

13.2 There have been a number of high profile attacks on young children in the last few years that have resulted in serious injury and the deaths of children. Some known dangerous dog breeds are banned in the UK but many are kept covertly and often trained to fight, dog fighting has been illegal in this country since 1835.

13.3 Dangerous dogs can be considered in two contexts, firstly dogs that come under the Dangerous Dogs Act 1991 and are classified as banned dogs as per the act. These are:

- Pit Bull Terrier
- Japanese Tosa
- Dogo Argentino
- Fila Braziliero
- Cross Bred Pit Bulls

13.4 The second group relates to dogs that are dangerous, or perceived to be. When you attend a patient or come into contact with a family that has a dog, you need to consider whether or not the dog poses any threat to the child's health, development or safety. This could be any dog of any breed. Considerations might include:

- Is it a large dog in a small flat?
- Is the dog left unattended with a child?
- Is the dog looked after properly (does it look healthy)?
- Is the dog being maltreated or abused by anybody there?
- Does it appear that more money is spent on the dog compared to the child?

13.5 Very few people would be able to recognise dogs in the first group as defined by the Dangerous Dogs Act 1991, and this information does not require that staff become canine experts. Many professionals have difficulty in recognizing dangerous dogs, particularly the 'pit bull' family of dogs.

13.6 Remember that dogs are often protective towards their home and family members, particularly when strangers are invited into the home. A sensible approach should be adopted, as often dogs will act to protect the environment and the people well known to them.

13.7 In the context of safeguarding, if you are not sure about a dog you should, if appropriate share your concerns with the family. In the event that you feel unable to do this you should discuss the issue, in the first instance, with your manager.

13.8 As with other safeguarding instances, if you believe there is a risk to children, you should make a referral to Social Care using the appropriate Trust pathway.

13.9 If the circumstances are extreme and there appears to be a serious risk to the child, you should contact the police immediately.

14.0 SUDDEN UNEXPECTED DEATH IN CHILDHOOD (SUDIC)

14.1 In January 2003 The Royal College of Pathologists and The Royal College of Paediatrics and Child Health established an intercollegiate group to review how sudden unexpected deaths in infancy should be investigated. The result was the report 'Sudden Unexpected Death in Infancy'. This was compiled by a working group chaired by Baroness Helena Kennedy QC, the report is now known as 'The Kennedy Report'. As a result of the report and its recommendations, many changes have been made into the way that deaths in infancy and childhood are managed and investigated.

14.2 Each county or unitary authority now has in place a 'rapid response procedure' for every unexplained child or infant death.

14.3 Personnel are obviously involved in the process. The first priority is clearly to preserve life wherever possible, in addition to this, personnel should gather as much information related to the event as possible. You will often have the opportunity to observe the scene at an early stage, this means you have the potential to gather vital information that other agencies cannot. Below are some examples of the information that can be useful in such a tragic event, in addition to a thorough clinical history:

- What position was the child in when you arrived?
- Do the parents/carers know what position they found the child or infant in?
- What were they wearing when you arrived?
- What was the temperature of the room? Was the temperature extreme?
- Where had the child been sleeping (particularly relevant to infants)?
- Note and report any obvious 'old' injuries;
- Note any inconsistencies in the history;
- Be aware of the potential importance of preserving the scene/do not disturb the scene unnecessarily.

14.4 Whilst the process of investigation that follows a child's death would look very closely at events leading up to that point, staff should still refer their concerns to Social Care in the normal way.

15.0 SUSPECTED ABUSE OF VULNERABLE ADULTS AND CHILDREN

15.1 Any allegation or suspicion of abuse must be taken seriously and acted on immediately. Any member of Medevent Limited who may come into contact with vulnerable adults have a duty to share, and if necessary refer or report concerns regarding suspected abuse or neglect to Social Care.

