

# Guidance for **Safeguarding Children in General Dental, Optical and Pharmaceutical Practice**





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<p><b>Purpose and Summary of Document:</b></p> <p>The purpose of this guidance is to clarify the roles and responsibilities of general Dental Practitioners, Optical Practitioners and Pharmaceutical Practitioners and their teams, in promoting the safety and wellbeing of children and young people.</p> <p>This guidance informs practitioners about the referral pathways for children and young people where there is a concern, in order for them to understand protocols and procedure requirements in Cambridgeshire and Peterborough. Essential contact details and guidance of training requirements are also provided.</p>			



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# 1 INTRODUCTION

This resource pack provides a quick point of reference to:

- help you make decisions about what to do when you have a concern about a child;
- give you the information to review the safeguarding arrangements within your practice, identify gaps and take action to improve where necessary;
- signpost you to sources of local information, help and support;
- inform you of your training requirements and how to access local training.

## 1.1 What is Safeguarding?

The term Safeguarding is broader than "child protection" and relates to the action taken to promote the welfare of children and protect them from harm.

In England, Safeguarding and promoting the welfare of children and Young people is defined in both The Children's Act (2004) and Working Together to Safeguard Children (2018) as:

- protecting children from maltreatment;
- preventing impairment of children's health or disability;
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care;
- taking action to enable all children to have the best outcomes.

Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

Various other statutory duties apply to other specific organisations working with children and families.

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/722305/Working\\_Together\\_to\\_Safeguard\\_Children\\_-\\_Guide.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/722305/Working_Together_to_Safeguard_Children_-_Guide.pdf)

## 2 STANDARDS AND GUIDANCE

The General Dental Council, General Optical Council and General Pharmaceutical Council provide procedures and guidance around raising concerns about the possible abuse or neglect of all patients. There are clear guidelines and standards on the links below:

### 2.1 General Dental Council

“You must raise any concerns you may have about the possible abuse or neglect of children or vulnerable adults. You must know who to contact for further advice and how to refer concerns to an appropriate authority such as your local social services department.”

(Standards 8.5 Standards and Guidance for Dental Professionals GDC)  
<https://standards.gdc-uk.org>

### 2.2 General Optical Council

“The profession has an overriding duty to safeguard children and vulnerable adults together with other health and social care practitioners and providers”

(Practice Protocol and Guidance on Safeguarding, Optical Confederation, June 2017)  
<http://www.opticalconfederation.org.uk/downloads/oc-safeguarding-guidance---updated--june-2017.pdf>

### 2.3 General Pharmaceutical Council

“to take action to safeguard people, particularly children and vulnerable adults”

(Standard 2 Pharmacy professionals must work in partnership with others. Standards for Pharmacy Professionals May 2017)  
[www.pharmacyregulation.org/sites/default/files/standards\\_for\\_pharmacy\\_professionals\\_may\\_2017](http://www.pharmacyregulation.org/sites/default/files/standards_for_pharmacy_professionals_may_2017)



### 3 PROFESSIONAL BODY GUIDANCE

Below are links to practice guidance from the specialist organisations:

#### 3.1 Child protection and the Dental Team

<https://www.bda.org/childprotection>

This is an educational resource for all members of the dental team. It gives an introduction to safeguarding children in dental practice.

It can be used as:

- a training resource;
- a fast response tool;
- a clinical governance resource.

#### 3.2 Optical Confederation-Guidance on Safeguarding Children and Adults

<http://www.opticalconfederation.org.uk/resources/guidance>

This guidance provides a five step guide for all optical staff and practices to safeguard children and to comply with all relevant legislation and was produced in line with the intercollegiate document.

#### 3.3 Safeguarding children: a guide for the pharmacy team

<https://www.cppe.ac.uk/learningdocuments/pdfs/safeguardingchildren.pdf>

This booklet provides an overview of the background and policy surrounding the safeguarding children and identifies resources and procedures available to support all pharmacy staff. It is in the form of an open learning programme.

For local policies and procedures on the following subjects the link will take you to the Cambridgeshire and Peterborough Safeguarding Board Website.

