INTRODUCTION

All children have the right to be protected from harm, and their safety and welfare is paramount.

A child is anyone under the age of 18. Children therefore means 'children and young people'.

Safeguarding and promoting the welfare of children is the process of protecting children from abuse or neglect, preventing impairment of their health and development, and ensuring they are growing up in circumstances consistent with the provision of safe and effective care which is undertaken so as to enable children to have optimum life chances and enter adulthood effectively.

The 'Every Child Matters'[1] programme, underpinned by the Children Act 2004[2] aims to improve the outcome for all children in five key areas:

- being healthy
- staying safe
- enjoying and achieving
- making a positive contribution
- achieving economic well being.

The 'Every Child Matters: Change for Children'[1] Green paper was published in 2003 alongside the Victoria Climbié Inquiry Report[3] and led to review and publication of the 'Working Together to Safeguard Children' 2006 document.[4]

Other core documents include the National Service Framework for Children, Young People and Maternity Services[5], which sets out a ten year plan to stimulate long-term and sustained improvement in children's health and well-being. There are many other documents which are important to inform strategy and delivery of services. These are referenced on the Government's website Every Child Matters: Change for Children.[1]

Safeguarding and promoting the welfare of children, and in particular protecting them from significant harm, depends upon effective joint working between agencies and professionals that have different roles and expertise.

Child Protection is a subset of safeguarding and promoting welfare. This refers to the activity which is undertaken to protect specific children who are suffering, or at risk of suffering, significant harm.

Social Services and the Police have statutory authority and responsibility to investigate allegations or suspicions about child abuse. The Ambulance Service must refer all such concerns to social services. However, in circumstances where the child could be described as at immediate risk, cases should be referred to the Police. Children with significant injury should be taken to hospital without delay. To help clinicians recognise where children are at risk, a set of recognition of abuse notes are attached (***refer to Appendix 1***).

OBJECTIVES

1. To ensure all staff are aware of, and can recognise, cases of suspected child abuse, or children at risk of significant harm.
2. To provide guidance enabling operational and Control staff to assess and report cases of suspected child abuse.
3. To ensure that all staff involved in a case of suspected abuse are aware of the possible outcome and of any subsequent actions.

PROCEDURE

Principles of safeguarding children

All health professionals may seek advice from a Designated Nurse or Doctor for Child Protection in their area during normal working hours. Ambulance clinicians may obtain contact information from a Senior Officer in Ambulance Control.

In the reporting of a suspected case of abuse, the emphasis must be on shared professional responsibility and immediate communication. Attempts must be made to work in partnership with the child and family, taking into consideration their race, culture, gender, language and experience of disability.

Although parents/carers should generally be kept informed of the actions required in the interest of safeguarding children, this may not always be practicable for Ambulance Clinicians. It is particularly important that parents should not be informed of an ambulance crew's concerns in circumstances when this may result in a refusal to attend hospital or in any situation where a child may be placed at further risk.

Action when abuse or risk of harm is suspected

There are a number of ways in which Ambulance Clinicians may receive information or make observations which suggest that a child has been abused or is at risk of harm. For example, the nature of an injury to a child might suggest that the child has been abused (e.g. the story given for an injury may be inconsistent with what is observed).

Observations about the condition of other children or adults in the household might suggest risk (e.g. a child living in an environment where domestic violence has taken place). Ambulance clinicians may observe hazards in the home, or find that children have been locked in a room. Signs of distress shown by other children in the home should be recorded.

An ambulance crew will often be the first professionals on scene and their actions and recording of information may be crucial to subsequent enquiries.

When attending a domestic dispute between adults, the presence of children in the household creates a need to notify under child protection. This applies even if the child was not injured in the violent episode on that occasion.

PATIENT ASSESSMENT

Ambulance clinicians should follow the normal history-taking routine, taking particular note of any inconsistency in history and any delay in calling for assistance. They should limit any questions to those of routine history-taking, asking questions only in relation to the injury or for clarification of what is being said. It is important to stop questioning when their suspicions are clarified. They should not question the child, but should listen and react appropriately to instil confidence. They should avoid unnecessary questioning or probing, as this may affect the credibility of subsequent evidence. They should write down exactly what they have been told.

