NHSBT Board
25th July 2023

Donor / Colleague Story

Safeguarding and Prevent: Highlighting the important work of Frontline Colleagues

Introduction

NHSBT has a statutory duty and responsibility to safeguard any child or adult who is using or employed by the service. The duty of Safeguarding includes recognition and action under the 'Prevent' strategy which in turn is part CONTEST, the Government's counter-terrorism strategy. It aims to stop people becoming terrorists or supporting terrorism and violent extremism. Safeguarding means protecting and promoting a person's health, well-being and human rights; enabling them to live free from harm abuse and neglect. NHSBT is therefore required to have effective Safeguarding and Prevent policies and processes to report incidents or issues of concern, and to provide accessible training for all staff. This story is a demonstration of how this works in reality and an example of good practice. It is also an opportunity to allow the board to be appraised of the complexity and challenges around what can be highly sensitive cases.

Compliance and learning from Safeguarding and Prevent related cases in NHSBT is monitored by the Safeguarding Oversight Group (SOG) which reports annually to the Clinical Governance Committee (CGC). Training on Prevent is required as part of the Prevent Statutory Duty 2015 by all clinical facing staff. However, this is currently under review, the Home Office is currently reviewing the content of the mandated Prevent Training for all public sector organisations, and this may become part of our mandatory training in the near future.

This case highlights the work of one of the frontline teams in Blood Donation. It demonstrates effective practice and compliance in relation to Safeguarding and Prevent. It is important to note that Prevent is about raising a concern and making an appropriate referral to external agencies, it is not about making any judgement about another individual. Also, feedback may not always be received from external agencies on the outcome of a referral under the duty, as in this case.

Considerations in relation to this Case Study

A donor attended one of our Donor Centres to donate blood for the first time. All normal donation processes on session were followed. Following their donation the donor fainted with a loss of consciousness and usual processes were used to support the donor to recovery. The donor soon regained consciousness after support from session staff.

Although it was initially confirmed by a Donor Carer that the donor was 'back to their usual self', the colleague then stated they wondered if the donor may have a degree of 'learning difficulties' as some of their behaviours and speech were of concern. The Registered Nurse (RN) was alerted to the donor's behaviour and the comments that had been made. They used their professional curiosity to understand more from the donor. This included who the donor lived with and identified someone at home to support when they arrived home (no one could come to collect them). The donor also mentioned children lived at the same address. The RN identified the donor as potentially 'vulnerable' due to the adverse event and their presentation in behaviour and language used in the conversation when recovering from the adverse event.

Issues that led to a referral under the Safeguarding/ Prevent Duty

The RN noted that whilst recovering the donor began 'muttering' to themselves and asked them if they were ok, and if they were talking to her (the RN). The donor replied, 'yes I'm ok, no I'm not talking to you'. The RN thought perhaps the donor maybe praying and so asked, 'are you praying?' and apologised if they were and if she had interrupted. The donor replied, 'no I'm not

praying'. A Donor Carer Supervisor (DCS), supporting the RN with the donor, heard and witnessed the conversations. The RN was speaking with the donor, trying to distract them from checking their own pulse and increasing their own anxiety, offering reassurance. In asking orientating questions there were replies given that concerned the RN. These included reference to the 'US marines'. The donor was also heard using the word 'explosion'.

The team at this point expressed concerns to the RN about the donor's words and behaviour. The RN considered if the donor could have a learning disability or mental health condition as the answers to questions were regarded as odd and unpredictable.

The RN identified concerns from a Prevent and Safeguarding perspective and followed processes under our policies, this included donor demographic considerations. This involved a referral (as per Prevent policy) through to the anti-terrorism line and completion of the Prevent National Referral Form (which is submitted to the local police). Additionally, a Local Authority (LA) Children's Social Care referral was made (as the donor stated earlier that there was a child living at the same address). Finally, a LA Social Care referral was made under section 42 of the Care Act 2014. Following this the LA Social Care team made contact and the donor's GP practice safeguarding lead was also informed. They arranged for the GP to contact the donor both as follow up for their faint and for an assessment of their mental health. A multidisciplinary support network was also put around this individual and this was confirmed by the local police, who later closed the case.

Reflections from NHSBT colleagues involved in this case.

By identifying the donor to be vulnerable and escalating their concerns meant that NHSBT was able to ensure the donor received appropriate support. By sharing the relevant information on a need-to-know basis allowed for professionals to work collaboratively in order to prevent potential risk of harm. Colleagues expressed that it would have been easy to say that the donor had used a word and ignored it. However, colleagues in BD make therapeutic relationships quickly in blood donation and the donors come and go at a fast pace so prompt consideration is essential. As a team they felt unsure in this situation and that something was not quite right; but identified due to their Safeguarding and Prevent training, the need to explore this further, making appropriate referrals. Colleagues can only work with facts, and the training from NHSBT combined with their professional curiosity enabled the referral to be appropriately made to minimise any potential risk or threat.

This case demonstrates an excellent example of due diligence and appropriate escalation in relation to NHSBTs statutory duties for Safeguarding and Prevent. Safeguarding and Prevent are everyone's responsibility and sensitivity is required to handle cases well. This case demonstrates the importance of NHSBT in identifying the vulnerable, and safeguarding individuals and the general public. The team were praised by the local police for their professionalism and actions to safeguard the donor and public. The processes followed and learning gained will be shared within the relevant safeguarding forums in NHSBT to build confidence and knowledge in this area.

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