London Ambulance Service NHS
NHS Trust

Safeguarding Children Procedure

DOCUMENT PROFILE and CONTROL.

Purpose of the document: is to ensure all LAS staff are aware of, and can recognise, cases of suspected child abuse; to set out organisational safeguarding children arrangements

Sponsor Department: Patient Experiences

Author/Reviewer: Head of Patient Experiences

Document Status: Final

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	Children Act 1989 and 2004	
	Data Protection Act 1998	
	"Working Together to Safeguard Children" (HM Government, 2006)	
	"London Child Protection Procedures" (London Safeguarding Children Board, 2007)	
	"What to do if you're worried a child is being abused" (HM Government, 2006)	
	"Safeguarding Children in whom illness is fabricated or induced" (Department for Children, Schools and Families, 2008)	
	"Responding to domestic abuse: a handbook for health professionals" (Dept of Health, 2005)	
	"Information Sharing: guidance for practitioners and managers! (Department for Children, Schools and Families, 2009)	

Document Status: This is a controlled record as are the document(s) to which it relates. Whilst all or any part of it may be printed, the electronic version maintained in P&P-File remains the controlled master copy. Any printed copies are not controlled nor substantive.

1. Introduction

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

Children's Services and the Metropolitan Police have statutory authority and responsibility to investigate allegations or suspicions about child abuse. The London Ambulance Service (LAS) will refer all such concerns to the local Children's Services department. However, in circumstances which could be described as an emergency, cases should be referred immediately to the Police. To help staff recognise cases of child abuse a set of Recognition of Abuse notes are attached at Appendix 3. Further training will be evaluated as part of the Training Needs Analysis, and revised on an annual basis.

Working Together (2006) states

"[it is] the statutory responsibility of all health organisations to make arrangements to safeguard and promote the welfare of children. This is defined as:

- *protecting children from maltreatment*
- *preventing impairment of children's health or development*
- *ensuring that children are growing up in circumstances consistent with the provision of safe and effective care*

And undertaking that role so as to enable those children to have optimum life chances and to enter adulthood successfully. "

Each borough has child protection protocols that meet that standards established by the Local Safeguarding Children Board, thereby complying with the guidelines within the Children Act (1989) and in Working Together (2006). In addition to raising concerns about children who are in need of protection, staff have a responsibility to inform the local Children's Services department of children who fall within the definition of a child in need. These are situations where, although the child is not being subjected to abuse, they are not receiving the care and support all children need.

2. Scope

This document sets out the Trust's safeguarding children policy and practice.

3. Objectives

1. To ensure all LAS staff are aware of, and can recognise, cases of suspected child abuse and where a child and/or their family need support.

2. To provide guidance enabling operational, PTS and control services staff to assess and report on cases of suspected children at risk and in need.

3. To ensure that all LAS staff are aware of their duties and responsibilities towards children who may be at risk of harm

4. To set out the Trust's organisational safeguarding children arrangements

4. Responsibilities

4.1 Medical Director/Safeguarding Lead – accountability for the Trust's safeguarding policy and practice

4.2 Head of Patient Experiences – operational and strategic lead

5. Principles of Safeguarding Children

5.1 All health professionals working directly with children should ensure that Safeguarding and promoting their welfare forms an integral part of all stages of the care they offer. Professionals who come into contact with children, parents and carers in the course of their work also need to be aware of their responsibility to safeguard and promote the welfare of children and young people.

5.2 It is essential that all professionals and their teams have access to advice and support from the safeguarding leads as well as the named and designated safeguarding leads for health organisations in the area (see paragraphs 2.3.5 and 2.11.23 in the *London Child Protection Procedures* (2007). LAS staff may obtain contact information from the Ambulance Operations Manager (AOM) in the Emergency Operations Centre (EOC), Clinical support Desk or the Head of Patient Experiences Department (HPED).

5.3 All LAS All staff involved in working with children should attend training in safeguarding and promoting the welfare of children, and should have regular updates as part of any post-registration educational programme.

5.4 LAS have in place relevant recruitment policies and practices, including enhanced Criminal Record Bureau (CRB) checks, for all staff – including agency staff, students and volunteers – who work with children.

