<table>
<thead>
<tr>
<th>Version</th>
<th>Date Approved</th>
<th>Publication Date</th>
<th>Approved By</th>
<th>Summary of Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>06/07/2012</td>
<td>July 2012</td>
<td>Board of Directors</td>
<td>New Policy</td>
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<tr>
<td>2.0</td>
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<tr>
<td>3.0</td>
<td>28/06/2016</td>
<td>June 2016</td>
<td></td>
<td>Review</td>
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<tr>
<td>4.0</td>
<td>27/10/2017</td>
<td>October 2017</td>
<td></td>
<td>Review</td>
</tr>
<tr>
<td>5.0</td>
<td>23/11/2018</td>
<td>November 2018</td>
<td>Policy Group</td>
<td>Review</td>
</tr>
<tr>
<td>6.0</td>
<td>18/07/2019</td>
<td>July 2019</td>
<td>Policy Group</td>
<td>Update of Vulnerable Persons Report Form</td>
</tr>
</tbody>
</table>
Contents:

1.0 Document Control .................................................................................................................4
2.0 Policy Statement .......................................................................................................................4
3.0 Scope .......................................................................................................................................5
4.0 Duties .......................................................................................................................................6
5.0 Roles of a Private Ambulance Service Provider ......................................................................7
6.0 Monitoring ...............................................................................................................................9
7.0 Sharing Information ..................................................................................................................9
8.0 Safeguarding Reporting Procedure .......................................................................................10
9.0 Race, Ethnicity and Culture ..................................................................................................11
10.0 Forced Marriages ....................................................................................................................12
11.0 Other Situations – Child or Adult at Risk of Significant Harm ...........................................12
12.0 Education, Training and Awareness ....................................................................................13
13.0 Duty of Care ............................................................................................................................14
14.0 Capacity ...................................................................................................................................15
15.0 Exceptions to Apply for Children ..........................................................................................15
16.0 Implementation of Policy .......................................................................................................16
Appendix 1 – Safeguarding Children Guidance Notes.................................................................17
Appendix 2 – Safeguarding Adult Guidance Notes.................................................................25
Appendix 3 – Vulnerable Person Report Form...........................................................................36
1.0 Document Control:

1.1 This document is only valid on the last date it was distributed. The source of the document currently resides locally with the Document Controller. Refer to the Document Controller if you are in any doubt about the authenticity of this document.

2.0 Policy Statement:

2.1 Jigsaw Medical (the Company) issues this statement in support of safeguarding for vulnerable adults and children who may come into their care. The Board of Directors takes very seriously their responsibility and accountability to protect those that may fall under this definition from any form of abuse. The definition of abuse can be located within Appendix 2.

2.2 The Company recognises its legal and moral duty and responsibility to safeguard and protect the welfare of children and adults by working in partnership with, and informing, Social Services and other Health Care Partners of any incidents where children or adults are perceived to be at risk.

2.3 A child is defined as a young person under the age of 18 years; an adult is defined as anyone over the age of 18.

2.4 The Company will seek to increase staff awareness of matters appertaining to Safeguarding Children and Adults through the provision of information, education and training programmes.

2.5 The Company has implemented this Safeguarding Policy and Process Guidelines to aid staff in the management of incidents where there is an identified or perceived risk of significant harm occurring to a child or adult.

2.6 Care Quality Commission (CQC) define safeguarding as:

‘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.’

This statement underpins the commitment that the Company holds in regard to protection.

2.7 We recognise the necessity for all staff to be trained in safeguarding so that they can
highlight any concerns to the relevant people and be aware of the process concerned with any allegations. Section 42 of The Care Act 2014 relates to the local authority investigating any concerns so it is vital that all staff are familiar with the process.

2.8 We are regulated by the CQC and ensure compliance with the five questions they ask. In relation to safeguarding the question is ‘Are services at this provider safe?’

2.9 The Company works in collaboration with various NHS trusts and private clients across the country. We ensure that for each individual Trust and client all staff receive an induction in relation to their safeguarding policies and their raising concerns process. Our policy is written to work in conjunction with each Trust but also to be robust enough to stand alone.

2.10 In accordance with The Care Act 2014 we have a reporting system in place to ensure that we are working in partnership with all necessary agencies. For NHS sub-contracted work, this is performed in accordance with our Client Trust’s Safeguarding process.

2.11 This policy is monitored by the Board of Directors periodically to ensure it is still effective and reflective of legislation.

2.12 The Company will monitor the effectiveness of the policy via audit and reporting to the Board of Directors on the success of its organisational and operational expectations described within this policy.

3.0 Scope:

3.1 The purpose of this policy is to assist all staff in relation to identifying and raising concerns in relation to safeguarding. The term ‘staff’ applies to all those employed by the Company, this includes all operational ambulance staff, event staff, training staff and all those employed within the Company.

3.2 The policy is also in place for the protection of any person who for any reason is connected to the Company; this includes any partners we work with, patients and their families.

3.3 Safeguarding relates to anybody whether they are a child or an adult and there are corresponding pieces of legislation in place to ensure that people deemed to be at risk are protected. Safeguarding is connected to Mental Capacity Act 2005, Deprivation of Liberty
Safeguards, Care Act 2014, Human Rights Act, Safeguarding Vulnerable Groups Act 2006. There is also a link to Prevent within safeguarding.

4.0 Duties:

4.1 Prior to engagement with the Company all staff will complete a DBS check in accordance with the Safeguarding Vulnerable Groups Act following completion of the interview process. Any disclosures are risk thoroughly investigated and risk assessed prior to engagement.

4.2 All staff have a duty of care to recognise the possible signs of abuse and to take action where it is reported or noted. Mandatory training is undertaken in relation to safeguarding, all staff will complete a minimum of safeguarding level 3 prior to working with the public. This training is monitored by the compliance team.

4.3 All staff have a duty of care to recognise the sign of possible radicalisation or extremism. Therefore it is a requirement of all employees and contractors for the Company that they will undertake an E-learning training programme which is provided by the Home Office in relation to Prevent. This is monitored by the Compliance team and can be accessed via www.elearning.prevent.homeoffice.gov.uk.

