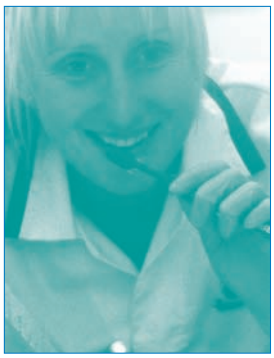

child protection and the dental team

an introduction to safeguarding children in dental practice

Funded by:

DH Department of Health

Disclaimer

The 'Child Protection and the Dental Team' handbook and website are intended as a guide only. Whilst the information is believed to be correct, it is not a substitute for appropriate legal advice. COPDEND and the authors can take no responsibility for the actions taken based on the information contained in this educational resource.

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Dental teams working in the UK are permitted to copy the Documents in Section 5

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child protection and the dental team

an introduction to safeguarding children in dental practice

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Authors' note

We have sought to follow current best practice in consent for clinical photography, by obtaining consent of children and their parents to publication of photographs in this context in both handbook and website. This has limited the number and choice of appropriate images available to us. Exceptions have been made by using archive material only where it is considered essential to understanding the text. Readers who want to view a wider range of relevant clinical photographs are referred to other sources. Suggested further reading is included in Section 5.

Where discussion of individual child protection cases is included it is based on real situations but details have been changed to protect the identity of the children, families and staff involved.

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About this resource

'Child Protection and the Dental Team: an introduction to safeguarding children in dental practice' is an educational resource consisting of this handbook and an accompanying website **(www.cpdt.org.uk. / www.childprotectionandthedentalteam.org.uk)**. It was commissioned and funded by the Department of Health for dental teams working in primary care in England. It was developed and produced by an expert group in association with the Committee of Postgraduate Dental Deans and Directors (UK).

The project began by identifying the concerns and learning needs of dental teams by consultation with interested specialist societies and staff groups. Their responses were used to develop new material for dental practice use. Practical recommendations and documentation were tested in the field by two dental teams (a general dental practice and a salaried primary dental care service).

Every effort has been made to ensure that the advice given is factually accurate, evidence-based where possible, and compatible with current guidance and legislation. It should be used with clinical judgement and in conjunction with locally agreed multi-agency child protection procedures and the ethical standards guidance appropriate to your professional role. It complements but does not replace the need for local child protection training.

Much of the content of the resource is applicable to dental professionals working throughout the United Kingdom. However, policy and procedures are stated as for England. Those working in Wales, Scotland and Northern Ireland should be aware that differences exist and are advised to use this resource in conjunction with locally available guidance.

Addenda for Scotland and Wales can be downloaded in pdf format from **www.cpdt.org.uk**

Foreword

Few can fail to have noticed the sad, and all too frequent, news stories of children who are abused or neglected. Health, education and social services are placing increasing emphasis on preventing abuse and neglect by early intervention to support families where children and young people may be at risk. The dental team, like all other health professionals, has a part to play which has been highlighted by the General Dental Council in its revised guidance “Standards for Dental Professionals”.

Every day many hundreds of children visit the dentist. Our profession is recognised as being well placed to notice children with signs of maltreatment. By working together with other professionals involved in child protection we can make a positive contribution to the welfare of children, above and beyond their oral health.

If you are a dental professional this resource aims to equip you to recognise the presenting features of child abuse. It will help you understand your responsibilities and the action you should take if you have concerns about a child. It includes simple practical measures to incorporate into everyday practice to help your dental team safeguard children.

I would like to thank Dr Jenny Harris who has been the driving force behind this project. Jenny has not only championed the need for this resource but has developed a team who have produced a programme which many others and I welcome.

I congratulate all the authors and also all who have contributed advice, ideas and examples of good practice to this primary-care led project.

Barry Cockcroft
Acting Chief Dental Officer – England

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Using this handbook

The handbook consists of five sections:

Section 1

Introduction:
RESPONSIBILITY – why **you** need to know about child protection

Section 2

Child abuse and neglect:
RECOGNISING – what **you** need to know to recognise abuse and neglect

Section 3

Child protection procedures:
RESPONDING – what **you** need to do if you're worried about a child

Section 4

Safeguarding children in dental practice:
REORGANISING – how to prepare **your** practice to safeguard children

Section 5

Further information:
RESOURCES – additional materials to support **you**

Section 5 includes **sample documents** that may be photocopied and adapted for use in your own dental practice.

The accompanying **website** **www.cpdt.org.uk** consists of equivalent information for those who prefer to access it electronically, with the following additional features:

- sample documents to download, customise and print
- navigation to help you respond quickly when you have concerns about a child
- links to other websites of interest
- pdf version of the handbook to download.

You are encouraged to reflect on previous child protection experience, to make notes on anything new you have learned and any further training needs you have identified. A suitable form for doing this and for recording **general CPD** is included (Section 5: Document 1). You are also urged to make a note of any child protection **significant events** that occur in your practice (Section 5: Document 2). Why not share your experiences and what you have learned with colleagues by submitting these records anonymously to the project team? A significant events library will be compiled with selected expert commentary on reported events, with a view to publication and circulation in due course.

The authors would welcome your **feedback** about any aspect of the handbook or website by post or email but regret that they are unable to enter into correspondence about individual cases.

Every member of the dental team has a part to play

MAKE SURE YOU DON'T MISS…

If you are:

Anyone who has contact with children (or adults who are parents) through your work in a dental practice

make sure you don't miss…

Section 1: P1.1 Child protection – whose responsibility?
Fig 3.3: P3.3 Child protection and the dental team: flow chart for action

A dentist, dental therapist, dental hygienist, dental nurse

make sure you don't miss…

Section 2: P2.3-8 Recognising abuse and neglect
Section 3: P3.4 What to do if you're worried about a child

Responsible for giving advice to children and young people on how to care for their teeth

make sure you don't miss…

Section 2: P2.9 The question of dental neglect
Section 3: P3.9 Managing dental neglect

A dental receptionist

make sure you don't miss…

Section 3: P3.9 Managing dental neglect
Section 4: P4.4 Best practice in record keeping

A dental practice owner, dental practice manager or senior dental nurse

make sure you don't miss…

Section 4: Safeguarding children in dental practice
Section 5: P5.8 Documents 4 and 7

child protection and the dental team

Section 1

Introduction:

RESPONSIBILITY

why **you** need to know about child protection

Child protection – whose responsibility?
Changes in child protection practice
Children in society

Child protection – whose responsibility?

Everyone's responsibility

Protecting children from those who would cause them harm is a responsibility shared by all members of society. When any of us, as members of the public, come to hear something about a child that concerns us, we have a responsibility to report our concerns to someone who can help.

A shared responsibility

Protection of children who are at risk of abuse and neglect is a responsibility shared by many different groups of professionals. In each local authority area it is coordinated by a multi-agency Local Safeguarding Children Board (LSCB), which replaces the Area Child Protection Committee (ACPC) in 2006. LSCBs/ACPCs are responsible for developing local procedures and providing training. Social services work together with the police, health services, education and probation services. In some areas there is input from other agencies such as the NSPCC, domestic violence forum, youth services or armed services. This is backed up by contributions from many other groups of professionals. By effective inter-agency working and discussion, professionals share the responsibility. Decisions about children are never taken by one individual but always shared by a team.

'…all agencies and professionals should work together to promote children's welfare and protect them from abuse and neglect.'

Working Together to Safeguard Children, Department of Health *et al* (1999)[1]

The dental team's responsibility

Members of the dental team are in a position where they may observe the signs of child abuse and neglect, or hear something that causes them concern about a child. Some dentists do not treat children themselves but, if they treat adults who are parents, they too need to be aware of these issues.

The General Dental Council's recently updated 'Standards Guidance'[2] (Figure 1.1) clearly states that the dental team have an ethical responsibility to find out about and follow local procedures for child protection. This is not just the dentist's responsibility, but one that is shared by all team members.[2,3]

Figure 1.1
The General Dental Council's recently updated 'Standards Guidance' clearly states the dental team's ethical responsibilities with respect to child protection.

Find out about local procedures for child protection. Make sure you follow these procedures if you suspect that a child may be at risk because of abuse or neglect.

Standards for Dental Professionals, 1.8 p7
Standards Guidance, General Dental Council (2005)[2]

In addition we have an ethical obligation to ensure that children are not at risk from members of our own profession and to take action to prevent this (see Section 4. Safe staff recruitment).

Maintain appropriate boundaries in the relationships you have with patients. Do not abuse those relationships.

Standards for Dental Professionals, 2.5 p7
Standards Guidance, General Dental Council (2005)[2]

In his report of the inquiry into the tragic death of Victoria Climbié,[4] commenting on how similar events might be prevented in the future, Lord Laming said:

'I am convinced that the answer lies in doing relatively straightforward things well. Adhering to this principle will have significant impact on the lives of vulnerable children.'

The dental team are not responsible for making a diagnosis of child abuse or neglect, just for sharing concerns appropriately. Research has shown that many feel unprepared for this role.[5] If we are to fulfil this responsibility and carry out this role effectively, we will have to communicate, cooperate and support one another within our own teams, and learn to work with other agencies for the benefit of children.

CHILD PROTECTION IS:

- everyone's responsibility
- a shared responsibility
- the responsibility of every member of the dental team.

Changes in child protection practice

Lessons from the past

When she died at the age of 9, Victoria Climbié had no fewer than 128 separate injuries. She had spent much of her last days in an unheated bathroom bound hand and foot inside a bin bag, lying in her own urine and faeces. In the space of just a few months, Victoria had been transformed from a healthy, lively, and happy little girl, into a wretched and broken wreck of a human being. The inquiry into her death[4] was highly critical of health professionals who, despite numerous contacts, failed to protect Victoria and prevent her death at the hands of her carers.

On a summer evening in 2002, 10-year-old friends Holly Wells and Jessica Chapman disappeared close to home. After an eleven day search their bodies were found, brutally murdered and dumped in a ditch. The man convicted of their murders was someone they knew, the school caretaker with a history of alleged sexual offences against children, who had managed to gain employment in a setting where he would have contact with children. The Bichard Inquiry that followed identified shortcomings in information sharing and errors in recruitment and vetting procedures.[6]

In 2004 an ambulance was called to a house to attend a lifeless 18-month-old twin boy. Paramedics found five starving children under the age of eight living in squalor, with urine soaked mattresses and dog excrement in their bedrooms. Meanwhile the living room and bedroom used by their parents were clean and stocked with high-tech entertainment equipment. The family were not known to social services and had apparently 'slipped through the net'.

It is estimated that 1 to 2 children in the UK die each week from abuse or neglect. Many of these cases do not receive high profile national news coverage but are no less shocking. Whenever a child dies in such circumstances, the case is reviewed to see what lessons can be learned. Recommendations for improvements in child protection procedures invariably follow. However, procedures and training by themselves do not protect children. What is needed, as highlighted above, is for everyone to recognise their own responsibility and as Lord Laming emphasised, 'to do relatively straightforward things well'.[4]

Improvements for the future

Recent government guidelines and legislation place emphasis on preventing abuse and neglect, improving multi-agency working and encouraging early intervention when problems are identified.[7,8] The focus is on working towards supporting all children, whatever their background or circumstances, to achieve five key outcomes:[9]

- being healthy
- staying safe
- enjoying and achieving
- making a positive contribution
- economic well-being.

RECENT DEVELOPMENTS INCLUDE:

- appointment of a Minister for Children, Young People and Families
- publication of the 'National Service Framework for Children, Young People and Maternity Services', a 10 year strategy to improve the health and well-being of children[10]
- appointment of the first Children's Commissioner for England, a 'champion' for children
- pilot schemes for shared electronic records and developing single unique identifying numbers for children.

There will always be a need for health care professionals to keep up-to-date with relevant changes in child protection policy, procedures and practice, in order to ensure that the lessons learned from past tragedies benefit the generation of children that follow.

Children in society

Children's rights

Children's rights are defined by the United Nations Convention on the Rights of the Child 1989 (UNCRC) (Table 1, P1.4).[11] This is an international human rights treaty that applies to all children and young people under the age of 18 years. The UK Government, in ratifying it in December 1991, agreed to make all its own laws, policy and practice compatible with the Convention.

Children's needs

To develop to their full potential, children have many and varied needs. These include the need for an adequate diet, exercise, opportunities for play and interaction with others, stable and affectionate relationships with parents or carers, to be kept safe and to receive appropriate healthcare.

When child protection concerns have been raised, agencies aim to look at the whole picture in their assessment of children and families. To make decisions and act in the best interests of the child they consider not only what has happened to the child, but also the child's health and development, and the wider family and environmental context (Figure 1.2).[1]

In 2006 a new tool will be introduced to help identify a child's needs at an early stage and tackle any problems before they become serious. The Common Assessment Framework[12] has been designed for use by staff in any agency (e.g. health or education). It is hoped that its use will improve multi-agency working.

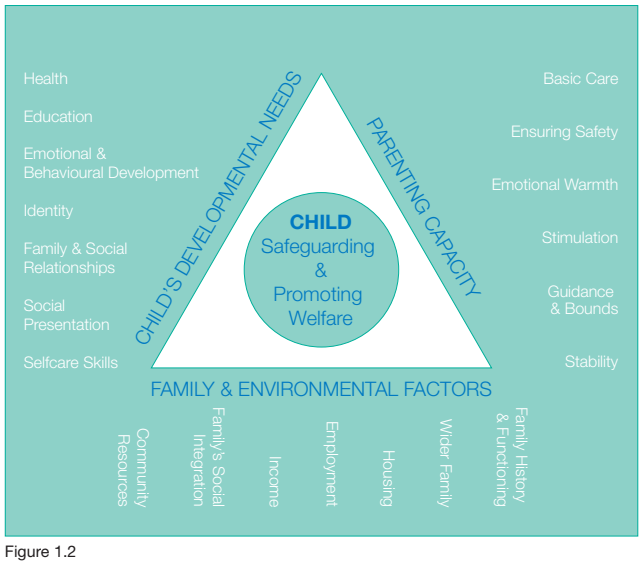


Figure 1.2
Framework for the assessment of Children in Need and their families[1]
(reproduced with permission of the Department of Health).

What children want

Increasingly children and young people are being consulted about what they want from health and other services. Being healthy and staying safe are things that really matter to children themselves.

When we provide dental care for children we need to take into consideration children's rights, their needs and what they want.

