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| **Whitecliff Group Practice**  **Whitecliff Surgery, Whitecliff Mill Street**  **Blandford Forum, Dorset, DT11 7BH** | **Eagle House Surgery,** **Whitecliff Mill Street, Blandford Forum, Dorset, DT11 7DQ** | **Whitecliff Group Practice**  **Child Okeford Surgery, Upper Street**  **Child Okeford, Dorset, DT11 8EF** |

**THE BLANDFORD GROUP PRACTICE**

**SAFEGUARDING CHILDREN OCTOBER 2019**

1. **INTRODUCTION**

Staff should read this protocol in conjunction with the guidelines issued by Dorset CCG.

This policy document is the practice agreed policy, applicable to all clinicians and staff as well as official visitors to the premises, and it represents the means by which the practice intends to keep children safe.

1. **POLICY STATEMENT**

Under the 1989 and the 2004 Children Acts a child or young person is anyone under the age of 18 years.

Child Protection refers to the activity that is undertaken to protect specific children who are suffering or at risk of suffering significant harm. All agencies and individuals should be proactive in safeguarding and promoting the welfare of children.

The practice recognises that all children have a right to protection from abuse and the practice accepts its responsibility to protect and safeguard the welfare of children with whom staff may come into contact. We intend to:

* Respond quickly and appropriately where abuse is suspected or allegations are made.
* Provide both parents and children with the chance to raise concerns over their own care or the care of others.
* Have a system for dealing with, escalating and reviewing concerns.
* Remain aware of child protection procedures and maintain links with other bodies, especially the primary care trust appointed contacts.
* The practice will ensure that all staff are trained to a level appropriate to their role, and that this is repeated on an annual refresher basis. New starters will receive training within 6 months of start date.

1. **BASIC PRINCIPLES**

* The welfare of the child is paramount.
* It is the responsibility of all adults to safeguard and promote the welfare of children and young people. This responsibility extends to a duty of care for those adults employed, commissioned or contracted to work with children and young people.
* Adults who work with children are responsible for their own actions and behaviour and should avoid any conduct which would lead any reasonable person to question their motivation and intentions.
* Adults should work and be seen to work, in an open and transparent way.
* The same professional standards should always be applied regardless of culture, disability, gender, language, racial origin, religious belief and/or sexual identity.
* Adults should continually monitor and review their practice and ensure they follow the guidance contained in this document and elsewhere.

1. **RESPONSIBILITIES**

Dr Ford is the appointed Clinical Safeguarding Lead within the practice.

Dr Nixon is the appointed Clinical Safeguarding Deputy Lead within the practice.

The Clinical Safeguarding Lead and Clinical Safeguarding Deputy Lead are responsible for all aspects of the implementation and review of the children’s safeguarding procedure in this practice.

1. **WHAT CHILD ABUSE IS**

There are 4 main categories of child abuse:

* Physical abuse
* Sexual abuse
* Emotional abuse
* Neglect/failure to thrive

These are not however exclusive, and abuse in one of these areas may easily be accompanied by abuse in the others.

**General Indicators:**

The risk of Child Maltreatment is recognised as being increased when there is:

* Parental or carer drug or alcohol abuse;
* Parental or carer mental health disorders or disability of the mind;
* Intra-familial violence or history of violent offending;
* Previous child maltreatment in members of the family;
* Known maltreatment of animals by the parent or carer;
* Vulnerable and unsupported parents or carers;
* Pre-existing disability in the child, chronic or long-term illness.

**Physical abuse may include:**

|  |  |  |  |
| --- | --- | --- | --- |
| Abrasions | Eye Injuries | Lacerations | Spinal Injuries |
| Bites (human) | Fractures | Ligature marks | Strangulation |
| Bruises | Hypothermia | Oral Injuries | Subdural haemorrhage |
| Burns or scalds | Intra-abdominal injuries | Petechiae | Teeth marks |
| Cold injuries | Intra-cranial injuries | Retinal haemorrhage |  |
| Cuts | Intra-thoracic injuries | Scars |  |

**Or consider:**

* Child with hypothermia and legs inappropriately covered in hot weather [concealing injury]
* For fabricated illness discrepancy in the clinical picture with one or more of the following:
* Reported signs or symptoms only in the presence of the carer;
* Multiple second opinions being sought;
* Inexplicably poor response to medication or excessive use of aids;
* Biologically unlikely history of events even if the child has a current or past physical or psychological condition.

