

# SAFEGUARDING

## Facilitators Guide

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Duration **Up to 2 hours**

Facilitator level **Senior trainee and above**

Learner level **Junior trainee/Staff nurse and Senior trainee/ANP**

Equipment required **Internet access- to allow access to listed resources**

## OUTLINE (USE THE SECTIONS THAT ARE RELEVANT FOR YOUR LEARNERS)

- Basics (10 mins)
- Main session: (2 x 15 minute) case discussions covering the key points and evidence
- Advanced session: (2 x 20 minutes) case discussions covering grey areas, diagnostic dilemmas; advanced management and escalation
- Sim scenario (30-60 mins)
- Quiz (10 mins)
- Infographic sharing (5 mins): 5 take home learning points

We also recommend printing/sharing a copy of your local guideline and local Safeguarding processes.

### PRE-READING FOR LEARNERS

The Child Protection Companion. Last published December 2017.

Available on RCPCH website and Paediatric Care Online

#### **RCPCH: Child Protection Evidence**

(evidence based resources for clinicians to help inform child protection procedures)

#### **Child Protection Processes: PaediatricFOAMed**

#### **DFTB: Skeletal Survey in NAI**

#### **St Emlyns: Child Protection**

<https://www.aliem.com/pem-pearls-child-abuse-case-1/>

Safeguarding children is everyone's responsibility. Abuse of children can come in many forms; physical, sexual and emotional abuse, and neglect.

Children can present in various ways- this teaching tool aims to discuss the terminology surrounding safeguarding, the investigations that are required and processes that occur when a child presents with suspected maltreatment.

Cruelty to children and young people is a criminal offence, and child abuse and neglect can have serious adverse health and social consequences for children and young people.

**These include:**

- effects on growth and physical development ([The impact of abuse and neglect on the health and mental health of children and young people](#) NSPCC)
- impaired language development and behaviour by age 4
- impaired ability to socialise, play and learn ([Developing an effective response to neglect and emotional harm to children](#) NSPCC)
- increased likelihood of being involved in antisocial behaviour ([Child abuse and neglect in the UK today](#) NSPCC)
- increased likelihood of suicidal thoughts and attempts during adolescence.

Bruising is the most common injury sustained by children who have been physically abused. Paediatricians must have the skills to differentiate abusive bruises from those that arise from everyday activity or unintentional injury

- Young children who are referred to the paediatric child protection team with suspected physical abuse (PA) frequently have bruises. It is unclear whether there is any difference between the pattern of bruises when PA is confirmed and when PA is excluded.
- Bruising is the commonest injury seen in physical abuse.
- The odds of a bruise on the buttocks or genitalia, cheeks, neck, trunk, head, front of thighs, upper arms were significantly greater in children with PA than in children with PA-excluded.
- Petechiae, linear or bruises with distinct pattern, bruises in clusters, additional injuries or a child known to social services for previous child abuse concerns were significantly more likely in PA.

**All professionals working with children have a duty to safeguard their wellbeing. So, if anybody identifies safeguarding concerns, they should raise it with their local Child Protection services.**

## **CASE 1 (15 MINS)**

**6-month-old child (Lisa) on a child protection plan presents to ED with coryzal symptoms and fever of 37.8 degrees. On examination it is felt that Lisa has a viral illness however after exposing her she is noted to have multiple bruises on their back of differing colors and sizes.**

**Lisa had been left with her grandmother and grandfather over the weekend as her mother had spent the weekend with her new partner.**

**Discussion points:**

**What is your next course of action?**

ABCDE assessment of Lisa

Two issues here are the viral illness but the concerning multiple bruises with differing colors and sizes. Assessment and examination to determine the viral symptoms and if further medical treatment is needed. Assessment of pain and suitable analgesia if required.

Detailed history with specific questions relating to safeguarding issues. (see below)

On examination you notice that Lisa is mildly coryzal. You note that the clothes Lisa is wearing seem inadequate. It's a cold day and Lisa has arrived solely in a baby grow. There is no respiratory distress and the child is cardiovascularly stable. Lisa is alert and active with normal power and tone and a level anterior fontanelle.

On exposing Lisa you notice multiple bruises. There are some bruises on her back, with further bruises behind Lisa's ears (they are round and look like finger-tip marks). These bruises concern you. You also notice the nappy is sodden and does not look like it has been changed in a while. The car seat Lisa has arrived in is really dirty with crumbs in it.

