

**PAEDIATRIC (0-18 YEARS) ATTENDANCE AT ACUTE AND
 EMERGENCY CARE SERVICES: POLICY FOR FOLLOW UP BY THE
 PUBLIC HEALTH NURSING SERVICE**

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DOCUMENT CONTROL

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1. INTRODUCTION

- 1.1 Each year in the United Kingdom, non-fatal injury results in more than six million visits to emergency care services and approximately two million of these are children. Unintentional injury is a leading cause of death among children aged 1-14 years and puts more children in hospital than any other cause. It is a major concern for all those seeking to improve health and reduce inequalities.

Up to a half of infants less than twelve months in age, and a quarter of older children, will attend an emergency care service each year. Children under five years old carry a disproportionate burden of injuries from falls and fires. They suffer nearly 45 per cent of all severe burns and scalds. About 50 per cent of these happen in the kitchen and approximately 50 per cent of all injuries to the under-fives occur in the home. In any one year, one in eleven children will be referred to a hospital outpatient clinic and one child in fifteen will be admitted into hospital.

In order to provide seamless care to children and young people there needs to be effective pathways and information sharing between health professionals in acute hospital trusts and primary care services.

- 1.2 Following the Laming Inquiry into the death of Victoria Climbié (DH 2003), Laming (DH 2009) recommended that information relating to a child's attendance at Accident and Emergency Departments, discharge from hospital and follow up appointments should be shared with primary care and community services.

2. PURPOSE & SCOPE

- 2.1 To promote effective communication pathways and systems which co-ordinate children's care between hospital and community services.
- 2.2 To identify children and families who may require increased support or services.
- 2.3 To safeguard children and young people and promote their welfare.
- 2.4 To reduce preventable accidental injuries in children by providing relevant health information to parents and carers.
- 2.5 This policy applies to all staff who receive information regarding a child or young person's attendance at an acute or emergency health care setting but specifically relating to Health Visitor and School Nurse professional practice.
- 2.6 This policy also applies to Trust Minor Injury Unit staff who are required to share attendance information with Health Visitor and School Nurse staff and, in the case of school age children, are required to make a professional judgement in relation to which attendances are shared.

3. DUTIES AND RESPONSIBILITIES

- 3.1 **The Trust Board** has a duty to ensure that it fulfils its statutory responsibilities to safeguard and promote the welfare of children.
- 3.2 **The Designated Non-Executive Director** supports the Executive Lead and the safeguarding team in all aspects of the Safeguarding Children agenda, monitors activity and outcomes and provides additional assurance to the Board in this area.
- 3.3 **The Director of Nursing and Patient Safety** is the Executive Director Lead for Safeguarding with the Trust.
- 3.4 **The Named Nurse for Safeguarding Children** is responsible for reviewing this policy at least every two years in conjunction with both the Health Visitor and School Nurse Best Practice Groups.
- 3.5 **Health Visitors and School Nurses** routinely receive verbal and written information from emergency care settings, (e.g. Accident and Emergency departments (A & E), Minor Injury Units (MIU), NHS Walk-In Centres and the NHS 111 service).
- 3.6 **Trust Minor Injury Unit staff** are required to share information with both Health Visitor teams and School Nursing teams but in the case of school age children are required to make a professional judgement in relation to the attendance information that is shared.
- 3.7 **Health Visitors** also routinely receive information regarding admissions to inpatient paediatric units for children aged less than 5 years.
- 3.8 This information is either sent directly to the Health Visitor/School Nurse by each service provider, from the child's GP surgery, or via the Safeguarding Children Team.
- 3.9 All referrals relating to school aged children received by the Health Visiting Service should be sent to the relevant School Nursing team.

4. EXPLANATIONS OF TERMS USED

- 4.1 **Child:** is anyone who has not yet reached his or her 18th birthday.
- 4.2 **Safeguarding Children:** Global term referring to systems in place to protect children from abuse. All agencies working with children, young people and their families take measures to ensure the risks of harm to a child's welfare are minimised and that appropriate steps are taken to address any concerns.
- 4.3 **Child Protection:** A term relating to activity undertaken to protect specific children who are suffering, or are likely to suffer significant harm.