**Emotional Abuse, Behavioural, Interpersonal & Social Functioning**

***Definition:*** Emotional abuse is the persistent emotional mal-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 include not giving the child opportunities to express their views, deliberately silencing them or ‘making fun’ of what they say or how they communicate.
* It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child’s developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction.
* It may involve seeing or hearing the ill-treatment of another.
* It may involve serious bullying (including cyber-bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

***Alerting features:***

|  |  |  |
| --- | --- | --- |
| Persistent harmful parent or carer – child interactions | Hiding or scavenging for food without medical explanation | Precocious or coercive sexualised behaviour |

***Or consider:***

|  |  |  |  |
| --- | --- | --- | --- |
| Physical / mental / emotional developmental delay | Changes in behaviour or emotional state without explanation | Extremes of emotion, aggression or passivity | Drug/solvent abuse |
| Low self-esteem | Self-harming/mutilation | Secondary enuresis or encopresis | Running away |
| Responsibilities which interfere with normal daily activities (such as school) | | | School refusal |

**Sexual Abuse**

***Definition:*** 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 (e.g. rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing.

They may also include non-contact activities, such as involving children in looking at sexual images or grooming a child in preparation for abuse (including via the internet).

Women can also commit acts of sexual abuse, as can other children.

***Alerting features:***

|  |  |
| --- | --- |
| Ano-genital symptom in a girl or boy that is associated with behavioural change | Hepatitis B or C in under 13s |
| Sexually transmitted infection | Pregnancy in under 13s |

***Or consider:***

|  |  |  |
| --- | --- | --- |
| Persistent unexplained ano-genital symptoms | Ano-genital warts (see CG89) | |
| Sexually transmitted infection in 13-15 year olds | Marked power differential in relationship | |
| **BEHAVIOUR CHANGES:**  Sudden changes  Inappropriate sexual display  Secrecy, distrust of familiar adult, anxiety left alone with particular person  Self-harm mutilation / attempted suicide | | Unexplained or concealed pregnancy |

**Neglect**

***Definition:***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.

Neglect may occur during pregnancy as a result of maternal substance abuse.   
Neglect involves failing to:

* Provide adequate food, clothing and shelter (including exclusion from home or abandonment).
* Protect a child from physical and emotional harm or danger; ensure adequate supervision (including the use of inadequate care-givers); or ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child’s basic emotional needs.

***Alerting features:***

|  |  |  |
| --- | --- | --- |
| Abandonment | Repeated injuries suggesting inadequate supervision | Failure to seek medical help appropriately |
| Repeatedly not responding to child or young person | Persistently smelly or dirty |

***Or consider:***

|  |  |  |
| --- | --- | --- |
| Poor personal hygiene, poor state of clothing | Untreated tooth decay | Poor attendance for immunisations |
| Frequent severe infestations (scabies, head lice) | Repeated animal bites, insect bites or sunburn | Low self-esteem |
| Faltering growth (due to poor feeding) | Treatment for medical problems not being given consistently | Lack of social relationships; children left repeatedly without adequate supervision |
| Parents failing to engage with healthcare, attend appointments (practice or wider health professional) and / or use A&E / Out-of-Hours services frequently. | | |

**Patterns of Maltreatment**

The previous sections reflect the increasing emphasis on the importance of observation of patterns of possible maltreatment, including the interaction between the parent or carer and the child or young person, as well as physical signs which are inconsistent with their developmental stage (not always the same as the age in months or years) or the explanation given.

The practice receptionist may be alerted by abuse on the phone or observing altercations in the waiting room.

Providing inappropriate supervision (or none) leading to accidental injury or burns can also be forms of maltreatment.

In addition, there are a number of injury patterns that cause immediate concern in terms of child protection including:

* Multiple bruising, with unusual bruises of different ages;
* Bruising in nonmotile baby, particularly facial bruising;
* Baby rolls over at six months;
* Baby attempts to crawl at eight months.

**Common presentations and situations in which child abuse may be suspected include:**

* Disclosure by a child or young person;
* Physical signs and symptoms giving rise to suspicion of any category of abuse;
* The history is inconsistent or changes;
* A delay in seeking medical help;
* Extreme or worrying behaviour of a child, taking account of their developmental age;
* Accumulation of minor incidents giving rise to a level of concern, including frequent A&E attendances.

