NHS
South East Coast Ambulance Service
NHS Foundation Trust

Pre Reading and Further Resources for Level 3 Safeguarding Children and Adult Training

Best placed to *care*, the *best* place to *work*

Contents

Introduction

This guide is intended to support staff undertaking their Level 3 Adult and Child Safeguarding training. There is no test at the end of the course this year, however reading through this document and having it to hand during the presentation will greatly aid your understanding of the case studies and enable you to participate fully in the taught session.

In feedback gathered, from previous presentations of the Level 3 Safeguarding training, staff have asked for more opportunities to take part in discussion type activities. By absorbing some of the core information beforehand, there is far more opportunity to share observations, thoughts and practice with peers on the day of your training. Please note that all participants are expected to contribute to group discussion in whatever format you feel comfortable with.

After your training, you may wish to keep a copy of this document for your own learning and future reference, although as Safeguarding legislation, guidance and best practice is periodically updated we would encourage you to periodically refer to the Zone for the latest version.

https://secamb.sharepoint.com/sites/Intranet-Safeguarding/SitePages/Level-3-Safeguarding-Adult-and-Children---Pre-Reading-and-Further-Resources.aspx

What is Safeguarding?

The CQC states 'Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It's fundamental to high-quality health and social care'

Safeguarding and Human Rights

The Human Rights act is closely linked with safeguarding practices.

Professional Curiosity

What do we mean by the term "professional curiosity"?
Professional curiosity is used when a practitioner explores and proactively tries to understand what is happening within a family or for an individual, rather than making assumptions or taking a single source of information and accepting it at face value. It is a combination of looking, listening, asking direct questions, checking out and reflecting on ALL the information received.

This does not mean we wish for you to be detectives; however, we should be taking into account the story we are being told and considering whether it is consistent with injuries/history/environment.

Being professionally curious – Child Neglect

Neglect is the most common reason for a child to be the subject of a Child Protection Plan in the UK. It is estimated to affect up to one in ten children. The warning signs & symptoms of child neglect vary from child to child.

Indicators

- Children who are living in a home that is indisputably dirty or unsafe.
- Children who are left hungry or dirty.
- Children who are left without adequate clothing, e.g., not having a winter coat.
- Children who are living in dangerous conditions, i.e., around drugs, alcohol or violence
- Children who are often angry, aggressive or self-harm
- Children who fail to receive basic health care.

Parents who fail to seek medical treatment when their children are ill or are injured.
Child neglect can be multifaceted and enduring, in dealing with neglect practitioners need to be professionally curious to determine further information in the interests of the child. It is essential that professional curiosity is always exercised.

Keep in mind the above when being professionally curious about an adult patient. Think of the Why? and How? questions, share your concerns where you feel necessary and discuss with a colleague.

Safeguarding Adults

As you will know from your Level 2 training, the Care Act 2014 sets out 6 key principles for safeguarding adults.

The Care Act applies to any adult at risk is any person who is aged 18 years or over and at risk of abuse or neglect because of their needs for care and/or support.

The above principals support that, living a life that is free from harm and abuse is a fundamental human right and an essential requirement for health and well-being that, as NHS staff, we have an important role to play in supporting patients to achieve this.

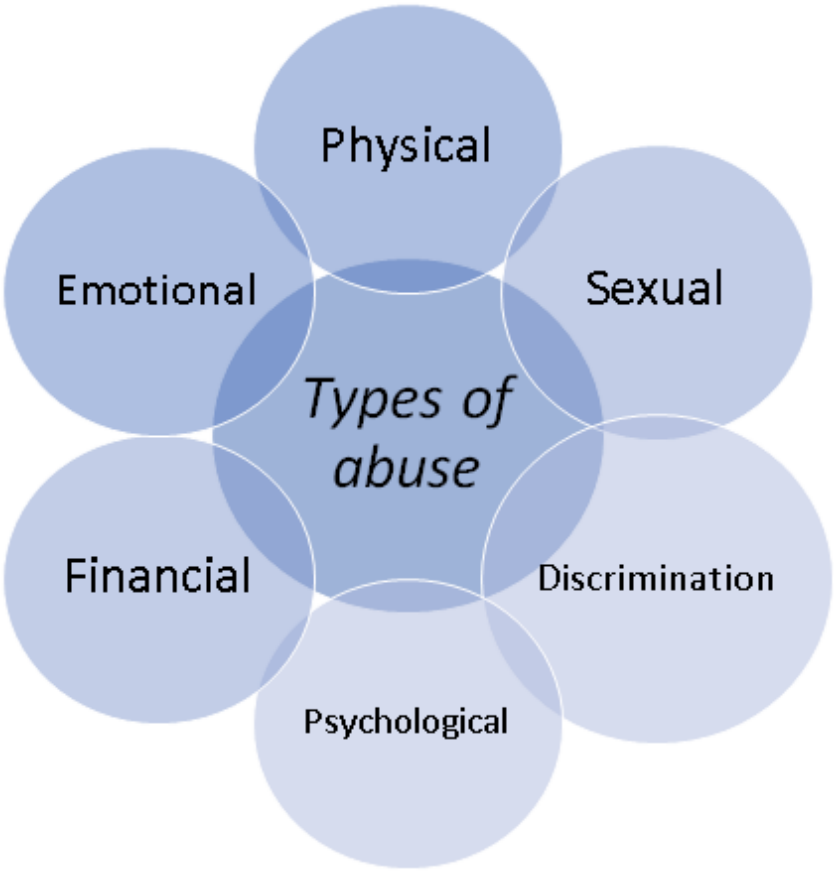
Safeguarding adults is about the safety and well-being of all patients but providing additional measures for those least able to protect themselves from harm or abuse.