5.5 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.

5.6 Although parents/carers should generally be kept informed of the actions required in the interest of child protection, this may not always be practicable for LAS staff. 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.

6. Action when significant harm is suspected

6.1 *"Sometimes, a single traumatic event may constitute significant harm (e.g. a violent assault, suffocation or poisoning). More often, significant harm is a compilation of significant events, both acute and longstanding, which interrupt, change or damage the child's physical and psychological development."* London Child Protection Procedures (2007)

6.2 There are a number of ways in which LAS staff 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, or parents/child give discrepant explanations).

6.3 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). Staff 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.

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

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[1] The *Children Act 1989* introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in the best interests of children, and gives local authorities a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering, or likely to suffer, significant harm.

7. Patient Assessment

7.1 LAS staff 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.

7.2 LAS staff 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.

7.3 The LAS is not there to investigate suspicions. The task for LAS staff is to be aware of safeguarding issues (see Appendix 3), but not to be experts in this area. They should ensure that any suspicion is passed to the appropriate agency as quickly as possible, i.e. staff in the A&E department, Children's Services or the police. This should be achieved by following the guidelines in Section 4.0.

7.4 Where the concern is regarding a child's general welfare, but there is no suggestion of abuse, it is helpful to try and gather information regarding the child's care, social and family support networks and document these, along with contact numbers, to facilitate subsequent Children's Services contact. This should include GP details.

8. Actions to be taken by LAS staff

8.1 If LAS staff attend/speak to a child and are concerned that the child may have been either physically, sexually, emotionally abused, or neglected, they should take the following actions:

8.1.1 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 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 the white copy of the Patient Report Form (PRF) is handed over and a LA279 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 information is sought regarding whether the child

is the subject of a child protection plan. Although individual A&E Departments should have access to this information for their area, they may need to ask for police assistance if the information is not easily accessible. PTS crews should complete a copy of the LA279 and provide a copy to the ward/clinic staff. They should also inform their manager, as the LAS is acting as a contractor for these services on behalf of the Acute/Primary Trust. **LAS staff should also make a safeguarding children referral irrespective that concerns may have been raised with A&E staff or any other agency.**

8.1.2 EOC should not allocate a crew to another emergency call until a referral has been completed. As soon as reasonably possible staff should fax a copy of the LA279 with an aim of ensuring all referrals are made within one hour (see Appendix 1) to EBS.

8.1.3 If the child is the patient and the parents/carers refuse to allow them to be conveyed to hospital, the staff should inform EOC and complete an LA279. EOC must contact the police and arrange for an LAS officer to attend the scene and liaise with EBS so that contact is made with the relevant Children's Services department using the 24-hour emergency number; PTS crews should follow the same procedure, also informing their site manager of the circumstances. EOC should ensure EBS and PED are made aware of the incident.

8.1.4 If the child is not the patient but the circumstances are suspicious, staff should consider the implications of leaving the child. If the child is accompanying another person (e.g. a parent) who is being conveyed, staff should inform A&E staff of their concerns immediately upon arrival. If no-one is conveyed to hospital, and the crew leave the scene, they should contact EOC and inform them of the incident. Referral form LA279 should be faxed to EBS accordingly.

8.2 In all cases where abuse of a child is suspected an LA279 must be completed and, where the child is conveyed to hospital, a copy provided to the A&E or other relevant hospital department. In all cases a copy must be faxed to EBS. The original form should be sent to Management Information department for archiving.

9. Action to be taken by EBS Staff

9.1 On receiving a referral about a potential case of child abuse/child in need from LAS staff EBS should make an onward referral to the relevant Children's Services number in that area.

9.2 EBS will check for any referrals that have been entered previously and ascertain if the child has come to the attention of the service before. EBS

will ensure follow up with the relevant Children's Services/Police/PCT by periodic reporting to ensure that information has reached the appropriate persons and to establish outcome action, which should be fed back to the referring staff.

9.3 The Children's Services staff may ask for details of the incident and what the staff consider to be the level of risk. This will include whether the child is at risk of 'significant harm'.

