Tower Hamlets CCG

Level 3 Safeguarding

Dr Emma Tukmachi Dr Rebecca Scott

Named GPs for Safeguarding Children

Welcome

Housekeeping

http://gp.towerhamletsccg.nhs.uk/

Safeguarding Training Requirements

Level I – Receptionist, Admin staff

Refresher training 2 hours minimum

- On line Level 1 +/- practice training -safeguarding lead GP

Level 2 – HCAs, Phlebotomists, Practice nurses, Pharmacists

Refresher training 3-4 hours minimum

- On line Level 2 +/- practice training eg multidisciplinary practice safeguarding meeting eg reviews current local safeguarding issues, recent learning from serious case reviews.
- Some staff may be appropriate to attend level 3 training

Safeguarding Training Requirements

Level 3 Core **-** Practice Nurses in urgent care centres / walk in centres and Nurse Practitioners.

First year - 8 hours minimum

Refresher training 6 hours minimum over 3 Years

Level 3 Specialist– GPs (includes additional competencies)

First year- 16 hours minimum

Refresher training 12-16 hours minimum over 3 Years

Tower Hamlets Level 3 Training

On line Level 2 and Level 3 Training half day

Personal Training portfolio demonstrating sufficient range of Safeguarding training modalities eg

- Practice Clinical Safeguarding meetings <5 and >5 yrs
- MDT Safeguarding practice meetings
  - reflection on learning from local and national serious case reviews and multiagency audits
  - case reviews and significant events relating to safeguarding children
- PLT, Local training and interagency training on related topics e.g. Domestic Violence, FGM, Prevent, CSE.

GP is personally responsible to demonstrate they are competent and up-to-date

What is the safeguarding concern?

- A patient discloses domestic violence but doesn't want to take any action now. She has two children aged 1 and 4.
- A family attends the practice requesting travel advice. They are travelling to Somalia for the summer holiday.
- A 14 year old boy attends the surgery with a cousin. They are asking for him to be registered temporarily as he is staying with them for 6 weeks while his family is abroad.

What is the safeguarding concern?

- A 14 year old girl who is in foster care attends with symptoms of a possible STI.
- A man attends the surgery and is noted to be intoxicated. He has a baby in a pushchair with him.
- 5m old baby attends with URTI. While examining her, you notice she has a small bruise on her arm.

Bruising in non-mobile children

Current SCR

Bruising is rare in infants and pre-cruisers

- Any bruise is highly significant
- Immediate referral to social care is obligatory

Bruising is common in cruisers and walkers

- Bruising in toddlers in atypical areas should raise concerns of NAI (trunk hands or buttocks)

NSPCC /Cardiff University Core-Info

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.

If you suspect non-accidental injury

Examine fully and document findings

Refer immediately to CSC by phoning MASH

The duty Social Worker will decide if they will attend the surgery or meet the family at the hospital

KEEP THE CHILD AT THE SURGERY UNTIL SW HAS DECIDED

It is the responsibility of the SW to arrange a **safeguarding medical examination** by an Acute Paediatrician (includes Retinal exam, CT brain scan and skeletal survey)
Older non-mobile children (eg severely disabled) will be seen by Community Paeds

Difficult conversations

What would you say to the parent of a baby if you noticed a bruise?

Discuss in pairs.

Referrals to Tower Hamlets Children's Social Care

Safeguarding Children: Flow chart for advice and referral

Tower Hamlets Clinical Commissioning Group

GP staff / Practice nurses

Identified lead for safeguarding within the practice / colleague

If you need advice from a health professional regarding a safeguarding concern

Urgent Telephone Advice

Designated Nurse Judith Lewsey (Tower Hamlets CCG) (9am-5pm : Mon to Fri) Tel: 07951 489421
Barts Health Safeguarding Children Team (Community) Tel: 020 8223 8879
On call paediatrician for child protection (Wellington Way) Tel: 020 8980 3510
Out of hours and weekends – Barts Health safeguarding children on call advisor Tel: 0203 594 0440

Non-Urgent Email Advice

Named GPs for Safeguarding Children Dr Emma Tukmachi emmatukmachi@nhs.net Dr Rebecca Scott r.scott2@nhs.net

If you would like to discuss your concerns with a social worker to decide the best course of action:

Child Protection Advice Line (CPAL) (open 9am-5pm) Tel: 020 7364 5006 Option 3 or 020 7364 3444
You may either be referred to the Early Help Hub or to the Multi Agency Safeguarding Hub (MASH).

If you are sure that you need to refer this family Tower Hamlets Children's Social Care team:

Complete Inter-agency referral form - see Safeguarding Children home page on CCG website http://gp.towerhamletsccg.nhs.uk
Email the form to the Multi Agency Safeguarding Hub MASH@towerhamlets.gcsx.gov.uk
Tel: 020 7364 5601 / 5606 / 2904 / 2972 Outside Office hours Tel: 020 7364 4079

The Multi-agency Safeguarding Hub (MASH)

- Multidisciplinary team: includes CSC, Health, Police, Housing, Education
- Function is to triage all new referrals of concern about children and families to determine what response to required.
- Require use of **interagency referral form**
- **Consent based model** – consent required from family unless seeking consent may be unsafe or inappropriate (e.g if could increase the risk of harm to a child), or where delay might increase the risk of harm.