4.4 The Chief Executive will ensure that the safeguarding policy is implemented consistently across the Company. The Chief Executive will also ensure that it corresponds with the policies in operation with the Trusts that the Company works with.

4.5 The safeguarding representative within the Company has responsibility for recording all instances of alleged or reported abuse that occurs during any operation not connected with NHS Trusts.

4.6 The Company works with various NHS Trusts across the country. Any allegations or reports of abuse in the first instance should be reported in accordance with the Trusts’ Safeguarding Policy. This is discussed and explained at the base induction.

4.7 The Director of Operations has responsibility to oversee any records of alleged or reported abuse. He will also liaise with the NHS Trusts and compile audits in relation to any concerns raised.

4.8 The Medical Director has senior responsibility within the Company who will liaise
along with the Managing Director and the National Operations Manager on all safeguarding issues.

4.9 All staff ultimately have an obligation to safeguard all whom they are in contact with, this includes their colleagues. Recent enquiries (Steven Hoskin, Winterbourne View and Staffordshire enquiry) have highlighted failures within health and social care and the need to ensure collaborative working. Due to the nature of the work within the Ambulance Service contact will be made on a daily basis with both adults and children and so it is imperative that all are aware of the different processes that occur both within the NHS and the Company and abide by these. There is an obligation within the duty of care for everyone to act upon any suspicions of abuse or neglect; this is not a declaration of abuse but it is a notification for further investigation.

5.0 Role of a Private Ambulance Service Provider:

5.1 All Health and Social Services professionals play an essential part in ensuring that children, adults, their families and carers receive the care, support and services they need in order to promote their health and development. The “front-line” nature of the Ambulance Service, Patient Transport Services within the Company means that staff may be the first to be aware that families or carers are experiencing difficulties in looking after their children or adults. The emergency, urgent care and planned care elements of the service give a unique position to note pre-disposing factors in the home and the history of events in each case.

5.2 Over recent years there have been a number of high profile cases such as the Baby P, Daniel Pelka, Winterbourne View, the Mid Staffordshire enquiry and the Jimmy Saville enquiry (operation yew tree) which have highlighted major failings by multiple agencies to act on evidence of abuse and neglect.

5.3 Such incidents are the extreme however there are undoubtedly many others where there is doubt over a person’s welfare, where there is a need to refer concerns to the Social Services Department, or other Health agencies, thus ensuring that the person and his/her family receive the necessary care, support and services they require.

5.4 Historically safeguarding and the Ambulance Service has been largely a grey area procedurally, however the Company feels that we have a duty to conform to the legislations, as due to the nature of the service, we come into contact with children and adults in a wide variety of situations, directly and indirectly.
The single guiding principle, which should be applied, is “That children and adults should be safe and be protected by effective intervention if they are at risk of significant harm”.

Many healthcare workers who come into contact with children or adults have an overwhelming impulse to deny that fellow human beings will harm their children or an adult. Staff will come into contact with:

- Adults who were abused as children
- Adults abused by adults or carers
- Children who have been abused by adults or by other children
- Children who have abused other children
- Children and adults who are self harming.

There are no class barriers with child or adult abuse. A victim may be just as likely to be from a very poor home as a family considered to be more fortunate.

As a professional service provider of pre-hospital, urgent and planned care the Company is in a unique position to note important pre-disposing factors such as The Home (the environment from which the child or adult comes) and the Initial Story (history of events). It should no longer be considered enough to merely mention concerns to hospital staff or other health care workers as being sufficient to protect a child or adult from risk of significant harm.

The Company has a duty of care to protect any child or adult who is perceived as being at risk of significant harm, neglect, deprived of liberty or at risk of being radicalised and as such should provide clear guidelines and a reporting mechanism that records and notifies incidents of actual or likely harm to a child or adult. The notification of a child or adult perceived to be at risk does not immediately label the child/adult and/or their parents/carers.

Notification raises the need to investigate matters further. At the other end of the spectrum, some children and adults are clearly at great risk and immediate action is required to provide protection. The Company’s responsibility is to ensure the appropriate professionals are made aware of the concerns.
6.0 Monitoring:

6.1 The policy will be monitored by the Operational Directorate for its' effectiveness; this will be undertaken on a bi-annual basis and will focus upon staff responsibilities, completion of training, appraisals and reports completed relating to any reported incidents. These reports will be presented to the Managing Director and made available to our clients.

6.2 Responsibilities of staff will be monitored through attendance at meetings, management of systems, development of reports and the appraisals process.

6.3 The production of reports showing trend analysis of reporting will be broken down into:

- Types of incident reported
- Grade of staff reporting
- Divisional comparisons
- Company performance
- Number of staff receiving support.

6.4 The Operational Directorate will monitor the reports from the Local Safeguarding Children Board and Child Death Review Panels.

6.5 The Operational Directorate will monitor the reports from the Local Safeguarding Adult Board and the Safeguarding Adult Reviews.

7.0 Sharing Information:

7.1 The Company has a Caldicott Guardian appointed to ensure appropriate sharing of information to relevant bodies within the NHS.

7.2 In accordance with legislative guidelines the Company will freely share information with other Health & Social Care providers and other Safeguarding Children or Adult partners, where such information will be in the best interest of the child or adult.

7.3 All requests for information sharing will be coordinated by the appointed Caldicott Guardian.

7.4 When a complaint about alleged abuse suggests that a criminal offence may have been committed, it is imperative that the reference should be made urgently. Following a
safeguarding child referral, the police should be contacted by the person making the complaint with the guidance and support of a Company representative.

7.5 Following a safeguarding children referral to the relevant Social Services, the relevant Safeguarding Lead should have a follow up call made by the Clinical Safeguarding Lead.

8.0 Safeguarding Reporting Procedure:

8.1 It is the responsibility of all staff to report any concerns to the relevant person which may involve alerting the police if a criminal offence may have been committed.

