SAFEGUARDING CHILDREN POLICY

The safeguarding policy has recently been updated so that this first page has the most IMPORTANT information regarding which professionals to phone. The numbers were all contacted and checked (May 2017) and will be updated annually.

Flow Chart for action at Southfield Dental Practice

Concerns about a Child's Welfare

↓

Assess the Child – Medical & Social History / Examination / Talk to the Child

↓

Discuss with Experienced Colleagues – Local Contact Numbers below

- Practice Owner & Provider 07775 686985 (Mr Chris Gollings)
- Safeguarding Lead 07917 842906 (Miss Julie Williams)
- Experienced Dental Colleague 01425 277245 (Mr Michael Pilling)

↓

You still have concerns

- Provide Urgent Dental Care
- Talk to child and parents (gain consent on sharing information)
- If no consent the contact Defence Organisation DPS 0800 561 1010
- Refer for medical exam if necessary

↓

Refer for Professional Advice, following up in writing within 48 hours
They will advise if the child already has carer, and which Social Worker to call …

A] depending where the child lives, contact the relevant safeguarding professionals (see below)

- Child's Safeguarding Area Teams:

Bournemouth CC	01202 458101 (2)
Poole Borough	01202 735046
Dorset CC (Ferndown)	01202 228866
Hampshire	01329 225379
S'ton Central	02380 833336
Social Care Team	01202 877445 (LACPC Local Area Protection)

B] if not emergency fill out the inter-agency referral form and email (see below)

- Referral Form – send to email: csprofessional@hants.gcsx.gov.uk https://hampshire.firmstep.com/default.aspx/RenderForm/?F.Name=Md_9d1aRLwN&HideAll=1 (copy this link into web browser)

C] If immediate emergency then contact the Police on 111

OTHER USEFUL CONTACTS

Child's HEALTH VISITOR
SOCIAL NURSE
School Nurse
GP of patient (child)
Police
Local Hospital (Bournemouth 01202 303626; Christchurch 01202 486361)

Child Line (cards)	0800 1111	www.childline.org.uk	Free telephone for children to use
Sure Start	www.surestart.gov.uk	Bridges and Pathways Children's Centre	
Children's Services	0300 551384	0300 5551373 (out of hours)	
CCPAS	0845 1204550		
NSPCC	0808 8005000 (referral portal available)		
Kidscape	0845 1205204		
Stop it Now	0808 1000900		
MindinfoLine	0845 7660163		
LSCB (MASH)	Local Safeguarding Children Board (or MASH)		

Individuals Working in Child Safety:

Margaret Smith	07990 515218
Lynne Lourence	07768 308089
Kate Roberts	07717 571852
Janice Carswell	07795 800747

Our Child Protection Policy Statement

We are committed to protect children (def: up to 18 years old) 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.

Children are an especially vulnerable group and the practice is particularly concerned to stress that the welfare of any child in our care is paramount. All children, without exception, have the right to protection from abuse. All suspicious and allegations of abuse will be taken seriously and responded to swiftly and appropriately.

You are expected to:

- Only provide treatment for individuals under 16 years old when consent has been given from a parent or guardian.
- Ensure another member of the practice team, or child's guardian, is present at all times when treating anyone under 16 years old.
- Never be left alone with child on the practice premises.
- Respect the wishes of a child as you would an adult.
- Take all reasonable steps to ensure the health, safety and welfare of any child in care.
- Report any evidence or reasonable suspicion that a child has been physically, emotionally or sexually abused whether by an adult or another child to the practice owner or the **Area Child Protection Committee** on depending on where they live
- **See Flow Chart on p4 for contact Details of Social Services**

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. By effective interagency working and discussion, professionals share the responsibility. Decisions about children are never taken by one individual but always shared by a team.

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.

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.

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.

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.

The dental team are not responsible for making a diagnosis of child abuse or neglect, just for sharing concerns appropriately.