Ambulance clinicians should accept the explanations given, and not make any suggestions to the child as to how an injury or incident may have happened. Similarly, if they are told of abuse, they should not question the child, but should accept what they are being told and act appropriately.

Remember the Ambulance Service is not there to investigate suspicions. The task for Ambulance Clinicians is to be aware of the issues of child abuse (***see Appendix 1)***, but not to be experts in this area. Ambulance clinicians should ensure that any suspicion is passed to the appropriate agency, i.e. staff in the Emergency Department (ED), social services or the Police. This should be achieved by following the guidelines in ***Appendix 2***.

ACTIONS TO BE TAKEN BY AMBULANCE CLINICIANS

If an ambulance crew attend a child and are concerned that the child may have been either physically, sexually, emotionally abused, or neglected, they should take the following actions:

1. If the child is the patient, and the parents/carers agree that he/she is to be conveyed to hospital, they should not let the parents/carers know they are suspicious if this may result in refusal to go to hospital. They should speak to the most senior member of nursing staff on duty and ensure that a copy of their documentation is handed over and a safeguarding children report form completed, with a copy provided to the hospital. This should be done away from a public area and in private if possible. Full details of their concerns or suspicions should be relayed to the receiving nurse, with a recommendation that the Child Protection Register should be consulted. Although individual EDs have access to the Child Protection Register for their area, they may need to ask for assistance if the central register needs to be consulted. Ambulance clinicians should complete a copy of the safeguarding children report form and provide a copy to the ward/clinic staff. They should also inform their site manager.
2. The crew should inform Ambulance Control about the situation so that they can report it. As soon as reasonably possible the crew should fax a copy of the safeguarding children report form (***see Appendix 3***) to Ambulance Control.
3. If the child is the patient and the parents/carers refuse to allow them to be conveyed to hospital, the crew should inform Ambulance Control and complete a safeguarding children report form. Ambulance Control will call the police and contact social services on the 24-hour emergency number, and will also arrange for an Ambulance Officer to attend the scene. Ambulance clinicians should follow the same procedure, also informing their site manager of the circumstances.
4. If the child is not the patient but the circumstances are suspicious, the crew should consider the implications of leaving the child. If the child is accompanying another person (e.g. a parent) who is being conveyed, the crew should inform ED staff of their concerns. If no-one is conveyed to hospital, and the crew leave the scene, they should contact Ambulance Control and inform them of the incident. At the earliest opportunity they should complete the safeguarding children report form and fax it to Ambulance Control.
5. In all cases where abuse of a child is suspected, a safeguarding children report form must be completed and, where the child is conveyed to hospital, a copy provided to the ED or other relevant hospital department. In all cases a copy must be faxed to Ambulance Control. The original form should be retained with the patient report form for recording and archiving.

ACTION TO BE TAKEN BY AMBULANCE CONTROL STAFF

1. On receiving details about a potential case of child abuse from an ambulance crew the senior Control Room Officer should consult the records in the control 'At Risk' register, and contact the 24-hour social services number in that area to start the referral process.
2. The Social Services staff may ask for details of the incident and what the crew consider to be the level of risk. This will include whether the child is at risk of 'significant harm'.
3. When the Control Officer receives the completed form from the crew, she/he should forward a copy to the relevant social services department, and send the original fax to the designated senior manager at Ambulance Headquarters. In addition, patient anonymised copies must be sent to the crew's Station Officer and Training Officer (or Site Manager for Ambulance Clinicians) so that any need for support of the crew by managers can be identified and provided. Ambulance Control must enable clinicians to complete and fax the safeguarding children report form as soon as practicable, utilising Officers to facilitate access to fax machines where that is difficult out of hours.

POLICE ASSISTANCE

The Police have a number of legal powers to protect children. These include the power to gain entry to a building in some circumstances, and the power to remove a child into police protection for up to 72 hours. Any Police Constable may effect this if he/she considers that a child is at risk of 'significant harm'. The child should have a clinical assessment before being taken into Police protection.