#### 3.4 Local Information Links

For local policies and procedures on the following subjects the link will take you to the Cambridgeshire and Peterborough Safeguarding Board Website:

- **Domestic abuse:**  
<http://www.safeguardingpeterborough.org.uk/?s=domestic+abuse>
- **Female genital mutilation (FGM)**  
<http://www.safeguardingpeterborough.org.uk/children-board/professionals/fgm-2/>
- **Child Sexual Exploitation (CSE)**  
<http://www.safeguardingpeterborough.org.uk/children-board/professionals/fgm-2/>

## 4 WHEN TO MAKE A REFERRAL TO CHILDRENS SOCIAL CARE (CSC)

If a member of your team has a concern regarding a child or young person, they must follow their agency's policy, including communicating those concerns to the Safeguarding Lead or professional.

If that is not possible you can contact Peterborough CSC or Cambridgeshire CSC for advice.

The family should be aware you are seeking advice UNLESS informing them places the child or children at further risk of harm. If parents haven't given consent best practice would be they have been informed but you can provide evidence that the child will be at increased risk so that CSC are able to respond effectively.

Please use following link to the Joint referral form for Cambridgeshire and Peterborough CSC: <http://www.safeguardingpeterborough.org.uk/wp-content/uploads/2017/04/Joint-Referral-Form-updated-032018.docx>

### 4.1 Early Intervention

Early Intervention means being aware of a vulnerable child or young person as early as possible to be able to work on their needs before having to refer to CSC.

Early intervention covers education (school nurse), health (health visitor, GP) and police.

“may involve HV and YOS working together to get to root of the families issues enabling them to put together the best support for them”

Early intervention is about working with children and families to provide and monitor effective support.

Sharing of information is vital with other professionals to allow this to happen

### 4.2 Making a Referral to CSC

When information is received, by way of a referral, which indicates that you have concerns about the safety and well-being of a child, Children's Services have 24 hours to decide what type of response is required. In making this decision, the social worker will have to determine whether:

- the child(ren) require immediate protection and thus urgent and immediate action is required;
- the child(ren) is/are in need;
- there are reasonable grounds to suspect that the child(ren) is/are suffering, or is/are likely to suffer, significant harm and whether further enquiries need to be made;
- any services which the child(ren) and/or family require and what they are;
- whether any further specialist assessments are needed to help Children's Services determine what further action to take;
- whether any action needs to be taken; and

- if there is no further action they can take, whether to refer the matter to a more appropriate agency (see Early Help).

### Information you will need:

- Details of the child and young person that you hold in the practice:
  - Name;
  - DOB;
  - Address;
  - contact telephone number;
  - Parents/carers details (if you have them).

The most important information CSC require is the exact nature of your concern (see examples below):

- If they do not attend an appointment is there a poor outcome on their health?
- Are there health implications from not following treatment?
- Why are you particularly worried about this child as a Health Professional?

### 4.3 Local Contact details

- Cambridgeshire Children's Social Care: 0345 045 5203
- Peterborough Children's Social Care: 01733 864170/180
- Out of hours/weekends (for both): 01733 234724
- Local Safeguarding Boards (LSCBs):
  - Cambridgeshire: 01480 373522 [www.cambslscb.org.uk](http://www.cambslscb.org.uk)
  - Peterborough: 01733 863744 [www.peterboroughlscb.org.uk](http://www.peterboroughlscb.org.uk)

### 4.4 Consent

**Remember** to use the support and advice of the safeguarding leads within your organisation if you are struggling with the issue of consent from the family prior to making a referral.

Where there is a clear likelihood of a child suffering Significant Harm, practitioners will be justified in sharing some confidential information in order to make decisions on sharing further information or taking action – the information shared should be proportionate.

Circumstances in which sharing confidential information in making a referral without consent will **normally** be justified in the public interest:

- when there **is** evidence that the child is suffering or is likely to suffer 'significant harm'; or
- there is reasonable cause to believe that a child may be suffering or is likely to suffer 'significant harm'; or
- to prevent 'significant harm' arising to children and young people or serious harm to adults, including through the prevention, detection and prosecution of serious crime.

**When consent should be sought:**

In all other cases, making a referral should be considered as accessing help and support for children and families. Help and support from services will be most effective if practitioner and services work in partnership with families to secure the best outcomes for their children.

**Are you worried about the outcome for you?**

It may be appropriate to agree anonymity where:

- The referrer is a member of the public;
- There is evidence of intimidation or threats of violence towards the professional involved.

## 5 ROLES AND RESPONSIBILITIES

Health Professionals are not responsible for investigating child abuse and neglect but they do have a responsibility for **sharing information and acting on concerns**. **All Health Professionals have a statutory duty of care:**

### 5.1 Duty of Care

The "duty of care" refers to the obligations placed on people to act towards others in a certain way, in accordance with certain standards. The term is sometimes used to cover both **legal** and **professional** duties that health care practitioners may have towards others, but there are distinctions between the two.