**Some other situations which need careful consideration are:**

* Disclosure by an adult of abusive activities;
* Girls under 16 presenting with pregnancy or sexually transmitted disease, especially those with learning difficulties;
* Very young girls requesting contraception, especially emergency contraception;
* Situations where parental mental health problems may impact on children;
* Parental alcohol, drug or substance misuse which may impact on children;
* Parents with learning difficulties;
* Violence in the family;
* Unexplained or suspicious injuries such as bruising, bites or burns, particularly if situated unusually on the body;
* The child says that she or he is being abused, or another person reports this;
* The child has an injury for which the explanation seems inconsistent or which has not been adequately treated;
* The child’s behaviour changes, either over time or quite suddenly, and he or she becomes quiet and withdrawn, or aggressive;
* Refusal to remove clothing for normal activities or keeping covered up in warm weather;
* The child appears not to trust particular adults, perhaps a parent or relative or other adult in regular contact;
* An inability to make close friends;
* Inappropriate sexual awareness or behaviour for the child’s age;
* Fear of going home or parents being contacted;
* Reluctant to accept medical help;
* Fear of changing for PE or school activities.

1. **IMMEDIATE ACTIONS**

* Concerns should immediately be reported to the Lead clinician within the practice or his / her deputy (above).
* In the absence of one of the nominated persons, the matter should be brought to the attention of the primary care trust appointed person, or, if it is an emergency, and the designated persons cannot be contacted, then the most senior clinician will make a decision to report the matter directly to social services or the police.
* If the suspicions relate to the designated person, then the deputy should be notified and the primary care trust appointed person and / or social services should be contacted directly.
* Suspicions should not be raised or discussed with third parties other than those named above.
* Any individual has the ability to make direct referrals to the child protection agencies; however, staff are encouraged to use the route described here where possible. In the event that the reporting staff member feels that the action taken is inadequate, untimely or inappropriate they should report the matter direct. Staff members taking this action in good faith will not be penalised.
* Where emergency medical attention is necessary it should be given. Any suspicious circumstances or evidence of abuse should be reported to the designated clinical lead.
* If a referral is being made without the parent's knowledge and non urgent medical treatment is required, social services should be informed.  Otherwise, speak to the parent/carer and suggest medical attention be sought for the child.
* If appropriate the parent/carer should be encouraged to seek help from the Social Services Department prior to a referral being made.  If they fail to do so in situations of real concern the designated person will contact social services directly for advice.
* Where sexual abuse is suspected the designated person will contact the Social Services or Police Child Protection Team directly.  The designated person will not speak to the parents.
* Neither the designated person or any other practice team should carry out any investigation into the allegations or suspicions of sexual abuse in any circumstances. The designated person will collect exact details of the allegations or suspicion and to provide this information to the child protection agencies that will investigate the matter under the Children Act 1989.

1. **ABUSE REPORTED OR ALLEGATIONS RECEIVED FROM A CHILD**

* React calmly.
* Reassure the child that they were right to tell you, and that they are not to blame and take what the child says seriously.
* Be careful not to lead the child or put words into the child’s mouth - ask questions.
* Do not promise confidentiality
* Fully document the conversation on a word by word basis.
* Fully record dates and times of the events and when the record was made, and ensure that all notes are kept securely.
* Inform the child/ young person what you will do next.
* Refer to the practice designated clinician or deputy.
* Decide if it is safe for a child to return home to a potentially abusive situation. It might be necessary to immediately refer the matter to social services and/or the police to ensure the child’s safety and that they do not return home.

1. **CONFIDENTIALITY**

Staff are required to have access to confidential information about children and young people in order to do their jobs, and this may be highly sensitive information. These details must be kept confidential at all times and only shared when it is in the interests of the child to do so, and this applies to the restriction of the information within the clinical team. Care must be taken to ensure that the child is not humiliated or embarrassed in any way.

If an adult who works with children is in any doubt about whether to share information or keep it confidential he or she should seek guidance from the designated clinical Safeguarding Children lead. Any actions should be in line with locally agreed information sharing protocols, and the Data Protection Act applies.

Whilst adults need to be aware of the need to listen and support children and young people, they must also understand the importance of not promising to keep secrets. Neither should they request this of a child or young person under any circumstances.

