

ADVICE SHEET

CHILD SAFEGUARDING GUIDELINE FOR ORTHODONTIC PRACTITIONERS



Safeguarding relates to actions taken to promote the welfare of children and protect them from harm.

Safeguarding of children is defined in 'Working Together to Safeguard Children 2015' as:

- Protecting children from maltreatment.
- Preventing impairment of children's health or development.
- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care.
- Taking action to enable all children to have the best outcomes

The tragic consequences of failures in safeguarding, for example, the Victoria Climbié and Peter Connelly cases, serve as stark reminders of responsibility to all those clinicians treating children. The Children Act 2004 specifies that local agencies (including health services and the police) have a duty to ensure that they consider the need to safeguard and promote the welfare of children when carrying out their functions. Therefore, all members of the orthodontic team have a responsibility to recognise and act if safeguarding concerns arise. Irrespective of race, ethnicity and culture, any form of abuse should not be accepted. A child-centred approach is essential and there should be a clear understanding of the needs and views of the child.

The Children Act 2004 is supported by the Equality Act 2010, the National Guidance for Child Protection in Scotland, Children and Young People (Scotland) Act 2014, The Children

(Northern Ireland) Order 1995 and the United Nations Convention on the Rights of the Child (UNCRC).

For the purposes of safeguarding, a child is defined as anyone who has not yet reached their 18th birthday. Entitlement to child services or protection therefore still applies to individuals aged 16-18 years of age even if they are in further education, the armed forces, or living independently.

Child Protection is part of safeguarding and promoting welfare. This encompasses the activities undertaken to protect specific children who are suffering, or are likely to suffer, significant harm.

Levels of concerns

There are two different levels of concern which have been described where a child or family is considered to require help from a multi-agency safeguarding team (Department of Health, 2014) :

- **In need** - children who need services to secure a reasonable standard of health and development, this includes children with disabilities (The Children Act 2004).
- **At risk** - there is reasonable cause to suspect that a child is suffering, or likely to suffer, significant harm.

Significant harm is defined as the threshold that justifies compulsory intervention in family life in the best interests of children (The Children Act 2004).

Neglect is the ongoing failure to meet a child's basic educational, emotional, medical or physical needs, which is likely to result in the serious impairment of the child's health or development. There are many categories of child abuse (Appendix 1). Specific signs and symptoms are associated with particular types of abuse, however, there are many general signs which can be present, these include:

- Withdrawal.
- Anxiety or depression.
- Aggression.
- Change in behaviour.
- Obsessive behaviour.
- Eating disorder.
- Nightmares/problem sleeping.
- Taking risks.
- Self-harm/thoughts of suicide.
- Drug or alcohol abuse.

Failure of attendance

Missed appointments or last minute cancellations may be a sign of neglect, abuse or a child in need. It is important to document details and reasons for failure of attendance, all attempts should be made to contact the patient to rearrange the appointments. It may be appropriate to ensure repeated missed appointments or safeguarding concerns are communicated with the patient's General Dental and Medical Practitioners for purposes of information sharing. However, the clinician must be able to justify their decision to share information i.e. if there is significant concern, and be mindful of the information sharing in relation to the Caldicott Principles (2013).

Information sharing and confidentiality

When you suspect a child to be in need or at risk:

- Record concerns
 - The record must be factual and accurate, what was seen and said needs to be recorded as well as documenting any physical evidence such as unexplained injuries (photographs/drawings are useful).

- Details of any witness/colleagues with whom you shared information, or who can corroborate any part of your record should be documented.
- Date and sign the record.
- Escalate according to local policies if appropriate (see Appendix 2).
- Follow up.

If urgent action is required, Children's Social Care, the Police or the NSPCC can be contacted as they all have statutory powers and can take emergency action.

Clinicians have a duty to share information with those agencies with a statutory duty to investigate possible child abuse. It is important that the Caldicott Principles (2013) regarding information governance are considered when sharing information. Issues of confidentiality also need to be considered and whether information should be disclosed in the absence of consent. The clinician needs to be able to justify the decision to share information.

The Data Protection Act (1998) and Human Rights Act (1998) provide a framework for appropriate information sharing and should not be barriers to sharing child safeguarding information. The decision and reasons to share or not to share information must be contemporaneously documented.

Details must include the information which has been shared, people involved and the purpose of sharing. No assumptions should be made that any information shared would be passed on appropriately and following up on actions taken is essential.

Consent considerations:

- If a child is considered to be a child in need
 - then parental consent is required to share information and escalate concerns. Refusal may leave you thinking that the child is at risk, but not always.
- If a child is considered to be a child at risk the practitioner must assess the level of risk on a case by case basis to warrant the sharing of information and escalation of concerns which may not require parental consent.