You think about the toddler you have just seen prior to reviewing Lisa who was a 3 year old boy that had fallen over with a minor head injury but you had noted multiple bruises on his shin and you now question if you should have been worried by these bruises.

## Why are the bruises on this child's back concerning? What bruising patterns are more concerning in children presenting to the ED?

Children, especially toddlers can often have accidents in the home or at school that can result in bruising. In the ED there are often bruises noted that are not worrying to us as clinicians based on the site of bruise and the child's developmental age. Bruising in children is common and often not a cause for concern. A polite inquisitive style including asking the child how they attained the injury can often give a plausible and valid reason for the injury.

Bruises are unusual in babies 6 months or less who are unable to move or crawl. When children become more mobile bruising becomes more common. These bruises are usually <1 cm in diameter, often over the forehead, bony part of the cheek or jaw, or shins. An active baby in the first 18 months might have two or perhaps three of this type of bruise at the same time.

In older children most accidental bruises are on bony prominences and are often associated with a graze. In children 18m to 3 years facial and forehead bruises are common, however in older children this is less common.

In older children bruises of the hands, feet, lower legs- in particular shins are common. Lower back bruises can be seen on older children but should be a cause for concern in children under the age of three.

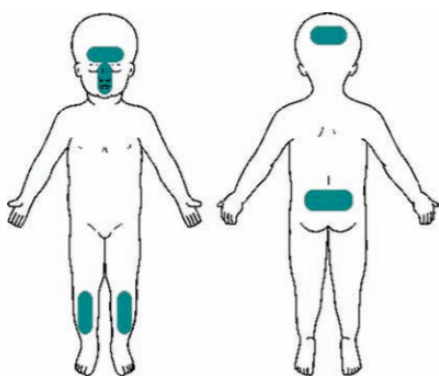


Figure 1 Accidental bruising patterns.

**Non-accidental bruises are more likely to be around the mouth and adjacent cheek, neck, eye-socket, ear, chest, abdomen, upper arms, buttocks and upper legs. All these areas are relatively protected.**

### Maguire S: Which injuries may indicate child abuse?

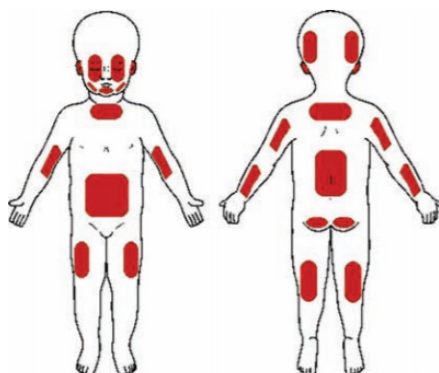


Figure 2 Abusive bruising patterns.

Concerning Bruising patterns  
( According to NICE guideline 89 Child maltreatment: when to expect child maltreatment <18's  
Suspect child maltreatment if a child or young person has bruising in the shape of a hand, ligature, stick, teeth mark, grip or implement.

Suspect child maltreatment if there is bruising or petechiae (tiny red or purple spots) that are not caused by a medical condition (for example, a causative coagulation disorder) and if the explanation for the bruising is unsuitable.

**Examples include:**

- bruising in a child who is not independently mobile
- multiple bruises or bruises in clusters
- bruises of a similar shape and size
- bruises on any non-bony part of the body or face including the eyes, ears and buttocks and back
- bruises on the neck that look like attempted strangulation
- bruises on the ankles and wrists that look like ligature marks or holding/restraint marks.

Now you have examined Lisa and are happy that the fever is only being caused by a coryzal illness. You prescribe some paracetamol and go on to take a more extensive history from her mother.

**What questions do you need to incorporate into a paediatric history when you are concerned about safeguarding issues?**

Do you need to extend the history- is there any explanation parents can give for the bruising? If there is a mechanism given does it fit the child's developmental age? Do you need to take a developmental history?

If there is a period of time as in this case when Lisa was left with grandparents, do you need to extend the history to asking other family members about the injury- including siblings who may be too scared of the consequences if they are to admit there was an accident with their brother/ sister? Can this be done over the phone or could you speak to them in person?