UNCRC Article	Implications for Child Protection	Implications for the Dental Team
Article 2: The rights of all children should be respected without discrimination	All children deserve protection. Many children do suffer discrimination due to gender, ethnicity, religion, social status, disability and may be particularly vulnerable to abuse or neglect	All children should have equal access to dental services regardless of location, ethnicity, social status or disability
Article 3: The best interests of the child shall be a primary consideration in all actions concerning children	The Children Act, 1989 emphasizes that in all matters relating to child protection the welfare of the child is paramount	All dental care for children must be carried out in child's best interests
Article 6: Every child has the right to life, survival and development	This is not a narrow concept but rather incorporates an adequate standard of living, including the right to housing, nutrition and the highest attainable standards of health, to promote full and harmonious development	Oral health and hygiene is an important part of every child's well-being and should be promoted by all members of the dental team
Article 12: Children have a right to express their views in all matters affecting them and have those views heard and given due weight in accordance with the child's age and maturity	The child's views must be taken into consideration in all child protection matters	The child's views should be taken into consideration when planning and providing dental care and treatment
Article 19: Children should be protected from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation	UK legislation and government guidance lays out procedures for multiagency working to protect children	The dental team need to be alert to indicators of possible abuse or neglect and to be prepared to act on any concerns
Article 23: Any mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community	It is well recognised that children with disabilities are more prone to abuse and neglect. They deserve equal levels of protection and care	Dental services and individual practitioners need to be sensitive to the needs of children with disabilities to ensure they are not excluded from appropriate standards of dental care. Members of the dental team need to be aware of the possibility of abuse or neglect in children with disabilities
Article 24: Children have a right to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health	Child abuse and neglect results in direct short and long term impacts on children's health, growth and development	Dental neglect or non-accidental oral injury affect a child's overall well-being. All children should have access to preventive dental care and to treatment services for oral disease and injury

Table 1 Children's rights: relevant extracts from the United Nations Convention on the Rights of the Child 1989[11] and their implications for the dental team.

child protection and the dental team

Section 2

Child abuse and neglect:

RECOGNISING

what **you** need to know to recognise abuse and neglect

What is abuse?
Categories of abuse
Prevalence
Recognising abuse and neglect
Vulnerable groups
The question of dental neglect

What is abuse?

Whilst most children grow and develop in loving, nurturing environments, it is a sad fact that a significant minority suffer harm either intentionally or inadvertently through the actions or omissions of their parents, carers or others. The reasons for such abuse or neglect are often complex and it may present in a variety of ways. Most child abuse occurs within a child's own family by persons known to the child. However, children may be abused in institutional or community settings by those known to them or, more rarely, by a stranger. A child is considered to be abused if he or she is treated in a way that is unacceptable in a given culture at a given time. The threshold beyond which actions or omissions become abusive or neglectful is, to a certain extent, socially and culturally defined. For example, physical punishment of children has become progressively less acceptable in the UK in recent years.

The context in which the action or omission occurs is also significant in determining whether the action is abusive. It is often the interaction between a number of factors which affect the level of harm to the child; for example, the protective effect of support from a family or social network, or the destructive effect of threatening behaviour and coercion accompanying the abuse.

Categories of abuse

Abuse and neglect are described in four categories, as defined in the Department of Health's document 'Working Together to Safeguard Children'.[1] Some level of emotional abuse is involved in all types of ill treatment of a child, though it may occur alone.

Physical abuse

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately causes illness in a child.

Emotional Abuse

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve causing children frequently to feel frightened or in danger, or the exploitation or corruption of children.

Sexual Abuse

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape, buggery or oral sex) or nonpenetrative acts (oral sex). They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

Neglect

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur in pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to provide adequate food and clothing, shelter (including exclusion from home or abandonment), failing to protect a child from physical and emotional harm or danger, failure to ensure adequate supervision (including the use of inadequate care-takers) or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

Prevalence

It is helpful, in thinking about child abuse and neglect, to recognise that there is a spectrum in terms of type and severity (Figure 2.1). At one end of the scale are children who are suffering extreme harm as a result of severe, persistent or malicious abuse. In Britain, at least 1 child per 1000 under 4 years of age per year suffers severe physical abuse; for example, fractures, brain haemorrhage, severe internal injuries or mutilation. An estimated one to two children die each week in England and Wales as a result of abuse or neglect.

In the early 1990s, there were over 38,000 children on child protection registers in England.[13] By 2004, this figure had dropped to 26,300 or 24 per 10,000, reflecting a steady downward trend. Neglect accounted for 42% of registrations (Figure 2.2). Children in the youngest age groups (aged 0 to 4) were assessed to be most in need of protection. Infants under 1 year had the highest rate of registration (51 per 10,000 in England).

These figures represent those children identified as having been abused or neglected and in whom ongoing risk warrants professional involvement, but underestimate the true prevalence of child maltreatment (see also Figure 2.3). **It is well recognised that most cases of abuse and neglect do not come to the notice of professionals and, as a result, children continue to suffer harm.**

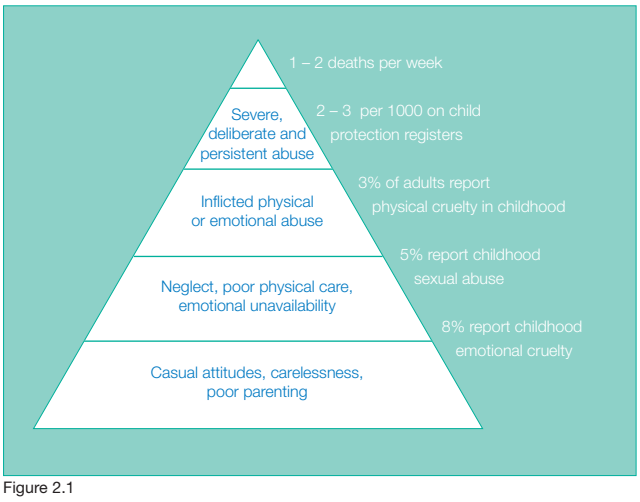


Figure 2.1
The pyramid of severity of child abuse and neglect.

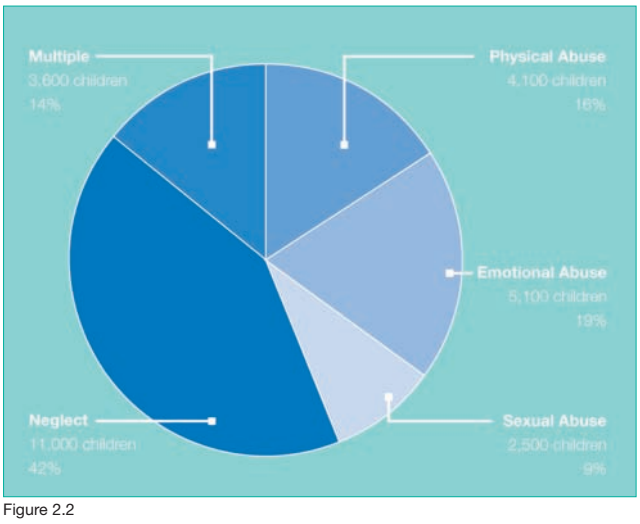


Figure 2.2
Children and young people on child protection registers in England at 31 March 2004[13]
(data used with permission of the Department for Education and Skills).

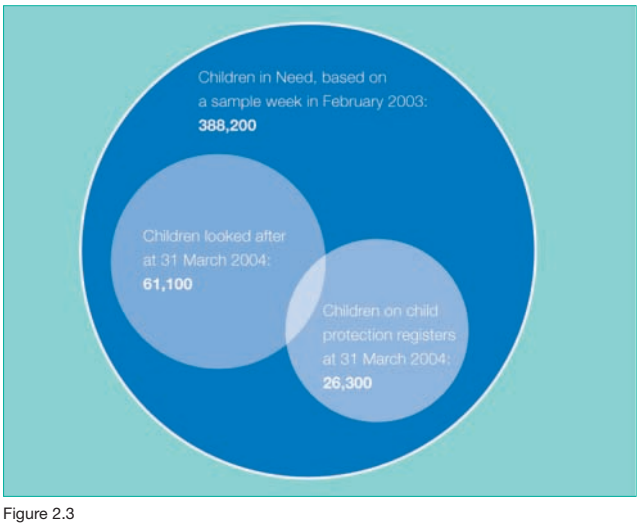


Figure 2.3
Numbers of Children in Need, children who are looked after, and children who are on child protection registers in England, and the relationship between them[13]
(reproduced with permission of the Department for Education and Skills).

Recognising abuse and neglect

An approach to assessment

Abuse or neglect may present to the dental team in a number of different ways:

- through a direct allegation (sometimes termed a 'disclosure') made by the child, a parent or some other person
- through signs and symptoms which are suggestive of physical abuse or neglect
- or through observations of child behaviour or parent-child interaction.

However it presents, any concerns should be taken seriously and appropriate action taken.

Because of the frequency of injuries to areas routinely examined during a dental check-up, the dentist has an important role in intervening on behalf of an abused child. It is assumed that the dentist will be examining a child who is fully dressed, so this will be the focus of discussion.

Physical abuse

Orofacial trauma occurs in at least 50% of children diagnosed with physical abuse.[14-17] It is always important to remember that a child with one injury may have further injuries that are not visible so, where possible, arrangements should be made for the child to have a comprehensive medical examination. It is important to state that there are no injuries which are pathognomonic of (that is, only occur in or prove) child abuse although some injuries or patterns of injury will be highly suggestive of it.

The assessment of any physical injury involves three stages (see also Section 3: Assessing the child):

- evaluating the injury itself, its extent, site and any particular patterns
- taking a history with a focus on understanding how and why the injury occurred and whether the findings match the story given (Figures 2.4, 2.5 and 2.6)
- exploring the broader picture, including aspects of the child's behaviour, the parent-child interaction, underlying risk factors or markers of emotional abuse or neglect.

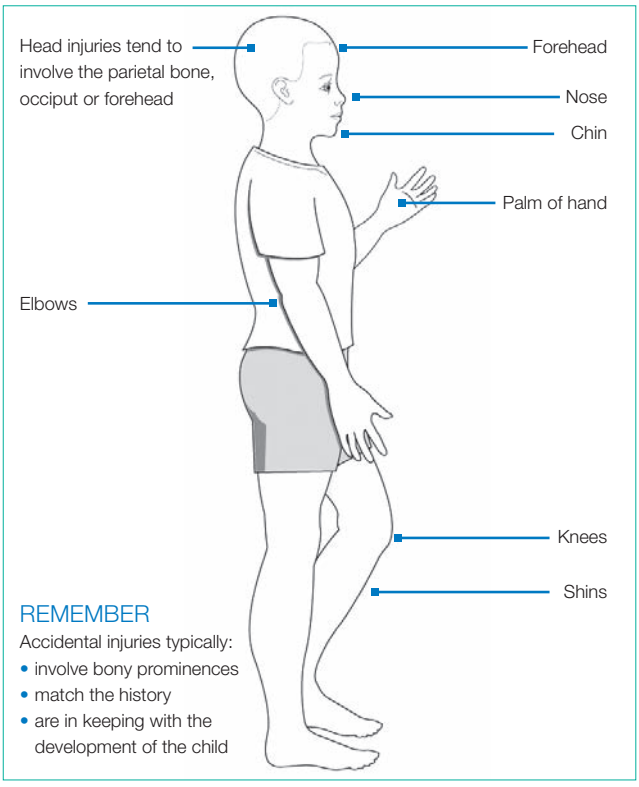


Figure 2.4
Typical sites of accidental injury.

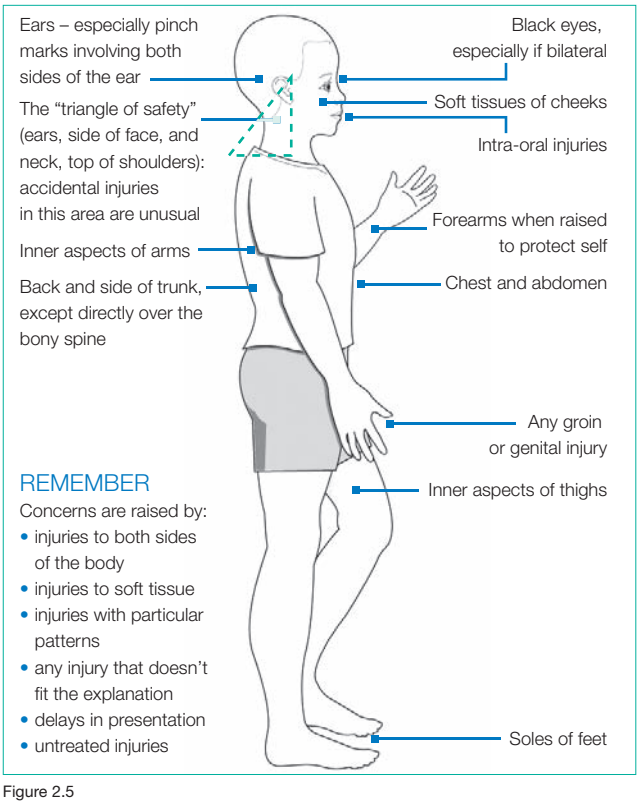


Figure 2.5
Typical sites of non-accidental injury (injuries that should raise concerns).

Figure 2.6

Burn on the side of the neck of a 6-year-old boy in the 'triangle of safety', an unusual site for an accidental injury. In this case there was a credible accidental explanation.

Figure 2.7

Pinch mark on the leg of a 7-year-old boy at a site where accidental bruising is unlikely. Note the two small bruises separated by a clear space.

Bruising

Accidental falls rarely cause bruises to the soft tissues of the cheek but instead tend to involve the skin overlying bony prominences such as the forehead or cheekbone. Inflicted bruises may occur at typical sites or fit recognisable patterns. Bruising in babies or children who are not independently mobile are a cause for concern. Multiple bruises in clusters or of uniform shape are suggestive of physical abuse and may occur with older injuries.[18] However, the clinical dating of bruises according to colour is inaccurate.[19]

Bruises on the ear may result from being pinched or pulled by the ear and there may be a matching bruise on its posterior surface. Bruises or cuts on the neck may result from choking or strangling by a human hand, cord or collar. Accidents to this site are rare and should be looked upon with suspicion.

Particular patterns of bruises may be caused by pinching (paired, oval or round bruises) (Figure 2.7), grabbing (Figure 2.8) or hand-slaps (Figure 2.9). Bizarre-shaped bruises with sharp borders are nearly always deliberately inflicted. If there is a pattern on the inflicting implement, this may be duplicated in the bruise — so-called tattoo bruising.

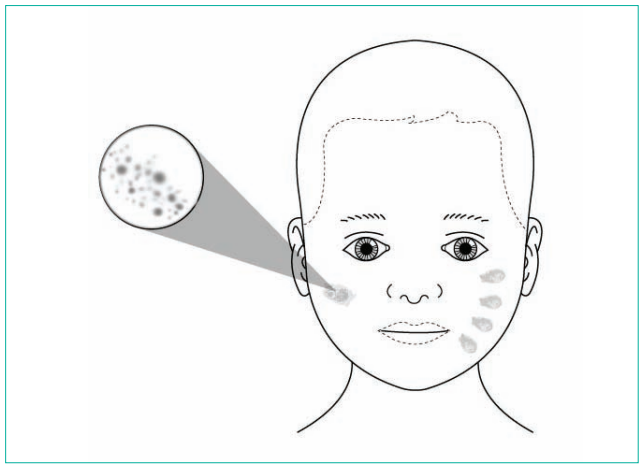


Figure 2.8

Artist's impression of grip marks such as may be present when a young child has been gripped and force fed. Note the round thumb imprint on one cheek with 3 or 4 finger-tip bruises on the other. You should also examine for intra-oral injuries.

