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Child Safeguarding in Dental Practice – What you need to know

Abstract: This paper aims to define the types of child abuse and how this may present to the dental team. It briefly outlines actions which should be taken if and when safeguarding concerns may arise.
CPD/Clinical Relevance: The dental practice is an environment where signs of child abuse commonly present. It is both an ethical and legal duty for the dental practitioner to act appropriately in the protection of children attending the practice. Child safeguarding is one of the GDC's recommended topics for Continuing Professional Development.
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In the UK in 2016, over 58,000 children were placed on Child Protection Plans (CPPs) because they were considered by local authorities either to be suffering from abuse or to be at risk of abuse.[1] Over the past 10 years, the numbers of children on CPPs and number of children in Local Authority Care (those removed from the family home) have increased.[2] This is thought to be at least in part due to increased reporting by both professionals and members of the public. There have also been increases in numbers of police-recorded child sexual offences and indecent image offences over the past few years.[2] Safeguarding children is one of the General Dental Council's recommended topics for CPD,[3] whilst keeping people safe and safeguarding them from abuse forms an important strand of one of the key lines of enquiry for Care Quality Commission inspections.[4]

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Dentists, and the dental team as a whole, can be instrumental in the wider safeguarding team in preventing harm to vulnerable children and adults. Our role as dentists is often not to diagnose abuse *per se*, but there are a number of ways in which the dental team can contribute to safeguarding the safety and wellbeing of children.

Dentists tend to see patients more frequently than other health professionals in most cases, and they are likely also to see siblings or other family members in the practice, and so they are well placed to be able to detect forms of abuse and act accordingly. Dentists may also witness concerning behaviours or injuries, or disclosures may be made in the dental setting.

Types of abuse

Neglect

Neglect can be defined as the persistent failure to meet a child's basic physical needs, likely to result in the serious impairment of the child's health or development.[5] It is the commonest form of child abuse, accounting for 49% of children on child protection plans in the UK.[2]

Neglect may present in a child as having consistently poor hygiene or clothing, persistent scabies or persistent headlice, inadequate access to food, faltering growth/failure to thrive, abandonment, inadequate supervision or failure to access appropriate medical treatment. It can be difficult to distinguish some of the above from poverty, and it can be very difficult to judge the threshold for neglect.[5] As such, it is almost always necessary for dentists to discuss their findings with experienced colleagues and/or other professionals before taking any further action.

Dental neglect

Dental neglect (Figures 1 and 2) has been defined by Harris *et al* in the British Society of Paediatric Dentistry's guidance on the subject, as *'the persistent failure to meet a child's basic oral health needs, likely to result in the serious impairment of a child's oral or general health or development'*.[6] As with

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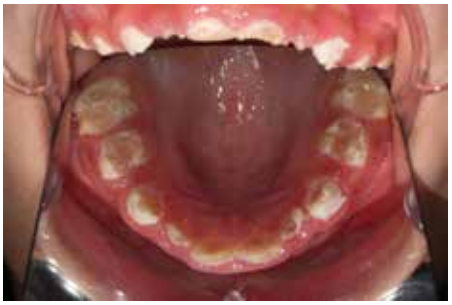

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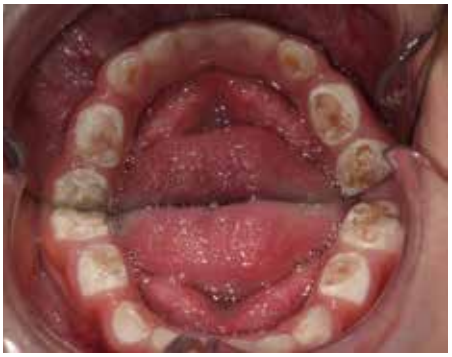

Figure 1. (a, b) A 3-year-old child with rampant, active, early childhood caries and poor oral hygiene.

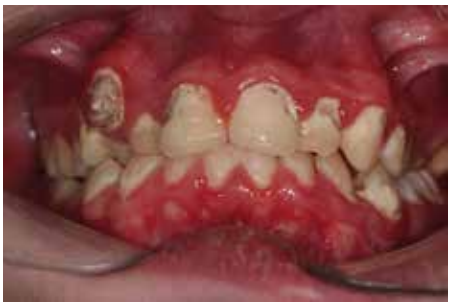

Figure 2. A 15-year-old boy with a poor attendance record, who had not brushed his teeth for some months, attending with acute periapical periodontitis of the UR3.