Resources and Acts

- 'Standard's' section 8 (GDC)
- Child Protection and the Dental Team (BDA)
- Children's Act 1989 / 2004 and due revision in 2016 (Gov)
- Working together to safeguard children 2015
- Equality Act 2010
- MASH (Multi Agency Safeguarding Hub) – these are on trial

Child protection and the dental team: Flow chart for action

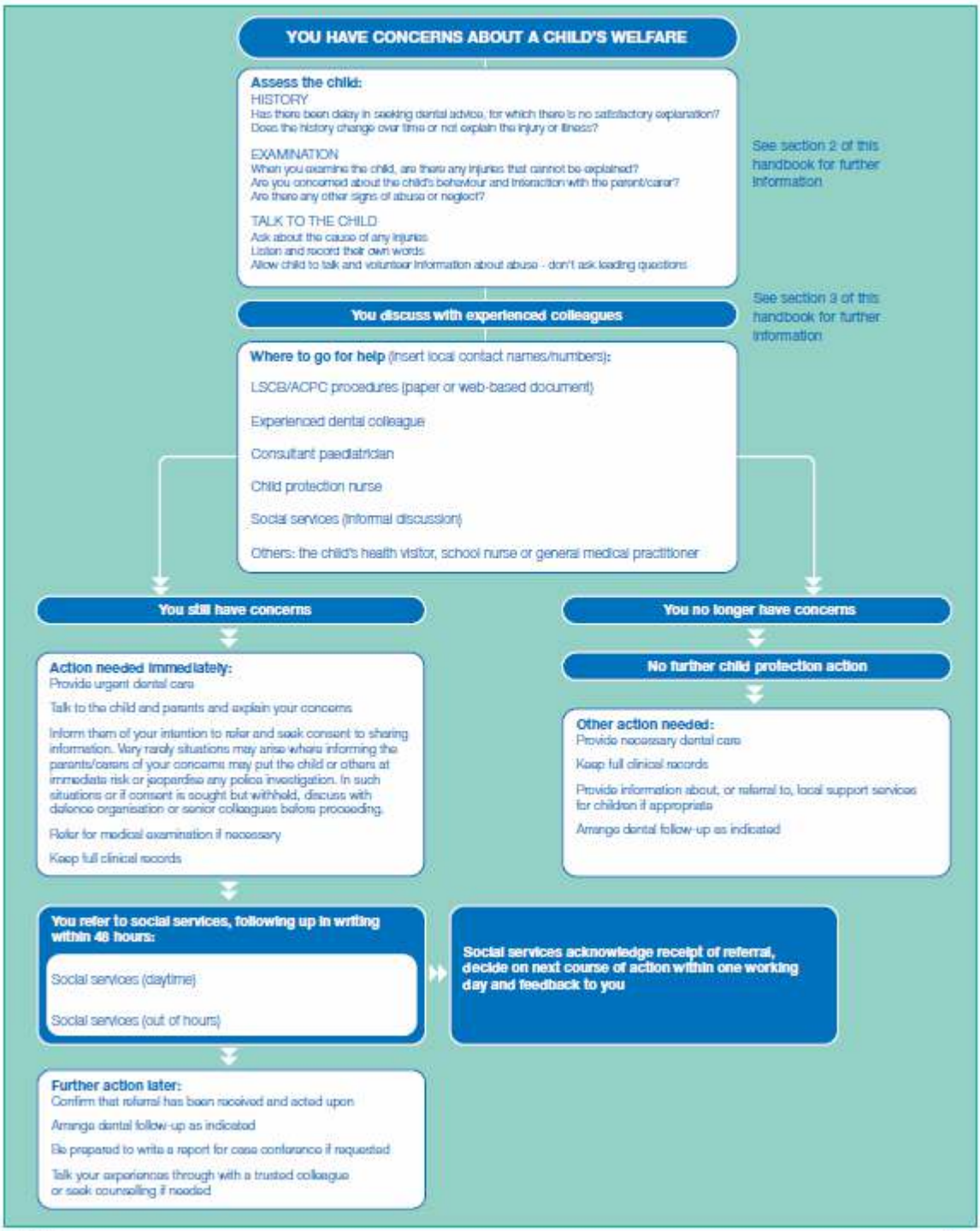

Figure 3.3 P3.3

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).

Recognising abuse and neglect (4 types of abuse)

An approach to assessment

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

• A direct allegation (sometimes termed a 'disclosure') made by the child, a parent or some other person
• Signs and symptoms which are suggestive of physical abuse or neglect
• 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.

1. Physical abuse

Facial trauma occurs in at least 50% of children diagnosed with physical abuse. 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.

The assessment of any physical injury involves three stages:

• 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.

