The responsibilities of the **dental team** in **child protection**

The dental team may well be one of the best-placed members of the health service to spot evidence of child abuse. **Alison Cairns**[1] and **Richard Welbury**[2] discuss what to look for and how to act when you are suspicious of this happening.

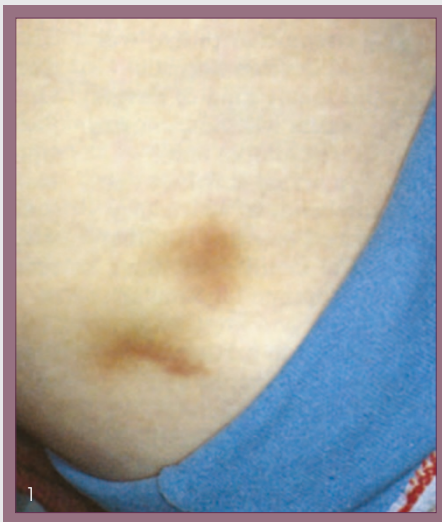
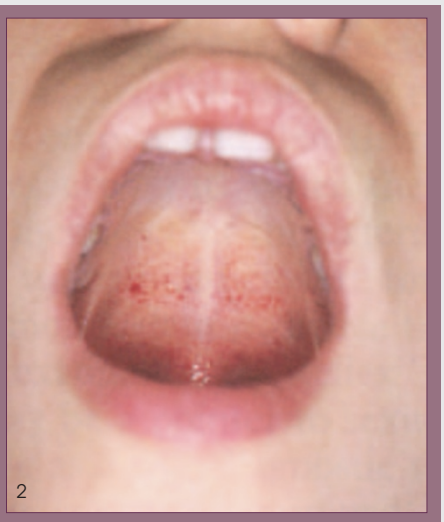
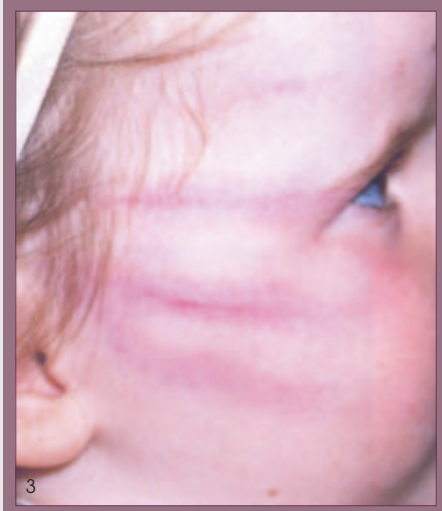
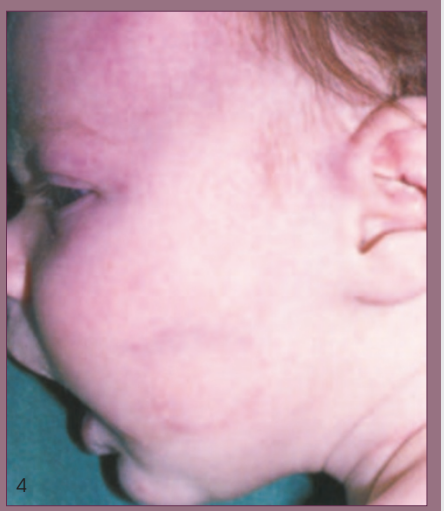
The nature of child abuse cannot be easily defined, because at any given time it is dictated by the culture of the population. As we know culture is diverse and evolving, and socially acceptable behavior can vary even between subpopulations. Child abuse can therefore be defined as the maltreatment of a child as judged by a specific culture at a specific time. In developed countries the types of child abuse are usually described as falling into 4 or 5 categories: physical; emotional; neglect; sexual; non-organic failure to thrive.

Child abuse and the protection of children is currently a high profile social problem. Child fatalities at the hand of abusers have raised the profile of child protection with politicians and the public. Public confidence in the services responsible for safeguarding children at risk of abuse and neglect has been weakened. Society's expectations are that children should be protected from abuse and that all organisations and personnel working with children, including the dental team, will be expected to know their roles and responsibilities.

In England and Wales a year long public inquiry following the death of Victoria Climbié[1] identified social service departments in two London boroughs, two police forces, two hospitals, and a specialist children's unit who all failed to act when presented with evidence of abuse. Guidance for healthcare practitioners in England and Wales is provided in a government summary document *What to do if you're worried a child is being abused*.[2] Specific recommendations of the Climbié enquiry with relevance to the dental team are those related to training* and procedures†. In Scotland, following the death of Kennedy McFarlane, a national audit into child protection services resulted in the publication, *It's everyone's job to make sure I'm alright*[3] and this is a good source of information and guidance for members of the dental team working in Scotland. There are specific recommendations with relevance to the dental team in this document‡. Both of the reports which followed the inquires into the deaths of these two girls found that the major failing in the child protection system was a lack of communication and information sharing between those who had been involved in their care. Although not directly implicated in either of these cases the dental team may find themselves in the position of suspecting abuse, and if these suspicions are not shared with other agencies a full picture of abuse may not be appreciated.

