



Scottish Ambulance Service

Child Protection Code of Practice, Training Notes & Supporting Arrangements



"It's everyone's job to make sure I'm alright"

Shirley Rogers
Director of Human Resources



Owner: Bill Mason	Version No: 0.06	Doc & page: Child Protection SAS arrangements.	Review arrangements: Children's Steering Group annually in April
Date of Release: 7 May 2004	Date Intranet Posting: 3 May 2004	Implementation: Immediate by all document holders, operational managers and persons identified in action plan	Approved by: Executive Team & Clinical Governance Committee 15th April 2004
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Section One

The High Level Action Plan

Action	Timescale	Lead Person/ Group	Review Arrangement
The Service will introduce a national Steering Group to initiate and coordinate all internal arrangements specific to children's needs. Membership – Dr Tom Beattie, Shirley Rogers (chair), Bill Mason, Jim McCafferty, & others as required	First meeting scheduled for 5 th April 2004. Thereafter bi-monthly.	S Rogers	Executive Team & Board progress reports. Minutes and specific reports to Clinical Governance committee
Guidance will be sought from a virtual specialist child protection reference group in relation to policy and operational arrangements for the protection of children – includes Police, Social Services, College, St Andrews University, Senior Paediatrician, Scottish Executive, CNORIS, front line staff & EMDC	Consultation & advice as and when required	Bill Mason	Steering Group monitoring
Divisional General Managers will nominate a local lead manager (ASM or HoS) to ensure children's issues are given a high profile and that Service policy in relation to children is met. These managers will receive specialist training in child protection and welfare matters.	By end of May 2004 By end of June 2004	General Managers Bill Mason to organise	Bi-monthly progress reports to Steering Group
The Scottish Executive Children's Charter & Standards will be launched and disseminated service wide. Thereafter existing arrangements reviewed and amended to achieve full compliance.	During May 2004 Ongoing through 2004/05	Executive Team All department heads	Department heads, local leads and Steering Group. PPU led Audit December 2004.
Divisional general managers will ensure that local contacts are established and maintained with Local Authority and Health Board teams established to meet the needs of integrated child welfare.	Ongoing through 2004/ 05	General Managers	Operational Management Team and Executive Team.
Through existing groups & teams, the Service will review & update children's arrangements - specifically: <ul style="list-style-type: none"> • Pain relief • Consent, capacity and confidentiality issues • Non emergency transport for the chronically disabled • IT links with other public sector databases • Paediatric Emergencies • Equipment – availability & suitability • Vehicles – design & suitability • Training & awareness of children's issues • Written materials • Hospital bypass arrangements 	All by December 2004	CE Group A Marsden J McCafferty I Shandley CE Group NOS Group NOS Group Training Team PFPI group A Marsden	Group & Committee Chairmen along with Steering Group and department heads.
The Service will create and disseminate child protection policy along with measures to: <ul style="list-style-type: none"> • Inform & alert staff of policy & new field guidance • System to monitor (anonymised) cases • Ensure appropriate training and awareness • Link to evolving sister agency arrangements & best practice 	During May 2004 and ongoing through EPRF and ECare initiatives.	Bill Mason leading a range of initiatives, some specifics outlined in policy	Steering Group
During 2004/ 05 the Service will create and deliver "The Year of the Child". An internal campaign to ensure that all the above arrangements are implemented and that a high level of focus and activity is maintained to achieve the degree of culture shift and necessary awareness at all levels.	Up to April 2005	All	All

Section Two

The Code of Practice

Child Protection Code of Practice & Supporting Arrangements

Introduction

All children in Scotland deserve to be cared for and protected from harm and to grow in a safe environment in which their rights and needs are respected.

Reports during 2003 (Caleb Ness, Victoria Climbié et al) have unfortunately identified serious failure amongst many professionals and organisations charged to protect and care for vulnerable children. The Scottish Executive is now committed to a three year reform of child protection services and of producing a children's charter, with national standards for the care & protection of children. Two of the standards are worth reinforcing – "children get the help when they need it" and "professionals take timely and effective action to protect children".

