



CPD4dentalnurses

YOUR FUTURE IN YOUR HANDS

Safeguarding Children Level 2 Annual Refresher 2026

Aims:

To reinforce and update dental professionals' knowledge of safeguarding children in line with current statutory guidance and the Intercollegiate Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2025). It will revisit key principles of safeguarding, highlight the importance of effective multi-agency working, and support dental team members in recognising concerns, responding appropriately, and understanding their professional responsibilities within a Level 2 safeguarding role.

Learning outcomes:

On completion of this verifiable CPD article, the participant will be able to demonstrate, through completion of a questionnaire, the ability to:

- Explain the meaning of *safeguarding*, *child protection*, and *looked after child*, and understand how these terms apply within dental practice.
- Demonstrate awareness of key updates within *Working Together to Safeguard Children (2023)*, including the emphasis on strong, effective multi-agency working.
- Recognise the legal, regulatory, and professional frameworks that underpin safeguarding responsibilities for dental professionals.
- Identify the main categories of child abuse and neglect.
- Recognise common indicators of abuse and neglect, including dental-specific and behavioural signs relevant to routine dental care.
- Understand their Level 2 roles, responsibilities, and professional boundaries, including how to escalate concerns and raise concerns about the conduct of colleagues in line with whistleblowing procedures.
- Describe appropriate actions to take when safeguarding concerns arise, including timely reporting, referral, and escalation in accordance with local safeguarding procedures.
- Demonstrate an understanding of how to record, store, and share safeguarding information lawfully and proportionately, in line with UK GDPR and professional guidance.
- Reinforce the importance of professional curiosity, child-centred practice, and accurate documentation when responding to safeguarding concerns.

- Pass an on-line assessment, scoring over 70%.

Introduction

The dental team has a statutory duty of care to all patients, and this includes ensuring that safeguarding arrangements are in place. ¹

The majority of children are very safe when they are at home. However, unfortunately, most cases of child abuse take place in the child's own home.²

Many of the signs of physical abuse manifest in the Oro-facial region.¹ Members of the dental team may be the first professionals in a position to suspect a non-accidental injury to a child. The General Dental Council state "as a dental professional, you are likely to notice injuries to the head, eyes, ears, neck, face, mouth and teeth, as well as other welfare concerns. Bruising, burns, bite marks and eye injuries could suggest that a concern should be raised."³ The General Dental Council state that "As a registrant you must take appropriate action if you have concerns about the possible abuse of children or vulnerable adults."³ In addition, staff working with adults need to be aware that any adult may pose a risk to children due to their health or behaviour.⁴

All health professionals working directly with children should ensure that safeguarding and promoting every child's welfare forms an integral part of all stages of the care they offer. It must be a child centred approach based on the needs and views of children.²

The UK government published a new edition of its statutory guidance Working together to Safeguard Children in December 2023. The new edition contains a new chapter emphasising that safeguarding depends on strong multi agency working. The chapter brings together new and existing guidance to highlight the importance that successful outcomes for children depend upon "strong multi-agency partnerships working across the whole system of help, support and protection including effective work from all agencies with parents, carers, and families."⁵ Safeguarding is the responsibility of all members of the dental team.

This 2026 refresher reflects current statutory guidance, evolving safeguarding risks, and the continuing emphasis on early intervention, information sharing, and professional curiosity within healthcare settings. Safeguarding Level 1 and 2 courses are available on the website, along with annual refreshers.

While this article covers UK general principles, some national variations (e.g., local procedures for referrals or statutory systems) differ slightly by country. You should check local authority safeguarding procedures in Wales, Scotland, and NI.

What age is considered a child?

- Children aged 17 and under fall under the umbrella of Child Protection Procedures.
- Once a person reaches the age of 18, adult safeguarding procedures apply.