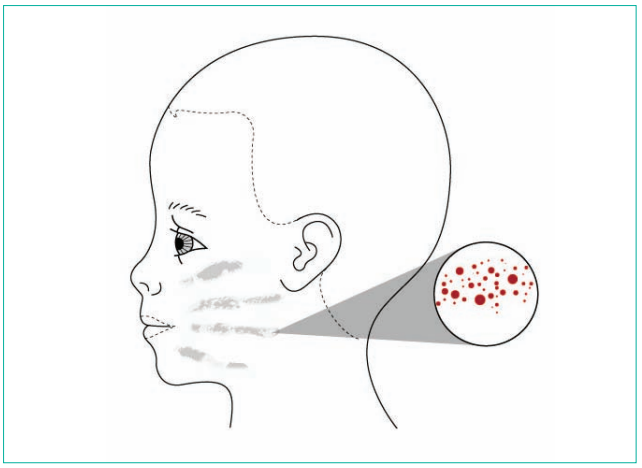


Figure 2.9

Artist's impression of a slap mark. Note the parallel lines of petechial bruising at finger-width spacing, the marks appearing in the gaps between the fingers.

Abrasions and lacerations

Abrasions and lacerations on the face in abused children may be caused by a variety of objects but are most commonly due to rings or fingernails on the inflicting hand. Such injuries are rarely confined to the orofacial structures. Accidental facial abrasions and lacerations are usually explained by a consistent history, such as falling off a bicycle, and are often associated with injuries at other sites, such as knees and elbows.

Burns

Approximately 10% of physical abuse cases involve burns. Burns to the oral mucosa can be the result of forced ingestion of hot or caustic fluids in young children. Burns from hot solid objects applied to the face are usually without blister formation and the shape of the burn often resembles the implement used. Cigarette burns result in circular, punched out lesions of uniform size (Figure 2.10).

Bite marks

Human bite marks are identified by their shape and size (Figure 2.11). They may appear only as bruising, or as a pattern of abrasions and lacerations. They may be caused by other children, or by adults in assault or as an inappropriate form of punishment. Sexually orientated bite marks occur more frequently in adolescents and adults. The duration of a bite mark is dependent on the force applied and the extent of tissue damage. Teeth marks that do not break the skin can disappear within 24 hours but may persist for longer. In those cases where the skin is broken, the borders or edges will be apparent for several days depending on the thickness of the tissue. Thinner tissues retain the marks longer. A bite mark presents a unique opportunity to identify the perpetrator.[20] For further discussion of the forensic aspects of bite mark identification see Section 3.

Eye injuries

Periorbital bruising in children is uncommon and should raise suspicions, particularly if bilateral. Ocular damage in child physical abuse includes acute hyphema (bleeding in the anterior chamber of the eye), dislocated lens, traumatic cataract and detached retina. More than half of these injuries result in permanent impairment of vision affecting one or both eyes.

Bone fractures

Fractures resulting from abuse may occur in almost any bone including the facial skeleton. They may be single or multiple, clinically obvious or detectable only by radiography. Most fractures in physically abused children occur under the age of 3. In contrast, accidental fractures occur more commonly in children of school age. Facial fractures are relatively uncommon in children.

Figure 2.10

Cigarette burn on the forehead of a 7-year-old girl, showing the typical appearance 0.8-1.0 cm diameter with a smooth, well-defined edge *(reproduced with permission of Elsevier, see page ii).*

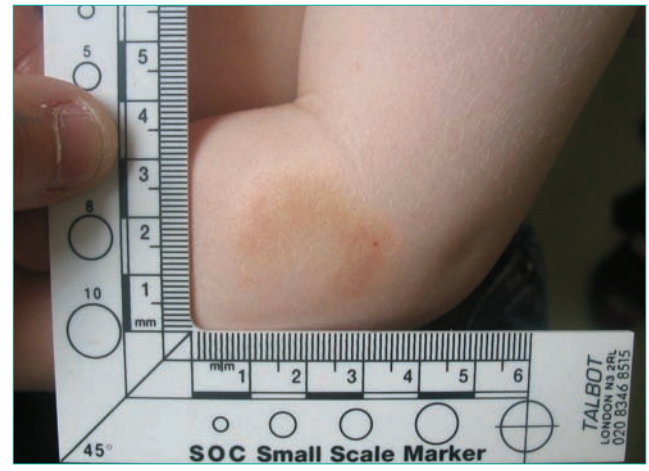


Figure 2.11

Human bite mark on a child's arm, presenting as diffuse bruising *(reproduced with permission of Dr GT Craig).*

When abuse is suspected, the presence of any fracture is an indication for a full skeletal radiographic survey. A child who has suffered sustained physical abuse may have multiple fractures at different stages of healing.

Intra-oral injuries

i

ii

Figure 2.12

(i) Torn and bruised frenum in association with other accidental dental and oral injuries and (ii) facial abrasions in a 7-year-old child (consistent with the history given of a fall from a skateboard).

Damage to the primary or permanent teeth can be due to blunt trauma. Such injuries are often accompanied by local soft tissue lacerations and bruising. The age of the child and the history of the incident are crucial factors in determining whether the injury was caused by abusive behaviour.

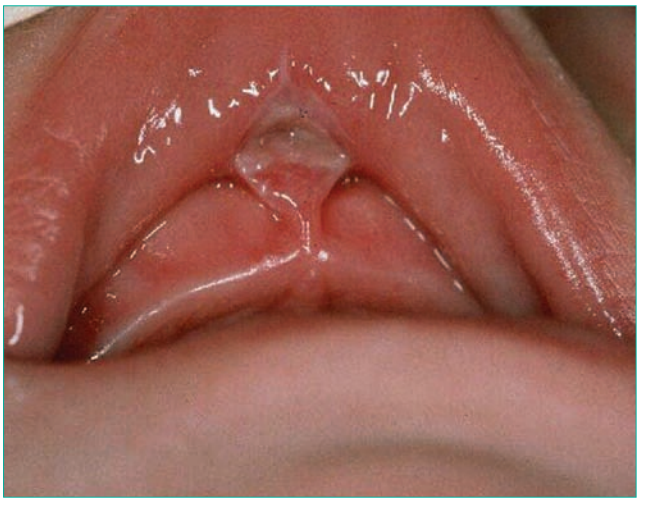


Figure 2.13

Torn frenum in a 3-month-old baby. Further investigation showed fractured ribs *(reproduced with permission of Elsevier, see page ii).*

Penetrating injuries to the palate, vestibule and floor of the mouth can occur during forceful feeding of young infants and are usually caused by the feeding utensil.

Bruising and laceration of the upper labial frenum is not uncommon in a young child who falls while learning to walk (generally between 8–18 months) or in older children due to other accidental trauma (Figure 2.12). However, a frenum tear in a very young non-ambulatory patient (less than 1 year) should arouse suspicion (Figure 2.13). It may be produced by a direct blow to the mouth. This injury may remain hidden unless the lip is carefully everted. Any accompanying facial bruising or abrasions should also be meticulously noted.

Differential diagnosis

Although dental practitioners should be suspicious of all injuries to children, they should be aware that the diagnosis of child physical abuse is never made on the basis of one sign as various diseases can be mistaken for physical abuse. The lesions of impetigo may look similar to cigarette burns, birthmarks can be mistaken for bruising and conjunctivitis can be mistaken for trauma. All children who are said to bruise easily and extensively should be screened for bleeding disorders. Unexplained, multiple or frequent fractures may rarely be due to osteogenesis imperfecta; a family history, blue sclerae and the dental changes of dentinogenesis imperfecta may all help in establishing the diagnosis.

CONDITIONS THAT MAY MIMIC PHYSICAL ABUSE:

- Birth marks e.g. haemangiomas, mongolian blue spots
- Infections e.g. scabies, impetigo
- Unintentional injury
- Bleeding disorders
- Osteogenesis imperfecta

Emotional abuse

Emotional abuse causes unhappiness and damage to the child's developing personality that may be irreversible. Such abuse often accompanies other forms of violence and neglect. It may be missed if the child appears well nourished and well cared for.[21]

The main clues to emotional abuse are found in the emotional state and behaviour of the child and their interaction with parents. The parent may ignore the child or use abusive or inappropriate language. They may threaten the child or have unrealistic expectations of the child's abilities to cope with dental treatment. Emotionally abused children often have delayed intellectual and social development. They may be clingy and become distressed when a parent is not present or, alternatively, they may be agitated, non-compliant and unable to concentrate, or withdrawn, watchful and anxious. Older children may self-harm, abuse drugs and alcohol, exhibit delinquent behaviour, run away from home and often have educational problems.

MARKERS OF EMOTIONAL ABUSE:

- Poor growth
- Developmental delay
- Educational failure
- Social immaturity
- Lack of social responsiveness
- Aggression
- Attachment disorders (both anxious and avoidant)
- Indiscriminate friendliness
- Challenging behaviour
- Attention difficulties

Sexual abuse

Sexual abuse is an abuse of power and may be perpetrated by male and female adults, teenagers and older children. Unless there are intraoral signs of sexual abuse or the child discloses abuse, a dentist is most likely to detect the problem through emotional or behavioural signs.

The intraoral signs associated with sexual abuse include erythema, ulceration and vesicle formation arising from gonorrhoea or other sexually transmitted diseases, and erythema and petechiae at the junction of the hard and soft palate which may indicate oral sex.[22]

PRESENTATION OF SEXUAL ABUSE:

- Direct allegation
- Sexually transmitted infection
- Pregnancy
- Trauma
- Emotional and behavioural signs
  - delayed development
  - anxiety and depression
  - psychosomatic indicators
  - self-harm
  - soiling or wetting
  - inappropriate sexual behaviour or knowledge
  - running away
  - drug, solvent or alcohol abuse

Neglect

Neglect is insidious and affects a child adversely both physically, educationally, psychologically, socially, and medically. Failure of the parent to recognise or meet their child's needs and comply with professional advice is a common factor in many sorts of neglect. Failure to take a child for appropriate health care when required and necessary dental care is neglectful.

In infancy, neglected children are often recognised by their poor physical state, failure to thrive (Figure 2.14) and delay in achieving developmental milestones such as walking. Older children may have behavioural problems, difficulty forming relationships and emotional problems. A neglected child may present to the dentist with unmet dental needs and may subsequently fail repeated appointments (see Section 2 The question of dental neglect).

MARKERS OF NEGLECT:

The child's needs	**Effects of neglect**
Nutrition	Failure to thrive; short stature
Warmth, clothing, shelter	Inappropriate clothing; cold injury; sunburn
Safe environment	Frequent injuries e.g. burns/cuts from playing with matches/knives
Hygiene and health-care	Ingrained dirt (finger nails); headlice; dental caries
Stimulation and education	Developmental delay
Affection	Withdrawn or attention seeking behaviour

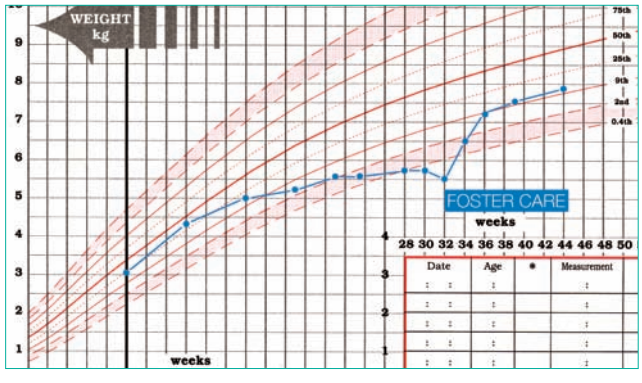


Figure 2.14

Growth chart of failure to thrive, secondary to neglect. The health visitor referred because of poor growth. Other markers of neglect were noted. Note the period of catch-up growth after the child goes into care.

In some instances, a number of the varied features described are present at one time and the diagnosis of child abuse is clear. However, there are occasions when clinical evidence is inconclusive and the diagnosis merely suspected. It is worth repeating that **members of the dental team are not responsible for making a diagnosis of child abuse or neglect, just for sharing concerns appropriately**. If in doubt, you should always take advice from an appropriate colleague as discussed fully in Section 3.

Vulnerable groups

Certain individuals or groups of children may be more vulnerable to abuse or neglect because of risk factors in their family or environment, or because of the way they are perceived by their carers. Recognising these vulnerable groups may enable the dental practitioner to take steps to promote and safeguard the well-being of such children and to respond appropriately to concerns.

It is important, however, not to stigmatize families because of the presence of particular risk factors; whilst the risks of maltreatment may be higher, the majority of children within these vulnerable groups are loved and cared for and do not experience abuse.

Parental factors

Young or single parents, parents with learning difficulties, those who themselves have experienced adverse childhoods and those with any mental health problems, including problems of drug or alcohol abuse, are all more at risk of abusing or neglecting their children.[23] They may often need extra support in meeting their children's needs and may be more vulnerable to the stresses inherent in parenting.

Social factors

Families living in adverse social environments, for example due to poverty, social isolation or poor housing may also find it both materially and socially harder to care for their children. Where such issues are affecting a child's care, it may be possible to intervene to support the family at an early stage before the child suffers harm.

Child factors

Age plays an important role in the patterns of child abuse. Younger children are much more vulnerable to physical abuse and neglect, with at least 10% of all abuse involving children under the age of 1. In contrast, sexual abuse more often (though not exclusively) involves older children, particularly girls.

Children with disabilities are much more at risk of experiencing abuse of all kinds.[24] A wide variety of factors may contribute to that risk including sometimes greater dependence on carers, increased stresses on the carers and difficulties for the young person to communicate concerns. It is also well documented that people with disabilities face barriers when accessing health services. Particular attention should therefore be given to supporting the needs, including the dental needs, of children with disabilities and being alert to signs, symptoms and behavioural indicators that may indicate abuse or neglect.

The question of dental neglect

The American Academy of Pediatric Dentistry has defined dental neglect as 'wilful failure of parent or guardian to seek and follow through with treatment necessary to ensure a level of oral health essential for adequate function and freedom from pain and infection'[25] No corresponding definition has been produced in the UK and there has been limited debate of this issue to date.

Many adults visit the dentist only when in pain for emergency treatment and choose not to return for treatment to restore complete oral health. They may choose to use dental services in a similar manner for their children. Dental professionals have traditionally respected this choice and not challenged this behaviour. However, children may suffer dental pain or other adverse consequences as a result and, when young, are reliant on their carers to seek treatment for them. Anecdotally, it is reported that other health professionals who work regularly with children are shocked that the dental team often fails to rigorously follow up such children.