In **ALL** children presenting to the ED ( irrespective of their presenting complaint) it should be commonplace to ask about:

- the family set up
- what adults do the children spend time with
- who lives in the same household as the child?
- Who has parental responsibility?
- Do the family have a social worker?
- Or have they been previously known to social care?

## Important points to be elicited in the context of physical abuse include:

- 1**  
**What the injuries are and how they presented**
- 2**  
**Timing of injuries and preceding events**
- 3**  
**The explanations given for the injuries and who gave them**
- 4**  
**Any discrepancy evident in the account**
- 5**  
**Action taken by parents or carers after the injury was discovered**
- 6**  
**Previous injuries**
- 7**  
**Explanation consistent or not with the developmental level of the child.**

Lisa's mother had noticed some bruising after picking up Lisa from her grandparents yesterday. She was worried about it but did not come immediately to hospital. Lisa's mother is unsure if her parents may have done this to Lisa. She wants Lisa to be OK but is worried that Lisa will be taken from her.

## CASE 2 (15 MINS)

Mo is a 3 month old boy. He has presented to the ED due to family concerns that he is not moving his left leg. Parents are concerned that it looks a bit swollen. Mo is normally fit and well. He was born at term by NVD. He lives with his Mother, Father and extended family.

On examination: Mo has normal observations. He has a normal respiratory, cardiovascular, abdominal and neurological examination. On further examination you notice that Mo is reluctant to move his left leg - there looks to be some swelling over the femur. He cries when you examine it.

You ask more questions- establishing that Mo's Dad has been away for the last few days at work and Mo has predominantly been with his Mum. Mo has a social worker who was allocated as mum had disclosed depression and had not wanted to continue with the pregnancy but due to pressure from the extended family had continued with the pregnancy.

Mo is not yet mobile or rolling. There is no history to suggest how this might

have happened. You can't find any other evidence of injury on examination. You do notice on examination that Mo's pram has old food in it, his clothes appear dirty. When you are examining him you notice that his nappy is very full and he has some evidence of nappy rash.

### What can some of the more subtle signs be that can alert you to child protection issues?

It is important especially when working in a fast paced ED to recognise the more subtle signs of neglect might highlight a cause for concern and a discussion with a Senior colleague.

#### Some of these signs may be

- 1 Child looking unkempt- soiled clothes, pram, dirty fingernails
  - 2 Large full wet nappy (that looks like its been on for a while) the child may have nappy rash- that might suggest nappy has been on for long periods of time
  - 3 Child who is mobile who has been brought out without shoes- an adult wouldn't come out without shoes on- so why should we expect a child who is walking to do the same?
  - 4 Child not dressed appropriately e.g. in cold weather no coat
  - 5 Poor dental hygiene or dental caries- that would suggest lack of teeth brushing
- 

These signs alone may be the product of a stressed parent who is worried about their child and quickly wants to get to the Emergency Department (a parent rushing out without a coat, or before changing a child who has just spilled food all over themselves). However a few of these signs along with a parents behaviour, an unusual injury or a general feeling about the family- may be signs of neglect or even physical abuse. It is important to discuss this with a Senior colleague.



These signs should be documented in the notes and even if they are the only concerns you have a discussion with social care or with a Health visitor (after discussion with a Senior colleague) can be a good way of sharing information and highlighting the more subtle signs.

## **ALWAYS DISCUSS THE MORE SUBTLE SIGNS OF NEGLECT WITH A SENIOR COLLEAGUE**

You decide to give Mo some analgesia and request some X Rays.  
Xray of the left femur shows a mid shaft spiral fracture of the left femur.

### **How do you move forward now?**

The first step is to make sure that Mo has been given adequate analgesia. If required discuss with Trauma and Orthopaedics regarding management of the fracture.

This is a concerning injury- Mo is non mobile and no history for the injury has been given.

#### **In house actions**

- Discuss with a Senior colleague in your department - make sure that your Registrar/ Consultant has been informed and knows there are safeguarding concerns
- Discuss with your local in house safeguarding team (usually present during working hours). There should be a local safeguarding team available usually through your hospital switchboard or intranet. This team should be able to give you advice and tell you the local processes in your hospital/ local area.
- Have a read of the local guidelines for the hospital you are working in this may give you an idea of for example who this child should be admitted under if there are acute concerns in ED and the child is not able to be discharged.