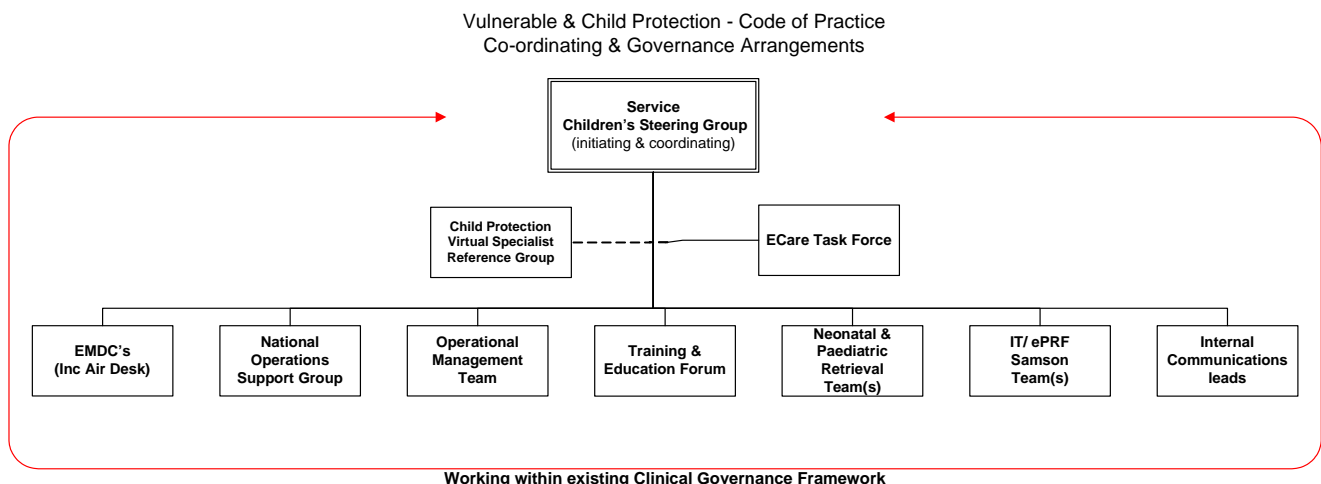
Ambulance crews are in the frontline of NHS Scotland and can play an important part in protecting children at risk - especially as they have a unique position of being "invited" into homes during times of crisis and may become aware of a situation not known to child protection agencies. Exchange of any such information gained can be vital and is not restricted by any issue of confidentiality. Indeed there may be an obligation to raise concerns with appropriate authorities.

Management & Governance Arrangements

Social Service Departments, The Children's Reporter Service and the Police have statutory authority and responsibility to investigate allegations or suspicions about child abuse. The Scottish Ambulance Service (SAS) policy is to refer all such concerns to Social Service teams (where possible via the hospital). However, in circumstances which could be described as an emergency, cases will be referred immediately to the Police.

Divisional General Managers, supported by their Emergency Medical Dispatch Centre (EMDC), operational care providers and a nominated local lead manager, are responsible for developing systems and contact points which will ensure local implementation and compliance with these arrangements. The lead Service Director is the Director of Human Resources who chairs a national Children's Steering Group (informed by a specialist reference group – see below) to initiate and coordinate Service arrangements.

Internal reporting is via existing governance arrangements to the Clinical Governance Committee via the Risk/Clinical Effectiveness Group who may receive anonymised reports via the critical incident reporting system.



Aims of these arrangements

- To reinforce that the needs and views of children are paramount
- To clarify issues of capacity, consent and confidentiality
- To raise staff awareness of child welfare concerns/ abuse.
- To provide guidance on how to assess, record & report on cases where there are concerns for a child
- To ensure that all SAS staff involved in cases of reported abuse are aware of the possible outcomes and supported during any investigation/ attendance at court.
- Continuing to develop with key partners, simple arrangements within agreed national frameworks, all supported by improving ICT and evolving practices

1. Principles of Child Protection

- 1.1. Arrangements must be child centred, compliant with appropriate legislation & recognised best practice.
- 1.2. All SAS staff may seek advice from their local designated person for Child Protection during normal working hours (or via Hospital AE department arrangements outwith). SAS crews may also obtain support and contact information from the duty manager in the EMDC.
- 1.3. In the reporting of a suspected case of abuse, the emphasis must be on shared professional responsibility and immediate communication. Attempts should be made to work in partnership with the child and family, taking into consideration any race, culture, gender, language, education and disability.
- 1.4. Although parents/ carers should generally be kept informed of the actions required in the interest of child welfare, this may not always be practicable for ambulance staff. It is particularly important that parents should not be informed of an ambulance crew's concerns in circumstances where this may result in a refusal to attend hospital or in any situation where the child or crew may be placed at further risk.

