Email to all Practices and GPs

As I am sure you are all aware child protection, which is now often referred to as safeguarding children, is a very important issue for practices and GPs.

The BMA has recently produced a very useful document called "Child protection - a toolkit for doctors". The document is 60 pages and is well worth reading.

The LMC has produced a 5 page summary of this document, which is attached to this email.

The LMC believes that each practice should have a nominated child protection lead and that all GPs should take part in regular training. This should occur at least every 3 years. It is also important that this training is disseminated to all staff who are involved in patient care.

You may wish to consider using this document to have a meeting within your practice to discuss the identification of non accidental injuries and also what action you would take if such and event occurred.

The meeting should be recorded and reflected upon and then can be used as part of you CPD for revalidation.

(See attached file: BP6, Child Protection Toolkit, July 09.ced.jb.doc)

Best wishes

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Child Protection Guidance

Briefing Paper BP06/2009

This document is based upon the comprehensive BMA guidance:

**Child Protection – a tool kit for doctors**


**Child abuse may consist of:**

- Physical abuse
- Emotional abuse
- Sexual abuse
- Neglect

**Primary Care Responsibilities:**

- The doctor must be familiar with relevant local child protection procedures and must know how to deal promptly and professionally with any concerns.
- A doctor’s primary responsibility is always to the child or children, which overrides the interests of parents or carers and normal data protection issues.
- If concerns are raised the doctor must ensure follow-on care.
- Clear, accurate, comprehensive and contemporaneous notes are essential, must include a future care plan and must identify who has lead responsibility.
  - concerns about a child’s welfare should always be recorded whether or not further action is taken
  - any discussions about a child’s welfare should be recorded
  - at the close of a discussion a clear and explicit recorded agreement should be reached about who will be taking what action, if any.
- All doctors must:
  - understand risk factors and recognise children who may need support and/or safeguarding, including unborn children who may be at future risk
  - recognise the needs of parents and know how to seek help and support for children at risk, especially if domestic violence or substance misuse is involved
  - liaise closely with other agencies and contribute to enquiries from other professionals about children and their family or carers
  - assess the needs of children and the capacity of parents/carers to meet those needs.
  - contribute to child protection conferences, family group conferences, strategy discussions and serious case reviews and their implementation
help ensure that abused children and parents under stress, for example with mental health problems, have access to support services

play an active part, through the child protection plan, in safeguarding children from significant harm

provide ongoing support to children, families and expectant parents.

- When making a child protection decision:
  - Children and young people should be involved in decisions which closely affect them.
  - The involvement and support of those with parental responsibility for, or regular care of, a child should be encouraged, provided it is judged to be in the best interests of the child or children, and provided an older child with mental capacity agrees to this approach.
  - The family should not be involved in discussions relating to these concerns if it would potentially increase the risk to the child.
  - It may be necessary to proceed without the consent of parents, carers, or, exceptionally, the children concerned. Both the law and the GMC permit the disclosure of information if it is necessary to protect a child against a risk of significant harm, since the public interest in protecting children overrides the public interest in maintaining confidentiality.
  - Good communication is essential and children should be assured that confidential information will only be revealed if it is absolutely necessary and in their best interests.
  - Doctors should avoid making promises of confidentiality that they cannot keep. If there is a risk of significant harm to the child, siblings or to others, doctors have a duty to take action, including, where necessary, the disclosure of relevant confidential information.
  - Distress should be minimised and adequate time taken to protect the child and to increase the chance of gaining accurate and complete information.
  - Leading or suggestive communication with children or other members of the family should be avoided.

- If serious risk of immediate harm is suspected the doctor must act immediately to protect the child by contacting one of following statutory bodies with responsibilities for child protection:
  - police
  - local authority social services

- The doctor should always make a full report of concerns and the precise action taken, which should be governed by the procedures set out by the LSCB.

- A doctor must never delay emergency action required to protect a child from harm or ignore early warning signs:
  - Decisions may have to be based on fragmentary and ambiguous evidence.
  - Discussion with colleagues and the advice of trained professionals, for example named child protection doctors and nurses, should be sought.
  - Corroboration from other sources may be helpful. Consultations, home visits, as well as information from health visitors, midwives and practice nurses can all help to build up a picture of a child in difficulty.

- It may be in the best interests of the child to undergo an examination for which consent is normally required. This may be permissible without explicit consent if there is a clear justification based
upon an informed judgement of the child’s best interests. This should be recorded in the child’s medical notes.