8.2 All staff working with NHS partners will receive an induction relating to the specific procedures for each Trust – who undertake the responsibility to liaise with the relevant local agencies and/or services.

8.3 In the case of an injured or unwell child or adult, immediate necessary treatment will be given and the child transported to the nearest Accident and Emergency department. If non-accidental injury is suspected then the concerns should be passed on to the senior nurse or doctor of the Accident and Emergency department.

8.4 Following the verbal handover it is imperative that the Safeguarding Concern Form is completed and passed onto the safeguarding person within the relevant NHS Trust and the Operations Manager. Where a Trusts procedure is verbal only, the individual Trust process should be followed.

8.5 If a concern is raised on non NHS work the form should be completed and handed to the relevant Operations Manager or the Safeguarding representative within the Company, who will assume responsibility for reporting this (such as; on an event medical cover provision or private patient transport).

8.6 The form should contain information pertaining to the concern and always using the person’s own words. Staff do not undertake any form of investigation.

8.7 If suspicions are raised and parents/carers/family refuse to have the child or adult examined, treated or conveyed to hospital advice should be immediately sought from the Operations Manager and Ambulance Control who will contact the police for their assistance. If staff feel threatened whilst waiting for assistance they should withdraw from the scene and
wait for assistance.

8.8 The Company appreciates that it may not always be possible to remain on scene because of the threat of violence towards staff. Should this be the case staff should withdraw from the scene and await the arrival of specialist assistance.

8.9 In accordance with Working Together to Safeguard Children we will respect race, ethnicity and culture and be sensitive towards different lifestyles; however, child abuse cannot be condoned for religious or cultural reasons.

8.10 If a safeguarding concern is raised relating to an employee or contractor of the Company, the Malpractice & Whistleblowing Policy (1.12) shall be adhered to.

9.0 Race, Ethnicity and Culture:

9.1 Children from all cultures are subject to abuse and neglect. All children have a right to grow up safe from harm. In order to make sensitive and informed professional judgements about a child’s needs, a parents’ capacity to respond to their child’s needs, it is important that professionals are sensitive to differing family patterns and lifestyles and to child-rearing patterns that may vary across different racial, ethnic and cultural groups. At the same time they must be clear that child abuse cannot be condoned for religious or cultural reasons.

9.2 Professionals should also be aware of the broader social factors that serve to discriminate against black and minority ethnic people. Working in a multi-racial and multicultural society requires professionals and organisations to be committed to equality in meeting the needs of all children and families and to understand the effects of racial harassment, racial discrimination and institutional racism, as well as misunderstanding or misinterpretation.

9.3 Professionals should guard against myths and stereotypes – both positive and negative – of black and minority ethnic families. Anxiety about being accused of racist practise should not prevent the necessary action being taken to safeguard and promote a child’s welfare. Careful assessment – based on evidence – of a child’s needs, and a family’s strengths and difficulties, understood in the context of the wider social environment, will help to avoid any distorting effect of these influences on professional judgements.

9.4 All children, whatever their religious or cultural background, must receive the same care and safeguards with regard to abuse and neglect.
10.0 Forced Marriages:

10.1 A forced marriage is defined as:

A marriage conducted without the freely given consent of both parties where duress is a factor. Duress includes emotional pressure and the use of violence (Foreign and Commonwealth Office).

10.2 There is a difference between an arranged marriage and a forced marriage. In arranged marriages, families arrange the match but the choice of whether or not to accept the arrangement remains with the individual. Arranged marriage is a vulnerable, long established tradition based on compatibility, consent and retaining choice. In forced marriages, there is no choice. No culture or religion sanctions forced marriages.

10.3 Planned or actual forced marriage places children and young people at risk of significant harm, which may include sexual, physical and emotional abuse and is contrary to the United Nations Convention on the Rights of the Child.

10.4 Whilst it is unlikely, it is possible that Ambulance personnel may become aware of such cases, as there is an increased risk of self-harm, attempted suicide, eating disorders and depression. It is imperative that any concerns are referred as a Child Protection and Safeguarding matter and that normal procedures are followed.

10.5 In the interests of the child/young person’s safety, staff making a referral should not inform the young person’s family. The decision regarding contact with parents/carers will be taken by Social Services at the strategy discussion stage, based on a risk assessment regarding likelihood of immediate harm to that young person.

11.0 Other Situations – Child or Adult at Risk of Significant Harm:

11.1 Whilst in principle professionals should seek, in general, to discuss any concerns with the family or carer and, where possible, seek their agreement to making referrals to Social Services, it is recognised that in many instances facing the Ambulance Service it may be inappropriate to do so and may place the child, adult and/or Ambulance Staff at further risk.
11.2 Examples of “other situations” include neglect, sexual abuse, emotional abuse, domestic violence or other circumstances where staff have concerns that the child or adult may be at risk of significant harm.

11.3 All Ambulance Crews should be aware that there is a high level of correlation between Domestic Violence and Children at Risk and should exercise heightened awareness of the possible risks, when called to such incidents.

11.4 Staff should take care not to become judgemental and must ensure that any report is factual and accurate.

11.5 The concern that Ambulance Staff may have, may not be directly related to the patient attended, but may be a concern for the family, extended family, neighbours or persons or children unrelated to an emergency incident. The same Safeguarding duty of care applies to all children and adults and if staff have a concern for welfare, neglect, sexual abuse or domestic violence then this should also be reported following the correct procedures.

12.0 Education, Training and Awareness:

12.1 In order to provide a greater understanding of some of the issues surrounding Safeguarding Children, information has been extracted from the Government Paper “Working Together to Safeguard Children 2013” and this is attached as an appendix to this document. A full copy of this document is available at http://www.dh.gov.uk/assetRoot/04/07/58/04075824.pdf in order to provide a greater understanding of some of the issues surrounding Safeguarding Adults.

12.2 Information has been extracted from the Government Paper “No Secrets” and this is attached as an appendix to this document. A full copy of this document is available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008486.