Any of the patients that we work with could be at risk of harm, abuse or neglect however the definition of an adult at risk is; aged 18 years or over; who 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 unable to protect him or herself against significant harm or exploitation.

Our aims when safeguarding adults are:

- To prevent harm and reduce the risk of harm, abuse and neglect to adults with care and support needs.
- To safeguard individuals in a way that supports them in making choices and having control in how they choose to live their lives, "Making Safeguarding Personal".

Types of Harm, Abuse and Neglect



Physical abuse – including assault hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions. Missing medication might be a form of neglect, but the deliberate use of medications such as benzodiazepines or opiates to 'sedate' patients without appropriate oversight from a prescriber is a form of physical abuse.

Sexual abuse – including rape and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting to.
Within the SECAmb catchment area we have four Sexual Assault Resource Centres.

- Beech House – Maidstone
- Saturn Centre – Crawley (adults)
- Pebble House – CSARC Brighton (<14)
- Solace Centre – Cobham

Psychological abuse – including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or unreasonable and unjustified withdrawal of services or supportive networks.

Financial or material abuse – including theft, fraud, exploitation, coercion in relation to an adult's financial affairs or arrangements, or the misuse or misappropriation of property, possessions or benefits.

Discriminatory abuse – including discrimination on grounds of race, gender and gender identity, disability,

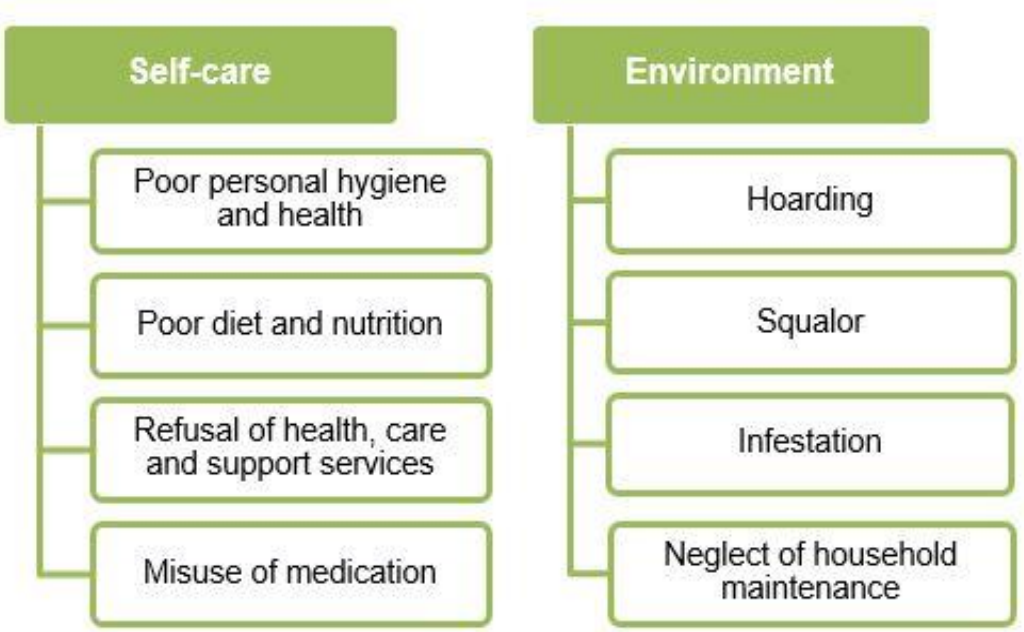
Organisational abuse – including neglect and poor care practice within an institution or specific care setting like a hospital or care home, e.g., this may range from isolated incidents to continuing ill-treatment

Neglect and acts of omission – including ignoring medical or physical care needs, failure to provide access to appropriate health, care and support, the withholding of the necessities of life, such as medication, adequate nutrition, and heating.

Self Neglect

Self neglect is the largest area of safeguarding that SECAmb receive safeguarding adult referrals for.

Self neglect can encompass any of the following behaviours or signs.



Have a low threshold for self neglect referrals even without consent.

Documenting Social History

- It is important that where there is a potential social care need on discharge, that SECAmb clinicians gather a detailed social history. Staff should consider obtaining a maximum of three images of the home environment to be used during a hospital discharge assessment.

- Images should be taken via the "Image" button just above the 'Next of Kin' field in the 'Patient Details' tab.

- Please consider taking pictures that show the following:
    - Ease of movement around the house, such as steep stairs, awkward steps, cluttered hallways or over furnished rooms. Access into and out of the house is less important.
    - The patient's bedroom/sleeping room.

- If the patient's bedroom appears unsuitable, a picture of any other suitable room for this use, e.g., another bedroom or the living room that could be re-purposed for sleeping.
- Any other challenges – remembering that solutions such as bathroom access is less important when a commode could be supplied to meet toileting needs.

- Following SECAmb guidelines:
  - Obtain explicit consent before taking photographs relating to a patient
  - Only ever take photographs with the ePCR app, not with the native iOS.

- For further support and guidance, please refer to:
  - ePCR User Guide in the 'ePCR Documents' section of the Content app on your iPad
  - Patient Photographic and Video Recording Policy.

The addition of a Clutter Score Rating is also a useful tool to summarise living conditions

clutter_image_ratings_-_combined.pdf (kmsab.org.uk)

Safeguarding Children

It is our responsibility as health care professionals to ensure we listen to the voice of the child and report their/our concerns to prevent/stop harm from occurring. Below are some key pieces of legislation and law that gives us guidance on how to do this.