9.4 EBS will log an entry using Datix case management system and the LA279 included within the electronic case record. EOC must facilitate crews to complete and fax the LA279 as soon as practicable, with a target of within one hour of the incident, utilising LAS Officers and Team Leaders to provide access to fax machines where that is difficult out of hours. Cooperation may be sought from A&E departments.

10. Police Assistance

10.1 The police have a number of legal powers to protect children. These include the power to gain entry into a building in some circumstances and the power to remove a child into police protection for up to 72 hours. Any Police Constable may affect 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.

10.2 In urgent circumstances where an ambulance crew think that a child is at immediate risk of significant harm, they should inform EOC, who will request police attendance and notify EBS and PED.

10.3 There may be circumstances where there are concerns for an unborn child, e.g. when a pregnant woman has been physically assaulted or is alcohol/substance dependant. In a situation of this type, LAS staff should make an immediate referral to Children's Services.

11. Subsequent Action

11.1 Child protection referrals notified by the LAS may be subject to enquiries by Children's Services departments and will be investigated by Children's Services and/or the Police. PED will act as contact point for any related enquiries arising from a referral [but see Para 10]. All action undertaken will be recorded in the electronic case record. Where more complex issues arise, the matter will be referred to the Head of PED who has a responsibility to alert other senior managers, where appropriate. Ambulance crews may be required to assist by giving a statement to clarify their observations in more detail. The staff involved may be requested to attend an interview or case conference, although most often

local complex safeguarding representatives will attend related meetings.

11.2 PED will manage any matters that escalate where an Internal Management Review, a chronology, Chapter 8 report or Serious Case Review is being undertaken.

12. PED and Senior Management Responsibilities

12.1 PED will furnish Children's Services with copies of the PRF or any other information, on request, save where the circumstances in section 8 apply or where an approach for documentary records is made by the police under the relevant legislation and guidance (see *Information Sharing: guidance for practitioners and managers* (2009), where Operational Information and Archives Department will respond to that but advise PED and EBS accordingly. PED will also enlist the assistance of Senior Managers to ensure that any request from a statutory agency for a statement or other information will be communicated through the crew's line manager. PED will liaise with Legal Services, Communications and local managers to ensure that any member of LAS staff instructed to attend Court to give evidence will receive appropriate support and advice from the Trust. This will include ensuring 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 LAS Officer.

13. Out of Hours arrangements

13.1 EBS are able to receive faxed LA279 referral forms 24/7, check the electronic record for previous referrals, and forward a referral to the appropriate Local Authority Social Services out-of-hours contact. The referral will be passed either over the phone or by fax (subsequently confirming receipt) or email, and faxed separately to the daytime Children's Services fax number. An electronic record will be created as per paragraph 5.3. At the earliest opportunity on the next working day EBS will confirm receipt of the fax with the local Children's Services contact.

EBS will be able to deal with routine enquiries and requests for information out-of-hours. Some elements of the paper archive may occasionally be difficult to access out-of-hours and requests requiring this may need to be dealt with in-hours. More complex requests will be referred to PED in-hours. EBS will liaise with CSD where necessary to assist any out of hours enquiry

14. Monitoring and Governance

14.1 PED will formulate pan-London data regarding the number and type of referrals, based on data complied by EBS, which will be reported to the London Safeguarding Children Board. Activity reporting will also be made available to all London local authorities and PCT commissioners on a regular basis a report/ update will be presented to the Clinical Governance Committee by the Trust Safeguarding Lead. The Medical Director's report to the Trust Board will also highlight progress on any key issues and risks being managed by/and learning for the organisation. The Trust policy as regards Child Death Reviews and Rapid Response processes etc are available on the Trust's website at: http://www.londonambulance.nhs.uk/health_professionals/safeguarding-child_protection/suidca.aspx

IMPLEMENTATION PLAN	
Intended Audience	For all LAS staff
Dissemination	Available to all staff on the Pulse
Communications	Revised Procedure to be announced in the RIB and a link provided to the document
Training	Training will be provided via the Trust's Education & Development department
Monitoring	There will be periodic review to ensure policy and practice meets statutory and practice requirements. Monitoring will be achieved through peer review via London Safeguarding Board and other relevant agencies. HPED will be responsible for monitoring which will take place annually. There will be assimilation of feedback from relevant agencies

Appendix 1

LA279

Child at Risk / In Need Report Form

<table>
<tr><td>Child's name(s)
…………………………………………........
…………………………………………........