12.3 All staff will receive training in relation to child and adult abuse as part of their induction training. All patient facing staff will receive enhanced training to Level 2 Safeguarding, further reference may be found in:
Joint Royal Colleges Ambulance Liaison Committee Guidelines 2016.

12.4 The Company is committed to improving and maintaining awareness of safeguarding children and adults issues and includes the subject as a module on all induction training courses for Emergency Services, Non-Emergency Patient Transport Service staff, and Commercial services contracts.

12.5 For further safeguarding children and adults (mandatory) modules refer to the Company's training needs analysis.

13.0 Duty of Care:

13.1 If a child or adult is perceived as being at immediate risk, immediate action MUST be taken to protect them. If a child or adult is perceived as being at possible risk, steps MUST be taken to investigate these matters further.

13.2 It is difficult in a document of this nature to provide guidance for every situation however, an algorithm is attached as an appendix to assist staff in their decision making.

13.3 The Named Professional for Safeguarding will review all incidents and where appropriate will make contact with the persons reporting to offer proactive support if required. Any action or a decision not to act will be recorded in the relevant section on the referrals form.

13.4 Support provided can include:

- Interviewing the relevant members of staff
- Partnership working with Social Services and other healthcare providers with staff involvement
- Staff involvement in case review.

13.5 If a member of staff has any concerns arising from an incident that they have witnessed and require immediate support then they should contact their Line Manager, or the Duty Manager out of hours to discuss their concerns.

13.6 All staff have a duty of care to report any suspected abuse regardless of whether consent has been given so that appropriate action can be taken.
13.7 Consent should be sought whenever possible and co-operation from the person deemed to be at risk.

13.8 We, at the Company are also aware that our staff can be placed in potentially vulnerable situations so encompass all people within the duty of care.

13.9 Any allegations will be treated seriously and dealt with efficiently; the alert will be made within 24 hours, complying with inter agency policy when necessary.

14.0 Capacity:

14.1 Mental Capacity Act 2005 is applicable in England and Wales and is designed to safeguard individuals who are deemed to lack capacity.

14.2 In accordance with the Act all staff who assume a person has capacity unless it is deemed otherwise.

14.3 If it is assessed that the person does not have capacity this must be documented within their Patient Clinical Record.

14.4 Any decisions made on behalf of a person without capacity must be taken in their best interest.

14.5 If a person has capacity and is not deemed to be at risk their decisions should be respected irrelevant of personal opinion regarding their wishes.

15.0 Exceptions to apply for Children:

15.1 If abuse is suspected for a child there is a possibility that the potential abuser may be escorting them; in this instance any discussions with the child may not be possible.

15.2 Priority in these circumstances is the safety of the child and the staff.

15.3 Upon arrival at the destination the designated person on site should be made aware of any concerns and any potential risk.
16.0 Implementation of Policy:

16.1 This policy has been written to be implemented in all areas of the Company.

16.2 All staff who are assigned to work on the Company’s NHS contracts will also receive on base inductions which will guide them on relevant contact persons and documentation to be completed.
Appendix 1 – Safeguarding Children Guidance Notes:

1.0 Background Information:

Legal Position:

1.1 The current guidance is outlined in the document “Working Together to Safeguard Children 2018” and it is from this document that much of the following advice is taken. A full copy of the document can be accessed at:


1.2 It reflects the principles contained within the United Nations Convention on the Rights of the Child, ratified by the UK Government in 1991. It also takes account of the European Convention of Human Rights, in particular Articles 6 and 8. It further takes account of other relevant legislations at the time of publication, but is particularly informed by the requirements of the Children Act 1989, which provides a comprehensive framework for the care and protection of children.

1.3 The Children Act 1989 places two specific duties on agencies to co-operate in the interests of vulnerable children:

- Section 27 provides that a local authority may request help from – any Health Authority, Special Health Authority or National Health Service Trust; in exercising the local authorities to provide support and service and those in secure accommodation.

1.4 The authority whose help is requested in these circumstances has a duty to comply with the request, provided it is compatible with its other duties and functions.

- Section 47 places a duty on – any Health Authority, Special Health Authority or National Health Service Trust; to help a local authority with its enquiries in cases where there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm.

The Concept of Significant Harm:

1.5 The Children Act 1989 introduced the concept of significant harm as the threshold
that justifies compulsory intervention in family life in the best interest of children. The local authority is under a duty to make enquires, or cause to enquires to be made, where it has reasonable cause to suspect that a child is suffering, or likely to suffer significant harm (s.47).

1.6 A Court may only make a Care Order (committing the child to the care of the local authority) or Supervision Order (putting the child under the supervision of a Social Worker, or a Probation Officer) in respect of a child if it is satisfied that:

- The child is suffering, or is likely to suffer, significant harm; and
- The harm or likelihood of harm is attributable to a lack of adequate parental care or control (s.31).

1.7 There are no absolute criteria on which to rely when judging what constitutes significant harm. Consideration of the severity of ill-treatment may include the degree and the extent of physical harm, the duration and frequency of abuse and neglect, and the extent of premeditation, etc.

Classification of Child Abuse:

1.8 Further information regarding the classification and types of child abuse are contained within these ‘Guidance Notes’ (Appendix 1).

- Neglect
- Physical injury
- Sexual abuse
- Emotional abuse.

1.9 In summary, a child is considered to be at risk of significant harm if he or she is treated by another person in a way that is unacceptable. This can be by an act or omission (failure to protect).

Abuse and Neglect:

1.10 Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting; by those known to them or, more rarely, by a stranger.

Physical Abuse:
1.11 Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning or suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer feigns the symptoms of, or deliberately causes ill health to a child whom they are looking after. The situation is commonly described using terms such as Factitious Illness by Proxy or Munchausen Syndrome by Proxy.

Emotional Abuse:

1.12 Emotional abuse is the persistent emotional ill-treatment of a child such as to cause severe and persistent adverse effects on the child’s emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. It may involve causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of ill-treatment of a child, though it may occur alone.