- **UNCRC 1989**
  - Adults must do what's best for me (Article 3)
  - I have the right to be listened to, and taken seriously (Article 12\0
  - I have the right to be protected from being hurry of badly treated (Article 19)

- **The Children Act 1989**
  - The child's welfare is paramount although every effort should be made to preserve home and family links

- **Working Together to Safeguard Children 2018**
  - A child centred approach means keeping the child in focus when making decisions about their lives and working in partnership with them and their families

Types of Abuse in Children

Emotional Abuse - is the ongoing emotional maltreatment of a child. It's sometimes called psychological abuse and can seriously damage a child's emotional health and development. Emotional abuse can involve deliberately trying to scare or humiliate a child or isolating or ignoring them.

Physical Abuse - a form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

Sexual Abuse - a child is sexually abused when they are forced or persuaded to take part in sexual activities. This doesn't have to be physical contact and it can happen online. Sometimes the child won't understand that what's happening to them is abuse.

Neglect - is the ongoing failure to meet a child's basic needs and is the most common form of child abuse. A child may be left hungry or dirty, without adequate clothing, shelter, supervision, medical or health care.
A child may be put in danger or not protected from physical or emotional harm.

Child Sexual Abuse

Noticing one sign doesn't necessarily mean that a child is being sexually abused, but the presence of several of these signs could suggest that is being abused and should prompt professional curiosity.

Signs that a child is being sexually abused may include:

- Urinary infections or sexually transmitted infections
- Avoids or is afraid of being left alone with people or a specific person.
- Exhibits an inappropriate knowledge of sex for their age.
- Uses inappropriate sexual language.
- Exhibits sexualised behaviour in their play or with other children.
- Running away from home
- Alcohol or drug use
- Anxiety
- Self-harm or attempts at suicide.
- Talks about a new older friend.
- Suddenly has money, toys or other gifts without reason.

Physical warning signs of sexual abuse are rare, but some of these may be an indicator that the child may have been sexually abused.

- Pain, discoloration, bleeding or discharges in genitals, anus or mouth
- Persistent or recurring pain during urination and bowel movements
- Wetting and soiling accidents unrelated to toilet training

If a child is being sexually abused online, they may exhibit the following behaviour:

- Spending more time than usual online, texting, or gaming
- Seeming distant, upset, or angry after using the internet or texting
- Being secretive about what they are doing online or who they are talking to.
- Having lots of new phone numbers, texts, or messages

Private Fostering

What is Private Fostering?

A private fostering arrangement occurs when a child under 16 (or 18 if the child is disabled) is cared for and lives with an adult who is not a relative for 28 days or more.

The Children Act 1989 defines a relative as a step parent (by marriage or civil partnership), grandparent, step grandparent, brother, sister, uncle, or aunt.

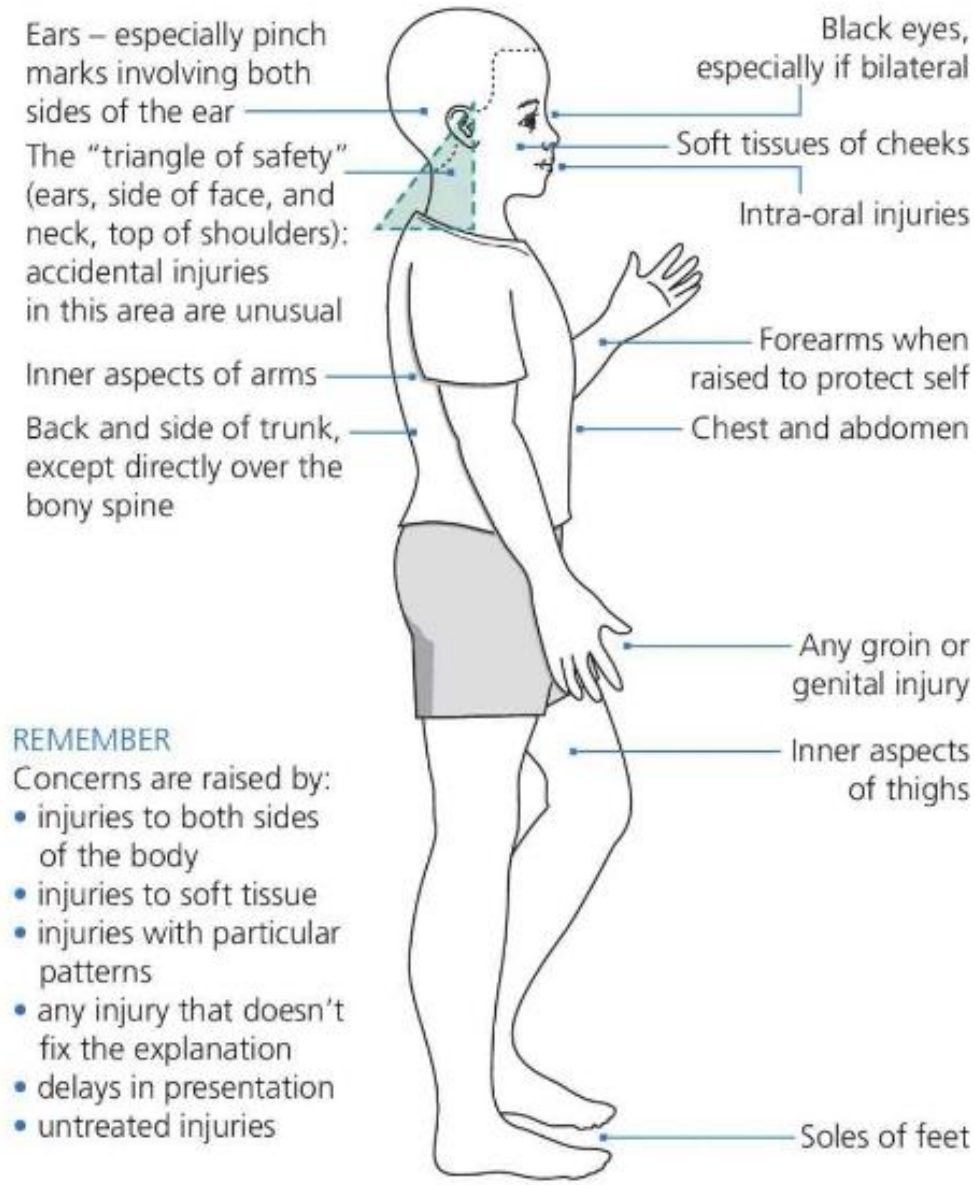
Private fostering is a private arrangement made by the parent(s), (or those with parental responsibility) for someone to care for their child because they are unable to do so (permanently or temporarily). This may be due to parental ill health, a parent going abroad or in to prison, a child being bought to the UK to study English, the relationship between the child and parent has broken down etc.