Dental neglect – wilful neglect?

Severe dental disease may result from a parent or carer's lack of knowledge of its causation or from difficulty implementing the dietary habits and oral hygiene measures they would wish to; for example, because of family stress or poverty. This cannot be equated with wilful neglect of a child. However, when the dental problems have been pointed out and appropriate and acceptable treatment offered, the following may be indicators that give concern:

- irregular attendance and repeatedly failed appointments
- failure to complete planned treatment
- returning in pain at repeated intervals
- requiring repeated general anaesthesia for dental extractions.

Dental neglect – general neglect?

When assessing whether multiple carious teeth and poor oral hygiene are an indicator of general neglect, the dentist should focus on assessing the impact of dental disease on the individual child (Figure 2.15). Severe dental disease can cause:

- toothache
- disturbed sleep
- difficulty eating or change in food preferences
- absence from school

and may put a child at risk of:

- being teased because of poor dental appearance
- needing repeated antibiotics
- repeated general anaesthetic extractions
- severe infection.

However, care should be taken to consider other relevant factors and to resist erroneous assumptions (such as that the number of carious teeth correlates with the severity of the problem) for the following reasons:

- the multi-factorial causation of dental caries
- variation in individual susceptibility to dental disease
- differences in the treatment dentists provide (for example, whether they choose to manage caries in primary teeth by monitoring or restoration or extraction)
- inequalities in dental health (for example, regional or social class differences in caries experience)
- inequalities in access to dental services and treatment.

The authors suggest that, in order to avoid misunderstanding, the term dental neglect should be reserved for situations where there is a failure to respond to a known significant dental problem. This is an area that requires sensitivity and clinical judgment. There is a need for further research to inform the dental team in making these decisions. The issue of what to do and when is addressed in Section 3.

Figure 2.15
Untreated carious teeth – but is it dental neglect?

child protection and the dental team

Section 3

Child protection procedures:

RESPONDING

what **you** need to do if you're worried about a child

Assessing the child
What to do if you're worried about a child
What happens next
Information sharing and confidentiality
Assessing the dental needs of children who have been abused
Forensic aspects of child protection practice
Giving evidence in court
Managing dental neglect

Assessing the child

History and examination

As with all aspects of dentistry, assessing a child with an injury or with possible signs of abuse or neglect starts with a thorough history. As well as getting details from the child and carer of any injury or presenting complaint, it is important to consider aspects of the past dental history, wider medical history and of the family and social circumstances.

Particular aspects of the presentation may in themselves raise some concerns and should be carefully evaluated. These would include, for example, a delay in the presentation, discrepancies between the history and examination findings or previous concerns about the child or siblings. A full dental examination should be carried out, noting in particular any dental, oral or facial injuries, their site, extent and any specific patterns. It is important also to note the general appearance of the child, their state of hygiene, whether they appear to be growing well or are "failing to thrive", their demeanour and interaction with their parents or carers and others. Look particularly for signs of "frozen watchfulness" where the child seems to take in everything going on, but in a detached, wary or fearful manner.

HISTORY: FEATURES OF CONCERN

- Changing or inconsistent history
- Developmentally inappropriate (does not fit with the age of the child)
- Delay in presentation
- Previous concerns, including siblings

EXAMINATION

- Dental examination
- Injuries (site, extent, patterns)
- General appearance (growth, hygiene)

Questions to ask yourself

A list of questions to ask yourself in such circumstances can be kept in the surgery to act as a prompt (see Section 5: Document 3). Within electronic patient records this could be incorporated into a custom screen (Figure 3.1).

Talking to the child

It is good practice to ask the child about the cause of any injuries and to allow them to talk if they volunteer information about abuse. You should avoid asking leading questions and should respond calmly and kindly with a non-judgmental attitude. A child who makes a disclosure of abuse should always be taken seriously. If requested to keep a secret, you should not do so but should explain that you may have to share information, but will explain with whom and when it will be shared.

The Department of Health poster, 'What To Do If You're Worried A Child Is Being Abused: a flow chart for referral'[26] as shown in Figure 3.2, summarises how you should proceed. This forms the basis for the flow chart for the dental team shown in Figure 3.3.

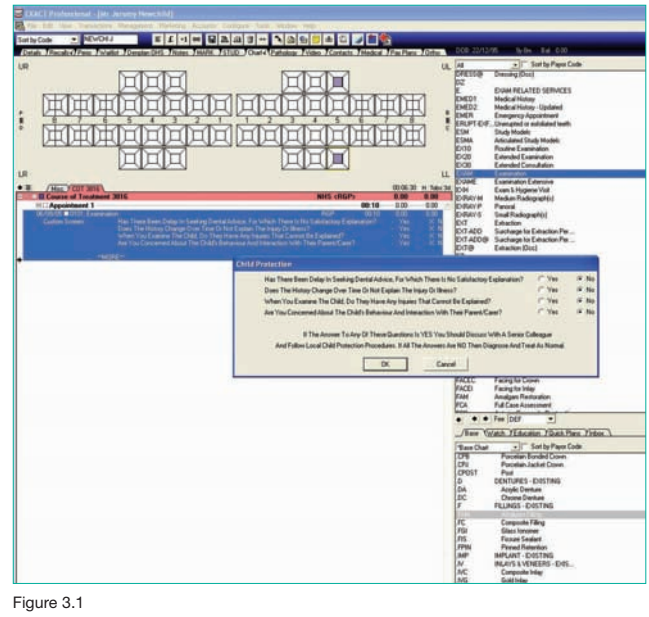
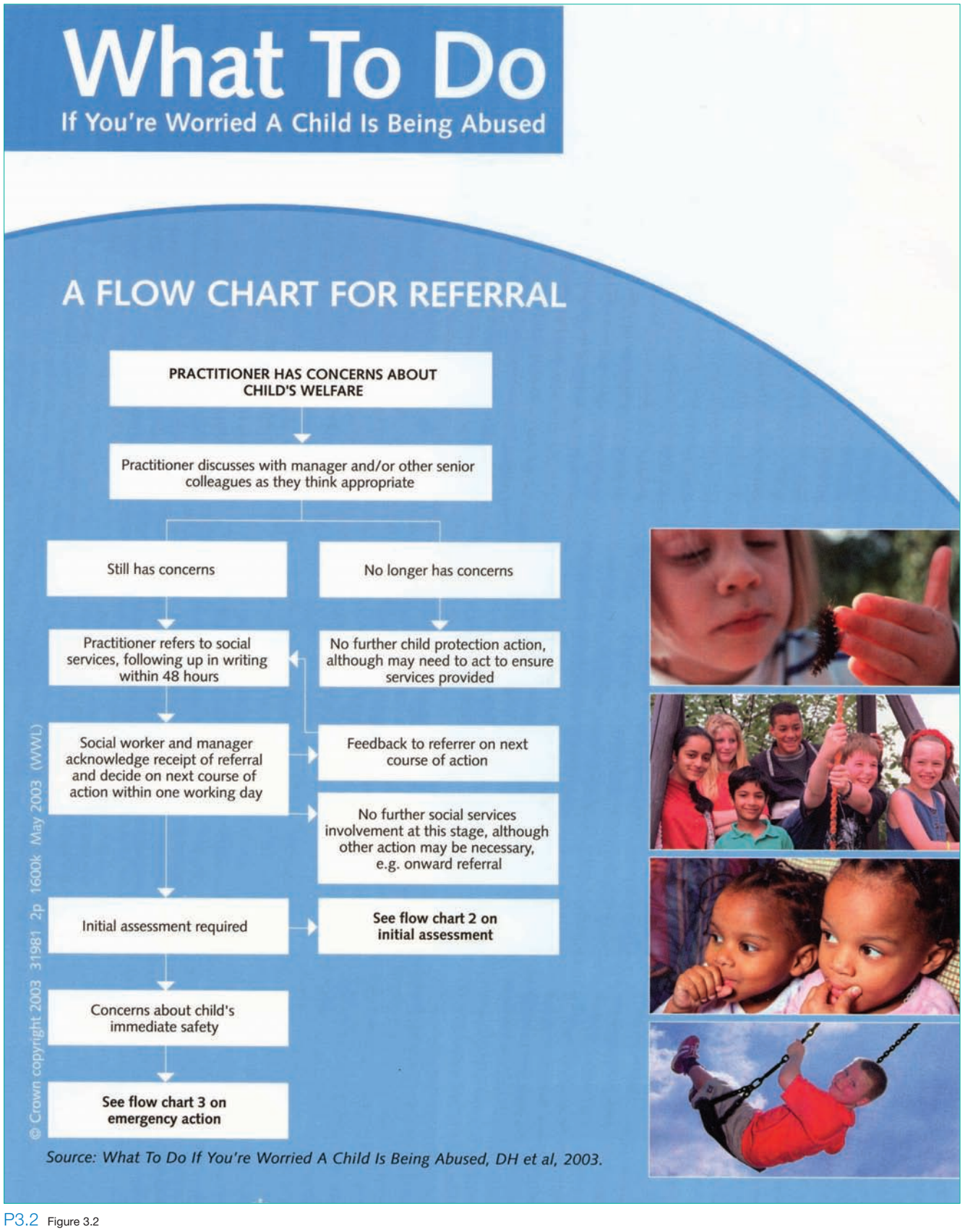


Figure 3.1

A custom screen within electronic patient records can be designed to act as a prompt. *(reproduced with permission of Software of Excellence).*



P3.2 Figure 3.2

'What To Do If You're Worried A Child Is Being Abused: a flow chart for referral[28] *(reproduced with permission of the Department of Health).*

Child protection and the dental team: Flow chart for action

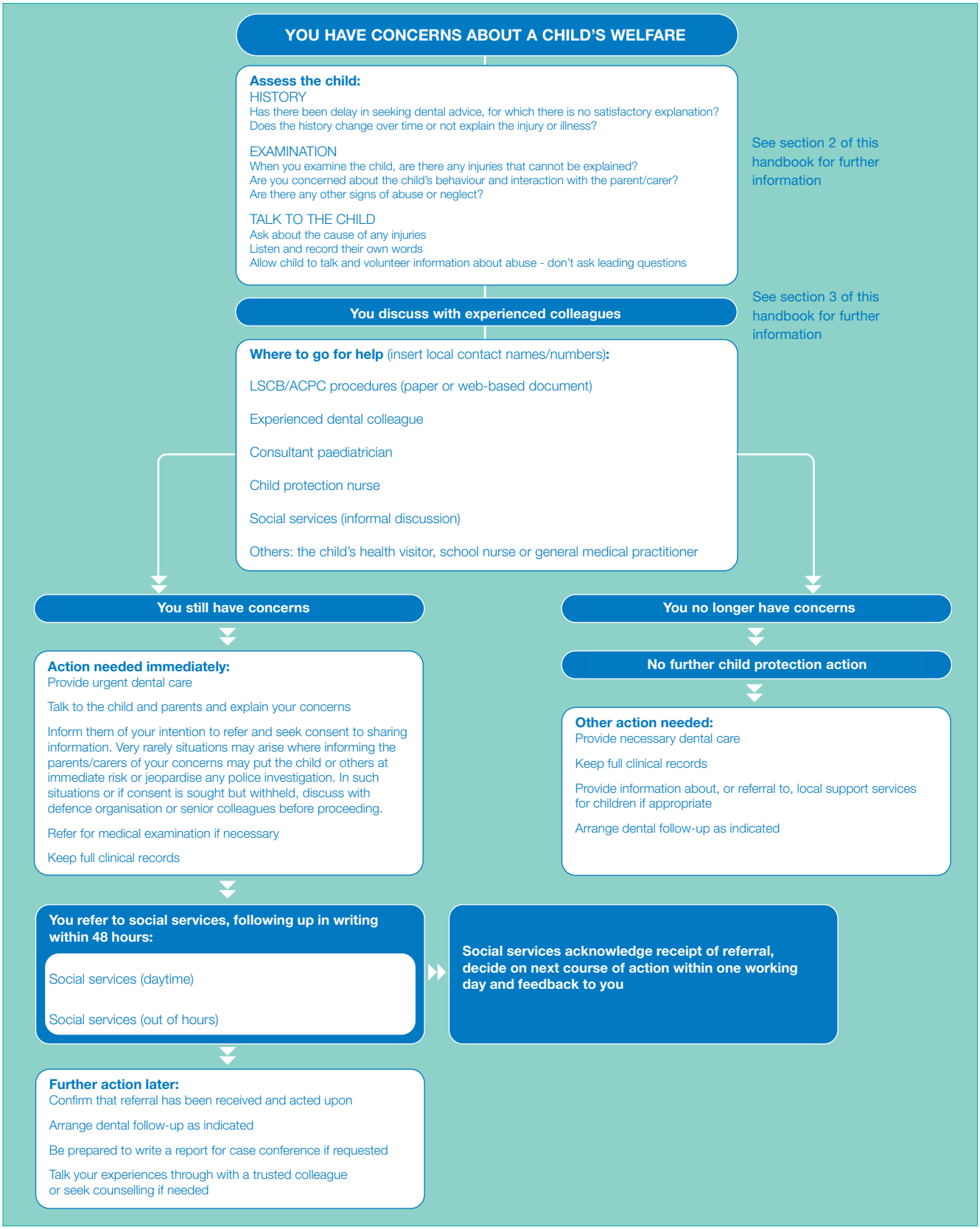


Figure 3.3

Child protection and the dental team: flow chart for action (for a version that can be photocopied and adapted with your local contacts, see Section 5: Document 4).

What to do if you're worried about a child

The most important thing to remember if you are faced with a child who may have been abused is that you do not need to manage this on your own. It is also important to remember that your first duty is to the child and that you have the responsibility for dealing with any injury or dental needs. No child should be left untreated or in pain because of underlying concerns about abuse.

Colleagues to consult

The first stage if you have any concerns should always be to discuss this with an appropriate colleague or someone else you can trust. This may be an experienced dentist, a senior dental nurse, a paediatrician, child protection nurse or a social worker. In the salaried primary dental care services close working relationships often exist with health visitors and school nurses, some of whom are highly experienced in child protection and may be a source of helpful advice.

Making a referral

If, having discussed it with an appropriate colleague, you remain concerned, then you should make a referral to your local social services. You should already have identified where and how to contact your social services team (see Section 4). Referrals should be made by telephone, so that you can directly discuss your concerns, and should be followed up in writing within 48 hours. Your letter should clearly document the facts of the case and include an explicit statement of why you are concerned. The telephone discussion should be clearly recorded, documenting what was said, what decisions were made and an unambiguous action plan.