Sexual Abuse:

1.13 Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape or buggery) or non-penetrative acts. They may include non-contact activities, such as involving children looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

Neglect:

1.14 Neglect is the persistent failure to meet a child’s basic physical and/or psychological needs, likely to result in the serious impairment of the child’s health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, or failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child’s basic emotional needs.

Female Genital Mutilation (FGM):
1.15 Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. The practice is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending childbirths. However, more than 18% of all FGM is performed by health care providers, and the trend towards medicalization is increasing.

1.16 Female Genital Mutilation (FGM) mandatory reporting duty is a legal duty provided for in the FGM Act 2003 (as amended by the Serious Crime Act 2015). The legislation requires regulated health and social care professionals and teachers in England and Wales to make a report to the police where, in the course of their professional duties they either:

Are informed by a girl under 18 that an act of FGM has been carried out on her or observe physical signs which appear to show that an act of FGM has been carried out on a girl under 18 and they have no reason to believe that the act was necessary for the girl’s physical or mental health or for purposes connected with labour or birth.

1.17 For purposes of the duty, the relevant age is the girl’s age at the time of the disclosure/identification of FGM (i.e. it does not apply where a woman aged 18 or over discloses she had FGM when she was under 18).

Key Facts:

- Female Genital Mutilation (FGM) includes procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons
- The procedure has no health benefits for the girls and women
- Procedures can cause severe bleeding and problems urinating, and later cysts, infections, infertility as well as complications in childbirth and increased risk of new born deaths
- More than 125 million girls and women alive today have been cut in the 29 countries in Africa and Middle East where FGM is concentrated (1)
- FGM is mostly carried out on young girls sometime between infancy and age 15
- FGM is a violation of the human rights of girls and women
- It is illegal in the UK under the Female Genital Mutilation Act 2003.

For more information please go to the following website:
Sources of Stress for Children and Families:

1.18 Many families although under great stress, nonetheless manage to bring up their children in a warm, loving and supportive environment in which within families may, however, have a negative impact on a child’s health, development and well-being, either directly or because they affect the capacity of parents to respond to their child’s needs. This is particularly the case when there is no other significant adult who is able to respond to the child’s needs.

The Mental Illness of a Parent or Carer:

1.19 Mental illness in a parent or carer does not necessarily have an adverse impact on a child, but it is essential always to assess its implications for any children involved in the family. Parental illness may markedly restrict children’s social and recreational activities. With both mental and physical illness in a parent, children may have caring responsibilities placed upon them inappropriately to their years, leading them to be worried and anxious. If they are depressed, parents may neglect their own and their children’s physical and emotional needs.

1.20 In some circumstances some forms of mental illness may blunt parents’ emotions and feelings, or cause them to behave towards their children in bazaar or violent ways. Unusually, but at the extreme, a child may be at risk of severe injury, profound neglect, or even death.

1.21 A study of 100 reviews of child deaths where abuse and neglect had been a factor in the death, showed clear evidence of parental mental illness in one-third of cases. In addition, postnatal depression can also be linked to both behavioural and physiological problems in the infants of such mothers.

Drug and Alcohol Misuse:

1.22 As with mental illness in a parent, it is important not to generalise or make assumptions about the impact on a child of parental drug and alcohol misuse. It is, however, important that the implications for the child are properly assessed. Maternal substance misuse in pregnancy may impair the development of an unborn child. A parent’s practical caring skills may be diminished by misuse of drugs and/or alcohol.
1.23 Some substance misuse may give rise to mental states or behaviour that put children at risk of injury, psychological distress or neglect. Children are particularly vulnerable when parents are withdrawing from drugs. The risk will be greater when the adult’s substance misuse is chaotic or otherwise out of control. Some substance-misusing parents may find it difficult to give priority to the needs of their children, and finding money for drugs and/or alcohol may reduce the money available to the household to meet basic needs, or may draw families into criminal activities. Children may be at risk of physical harm if drugs and paraphernalia (e.g. needles) are not kept safely out of reach. Some children have been killed through inadvertent access to drugs (e.g. methadone stored in a fridge).

2.0 Role of Social Services:

2.1 Local authorities, acting in order to fulfil their Social Services functions, have specific legal duties in respect of children under the Children Act 1989. They have a general duty to safeguard and promote the welfare of children in their area who are in need.

2.2 Social Services departments also have a duty to make enquires if they have reason to suspect that a child in their area is suffering, or likely to suffer significant harm, to enable them to decide whether they should take any action to safeguard to promote the child's welfare. They need the help of other agencies in order to do this effectively.

2.3 A child who is at risk of significant harm will invariably be a child in need. The social services department is responsible for co-ordinating an assessment of the child’s needs, the parents’ capacity to keep the child safe and promote his or her welfare, and of the wider family circumstances.

2.4 In the great majority of cases, children are safeguarded from harm by working with parents, family members and other significant adults in the child’s life to make the child safe, and to promote his or her development within the family setting. Where a child is at continuing risk of significant harm, Social Services are responsible for coordinating an inter-agency plan to safeguard the child which sets out and draws upon the contributions of family members, professionals and other agencies.

2.5 In few cases, the Social Services department, in consultation with other involved agencies and professionals, may judge that a child’s welfare cannot be sufficiently safeguarded
if he or she remains at home. In these circumstances, the Social Services department may apply to the Courts for a Care Order, which commits the child to the care of the local authority. Where the child is thought to be in immediate danger, the Social Services department may apply to the courts for an Emergency Protection Order, which places the child under the protection of the local authority for a maximum of eight days, alternatively the police may be called to take out a Police Protection Order (PPO) which allows the child to be removed to a place of safety for a period of up to 72 hours.

2.6 Because of their responsibilities, duties and powers in relation to vulnerable children, Social Services departments act as the principal point of contact for children about whom there are child welfare concerns. Social Services may be contacted directly by parents or family members seeking help, concerned friends and neighbours, or by professionals and others from statutory and voluntary agencies.