Additionally, concerns and allegations about adults should be treated as confidential and passed to a designated or appointed person or agency without delay.

1. **PHYSICAL CONTACT**

A parent or carer should be present at all times, or a chaperone offered. Children should only be touched under supervision and in ways which are appropriate to, and essential for clinical care.

Permission should always be sought from a child or young person before physical contact is made and an explanation of the reason should be given, clearly explaining the procedure in advance. Where the child is young, there should be a discussion with the parent or carer about what physical contact is required. Regular contact with an individual child or young person is normally part of an agreed treatment plan and should be understood and agreed by all concerned, justified in terms of the child's needs, consistently applied and open to scrutiny.

Physical contact should never be secretive or hidden. Where an action could be misinterpreted a chaperone should be used or a parent fully briefed beforehand, and present at the time. Where a child seeks or initiates inappropriate physical contact with an adult, the situation should be handled sensitively and a colleague alerted.

1. **ATTITUDE OF PARENTS OR CARERS**

Parental attitude may indicate cause for concern:

* Unexpected delay in seeking treatment
* Denial of injury pain or ill-health
* Incompatible explanations, different explanations or the child is said to have acted in a way that is inappropriate to his/her age and development
* Reluctance to give information or failure to mention other known relevant injuries
* Unrealistic expectations or constant complaints about the child
* Alcohol misuse or drug/substance misuse
* Violence between adults in the household
* Appearance or symptoms displayed by siblings or other household members

1. **MANAGEMENT AND STORAGE OF CHILD PROTECTION RECORDS IN GENERAL PRACTICE**

* Social care and general practice should work together to ensure that requests for information and case conference minutes are sent to the right general practice, bearing in mind the complexity of family structure and the fact that families can fragment and migrate and may have members with several different surnames.
* The doctor who best knows the family or the practice child safeguarding lead should handle and respond to child protection information requests, read Case Conference minutes and make sure that any key information relevant to the children and adults mentioned in the minutes is easily available in the appropriate individual record or records. The full case conference minutes should be stored in the electronic record of the child /children who are named in the plan. The Safeguarding lead should also ensure that any healthcare actions in the CP Plan which fall within the responsibility of the practice are set in place and monitored.
* The records of children and adults linked by the Child Protection Plan (previously child protection register) should be coded / flagged so that any clinician seeing adult or child is aware of the concerns and the Child Protection Plan (e.g. where mental or physical ill-health or drug use in a parent is linked with neglect/abuse of a child).
* The key points from the minutes should be clear in the records e.g. current relevant health issues for children and adults, need for health follow up, category of abuse, date of review case conference etc.

***GMC Guidance 2012 (pages 33-34):***

* You should store information or records from other organisations, such as minutes from child protection conferences, with the child’s or young person’s medical record, or make sure that this information will be available to clinicians who may take over the care of the child or young person. If you provide care for several family members, you should include information about family relationships in their medical records, or links between the records of a child or young person and their parents, siblings or other people they have close contact with.
* Patients, including children and young people, have a legal right to see their own medical records unless this would be likely to cause serious harm to their physical or mental health or to that of someone else. A parent may see their child’s medical records if the child or young person gives their consent, or does not have the capacity to give consent, and it does not go against the child’s best interests. (For more advice, see paragraphs 53–55 of GMC 0–18 years: guidance for all doctors).
* Storing and disposing of medical records, must be done in line with official guidance on managing records, including the retention schedules published by the UK health departments.

***Guidance for Scanning and Coding:***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | | ***Read code significant details*** | ***Scan in summary*** | ***Further details from full minutes*** | ***Minimum Retention***  ***Period for full minutes*** | |
| ***Child (subject of case conference)*** | ***Yes*** | | ***Yes*** | ***Yes*** | | ***26 years, but Read code to remain on record*** |
| ***Other Children (not subject of conference but living in same household/ same carers)*** | ***Yes*** | | ***Yes*** | ***No*** | | ***26 years, but Read code to remain on record*** |
| ***Adults named in report*** | ***Yes*** | | ***Yes*** | ***No*** | | ***When index child reaches 26 years, but Read code to remain on record*** |

There is no reason why the minutes should not remain on the GP records for as long as that record in retained under the NHS Code of Practice (DH 2011).