In Scotland, a child legally become an adult at aged 16, but statutory guidance which supports the Children and Young People (Scotland) Act 2014 includes all children and young people up to the age of 18.⁶

Definitions

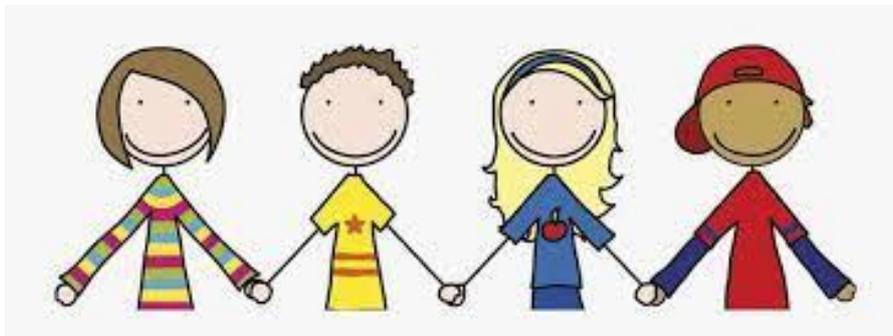
Safeguarding (Known as Child Protection in Scotland)

The term safeguarding and promoting the welfare of children is defined in Working Together to Safeguard Children (2023) as:

- “Providing help and support to meet the needs of children as soon as problems emerge.
- Protecting children from maltreatment, whether that is within or outside the home, including online.
- Preventing impairment of children’s mental and physical health or development.
- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care.
- Promoting the upbringing of children with their birth parents, or otherwise their family network through a kinship care arrangement, whenever possible and where this is in the best interests of the children.
- Taking action to enable all children to have the best outcomes in line with the outcomes set out in the Children’s Social Care National Framework.”⁵

Child protection is part of safeguarding and promoting the welfare of children and is defined in Working Together to Safeguard Children (2023) as “activity that is undertaken to protect specific children who are suspected to be suffering, or likely to suffer, significant harm. This includes harm that occurs inside or outside the home, including online.”⁵

Looked After Children



This term is used to describe any child who is in the care of the local authority or who is provided with accommodation by the local authority social services department for a continuous period of more than 24 hours.

Each UK nation has a slightly different definition of a looked after child and follows its own legislation, policy, and guidance. Generally looked after children are:

- Living with foster parents;
- living in a residential children's home; or,
- living in residential settings like schools or secure units.

In Scotland, the definition also includes children under a supervision requirement order. This means that many of the looked after children in Scotland are still living at home, but with regular contact from social services.

There are a variety of reasons why children and young people enter care:

- The child's parents might have agreed to this – for example, if they are too unwell to look after their child or if their child has a disability and needs respite care.
- The child could be an unaccompanied asylum seeker, with no responsible adult to care for them.
- Children's services may have intervened because they felt the child was at significant risk of harm. If this is the case the child is usually the subject of a court-made legal order.⁷

Legislation, Policy and Guidance



Each of the four UK nations have their own child protection system and laws to help protect children from abuse and neglect, however they are all based on similar principles.⁸ The relevant legislation, policy and Guidance for each of the four nations can be accessed through the relevant links in the further reading section of this article.

CQC Safeguarding Expectations in Dental Practice

At the time of writing, the Care Quality Commission (CQC) safeguarding guidance webpage was last updated in September 2025, and the intercollegiate document 5th edition was published in November 2025 on the RCPCH website, and is available from the link below or at the end of this article.^{9,4} The 2025 revision updates and consolidates guidance from two intercollegiate documents published in 2019 and 2020 relating to safeguarding children, young people, and looked after children. The framework was developed with a focus on equity, inclusion, amplifying the child's voice, and reflecting a four-nations perspective.

Safeguarding adults, children and young people must be fully embedded within existing practice systems and processes used to deliver care. It is the responsibility of all staff who come into contact with vulnerable adults, children and young people to protect them from abuse, neglect, or improper treatment.⁹

Health and social care providers have a statutory duty to protect and promote the health, safety and welfare of people who use their services. Risks to adults, children and young people increase where safeguarding systems and processes are ineffective, or where staff are unclear about the actions required when a safeguarding concern arises.⁹

What the CQC Look for During an Inspection

During inspection, the CQC assesses safeguarding systems and processes to ensure they are effective. Inspectors expect all practice staff to be able to demonstrate appropriate safeguarding competence relevant to their role.