3.0 Recognition or Non-Accidental Injuries within Children: Bruises:

3.1 To the soft part of the ear which could be caused by slaps to the side of the head.

Black Eye:

3.2 Bruising around one or both eyes could be caused by a fist or blow or, in the case of both eyes, possibly a blow across the bridge of the nose with something like a feeding bottle.

Suspicious Patterns of Bruising:

3.3 For example finger marks which could be caused by hard slaps to the body or the child being forcibly gripped and shaken.

Abnormal Bruising:

3.4 Over areas of the body not normally injured for example, abdomen, chest, back and perineum.

Different Stages of Bruising:

3.5 Could mean repeated assaults over a period of time.
Torn Frenulum:

3.6 This is the tissue attaching the inside of the top lip to the inner upper jaw. Not a common injury but may be caused by a feeding bottle being rammed into a child’s mouth, this would also cause dark red spots of blood beneath the membrane (petechial spotting) on the inside of the top lip.

Frozen Awareness:

3.7 Where a child’s eyes have a frozen look but follow your every move. The child’s fear that you will abuse them if you approach.

Burn Marks:

3.8 Caused by hot objects placed on the child’s body for example keys, poker ends, hot iron, etc.

Cigarette Burns:

3.9 In various stages of healing. A combination of fresh, raw burns or healed pink circles. These are normally deep burns.

Scalds with Inconsistent History:

3.10 “The child stepped into a bath of hot water”. If only the tops of the child’s feet are scalded, is this history plausible?

Bite Patterns:

3.11 Bruising and abrasions in bite patterns on the child’s limbs.
Appendix 2 – Safeguarding Adults Guidance Notes:

1.0 Background Information:

1.1 An ‘Adult at Risk’ has been defined by the Law Commission as a person aged 18 years and over who appears to have health and social care needs and appears to be at risk of harm. The Care Act 2014 applies the definition ‘A person aged 18 or over who is at risk of abuse or neglect because of their need for care or support. These definitions provide a broader scope for adults requiring protection however practitioners must consider factors relating to a person’s vulnerability e.g.

- Personal characteristics of the ‘adult at risk’ that increase or decrease vulnerability such as; mental capacity, communication ability, levels of isolation and integration, levels of physical dependence on others, any previous experiences of abuse
- Social factors which increase or decrease vulnerability such as; levels of isolation and integration, levels of family support, levels of independence and engagement with the community, levels of access to information, support and advice.

1.2 “Any work or activity which aims to support the vulnerable adults or adults at risk to retain independence, well-being and choice and to live a life which is free from abuse and neglect”. The six key principles which underpin all adult safeguarding work are:

- **Empowerment** – Personalization, person-led decision and informed consent
- **Prevention** – To take action before harm occurs
- **Proportionality** – Take the least intrusive response appropriate to the risk presented
- **Protection** – Support and represent those in greatest need
- **Partnership** – Local solutions working with other agencies and communities
- **Accountability** – Accountability and transparency in delivering safeguarding.

Consent for Sharing Information:

1.3 Company staff will adhere to the principles of the Caldicott Committee’s report on the review of patient-identifiable information sharing by recognising that confidential patient information may need to be disclosed in the best interest of the patient on the basis that:
Classification of Adult Abuse:

1.4 Abuse is the violation of an individual’s human and civil rights by any other person. It can vary from a seemingly trivial act of not treating someone with the proper respect to extreme punishment or torture. In the context of adults the recognised forms of abuse include:

- Physical abuse
- Sexual abuse
- Emotional or psychological abuse
- Financial or material abuse
- Neglects and acts of omission
- Discriminatory abuse
- Self-neglect
- Modern slavery
- Organisational abuse.

1.5 A person may be subject to one or a combination of these. More detailed descriptions of the forms of abuse can be found in this Appendix.

1.6 Abuse can take place in any context. It may occur when an adult lives alone or with someone else. It may occur in the adults own home, either when they receive a service there or when the abuser either lives with them or visits them. It may also occur within nursing, residential or day settings in hospitals or in public places.

1.7 Particular groups of adults may be more vulnerable to abuse. These include people from minor ethnic groups, people with physical disabilities, people with learning difficulties, mental health problems, severe physical illnesses, older people, the homeless, people with sensory impairments or those diagnosed as HIV positive. Some people with special needs (e.g. sensory impairment or learning disabilities) may demonstrate challenging behaviour which may or may not be as a result of abuse.
Physical Abuse:

1.8 Physical abuse is non-accidental harm to the body, for example:

- Being hit, slapped, pushed, shaken, kicked, bitten, burned or scalded
- Purposely under or over medicating or other misuse of medication
- Deliberately being underfed, being given alcohol or a substance that is known to cause harm (e.g. sugar for diabetic)
- Being confined, picked up or otherwise physically restrained.

1.9 Some indicators of physical abuse are:

- Any injury not explained by the history given
- Different versions of the cause of an injury given to different people
- Any self inflicted injury
- Unexplained fractures, laceration, bruises or burns
- Weight loss, dehydration, complaints of hunger
- Untreated medical problems
- Poor personal hygiene including incontinence.

Sexual Abuse:

1.10 Sexual abuse is the involvement of someone in sexual activities which they do not have the capacity to understand, have not consented to, or to which they were pressurised into consenting. It can also include the involvement of people in sexual activities where one party is in a position of trust, power or authority, or where a sexual relationship is outside law and custom. Sexual abuse can include:

- Rape or sexual assault
- Unwanted touching or being forced to touch another person in a sexual manner
- Being subject to sexual innuendoes and harassment
- Not having a choice about someone in the same sex to undertake intimate personal care.

1.11 Some indicators of sexual abuse include:

- Full or partial disclosure, or hints, about sexual abuse
- Inappropriate sexualised behaviour
- Torn, stained or blood stained underclothing or bedding
- Pain, itching or bruising in the genital area, thighs and/or upper arms
- Sexually transmitted disease, urinary tract infection and vaginal infection
- Obsession with washing
- Pregnancy in a person who is unable to consent to sexual relations.