- 4.4 **Emergency Care Service:** Accident and Emergency departments (A & E), Minor Injury Units (MIU), NHS Walk-in Centres and the NHS 111 Service.
- 4.5 **Professional Judgement:** Assessment or actions taken appropriate to client need based on professional knowledge and experience; carried out within professional codes of conduct. Local/National Policy and evidence based practice boundaries. Recognising own professional limitations and making appropriate referrals to other professionals and agencies for additional expertise.

5. HEALTH VISITOR SERVICE FOLLOW UP

5.1 Any verbal or written information from an emergency care service e.g. Accident and Emergency departments (A & E), Minor Injury Units (MIU), NHS Walk-In Centres and the NHS 111 Service), must be initially reviewed and assessed by a Health Visitor and shared with the child's Named Health Visitor, **ideally on the same day as it is received into the team**. It may be necessary to gain further clarification of the information received from the referring service, (e.g. from the Safeguarding Team of the service involved). The following actions must then be completed:

- any attendance at an emergency care service of a child **under the age of 1 year** pertaining to an accident, must be followed up by a face-to-face contact, preferably a home visit, by a Health Visitor, within **5 working days of receipt of verbal or written notification**;
- where more than three attendances occur, involving a child aged over 1 year, within a six month period, or to children within the same family, a Health Visitor or a delegated member of the team will follow-up with a face-to-face contact **within 5 working days of verbal or written notification**;
- any serious injury or illness should be followed up by a Health Visitor face-to-face contact with the family. This should be completed **within five working days**;
- attendances at an emergency care service of any child in relation to minor illnesses must be reviewed, particularly in relation to other recent attendances, to ensure there are no concerns regarding Fabricated or Induced Illness, (FII), or inappropriate use of emergency health services, due to a lack of parental knowledge/understanding. In either situation, a face-to-face contact should be considered, for reassessment of the family's circumstances, and for the delivery of public health messages in terms of the management of minor illnesses.

Any variant from these standards must be documented in the child's RiO progress notes and the document scanned onto the electronic record. Consideration will be given to professional judgment in terms of following up more minor attendances.

5.2 Any admissions to inpatient paediatric units must initially be reviewed and assessed by a Health Visitor, and shared with the child's Named Health Visitor. It may be necessary to gain further clarification of the information received from

the referring unit, (e.g. from the Named Nurse of the inpatient unit involved). The following actions must then be completed:

- any paediatric admission of a child aged less than 1 year must be followed up **within 5 working days** by a Health Visitor. Professional judgement will indicate whether telephone contact or face- to-face contact is required;
- any paediatric admission by a child aged over 1 year must be followed up **within 5 working days** by either a Health Visitor or delegated team member, based on professional judgement by the Health Visitor.

Any variant from this standard must be documented in the child's RiO progress notes. Consideration will be given to professional judgment in terms of following up more minor admissions.

- 5.3 All attendances and admissions must be recorded on the child's electronic RiO progress notes and the document scanned onto the electronic record.
- 5.4 Significant attendances, (i.e. those attendances that must be followed up as per point 5.1 above), and all hospital admissions, must also be added to the RiO Significant Events, and Risk History screens and consideration given to the addition of a RiO Alert, (see Appendix 1). **This allows the identification of risk to or from anyone, but within the context of this Policy, allows risk to be identified to or from the child.**
- 5.5 Should the follow-up be declined and the concerns determined to be significant, the member of staff should follow the Trust *No Response Policy* and contact a member of the Safeguarding Children team to discuss next steps.

6. SCHOOL NURSE SERVICE FOLLOW UP (INCLUDING ROLE OF TRUST MINOR INJURY UNITS)

- 6.1 School Nurses will, in the majority of instances, only receive referrals from Trust Minor Injuries Unit (MIU) departments of any children who present at MIU with any of the problems stated in paragraph 6.3 below.
- 6.2 Accident and Emergency departments may also screen attendances and share only those which require the involvement of a School Nurse. However Accident and Emergency departments outside of Somerset may still chose to share all school age children's attendances with Somerset School Nursing staff. Such attendances will require formal triage to determine whether School Nurse follow up is required.
- 6.3 MIU will always refer cases to the School Nursing Service in the following situations
- any child protection – actual or suspected abuse, physical, sexual, neglect issues or child involvement in domestic violence incidents;
 - overdoses and other incidents of deliberate self-harm or significant risk-taking behaviour;