Parents and Private Foster Carers have a duty to inform the Local Authority regarding private fostering arrangements, but professionals need to recognise these arrangements and have a duty to inform the Local Authority.

Non accidental injuries (NAI) to children

Some signs to look out for when assessing children during your top-to-toe survey. Any marks should have a clear reasoning from the parent/carer. If in doubt, please seek support from colleagues and make a safeguarding referral.

Typical Abusive Injuries



Child Death

The Safeguarding team deal with all Child Deaths (anyone under the age of 18) in the geographical areas SECAmb covers. This is not because all child deaths have a safeguarding element to them, simply, the safeguarding team have the expertise to oversee the process that follows the death of a child.

Some studies suggest up to 29% of child deaths could be preventable. This is why there is significant focus, not on just seeking to identify any criminal behaviour, but also identify the circumstances surrounding the death. We work with our Police colleagues in paediatric arrest cases, and they should be called to scene immediately a cardiac arrest is confirmed, or it is very likely that a child might die. However, they do not need to be called to expected deaths if there are no suspicious circumstances. Equally, police do not need to be called to a stillbirth that is witnessed by an HCP, e.g., a community midwife.

Each child death review case is contributed to by the Specialist Safeguarding Practitioners and each person involved will receive a follow up email directly or via their manager. It is important that staff feel supported after attending/taking a call involving a traumatic incident and each staff member will be offered information and guidance.

A Child's Understanding, Gillick Competence, and Consent to Treatment for Under 18's

Age of consent
In law, a person's 18th birthday draws the line between childhood and adulthood (Children Act 1989 s105) - so in health care matters, an 18 year old enjoys as much autonomy as any other adult. To a more limited extent, 16 and 17 year-olds can also take medical decisions independently of their parents. The right of younger children to provide independent consent is proportionate to their competence - a child's age alone is clearly an unreliable predictor of his or her competence to make decisions.
Gillick competence is concerned with determining a child's capacity to consent.

Gillick competence
Victoria Gillick challenged Department of Health guidance which enabled doctors to provide contraceptive advice and treatment to girls under 16 without their parents knowing. In 1983 the judgement from this case laid out criteria for establishing whether a child under has the capacity to provide consent to treatment; the so-called 'Gillick test'. It was determined that children under 16 can consent if they have sufficient understanding and intelligence to fully understand what is involved in a proposed treatment, including its purpose, nature, likely effects and risks, chances of success and the availability of other options.

If a child passes the Gillick test, he or she is considered 'Gillick competent' to consent to that medical treatment or intervention. However, as with adults, this consent is only valid if given voluntarily and not under undue influence or pressure by anyone else. Additionally, a child may have the capacity to consent to some treatments but not others. The understanding required for different interventions will vary, and capacity can also fluctuate

such as in certain mental health conditions. Therefore, each individual decision requires assessment of Gillick competence.
If a child does not pass the Gillick test, then the consent of a person with parental responsibility (or sometimes the courts) is needed in order to proceed with treatment.

Children under the age of 16 can consent to their own treatment if they are believed to have enough intelligence, competence and understanding to fully appreciate what is involved in their treatment. This is known as being Gillick competent.
This consent to treatment cannot be overridden by a person with parental responsibility. However, a Gillick Competent child who refuses treatment can be.

Examples:

- A clinician advises that that the best treatment for pain would be Paracetamol. A parent disagrees and, for example, states that they do not believe in taking medication; however, the child is deemed Gillick competent and wishes to take the medication. In this case, the child should be given the treatment.
- A child has abdominal pain and attending A&E is indicated. Whilst the child understands the explanation, they state they do not wish to go to hospital and just want to go to sleep. The parents wish to follow clinical advice and can overrule the child's decision to decline treatment.

There is no lower age limit for Gillick competence guidelines to be applied. That said, it would rarely be considered that a child under 13 years would be Gillick Competent or appropriate/safe for a child less than 13 years of age to consent to treatment without a parent's involvement.

16-17 year olds
Young people aged 16 or 17 are presumed in law, like adults, to have the capacity to consent to medical treatment. However, unlike adults, their refusal of treatment can in some circumstances be overridden by a parent, someone with parental responsibility or a court. This is because we have an overriding duty to act in the best interests of a child. This would include circumstances where refusal would likely lead to death, severe permanent injury or irreversible mental or physical harm.

Parental responsibility

This could be:

- the child's mother
- the child's father if named on the child's birth certificate or married to the mother at the time of the child's birth
- the child's legally appointed guardian
- a person with a residence order concerning the child
- a local authority designated to care for the child

A person with parental responsibility must have the capacity to give consent.

If a parent refuses to give consent to a particular treatment, this decision can be overruled by the courts if treatment is thought to be in the best interests of the child.