2. Action when abuse or risk of harm is suspected

- 2.1. There are a number of ways in which ambulance crews may receive information or make observations which give rise for concern about a child, or suggest that a child has been abused or is at risk of harm. For example, the nature or extent 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). There may also be information provided to you from the EMDC, alerting you of previous calls & or multi agency experience.
- 2.2. Observations about the condition of other children or adults in the household might suggest risk (e.g. a chaotic lifestyle, drug or substance abuse, history of domestic violence, inadequate food, shelter, clothing etc.). Staff may observe hazards in the home, or find that children have been locked in a room. Signs of distress or injury shown by other children in the home should also be noted.
- 2.3. With or without treatment, refusal to allow Hospital or GP referral may also create concern. Especially where the lifestyle is seen as nomadic and there is a history of previous or ongoing injury/ illness.

2.4. An ambulance crew may often be the first professional on scene and their initial actions (identifying and recording) may be crucial to subsequent enquiries and solutions. Do not assume that another agency is aware and dealing with the case – take positive steps to report any concern.

3. Patient & Scene Assessment

3.1. Crews should follow the normal history-taking routine, taking particular note of any inconsistency or 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 suspicions are clarified and not unnecessarily question the child, or probe, as this may affect the credibility of subsequent evidence. They should record exactly what they have been told and the context it was given as soon as possible thereafter. Do not paraphrase the child's words, or use complex adult or official language.

3.2. Crews 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.

3.3. Remember ambulance personnel are not there to investigate suspicions or make judgements. The task for ambulance crews is to be aware of child abuse - but not to be experts in this area. They should ensure that any suspicion is passed to the appropriate agency, i.e. staff in the A&E Department, Social Services, Children's Reporter or the Police. If possible, care should be taken to protect and not unnecessarily disturb or contaminate potential forensic evidence (such as clothing, weapons etc).

4. Actions to be taken by Ambulance crews

4.1. If a crew attend a child and are concerned that the child may have been either physically, sexually, emotionally abused, or neglected, they should undertake in addition to any treatment, the following:

4.1.1. 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 as this may result in refusal to go to hospital. On arrival they should speak to the most senior member of nursing/ medical staff on duty and ensure this discussion is recorded on the patient report form (PRF), with a copy provided to the hospital. This should be done away from a public area and in private if possible.

4.1.2. The crew should inform the EMDC about the situation so that they can also record details and where necessary, take steps to report it further (or check on hospital reporting intentions).

4.1.3. If the child is the patient and the parents/ carers refuse to allow them to be conveyed to hospital, the crew should immediately inform the EMDC and complete a refusal form/ PRF as normal. The duty manager in the EMDC will be notified and inform the Police and or Social Services on a direct line or 24-hour contact number. Should it be necessary, they will also arrange for an SAS officer to support the crew on scene.

4.1.4. If the child is not the patient/ reason for attendance, 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 A&E staff as above of their concerns. If no-one is conveyed to hospital, and the crew leave the scene, they should contact EMDC and inform them of their concerns who will follow up as (4.1.3) above.

4.2. In all cases where there are concerns for a child or abuse is suspected a PRF must be completed and, where the child is conveyed to hospital, a copy provided to the A&E department. This may require to be supported/ clarified by an additional written statement.

5. Action to be taken by EMDC staff

5.1. On becoming aware of a concern for a child or on receiving details about a potential case of abuse from an ambulance crew, the duty manager must ensure that this policy and local arrangements are followed.

5.2. There should be no hesitation in seeking assistance or referring the concerns to Social Services or the Police immediately it is possible to do so. It may be necessary to ask the crew to remain at scene (to protect the child if it is safe to do so) until the Police are able to attend.