'I used to think it wasn't my business to interfere – but now I see that my phone call could be the first link in the chain to put the family in touch with the support they need'

A dental therapist, speaking after a child protection training session

Informing the child and parents

It is good practice to explain your concerns to the child and parents, inform them of your intention to refer and seek their consent. Research shows that being open and honest from the start results in better outcomes for children. There are certain exceptions and reasonable judgement must be made in each case. Usually you should not discuss your concerns with the parents in the following circumstances:

- where discussion might put the child at greater risk;
- where discussion would impede a police investigation or social work enquiry;
- where sexual abuse by a family member, or organised or multiple abuse is suspected;
- where fabricated or induced illness is suspected;
- where parents or carers are being violent or abusive, and discussion would place you or others at risk;
- where it is not possible to contact parents or carers without causing undue delay in making the referral.

Informal advice could be taken first without disclosing the childs name. Further discussion of information sharing and confidentiality follows later.

'I know I did the right thing in referring him, but what was so difficult was the feeling that I'd gone behind their backs and didn't discuss it with the family first. I think things have changed for the better now you're advised to explain your concerns to the parents first. Of course it wouldn't be easy, but I'm convinced that's the best way to do it'

A dentist reflecting on a child protection referral she had made some years ago

Useful guidance

Figure 3.3 provides a concise summary of the action you should take. Other suggestions to help your team prepare to respond to concerns about the welfare of a child are discussed in Section 4. Further detailed guidance can be obtained from your 'LSCB/ACPC Procedures'. If not already supplied to your practice, a copy of this informative document should be available from your local social services department or online if they have a website (go to www.dfes.gov.uk/acpc and follow links or, if a link is not available, use your preferred search engine to find the website for your LSCB/ACPC). For further advice on finding your local contacts see Section 5.

What happens next?

Many practitioners worry that by making a referral to social services, they will initiate a process that will quickly get out of hand, and end up with severe and drastic action being taken to remove the child and punish the family. This is a misperception that does not reflect current practice in the UK. Less than 50% of children investigated for possible abuse end up being placed on child protection registers.[13] It is estimated that fewer than 1% of children referred to social services for possible abuse end up in judicial proceedings.[27]

When a child is referred to social services on suspicion of abuse, the duty social worker will note details of the child and family and the concerns that are being raised. The social work team manager will then convene a **strategy discussion** (often by telephone) with a senior member of the police child protection team. This happens within one working day and often involves a paediatrician or other health professional. The purpose of this strategy discussion is to share information and decide on how best to manage the referral, taking note of the concerns that have been raised. They may decide that a social worker will visit the family to carry out an **initial assessment** or initiate a joint investigation with the police. If the concerns are minor, or the family is already known to other professionals, it may be appropriate for those professionals to take the lead in supporting and working with the family, rather than continuing down a child protection route. In extreme cases, where there is the risk of immediate harm to the child, legal action may be required through an **emergency protection order** or police powers of protection.

In those cases where the initial assessment identifies ongoing concerns and risks, a **multiagency case conference** may be held. Parents are normally invited to these conferences. At the conference, all those present are given an opportunity to share information about the child and family, including any concerns they may have. The conference chair then summarises any identified risks to the child, along with any factors that may be serving to protect the child or support the family. An **action plan** is then agreed with the family in order to provide support and ensure the safety of the child. This plan will include a decision on whether the child's name should be placed on the **child protection register** – a decision that is then reviewed at a further case conference after 3 months and at any subsequent conferences that may be held, until such time as the child is felt to be no longer at risk of significant harm. At any stage in this process, it may be necessary to take legal action to protect the child, but this would only be where it has been shown that the child cannot be protected without recourse to such action.

Further details of the process are discussed in the Department of Health booklet 'What To Do If You're Worried a Child is Being Abused'.[28]

Coping with the aftermath

It is quite normal to have some anxiety about the consequences of making a child protection referral. These may include fears about potential adverse consequences for the child or family, or repercussions on your dental practice or yourself.[5,29] Talking it through, or 'debriefing', with an experienced colleague may be helpful or you may wish to seek independent confidential counselling. This may be available through your local occupational health department or child protection named nurse (see also Section 4: Regular team training: Special considerations; Section 5: Finding your local contacts).

'I still think this is a really difficult thing for us, working in a small town where everyone knows everyone else'

A dental practice owner

'I had some sleepless nights after I referred the little girl. I wondered whether I had done the right thing. It helped to talk to someone who had seen this kind of thing before'

A dental nurse

Information sharing and confidentiality

Whenever a child in this country dies as a result of abuse, local agencies are required to undertake a serious case review to look at the case and any lessons that might be learned from it. One consistent theme comes out in all these case reviews; a failure of communication between professionals involved with the child. If we are ever going to protect children from abuse, it is crucial that we learn to communicate with each other and share information.

As a dental practitioner seeing a child, you will have information about the child that no other professional will have. You have a responsibility to share that information appropriately. Where you have identified concerns, you should highlight those to the social worker to whom you are referring the child, backing those concerns up in writing. In other situations you may be asked to provide information for the purposes of an initial assessment or as a contribution to a case conference.

Ethical guidance

Practitioners are often anxious about the legal or ethical restrictions on sharing information, particularly with other agencies. You should be aware of the law and should comply with the principles of current ethical guidance for the dental team.[2] These do not provide an absolute barrier to information sharing. However, the amount of information shared should be proportionate to your level of concern about the child. You should be prepared to exercise your judgment. A failure to pass on information that might prevent a tragedy could expose you to criticism in the same way as an unjustified disclosure.

Consent

In most situations, it will be appropriate to share any concerns you have identified with the family and to obtain their consent to sharing information with others. However, as discussed earlier, there may be situations where to discuss your concerns with the family could put the child at greater risk or may put you or your staff at risk. In practice, such situations are rare. Restrictions on sharing information are embodied in the common law duty of confidence, the Human Rights Act 1998 and the Data Protection Act 1998. Within these frameworks there is provision for sharing information where:

- those likely to be affected consent; or
- the public interest in safeguarding the child's welfare overrides the need to keep the information confidential; or
- disclosure is required under a court order or other legal obligation.

Therefore, if you have concerns about a child's welfare, and you consider the sharing of information to be important in safeguarding that child, you should consider sharing that information even if you are unable to gain parental consent to do so. Sources of further guidance include the defence organisations (Dental Defence Union, Dental Protection Limited, MDDUS or other) and PCT Caldicott guardians (see also Section 5: Further information). Defence organisations welcome enquiries from practitioners in any and every situation and can provide immediate advice and legal assistance if necessary.

Assessing the dental needs of children who have been abused

Children who have been subject to abuse or neglect need a full assessment of their health and developmental needs. This process is coordinated by social services and may require input from a range of professionals. You may be called upon to assess the dental health, oral injuries and unmet dental needs of such children, whether existing patients of your practice or new. In such circumstances the social worker should have obtained consent for dental examination from the parent, alternatively the courts may order an assessment to be carried out. If consent is not available, seek the advice of an experienced colleague or defence organisation before proceeding.

Particular attention should be paid to the following:

- oral examination and assessment of dental health and oral hygiene;
- documentation of any injuries and interpretation in the light of any history given and the developmental stage of the child;
- records of previous dental attendance and treatment (which may provide a positive indicator of appropriate care);
- treatment required, in your opinion, and how it could be carried out.

All assessments should be thoroughly documented, dated and signed. You may be required to provide a written report for social services, or in criminal or civil proceedings a statement that may be placed before the courts.

Forensic aspects of child protection practice

Any situation where a child has been harmed as a result of abuse or neglect potentially involves a criminal offence against that child. The responsibility for carrying out any criminal investigation rests with the police and will usually be carried out by the local police child protection team. Other agencies have a responsibility to **cooperate with the police** in their investigations. Comprehensive, contemporaneous and accurate record keeping is essential to this process (see Section 4). You may be requested to assist the police by providing a statement, copies of records or by carrying out particular forensic examinations or tests where you are qualified to do so. You need to obtain consent and should consider taking advice from your defence organisation in all such situations.

Diagrams and clinical photographs

When you examine a child, you should consider whether your notes should include a diagram of your findings (see Section 5: Document 5) or be supplemented by clinical photographs. Diagrams and photographs should be clearly labelled with the child's identity and the date and time marked. They should be referred to in the clinical notes. Diagrams should be annotated with descriptions and measurements of any injuries. Other than for medical record purposes, it is not the role of the dental team to attempt to take photographs of forensic quality. There are very precise requirements for such photographs. A rigid, right-angled measuring scale must be incorporated (as in Figure 2.11) and multiple views may be required when marks involve different parts of curved body surfaces.

DNA sampling

Where a child has been assaulted, it may be possible to obtain forensic evidence, including DNA sampling.[20] You may be asked to assist the police in obtaining such samples, for example through taking swabs of a bite mark or other injury. Strict procedures must be followed in order to ensure the validity in court of any samples. This may involve, for example, a clear, documented "chain of evidence" where a sample is passed from one person to another with no possibility of contamination.

Bite marks

Documenting and interpreting the significance of bite marks must be carried out by someone with training and experience in forensic odontology. **Dental practitioners should be clear about their own limitations and only offer opinions within their level of expertise.** Certain features of the injury may help to distinguish animal from human bites and adult from child bites. It may also be possible to match the impression left with the dentition of a suspected perpetrator. Assessment of these cases may involve:

- examination of the injury and provision of diagrams, documentation and forensic photographs obtained according to a clear procedure;
- examination, photographs and impressions of the victim's own dentition;
- examination, photographs and impressions of any alleged perpetrator or other family members.

Local police may have a preferred expert. Alternatively, the British Association for Forensic Odontology (www.bafo.org.uk) can supply contact details of suitably qualified members who can be approached to advise and undertake such work (see Section 5: Finding your local contacts).

Giving evidence in court

In cases of severe child abuse or neglect, two parallel legal processes may be required: the prosecution of an alleged offender in the criminal courts and the protection of children under the Children Act in the civil courts. The two processes take different routes and rely on different levels of evidence. The decision as to whether or not criminal proceedings should be initiated is undertaken by the police in conjunction with the Crown Prosecution Service and based on three main factors:

- whether or not there is sufficient evidence to prosecute;
- whether it is in the public interest that proceedings should be instigated against a particular offender;
- whether or not a criminal prosecution is in the best interests of the child.

The evidential standard required by the criminal court is proof 'beyond reasonable doubt' that the defendant committed the offence. In contrast, civil proceedings are initiated by the local authority for the protection of the child and rely on finding 'on the balance of probabilities' that a child has suffered or is likely to suffer significant harm.

As a professional involved in a case, you may be called upon to provide evidence in either court. In both situations your responsibility to the court is to provide an accurate and unbiased account of your findings, your opinion based on those findings and any action that you took as a consequence. In a court situation, you should never venture beyond your level of expertise or provide opinions that you are unable to back up.

Further advice is available from your defence organisation. Support and training may also be available locally for those unfamiliar with court procedures. Your local child protection named nurse or doctor may be able to advise (see Section 5: Finding your local contacts).

Managing dental neglect

When a child presents with a neglected dentition, you should not seek to blame the parents or carers but to support them. Some LSCB/ACPC procedures make provision for initial management of minor concerns about the welfare of a child, where the criteria for immediate referral to social services are not met.[30] It should be noted that this relates only to neglect or emotional abuse. Three stages of intervention are described:

1 Preventative single agency response - raise concerns with parents, offer support, set targets, keep records, monitor progress
2 Preventative multi-agency response - liaise with other professionals, check Child Protection Register (where this facility is available), agree a joint plan of action, review at agreed intervals
3 Referral to social services - if the situation is too complex or deteriorating

These principles of management may be appropriate when there is isolated dental neglect, unaccompanied by signs of general neglect. Table 3 shows how the dental team might put this into practice where resources permit. The case study overleaf provides further illustration. See also Section 5: Document 6 for an example of a letter that could be used to communicate with health visitors regarding vulnerable young children who need dental care.

Much of this will be familiar to those who already employ a preventive approach to treatment planning for children. If you have any doubts about the appropriateness of such action, you should discuss with an experienced colleague and proceed to refer the child to social services as indicated earlier (Figure 3.3).

Guide for action	Example applied to a 4-year-old child with caries who only attends when in pain	Suggested team member/s responsible
Raise concerns with parents	Explain clinical findings, the possible impact on the child, and why you are concerned	Dentist
Explain what changes are required	Explain treatment needed and expectation of attendance	Dentist
	Give advice on changes needed in diet, fluoride use and oral hygiene	Therapist, hygienist or dental nurse as appropriate
Offer support	Consider giving free fluoride toothpaste and brush	Dental nurse
	Offer the parent or carer a choice of appointment time	Dental receptionist
	Listen for indications of a breakdown in communication, or parental worries about the planned treatment, and offer to discuss again or to arrange a second opinion if this is the case	All team members
Keep accurate records	Keep accurate clinical records	Dentist and/or other team members
	Keep accurate administrative records of appointments and attendance	Dental receptionist
Continue to liaise with parents/carers	Keep up open communication with the parents and repeat advice, so that they know what is expected of them	All team members
Monitor progress	Arrange a recall appointment	Dentist
If concern that child is suffering harm, involve other agencies or proceed to make a child protection referral	Consult other professionals who have contact with the child (e.g. health visitor, nursery nurse) and see if your concerns are shared	Dentist
	Take further action without delay if indicated	Dentist

Table 3
Preventative single agency response to dental neglect: a team approach.

Case study

This case study illustrates good practice in:

- multi-agency working
- early intervention to safeguard children
- management of dental neglect

A family of four children aged 7, 4, 3 and 1 attended for a dental examination. The eldest had been a patient at the practice two years previously but then failed to complete a course of treatment. On this occasion all four children had dental caries and poor oral hygiene, the younger children presenting with more extensive caries at an earlier age than their older siblings.

At subsequent appointments it became apparent that all the children were consuming frequent sugar-containing snacks and drinks. The two youngest children were drinking juice from a bottle throughout the day and night. Advice was given on caries prevention. Their mother reported increasing difficulty coping with the children's eating and sleeping habits and behaviour. She readily agreed to the dentist's offer to contact their health visitor to see if any support and advice might be available.

The health visitor visited the family at home on several occasions over the next six months to give advice on various aspects of health and parenting. She put them in touch with local Sure Start services. The situation soon improved and there were no further concerns.