**Read Codes for SystmOne: use appropriate templates.**

**Entry on Family Members Notes:**

* Check entry is coded properly.
* Via letters – Link the Child Protection Plan to the problem.
* Check that all the family are linked. Register the whole family with the same GP and address code as ‘family member on Child Protection Plan’.
* Put on Child Protection Plan, the reason, when the plan was put in place and the next review date.
* Note as Vulnerable Family on the ‘home screen’ and denote if Child Protection Plan or Child in Need, etc and any other key points.
* Relationships have been updated.
* MARAC (Domestic Violence) - Mark read codes on all family members (see also below).

**Information for Child Safeguarding Meetings:**

* Search children with: Child Protection Plan, and other vulnerable children with concerns raised by the GPs.
* Ensure codes are up to date.
* Note children that have DNA’d GP and hospital appointments.
* Bring list to meeting, with the list the Health Visitor will provide in advance.

**Other Actions:**

Looked After Child – Should have an annual review and a leaving care medical at 18 years old.

1. **DOMESTIC VIOLENCE:**

**POLICE DOMESTIC ABUSE REPORTS / (SCARF) GUIDANCE FOR GPs ON MANAGEMENT OF SINGLE COMBINED ASSESSMENT OF RISK FORM**

**The definition of domestic abuse was updated by the Home Office in 2013:**

*Any incident or pattern of incidents of controlling, coercive or threatening behaviour,*

*violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse*

* psychological
* physical
* sexual
* financial
* emotional

**Controlling behaviour is: a range of acts designed to make a person subordinate** and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

**Coercive behaviour is: an** act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.\*\*

*This definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced mamage, and is clear that victims are not confined to one gender or ethnic group.*

**Currently Dorset Police will distribute PPN’s where there are children involved** to health practitioners via the Dorset Healthcare Safeguarding Children Team. This vital information is shared with health visitors and school nurses, to enable them to assess risk to the victim and any children in the household and to ensure that health staff is made aware of any potential risks to professionals. Health vis tors will share the SCARF report with the victim's GP.

**Action by GPs:**

**See below chart for coding, flagging, scanning and sharing**

No specific action is required by the GP in respect of the victim, however, if the victim seeks support, the GP can signpost them to domestic abuse support services. Also the information might be useful when assessing the patients holistically especially if attendances are related to mental health, substance misuse, employment or recurrent unexplained medical

symptoms.

GPs may be aware of other issues, which place the children at risk of harm and the PPN information may elevate concerns, if so, a referral can he made to Children's Social Care, who will have also received a copy of the PPN.

Children's Social Care's response to the receipt of this information does not automatically result in intervention or contact with other agencies, who may already be working with the family. They may, for example collate 3 reports before they make contact with the family. This is often by letter to offer the family support if they choose. Clearly where there is

serious injury or where there is evidence the children may have suffered harm they would make an assessment of the case.

**GPs can seek support or guidance from MASH:**

**The Safeguarding Children Team on the advice line 01202 228866.**

Dr Sam Abdollahian: [sam.abdollahian@dorsetccg.nhs.uk](mailto:sam.abdollahian@dorsetccg.nhs.uk)

Dr Isi Sosa: [isi.sosa@dorsetccq.nhs.uk](mailto:isi.sosa@dorsetccq.nhs.uk)

From April 2015, Dorset Police has agreed that **scanning PPN into the Primary care patients' electronic notes of the victim and perpetrator is acceptable,** if the practice believes it is in the best interest of the family. It is important to ensure that these documents **are stored in** a safe area of the patients' notes (for example — Safeguarding folder provided by System One) In relation to the children it is important to flag and code the event including details of where the PPN can be found

Current advice by Dorset Police as originator of the PPN form is that PPN forms must not be shared with patients (victims, perpetrators or witnesses) and if in doubt the GP practice should contact Dorset Police for further advice. However, if a health practitioner involved with the child is aware that the child is being seen in a secondary or tertiary care setting, and the information they hold is relevant, under safeguarding this information should be shared.

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1. **CHILDREN MOVING TO AND FROM OTHER GP PRACTICES**

**Releasing patient records containing child protection information such as case conference minutes**

This should be the responsibility of the GP who according to Government guidelines must determine the presence of third party information, the necessity to redact certain content, and the necessity and proportionality of the request (see Tool 12 RCGP/NSPCC Safeguarding Children Toolkit). The GP must also consider any possible detrimental effect of release to the child or adults of potentially sensitive child protection information contained in the records such as details of a medical assessment for child sexual abuse. This may be especially relevant if the child or adult has no previous knowledge or recollection of abuse perpetrated when they were very young.