5.3. Police and Social Services staff will require details of the incident and what the crew consider to be the level of risk – including if the child remains at risk of 'significant & or immediate harm'. This requires a subjective assessment, but should err on caution and giving the benefit of any doubt to the child.

5.4. The Shift Manager must ensure that an anonymised critical incident report form is completed & submitted to the Service Risk Manager by the end of the duty period.

5.5. EMDC staff must facilitate crews to complete all necessary documentation immediately and to be available to support any investigation. They should also make arrangements to ensure that the crew are guided & supported during what may be an emotional and difficult time – this will include informing immediate line management but the specific case details must remain anonymous.

6. Police Assistance

6.1. The police have a number of legal powers to both protect children and investigate criminal activity. These include the power to gain entry into a building in some circumstances and the power to remove a child to a place of safety. Any Police Officer may affect this if he/she considers that a child is at immediate risk of 'significant harm'.

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

6.3. There may be circumstances where there are concerns for an unborn child, e.g. when a pregnant woman has been physically assaulted or is taking drugs, but refuses hospitalisation. In a situation of this type, advice may be sought from Social Services, although the advice given may include immediate referral to the Police.

7. Consent, Capacity & Confidentiality

7.1. Current Service policy on Consent (including capacity) was introduced in January 2003. In terms of child protection, the key aspects may be summarised as:

- Where a child (patients who are under 16 years of age) is considered to have the capacity to make a decision about treatment, **they can**.
- As with adults, they must understand the implications of the proposed treatment.
- A parent **cannot** over-ride consent given by a competent child
- Legally a parent (or legal guardian) **can** over-ride refusal (although very rarely applied).

7.2. Ambulance staff are rightly governed by a range of policies & legislation that normally protects personal health information – including the Data Protection Act, Common Law, Human Rights Act et al, which normally require strict adherence. However, in terms of child protection, the key aspects may be summarised as:

- The Service Caldicott (information) Guardian confirms that disclosure without consent for the purpose of child protection, or in the prevention or detection of serious crime, is acceptable and appropriate
- Information sharing between professional and statutory agencies for the above purposes is an important aspect (particularly post Soham) of preventing risk to vulnerable children
- There are **no** other professional or Service obligations to prevent disclosure in these cases

8. Subsequent Actions

8.1. Child protection concerns notified by ambulance personnel will be subject to enquiries by Social Service departments and/ or the Police. Ambulance crews may be required to assist by giving a statement to clarify their observations in more detail. SAS staff may also be required to attend a case conference or hearing, accompanied by an SAS manager as appropriate. The Service will fully cooperate and support this need.

9. Training

9.1. Training in child protection issues will form part of core training for all operational ambulance staff. As arrangements are improved e.g. in line with the new child standards, then refresher training will be undertaken as part of scheduled post proficiency courses.

9.2. The recognised training material used by the Scottish Ambulance Service has been developed from reference work of the Children's Panel Training Unit of University of St Andrews (2004)

9.3. Operating divisions are encouraged to supplement this training via on the job training/ advice/ information supplied by local Police or Social Services.

Conclusion

The Scottish Ambulance Service is committed to ensuring that our arrangements are child centred and fully integrated with other public & voluntary sector partners, to deliver safe and effective care to this potentially vulnerable group of patients. We are determined to ensure that our arrangements are robust and protective, fully meeting the aims of the Children's Charter and the Standards therein (April 2004). If you have any doubts about your responsibilities, or are unsure what to do in a specific case, then seek guidance from the most appropriate manager or professional. Further information is available in the associated child protection background training notes, or from any member of the Service training team.

Shirley Rogers
Director of Human Resources
5th April 2004

Further reading & references:

The Children's (Scotland) Act 1995

It's everyone's job to Make Sure I am Alright – Child Protection Review, (November 2002)

Protecting Patient Confidentiality (April, 2002)

The Age of Legal Capacity (Scotland) Act 1991

The European Convention on Human Rights Act 1998

Children's Charter (2004)

Standards for the Care & Protection of children (April 2004) where further legislation is listed

Specialist Reference Group & people who have assisted in the compilation of this CoP:

Director of Human Resources – Shirley Rogers

Consultant Medical Director – Andrew Marsden

Consultant Paediatrician – Tom Beattie

Service Continuous Improvement Manager – Bill Mason

Service Clinical Audit Manager – Robin Lawrenson

Tayside Police, Family Protection Unit – DS Dougie Gray

Fife Social Services/ Police Child Protection Team – Teresa Stephenson

Scottish Executive – various departments & in particular Vijay Patel

Operational ambulance staff – EMDC & Paramedics

Ambulance Training College -

St Andrews University – Children's Panel Training Support Unit – Judith Bell

CNORIS – Donna O'Boyle

London Ambulance Service – best practice post Victoria Climbié report 2003

The Scottish Ambulance Service wishes to recognise and thank all those identified and to all those missed, for their many and valued contributions to this Code of Practice.