What happens after referral received by MASH

Possible Outcomes:

- No further action
- Referred to Early Help Hub
- MASH Inquiry

  MASH inquiry form - return within 4 hours.
- Statutory Assessment: child in need or child protection

  Network check form

If allegation regarding the conduct of a professional in Tower Hamlets – LADO referral

Information Sharing Across Agencies

- Child Protection conferences
- Serious Case Reviews

"You receive a letter or phone call from a social worker requesting information regarding a child and his siblings where there are child protection concerns"

What do you need to consider when sharing information?

GMC Protecting children and young people / Confidentiality and sharing information

Responding to requests for information

46. You should consider all requests for information for child protection purposes seriously and quickly

47. You must also cooperate with requests for information needed for formal reviews carried out after a child or young person has died or been seriously harmed and abuse or neglect is known, or is suspected, to have been a factor. The purpose of such a review is to learn lessons from mistakes and to improve systems and services for children and young people.

48. Before sharing confidential information, you should do **all** of the following.

a. Check the identity of the person who has asked for the information

b. Check that the request is valid, understand why the person or agency is asking for the information, what information they need, and how they may use the information in the future.

c. Make sure that you have met one of the conditions for sharing information set out in paragraph 31.

31. Confidentiality is not an absolute duty. You can share confidential information about a person if any of the following apply:

a. You must do so by law or in response to a court order.

b. The person the information relates to has given you their consent to share the information (or a person with parental responsibility has given consent if the information is about a child who does not have the capacity to give consent).

c. It is justified in the public interest – for example, if the benefits to a child or young person that will arise from sharing the information outweigh both the public and the individual's interest in keeping the information confidential.

Seven Golden Rules for Information Sharing

(HMG 2015)

1. Remember that the Data Protection Act 1998 and human rights law are not barriers to **justified information sharing**, but provide a framework to ensure that personal information about living individuals is shared appropriately.
2. **Be open and honest** with the individual (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.
3. **Seek advice** from other practitioners if you are in any doubt about sharing the information concerned, without disclosing the identity of the individual where possible.
4. **Share with informed consent where appropriate** and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, there is good reason to do so, such as where safety may be at risk.

5. **Consider safety and well-being**: Base your information sharing decisions on considerations of the safety and well-being of the individual and others who may be affected by their actions.

6. **Necessary, proportionate, relevant, adequate, accurate, timely and secure**: Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those individuals who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely (see principles).

7. **Keep a record of your decision and the reasons for it** – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

Good record keeping

- Think family & households
- Always document who attends appt with a child
- Safeguarding codes – 13I codes create red flag

Vulnerable child	**13IF-1**
Child in need	**13Is**
Child subject of a CP plan	**13Iv**
Family member subject to a CP plan	**13Iy**
Child removed from protection register	**13I0**

- Full CP conference report should be scanned into child's records.

LSCB SCR Thomas 2016

16 yr boy who sexually assaulted a young girl

Childhood in Cumbria to age 10:

- Extreme neglect of physical and emotional needs
- ? Sexual abuse
- Educational needs learning behaviour and emotions
- Considering legal proceedings when family moved to Tower Hamlets

LSCB SCR Thomas 2016

2008 Tower Hamlets social care - child in need

2009 weekly boarder at East Sussex special school for behaviour, difficulty accessing CAMHS

2013 considering removal into care, not pursued as almost 16 years

2014 allocated to Sheffield 52 week residential school. Before this move, there was an alleged sexual assault on another boy but not proven.

Communication failures on risk with Sheffield and “shared lives provider”

LSCB SCR findings – relevant to GPs

2. Assessments did not adequately explore indicators of sexual abuse

- if have concerns then refer.

3. Mother's aggressive behaviour deflected professionals from protecting the child

- discuss with others, use practice safeguarding MDT meetings.
- make sure you are hearing the child's voice.

5. Residential school seen as protective did not protect when at home and no CAMHS provision.

6. Polarised professional viewpoints became entrenched

- escalate concerns if disagree with decision

Neglect

The ongoing failure to meet a child's basic needs.

- Toxic trio in parents: mental health problems, drug & alcohol abuse, domestic violence
- Don't wait for trigger incident – children are already suffering harm, not just about to.
- Consider your DNAs.

Exercise

Liam - 15 years old

Shireen - 10 years old

Lewis - 8 years old

Read the scenario handed out and in your group rate your level of concern from

0 = most concern

10 = least concern

SCR Jamila – acute neglect

5 month old baby Jamila – died in Oct 2013

Mother aged 18, 3rd child

Forced marriage aged 13 in Somaliland and hx of DV.

Returned to UK in 2012 and came to Tower Hamlets

Gateway midwifery, health visitors, family support worker, young parents group.

Impressed by mother's parenting

Dropped out of contact after early July 2013.

Preschool concerns Sept 2013

LAS called Oct 2013 – Jamila in cardiac arrest

Children in severe state of neglect.

Recommendations for Health

1. **Safeguarding MDT meetings** (under 5s and over 5s) – record in the patient's record.
2. **Need for a shared IT system** highlighted - to improve communication between health professionals.
3. **Practice DNA policy**
   - record all DNAs
   - consider safeguarding concerns and record this
4. **Barts Health Gateway midwifery team** to ensure sharing information: acknowledgment of referral, birth plan, discharge summary.