In urgent circumstances, where an ambulance crew think that a child is at immediate risk of significant harm, they should inform Ambulance Control, who will request Police attendance.

There may be circumstances where there are concerns for an unborn child, e.g. when a pregnant woman has been physically assaulted. In a situation of this type, advice should be sought initially from Social Services, although the advice given may include reporting the incident to the Police.

ACTIONS TO BE TAKEN BY THE DESIGNATED SENIOR OFFICER

The designated Senior Officer, or her/his deputy, will ensure that all safeguarding children report forms are collected from control daily and a check made to see if the child has come to the attention of the service before. In all cases, a follow-up will be made to the relevant Social Services/Police/PCT department to ensure that information has reached the appropriate persons and to establish what action is planned.

Subsequent Action

Safeguarding children concerns notified by the ambulance service will be subject to enquiries by Social Services departments and will be investigated by Social Services and/or the Police. Ambulance clinicians may be required to assist by giving a statement to clarify their observations. Ambulance clinicians may be requested to attend a case conference, accompanied by a manager and supported by other designated professionals for safeguarding children.

Senior Management Responsibilities

Senior Managers will ensure that any request from a statutory agency for a statement or other information will be communicated through the crew's line manager. They will also ensure that any member of Ambulance Service staff instructed to attend court to give evidence will receive appropriate support and advice from the Trust. This will include ensuring that the documentation is available in good time, allowing time for brief / debrief before and after a Court appearance or case conference, and that the member of staff will be accompanied by an officer.

Key Points – Suspected Cases of Child Abuse

- The safety and welfare of the child is paramount.
- There is a duty to report concerns.
- Staff should not investigate suspicions themselves.
- Police should be involved where there may be an immediate risk to the child.
- Staff should document the circumstances giving rise to their concern as soon as possible.

REFERENCES

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[3] Lord Laming. The Victoria Climbié Inquiry: Report Of An Inquiry: London: HMSO. Available from: http://www.victoria-climbie-inquiry.org.uk/finreport/finreport.htm, 2003.

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[6] Department of Health. No Secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse. 2000.

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[8] Children Act 1989 (c.41) Available from: http://www.opsi.gov.uk/acts/acts1989/Ukpga_19890041_en_1.htm, 1989.

[9] Data Protection Act (1998) London: HMSO. Available from: http://www.opsi.gov.uk/ACTS/acts1998/19980029.htm.

METHODOLOGY

Refer to methodology section.

APPENDIX 1 – SAFEGUARDING CHILDREN

RECOGNITION OF ABUSE

Introduction

For the purposes of safeguarding children procedures, a child is anyone under the age of 18. All children deserve the opportunity to achieve their full potential. They should be enabled to be as physically and mentally healthy as possible, receive maximum benefit from educational opportunities, live in a safe environment, experience emotional well-being, feel loved and valued, become competent in looking after themselves, have a positive image of themselves and have opportunities to develop good interpersonal skills and confidence. If they are denied the opportunity to achieve their potential in this way they are at risk, not only of an impoverished childhood, but of experiencing disadvantage and social exclusion in adulthood.

SIGNIFICANT HARM

The Children Act (1989)[8], now Children Act (2004)[2], introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in the best interests of the children (***see Table 1***). The Local Authority is under a duty to make enquiries, or cause enquiries to be made, where it has reasonable cause to suspect that a child is suffering, or likely to suffer, significant harm.

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, the extent of premeditation and the degree of threat and/or coercion.

Some children may be suffering, or at risk of suffering, significant harm, either as a result of a deliberate act, of a failure on the part of a parent or carer to act or to provide proper care, of the child being beyond parental control, or all of these factors. These children need to be made safe from harm, as well as their other needs being met. 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.

Table 1 – Examples of abuse

Physical abuse	Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, suffocating, or otherwise causing physical harm. Physical harm may also be caused when a parent or carer feigns the symptoms of, or deliberately causes ill-health to, a child they are looking after. This situation is commonly described using terms such as 'factitious illness'.
Emotional abuse	Emotional abuse is the persistent emotional ill-treatment of a child so 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.
Sexual abuse	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 or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.
Neglect	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 the 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.