Section Three

The Background Training notes

The information contained in this training document was developed by the Children's Panel Training Unit, University of St Andrews (2004) and has been adopted as the central reference material for the training of Scottish Ambulance Service staff in child protection issues. In addition to this written material, a PowerPoint presentation is also available.

The Scottish Ambulance Service would like to place on record our thanks to the Children's Panel Training Units and in particular Judith Bell at St Andrews University for her permission to use the material.

In addition to this core material for Scotland, the NHSTD have additional background information within UK new entrant ambulance training notes.

BACKGROUND TRAINING NOTES

CHILD ABUSE AND CHILD PROTECTION

Child abuse is a painful and difficult subject to talk about. All of us have been children and have taken those childhood experiences with us into adult life. We must be able to address our own feelings and reactions to the subject if we are to hear what children are telling us and make decisions in their best interests. If we are overwhelmed and immobilised by distressing feelings, we will not be capable of responding appropriately to protect the child. If we are to remain calm we must concentrate on understanding:

- the nature of child abuse
- the child protection process
- what we should expect from other agencies
- how can we feel sure the child will be protected.

DEFINITIONS AND CLASSIFICATION OF CHILD ABUSE

Children may be in need of protection where their basic needs are not being met in a manner appropriate to their stage of development, and they will be at risk from avoidable acts of commission or omission on the part of their parent(s), brothers or sisters or other relatives or a carer.

The following are the standard categories used in Scotland for the recording and classification of abuse. Although these are presented as discrete definitions, it should be borne in mind that in practice there can be overlap between categories and child abuse as experienced by an individual child may not always fit neatly into one category.

Physical Injury

Definition

Actual or attempted physical injury to a child, under age of 16 (or 18 in the case of children subject to supervision requirements or children with special needs), where there is definite knowledge, or reasonable suspicion, that the injury was inflicted or knowingly not prevented.

Physical indicators

Physical injury may include a serious incident or a series of minor incidents involving bruising, fractures, scratches, burns or scalds; deliberate poisoning; attempted drowning or smothering; serious risk of actual injuries resulting from parental lifestyle prior to birth, for instance substance abuse; physical chastisement deemed unreasonable.

Behavioural indicators may include:

- running away
- wariness of adults
- constantly trying to please parent/ does not turn to parent for support
- reluctant to undress at school
- inappropriately dressed to hide marks
- fear of physical contact
- afraid to go home.

Physical neglect

Definition

This occurs when a child's essential needs are not met and this is likely to cause impairment to physical health and development. Such needs include food, clothing, cleanliness, shelter and warmth. A lack of appropriate care results in persistent or severe exposure, through negligence, to circumstances which endanger the child.

Physical neglect may also include a failure to secure appropriate medical treatment for the child, or when an adult carer persistently pursues or allows the child to follow a lifestyle inappropriate to the child's developmental needs or which jeopardises the child's health.

Physical indicators

- underweight, poor growth pattern, constant hunger
- poor physical hygiene, severe nappy rash, skin rash, thin hair, body odour
- unattended needs e.g. for glasses, dental care, untreated injuries
- fatigue, listlessness, lethargy
- recurrent and persistent minor infections
- failure to thrive with no organic cause

Behavioural indicators

dull, inactive, rocking, head banging, pale and listless
begging or stealing food
inappropriate clothing for the weather
self-mutilation
frequent absence from school

Percentile charts are used by the doctors and health visitors to record a child's height and weight and, for young children head circumference, and to make comparisons over time.