You speak to your consultant in ED who points you in the direction of the hospital intranet page for safeguarding. You speak to the Lead Safeguarding nurse, Brian. He tells you that you need to discuss the matter with local Child Protection Services. Brian asks you to discuss the matter with both the General Paediatric team and the Trauma and Orthopaedic team once the initial process has been started by the local safeguarding team. Mo needs admission for management of the fracture along with a child protection examination and further investigations.

## Local Processes

- Some children who already have a known Social worker - the social worker can be contacted directly (usually if they present in hours). If they are not available or it is out of hours you may need to speak to the duty or on call Child Protection Services social worker
- How you refer to your local Children's Protection services differs internationally and from region to region. Please ensure you are familiar with the local policy in your area.
- All services will have a 24 hour accessible referral system, usually by phone in the first instance and then often followed by a written referral by secure email or via on-line web-portal

You wonder - What information should you be expected to provide when you make the referral to the Local Children's Protection services.

ED is really busy- there are lots of patients waiting to be seen- can somebody else complete this referral?

## IMPORTANT INFORMATION THAT IS REQUIRED TO MAKE A REFERRAL -

it's much easier if you know this before making the call!!!

1

Name, date of birth and address of the child, parents, siblings and any other household members

2

If the family lives between different households- e.g parents are separated- addresses of all places the child spends time

3

School/ Nursery/ GP name and address

4

Concerns that have led you to refer the child on this occasion

5

Have there been any previous concerns that you know about? Previously known to Social Care? Name and number of social worker/ family support worker?

6

Where the child is now and how can they contact you- This is really important if you are going off shift/ the child is moving to a different place from the ED for admission.

7

They may also like to know if there are any other children in the household who may at present be at risk.

**IT IS EVERYONE'S RESPONSIBILITY TO SAFEGUARD CHILDREN** - However the form can be completed by medical or nursing staff. Some trusts will insist that before a child is admitted to a ward this form should be completed ( you know the story so it may be that you are the best person to do this).

It needs to be clearly handed over to staff if the referral has not been done and why- along with any communication that has already taken place with Social Care.

After you have made the referral to Social Care they are able to tell you that Mo's known social worker is actually on duty. Mo's mother has been very low in mood and the social worker had been having regular contact as they had been concerned she was not coping. The social worker and a member of the police are en route to the hospital to talk to Mo's parents. There are no other children at home. You inform then Mo is being admitted to the Trauma and Orthopaedic (T and O) ward- under joint care with General Paediatrics team- who are preparing to perform a full child protection medical examination and further investigations.

**You wonder if Mo's Mum and Dad will agree to all of this and what will happen if they don't?**

The legislation on holding a child against their parent's wishes differs internationally.

In most countries the police force are the appropriate first responders to contact when you are concerned that a child may be at risk of harm if they are removed from a place of safety (eg hospital).

In general police powers to hold a child in a place of safety do not override the parent or guardian's rights to consent (or to refuse consent) to medical investigation / treatment and in most countries a court order is required to over-ride the parent/ guardian's wishes.

## ADVANCED DISCUSSION

This is an opportunity to cover grey areas, diagnostic dilemmas and advanced management and escalation if there are more experienced trainees or senior registrars in your group.

## ADVANCED CASE 1: (CHILD PROTECTION PROCESSES) 20 MINS

You have just seen Eric, a 7 year old boy who, with his siblings, have an allocated social worker. He presented with a two day history of fever and not drinking. On examination you believe he has findings consistent with bacterial tonsillitis. You want to discharge him on oral antibiotics. During your clerking Mum mentions that they have a Social worker who mum gives you the name and number of.

Mum has attended during schooltime with all of the children- you notice three of them should be in school. You need to inform the Social worker about the attendance to ED.