By law, healthcare professionals only need one person with parental responsibility to consent for them to provide treatment.

In an emergency, where treatment is vital and waiting for parental consent would place the child at risk, treatment can proceed without consent. This is where, in most circumstances, contact between a young person and the ambulance service sits. This should be reserved for situations where it can be reasonably foreseen that to not receive treatment, in a timely manner, would likely result in death or severe physical or mental harm.

When consent can be overruled (beyond emergency situations)
If a young person refuses treatment, which may lead to their death or a severe permanent injury over time, their decision can be overruled but the Court of Protection.

Health professionals should still encourage the young person to inform his or her parent(s) or get permission to do so on their behalf, but if this permission is not given they can still give the child advice and treatment. If the conditions are not all met, however, or there is reason to believe that the child is under pressure to give consent or is being exploited, there would be grounds to break confidentiality.

Under 16: safeguarding considerations
If a young person under the age of 16 presents to a health care professional, then discloses a history raising safeguarding concerns:

If they are not deemed to be Gillick competent, the health professional is obliged to raise the issue as a safeguarding concern and escalate their concerns through the safeguarding process.

If they are deemed to be Gillick competent and disclosure is considered essential to protect them from harm or to be in the public interest, the health professional should escalate concerns through the safeguarding processes.

In both cases, the health professional should inform the young person of this action, unless doing so could pose significant additional risk for their safe care.

If in doubt, seek advice from a senior clinician or Safeguarding On Call team via your OTL, PP Hub or CSN.

Harmful Cultural Practices

"Harmful practices" is a collective term for a number of different forms of abuse which all share a similar characteristic, that they are seen as acceptable practices within some sections of society.

Harmful practices can cover, amongst other forms of abuse, child marriage, forced marriage, female genital mutilation, breast flattening, child abuse linked to faith or belief and so called "honour-based" abuse.

All these practices in isolation are physically and / or emotionally abusive, however their perseverance in society means that they stop being seen as abusive and start to be seen as acceptable and even a rite of passage therefore losing the label of abuse.

All forms of harmful practices are grounded in some form of discrimination and are likely to cause harm and suffering. Violence does not necessarily need to be involved; however it is often a feature.

Culture and safeguarding

Something that is linked to a person's faith or culture is not an excuse for physical abuse. Whilst we should be aware that culture and faith is an important part of many families lives, as professionals we need to maintain a culturally competent approach – not alienating the families we are working with, but not losing sight of any potential harm.

Vulnerable groups

UNICEF identify that both boys and girls are at risk of harmful practices, although girls are often at greater risk. They also note that societies where harmful practices such as child marriage and female genital mutilation take place, often reflect values that hold girls in low esteem. In many cases, the vulnerable groups are the same as the groups vulnerable to other forms of abuse, e.g., those with additional needs, children where there are other issues in the family home. However harmful practices may also take place in households where no other issues are present other than the specific beliefs of the family and possibly the associated wider community.

Using professional curiosity can support in identifying where these practices may be taking place.

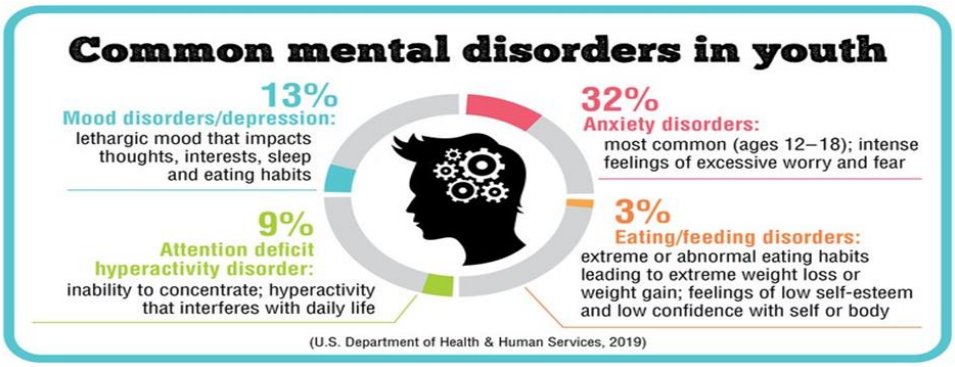
Mental Health in Children

It can be tough growing up. Many thousands of young people go through periods of mental ill health. When this happens, it can be difficult for them to make and keep friends, manage at school and feel good about themselves. It can also be bewildering for their families. In the last three years, the likelihood of young people having a mental health problem has increased by 50%. The Good Childhood Report 2022 shows that children's happiness continues to decline. The following data suggest that:

1 in 6 children are likely to have a mental health problem

1 in 4 17-19 year olds are likely to have a mental health problem

66% said they couldn't get support when they needed it



As the number of young people needing mental support increases, many are forced to find their own way of coping. Specialist services are overstretched, and young people are often refused treatment or made to join a long waiting list.

Some Signs a child might be struggling.

A large number of children and young people will experience behavioural or emotional problems at some stage. For some, these will resolve with time, while others will need professional support. It might be difficult to know if there is something upsetting the child, but there are ways to spot when something's wrong. Healthcare professions can speak to the child or ask parents if they have recognised:

- Significant changes in behaviour.
- If the child has been feeling tearful, miserable, lonely, or hopeless.
- Are they withdrawing, or avoiding friends or social situations?
- A change in eating behaviours.
- Do they find it hard to concentrate, and/or losing interest in schoolwork.
- Are they feeling irritable, angry or frustrated?
- Have they become self-critical, or feeling less confident?
- They do not want to do things they usually like?
- Have they Self-harmed or are they neglecting themselves?
- Have they experienced suicidal thoughts?