- any safeguarding issues of a sexual nature, including child sexual exploitation;
- sexually transmitted infections and/or pregnancy (although MIU may **not** share this information if the young person is deemed to be Fraser competent and there were no safeguarding concerns);
- drug / alcohol misuse / abuse;
- assaults;
- bullying issues or other emotional health problems;
- problems or crisis management association with the following conditions
 - * epilepsy;
 - * diabetes;
 - * anaphylaxis;
 - * asthma;
 - * any other chronic conditions managed with medication.
- serious injuries, particularly those likely to cause prolonged absence from school and / or long term health problems;
- parental admissions to hospital may also need to be referred to the School Nurses if it is felt it may impact upon the child, such as adult mental health issues, domestic abuse, drug and alcohol issues;
- any other presentation that MIU staff professional judgement suggests required the involvement of the School Nursing Service.
- Elective Home Educated children (EHE) any children of statutory school age identified as being either electively home educated or not currently attending a school.

6.4 This list is not exhaustive. Any children identified who are affected by other issues, may need to be referred to the School Nurse, based on the professional judgement of the assessing MIU practitioner.

6.5 Direct verbal liaison between A&E / MIU professionals and School Health Team professionals is always an option, to ensure a shared and explicit understanding of the child's health needs and situation presenting on attendance.

6.6 MIU staff who are unsure whether information should be forwarded to any other professional should discuss the issue with a member of the Trust Safeguarding Children Team or Somerset Direct on 0300 123 2224.

- 6.7 On occasion the School Nurse Team may be required to follow up in Schools directly, with older children of secondary school age, following an A&E/MIU attendance. This will be based on the School Nurse's own professional judgement and can be arranged in School via the School's normal communication routes, or via the School-based health clinic.
- 6.8 In the event of a significant mental health issue, the RiO electronic record system can be used for reference, to establish the care plan for the child. Liaison may be required with the local CAMHS Team who will be assessing the needs of the child or young person, to establish whether School Health Team intervention is required. Agreement will be reached about which service is able to offer an assessment and / or input, with this decision clearly documented on the RiO electronic record.
- 6.9 If a child presents with mental health issues but is not known to CAMHS, liaison with their School is important to establish whether the child needs to be referred to CAMHS or other services for further assessment or support.
- 6.10 Consideration should always be given to the ages of other children in the family. Any pre-school aged children will have a Health Visitor linked to them via their geographical location. Liaison with Health Visitors and other involved professionals may add to the understanding of the child/ren's situation. This is aimed at improving the planning for assessments and interventions.

7. INVOLVEMENT WITH SCHOOL STAFF

- 7.1 On occasion it may be necessary to obtain further information about specific children following an A and E / MIU attendance. These occasions will require liaison by a School Nurse with the child/young person's School regarding attendance or concerns regarding their health and wellbeing.
- 7.2 Following an A and E / MIU attendance a learning need may be highlighted for school staff to receive training around a special medical need i.e. anaphylaxis. The School Nurse should liaise with the parents of the child to establish any special medical need and commence an individual health care plan. This will then identify the medical needs of the child and training needs of school staff.
- 7.3 In the event of a trend in attendances through A&E / MIUs with a specific issue, such as alcohol consumption, within a particular School, it may indicate liaison maybe required with the pastoral Head or PSHE coordinator to plan targeted work within the School.

8. CHILD PROTECTION ACTIONS

- 8.1 Any attendance at acute or emergency care settings by a vulnerable child, (e.g. a child with a Child Protection Plan, a child identified as a Child in Need, a child open to a professional in line with the Trust *Clinical Supervision of Child Protection Case Work Policy*), must be followed up with a face to face contact at home/school by a Health Visitor/ School Nurse Team member **within 5 working days** of receipt, (unless multi-agency discussion identifies a different course of

action). It may be necessary to gain further clarification of the information received from the referring service/unit, (e.g. from the Safeguarding Team/Named Nurse of the service/unit involved).The child's Social Worker must be informed. Where no Social Worker has been allocated the attendance must be shared with Children's Social Care via Somerset Direct.