Each practice should identify a designated safeguarding lead who provides advice and support to colleagues. This individual should be aware of safeguarding leads within the Integrated Care System (ICS) and have appropriate links with local authority safeguarding teams.

The CQC expects practices to provide evidence that they:

- Give sufficient priority to safeguarding adults, children and young people at risk.
- Actively engage with local safeguarding arrangements and procedures.

Inspectors also expect evidence that staff:

- Take a proactive approach to safeguarding, including prevention and early identification of concerns.
- Respond appropriately to signs, disclosures or allegations of abuse and ensure these are accurately recorded.
- Work effectively with other organisations to support safeguarding processes and implement protection plans.⁹

Legislation, Training and Professional Guidance



Practices must ensure that all staff receive safeguarding training at the appropriate level for their role, including face-to-face training where required.

Intercollegiate safeguarding guidance for adults and for children and young people provides a framework outlining minimum training and competency expectations for healthcare staff. These frameworks describe different safeguarding levels, with staff groups listed as examples rather than exhaustive categories. Practices are expected to meet these training requirements.⁹

The General Dental Council requires registered dental professionals to raise safeguarding concerns where patients may be at risk.³

National guidance, [Working Together to Safeguard Children](#), supports professionals in understanding their safeguarding responsibilities when working with children and young people.⁵

The British Dental Association provides a practical child protection workbook for dental teams, available via a free professional account.⁹

Additional supporting resources include:

- [The Safeguarding accountability and assurance framework from NHS England.](#)
- [Information-sharing guidance for practitioners working with children, young people, parents and carers.](#)

Training

The latest [Intercollegiate Document](#) was published in November 2025. The 2025 update brings together and refreshes two earlier intercollegiate frameworks: *Safeguarding Children and Young People: Roles and Competencies for Health Care Staff* (2019) and *Looked After Children: Roles and Competencies for Health Care Staff* (2020). The revised competency framework was developed using principles of equity and inclusion, with a strong emphasis on listening to the child's voice and recognising the differing safeguarding arrangements across the four UK nations.

The updated intercollegiate document now identifies five levels of competence. It is stated that "A few of the behaviours, knowledge, skills and competencies described may not be applicable to all staff roles, services or organisations. The guidance is not statutory, and health care providers have a responsibility to ensure that the duration and frequency of training (alongside the identified syllabus) is appropriate for the staff and the children and young people they support." Therefore, dental care professionals should review the competencies described below and ensure that they are confident that they have the level required depending on their role within the practice.

The levels of competence are now as follows:

Level 1 Competencies: Recognition

All health care professionals and staff who will have different levels of patient contact, as well as volunteers across health care services. Read level one competencies here: [Level 1 competencies](#).

Level 2 Competencies: Response

All health care professionals and staff who encounter children and young people, but do not provide clinical care to children and young people. Read level 2 competencies here: [Level 2 competencies](#).

Level 3 Competencies: Action and Expertise

All health care professionals and staff who deliver a clinical service to children and young people. Mental health and drugs and alcohol rehabilitation services who deliver care to adults, but where the situation has significant impact and risk for children and young people/families, are included. Read level 3 competencies here: [Level 3 competencies](#).

Level 4 Competencies: Leadership Role and Additional Responsibility

Professionals who deliver a senior leadership role within providers for safeguarding children and young people or children and young people in care. Read level 4 competencies here: [Level 4 Competencies](#).

Level 5 Competencies: Strategic Oversight and System Response

Professionals who deliver a senior leadership and strategic role within health care systems for safeguarding children and young people or children and young people in care. Read level 5 competencies here: [Level 5 Competencies](#).

Categories of Abuse



There are four main categories of abuse: emotional, physical, sexual and neglect.¹⁰ Child abuse is any action by another person – adult or child – that causes significant harm to a child. It can be physical, sexual, or emotional, but can just as often be about a lack of love, care and attention. Neglect, whatever form it takes, can be just as damaging to a child as physical abuse.

An abused child will often experience more than one type of abuse, as well as other difficulties in their lives. It often happens over a period of time, rather than being a one-off event.