**How does a child come to be placed on a 'Child in need' or 'Child Protection plan'?**

### Child Protection Processes: The Lowdown (PaediatricFOAMed)

Each time a referral is made to the Local Child Safeguarding team the team receiving the referral will decide on one of 4 potential outcomes:

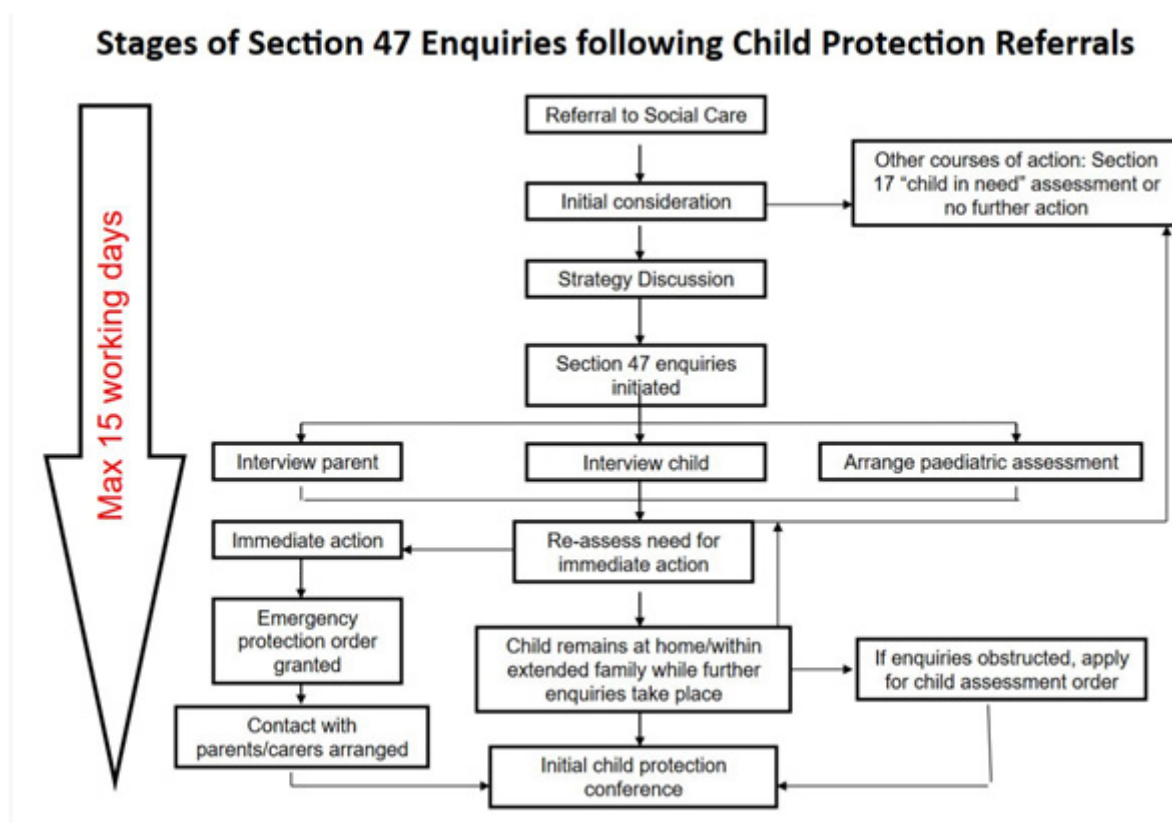
- 1**  
No further action is required
- 2**  
The case is suitable for Early Help (see Chapter 1 in 'Working Together to Safeguard Children')
- 3**  
An assessment of the family is carried out leading to the child becoming a Child in Need (CIN) under Section 17 of the Children Act 1989
- 4**  
The child has sustained or is at risk of significant harm and Child Protection proceedings must be started under Section 47 of the Children Act 1989

Once the referral has been made you should chase the outcome and if you don't agree challenge it.

Section 47: Local authority should coordinate an investigation where a child has been subject to or at risk of harm. The aim of the meeting is to decide if any action is required to safeguard the child.

If the threshold has been met for a Section 47 meeting- then a 'strategy' meeting should be arranged. Meeting between social care, police and medical team. A decision will be made if it should be a 'single' or 'joint agency' between social care and police.

The role of the Doctor in the strategy meeting is to consider the need for and timing of a medical examination.



### The Aim of the Child Protection Plan is to-

- 1** Ensure the child is safe and prevent them from suffering further harm
- 2** Promote the child's health, welfare and development (this is where we can contribute most to the discussion!)
- 3** Support the family to protect and promote the child's welfare, provided this is in the child's best interests.