Non-organic failure to thrive

Definition

Children who significantly fail to reach normal growth and developmental milestones (i.e. physical growth, weight, motor, social and intellectual development) where physical and genetic reasons have been medically eliminated and a diagnosis of non-organic failure to thrive has been established. Factors affecting a diagnosis may include inappropriate relationships between the care giver(s) and child, especially at meal times, for instance the persistent withholding of food as punishment and the sufficiency and/or suitability of the food for the child. In its chronic form, non-organic failure to thrive can result in greater susceptibility to more serious childhood illnesses, reduction in potential stature, and with young children particularly, the results may be life threatening over a relatively short period.

Emotional abuse

Definition

Failure to provide for the child's basic emotional needs, such as to have a severe effect on the behaviour and development of the child. This may include situations where, as a result of persistent behaviour by the parent(s)/ care giver(s), children are rejected, denigrated or scapegoated; inappropriately punished; denied opportunities for play and socialisation appropriate to their state of development or encouraged to engage in anti-social behaviour; put in a state of terror or extreme anxiety by the use of threats or practices designed to intimidate them; isolated from normal social experiences, preventing the child/ family members from forming relationships.

Children who are left on their own for long periods, are under stimulated or suffer sensory deprivation, especially in infancy; who do not experience adequate nurturing or who are subject to a large number of care givers, may also come into this category.

Sustained or repeated abuse of this type is likely in the longer term, to result in failures or disruptions of development of personality, inability to form secure relationships and may additionally have an effect on intellectual development and educational attainment.

Physical indicators

- language delay or speech disorder
- failure to thrive (no organic cause)
- sleep disorders
- psychosomatic complaints e.g. headache, nausea, abdominal pains

Behavioural indicators

general developmental delay
hyperactive/disruptive behaviours
behaviour extremes e.g. withdrawn/aggressive
over-adaptive behaviour (frozen watchfulness)
inhibited play
unusually fearful of consequences of actions, often leading to lying
scapegoat of the family
compulsively clean and neat
limited attention span
low self esteem
poor peer relationships.

Sexual abuse

Definition

Any child below the age of 16 may be deemed to have been sexually abused when any person(s) by design or neglect, exploits the child, directly or indirectly, in any activity intended to lead to the sexual arousal or other forms of gratification of that person or any other person(s) including organised networks. This definition holds whether or not there has been genital contact and whether or not the child is said to have initiated the behaviour.

Sexual abuse may include activities such as incest, rape, sodomy or intercourse with children; lewd or libidinous practices or behaviour towards children; homosexual practices towards children; indecent assault of children; taking indecent photographs of children or encouraging children to become prostitutes or witness intercourse or pornographic materials.

Activities involving sexual exploitation, particularly between young people, may be indicated by the presence of one or more of the following characteristics - lack of consent; inequalities in terms of chronological age, developmental stage or size; actual or threatened coercion.

Physical indicators

- difficulty in walking or sitting
- pain, swelling or itching in the genital area
- love bites or bite marks
- pain during urination
- pregnancy
- vaginal/penile discharge
- sexually transmitted disease
- recurrent urinary/vaginal infections
- genital warts
- eating disorders

Behavioural indicators

Reactions similar to those following any other severe stress including:

- regressive behaviour in younger children, e.g. bedwetting
- fears, nightmares or phobias
- running away
- mood swings, personality changes
- depression, anger, aggression
- deterioration in performance in school
- self-mutilation

Reactions directly related to sexual abuse including:

- sexualised drawings
- sophisticated or unusual sexual behaviour or knowledge
- age inappropriate play
- overtly seductive behaviour or aversion to intimacy with persons of the opposite sex
- confusion over sexual identity
- extreme mistrust.