While every young person is unique, these feelings can often be expressed differently at varying ages. Therefore, it is worth considering if these changes have been caused by any specific events, or occurrences in their life? Does it only happen at home, school or college, or when they are with others or alone?

When to get professional help for a child or young person.

If you're worried or unsure, there is support out there:

- GP
- School wellbeing services/ school nurse
- Children and Young People Safe havens (area dependant)
- CAMHS – Children and Mental Health Services (National)
- YoungMinds | Mental Health Charity For Children And Young People | YoungMinds
- Children and young people's mental health services (CYPMHS) information for children and young people - NHS (www.nhs.uk)
- Papyrus UK Suicide Prevention | Prevention of Young Suicide (papyrus-uk.org)
- http://www.hopeservice.org.uk/

School, universities and workplaces are investing a huge amount in wellbeing services in supporting individuals and breaking down the stigma around mental wellbeing. Alongside this they are focusing on individuals investing in self- care, the five ways to wellbeing and promoting resilience strategies to aid both children's wellbeing and recovery.

The Future

The NHS Long Term Plan sets out the priorities for expanding Children and Young People's Mental Health Services (CYPMHS) over the next 10 years.
It aims to widen access to services closer to home, reduce unnecessary delays, and deliver specialist mental health care which is based on a clearer understanding of young people's needs and provided in ways that work better for them.

Domestic Violence and Abuse

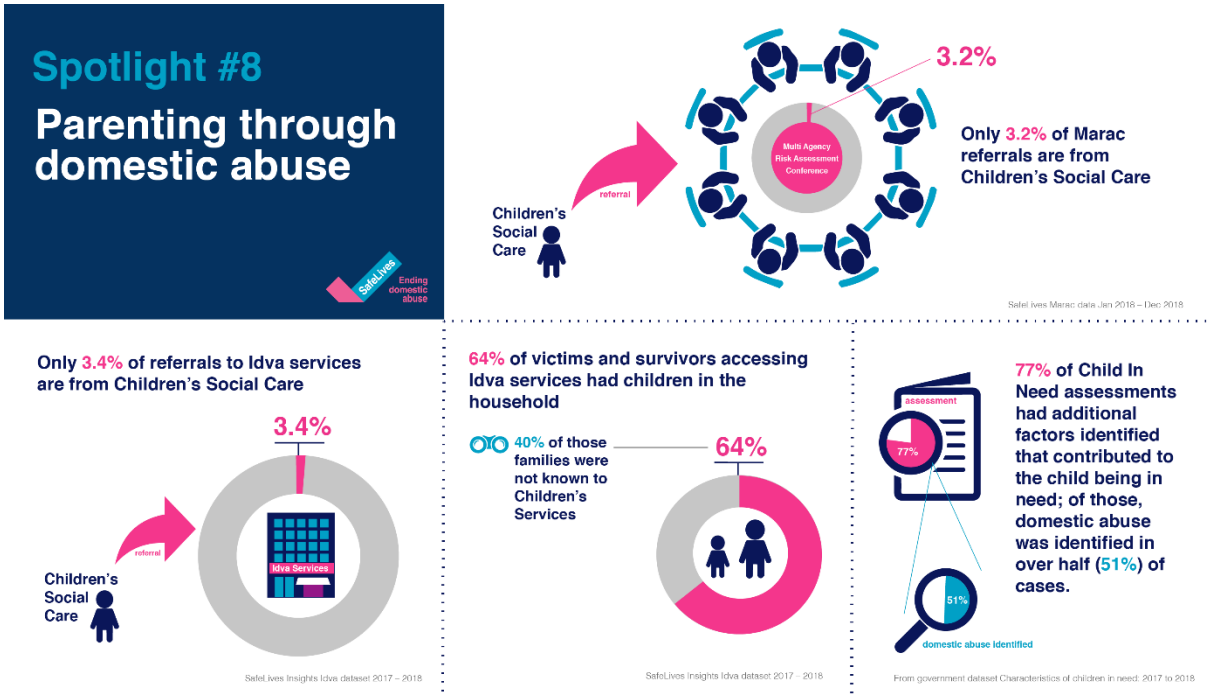
The cross-government definition of domestic violence and abuse is any incident or pattern of incidents of controlling, coercive, threatening behaviour, honour based violence, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality (Gov.UK, 2013). The offence of coercive and controlling behaviour in intimate and familial relationships was introduced into the Serious Crime Act (2015) and recognition of violence against women domestic abuse and sexual violence (VAWDASV) is part of the Social Services and Well-being (Wales) Act 2014.

Each Trust iPad has the Bright Sky app installed, this is a covert app that can be downloaded, looks like a weather app, and can be shared with patients safely.

Children and Domestic Abuse

Children must be protected from domestic abuse. Even without consent a safeguarding referral must be made for a child living in a house where domestic abuse is taking place.

Some statistics from Save Lives on domestic abuse and children.