WHO IS VULNERABLE TO ABUSE?

Although any child can potentially be a victim of abuse, there are some groups of children who may be particularly vulnerable. These include children with learning disabilities, severe physical illnesses or sensory impairments. Sources of stress within families may have a negative impact on a child's health, development or well-being, either directly or because they affect the capacity of parents to respond to their child's needs. Sources of stress may include social exclusion, domestic violence, the unstable mental illness of a parent or carer, or drug and alcohol misuse. Parents who appear over-anxious about their child when there is no sign of illness or injury may be a sign of their inability to cope.

Children with special needs

This group of children have particular needs because of a psychological or medical difficulty. For example, deaf or autistic children may demonstrate challenging behaviour, which may or may not be as a result of abuse. Children with special needs are more likely to be abused than children in the general population.

Children in need

Children who are defined as being 'in need' are those whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services (section 17 (10) of the Children Act 1989[8]), plus those who are disabled. The critical factors to be taken into account in deciding whether a child is in need under the Children Act 1989[8] are what will happen to a child's health or development **without services** being provided. Local Authorities have a duty to safeguard and promote the welfare of children in need.

RECOGNITION OF CHILD ABUSE

Non-accidental injury

For an injury to be accidental it should have a clear, credible and acceptable history and the findings should be consistent with the history and with the development and abilities of the child. When looking at injuries in children you should be aware of the possibility of the injury being non-accidental and consider it in every case, even if you promptly dismiss the idea.

Examples of abuse indicators may be:

- any injury in a non-mobile baby
- accidents / injuries in unusual places, e.g. the buttocks, trunk, inner thighs
- bruises of varying ages
- small deep burns in unusual places or repeated burns and scalds, or 'glove and stocking' burns
- poor state of clothing, cleanliness and/or nutrition
- delayed reporting of the injury.

When assessing an injured child, you should use your clinical knowledge regarding what level of accidental injury would be appropriate for their stage of development. Although stages of development vary (e.g. children may crawl or walk at different ages), injuries can broadly be divided between mobile and non-mobile children.

NON-MOBILE BABIES

Any injury in a non-mobile baby must be considered carefully and have a credible explanation if it is to be considered accidental.

Healthy babies do not bruise or break their bones easily. They do not bruise themselves with their fists or toys, bruise themselves by lying against the bars of a cot, or acquire bruises on the feet when they are held for a nappy change.

Bruising on the ears, face, neck, trunk and buttocks is particularly suspect. Petechial spots (tiny blood spots under the skin) which disappear very rapidly, may indicate attempted smothering. A torn frenulum (behind the upper lip) is rarely accidental in babies, and bleeding from the mouth of a baby should always be regarded as suspicious.

Fractures

Fractures may not be obvious on observation and the baby may present only with crying on handling. Often a fracture will not be diagnosed until an x-ray is performed. Fractures in babies are seldom caused by 'rough handling' or putting their legs through the bars of the cot. Babies rarely fracture their skull after a fall from a bed or a chair. Fractures in non-mobile infants should be assessed by an experienced paediatrician to exclude non-accidental injury.

Shaking injuries

When small babies are shaken violently their head and limb movements cannot be controlled, and this results in severe brain damage from haemorrhage inside the skull. Finger bruising on the chest may indicate that a baby has been held tightly and shaken. These babies usually present with collapse or respiratory problems and the diagnosis is only made on further detailed assessment.

Burns and scalds

Accidental burns and scalds are fairly common in older babies (over six months). Burns from grabbing hot objects (e.g. hair tongs, irons etc.) are found on the palms of the hands, and not the back of the hands. Scalds caused by pulling over hot liquids are usually on the front of the face, neck, chest and legs, with multiple splash marks.

MOBILE BABIES AND TODDLERS

Bruising

It is normal for toddlers to have accidental bruises on the shins, elbows and forehead. Bruises in unusual areas such as the back, upper arms, and abdomen do not tend to occur accidentally.