15.2 Failure to act might place the victim at greater risk and they may be discouraged from disclosing the same or further details again as they may feel they were not believed. Failure to report suspected or alleged abuse may also put other people at risk.

15.3 If staff have a concern and wish to seek further advice or clarity initially prior to making a formal referral, they should contact one of the following;

- HEOC Duty Manager
- Duty Operational Manager (DOM)
- Their line Manager
- Trusted Named Professional
- Clinical Support Desk (or Clinical Advice Line)

15.4 This list maybe different depending on the Trust in question.

15.5 It is essential that concerns are shared even if no further action is taken following a discussion with one of the above.

15.6 All Medevent Limited personnel MUST ensure that they are fully aware of the procedures to be followed in any given NHS Trust, in the event that a safeguarding issue arises. All workers have a responsibility to read, understand and to adhere to the requirements of associated policies and their appendices, and maintain an up to date knowledge of current practice in relation to safeguarding.

15.7 Any staff member who suspects abuse MUST follow the procedures and guidance cited in the Medevent Limited policy AND importantly, the procedures cited in the relevant Trust documentation. The aforementioned information clearly outlines how a relevant Trust expects staff to recognise possible examples of abuse and what immediate actions workers are to take including **reporting concerns to the Safeguarding teams at the relevant Local Authorities.**

15.8 The police (along with Social Care) are the leading agencies coordinating the response to adult abuse allegations. They have an important responsibility to work closely with other agencies and organisations and undertake assessments and investigations. The multi-agency approach is aimed at preventing abuse (Safeguarding) and providing a timely provision of help when it is needed in a proactive sense.

15.9 Through different agencies working together to both safeguard vulnerable people and also share concerns, this multi-agency approach helps achieve a swift, effective response from agencies acting together when abuse is suspected.

15.10 The prime objective in any investigation of alleged abuse is to secure the best outcome for the vulnerable or abused individual in question. Whilst most cases will be resolved at a local and informal level, on some occasions cases may require more formal measures to be taken, including potential action through the courts.

REFERENCES

Children Act 2004
www.opsi.gov/acts2004/20040031.htm

Working together to safeguard children 2006
www.everychildmatters.gov.uk

National Health Service and Community Care Act 1990
www.opsi.gov.uk/ACTS/acts1990/Ukpga 19900019 en 1.htm

Domestic Violence, Crime and Victims Act 2004
www.opsi.gov.uk/ACTS/acts2004/20040028.htm

Mental Capacity Act
www.opsi.gov.uk/acts/acts2005/20050009.htm

No Secrets 2000
http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_4003726

Responding to a domestic abuse A handbook for health professionals 2006
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4126161

JRCALC Clinical Practice Guidelines 2006
http://jrcalc.org.uk/

Forced marriage
www.forcedmarriage.net
www.bia.homeoffice.gov.uk/partnersandfamilies/forcedmarriage

The Female Genital Mutilation Act 2003
www.opsi.gov.uk/acts2003/ukpga

WT2010; Chapter 6; 6.14 to 6.19
www.forwarduk.org.uk

Understanding the links; Information for; child abuse, animal abuse and domestic violence. NSPCC
www.nspcc.org.uk/inform

Dangerous Dogs Law; Guidance for Enforcers; Department for Environment Food and rural Affairs (Defra); March 2009
www.defra.gov.uk

Appendix 1 – Equality Impact Appraisal Tool

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	Race	No	
	Ethnic Origins	No	
	Nationality	No	
	Gender	No	
	Culture	No	
	Religion or belief	No	
	Sexual Orientation	No	
	Age	No	
	Disability – learning disabilities, physical disability, sensory impairment and mental health problems.	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
5.	**If so, can the impact be avoidable?**	N/A	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	
8.	**Assessment Approved by QGPSR**		**Date:**

If you have identified a potential discriminatory impact of this procedural document, please seek advice from the Equality and Diversity lead together with any suggestions as to the action required to avoid/reduce this impact.