A recent UK study found that 59% of the signs of physical child abuse manifest on the head, face or neck.[4] This would suggest that dental professionals are in an ideal position to alert child protection agencies to concerns

* Recommendations 87 and 88
† Recommendations 12 and 88
‡ Recommendations 1, 4, 7 and 10

1. Pinch mark on the neck of a child. Reproduced from Meadow R (1993) ABC of Child Abuse. London BMJ Books. 'Pinching', page 1. © 1993 with permission from Blackwell Publishing.
2. Bruising on the palate of a child due to oral sex. Reproduced from Meadow R (1993) ABC of Child Abuse. London BMJ Books. Petechial bruising on palate', page 38. © 1993 with permission from Blackwell Publishing.
3. Bruises consistent with a hand slap. Reproduced from Hobbs C, Wynne J (2001) Physical Signs of Child Abuse, 2nd Ed. A Colour Atlas. London, Harcourt Publishers Ltd. Fig 4.3, page 17.© 2001 with permission from Elsevier.
4. A 6-week old baby with a human bite mark on her cheek. Reproduced from Hobbs C, Wynne J (2001) Physical Signs of Child Abuse, 2nd Ed. A Colour Atlas. London, Harcourt Publishers Ltd. Fig 6.2, page 48. © 2001 with permission from Elsevier.

"It is only a matter of time until we are all mandated reporters of suspected abuse"

about possible abuse. Indeed this group of professionals may be the first, or only, healthcare workers to see an 'at risk' child, especially if they are attending either for a routine check or because of dental trauma. The head and neck region is often the target of impulsive violence, and orofacial injuries may occur in isolation or along with other injured body parts. The most commonly seen injuries are bruising, abrasions and lacerations, burns, bite marks, tooth trauma and eye injuries.

Governing legislation varies between countries in the United Kingdom and there are differences in the way the child protection system is structured. Luckily for the dental team involvement is essentially the same. When a case is suspected, thorough notes must be kept, including drawings and photographs of the suspect injuries. A note of any unusual behaviour by the child or parent should also be recorded. The local child protection team is available for help and discussion before any formal referral is made. However when a referral is made, the dental team should inform the family that they are making the referral to the local social services department. It is important to remember the reason for which you are referring; that is to help the family receive the support they need. Only if the child is in danger will a referral result in the child being removed from the family home. The purpose of intervention is to give the family the help required to enable them to cope with the pressures which have previously resulted in abuse. After any formal referral to social services you should contact them again 24 hours later to make sure that the referral is being dealt with. Your involvement may end here or you may be asked to provide further evidence on your findings.

What to look out for

There are a number of indicators that may lead you to suspect abuse. Ask yourself the following questions:

- Could the injury have been caused accidentally and if so how?
- Does the explanation for the injury fit the age and the clinical findings?
- If the explanation is consistent with the injury, is this itself within normally acceptable limits of behaviour?
- If there has been delay in seeking advice, are there good reasons for this?

Have you made any unusual observations in the following areas?

- The general demeanour of the child.
- The nature of the relationship between guardian and child.
- The child's reactions to other people.
- The reaction of the child to any medical or dental examination.
- Any comments by the child and or guardian that give concern about the child's upbringing or lifestyle.

Diagnosis of child abuse is complex and multifactorial, and is well beyond the remit of any dental professional. It is imperative, however, that suspected cases are referred on for appropriate management. Opportunities for intervention may be sparse, and when physical signs are detected it is essential that steps are taken to help, as another opportunity with such clear evidence may not arise again for some time.

Recent studies into the role of the dental team have uncovered a need for inter-agency child protection training. Government guidance strongly suggests that the dental team should undergo this training, and it is only a matter of time until we are all mandated reporters of suspected abuse. It is our professional responsibility to ensure that we are up-to-date on our local child protection referral protocol.

Dental neglect

What about dental neglect? The American Academy of Paediatric Dentistry[5] has defined dental neglect as 'willful 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, and there has been limited debate of this issue to date.

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.

Help and training in the future

In 2004 in England the Chief Dental Officer commissioned the production of a training document for the dental team entitled *Child Protection and the Dental Team*. This will be available in 2006. The Chief Dental Officer in Scotland has prioritised the delivery of a series of half-day courses throughout Scotland in 2005-2006 for the dental team. These have input from both dental and child protection services and highlight both the signs that the dental team may encounter and distribute the contact details of appropriate individuals in each geographic area to whom referrals should be made. In both these initiatives the question of dental neglect in relation to general neglect will be raised.

Images from the NSPCC's current TV advertising campaign – Talk 'til it stops.

1. Department of Health. *The Victoria Climbié Inquiry*. Report of an inquiry by Lord Laming. London: Stationary Office, 2003.
2. Department of Health Publications. *What to do if you're worried a child is being abused*. London, 2003.
3. Scottish Executives report of the child protection audit and review. *It's everyone's job to make sure I'm alright*. Edinburgh, 2002.
4. Cairns A M, Mok J Y Q, Welbury R R. Injuries to the head, face, mouth and neck in physically abused children in a community setting. *Int J Paed Dent* 2005; **15**: 311-319.
5. American Academy of Paediatric Dentistry Reference Manual, 2004-2005.

See also our book review on page 11 and our news article on page 6

[1]Alison Cairns is a Specialist in Paediatric Dentistry, [2]Richard Welbury is a Professor of Paediatric Dentistry both at Glasgow Dental School and Hospital