Age/ DOB …………………………………</td><td colspan="2">Address:
…………………………………………........
…………………………………………........
…………………………………………........</td></tr>
<tr><td>Next of kin (give name & relationship)

…………………………………………........
…………………………………………........
…………………………………………........</td><td colspan="2">School / Nursery

…………………………………………........
…………………………………………........
…………………………………………........</td></tr>
<tr><td>GP(inc. address/ tel no)
…………………………………………........
…………………………………………........
…………………………………………........</td><td colspan="2">Child's/ parents Tel number:

………………………………………..</td></tr>
<tr><td colspan="3">Details of significant family members, members of staff, friends or other people who are with the child, e.g. childminder:

</td></tr>
<tr><td colspan="3">Home circumstances - is the child:

Fostered Yes ☐ No ☐ With a childminder Yes ☐ No ☐

Living with parents Yes ☐ No ☐ Living with other relatives Yes ☐ No ☐</td></tr>
<tr><td colspan="2">Date:…………………………………

Time:…………………………………

CAD no. ……………………………</td><td>Crew 1..

Crew 2..

Call sign..</td></tr>
</table>

CAD N°

Concerns *(please tick)*:		Reason for concern *(please tick)*:	
Physical abuse	☐	Physical signs	☐
Sexual abuse	☐	Inconsistent story	☐
Emotional abuse	☐	Behavioural / developmental signs	☐
Neglect	☐	Environment	☐
Parental incapacity	☐	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 ☐

Child does not speak English ☐

Not possible to speak to child alone ☐

If child able to speak, what he/she says happened:…………………………………………………………………………………
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CAD N°

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 ☐

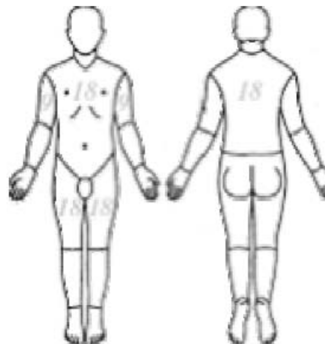
Do you think the child has suffered / is likely to suffer significant harm if he/ she remains in this environment? Yes ☐ No ☐

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

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

Obs (as appropriate)

BP
Pulse
BM
Temp



Injury = X ?Fracture = #
Burns = :::::: Pain = O

CAD N^{o}

Child conveyed to hospital ☐ Not conveyed to hospital ☐	Parent / carer conveyed to hospital Accompanied by other person ………………….........................
Hospital ……………………………… Hospital staff signature …………………… Hospital Staff Name................................. LAS signature ……………………………… Date / Time …………… / …………………	Reported to: EOC ☐ Social Services ☐ Police ☐ In person ☐ By telephone ☐ Form sent to ………………………………................. By e-mail .... Fax..
CONSENT (where applicable to be completed by *parent/guardian or child*)) The information contained in this form may be shared between the London 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: …………………………	

When completed this form must be faxed to the Emergency Bed Service on 020 7357 6380 who will forward it to the appropriate authority

For advice/support ring EOC on 020 7921 5197 and/or speak to the Ambulance Operations Manager/Operational Control Manager.

During office hours advice may also be sought from Patient Experiences – 020-7887-6678, or for routine enquiries regarding referrals, EBS can be contacted 24hrs by phone on 020 7407 7181.

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

Appendix 2

Protection of Children & 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 booklet and Report Form LA279.

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, you may wish to consider moving to a more private place. However, where the adult is particularly vulnerable, consideration must be given to ensuring they feel safe and confident at all times, which may mean having a quiet conversation in view of others. In all instances, 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 be later accused of "corrupting evidence" or "alerting."