If the GP has any doubt about disclosing certain content he should discuss this with: the practice lead in safeguarding, the child’s social worker if the child is still within the child protection system, the local NHS adviser on safeguarding such as the Named Safeguarding GP or the medical indemnity organisation.

**Joining or leaving a practice**

The point in time when a child or family with a Child Protection Plan joins or leaves a practice is often critical because the children may at this stage become ‘lost’ in the system. Families may or may not disclose child protection information at registration and GP records take time to transfer. Social care departments have an obligation to arrange safe handover of family cases with an active child protection plan to the new area department which should hold a receiving-in case conference but this does not always happen.

***Joining*:** If the Practice receives a patient who is on a child protection plan / risk register, then it is the GPs responsibility to contact the previous surgery to get any detailed information. The practice registration system for children will include obtaining details of parental responsibility, school and past support from other agencies and obtaining as much information as possible about the child’s health and social history. Health visitors and social care may know of Child Protection Plans before practices receive records. If you suspect child protection problems but have insufficient information try to discover the previous practice and contact them, your health visitor or social care department.

***Leaving*:** A clear entry should already be present in the main part of individual records confirming that there is a current Child Protection Plan with contact details of the social care department issuing the minutes so that the new practice can request information if needed at any point.

The complete electronic record (including scanned minutes) minutes should be send to the Patient Services Unit or equivalent agency as usual. It would be helpful to send the records of all family members coded with a Child Protection Plan. Any written records should be sent with all attachments opened and printed out. The pink papers, which are kept separately, should also be sent to the receiving practice. It should be sent in a sealed envelope marked urgent and confidential for attention of the new GP. If the new GP practice should make contact for information relating to the family or the Plan, this must be shared as appropriate.

**Disposal of case conference minutes**

Once they have been scanned into the GP record they should remain on record following the retention schedule in Records Management: NHS code of practice. Part 2 (i.e. 30 years after the last entry in the record) 5. The same documents give a specific minimum retention period for holding records relating to child protection plans/registers (until the child is 26). The principles of the NHS code of practice apply to the Department of Health, Good practice guidance to GP electronic records. As the information may have relevance reaching into adulthood, best practice would be to scan and retain the minutes in the GP record. Social care have an obligation to keep child protection papers for 75 years so if case conference information is not on the GP record and is required, contact the relevant department

The principles of this guidance may apply to storage of other multi-agency information.

N.B. The time limit for starting a medical negligence claim for an injured child is three years after the injured child turns 18. For medical negligence claims involving adults, the time limit is three years from the date of injury, or three years from the date an individual becomes aware of the negligence or injury.

**CHILD PROTECTION: SOURCES OF ADVICE & SUPPORT**

# PRACTICE cONTACT INFORMATION

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| --- | --- |
| Practice Clinical Safeguarding Children Lead | Dr Ford |
| Practice Clinical Safeguarding Children Deputy Lead | Dr Nixon / C. Tilley |

SAFEGUARDING USEFUL CONTACTS ACROSS DORSET, BOURNEMOUTH AND POOLE (OCT 2016)

**Children Safeguarding**

**Social Care Local Offices**

**For referrals, discussing a possible referral, follow up on cases, source of information** about children and families

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| --- |
| Bournemouth Children First : 01202 458101  MASH@bournemouth.gov.uk |
| Poole Hub: 01202 735046  MASH@poole.gov.uk |
| Dorset: 01202 228866  MASH@dorset.gov.uk |
| OOH: 01202657279 |
| Dorset Police: 999 (if emergency)  01202/01305 222222  (non- emergency) |
|
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**Dorset HealthCare Trust**

**Safeguarding Advisory Team**

**For advice and support** (not referrals) Monday – Friday (9:00 – 17:00)

|  |  |
| --- | --- |
| **Tel: 01305 361469** [**safeguading.team@dhuft.nhs.uk**](mailto:safeguading.team@dhuft.nhs.uk) | |
| **Named Nurse. DHC**  Liz Balfe  [liz.balfe@dhuft.nhs.uk](mailto:liz.balfe@dhuft.nhs.uk) | **Named Doctor. DHC**  Dr Judith Barnsley |

**Safeguarding Children Designated Team Dorset CCG**

Source of support/escalation/education.