Other types of abuse include child sexual exploitation, county lines, child criminal exploitation, bullying and cyberbullying, radicalisation, fabricated or induced illness, online abuse, harmful sexual behaviour, child trafficking and modern slavery, female genital mutilation, and domestic abuse.¹⁰ These are described in the full level 1 and 2 safeguarding courses.

Emotional Abuse



Emotional abuse involves the persistent emotional maltreatment of a child which can result in severe and persistent adverse effects on the child's emotional development. Emotional abuse can involve deliberately trying to scare or humiliate a child or isolating or ignoring them.

Children who are emotionally abused are usually suffering another type of abuse or neglect at the same time- but this is not always the case.¹¹

Examples of psychological/emotional abuse include:

- Threats of harm or abandonment
- Making the individual feel unwanted and unloved (deprivation of contact)
- Humiliation
- Blaming
- Controlling
- Coercion
- Harassment
- Verbal abuse
- Isolation or withdrawal from service or supportive networks

Recognising Emotional Abuse

- Poor growth
- Developmental delay
- Education failure
- Social immaturity
- Lack of social responsiveness, aggression or indiscriminate friendliness
- Challenging behaviours
- Excessively good behaviour (trying to please parent)
- Attention difficulties
- Concerning parent-child interaction

Physical Abuse

Physical abuse is deliberately hurting a child and may involve hitting, shaking, throwing, poisoning, burning, or scalding, drowning, suffocation or otherwise causing physical harm to a child. It also includes fabricated and induced illness. Fabricated or induced illness (FII) is a rare form of child abuse which happens when the parent' carer exaggerates or deliberately causes the symptoms of illness. FII used to be known as "Munchausen's syndrome by proxy". This is not the same as Munchausen's syndrome, where a person pretends to be ill or causes illness or injury to themselves).

Recognising Physical Abuse

- Bruising, abrasions, lacerations, burns, bite marks, eye injuries, bone fractures, intra-oral injuries
- Site, size, patterns
- Delay in presentation
- Does not fit the explanation given¹¹

Dental professionals are in a position to notice injuries to the head, eyes, ears, neck, face, mouth, and teeth.² The Department of Health produced the following chart which shows typical features of non-accidental injuries in children. As a child attending a dental practice is fully clothed only some of the child's injuries may be apparent.

Typical features of non-accidental injuries (injuries that should raise concerns)

Ears – especially pinch marks involving both sides of the ear

The “triangle of safety” (ears, side of face, and neck, top of shoulders): accidental injuries in this area are unusual