In the months that followed, the two younger children required dental extractions under general anaesthesia. A note was made that they remained at high risk of caries and would require regular preventive care. When they missed a subsequent recall appointment and no response was received to a letter offering a further appointment, the health visitor was informed by letter (Section 5: Document 6) in accordance with practice policy. This prompted the family to phone for a further appointment and they now attend for regular dental care (Figure 3.4).

i

ii

iii

iv

v

Figure 3.4

(i) This family will require ongoing preventive dental care. The older siblings (ii, iii) had needed simple dental treatment under local analgesia. The need for extractions under general anaesthesia at an early age in the younger children (iv, v) alerted the dentist to liaise with their health visitor to arrange support.

child protection and the dental team

Section 4

Safeguarding children in dental practice:

REORGANISING

how to prepare **your** practice to safeguard children

Staff member to lead on child protection
Child protection policy
Step-by-step guide of what to do if you have concerns
Best practice in record keeping
Regular team training
Safe staff recruitment

Tips for best practice:

Safeguarding children is not just about referring them when you have concerns but is about changing the environment to ensure that risks to children's welfare are minimised. By following these tips for best practice, a dental practice will be well placed not only to fulfil the responsibilities of current legislation and ethical guidance but also to take an active role in safeguarding children:

1. Identify a member of staff to take the lead on child protection
2. Adopt a child protection policy
3. Work out a step-by-step guide of what to do if you have concerns
4. Follow best practice in record keeping
5. Undertake regular team training
6. Practice safe staff recruitment

Staff member to lead on child protection

In a busy dental practice there are many important clinical governance issues competing for time and attention. Appointing an individual staff member to lead on child protection can be an effective way of ensuring that this issue is not overlooked.

The child protection lead should be someone who:

- is a good listener
- has respect for confidential information
- is able to handle difficult or distressing issues sensitively
- thinks before taking action.

The child protection lead could be a dentist or any other suitably trained member of the dental team. The **role of the child protection lead** might include the following duties:

- keeping an up-to-date list of local contacts for child protection advice and referral
- making this information readily available to staff
- ensuring that LSCB/ACPC procedures are available and up-to-date
- organising staff training
- auditing practice
- keeping details of local sources of confidential emotional support for staff (this might be needed by staff who are involved in distressing child protection cases, or who have been abused themselves or observed abuse in their families).

See Section 5 for information to support these activities and a check list to monitor your progress (Section 5: Document 7).

The child protection lead might also be, but would not have to be, the senior member of staff to whom colleagues would turn for advice when establishing whether they have concerns about a child. However, it would be inappropriate to make this person responsible for making all child protection referrals within the practice. Referral remains the responsibility of the person who recognises the suspected abuse or neglect, usually the treating dentist.

Child protection policy

A policy is a plan or course of action intended to influence and determine decisions and actions. A suitable child protection policy statement for a dental practice should affirm the practice's commitment to protecting children from harm and should explain how this will be achieved (Figure 4.1; Section 5: Document 8). The date on which the policy is adopted should be stated, together with a date when it will be due for review.

However, a policy alone is not enough. Safeguarding children is about changing the whole environment. You can do this by:

- listening to children
- providing information for children
- providing a safe and child-friendly environment
- having other relevant policies and procedures in place.

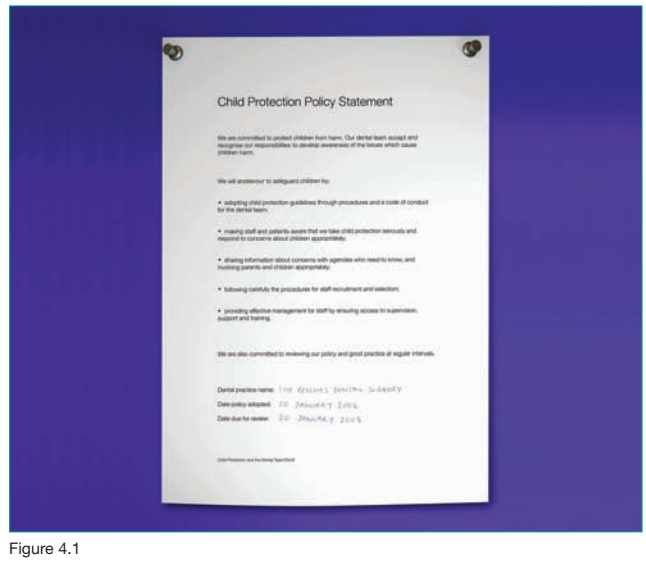


Figure 4.1

An example of a suitable child protection policy statement.
(adapted with permission from Volunteer Development Agency[31])

Listening to children

You should create an environment in which children know their concerns will be listened to and taken seriously. You can communicate this to children by:

- **asking for their views** when discussing dental treatment options, seeking their consent to dental treatment (as appropriate to their age and understanding) in addition to parental consent[32]
- **involving them** when you ask patients for feedback about your practice e.g. by providing a suggestion box or by carrying out a patient satisfaction survey
- **listening** carefully and taking them seriously if they make a disclosure of abuse.

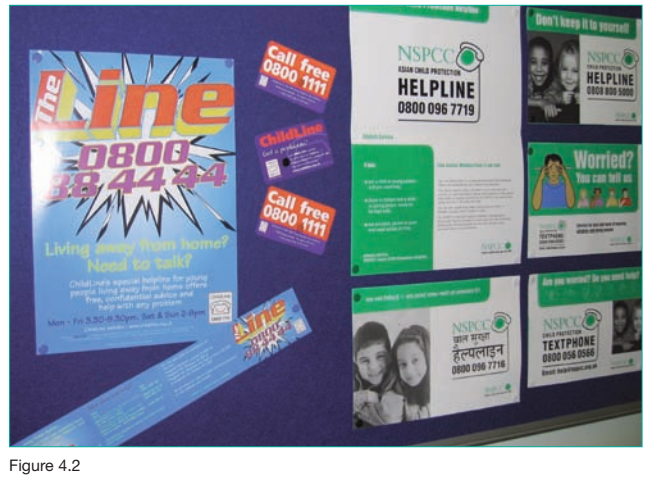


Figure 4.2

A dental practice can contribute to safeguarding children simply by providing them with information about local services and sources of help.

Providing information for children

To support children and families, you can provide information about:

- **local services** providing advice or activities e.g. Sure Start services (see Section 5: Finding your local contacts), parenting courses, toddler groups and youth groups
- **sources of help** in times of crisis e.g. NSPCC Child Protection Helpline, NSPCC Kids Zone website, Childline, Samaritans, local support groups for children or parents (see Section 5: Finding your local contacts) (Figure 4.2).

Providing a safe and child-friendly environment

A safe and child-friendly environment can be provided by:

- taking steps to ensure that areas where children are seen are **welcoming and secure** with **facilities for play**
- considering whether young people would wish to be **seen alone or accompanied** by their parents
- ensuring that **staff never put themselves in vulnerable situations** by seeing young people without a chaperone
- ensuring that your practice has **safe recruitment procedures** in place.

Other relevant policies and procedures

Clinical governance policies that you already have in place will also contribute to your practice being effective in safeguarding children. Relevant policies and procedures include:

- **complaints procedures** so that children or parents attending your practice can raise any concerns about the actions of your staff that may put children at risk of harm
- **public interest disclosure policy** (or 'whistleblowing' policy) so that staff can raise concerns if practice procedures or action of other staff members puts children at risk of harm
- **code of conduct for staff** clarifying the conduct necessary for ethical practice, particularly related to maintaining appropriate boundaries in relationships with children and young people (e.g. including a statement that staff members will be chaperoned when attending to unaccompanied children)
- **guidelines on use of restraint** (or 'physical intervention') so that staff know how to intervene appropriately for children unable to comply with dental care[33]
- **consent policy and procedures** as discussed above.

These are just a few examples. For a comprehensive checklist of further policies, procedures and good practice guidelines of relevance to child abuse, domestic violence and abuse of vulnerable adults see 'The Management of Abuse: a resource manual for the dental team'.[34]

'Previously child protection for me was just about referring abuse, but now I realise that things have moved on and it's also about creating an environment where children's needs and rights are protected. I've been pleased and surprised to find that we already do much of what's needed through our existing policies and procedures'

A dentist who manages a salaried primary dental care service

Step-by-step guide of what to do if you have concerns

When you have concerns about a child it is essential to be able to access information and advice immediately so that you can take action promptly. As a minimum, every dental practice should have:

- a copy of the **LSCB/ACPC procedures** folder (Figure 4.3) or the website saved as a 'favourite' if available online
- an up-to-date list of **telephone numbers** of local contacts for advice or referral.

Teams working regularly with children will find it useful to work out their own step-by-step guide of what to do if they have concerns about a child. This could be done by adapting the flow chart in Section 3 (Figure 3.3) with local information (Section 5: Document 3). Alternatively, written guidelines could be produced, perhaps using a published example of good practice as a template.[35]

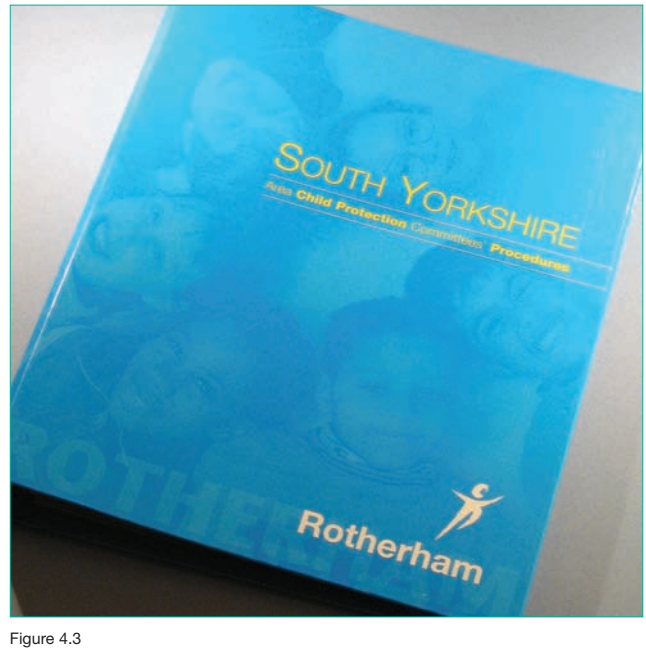


Figure 4.3

All professionals working with children should have access to their LSCB/ACPC procedures.

Best practice in record keeping

A routinely high standard of record keeping is a clinical governance requirement. Furthermore it is essential for a dental team who intend to take safeguarding children seriously.

Basic information

When a child attends any healthcare service for the first time, basic personal information must be recorded. Accurate records of these simple details contribute to safeguarding children. The information required is defined in government guidance[28] and must be recorded for every child and checked for changes at every visit:

- full name
- address
- gender
- date of birth
- school
- name(s) of person(s) with parental responsibility
- primary carer(s), if different.

'Front-line staff in each of the agencies which regularly come into contact with families with children must ensure that in each new contact, basic information about the child is recorded'

Recommendation 12, Victoria Climbié Inquiry[4]

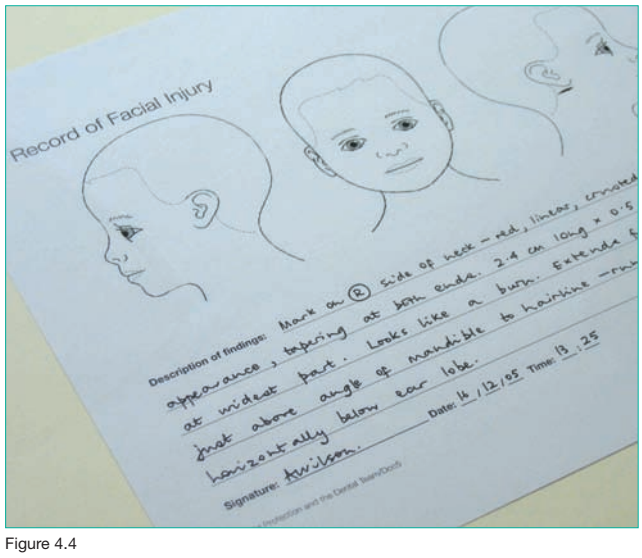


Figure 4.4
A face map proforma, completed to record the injury illustrated in Figure 2.6.

Clinical records

When treating children, in addition to details of examination, diagnosis and treatment provided, it is good practice to record:

- **who accompanied the child** and, if not the parent, their relationship to the child
- **observations of behaviour**, not only physical signs
- a summary of any **discussions with the child and parent**.

These recommendations apply at any time, even when there are no concerns about the child. When there are child protection concerns, the following additional points are particularly pertinent:

- record observations and reasons given for **seemingly trivial injuries** which may, over a period of time, show a repeating pattern of injury
- make **diagrams** in addition to written descriptions (drawings, either freehand or on a mouth, face or body map proforma or clinical photographs with consent) clearly labelled with the child's name and date (Figure 4.4; and Section 5: Document 5)
- record observations in a way that will be **understandable to colleagues** so that, even if no single team member gets to know the child well, a written record builds up over time. This overcomes the problem that abusers sometimes avoid detection by taking a child to different practitioners on different occasions so that no-one picks up on 'the big picture'
- clearly state the **difference between the facts and your opinion**
- keep **administrative notes** such as attendance, non-attendance and cancelled appointments in addition to the clinical notes.

The clinical records should be:

- **only accessible to health professionals who 'need to know'**
- readily accessible to those who need to know, so should be **stored in one place**
- **stored securely:** paper-based records should be stored in locked filing cabinets in rooms accessible only to staff, and never left unattended when in use; electronic records should be password protected**.**

GOOD PRACTICE GUIDELINES FOR CLINICAL RECORD KEEPING

Handwritten records should be:

- contemporaneous
- legible
- clear and unambiguous
- written in black ink or ball pen (not other colours, not pencil)
- stored securely
- signed, dated and timed
- and should only contain abbreviations that are defined.

Electronic records should be:

- checked before confirming any entry
- backed up regularly
- secure
- not modifiable after saving.

'Over the years he had seen several of us at the practice and had been referred for GA extractions but had missed a number of appointments at the hospital. It was only because of my colleagues' detailed record keeping in the past, including what they had explained to his mum, that I could see how his needs were being neglected and so had the confidence to act'

A dentist reflecting on the care of an 11-year-old child who returned for a second time with a swollen face due to a severe dental infection

'In court there was a discussion about who was given the dental appointment card - it was only the fact that the receptionist had written down that she gave it to the social worker, and not the parent that helped the family show in court that on this occasion they had not wilfully missed the dental appointment – of course this was only a tiny part in a much bigger picture, but we were thanked for the accuracy of our record keeping'

A practice manager after being asked to submit evidence in a child protection case

Standards for record keeping

Detailed guidance on clinical record keeping is available from other sources.[36] Records should be kept for the legally required minimum period.

Regular team training

Frequency of training

Child protection training should be mandatory for all staff at induction, with updates at regular intervals thereafter. However, it has been reported that many dentists have never received any child protection training.[29] More specific guidance on frequency of training may be issued by regulatory bodies in due course.