Generally, the law imposes a duty of care on a health care practitioner in situations where it is "reasonably foreseeable" that the practitioner might cause harm to patients through their actions or omissions. This is the case regardless of whether that practitioner is a nurse, midwife, health care assistant or assistant practitioner. It exists when the practitioner has assumed some sort of responsibility for the patient's care. This can be basic personal care or a complex procedure.

### 5.2 Role of the Safeguarding Practice Lead (SPL)

It is recommended that all practices should have a named Safeguarding Practice Lead (SPL) who should be a Clinician. Their role is:

- to act as a first point of contact for colleagues with safeguarding concerns;
- to act as a local champion for children and safeguarding best practice;
- to alert the Primary Care Safeguarding team of any barriers to effective working;
- to disseminate relevant up to date information to the practice;
- signpost colleagues to sources of advice;
- be aware of the training needs for their practice.

You do not need to have lots of experience in Safeguarding, just an active interest and willingness to move the practice forward.

## 6 SAFER RECRUITMENT

Cambridge and Peterborough Safeguarding board have published guidance around safe recruitment.

[http://cambridgeshirescb.proceduresonline.com/chapters/p\\_safer\\_recru.html](http://cambridgeshirescb.proceduresonline.com/chapters/p_safer_recru.html)

It is important that all organisations which employ people to work with children and young people adopt procedures to help deter, reject or identify people that may abuse the vulnerable. There must be the creation and maintenance of a safe working culture within your organisation.

The LSCB and CQC guidance recommends that safer employment extend beyond criminal record checks and what that should be:

- making a clear statement in adverts and job descriptions regarding commitment to safeguarding;
- seeking proof of identity and qualifications;
- providing two references, one of which should be the most recent employer;
- evidence of the person's right to work in the UK.

<https://www.gov.uk/government/organisations/disclosure-and-barring-service>

### 6.1 Dealing with an allegation

If a serious allegation is made against a member of practice staff and it relates to conduct towards a child, you must inform the Local Area Designated Officer (LADO) who is employed by the Local Authority.

You should inform the LADO if a staff member has:

- behaved in a way that has harmed, or may have harmed, a child, or;
- possibly committed a criminal offence against or related to a child, or;
- behaved towards a child/children in a way that indicates unsuitability to work with children.

The LADO assumes oversight of the investigation process from beginning to end and will give you advice. They will also liaise with the police and social care if necessary.

- Peterborough LADO      01733 864038
- Cambridgeshire LADO    01223 727967

### 6.2 Whistle Blowing

It is important to build a culture that allows practice staff to feel comfortable about sharing information, in confidence and with a lead person, regarding a concern about quality of care or behavior of a colleague.

<https://www.gov.uk/whistleblowing>

## 7 SAFEGUARDING TRAINING

It is the responsibility of each organisation to ensure that those staff whose work brings them into contact with children, should undertake introductory safeguarding training as set out in “Safeguarding Children and Young people: roles and competences for health care staff. Intercollegiate Document Third Edition (2014)”.

Whilst face to face training is advocated, it is recognized that this is not always possible. Where e-learning is undertaken it is important that it is not used in isolation, but is part of an individual’s personal development plan. It is recommended that the Safeguarding Lead ensures an up-to-date record of all staff training on safeguarding is held at the practice.

The identification of training needs is not a single event, but is a dynamic, ongoing process identified through appraisals, clinical supervision and course evaluations.

### 7.1 Safeguarding Children Level 1

#### **All Staff working in Health care settings.**

This training is mandatory for **ALL** staff

Competences:

- Recognise potential indicators of child maltreatment including: fabricated and induced illness, child trafficking and Female Genital Mutilation.
- Understand potential impact of parents/carers physical and mental health on the well-being and development of the child including Domestic Abuse, internet and online social networking.
- Understand the importance of children’s rights in the safeguarding / child protection context.
- Take appropriate action if they have concerns including appropriate reporting of concerns and seeking advice.
- further training needs will then be dependent on the individual’s roles and responsibilities.