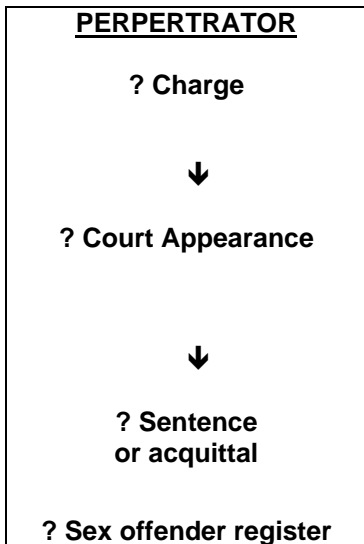
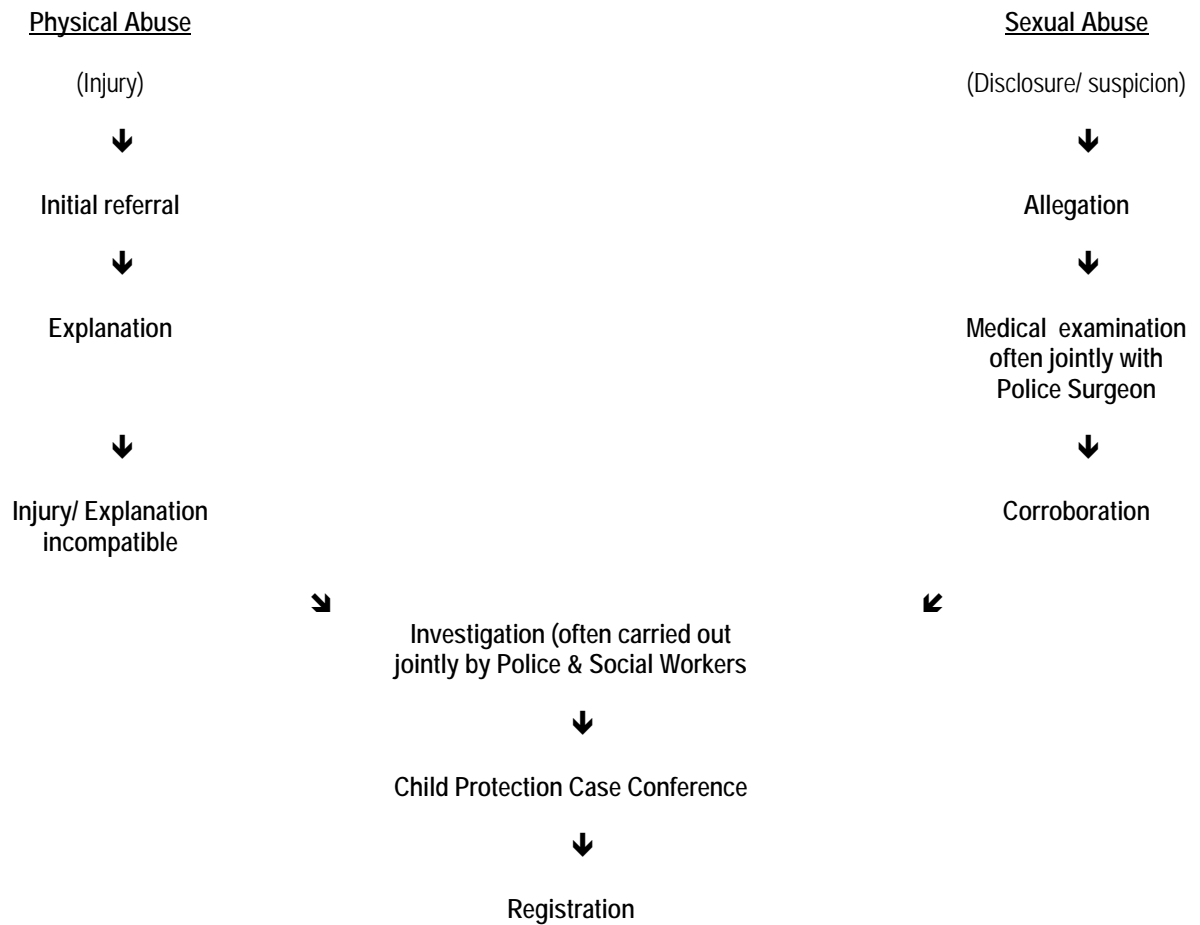
Impact of sexual abuse

The sexual abuse of children often follows a predictable pattern of stages and phases:

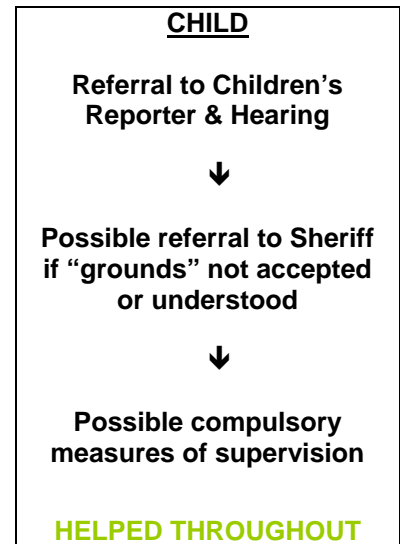
1. Engagement or entrapment: The offender initiates the contact with the child by offering bribes, rewards, special attention or affection. This is referred to as 'grooming the victim'. Sexual abuse is usually well planned by the offender who uses his/her close and trusted relationship to access the child.
2. Sexual interaction stage: Once the child responds to the special attention, the adult begins some form of sexual activity. The interaction is usually progressive.
3. Secrecy stage: Once the sexual activity has begun the adult imposes secrecy by threatening that no one will believe them if they tell; the child, family or pets will be hurt if they tell; the family will be broken up; something bad will happen to the offender; the child will be removed from the family and blamed for the abuse. Many survivors never tell about having been sexually abused.
4. Disclosure stage: Following disclosure the child will be in crisis because of the anxiety caused by the telling of the secret.
5. Suppression stage: Without adequate family or other support and fearing the threats of the offender, the child may retract, withdraw or minimise the disclosure. It is very common for children to retract their disclosure after the initial 'telling'.

"The greatest re-assurance we can give to children is that they are understood and accepted right down to the painful bit in the middle" Winnicot

SIMPLISTIC SCHEMATIC OF CHILD ABUSE INVESTIGATION



Different standards of proof required e.g. child protection does not require a conviction



NB -

1. The above schematic is simplistic and not intended to give full account of the full legal systems used in this area
2. More often than not, a prosecution will fail due to lack of corroborative evidence or it is not in the child's best interest to pursue a prosecution.
3. Even though a criminal prosecution may fail or not proceed, this does not prevent compulsory measures of child supervision and protection being put in place through a Children's Panel Hearing.

Section Four

Draft double sided guidance card



Concerns for Child Welfare or Protection – Field Guidelines for Ambulance Staff



These guidelines summarise what **you** need to be aware of if someone tells you, or if you suspect that someone has been abused or have concerns about child welfare. This may include the patient or another child you see during your work. It is your role and responsibility:

- to ensure your conduct and communication is exemplary
- to treat everyone with respect and not make judgements
- to listen to the person telling you & ensure their current safety
- to recognise that normal confidentiality does not prevent disclosure for child protection purposes
- to report any abuse or concerns via recognised procedures (normally via the Hospital if at all possible)
- to keep a good record of your observations & what you have been told
- to seek advice from the EMDC duty manager, Hospital staff or other specialists

Remember - any allegation or suspicion of abuse or neglect must be taken seriously. Do not assume someone else is dealing with the problem, record and report immediately it is possible to do so. As a health care worker who may come into contact with children at risk, you have a duty to report any concerns about neglect or abuse. If you do not report it, you may be putting the child at greater risk. You may also discourage any future disclosure, as they may feel they were not believed. **This may put other children and people at risk!**



If someone tells you, or you suspect abuse



- ◆ If possible, move to a private place. If the child wishes to do so, let them tell you what happened in their own words. Reassure them that they have done the right thing in telling you. Do not ask leading questions as this might affect any subsequent enquiry.
- ◆ Be sensitive to any feelings of guilt, anger, isolation or embarrassment.
- ◆ **Never** promise to keep a secret. Tell the child as soon as possible that you will have to report to at least one other person, as it is your duty to do so (This will give them the chance to stop talking if they are not happy).
- ◆ Avoid any unnecessary examination, or physical contact e.g. hugging – protect potential forensic evidence
- ◆ Do not share information with someone who does not need to know about the allegation or suspicion.
- ◆ **Patient care will take precedence at all times** – whenever there is doubt, consider referral to Hospital/ GP as the preferred option rather than to treat & refer. If abuse is not a concern, then full confidentiality & consent will be as per Service procedure.
- ◆ Do not be concerned if the child subsequently wishes to withdraw, or minimise the disclosure. Further information & support is available via your trainer, line manager, welfare officer, or on the Service intranet "Samson".