**Emotional or Psychological Abuse:**

1.12 Emotional or psychological abuse is any action which has an adverse effect on an individual’s mental well-being, causing suffering and affecting their quality of life. This may include the threat that other types of abuse could take place. Psychological abuse can include:

- Living in a culture of fear and coercion
- Being bullied, controlled or intimidated
- Being humiliated, ridiculed or blamed
- Being threatened with harm or abandonment
- Being isolated or deprived of contact
- Being withdrawn from services or supportive networks
- Having no choice about who to live with or spend time with
- Being consistently ignored.

1.13 Abuse occurs where there is a power imbalance and a person may be reacting to living in fear because of threats and coercion.

1.14 Some indicators of psychological abuse include:

- Self harm
- Emotional withdrawal and symptoms of depression
- Unexplained fear
- Severe lack of concentration.

**Financial Abuse:**

1.15 Financial abuse is the theft or misuse of money or personal possessions and can include:

- Money being withheld or stolen
- Goods or services purchased in someone’s name without their consent
- Being deliberately overcharged for goods or services
- Misuse or misappropriation of property, possessions or benefits
• Money being borrowed by someone who is providing a service to the adult.

1.16 Some indicators of financial abuse include:

• Someone being dependent on the adult for the provision of accommodation (this may also apply to other forms of abuse)
• A person lacking goods or services which they can afford
• A person living in poorer circumstances than other members of a household
• A person being encouraged to spend their money on items intended for communal use in a residential home
• Benefits being absorbed into the household income and not being used for the vulnerable person.

Neglect and Acts of Omission:

1.17 A person will suffer if his or her physical and or emotional needs are being neglected. Examples of neglect can include:

• Failing to respond to a person’s needs or preventing someone else from responding to their needs
• Ignoring someone’s medical or physical care needs
• Failing to provide access to appropriate health, social care or educational services
• Withholding necessities of life such as medication, adequate hygiene, nutrition or heating
• Preventing someone from interacting with others.

1.18 When a professional or paid care provider does not ensure that the appropriate care, environment or services are provided to those in their care, they may be open to a charge of ‘wilful neglect’. It should be noted however that adults have a right to choose their own lifestyle in their own home (including self neglect) if they have the capacity to make such a decision.

1.19 Some indicators of neglect can include:

• Neglect of accommodation, including inadequate heating and lighting
• Failure to provide basic personal care needs
• Inadequate or unsuitable food
• Failure to give medication or giving too much medication
• Failure to ensure appropriate privacy and dignity.
Discriminatory Abuse:

1.20 Discriminatory abuse includes ill-treatment 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
- 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.

1.21 Some indicators of discriminatory abuse include:

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

Self Neglect:

- Wide ranging neglect to personal hygiene
- Neglect to personal living space hygiene
- Hoarding.

Modern Slavery:

- Human trafficking
- Forced labour
- Domestic servitude
- Sexual exploitation
- Coerce, deceive and force individuals into life of abuse.

Organisational Abuse:

- Neglect in a care or organisational setting
- Neglect and poor professional practise as a result of policy or procedures.
2.0 Deprivation of Liberties Safeguardings (DoLs):

2.1 The Deprivation of Liberty Safeguardings (DoLs) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals are supported living are looked after in a way that does not inappropriately restrict their freedom.

2.2 Sometimes we have to place restrictions on people for their own safety. There are different levels of restriction ranging for example from a locked door to physical restraint. At some point the degree of intensity of these restrictions become what is legally known as a deprivation of liberty.

2.3 Deprivation of Liberty Safeguardings applies to persons over the age of 18 only. There are separate safeguards with regards to persons under 18.

3.0 Background:

3.1 Deprivation of liberty legislation arises from the “Bournewood” case which was heard by the European Court of Human Rights. The case decided that where a person is deprived of their liberty without any legal authority then it is a breach of Article 5 of the European Convention of Human Rights.

“No one should be deprived of their liberty unless it is prescribed by law”

3.2 Therefore, when a person needs to be deprived of their liberty there must be safeguards in place that will ensure that:

- It is in the person’s best interests
- They have representatives and rights of appeal
- The deprivation of liberty is regularly reviewed and monitored.

3.3 The Safeguards cover people in both hospitals and care homes registered under the Care Standards Act 2000. They became statutory obligation on 1st April 2009.

3.4 Some examples that are likely to be deprivation of liberty are:

- Force being used to convey (transport) a resisting person to hospital
3.5 Transporting a person who lacks capacity from their home, or another location, to a hospital or care home will not usually amount to a deprivation of liberty (for example, to take them to hospital by ambulance in an emergency). Even where this is an expectation that the person will be deprived of liberty within the care home or hospital, it is unlikely that the journey itself will constitute a deprivation of liberty so that an authorisation is needed before the journey commences. In almost all cases, it is likely that a person can be lawfully taken to a hospital or a care home under the wider provisions of the Act, as long as it is considered that being in the hospital or care home will be in their best interests.

3.6 The following examples are unlikely to be a deprivation of liberty by themselves:

- Locked ward
- Keypad/double door handles
- Bringing back the patient who has wandered
- Reasonable persuasion being used to take a confused person to hospital
- Placing reasonable limitations on visitation rights
- Refusing to let the patient leave without an escort whose job is to support them
- Force being used to convey (transport) a resisting person to hospital.

This isn’t a deprivation of liberty, ref para 2.14 MCA DoLS Code of Practice 2009.

3.7 Remember a person must lack capacity as defined in the Mental Capacity Act 2005 and be considered in need of deprivation of liberty before any person's liberty in any form MUST ensure that a full Mental Capacity assessment has been completed and this assessment is fully documented unless they are lawfully detained under the Mental Health Act 1983.

3.8 When attending a patient that has a Deprivation of Liberty Order in place the attending staff must ensure that the Order is valid and request to see a copy of the Order to confirm this. When transporting the patient then a request to take a copy of the Order with the patient to the hospital must be made to the senior manager responsible for ensuring the
compliance of the Order. If this is refused then the refusal must be documented and the name of the refusing manager recorded.