### 7.2 Safeguarding Children Level 2

**All** non-clinical and clinical staff who have any contact with children, young people and/or parents/carers.

Competences:

- As outlined for Level 1.
- Uses professional and clinical knowledge, and understanding of what constitutes child maltreatment, to identify any signs of child abuse or neglect.
- Able to identify and refer a child suspected of being a victim of trafficking or sexual exploitation; at risk of FGM or having been a victim of FGM; at risk of exploitation by radicalisers:
  - Acts as an effective advocate for the child or young person;
  - Recognises the potential impact of a parent’s/carer’s physical and mental health on the wellbeing of a child or young person, including possible speech, language and communication needs;

- Clear about own and colleagues' roles, responsibilities, and professional boundaries, including professional abuse and raising concerns about conduct of colleagues.
- As appropriate to role, able to refer to social care if a safeguarding/child protection concern is identified (aware of how to refer even if role does not encompass referrals).
- Documents safeguarding/child protection concerns in order to be able to inform the relevant staff and agencies as necessary, maintains appropriate record keeping, and differentiates between fact and opinion.
- Shares appropriate and relevant information with other teams.
- Acts in accordance with key statutory and non-statutory guidance and legislation including the UN Convention on the Rights of the Child and Human Rights Act.

Cambridgeshire and Peterborough Children and Adult Safeguarding Board provides training locally, see link below for brochure:

- [Peterborough LCSB / Professionals / Training](#)



## 8 CONFIDENTIALITY AND INFORMATION SHARING

“Without the trust that confidentiality brings, children and young people might not seek medical care and advice or they might not tell you all the facts to provide good care”

(General Medical Council: The Information Governance Review March Section 10.1 Children and families March 2013)

Professionals in Health and Social care know that it is not only the confidentiality of children and young people that needs to be protected, but also their safety.

It is important to keep a balance between the need to maintain confidentiality and the need to share information to protect others.

For more information, check your organisations policies and procedures (page 6)

Link below sets out guidance and principles together with a flow chart:

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/721581/Information\\_sharing\\_advice\\_practitioners\\_safeguarding\\_services.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721581/Information_sharing_advice_practitioners_safeguarding_services.pdf)

### 8.1 General Data Protection Regulation (GDPR)

GDPR is designed to give individuals better control over their personal data.

Keeping detailed and comprehensive records is fundamental to good safeguarding practice. Safeguarding is about protecting vulnerable people from harm, by putting their safety and well-being at the heart of decision-making.

Guidance makes it clear that the individual's right to be forgotten is not absolute and there will be circumstances where a request to erase data can be refused, in the case of Safeguarding Children, as this could be a particular issue for those children that have been in care

<https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/applications/children/>

## 9 RECORD KEEPING

All professionals are likely to observe and identify injuries to the head, eyes, ears, neck, face, mouth and teeth as well as other welfare concerns. Bruising, burns, bite marks and eye injuries are the types of injury that could suggest a concern should be raised. Dental health staff are also well placed to identify the risks to oral and general health that are associated with inadequate oral hygiene, both in the short and long term.

Accurate record keeping is an essential part of the accountability for Safeguarding. It is an extremely important element to ensure effective inter-agency working. Documentation within all practices should accurately reflect not only the care provided but also any concerns in respect of a child, young person.

All action taken should be fully documented in the records. Record all discussions, decisions, actions agreed and responsibilities for carrying out those actions. Ensure that a date and time of all entries are made. A record of who attends with the child, young person or adult should be made (for all consultations). Consultation discussions with other colleagues should also be carefully recorded. If there is a difference of opinion, a recorded discussion must take place between those holding the different views in order to justify any actions or inactions.

If you make a professional judgement and decide not to share your concern with the appropriate authority, you must be able to justify how you came to this decision. You should contact your professional association for advice.

## 10 ADVICE

All professionals have a responsibility to raise any concerns about the possible abuse or neglect of children, young people and vulnerable adults. The responsibility includes knowing who to contact for further advice and how to refer to an appropriate authority.

Safeguarding is dependent on professionals raising concerns and on sharing information appropriately. However, professionals are frequently uncertain as to whether their concerns reach a threshold for action.

Always check and follow the practice's policy and seek advice internally in the first instance. (See Appendix 5 for pathway).