Figure 3. Left arm of 7-year-old boy showing bruising on the forearm where he had been grabbed.

generalized neglect and other forms of abuse, it may present in isolation or alongside other forms of abuse. A recent clear case of dental neglect seen by the author was a child who presented with acute pain and odontogenic infection, with evidence of extensive untreated dental disease, a poor attendance record and poor oral hygiene, with clinical records showing that previous dentists had explained the presence of disease, given appropriate advice on oral hygiene and attendance for appointments, and had made plans to carry out the necessary treatment. With the family being aware of existing disease and having failed both to ensure access to professional care and to ensure adequate home care, this was a clear case of dental neglect. In addition, the boy was noted to be grubby in appearance (not an especially alarming feature on its own) and smelled strongly of stale urine. It was also noted that he had been excluded from school due to behavioural problems, appeared of particularly short stature, and other family members had previously raised concerns with social services. When concerns were raised with his mother, she became abusive towards staff. With all these features present, a child protection (section 47) referral was made to the local children's social services department.

However, as Harris *et al* point out,[6] cases are not always so clear-cut. Dental neglect does not always warrant a child protection referral; indeed, a preventive single-agency approach, with the dental team supporting the family to ensure that dental needs are being met, monitoring attendance and compliance, would be appropriate in a case of extensive caries where the family have found it difficult to access care, but where no other child protection concerns are present. If attendance does not improve or conditions deteriorate, then it may be appropriate to take a preventive, multi-agency approach, involving school nurses/health visitors and/or GPs or social workers, if one is assigned, in order to ensure compliance.[6,7]

If unsure as to the most appropriate course of action, or if uncertain of the diagnosis of neglect, then the practitioner should discuss the case with the practice/service safeguarding lead and, if appropriate, with a social worker. If unsure about whether to make a referral and looking for general advice, then it may not be necessary or appropriate to share personal information regarding the child.[7]

However, best practice in information governance should be observed when sharing information.[8] As such, where possible, and where doing so is not thought to endanger the child, then consent to make a referral and share information should be sought where a referral is deemed necessary. That said, if consent is not given to share information in a safeguarding situation, the duty of care to the child over-rides this and the appropriate information will need to be disclosed to the appropriate authorities.[7,8] Serious Case Reviews examining numerous high-profile fatalities caused by abuse have highlighted the failure of agencies to share information as contributing to the failure to recognize the extent of the abuse and failure to take appropriate preventive action.

Physical abuse

Physical abuse, as defined by the UK government, is *'a form of abuse which 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 induces, illness in a child'*.[9] Over half of injuries sustained in child physical abuse are seen in the orofacial region,[10,11] and are thus recognizable by the dental team. However, injuries at other sites may also be noted on other areas of exposed skin. Injuries seen may be bruises (particularly in the shape of implements, slap marks or grip marks), abrasions and lacerations, burns (such as the well-defined, round wound seen in cigarette burns), bite marks, eye injuries and/or fractures. Features to be particularly suspicious of are injuries presenting late or untreated, those with histories not compatible with the clinical appearance or age and stage of development of the child, injuries noted bilaterally – therefore less likely to be caused during one episode of accidental trauma – and bruising or

injuries to children who are too young to be mobile or are non-ambulatory. Whilst accidental injuries will tend to occur on bony prominences such as elbows, knees, shins, forehead, nose and chin, injuries at other sites are less likely to be caused accidentally. Extra-oral sites of injury to be wary of are ears, side of face and neck/top of shoulders, soft tissues of the cheeks, periorbital haematoma (especially bilaterally), chest, abdomen, back (except over bony spine), the inner aspect of the arms (Figure 3), forearms, (where the victim may raise arms in defence), or ligature marks on the wrists or ankles, bruising to the soles of feet, inner thigh or certainly any injury to the groin area or genitals.[7,8] That said, non-accidental injuries do not occur exclusively at these sites; the author recently attended a child who sustained a large haematoma on the forehead following his head being forced into a table by his father.