Non Fatal Strangulation

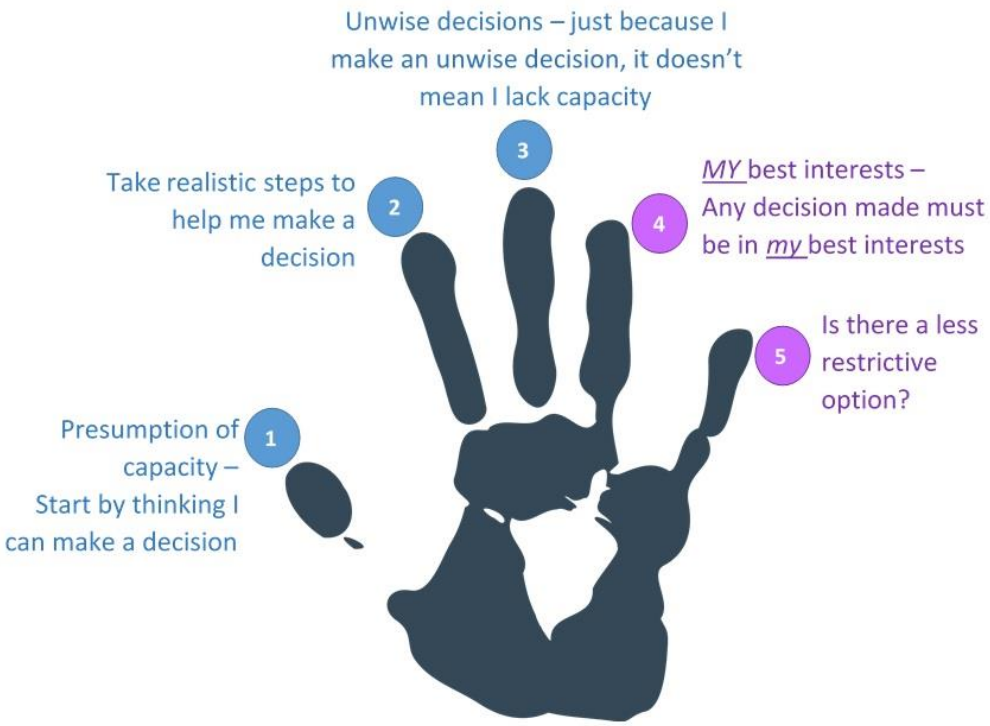
Strangulation can be defined as obstruction of blood vessels and/or airways by external pressure to the neck resulting in decreased oxygen supply to the brain. Non-fatal strangulation is where such strangulation has not directly caused the death of the victim.

It is estimated that more than 20,000 victims of domestic abuse in the UK experience strangulation each year, and in the **Insights 2021-22 dataset** found that 44% of service users had experienced non-fatal strangulation. Non-fatal strangulation significantly increases the risk of being killed, with homicide reviews showing victims of non-fatal strangulation are seven times more likely to be killed at a later date.

Only 50% of people who are strangled will have any visible injury to the neck or head. Despite this, numerous longer-term effects of strangulation are reported, including internal bleeding, dizziness and nausea, tinnitus or ear bleeding, sore throat or a raspy voice, loss of memory and even stroke several months later as a result of blood clots.

Beyond the physical and neurological impact, strangulation has been found to result in long-term mental health impacts. Post-traumatic stress disorder is closely linked to experiencing fear of imminent death.

Mental Capacity



Capacity is the ability of an individual to make decisions regarding specific elements of their life.

Remember, capacity is to be determined for a specific understanding and decision that needs to be made.

To determine a lack of capacity, there must be an impairment of the mind or brain (diagnostic) and that the person is unable to make a decision due to that impairment (functional).

Remember capacity can fluctuate!

[Assessment of capacity in clinical practice - Mental Capacity Toolkit]

Best Interest decisions

it is important, for the application of the MCA, to have a fundamental understanding of the best interest's principle.

If a person has been assessed as lacking capacity, then any action taken, or any decision made for, or on behalf of that person, must be made in his or her best interest. The person who must make the decision is known as the 'decision-maker' and normally will be the carer responsible for the day-to-day care, or a professional such as a doctor, nurse or social worker where decisions about treatment, care arrangements or accommodation need to be made.

Some of the factors to take into consideration are:

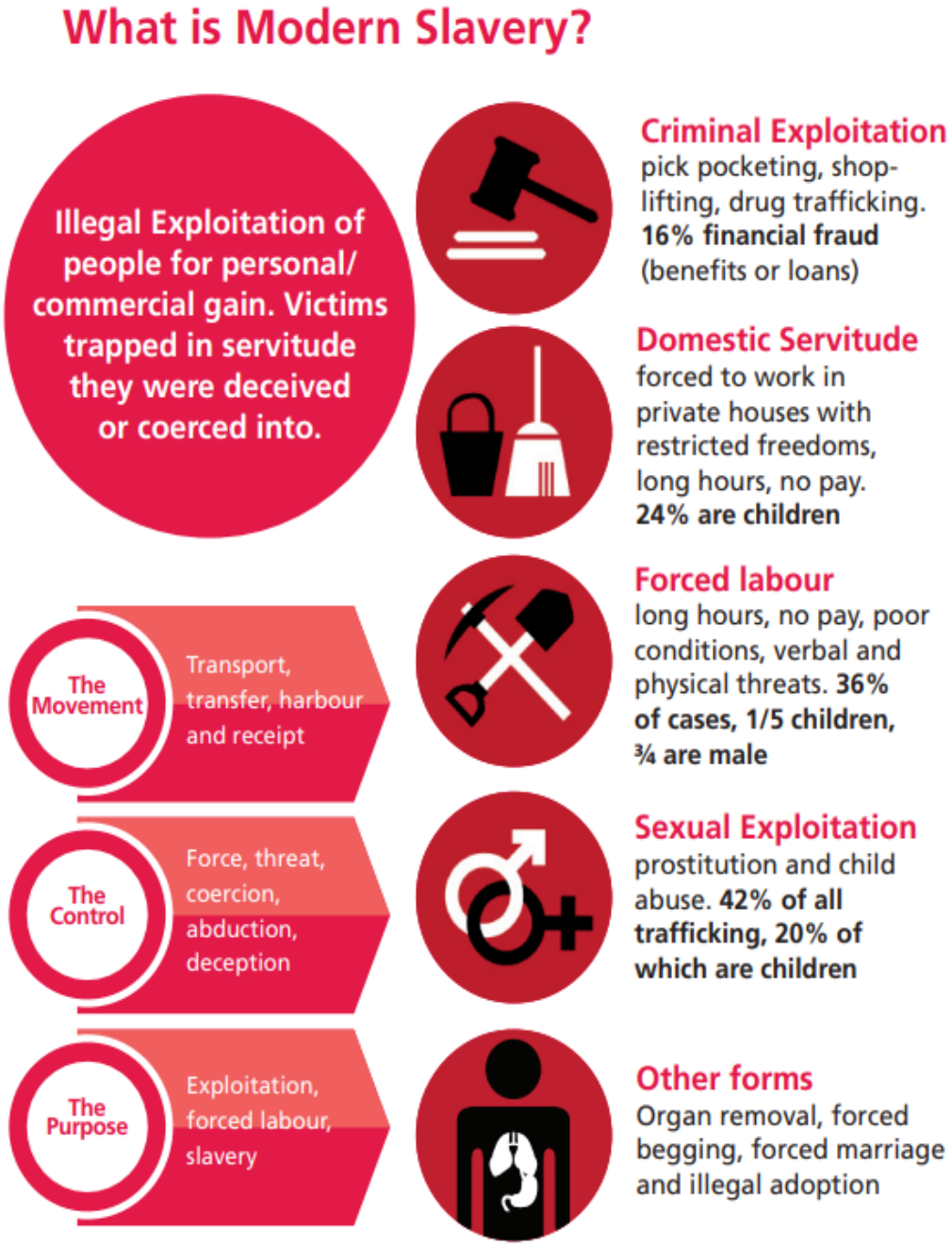
- Do not discriminate. Do not make assumptions about someone's best interests merely based on the person's age or appearance, condition, or any aspect of their behaviour.
- Consider all relevant circumstances.
- If faced with a particularly difficult or contentious decision, please seek support from senior colleagues.
- Will the person regain capacity? If so, can the decision wait?
- Involve the individual as fully as possible.
- Consider the individual's past and present wishes and feelings, and any beliefs and values likely to have a bearing on the decision.
- Consult as far and as widely as possible.