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## REFERENCES

- Section 10 Children's Act (2004)
- Working Together to Safeguard Children (2015); A guide to inter-agency working to safeguard and promote the welfare of children (March 2015)
- Speak up for a healthy NHS; How to implement and review whistleblowing arrangements in your organisation Public concern at Work (PCAW) 2010  
<http://www.pcaw.org.uk/>
- Standard 8.5 Standards for the Dental Team General Dental Council (GDC) 2013
- Standard 2 Pharmacy professionals must work in partnership with others; Standards for Pharmacy Professionals General Pharmaceutical Council (GPC) May 2017
- Standard 11 Protect and safeguard patients, colleagues and others from harm; Standards of Practice for Optometrists and Dispensing Opticians General Optical Council (GOC) April 2016
- Guidance on Domestic Violence and Abuse; GOV.UK 2018
- Female Genital Mutilation (FGM): Help and Advice GOV.UK 2018
- Child Sexual Exploitation; definition and guide for practitioners; Department for Education (DfE) GOV.UK 2017
- Child Sexual Exploitation Joint Strategy 2015; Cambridgeshire and Peterborough Local Safeguarding Children's Boards 2016
- Disclosure and Barring Service (DBS) checks (formerly criminal record (CRB) and barring checks) Care Quality Commission (CQC) 2017
- Safeguarding children and young people: roles and competences for health care staff Intercollegiate document 3<sup>rd</sup> Edition: March 2014
- Information for Professionals: Making referrals to Children's Social Care Cambridgeshire and Peterborough Safeguarding children and Adults Boards 2017

## APPENDIX 1

Baby L was tragically murdered in 2007 by his father at the age of 5 weeks.

### Background

Whilst Baby L's mother was pregnant, she was seen by her GP and attended A&E on a number of occasions with minor injuries. This gave rise to suspicions that she was suffering domestic abuse. However, she consistently denied this on every occasion, providing credible explanations for how the injuries had occurred. As well as her injuries there were a number of other indicators that were suggestive of domestic abuse.

After Baby L was born, a social worker and health visitor undertook a joint visit the day before he died. The visit was due to concerns about the parenting of his sibling and suspicions that the mother was being subjected to domestic abuse, something she continued to deny. Baby L was examined and was considered to be making normal developmental progress with no visible injuries.

The next day, Baby L died of horrific injuries. He had multiple bruising to his body, fractured ribs, 'classic' head injuries from shaking and a split liver.

Baby L's mother described being subjected to the most horrific violence whilst in the relationship with the children's father. Medical staff noted a catalogue of injuries including scarring from knife wounds, damage to joints from constant beatings and permanent damage to fingers and her wrist. The injuries included burn marks from an iron and injuries to her throat where she was regularly held around the throat. She also had a temporary denture due to her front teeth being knocked out by the perpetrator.

Father of Baby L was sentenced to life imprisonment by the Crown Court for Baby L's murder and GBH of mother.

As a result of Baby L's death a Local Safeguarding Children Board Serious Case Review was undertaken looking at all agencies' involvement with the case.

### Lessons learnt

A number of key lessons came out of the review including the importance of information sharing and good record keeping.

During the investigation Baby L's mother disclosed that the only health care professional she had confided in about the domestic abuse was her dentist. This information was disclosed when she attended dental treatment for her denture after her teeth had been knocked out. The dentist did not share this information with any agency. She also disclosed further information at a later dental appointment when her head had been shaved by her partner and again the information was not shared.

Of note, the dentist in this case became a significant witness for the prosecution at Crown Court and gave evidence about the disclosures made during the consultation by Baby L's mother.

## APPENDIX 2

A parent enters the pharmacy with a child around 4 years old. She is one of your regular customers – always collecting prescriptions for various things, many times for the children. She seems very agitated, and is shouting and swearing at the child – nothing new to you, as this is what happens each time. This time she asks for some Phenergan. Having understood from her the reason for the purchase – the child has a cold and is struggling to sleep – you consult with the pharmacist and identify an appropriate medicine for the symptoms she has described to you. After she has left the pharmacy, one of your colleagues comments “Do you know that’s the 3rd time I’ve seen her in two weeks asking for the same thing – wonder why she needs more? That child didn’t look or sound like they had a cold.”

### **The Health Visitor/GP could be informed**

It’s one of the hottest and sunniest days of the year so far, and a mother wheels a pushchair in to the pharmacy. The child in the pushchair, who is just a toddler, is looking very red – sunburnt in fact.

### **The Health Visitor/GP could be informed**

Vickie is concerned about a young girl of 14 asking about going on the pill, she is always accompanied by a man.

She felt it didn’t look right between the 2 of them. She felt he must be older than her dad and the child looked scared.

She had bags under her eyes and looked really tired and exhausted. She also should be at school when she is attended the Pharmacy

Children are now sexually active under the age of 16 but there is something about this situation that feels all wrong to me....