The document should specify timescales and allocate professionals to lead on each point of the plan. Crucially, **a review conference should be held at regular intervals** – first review is at 3 months then at 6 monthly intervals. If all the points of the CP Plan have been achieved, and the child is no longer considered to be at risk of harm, the CP plan can be discontinued. However, if not, or if the child has been on a CP plan for approaching 2 years, **a legal planning meeting** is held to decide if care proceedings should be started. This may result in the child being taken into care, becoming **‘Looked After’**.

**You want to inform Social Care about the fact that Eric attended the ED and that his siblings were not in school- it is nearly midnight and you wonder how you can do this - as you are due to be on two weeks of annual leave after today?**

### **How can you do this?**

Children attend emergency departments at all times of the day. Often they may be a child who is known to Social care who you need to inform of their attendance but there is nothing that is acutely concerning about the presentation. Some hospitals will have automatic alerts that come up when you see a child who is on a child protection plan. Often the alert says ‘ please inform the social worker of every attendance’. This can be hard when you are seeing the child out of hours.

Check with your hospital what the system is- sometimes it is enough to document in the notes and there may be a fallback mechanism for a team to contact Social care within working hours.

There is always an option of calling the out of hours Local Children’s Protection Services to inform them of the attendance and any further information. You are unlikely to get through to the child’s own social worker however you can leave information in a secure way.

You leave a message with the Local Authority Children’s safeguarding team. Who are able to look at the case noted and inform you that the family’s social worker is due to go and visit the following day- so they will leave a note for her of the information you have given.

## ADVANCED CASE 2: 20 MINS

### What investigations form part of the assessment for Non accidental Injury?

Liah is an 8 year old girl who you had seen on your previous shift in ED- she had presented with multiple bruises. You were concerned at the time that she had ITP. You had seen her and sent bloods off before you left - however you handed her over to a colleague as her bloods were not back when you left.

You find out when you are back on shift that her results were normal. Liah was admitted under the General Paediatrics team. She is undergoing investigations for suspected Non accidental injury.

### What are the investigations that should be performed in a child with suspected Non accidental injury?

### What investigations need to be performed- when concerned about child protection?

(The Child Protection Manual: RCPCH)

## The Child Protection Manual: RCPCH

1-Full blood count

2-Coagulation studies  
(basic and extended)

3-Liver function tests

4-Amylase

5-Bone chemistry and vitamin D/  
parathyroid hormone

6-Urine and blood toxicology  
(if appropriate depending on history)

7-Skeletal survey with follow up films

8-Bone scan (done in certain  
situations)

9-Computed tomography (CT) head  
scan

10-Magnetic resonance imaging  
(MRI) brain and spinal cord

11-Ophthalmology examination

You hear from the Medical Team that Liah's parents initially refused these investigations along with an examination of Liah specifically to look for injuries (Child Protection Medical examination).

## How do you speak to parents who get upset or confrontational?

**1-** Do not be judgemental. You don't know what happened

**2-** Speak to the parents in a neutral tone, calmly and kindly

**3-** Use open body language

**4-** Explain that you would like to go through the history with them again even though you know they have already been through it with a number of doctors

**5-** Explain to the parents that the child is the most important thing for you, your role is to find out what has happened and so you are obliged to refer Local Children's Protection Services

**6-** Many parents will become upset and angry. That's why it's important to have another health professional with you. Many, on the other hand, will surprise you if you explain the situation well, by behaving very reasonably

**7-** Call security if you feel the situation may escalate or if you feel that you and other health professional staff are at risk of harm

**If the situation becomes too confrontational and the parents insist on taking the child out of the hospital, you cannot restrain them. Advise them that you will be calling the police**

## What happens if consent is not gained?

Communication is key in cases of suspected non accidental injury. Open and honest conversation with the family about the need for investigations to check for any underlying conditions that may have caused the bruising. Early open and honest conversation with the family regarding the need for involvement with Local Children's Protection Services care social team.

**Consent must be gained from parents before investigation or examination.**

You can get consent or authorization from:

**1**  
A child or young person who has the maturity and understanding to make the decision,

**2**  
A person with parental responsibility if the child or young person does not have the capacity to give consent (it is usually enough to have consent from one person with parental responsibility)

**3**  
The courts – for example, the family courts or the High Court.



## **When consent is not given**

If the child refuses- explore their ideas, concerns and expectations. If they understand and are competent then their decision must be respected- even if it means that forensic evidence is inadequate.