Reporting

Any allegation or suspicion of abuse must be taken seriously and reported immediately. Complete the Report Form LA279 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 3

London Ambulance Service NHS Trust

Safeguarding Children Recognition of Abuse

Introduction

For the purposes of child protection/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) introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in the best interests of the children. 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.

Examples of abuse are:

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 ”fabricated or induced illness”, and was previously known as “Munchausen’s Syndrome by Proxy”.
Emotional abuse	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.
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. Children with additional needs often have a range of carers and may not be able to adequately alert trusted adults when harmed or in fear.

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.

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
- frequent accidents in unlikely places, e.g. the buttocks, trunk, inner thighs
- soft tissue injuries under clothing
- small and/or deep burns in unlikely places or repeated burns and scalds, or 'glove' and 'sock' burns
- poor state of clothing, cleanliness and/or nutrition
- late reporting of the injury or delay in seeking help

(I have removed the reference to bruising because it is inconsistent with research findings – it is not possible to age bruising by visual assessment. To this end I have inserted the most up-to-date information about bruising at the end of this document)

When assessing an injured child, you should use your judgement 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.

An excellent document, available free of charge, is the Child Accident Prevent Trust/Department for Children, Schools and Families booklet: “Accidents and Child Development”, which goes into detail about the types of accidents that are likely to occur at each stage of a child’s development. This is available to order from:
http://publications.teachernet.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DCSF-00255-2009

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 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. After a difficult delivery the clavicle (collar bone), humerus or femur may be broken and not noticed until a lump appears about 2-3 weeks later. In this case the baby would require paediatric assessment to confirm any suspicions of 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. It may also cause metaphyseal fractures of the limbs as a result of the rotary movement. Finger bruising or grip-type markings on the back and front on the chest may indicate that a baby has been held tightly and shaken.

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, radiators 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

A torn frenulum at this age may occur when the child falls flat on a carpet while running, but there are usually friction burns of the nose and chin at the same time. Non-accidental fractures are uncommon after the age of two years. Once the child can talk he/she is more able to tell how the injury was sustained.

Bruising

It is unsafe to provide information about ageing and colouration of bruises, as this could lead to incorrect assessments and assumptions being made. Please see the information at the end of this document.

It is normal for toddlers to have accidental bruises on the shins, elbows and forehead. They usually fall forward, so bruises on the back or buttocks are suspect. They do not bruise both sides of the body at the same time and the bruise cannot be round a curved surface.

Two black eyes may appear 2-3 days after an accidental blow in the middle of the forehead when the bruise begins to resolve. This sign is significant, however, if it occurs without forehead swelling.

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 is highly unlikely to be accidentally caused.

Flame burns are usually less deep, have a less definite outline and may be fan-shaped. Friction burns may look similar to a flame burn and are usually seen on the prominent areas of the body such as the nose and chin, the heels or the shoulders.

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 and should not be confused with chickenpox scars or impetigo.

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, depending on the direction and strength of the force which caused them.

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 — A fracture line which goes right around the bone or obliquely across it is oblique due to a twisting force, which is often a feature in non-accidental injuries.

Metaphyseal Occur at the extreme ends of the bone and are not seen accidentally. Caused by a strong twisting force.

Skull fractures These must be consistent with the history and explanation given, as babies and small children do not fracture their skulls from falls of only a few feet. 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 (Munchausen syndrome by proxy), 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.
Please see the document "Safeguarding Children in whom illness is fabricated or induced", this is available for download at:
http://www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/safeguardingchildren/safeguarding/

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, or their account may sound rehearsed.

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

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. Neglect includes the failure to seek timely medical attention, failure to ensure school attendance and the failure to ensure that a child is safe from harm (such as failure to use or strap a child into a car seat).

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. Neglected babies and children are often chronically understimulated, and may appear to be developmentally delayed.

In pre-school and school-age children, indicators of neglect 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 humiliated or denigrated before others.
- If the child is living in a family where there is domestic violence, whether or not they witness it or are caught up in it physically
- If the child is scapegoated
- 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. 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 by peers or staff, lack of warmth and affection, etc.