'It's like resuscitation training, it doesn't happen often and you need to keep up-to-date with changes, so in our team we are going to do a refresher course every 3 years'

A senior dental nurse

Content of training

When arranging training, you should check that the aims and objectives of a course meet the learning needs of your team. Guidance is available on the recommended **key outcomes** of training for staff with varying levels of involvement with children (Table 4). These three levels, or adaptations of them, are used by many LSCBs/ACPCs as the basis for their interagency training programmes. **Level 1 training** would be appropriate for all members of the dental team who have contact with children in the course of their work. Members of the dental team who do not have contact with children should also train at this level if they have contact with adults who are parents. The reason for this is that they might hear something that gives concern about the welfare of a child and they need to know what action to take. **Level 2 training** would be appropriate for those dentists and other team members who have greater involvement with children and for whom child protection is a regular feature of their work, for example the child protection lead person within a practice or a dentist with a special interest in children's dentistry. **Level 3 training** will usually be reserved for interested dental specialists in the field.

It has been suggested, in preliminary findings of a recent study, that dentists who have done child protection training point to the following factors as being most valuable:[37]

- the **opportunity to discuss** case scenarios of relevance to dentistry
- **hearing other viewpoints** and interacting with participants from other agencies
- **meeting local professionals** (in healthcare and social services) whom they might contact in the future for advice or to refer.

Sources of training

Postgraduate medical and dental deaneries provide courses and lectures which are dentally relevant and may be open to the whole dental team. They are often free or at nominal cost and provide verifiable CPD.

In-practice training can be arranged to meet the needs of your own team. Salaried primary dental care services often have established links with health trust child protection nursing departments for provision of training. Similar training may be available to individual dental practices. It would be wise to discuss your team's objectives with the trainer when arranging a course and to request that case studies relevant to dental practice are included.

LSCBs/ACPCs provide an ongoing program of multi-agency training in every area. These courses give a valuable opportunity to meet staff in other agencies to whom you might refer, so helping you to build a network of local contacts for advice on child protection. Information provided will be up-to-date and authoritative. It may be more difficult to relate your learning to a dental practice setting unless you have some prior knowledge or are used to multi-agency working. Courses range from basic awareness courses to advanced or specialised topics.

Distance learning could be used by staff members individually for self-directed study or as an introduction to support in-practice team learning and clinical governance activities. An example of a suitable certificated course is the NSPCC/Educare 'Child Protection Awareness in Health' programme.

For further information and contacts see Section 5: Providers of child protection training.

Special considerations

Providers of child protection training should be aware of:

- the stressful nature of child protection training
- the potential for disclosure of childhood abuse by course participants
- the need to provide support or referral for participants if necessary.

More than 1 in 10 adults in the UK remember being abused as children.[38] This suggests that, even in small dental practices, it is likely that training may bring back unpleasant memories for some members of staff. Team leaders would do well to be prepared for such eventualities with details of agencies able to offer support (see Section 5: Finding your local contacts).

Training level	Appropriate for:	Key outcomes:
Level 1. Introduction	Those in contact with children or parents	Contribute and take whatever actions needed to safeguard children
		Recognise and respond to concerns about a child in need
		Appreciate own role and that of others
		Communicate and act appropriately within national and local guidance to safeguard children
		Familiar with local arrangements, services and sources of advice for supporting families and safeguarding children
Level 2. Foundation	Those who work directly with children, or adults who are parents	Accomplish core tasks together to safeguard and promote children's welfare e.g. assessments, planning, core groups, conferences, and decision making
		Sound understanding of principles and processes for effective collaboration
		Communicate and develop working relationships in the interest of children
		Understand contribution made by others to safeguarding children and impact of own decisions and actions on others
Level 3. Post-foundation	Those involved in assessment and intervention to safeguard children	Co-work on complex tasks or particular areas of practice that have specific knowledge or skill requirements, e.g, joint enquiries and investigations, investigative interviews, complex assessment
		Establish and maintain partnerships of mutual trust and respect
		Understand legal and organisational frameworks, including levels of accountability of decision making, in other agencies

Table 4

Key outcomes of child protection training[1] *(reproduced with permission of the Department of Health).*

Safe staff recruitment

Some abusers seek employment in situations where they will come into contact with children so they can groom them for abuse. You need to follow safe recruitment processes to ensure that children attending your dental practice cannot be targeted this way.

- Include your **child protection policy** in information sent to potential job applicants; this alone has been shown to discourage potential abusers from applying
- Check **application forms** carefully. Are there any gaps in employment? Ask about these at interview
  Is there any indication that the applicant may have been dismissed from previous employment? Ask about frequent job changes and the reasons for them
- Request **proof of identity** and ask about any change of name. Check documentation carefully e.g. birth certificate, marriage certificate
- Ask for **references** from former employers, and take these up prior to confirming an offer of employment
- Carry out a **Criminal Records Bureau (CRB) check** (Figure 4.5). At present NHS employers are advised to undertake CRB checks for new staff as a matter of good practice. Checks are expected to become mandatory. When recruitment of a member of staff is needed urgently it may be possible for them to start work for a probationary period, conditional on a satisfactory check. For updated advice, consult the NHS Employers' website and CRB website (see Section 5: Further information).

In addition, it is necessary to establish that newly appointed dental staff who work with children have kept up-to-date with current thinking on managing children's behaviour in the dental surgery. Some techniques that were previously thought acceptable may now be considered physically or verbally abusive and the dental team need to be aware of this in order to avoid unintentionally harming children.

Your LSCB/ACPC may have **recruitment standards** for agencies working with children. Further information on recruitment is also available to members from dental professional organisations such as the British Dental Association (see Section 5: Further information).

Figure 4.5
CRB checks should be carried out for new dental practice employees.

Additional note (2009 reprint):
New arrangements for safeguarding vulnerable children and adults come into force from October 2009. Further information is available from **www.isa-gov.org.uk**

child protection and the dental team

Section 5

Further information:

RESOURCES

additional materials to support **you**

Glossary
References
Finding your local contacts
Further information
Providers of child protection training
Documents to photocopy

Glossary

ACPC	Area Child Protection Committee; see also LSCB
bite mark	a mark caused by the teeth with or without the influence of other mouth parts[39]
child	includes children and young people under the age of 18, and also includes vulnerable young people over 18
children 'in need'	children who are unlikely to reach or maintain a satisfactory level of health or development without the provision of services, plus those who are disabled
child protection	actions taken to protect children who are suffering or are at risk of suffering significant harm; child protection forms a part of safeguarding children
CRB	Criminal Records Bureau; an executive agency of the Home Office set up to help employers identify candidates who may be unsuitable to work with children or other vulnerable people
dental team	a group of dentists, dental care professionals (DCPs) and other staff who work together to provide oral health care services
disclosure	'to disclose' or 'make a disclosure', these terms are used in three different ways in the context of safeguarding children; 1. when a child tells you directly that they have been abused; 2. when you share information with others; and 3. when you request a CRB disclosure when recruiting new staff
fabricated or induced illness	when a parent or carer fabricates the symptoms of, or deliberately induces illness in a child; formerly known as Munchausen syndrome by proxy; a form of physical abuse
groom/grooming	when a potential abuser befriends a child with the intention of harming them
LSCB	Local Safeguarding Children Board; a multiagency board responsible for developing local procedures and providing training; LSCBs replace Area Child Protection Committees (ACPCs) in 2006
PCT	primary care NHS trust
policy	an officially agreed plan of what to do in specific situations
procedures	a set of actions which is the official or accepted way of doing something
safeguarding	measures taken to minimise the risks of harm to children; this includes protecting children from maltreatment, preventing impairment of their health or development, and ensuring that children grow up in a safe and caring environment

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Finding your local contacts

All details are correct at the time of writing but readers are advised that some may be liable to change.

1. To ask advice or make referrals

Local Safeguarding Children Boards/Area Child Protection Committees

www.everychildmatters.gov.uk/lscb

This website provides information about the work of LSCBs in England in safeguarding children from abuse and neglect. LSCBs' contact details are currently available on this site.

Alternatively:

- for the telephone number, see 'Social Services: Children's Services' in your local telephone directory;
- to find the website of your LSCB/ACPC (if a website is available), use your preferred search engine inserting 'LSCB' or 'ACPC' together with the name of your local council (e.g. city council, metropolitan borough council etc).

British Association for Forensic Odontology

www.bafo.org.uk

Supplies contact details of suitably qualified members to undertake work or provide advice.

Health visitors, school nurses, child protection nurse advisor, consultant paediatrician

Contact details are available from the local telephone directory, PCT or hospital trust website, or local information leaflets.

You may be able to obtain a list of all local health visitors and school nurses from the PCT, but these need frequent updating. Alternatively a child's health visitor (for pre-school children) can often be contacted via their general medical practitioner's surgery. The name of a school nurse (for school-aged children) can usually be obtained from the child's school.

2. To support children and families

National Society for Prevention of Cruelty to Children (NSPCC)

Weston House, 42 Curtain Road, London EC2A 3NH

www.nspcc.org.uk 020 7825 2500

Provides help for those needing advice including: a telephone helpline (0808 800 5000); online advice topics and advice leaflets, including positive parenting tips; publications for parents and carers, and children and young people; www.there4me.com providing confidential online advice for children aged 12-16.

ChildLine 0800 1111

www.childline.org.uk

A free 24-hour telephone helpline (0800 1111) for children and young people in the UK, providing confidential counselling about any problem.

Sure Start

www.surestart.gov.uk

Sure Start is the government programme to deliver the best start in life for every child in England.

It offers help to parents of young children by supporting services in disadvantaged areas, bringing together early education, childcare, health and family support. Information about your local Sure Start settings can be obtained from the website or your local telephone directory. Responsibility for early education and childcare in Scotland, Wales and Northern Ireland rests with separate devolved administrations.

3. To support staff who have worries about management of child protection cases with which they have been involved

Debriefing may be available from your local **child protection advisor or child protection named nurse.** Confidential counselling may be available from your local **occupational health service**.

If it is affecting your health, you should seek advice from your own **general medical practitioner**.

4. To support staff who were abused as children

Local providers of child protection training should be able to recommend local sources of support for adult survivors of child abuse. Alternatively the following organisations may be able to help:

The National Association for People Abused in Childhood (NAPAC)
42 Curtain Road, London, EC2A 3NH
www.napac.org.uk 020 8313 9460

Provides information for adult survivors of childhood abuse including: details of local support groups, a help and advice pack, a book list and 'info-line' (0800 085 3330 – temporarily suspended in October 2005).

Samaritans 08457 90 90 90
www.samaritans.org.uk

Provides confidential emotional support for people who are experiencing feelings of distress or despair.

Further information

All details are correct at the time of writing but readers are advised that some may be liable to change. This section is included to assist you in your work. It is not intended to be a comprehensive list of all relevant information and services.

1. Further reading

Management of Abuse: a resource manual for the dental team
Sinha S, Acharya P, Jafar H, Bower E, Harrison V and Newton JT. London: Stephen Hancocks Limited, 2005.
www.shancocksltd.com
An informative, well illustrated and extensively referenced text on child abuse, domestic violence, abuse of vulnerable adults and effective protection. Verifiable CPD and a 'legislative update' are available.

'It doesn't happen to disabled children': child protection and disabled children
National Working Group on Child Protection and Disability. London: NSPCC, 2003.

2. Online information resources

National Society for Prevention of Cruelty to Children (NSPCC)
www.nspcc.org.uk
Including information about the NSPCC's publications, library, training and consultancy services, and NSPCC Inform.

NSPCC Inform
www.nspcc.org.uk/inform
A free, online, specialised child protection information resource to support any professionals working to protect children.

CORE INFO Welsh Child Protection Systematic Review Group
www.core-info.cf.ac.uk
Systematic reviews of physical aspects of child protection e.g. bruising, fractures, oral injuries and bites. See reference list for resulting publications (Maguire *et al*, 2005a; Maguire *et al*, 2005b). Further articles are currently in press. See also a series of user-friendly information leaflets published with the NSPCC, downloadable from NSPCC Inform: *Core-info: bruises on children; Core-info: fractures in children; Core-info: oral injuries and bites on children; Core-info: thermal injuries on children.*

3. Guidance documents

General Dental Council
www.gdc-uk.org
London: General Dental Council, 2005.
Standards Guidance: Standards for Dental Professionals
Standards Guidance: Principles of Patient Consent
Standards Guidance: Principles of Patient Confidentiality
Standards Guidance: Principles of Dental Team Working

National Service Framework for Children, Young People and Maternity Services
Primary Care Version. London: Department of Health, 2004, document no. 40620.
A 10 year strategy that sets out to improve the health and well-being of the nation's children. It sets standards to promote child-centred health and social services, and places emphasis on early intervention to meet children's needs, tackling health inequalities and promoting and safeguarding the welfare of children.

Every child matters
www.everychildmatters.gov.uk
Every child matters: summary, publication ref. DfES/0672/2003. Department for Education and Skills, 2003.
Every child matters: change for children, publication ref. DfES/1081/2004. Department for Education and Skills, 2004.

What To Do If You're Worried A Child Is Being Abused
Full report, publication no. 31533. Summary, publication no. 31815. A flow chart for referral, publication no. 31981. London: Department of Health, 2003.

The summary and flow chart, containing useful guidance on information sharing and referral, were circulated to dentists. They remain the basis of current practice.

Working Together to Safeguard Children
A guide to inter-agency working to safeguard and promote the welfare of children. HM Government. London: The Stationery Office, 2006. Available at:
www.everychildmatters.gov.uk

Tips on ordering government guidance publications
Many Department of Health **(www.dh.gov.uk)** and Department for Education and Skills **(www.dfes.gov.uk)** documents are available online to view or download. Alternatively, hard-copy publications and may be ordered as follows, often free of charge:

Department of Health Publications
PO Box 777
London SE1 6XH
Tel: 08701 555455
Fax: 01623 724524

Department for Education and Skills
PO Box 5050
Sherwood Park
Annersley
Nottingham NG15 0DJ
Tel: 08456 022260
Fax: 08456 033360

4. Employment and legal

Providers of advice services and publications for members on a wide range of issues of relevance to dental practice, including staff recruitment and clinical governance:

British Dental Association
64 Wimpole Street, London W1G 8YS
www.bda-dentistry.org.uk 020 7935 0875

General Dental Practitioners' Association
61 Harley Street, London W1G 8QU
www.gdpa.org.uk 020 7636 1072

Providers of medicolegal advice services, publications and telephone advice lines for members:

Dental Defence Union
MDU Services Ltd, 230 Blackfriars Road, London SE1 8PJ
www.the-ddu.com 0800 374 626

Dental Protection Ltd
33 Cavendish Square, London, W1G 0PS
www.dentalprotection.org 020 7399 1400

Medical and Dental Defence Union of Scotland (MDDUS)
Mackintosh House, 120 Blythswood Street,
Glasgow G2 4EA
www.mddus.com 0141 221 5858

Sources of information for employers including guidance on pre-employment checks is currently provided by:

NHS Employers website
www.nhsemployers.org
www.nhsemployers.org/EmploymentPractice/criminal_records_bureau.asp

Criminal Records Bureau
PO Box 110, Liverpool L69 3EF
0870 90 90 811
www.crb.gov.uk
For current requirements regarding CRB disclosures when recruiting staff.