This would be viewed as an exceptional circumstance, as referenced in Section 4.3 of the GDC Standards Guidance (2013). Informing parents of concerns and the referral is good practice, however, clinicians should be mindful that requesting consent may, in some circumstances, put a child at further risk of harm.

The clinician-parent-child relationship is pivotal and must be founded on mutual trust and respect, as well as a common aim to benefit the child. Where the child presents with symptoms or signs suggesting he or she has been subject to abuse it may no longer be possible to regard parent and child as a single unit.

Such situations are uncomfortable, stressful and possibly dangerous to all concerned. Nonetheless this must not compromise the duty to take action where needed. It may be easier to avoid confrontation but it may not be fair or just.

Remember, consent is not needed to share information that would keep a child safe. Section 4.3 in the GDC Standards Guidance (2013) and local consent policies should be referred to should more information be required. In addition, advice should be sought from the clinician's indemnity adviser regarding the decision to share information in the absence of consent.

Early need

Some children may benefit from early help and assessing need early is important to help provide effective support and promote the child's welfare. Assessment should be undertaken with the agreement of both the child and parents or carers. If consent is not given, the matter may require escalation through local pathways. Those who may be in need of early support may include:

- Children with disabilities and additional needs.
- Children with educational needs.
- Young carers.
- Those showing signs of anti-social or criminal behaviour.

- Challenging family circumstances.
- Early signs of abuse or neglect.

Adults and their dependants

Consideration must be given to the child dependants of adult patients and fellow staff members as safeguarding duties also extends to them. Adult patients should therefore be routinely asked if they have children or dependents and this should be documented.

Safeguarding in primary care

Healthcare professionals have an obligation to ensure that local child protection policies are in place and regularly updated. Within a practice setting, a child protection lead should be established and an up-to-date list of local contacts should be available. Should a child safeguarding concern arise, information and advice can be sought from experienced colleagues, social services, the patient's General Medical Practitioner, a school nurse, health visitors, social workers, the Local Safeguarding Children Board (LSCB), the Area Child Protection Committee (ACPC) and the clinician's indemnity adviser. Should a concern about a child's welfare arise, flowcharts showing the appropriate steps that should be taken can be found in Appendix 2 (these are subject to local variation). When considering the sharing of information, it is also important to refer to the GDC Standards Guidance and ensure disclosure is in concordance with the Caldicott Principles (2013) to avoid breach of patient confidentiality.

Safeguarding in a hospital setting

Local trust child protection policies should be in place. Each trust should have a hierarchy for initial inquiry and escalation. Should a concern about a child's welfare arise, flowcharts showing the appropriate steps that should be taken can be found in Appendix 2 (these are subject to local variation).

Regular safeguarding training is recommended to ensure up to date knowledge of local safeguarding policies. **The General Dental Council recommend safeguarding as a topic for continuing professional development for dental professionals.**

Safeguarding training and development may involve:

- Regular, structured staff training and updates of local procedures.
- Documentation of all safeguarding incidents (paper or electronic) and sharing of
- scenarios and the lessons learned with the whole team (via email for example).
- Regular safeguarding audits and meetings.

Further reading and resources

- *Caldicott review: information governance in the health and care system (2013)* <https://www.gov.uk/government/publications/the-information-governance-review>
- *Child Protection and the Dental Team – An introduction to safeguarding children in dental practice (2016)* <https://www.bda.org/childprotection/Pages/default.aspx>
- *Children and Young People (Scotland) Act (2014)* <http://www.legislation.gov.uk/asp/2014/8/contents>
- *The Children (Northern Ireland) Order (1995)* <http://www.legislation.gov.uk/nisi/1995/755/article/119>
- *Department of Education Guidance for Practitioners relating to abuse and sharing information (2015)* <https://www.gov.uk/government/publications/what-to-do-if-youre-worried-a-child-is-being-abused--2>

- *Eliminating female genital mutilation. World Health Organisation (2008)* <http://www.who.int/reproductivehealth/publications/fgm/9789241596442/en/>
- *Guidance on Child Protection and Vulnerable Adults (2013)* <https://www.gdcuk.org/api/files/Guidance%2520on%2520Child%2520Protection%2520and%2520Vulnerable%2520Adults%2520November%25202013.pf+%26cd=1&hl=en&ct=clnk&gl=uk>
- *HM Government: 'Working Together to Safeguard Children' (2015)* <https://www.gov.uk/government/publications/working-together-to-safeguard-children--2>
- *Information Sharing - Advice for practitioners providing safeguarding services to children, young people, parents and carers (2015)* <https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice>
- *Mandatory reporting on FGM. General Dental Council (2015)* <https://www.gdc-uk.org/professionals/standards/fgm>
- *National Guidance for child protection in Scotland (2014)* <http://www.gov.scot/Publications/2014/05/3052>
- *National Society for the Prevention of Cruelty to Children* <https://www.nspcc.org.uk>
- *Standards for the Dental Team – The General Dental Council (2013)* <https://www.gdc-uk.org/api/files/Standards%20for%20the%20Dental%20Team.pdf>