Bruising caused by a hand slap leaves a characteristic pattern of 'stripes' representing the imprint of fingers. Forceful gripping leaves small round bruises corresponding to the position of the fingertips. 'Tramline' bruising is caused by a belt or stick and shows as lines of bruising with a white patch in between. Bites result in small bruises forming part or all of a circle.

Burns and Scalds

Burns are caused by the application to the skin of dry heat and the depth of the burn will depend on the temperature of the object and the length of time it is in contact with the skin.

Abusive burns are frequently small and deep, and may show the outline of the object, whereas accidental burns rarely do so because the child will pull away. For example, a burn reflecting the shape of the soleplate of an iron should be treated with suspicion.

Cigarette burns are not common. They are round, deep and have a red flare round a flat brown crust. The burns usually leave a scar.

Scalds are caused by steam or hot liquids. Accidental scalds may be extensive but show splash marks, unlike the sharp edges of damage done when the child is dunked in hot water (although splash marks may also feature in a non-accidental burn, indicating that the child had tried to escape hot water). The head, face, neck, shoulders and front of the chest are the areas affected when a child pulls over a kettle. If the child turns on the hot water in the bath, the soles of the feet are in contact with the bath and will be less affected than the tops.

Fractures

Children's bones bend rather than break, and require considerable force to damage them. There are various kinds of fractures (***see Table 2***), depending on the direction and strength of the force which caused them.

The diagnosis will usually be radiological unless there is deformity of the bone, and may not be known initially to Ambulance Clinicians. Documentation of the history given is therefore an important part of the initial assessment.

Table 2 – Types of fractures in children

Greenstick	The bones bend rather than break. This is a very common accidental injury in children.
Transverse	The break goes across the bone and occurs when there is a direct blow or a direct force on the end of the bone, e.g. a fall on the hand will break the forearm bones or the lower end of the humerus.
Spiral or oblique	A fracture line which goes right around the bone or obliquely across it is due to a twisting force, which may be a feature in non-accidental injuries.
Metaphyseal	Occur at the extreme ends of the bone and are only seen radiologically. These are caused by a strong twisting force.
Skull fractures	These must be consistent with the history and explanation given. Complex (branched), depressed or fractures at the back of the skull are suspect.
Rib fractures	These do not occur accidentally, except in a severe crushing injury. Any other cause is highly suspicious of non-accidental injury.

Deliberate poisoning and attempted suffocation

These are very difficult to assess and may need a period of close observation in hospital. Deliberate poisoning, such as might be found in a case of a child in whom illness is fabricated or induced by carers with parenting responsibilities (factitious illness), may be suspected when a child has repeated puzzling illnesses, usually of sudden onset. The signs include unusual drowsiness, apnoeic attacks, vomiting, diarrhoea and fits.

OLDER CHILDREN AND ADOLESCENTS

If the injury is accidental, older children will give a very clear and detailed account of how it happened. The detail will be missing if they have been told what to say.

Overdosing and other self-harm injuries must be taken seriously in this age-group, as they may indicate sexual or other abuse (such as exploitation).

NEGLECT

Neglect is more difficult to recognise and define than physical abuse, but its effects can be life-long. When a child is neglected this means his or her basic needs are not met. Neglect comprises both lack of physical care and supervision and a failure to encourage the child in terms of their emotional, physical and educational development. Impairment of growth, intelligence, physical ability and life-expectancy are only a few of the effects of neglect in childhood.

A neglected or abused infant may show signs of poor attachment. They may lack the sense of security to explore, and appear unhappy and whining. There may be little sign of attachment behaviour, and the child may move aimlessly round a room or creep quietly into corners.

In pre-school and school-age children, indicators of neglect may include poor attention span, aggressive behaviour and poor co-operative play. Indiscriminate friendly behaviour to unknown adults is often a feature of children who are deprived of emotional affection. Other signs include repetitive rocking or other self-stimulating behaviour. Personal hygiene may be poor because of physical neglect, and this may lead to rejection by peers.