8.2 Any report of suspected or confirmed Non Accidental Injury, (NAI), or Fabricated and Induced Illness, (FII), must be followed up with a face-to-face home/school visit by a Health Visitor/ School Nurse and by liaison with the child's Social Worker, (unless multi-agency discussion identifies a different course of action), **within 2 working days**. Where the child has had no previous contact with Children's Social Care the information must be discussed with Children's Social Care via Somerset Direct. It may be necessary to gain further clarification of the information received from the referring service/unit, (e.g. from the Safeguarding Team/Named Nurse of the service/unit involved).The Trust Safeguarding Children Team must be informed.

8.3 It remains the responsibility of the referring service/unit to follow Child Protection Procedures where a child is considered at risk of significant harm when in attendance at an acute or emergency care setting.

NB - any Trust employee who identifies a physical injury/bruising/markings to a non-ambulatory infant **must** immediately share the information with a member of the Trust Safeguarding Children team and consider making an urgent referral to Children's Social Care via Somerset Direct. A paediatric assessment will be required to determine the mechanism of the injury and to ensure the injury is documented and assessed as soon as possible to rule out a Non-Accidental Injury. Staff must remember "**non-cruisers don't bruise**".

8.4 In the event of being unable to access the family of a vulnerable child for follow up, staff must refer to the Trust *No Response Policy* and ensure the situation is discussed with a member of the Trust Safeguarding Children Team. The School Nurse will also follow up with school staff regarding any concerns in School regarding the child/young person's well-being.

8.5 Children who are not in education, (including those who are home schooled), and need follow-up, will be managed in a process agreed following a discussion about the notification with a member of the Safeguarding Children team.

8.6 Hospital letters should be uploaded to RiO together with any planned follow up action. If no follow-up action is planned, this should also be indicated in the clinical record together with the reason why not. This should be completed within 5 working days of receipt of the letter.

8.7 Any letters not relevant to the ongoing care of a child/young person should be shredded.

9. CHILDREN / YOUNG PEOPLE WHO ARE NOT REGISTERED WITH A GP

- 9.1 Where a Health Visitor/School Nurse receives a hospital letter/professional notification that identifies that a child/young person is not registered with a GP, the parent/carer should be encouraged by the relevant practitioner to register the child/young person at the earliest opportunity, and information must be given to them regarding local GP practices and how to register.
- 9.2 The practitioner will monitor whether GP registration has taken place **within a month** of identifying the absence of GP registration. If this does not occur, the Health Visitor/School Nurse will liaise with a member of the Trust Safeguarding Children Team to discuss what further steps, if any, need to take place to ensure the child has access to local health services.

10 CHILDREN ELECTIVELY HOME EDUCATED (EHE)

- 10.1 Children who are electively home educated are often not regularly in contact with other professionals and may only present to either their GP or at an MIU or Accident and Emergency centre in a health emergency.
- 10.2 Though there are unlikely to be concerns about the general health and wellbeing of the majority of these children, recent national incidents have highlighted that a small proportion may become “invisible” to services generally and specifically to the Educational Welfare Officers who hold a register of EHE children in Somerset.
- 10.3 Any children who are identified as elective home educated or do currently not have a school should be referred to the relevant School Nurse team by the MIU staff.
- 10.4 The School Nurse has responsibility for making the Local Authority Education Welfare Officers aware that they have identified an EHE child. Education Welfare Officers can be contacted at:
Contact: Children and Young People's Team
Address: Customer Contact, PO Box 618, Taunton, Somerset TA1 3WF
Email: childrens@somerset.gov.uk
Contact no: 0300 123 2224

11 RECORD KEEPING

- 11.1 Record keeping and assessment processes must involve:
- assessment of the type of follow up activity needed according to the information shared;
 - liaison with referrer and/or GP as appropriate;
 - entering the attendance on the child's RiO progress note;

- ensuring the attendance is recorded as a Significant Event, (see Appendix A);
- ticking “This is a significant event” box below the progress note on RiO;
- uploading notification document onto RiO and shredding the original document;
- providing telephone contact to family within 5 working days or receipt of information;
- completing home visit to family if indicated, complete or update Family Health Needs Assessment, observing parenting capacity, home environment and determining level of current/future risk. Devising care plan providing relevant health information and advice, including referral to other agencies;
- considering discussion with the Trust Safeguarding Children Team.