Intra-orally, whilst a torn labial frenum can be caused in falls while learning to walk or accidental trauma in older children, in non-ambulatory patients, it is usually a sign of force-feeding or a blow to the mouth. Other penetrating or blunt trauma may also be seen in the mouth and, when taking a history and examining a child presenting with orofacial trauma, one must always carefully consider the compatibility of the history with the clinical findings and age of presentation of the child.

There are some conditions which can present and look similar to physical abuse: vesiculobullous diseases and impetigo can mimic burns, and children who present frequently with bruising or who are reported to bruise very easily may benefit from referral to exclude bleeding disorders. Some birthmarks can be mistaken for bruising and conjunctivitis may be confused with orbital trauma. Recurrent fractures may present in osteogenesis imperfecta.

However, if suspicious of non-accidental injury, then the first step is to discuss with a trusted colleague, such as a practice/department safeguarding lead, named nurse or doctor.[7,12] If still concerned, an urgent referral needs to be made via the pathways set out by the Local Safeguarding Children Board (LSCB), with a paediatrician seeing the child on the same day.

With some exceptions, it is best practice to explain your concerns to parents and seek consent for referral.[13] However, when parents/carers are being abusive or violent, putting you or colleagues at risk, if the child may be placed at greater risk, if referral may interfere with a police investigation or social work enquiry, in cases of sexual or organized abuse, or where fabricated or induced illness is suspected, then referral should proceed without discussion with parents/carers.[7]

Emotional abuse

Emotional abuse, also known as psychological abuse, is usually found alongside other forms of abuse and/or neglect, but may occur alone, and may be difficult to identify. It is defined as the persistent emotional maltreatment of a child and may have far-reaching implications for the child's emotional and mental wellbeing. This may involve parents or carers telling the children that they are worthless, unloved or inadequate. It may include not giving children opportunities to express their views, deliberately silencing them or making fun of what they say or how they communicate. It also may involve bullying, including online bullying by peers.[7,8]

Possible indicators of emotional abuse which may be noted in the dental surgery are poor growth, developmental/educational delay, low self-esteem, marked changes in behaviour or emotional state not fully explained by non-maltreatment stressful events (such as bereavement or parental separation), including becoming highly anxious, distressed or withdrawn, being emotionally immature, having attachment disorders, displaying aggressive/oppositional/challenging behaviour or excessively good behaviour/desire to please.[7,8] There also may be a history of running away. Parents/caregivers may ignore the child or use abusive or threatening language, or have unrealistic expectations of the child's ability to cope with dental treatment.

Sexual abuse

Sexual abuse is legally defined slightly differently across the four nations of the UK,[12,14-16] but essentially involves either contact abuse, where a perpetrator, who may be an adult or child, engages in physical sexual activity with a child, or non-contact abuse, where the abuser involves the child in looking at or producing pornographic material, encouraging sexual behaviours or grooming them in preparation for abuse. Victims do not always see themselves as victims. Dentists are most likely to pick up on sexual abuse through behavioural or emotional signs, unless disclosures are made or lesions are present in the orofacial region, such as features of sexually-transmitted diseases or petechiae in the palate, which may indicate oral sex.[7,8] Inappropriate, sexualized behaviours, pregnancy or other emotional signs of abuse may be seen. As with physical abuse, suspected cases of sexual abuse or emotional abuse need to be discussed with safeguarding leads and referred using local procedures as per LSCBs, usually by telephone and followed up in writing within 48 hours.

Other behaviours suggestive of abuse

Maltreatment should be considered when behaviours such as self-harming, runaway behaviour, unexplained secondary day- or night-time wetting or soiling or smearing of faeces are seen. It should be suspected where there is repeated stealing, hiding or hoarding of food where not explained by conditions such as Prader-Willi Syndrome.[8]

Conclusions

Increased vigilance, awareness and improved safeguarding training over recent years have helped identify many children in need or at risk of abuse and helped them and their families receive the necessary support. Safeguarding is a complex and delicate area where dentists may feel out of their depth and it can undoubtedly be a stressful part of a clinician's work. Meticulous record-keeping, good communication skills and sensitive handling are imperative. However, there are always colleagues, both within and outwith the profession, who can be looked to for support and advice, such that safeguarding issues never have to be dealt with alone.[12,14-16]

It is the duty and privilege of clinicians to provide care and support to children at risk of abuse, and their families, in a child-centred manner, in order to prevent harm to vulnerable children and young people.

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