Sexual abuse

Although some children are abused or harmed 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. Both men and women can harm children, although it is significantly less common for women to be implicated in cases of sexual abuse. 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 obvious 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 urinary and vaginal infections
- bruising, grazes or bites to the genital or breast area, thighs and other areas that may indicate force or coercion
- sexually transmitted diseases
- pregnancy, especially when the identity of the father is vague
- a change in bowel habit, such as soiling or constipation
- Behavioural and emotional indicators

- inappropriate sexual knowledge for the child's age
- sexualised language and behaviour
- 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

Forced marriage

See guidance at
http://www.fco.gov.uk/en/fco-in-action/nationals/forced-marriage-unit/

These notes have been developed for training purposes and should be read in conjunction with The London Ambulance Service's procedure Safeguarding Children (TP/018)

Bruising Information

The information in this leaflet is based on a systematic review of all the quality work in the world literature about bruising on children. Bruising is the most common injury to a child who has been physically abused. These key messages should help you to know when to be concerned about bruising on children.

What do we know about bruising?

- Bruising is strongly related to mobility.
- Once children are mobile they sustain bruises from everyday activities and accidents.
- Bruising in a baby who is not yet crawling, and therefore has no independent mobility, is very unusual.
- Only one in five infants who is starting to walk by holding on to the furniture has bruises.
- Most children who are able to walk independently have bruises.
- Bruises usually happen when children fall over or bump into objects in their way.
- Children have more bruises during the summer months.

Where would you expect to see bruising from an accidental injury?

- The shins and the knees are the most likely places where children who are walking, or starting to walk, get bruised.
- Most accidental bruises are seen over bony parts of the body, e.g. knees and elbows, and are often seen on the front of the body.
- Infants who are pulling to stand may bump and bruise their heads, usually the forehead.
- Fractures are not always accompanied by bruises.

When should you be concerned?

- There are some patterns of bruising that may mean physical abuse has taken place.
- Abusive bruises often occur on soft parts of the body, e.g. cheeks, abdomen, back and buttocks
- The head is by far the commonest site of bruising in child abuse.
- Clusters of bruises are a common feature in abused children. These are often on the upper arm, outside of the thigh, or on the body.
- As a result of defending themselves, abused children may have bruising on the forearm, face, ears, abdomen, hip, upper arm, back of the leg, hands or feet.
- Abusive bruises can often carry the imprint of the implement used or the hand.
- Non-accidental head injury or fractures can occur without bruising.
- Bruises which have *petechiae* (dots of blood under the skin) around them are found more commonly in children who have been abused than in those injured accidentally.

Can you age a bruise accurately?

The answer is **no**.

Estimates of the age of a bruise are currently based on an assessment of the colour of the bruise with the naked eye. The accuracy of observers who estimate the age of a bruise visually is no better than 50 per cent. The evidence is that we cannot accurately age a bruise from an assessment of colour – from either a clinical assessment or a photograph. A practitioner who offers a definitive estimate of the age of a bruise in a child by assessment with the naked eye is doing so from their own experience without adequate published evidence.

Implications for practice

A bruise should never be interpreted in isolation and must always be assessed in the context of the child's medical and social history, developmental stage and explanation given. Any child who has unexplained signs of pain or illness should be seen promptly by a doctor.

Bruising that suggests the possibility of physical child abuse includes:

- bruising in children who are not independently mobile
- bruising in babies
- bruises that are seen away from bony prominences
- bruises to the face, back, abdomen, arms, buttocks, ears and hands
- multiple bruises in clusters
- multiple bruises of uniform shape
- bruises that carry an imprint – of an implement or cord
- bruises with *petechiae* (dots of blood under the skin) around them.

This leaflet is based on the work of the Welsh Child Protection Systematic Review Group who are engaged in a rolling programme of systematic reviews of published research literature on aspects of physical child abuse. The information in this leaflet was current in September 2007. This is a collaborative project between the Department of Child Health – Cardiff University and the NSPCC.

Information about this and the project's other systematic reviews – on fractures, bites and oral injuries, burns and scalds, non-accidental head injuries, and abdominal injuries, as well as the reviews and annual updates – can be found at the CORE-INFO website: **www.core-info.cf.ac.uk**.