12 TRAINING REQUIREMENTS

- 12.1 This policy is referenced in mandatory Trust Child Protection Training. The policy is also referenced in Student Health Visitor and School Nurse Trust training and action learning sets.
- 12.2 To improve understanding of the School Nursing role by MIU staff and ensure MIU staff are competent to screen school age children’s’ attendances at MIU, annual training sessions will be arranged facilitated by members of the School Nursing service.
- 12.3 Area links between School Nursing teams and their local Trust MIU departments will be established to further aid communication between the two services.

13 EQUALITY IMPACT ASSESSMENT

All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

14 MONITORING COMPLIANCE AND EFFECTIVENESS

- 14.1 The monitoring of compliance and effectiveness of this protocol will include the number of follow-ups completed. Compliance will be reviewed by the Health Visitor and School Nurse Best Practice Groups and through review of DATIX incident reports regarding any exceptions by the Named Nurse and Professional Leads for Health Visiting and School Nursing. Serious incidents in relation to

safeguarding and child protection incidents will also be reviewed by the Trust Safeguarding Children Best Practice Group and Safeguarding Steering Group.

- 14.2 The Health Visitor Best Practice Group will provide a report to the Clinical and Social Care Effectiveness Group every six months.

15 COUNTER FRAUD

- 15.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

16. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

- 16.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)**, the fundamental standards which inform this procedural document, are set out in the following regulations:

Regulation 10:	Dignity and respect
Regulation 11:	Need for consent
Regulation 12:	Safe care and treatment
Regulation 13:	Safeguarding service users from abuse and improper treatment
Regulation 15:	Premises and equipment
Regulation 16:	Receiving and acting on complaints
Regulation 17:	Good governance
Regulation 18:	Staffing
Regulation 19:	Fit and proper persons employed
Regulation 20:	Duty of candour
Regulation 20A:	Requirement as to display of performance assessments.

- 16.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

Regulation 16:	Notification of death of service user
Regulation 17:	Notification of death or unauthorised absence of a service user who is detained or liable to be detained under the Mental Health Act 1983
Regulation 18:	Notification of other incidents

- 16.3 Detailed guidance on meeting the requirements can be found at <http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf>

17 REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

17.1 References

Children Act 1989
Children Act 2004, Section 11
Escalation Policy, (Somerset LSCB, 2013)
NICE CG89 – When to suspect Child Maltreatment

Safeguarding Children and Young People: roles and competences for health care staff. Intercollegiate document, 2014
Working Together to Safeguard Children, 2015

17.2 **Cross reference to other procedural documents**

Confidentiality and Data Protection Policy
Development & Management of Procedural Documents
Information Governance Policy
Healthy Child Programme Guidelines
Learning Development and Mandatory Training Policy
Mandatory Training Matrix (Training Needs Analysis)
No Response Policy
Record Keeping and Records Management Policy
Risk Management Policy and Procedure
Safeguarding and Protection of Children Policy

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

18 **APPENDICES**

- 18.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such. This should include any relevant Clinical Audit Standards.

Appendix A Significant Event Chronology Guidance

Significant Event Chronology Guidance

The following is a guide for Public Health Nurses in relation to recording of Significant Events on the RiO electronic records system.

ALERTS - These are there to draw attention to a specific area of concern including safeguarding children concerns. They should be added to records and can be helpful as a way of creating the sort of Significant Event Chronology that was in use when paper records were being used.

SIGNIFICANT EVENTS PAGE – This captures all types of significant events including referrals history and should illustrate a person’s journey through Somerset Partnership services. It contains hyperlinks to the related progress note. Whilst this provides a more detailed chronology than Health Visitors have been used to it is important that this is completed in a timely way when progress notes are updated.

RISK HISTORY SCREEN – This can be found on the Client History Menu. It is the most helpful tool for Health Visitors wishing to create a Significant Events Chronology that mimics similar paper documents previously in use. For this to be most useful it requires staff to diligently flag progress notes that they write as risk related when appropriate. When planning to write a long progress note (often because a particular incident is significant and requires a long description), staff must include a brief summary note, (e.g. “Emergency Department attendance”, “Domestic Abuse notification”, “Missed Appointment”), which is flagged as risk related and so added to the Risk History Screen. The larger descriptive entry does not need to be added to the Risk History Screen, thereby creating a brief overview of significant events.