**Updated by the Clinical Governance Directorate of the British Orthodontic Society
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Type	Description	Signs/ symptoms
Physical Abuse	- Deliberate aggressive actions on a child that inflicts pain - 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	- Unexplained recurrent injuries - Improbable excuses or refusal to explain injuries - Wearing clothes to cover injuries, even in hot weather - Bald patches on scalp - Self-destructive tendencies - Aggression towards others - Fear of physical contact - Fear of suspected abuser being contacted
Sexual Abuse	- Forcing or enticing a child to take part in sexual activities, whether or not the child is aware of what is happening - May involve physical contact, including assault by penetration (e.g. rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing - May also include non-contact activities e.g. involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways - Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children	- Being overly affectionate or knowledgeable in a sexual way inappropriate to the child's age - Extreme reactions e.g. depression, self-mutilation, suicide attempts, running away, overdoses, anorexia - Personality changes - Regressing to younger behaviour patterns e.g. thumb sucking - Being isolated or withdrawn - Lack of trust or fear of someone they know - Worried about outdoor clothing being removed
Sexual Exploitation	- Forcing or enticing a child into a sexual relationship or sexual acts whilst under the influence of drugs or alcohol, or because they are exchanging sexual favours for money, accommodation, drugs or alcohol or gifts - The relationship between the child and their abuser is based on a power imbalance	- Go missing from home, care or education - Involved in abusive relationships, intimidated and fearful of certain people or situations - Associate with groups of older people, or antisocial groups/activities (e.g. gangs, fights, petty crime), or with other vulnerable peers - Have older boyfriends or girlfriends - Spend time at places of concern (e.g. hotels or known brothels) - Unexplained physical injuries - Changed physical appearance (e.g. weight loss)
Trafficking	- Victims are coerced or deceived by the person arranging their relocation - They are denied their human rights and exploited	- Rarely leaves the house - Has no freedom - Is orphaned or living apart from family - Not registered with a school or GP - Has injuries from workplace accidents
Grooming	- When someone builds an emotional connection with a child to gain their trust for the purposes of sexual abuse, sexual exploitation or trafficking - Can occur online, face-to-face, by a stranger or by someone they know (e.g. a family member, friend or professional)	- Secretive behaviour, including about what they are doing online - Have older boyfriends or girlfriends - Have new items e.g. clothes or mobile phones that they can't or won't explain - Have access to drugs and alcohol

Emotional Abuse	• Persistent emotional ill-treatment which causes severe and persistent adverse effects on emotional development • May involve deliberately trying to scare, humiliate or ignore a child	• Physical, mental and emotional development lags • Loss of self-confidence • Overreaction to mistakes • Extreme fear of any new situation • Neurotic behaviour (e.g. rocking, hair twisting, self-mutilation) • Abnormally aggressive behaviour
Neglect	• 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 • May involve a parent or carer failing to provide: - adequate food, clothing and shelter - protection from physical and emotional harm or danger - adequate supervision - access to appropriate medical care or treatment - response to basic emotional needs	• Poor personal hygiene • Poor state of clothing • Emaciation • Untreated medical and dental problems • Destructive tendencies
Female Genital Mutilation (FGM)	• All procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for cultural or other non-medical reasons (World Health Organisation 2008) It is a mandatory obligation for healthcare workers to report FGM to the police. Please refer to available guidance as outlined: https://www.gdc-uk.org/professionals/standards/fgm	• A long holiday abroad or going 'home' to visit family • A special occasion/ ceremony to 'become a woman' or get ready for marriage • A female relative being having experienced FGM
Domestic Violence and Abuse	• Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are intimate partners or family members • A child witnessing domestic abuse is a form of child abuse	• Aggression • Antisocial behaviour • Depression or anxiety • Poor performance at school
Radicalisation	• Exposure to extremist ideology • Can range from a child adopting or complying with extreme views to children being groomed for involvement in violent attacks • Exposure can occur via peer network, family, family friends, older children or via the internet	• May go missing
Bullying and cyberbullying	• A form of emotional abuse • Most often inflicted by a child's peers • Boys are usually more exposed to direct physical bullying than girls • Both genders are likely to face indirect bullying, such as social isolation • Cyberbullying occurs online, using social networks, game or mobile phones • Teasing or bullying can be a primary motive for requesting treatment of a malocclusion	• Anxiety • Insecurity • Low self-esteem • Belongings getting lost or damaged • Unexplained physical injuries • Afraid to go to school or skipping school • Poor performance at school

Child Protection Flowchart for Action (Adapted from BDA child protection flowchart)