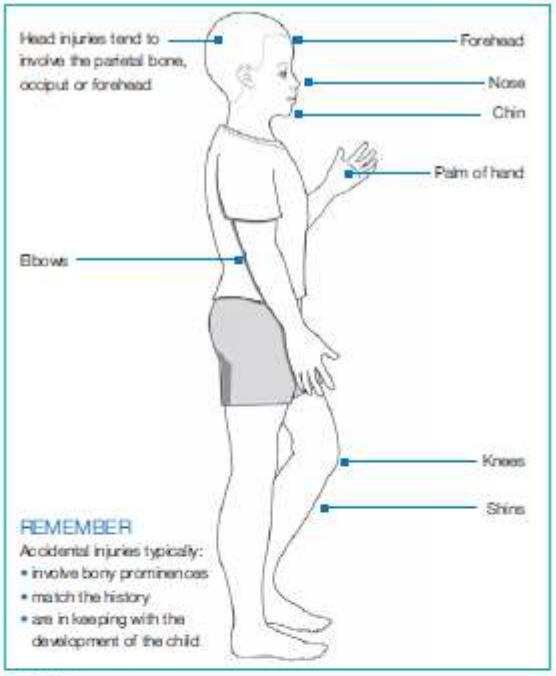

Figure 2.4
Typical sites of accidental injury.

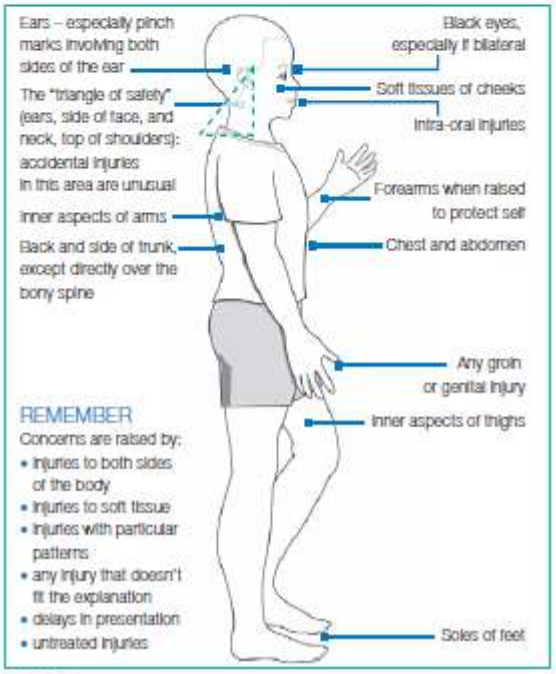

Figure 2.5
Typical sites of non-accidental injury (injuries that should raise concerns).

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. However, the clinical dating of bruises according to colour is inaccurate.

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.

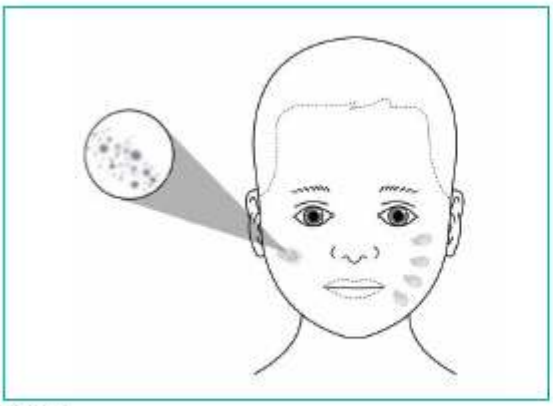

Figure 2.8
Artist's impression of grip marks such as may be present when a young child has been gripped and force fed. Note the round thumb imprint on one cheek with 3 or 4 finger-tip bruises on the other. You should also examine for intra-oral injuries.

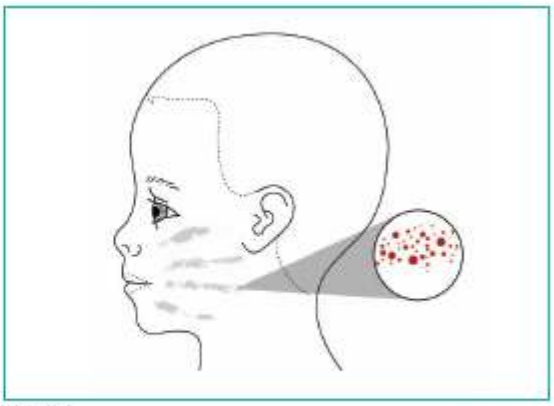

Figure 2.9
Artist's impression of a slap mark. Note the parallel lines of petechial bruising at finger-width spacing, the marks appearing in the gaps between the fingers.