EMOTIONAL ABUSE

Emotional damage occurs as a result of all forms of abuse, but emotional abuse alone can be difficult to recognise as the child may be physically well cared-for and the home in good condition. Some factors which may indicate emotional abuse are:

- if the child is constantly denigrated before others
- if the child is constantly given the impression that the parents are disappointed in them
- if the child is blamed for things that go wrong or is told they may be unloved / sent away
- if the parent does not offer any love or attention, e.g. leaves them alone for a long time
- if the parent is obsessive about cleanliness, tidiness etc.
- if the parent has unrealistic expectations of the child, e.g. educational achievement / toilet training
- if the child is either bullying others or being bullied him / herself.

Children can be at risk of emotional abuse because of the circumstances of adults in their immediate surroundings, e.g. if there is an atmosphere of domestic violence, adults with mental health problems or a history of drug or alcohol abuse. It cannot be assumed that a child is safe in a care setting, as children in this environment can be subject to exploitation, e.g. for prostitution.

SEXUAL ABUSE (*refer to sexual abuse guideline*)

Although some children are abused by strangers, most are abused by someone known to them. Some are abused by other children, including siblings, who may also be at risk of abuse. The majority of abusers are male, although occasionally women abuse children sexually or co-operate with men in the abusing behaviour.

Both girls and boys of all age groups are at risk. The sexual abuse of a child is often planned and chronic. A large proportion of sexually abused children have no physical signs, and it is therefore necessary to be alert to behavioural and emotional factors that may indicate abuse.

Allegation of abuse by the child

Any allegation of abuse by a child is an important indicator and should always be taken seriously. It is important to note that children may only tell a small part of their experience initially. Adult responses can influence how able a child feels to reveal the full extent of the abuse. If abuse is alleged, the adult being told about the abuse must be careful not to ask probing questions (*see Guidelines and Operational Procedures*).

Physical signs and symptoms

The following symptoms should give cause for concern and further assessment:

- soreness, discharge or unexplained bleeding in the genital area
- chronic vaginal infections
- bruising, grazes or bites to the genital or breast area
- sexually transmitted diseases
- pregnancy, especially when the identity of the father is vague.

Behavioural and emotional indicators

- inappropriate sexual knowledge for the child's age
- overt sexual approaches to other children or adults
- fear of particular people or situations, e.g. bath time or bedtime
- drug and alcohol abuse (older children)
- suicide attempts and self-injury
- running away and fire-setting
- environmental factors and situation of parents (e.g. domestic violence, drug or alcohol abuse, learning disabilities).

These notes have been developed for training purposes and should be read in conjunction with the ambulance service's operational procedure – Suspected Cases of Child Abuse and Report Forms for the Protection of Children and Vulnerable Adults.

APPENDIX 2 – Protection of Children and Vulnerable Adults

GUIDELINES FOR STAFF

These guidelines **summarise** what you need to be aware of if someone tells you they have been abused, or if you suspect that someone has been abused.

The guidelines should be used in conjunction with the Protection of Children and Vulnerable Adults Operational Procedures, Recognition of Abuse notes and Report Forms.

It is your role and responsibility:

- to listen to the person telling you about the abuse
- to ensure their safety and your own safety
- to report the abuse via the appropriate channels
- to keep a detailed record of your observations and / or what you have been told.

If someone tells you they have been abused

If the person is an adult, move to a private place if possible. Let them tell you what happened in their own words. Reassure them that they have done the right thing in telling you about the abuse. Do not ask leading questions as this might affect a subsequent Police enquiry.

Never promise to keep a secret. Tell them as soon as possible that you will have to report to at least one other person, as it is your duty to do this. (This will give them the chance to stop talking if they are not happy for this to happen).