3.9 While carrying out your duties if you come across a patient that has their liberty deprived and there has been no formal assessment completed you must report this via a safeguard alert and in some cases report this to the police immediately. For further information please go to: http://www.scie.org.uk/publications/atalance/atalance43.asp.

4.0 Prevent:

4.1 Prevent is the Government’s national counter terrorism strategy. It aims to reduce the risk to the United Kingdom and its interests overseas from national and international terrorism, so that people can go about their lives freely with confidence. These forms of terrorism include:

- AL-Qaida influenced groups
- Environmental extremists
- Animal rights extremists
- Faith based influenced groups
- Extreme right wing groups
- Republican and loyalist Irish groups.

4.2 Prevent is a Government strategy and is led by the Home Office. Prevent focuses on working with individuals and communities who may be vulnerable to the threat of violent extremism in local extremism and terrorism. Supporting those vulnerable individuals and reducing the threat from violent extremism in local communities is priority for the health service and its partners. The overall aim of the Prevent strategy is to prevent people becoming terrorists or being involved in supporting violent extremism. In order to achieve this aim, there are 5 national strategic objectives as follows:

- Challenge the ideology behind violent extremism and support mainstream voices
- Disrupt those who promote violent extremism and support the places where they operate
- Support individuals who are vulnerable to recruitment or have already been recruited by violent extremists
- Increased the resilience of communities to violent extremism
- Address grievances that ideologies are exploiting.
5.0  Indicators of Concern:

5.1  Indicators that crew may observe or identify regarding behaviour or actions may include:

- Graffiti symbols, writing or artwork promoting violent extremist messages or images witnessed when attending a patient’s home
- Patients/staff accessing violent extremist material online, including social networking sites
- Parental/family reports of persons changing their behaviour, friendships or actions that are not usual for that individual
- Patients voicing opinions drawn from violent extremist ideologies and narratives
- Use of extremist or hate terms to exclude others or incite violence
- Harmful influences on vulnerable individuals from parents, spouse, family members, friends or external groups
- Inappropriate use of the interest on Company premises by staff members.

The above list is not exclusive.

5.2  Any crew that have come into contact with a patient or any persons displaying any of the indicators listed above while on duty they must complete a safeguarding alert for that person capturing all the relevant details. This must be followed up by an email to info@jigsawmedical.com as soon as practically possible informing the safeguarding team of their concerns so it can be followed up urgently with the relevant authorities.

5.3  If any crew have concerns of a Prevent nature with regard to any individual working for the Company then these concerns must be emailed to info@jigsawmedical.com in confidence. These concerns will then be passed to the relevant authority so the individual can be supported.

5.4  If immediate concerns are raised during a medical assessment, this can be reported directly to the emergency services calling 999 or the Confidential Counter Terrorism Hotline on 0800 789321. These numbers can also be used if concerns are related to fellow contractors and/or members of the general public.

5.5  It is very important to remember that by reporting any individual through the Prevent process is not making them a criminal. There are teams within the local authorities and police that are in place to support these individuals outside of the criminal processes.
6.0 Allegations Management:

6.1 Children and vulnerable adults can be subjected to abuse by those who work with them in any and every setting. All safeguarding allegations of abuse or maltreatment of children and adults by a professional, staff member or contractor, must therefore be taken seriously and treated in accordance with consistent procedures.
Appendix 3

Safeguarding / Vulnerable Person Form

SAFEGUARDING / VULNERABLE PERSON FORM
Please complete clearly and hand to manager upon completion

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<th>Date:</th>
<th>Time:</th>
<th>Location:</th>
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<table>
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<tr>
<th>Details of Patient:</th>
<th>Name:</th>
<th>Address:</th>
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<td></td>
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<tr>
<td>Telephone Number:</td>
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<td>Date of Birth:</td>
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<tr>
<td>Gender:</td>
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<tr>
<th>Adult/Child:</th>
<th>GP Name &amp; Address:</th>
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<tr>
<th>GP Telephone Number:</th>
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**Concerns:** (indicate all that apply)

- Physical abuse
- Sexual Abuse
- Neglect and Acts of Omission
- Discriminatory Abuse
- Emotional/Psychological Abuse
- Financial/Material Abuse
- Domestic Abuse/Violence
- Sexual Exploitation

**Reasons for Concerns:** (indicate all that apply)

- Physical Signs
- Inconsistent Story
- Prevent
- Self Neglect
<table>
<thead>
<tr>
<th>Behavioural/Development Signs</th>
<th>Disclosure by Victim/Others</th>
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<tbody>
<tr>
<td>Environment</td>
<td>Female Genital Mutilation</td>
</tr>
<tr>
<td>Substance Misuse</td>
<td>DoLS</td>
</tr>
<tr>
<td>Sexual Exploitation</td>
<td>Fire Risk</td>
</tr>
</tbody>
</table>

**Consent Obtained?**
- Yes
- If ‘No’ please explain why below: No

**Is child/adult in immediate harm?**
- Yes
- No

**Police Incident Number:**
If ‘Yes’ – record actions taken and Police Incident Number

**Details of Person referring/raising concern:**
- Name: [Blank]
- PIN: [Blank]
- Paramedic [ ]
- Technician [ ]
- ECA [ ]
- First Aider [ ]
- Doctor [ ]
- Other Staff [ ]

**Referral is for:**
- Adult [ ]
- Child [ ]
- Both [ ]
- Safeguarding [ ]
- Welfare [ ]
Narrative of Concerns: Record your reasons for raising concern; include if necessary, people present, environment, living situation.
Document Control: This is a controlled document and should not be copied or amended in any way without the express permission of the Document Controller.

Jigsaw Medical is a trading style of CRG Clinical Services Ltd.
Narrative of Concerns by person:

Use their words only and do not paraphrase
<table>
<thead>
<tr>
<th>Person conveyed to hospital:</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>If 'No' – state location of person:</td>
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