- Practices should have written protocols that identify roles and responsibilities for their entire team, including receptionists, and set out best practice in relation to child protection and the management of confidential information.

- All members of the primary health care team should know how to act on concerns, especially if a child is considered to be at risk of significant harm.

- All members of the primary health care team should be familiar with local procedures and the names and contact details of colleagues with experience in child protection, such as the named and designated professionals within their Trust. Effective support and protection for vulnerable children can only be provided by an interdisciplinary team of health and social care professionals where good liaison and communication exists.

  - GPs are well placed to recognise when a parent or other adult carer has problems which may affect their ability to look after a child.
  - Doctors should collaborate closely with all members of the primary care team to secure the safety and wellbeing of children.
  - Health visitors have an important role in the protection of vulnerable children and support of families.
  - There should be structured liaison between health visitors and GPs in order to identify and support children who may be at risk.
  - Midwives are also well placed to identify any problems during pregnancy, birth and the child’s early care.
  - An increasingly multi-professional approach to child protection means that teachers, school nurses and nursery nurses may provide important information about children who may be vulnerable or at risk.

- Doctors have a key role to play in child protection case conferences and the BMA considers it important that, as far as possible, doctors should attend them in person, in addition to sending a written report containing relevant information such as immunisations, A&E and out-of-hours attendance and non-attended appointments.

**Children have the right:**

- to be protected from physical or emotional harm or neglect
- to child-centred health care
- to be looked after appropriately, without discrimination of any kind
- to be encouraged in every possible way to develop their full potential
- to take opportunities to be involved, from the beginning, and to choose not to be involved in decision-making
- to receive clear information about matters closely affecting themselves and about the right to decline detailed information at a particular time
- to have opportunities to express opinions without pressure or criticism
- to ask someone else to decide a particular issue to receive an explanation of the reasons when their preference cannot be met
- to confidentiality – subject to certain constraints
• to redress – where appropriate – through a fast, accessible complaints procedure.

**Symptoms of physical child abuse may include:**

• broken bones that are unusual and unexplained
• bruise marks shaped like hands, fingers, or objects (such as a belt)
• bruises in areas where normal childhood activities would not usually result in bruising
• burn (scalding) marks, seen when a child is placed in hot water as a punishment – particularly ‘glove’ or ‘sock’ burn patterns
• burns from an electric stove, radiator, heater or other hot objects, usually seen on the child’s hands, arms or buttocks
• cigarette burns on any part of the body
• black eyes in an infant or a similar injury that does not have an appropriate explanation
• human bite marks
• lash marks
• choke marks around neck
• circular marks around wrists or ankles (indicating twisting or tying up)
• separated sutures
• bulging fontanelle
• evidence of unexplained abdominal injury (such as bruised or ruptured intestines due to punching)
• unexplained unconsciousness in infant.

**Typical injuries in abused children include:**

• bleeding in the back of the eye, seen with shaken baby syndrome or a direct blow to the head
• internal damage, such as bleeding or rupture of an organ from blunt trauma
• any fracture in an infant too young to walk or crawl
• evidence of fractures at the tip of long bones or spiral-type fractures that result from twisting
• fractured ribs, especially in the back
• evidence of skull fracture (multiple fractures of different ages may be present)
• subdural hematoma without plausible explanation
• multiple bruises that occurred at different times – especially in unusual areas of the body or in patterns that suggest choking, twisting, or severe beating with objects or hands
• other unusual skin damage, including burns or burn scars.

**Emotional indicators of potential abuse or neglect can include:**

• a baby or child who cries constantly
• a baby or child who fails to thrive normally without clinical explanation
• a child who is often bruised or injured
• a child who is often very withdrawn
• a child who is often very dirty or smelly
• a child who is often hungry, or under or overdressed for the time of year
• a child who is often left at home alone
• a child who is left in unsafe situations, or without medical attention when they need it
• a child who is constantly ’put down’, insulted, sworn at or humiliated
• a child who seems very afraid of particular adults, and reluctant to be alone with them
• a child who has unexplained changeable emotions, such as depression, anxiety or severe aggression
• a child who shows sexual knowledge or behaviour that is inappropriate for their age
• a child who is growing up in a home where there is domestic violence
• a child who is living with parents or carers who are involved in serious drug or alcohol abuse.

Adapted by Dr Christine Dewbury
(July 2009)