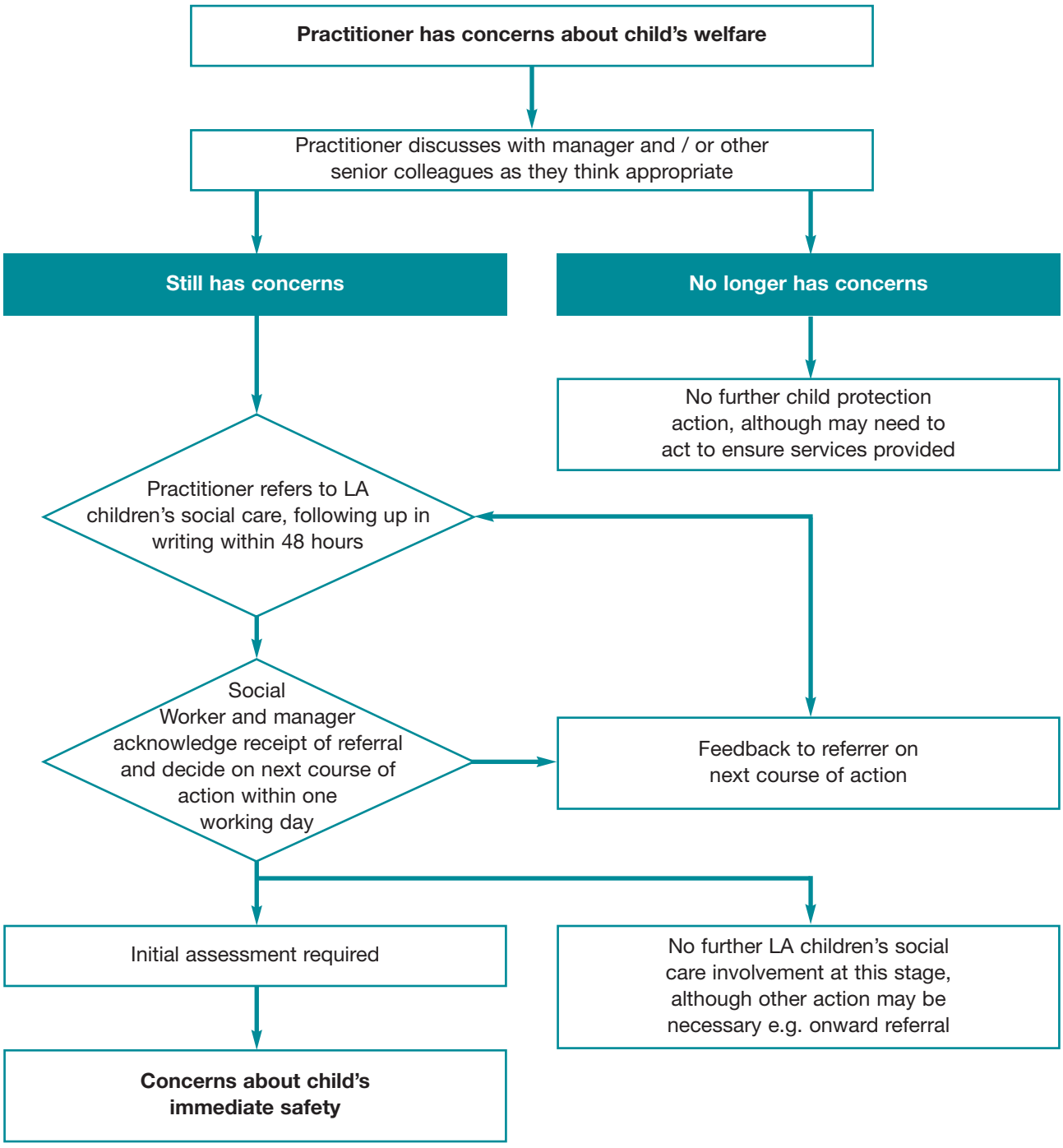
Do not talk to anyone who does not need to know about the allegation or suspicion of abuse, not even the witnesses, if there were any. By inadvertently telling the alleged abuser, for example, you may later be accused of 'corrupting evidence' or 'alerting'.

Reporting

Any allegation or suspicion of abuse must be taken seriously and reported immediately. Complete the report form in as much detail as possible and follow the *Operational Procedure* for reporting the abuse.

Remember: As a health care worker who may come into contact with children and vulnerable adults, you have a duty to report concerns about abuse. If you do not report the abuse you may be putting the victim at greater risk. You may also discourage them from disclosing again, as they may feel they were not believed. This may put other people at risk.

APPENDIX 2 – Child Protection Algorithm[4] – What happens next?[1]



[1] This is included to inform Ambulance Clinicians of the normal procedure for following up a report of suspected abuse. Senior managers should make every effort to provide feedback to Ambulance Clinicians as to what has occurred as a result of them reporting their suspicions.