Prevent

What is Prevent? The Government's counter-terrorism strategy is known as CONTEST. Prevent is part of the strategy and its aim is to stop people becoming terrorists or supporting terrorism. The strategy promotes collaboration and co-operation among public service organisations. The Office for Security and Counter Terrorism in the Home Office is responsible for providing strategic direction and governance on Contest.

Contest has four key principles:

- Pursue: to stop terrorist attacks
- Prevent: to stop people becoming terrorists or supporting terrorism Protect: to strengthen our protection against a terrorist attack
- Prepare: to mitigate the impact of a terrorist attack. The health service is a key partner in Prevent: and encompasses all parts of the NHS,



What should I look for?

- Look malnourished or unkempt, withdrawn, anxious and unwilling to interact.
- Under the control and influence of others
- Live in cramped, dirty, overcrowded accommodation
- No access or control of their passport or identity documents or use false or forged documents Appear scared, avoid eye contact, and be untrusting.
- Show signs of abuse and/or have health issues.
- Show old/untreated injuries, or delay seeking medical care with vague/inconsistent explanation for injuries.
- Appear to wear the same or unsuitable clothes, with few personal possessions.
- Fear authorities and in fear of removal or consequences for family
- In debt to others or a situation of dependence

Safeguarding Allegations

The safeguarding team manage allegations made against staff. We work with other agencies to investigate including.

- Police
- The Local Authority Designated Officer (LADO)
- Professional Organisations e.g., HCPC, NMC
- Disclosures and Barring Service

It is imperative that you consider how conduct, both in and out of the workplace, will reflect on the public perception of the Trust, and your profession. Examples of behaviours that will be investigated include conduct with children, perpetrating Domestic Abuse, inappropriate relationships with patients, sexual assaults etc.

Even well intentioned episodes can call someone's conduct into question for example, never arrange to meet a patient to follow up on them. If you meet someone outside of work who you have treated, have an open and honest conversation with your manager and talk about how this may be perceived.

You have a professional and moral obligation to raise your concerns if you have worries about the conduct of a colleague or other professional.

If you have a safeguarding concern, you should raise your concerns through Datix or by contacting a member of the safeguarding team for advice.

All allegations or concerns related to SECAmb staff and volunteers are dealt with in strict confidence.

Making a Safeguarding Referral

The safeguarding team triaged over 29,000 referrals in 2022/23. An increase of over 20% on the year before. To support us in sharing your referrals in a timely way we ask that you ensure that your referrals are:

Clear	Referrals should make your concern clear to the reader.
Concise	Try to keep your referral concise, use bullet points if needed.
Correct	Be as factual as possible. If you have a 'gut feeling' make that clear.
Complete	Full name, address, date of birth, contact number, safe contact number, GP, details of other subjects of referral eg, children.
Consent	Consent should always be obtained except in extenuating circumstances. IF NO CONSENT – PLEASE EXPLAIN WHY

Things to keep in mind when making a referral.

- Do not be judgemental, we often do not know the whole story.
- Be polite, you may need to raise a concern but ensure this is done in a respectful way.
- Check your bias, we all have different bias, but when making a safeguarding referral we need to ensure we are sharing clear information instead of our beliefs.

For full guidance on referral completion: Safeguarding Referral Guide - DCIQ 2024 Parts1-4.mp4

Sources of Support

Safeguarding Team
safeguarding@secamb.nhs.uk
0330 3326 291

Wellbeing Hub – 0300 123 9193
Samaritans – 116 123
Victim Support Domestic Violence Helpline - 0808 169 6835