5. Other information

CHI Self-assessment tool for child protection for clinical teams
Commission for Health Improvement. The Stationery Office, 2004.

Already circulated by PCTs in some areas, this audit tool is recommended by a number of Salaried Primary Dental Care Service teams who have used it to identify what they do well and what they need to improve in the area of child protection. Available from **www.tso.co.uk/bookshop**, or online to view or download at **www.hcsu.org.uk**

BDA Mouth Maps
www.bda-dentistry.org.uk/bdashop

Mouth maps available from BDA publications to assist accurate record keeping for intra-oral injuries or pathology.

The British Association for the Study and Prevention of Child Abuse and Neglect
17 Priory Street, York YO1 6ET
Tel: 01904 613605
www.baspcan.org.uk

For all professionals working in health, education, police, social services and voluntary agencies. The website has information about conferences on child protection topics such as neglect, child deaths, emotional abuse.

Providers of child protection training

The following information may be useful when arranging child protection training. Further discussion of training is included in Section 4.

1. Postgraduate medical and dental deaneries

Links to all UK postgraduate deanery websites are available from **www.copdend.org.uk**

2. Your local PCT or hospital trust child protection department

For contact details see above, Section 5 Finding your local contacts 1.

3. LSCBs/ACPCs

For contact details see above, Section 5 Finding your local contacts 1.

4. Distance learning

NSPCC Child Protection Awareness in Health
EduCare Administration, P.O.Box 3261,
Leamington Spa, CV32 5RS
www.debrus-educare.co.uk 01926 436211

A short distance-learning programme for anyone who comes into contact with children through their work in a health setting. Four modules, paper-based or online, with questionnaires. Individual feedback and an NSPCC certificate on successful completion.

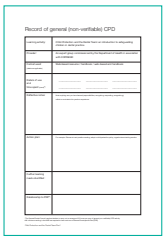
5. Specialist courses

A full list of specialist and advanced courses is beyond the scope of this publication. However, colleagues who work regularly in child protection have recommended courses run jointly by paediatricians and lawyers.

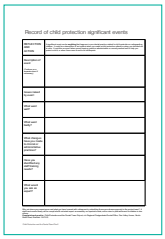
Documents to photocopy

The following documents can be photocopied and annotated with local information, or adapted by adding your practice address and logo. Electronic versions are available to download from the website **www.cpdt.org.uk**

Document 1
Record of general (non-verifiable) continuing professional development

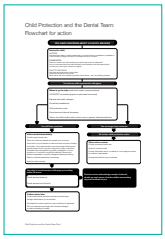

Record of general (non-verifiable) CPD

Document 2
Record of child protection significant events

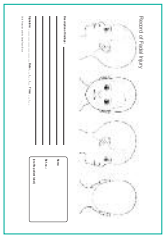

Record of child protection significant events

Document 3
Assessing the child: question prompts
Formatted to scan and print onto self-adhesive paper or labels (99.1mm x 38.1mm x 14, e.g. Avery A4 L7163 or J8163) for use in paper-based clinical records. Do not photocopy onto labels without first checking photocopier manufacturer's instructions.

Document 4
Child protection and the dental team: flow chart for action


Child Protection and the Dental Team: Flowchart for action

Document 5
Record of facial injury


Record of Facial Injury

Document 6
Letter to health visitors regarding children under 5 who fail to attend

Document 7
Safeguarding children in dental practice: practice check list

Safeguarding Children in Dental Practice: a check list

Document 8
Child protection policy statement

Child Protection Policy Statement

Record of general (non-verifiable) CPD

Learning activity:	Child Protection and the Dental Team: an introduction to safeguarding children in dental practice
Provider:	An expert group commissioned by the Department of Health in association with COPDEND
Format used: (delete as applicable)	Web-based resource / handbook / web-based and handbook
Date/s of use and time spent (hours)*:	_____ _____ _____ _____ _____ _____
Reflective notes:	Note anything new you have learned (responsibilities, recognising, responding, reorganising); reflect on and relate it to previous experience.
Action plan:	For example: Discuss at next practice meeting; adopt a child protection policy; organise team training session.
Further learning needs identified:	
Relationship to PDP#:	

*The General Dental Council requires dentists to carry out an average of 35 hours per year of general (non-verifiable) CPD activity.
#All clinicians working in the NHS are required to have and use a Personal Development Plan (PDP).

Record of child protection significant events

REFLECTION AND ACTION	A significant event can be **anything** that happens in your dental practice related to child protection or safeguarding children. It could be a description of an incident when you made a child protection referral or when you decided not to refer. It could be an event when record keeping, practice administration or security worked well to help you protect a child, or when these were found to be inadequate.
Description of event (Continue on a separate sheet if necessary)	
Issues raised by event	
What went well?	
What went badly?	
What changes have you made to clinical or administrative practices?	
Have you identified any staff training needs?	
What would you ask an expert?	

Why not share your experiences and what you have learned with colleagues by submitting these records anonymously to the project team? A significant events library will be compiled with selected expert commentary on reported events, with a view to publication and circulation in due course.

Copy/print and send to: Child Protection and the Dental Team Project, c/o Regional Postgraduate Dental Office, Don Valley House, Savile Street East, Sheffield S4 7UQ

Has there been delay in seeking dental advice, for which there is no satisfactory explanation? YES / NO

Does the history change over time or not explain the injury or illness? YES / NO

When you examine the child, are there any injuries that cannot be explained? YES / NO

Are you concerned about the child's behaviour and interaction with the parent/carer? YES / NO

If the answer to <u>any</u> of these questions is YES you should discuss with a senior colleague and follow local child protection procedures. If all the answers are NO then diagnose and treat as normal.

Signature: ..... Date: ..../...../..... Time: ..... : .....

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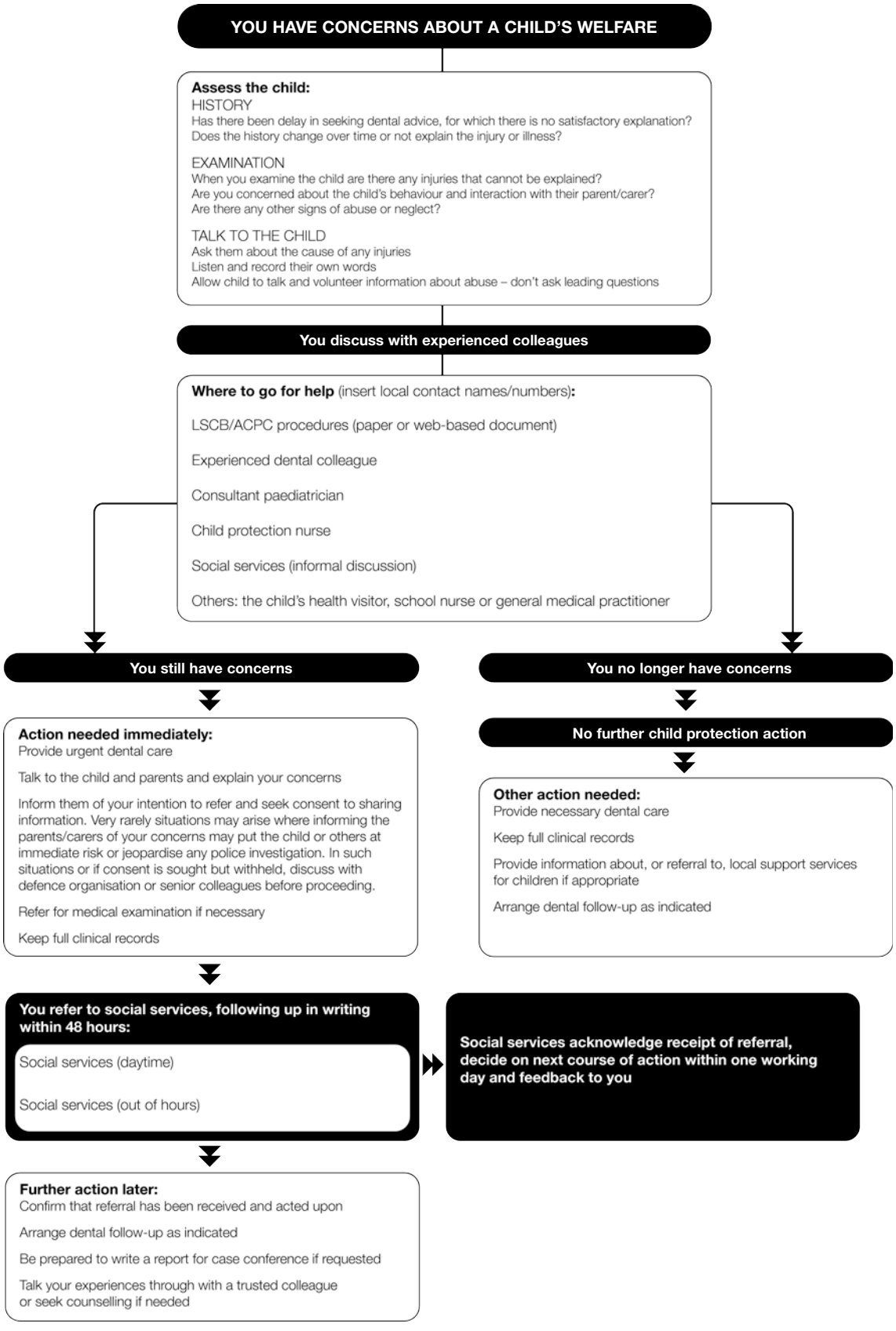
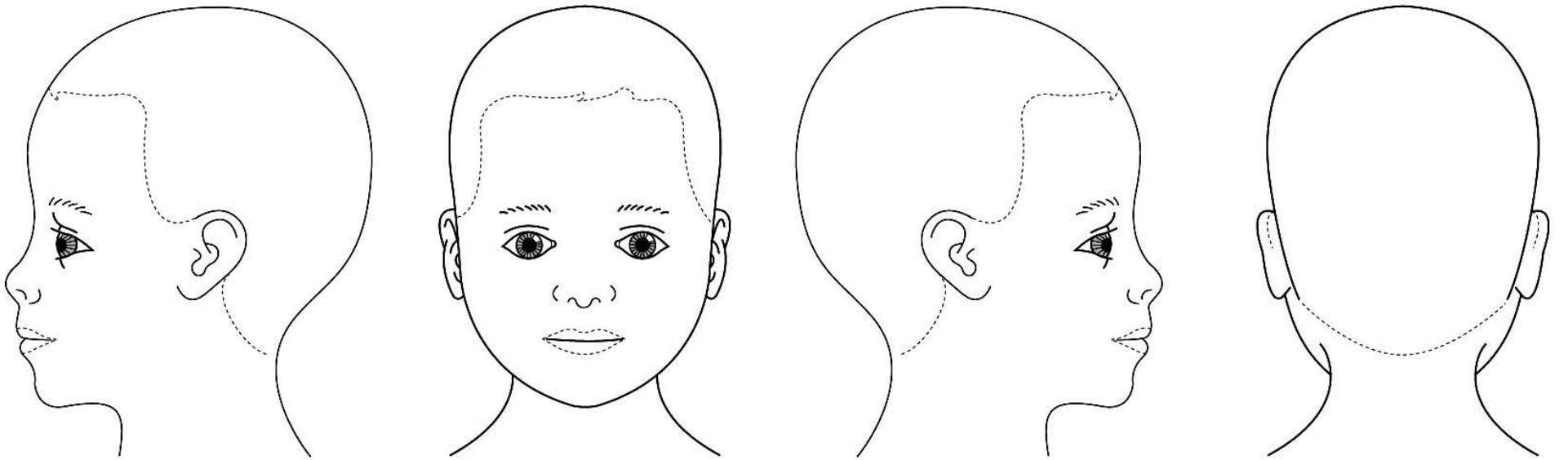
Child Protection and the Dental Team: Flowchart for action



Record of Facial Injury



Description of findings: _____

_____

_____

_____

_____

Signature: _____ **Date:** ___ / ___ / ___ **Time:** ___ : ___

Name:

Ref. no.:

(or affix patient label)

To:

Practice name

Address

Telephone

Date:

Dear Health Visitor,

Re: D.O.B.:

Address:

To improve sharing of information between health professionals for the benefit of children, we are informing health visitors of children under 5 who fail to attend dental appointments.

This child was referred to us for dental treatment by _____

Unfortunately he/she missed a dental appointment on _____

The child
Delete as applicable

has not yet attended our service for dental examination.
has attended previously and is known to require dental treatment or follow up.

The family have since failed to respond to our letter. It may be that they have chosen to seek dental care elsewhere. However, we would be happy to arrange another appointment at their request.

If this family is known to you, we would welcome working together to promote their oral health.
Thank you for any assistance you are able to give.

Yours sincerely,

Dental Nurse

Safeguarding Children in Dental Practice: a check list

Tick box when achieved

Policy

- ☐ Staff member to lead on child protection (insert name) _____
- ☐ Child protection policy in place
- ☐ Other relevant policies and procedures in place (e.g. complaints procedures, public interest disclosure policy etc)

Information available

- ☐ LSCB/ACPC procedures: hard copy or website saved as a 'favourite'
- ☐ Step-by-step guide of what to do if concerned about a child
- ☐ Up-to-date list of local contacts for child protection advice and referral
- ☐ List of local services and sources of help to support children and families
- ☐ List of local sources of confidential emotional support for staff

Record keeping

- ☐ Basic information is recorded for every child and checked for changes at every visit
- ☐ Face maps/mouth maps are available to make diagrams of injuries
- ☐ Records are accessible only to those who 'need to know' and are stored securely in one place

Training

- ☐ All staff know what information and guidance is available and where it is kept
- ☐ Child protection training is arranged for new staff at induction (insert method e.g. NSPCC/Educare distance learning programme) _____
- ☐ Child protection issues are discussed regularly and training is repeated at intervals
- ☐ Local contact to arrange training (insert name/number) _____

Safe staff recruitment

- ☐ Recruitment processes take account of the need to safeguard children
- ☐ CRB checks are carried out according to current guidance
- ☐ We know how to check for changes in legislation

Signature: _____ Date: _____ /_____ /_____

Name/Designation: _____ Due for review: _____ /_____ /_____

Child Protection Policy Statement

We are committed to protect children from harm. Our dental team accept and recognise our responsibilities to develop awareness of the issues which cause children harm.

We will endeavour to safeguard children by:

- adopting child protection guidelines through procedures and a code of conduct for the dental team;

- making staff and patients aware that we take child protection seriously and respond to concerns about the welfare of children;

- sharing information about concerns with agencies who need to know, and involving parents and children appropriately;

- following carefully the procedures for staff recruitment and selection;

- providing effective management for staff by ensuring access to supervision, support and training.

We are also committed to reviewing our policy and good practice at regular intervals.

Dental practice name:

Date policy adopted:

Date due for review:

Published by:

COPDEND

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DH Department of Health

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