Monday – Friday (9:00 – 17:00)

|  |  |  |
| --- | --- | --- |
| Designated Nurse | Wendy Thorogood | 01305 213563 / 07824835669  [Wendy.thorogood@dorsetccg.nhs.uk](mailto:Wendy.thorogood@dorsetccg.nhs.uk) |
| Deputy Desig. Nurse | Helen Duncan-Jordan | 01305 213646 / 07795882133  [Helen.duncanjordan@dorsetccg.nhs.uk](mailto:Helen.duncanjordan@dorsetccg.nhs.uk) |
| Children Safeguarding Lead GP |  |  |
| Dr Isi Sosa | 01305 213644 / 07831774906  [Isi.Sosa@dorsetccg.nhs.uk](mailto:Isi.Sosa@dorsetccg.nhs.uk) |
| Dr Sam Abdollahian | 01305 213644/ [Sam.Abdollahian@Dorsetccg.nhs.uk](mailto:Sam.Abdollahian@Dorsetccg.nhs.uk) |
| Designated Doctor | Dr Wendy D’arrigo | 01305 253331 |
| LAC Nurse | Penny Earney | 01305213626/ 07867467783  [penny.earney@dorsetccg.nhs.uk](mailto:penny.earney@dorsetccg.nhs.uk) |

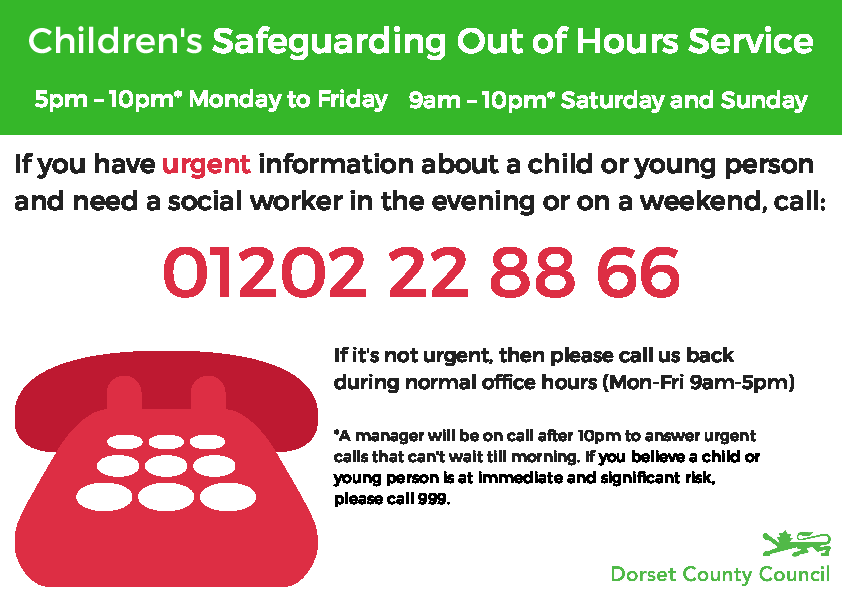
**CHILDREN - Safeguarding in Acute Sector and NHS Trusts**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Poole Hospital | Royal Bournemouth Hospital | Dorset County Hospital |
| Named Doctor | Dr Kelsall  01202 448312 | Dr Karim Hassan  01202 704171 | Dr Phillip Ward D’Arrigo  01305254748 |
| Named Nurse | Lynne Lourence  01202 448275 | Pippa Knight  01202 704235 | Allison Ryder  01305 254748 |
| Named Midwife | Pauline Hawkes  01202 448577  Specialist Midwife  Jacqueline Oxborrow  01202 448459  07760131416 | Carmen Cross  01202 704235  Specialist Midwife  Julie Davis  01202 704685  07909966439 | Jo Hartley  01305 254207  Specialist Midwife  Jerry Graham  01305 254748 |

**CHILDREN - Early Help Arrangements/Early Intervention**

When the case does not meet social services threshold but support is still needed

|  |  |
| --- | --- |
| Bournemouth: 01202456256 (Children First) | West Dorset: 01305224026 |
| Poole: 01202261999 (Children and Young People Integrated Service) | North Dorset: 01305224310 |
| Christchurch: 01202225724 | Weymouth/Portland: 01305225750 |
| East Dorset: 01202225710 | Purbeck: 01305225729 |

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