APPENDIX 3 – Safeguarding children Report Form

Child's name(s) .....

.....

.....

Age / DOB .....

Address .....

.....

.....

.....

Next of kin .....

School / Nursery .....

Date .....

Time .....

CAD no. .....

Crew 1. .....

2. .....

Call sign .....

Concerns *(please tick)*:

- ☐ **Physical abuse**
- ☐ **Sexual abuse**
- ☐ **Emotional abuse**
- ☐ **Neglect**
- ☐ **Parental incapacity**

Reason for concern *(please tick)*:

- ☐ **Physical signs**
- ☐ **Inconsistent story**
- ☐ **Behavioural / developmental signs**
- ☐ **Environment**
- ☐ **Disclosure by victim/other person**

Please give a written description of your concerns, including the general appearance, state of health, demeanour and behaviour of the child:

Version of events given by the child:

Child too young to speak ☐
Not possible to speak to child alone ☐
Child does not speak English ☐

If child able to speak, what he / she says happened:

.....

.....

.....

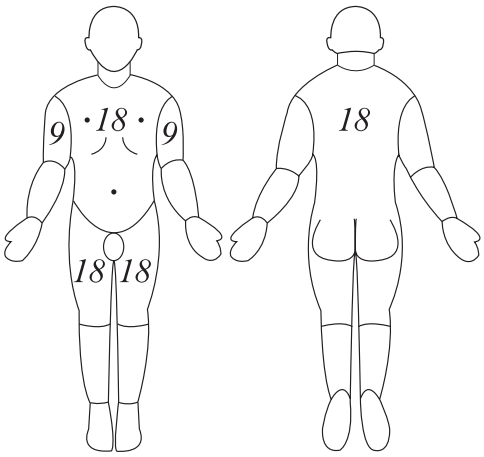
.....

.....

Please give a description of your findings. If the child has a physical injury, please mark it below using the front and back figure :

Injury = X ?Fracture = #

Burns = O Pain = ●



Details of significant family members, members of staff, friends or other people who are with the child, e.g. childminder:

Home circumstances – is the child:

Fostered	☐ Yes	☐ No	**With a childminder**	☐ Yes	☐ No
Living with parents	☐ Yes	☐ No	**Living with other relatives**	☐ Yes	☐ No

Is the child a resident of a residential care home / hostel? ☐ Yes No ☐

If Yes, please state name and address of the home / hostel .....

.....

Do you have concerns about the standard of care received by the child at home or in a residential home / hostel? ☐ Yes ☐ No

Do you have concerns about the welfare of other people there? ☐ Yes ☐ No

If Yes, please include in 'Details of the Environment' below.

.....

.....

.....

List your concerns about the environment or home (including residential care homes / hostels):

General level of care ..... Safety .....

Other (please give details) .....

.....

Has an adult on scene been aggressive towards the child (or the crew)? ☐ Yes ☐ No

Is there evidence of family / domestic violence? ☐ Yes ☐ No

Do you think the child has suffered / is likely to suffer significant harm if he / she remains in this environment? ☐ Yes ☐ No

Are the parents aware of your concerns? ☐ Yes ☐ No

Child conveyed to hospital ☐

Not conveyed to hospital ☐

Parent / carer conveyed to hospital ☐

Accompanied by other person ☐

.....

Hospital .....

Hospital staff signature .....

Hospital staff name .....

Crew signature .....

Date / Time .....

Reported to:

Ambulance Control ☐

Social Services ☐ Police ☐

In person ☐ By telephone ☐

Form sent to .....

☐ By e-mail ☐ Fax ☐ Post

CONSENT (where applicable)

The information contained in this form may be shared between the ambulance service and other agencies, in order to protect you from harm.

Declaration: I consent to the information recorded on this form being shared with other agencies responsible for my ongoing welfare.

Name: ..... **Signature:** .....

For advice / support ring .....

When completed this form must be faxed to .....

The Ambulance Service will act in accordance with the Data Protection Act (1998)[10] and the obligations contained therein, within its role as Data Controller.