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 facial 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.

Eye injuries

Periorbital bruising in children is uncommon and should raise suspicions, particularly if bilateral. Ocular damage in child physical abuse includes 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).*

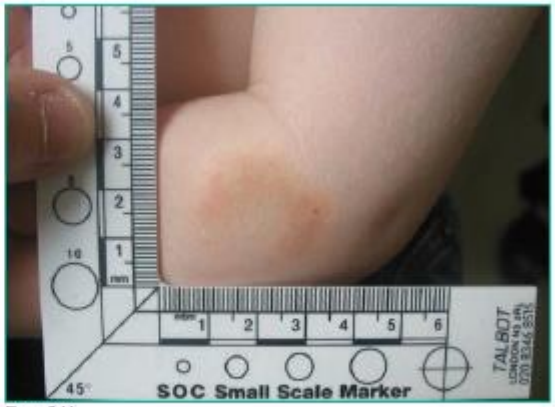

Figure 2.11
Human bite mark on a child's arm, presenting as diffuse bruising *(reproduced with permission of Dr GT Craig).*

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 (require full paediatric evaluation)

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 2.12

(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).

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 earning 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 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 averted. Any accompanying facial bruising or abrasions should also be meticulously noted.

Figure 2.13

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

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.

2. 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.

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.

3. 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.

4. 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 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.

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

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**.

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.

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. 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. 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.

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.

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. 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.

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 organized 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 child's name.

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' No corresponding definition has been produced in the UK.

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

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 willful 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. 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 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?

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. It should be noted that this relates only to neglect or emotional abuse. Three stages of intervention are described:

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.

P3.9

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:

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 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).

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 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. 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.

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
- **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.

Providing information for children

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

- **local services** providing advice or activities e.g. Sure Start
- **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

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**
- 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** 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
- **guidelines on use of restraint** (or 'physical intervention') so that staff know how to intervene appropriately for children unable to comply with dental care
- **consent policy and procedures** as discussed above.

Best practice in record keeping

A routinely high standard of record keeping is a clinical governance requirement.

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 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.

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.
- 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.

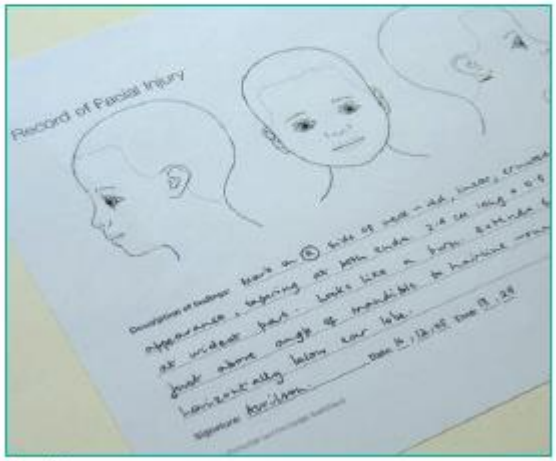

Figure 4.4
A face map proforma, completed to record the injury illustrated in Figure 2.6.

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**.**

Regular team training

Frequency of training

Child protection training should be mandatory for all staff at induction, with updates at regular intervals thereafter

Content of training

When arranging training, you should check that the aims and objectives of a course meet the learning needs of your team.

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.

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** At present NHS employers are advised to undertake CRB checks for new staff as a matter of good practice.

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 needs to be aware of this in order to avoid unintentionally harming children.

Julie Williams has assisted Chris Gollings in updating this practice Safeguarding Policy

Chris Gollings is the overall Legal Person at Southfield Dental Practice

Checked by: Chris Gollings (and Julie Williams Lead in Safeguarding)

Date: 12 Jan 2018

Previous Dates: 17 May 2017; 12 Feb 2017; 03 Feb 2017; 25 Feb 2016; 13 July 2016

Signed by: CAG, CLG, JW, LD, LW, LS

Policy

☑ Staff member to lead on child protection: **Julie Williams**

☑ Child protection policy in place

☑ Other relevant policies and procedures in place (e.g. complaints procedures, Public 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

☑ Child protection issues are discussed regularly and training is repeated at intervals

☑ Local contact to arrange training (insert name/number) **Christian Gollings 01425 489283**

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