Sometimes a child or young person may refuse consent because they are afraid of the person who is abusing them, or because they are under pressure to refuse. If you suspect this, you should consider the risk of harm to the child or young person and discuss your concerns with your named or designated professional or lead clinician or, if they are not available, an experienced colleague.

If a child or young person refuses, or their parents refuse, to give their consent to a child protection examination that you believe is necessary, and you believe that the child or young person is at immediate risk of harm, you should contact the police and Local Children's Protection Services, which may take emergency action to protect them.

The medical team informed you that they did eventually get consent for the investigations along with the Child Protection Medical Examination.

### **What is the process for a Child Protection Medical Examination?**

#### **What tools can you use to help you document correctly?**

#### **(Paediatric FOAM Child protection documentation- where do we start?)**

This an extensive history and examination that focuses on history from both the child and parents.

Try not to use medical jargon- remember there are going to be non-medical professionals reading the report.

#### **The documentation is usually made up of-**

##### **1**

Medical proforma- most trusts will have their own version. It can act as a prompt to remind you of what questions to ask. Remember to use the child's own words as much as possible. Consent must be gained, and ideally written consent is best

## 2

Growth chart- good practice to document the height and weight especially if there are child protection concerns. For example, neglect may present as a child that is failing to thrive. (available on RCPCH website <https://www.rcpch.ac.uk/resources/growth-charts> )

## 3

Medical Photography- this is an extremely useful resource. Consent again must be gained. This is useful for example in a child with bruising which may change over time. Generally, this requires written consent and needs to be done via the hospital's medical illustration department. This isn't always available out of hours- in some hospitals A and E may have a camera that can be used for this purpose (not appropriate to use a phone camera!).

## 4

Body mapping- Essential way of documenting examination findings. Dr Gayle Hann (Consultant Paediatrician, North Middlesex Hospital) and Dr Caroline Fertleman (Consultant Paediatrician, Whittington Hospital) have recently published new, **more detailed body maps in different age groups** to help paediatrician's make better documentation. These can be found here:

<http://www.londonpaediatrics.co.uk/resources>

Body mapping can be overwhelming especially if there are lots of areas to draw. Have a colleague with you- draw it as you examine the child. It is useful to examine with a tape measure handy so you can measure the areas. Draw the injury as close to what you can see as possible use terminology like (graze, cut, scar, linear, colour). It makes it easier to number the marks- so it is easier to describe them in your written report- which always must accompany any body map.

Liah disclosed during the child protection examination that she had for the last few months been hit by her older brother. Social care are now involved and with support and her brother no longer being allowed to visit Liah was eventually discharged home with her mother and father.

## QUIZ QUESTIONS (10 MINS)

### Question 1.

Blood tests have been performed for Zain a 4 month old child who you have seen in ED He has unexplained bruising- your consultant asks you to request further investigations before the child goes to the ward- what are they?

**A**

No further investigations required if bloods are normal

**B**

Ophthalmology review, Xray or areas that are bruised, CT head

**C**

Ophthalmology review, CT/ MRI head

### Question 2.

What does a 'Section 47' mean?

**A**

This refers to children who have a Police protection order in place- police have the right to remove them to a place of safety for 72 hours- parents still have consent

**B**

Local authority should coordinate an investigation where a child has been subject to or at risk of harm. The aim of the meeting is to decide if any action is required to safeguard the child.

**C**

Child is under a child protection plan and should therefore be raised to the Local Authority Children's care social team

### Question 3.

**You are asked by your consultant to organize some photographs of a child who has presented with bruising- it is a Sunday and medical illustration is not open- what should you do?**

**A**

With consent from parent use the consultant's phone

**B**

Get the parent to take photos on their phone and then get them to send them to your secure work account

**C**

Try to get the designated camera from another area in the hospital (A&E) if this is not available then do not take the photos and organize for them to be done as soon as medical illustration is available.

## Finish - infographic of the take home tips (5 mins)

- 1 Always be clear when presenting your findings and your opinion.
- 2 Remember to seek senior (and peer) support. But think about challenging if you feel the Senior does not share the same opinion.
- 3 Child protection cases can be complex – don't lose focus on the child at the center of it all.
- 4 Always ask for Senior help if you are unsure or the opinion of the named Safeguarding lead at your hospital or Local Children's Protection Services social team

## REFERENCES

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