### **Ring Children’s Social Care for advice.**

## APPENDIX 3

- The optometrist routinely referred the patient, via the GP, for further investigation on the cause of double vision on 16/05/15.
- The GP's surgery faxed the referral to the ophthalmology triaging system on 06/05/15 as a routine referral.
- The following month the child became subject to child protection plan.
- Following several appointments with the GP and Peterborough Hospital for weight loss and nausea, the patient was diagnosed with a posterior fossa tumour.
- Patient died on 03/08/15.

This young girl attended the optometrist for an eye test as she had been experiencing blurred vision with double vision. The eye test findings indicated a possible decompensation of congenital 4th cranial nerve palsy with an increase in short-sighted prescription. The Optometrist routinely referred the patient to the GP for further ophthalmological investigation for the double vision. The GP's surgery faxed the referral on 06.05.15. On 01/07/15, a CT scan showed a posterior fossa tumour and concern was raised whether faster ophthalmology referral timelines could have picked up the tumour earlier.

If the ophthalmologist was aware of the Child Protection plan would they have marked it as urgent due to her mother's inability to comply with treatment or seek advice at times?

The communication between primary care professionals could be improved.

The GP did not see the referral letter and followed the suggested timeline mentioned by the optometrist in the original referral. The optometrist was not aware of the child protection plan when they saw the patient.

### **Contributory factors**

Delay in the GP surgery forwarding the referral. The optometrist may have considered sending the referral as urgent rather than routine, even though there were no other neurological findings during the test to indicate that an urgent referral was indicated, as it related to a child presenting with acute symptoms of blurred vision with intermittent double vision. When the patient was seen at the Peterborough city hospital for continuing sickness, headaches and staggering gait but was discharged back to the GP's care for continuing treatment for gastro-oesophageal reflux which was diagnosed by the GP on 08/06/15, ongoing health issues were missed.

Signs of continued poor health were missed by several healthcare clinicians – in primary care setting as well as the secondary setting.

### **Lessons learned**

The optometrist has reflected on the incident with the support from his employer and has reviewed the College of Optometrists referral guidelines again. Please note that this is the only action that relates to the optometrist involvement.

The GP should review the optometry referral letters before deciding what timelines the onward referral should be – pick any signs or symptoms which may improve the patient's overall health.



Better communication within primary care as well as between secondary care and primary care.

### **Arrangements for Shared Learning**

A meeting with the optometrist and his employer has already taken place to ensure that learning from this incident is taken on board so that the chance of a similar incident occurring is significantly reduced.

## APPENDIX 4

### Key contacts

#### Cambridgeshire and Peterborough CCG-Safeguarding Team

##### **Dr Emelia Wawrzkowicz - Designated Doctor for Safeguarding Children**

- [emilia.wawrzkowicz@pbh-tr.nhs.uk](mailto:emilia.wawrzkowicz@pbh-tr.nhs.uk)
- 01733 673090/ 07739 795728

##### **Sarah Hamilton - Designated Nurse for Safeguarding Children**

- [sarah.hamilton5@nhs.net](mailto:sarah.hamilton5@nhs.net)
- 07932 643813

##### **Deborah Spencer - Designated Nurse for Looked After Children**

- [deborahspencer1@nhs.net](mailto:deborahspencer1@nhs.net)
- 07814 770140

##### **Julie May - Named Nurse for Children in Primary Care**

- [juliemay1@nhs.net](mailto:juliemay1@nhs.net)

##### **Zaneta Bushell - Safeguarding Administrator**

- [capccg.safeguardingchildren@nhs.net](mailto:capccg.safeguardingchildren@nhs.net)
- 01223 725448

#### Children's Social Care

- Cambridgeshire Children's Social Care ..... 0345 045 5203
- Peterborough Children's Social Care ..... 01733 864170/180
- Out of hours/weekends (for both)..... 01733 234724

#### Police

- Non-Emergency ..... 101
- Emergency ..... 999

#### Local Safeguarding Boards (LSCB's)

- Cambridgeshire ..... 01480 373522 [www.cambslscb.org.uk](http://www.cambslscb.org.uk)
- Peterborough ..... 01733 863744 [www.peterboroughlscb.org.uk](http://www.peterboroughlscb.org.uk)

NSPCC National Helpline.....0808 800 5000

Childline.....0800 1111

## APPENDIX 5