Inner aspects of arms

Back and side of trunk, except directly over the bony spine

Black eyes, especially if bilateral

Soft tissues of cheeks

Intra-oral injuries

Forearms when raised to protect self

Chest and abdomen

Any groin or genital injury

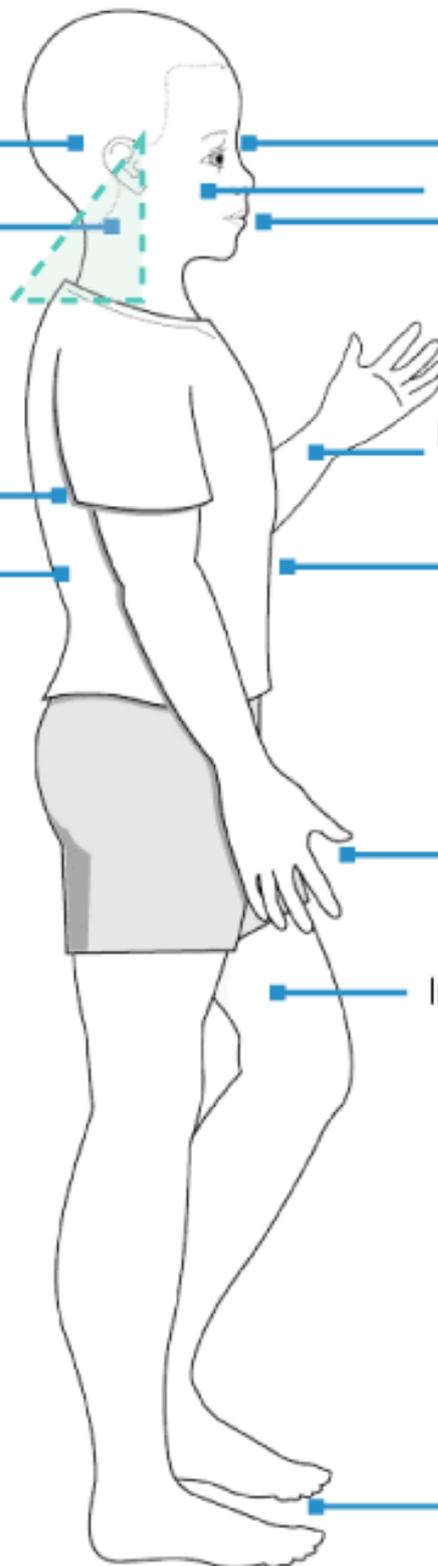
Inner aspects of thighs

Soles of feet

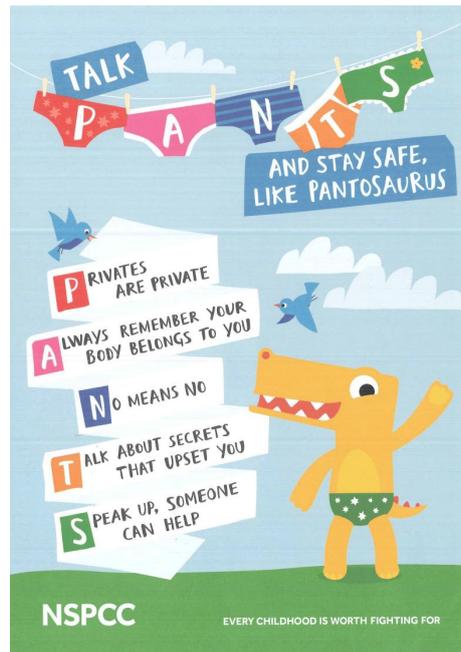
REMEMBER

Concerns are raised by:

- injuries to both sides of the body
- injuries to soft tissue
- injuries with particular patterns
- any injury that doesn't fit the explanation
- delays in presentation
- untreated injuries



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.

Child sexual exploitation (CSE) is a type of sexual abuse. Children in exploitative situations and relationships receive something such as gifts, money, or affection as a result of performing sexual activities or others performing sexual activities on them.

Children or young people may be tricked into believing they are in a loving, consensual relationship. They might be invited to parties and given drugs and alcohol. They may also be groomed and exploited online.

Some children and young people are trafficked into or within the UK for the purpose of sexual exploitation. Sexual exploitation can also happen to young people in gangs.¹¹

Recognising Sexual Abuse

- Direct allegation (disclosure)
- Sexually transmitted infection
- Pregnancy
- Trauma
- Emotional and behavioural signs e.g., delayed development, anxiety and depression, self-harm, drug, solvent, or alcohol abuse.

Unless there are intraoral signs of sexual abuse or the child discloses abuse, a dental professional 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.

Neglect

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, it is likely to result in the serious impairment of the child's health or development and includes failing to ensure access to appropriate medical care or treatment. This includes dental treatment.

Recognising Neglect

- Failure to thrive
- Short stature
- Inappropriate clothing
- Frequent injuries
- Ingrained dirt
- Developmental delay
- Withdrawn or attention seeking behaviour
- Untreated injuries, medical and dental issues
- Missed medical appointments (including dental appointments)
- Recurring illness or infections¹¹

Dental neglect is defined by the British Society of Paediatric Dentistry 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.'



Untreated Rampant Caries, Indicative of Dental Neglect.

Dental neglect may occur in isolation or may be an indicator of a wider picture of child maltreatment.

To maintain optimal oral health, children need:

- Fluoride- usually supplied by using a fluoride toothpaste twice daily

- A good diet- limited frequency of sugary foods and drinks
- Facilities, supervision, and assistance to practice good oral hygiene
- Regular dental visits

Impact: When assessing a child with dental disease it is important to assess the impact of the disease on the individual. Severe untreated dental disease can cause:

- Toothache
- Disturbed sleep
- Difficulty eating or change in food preferences
- Absence from school and interference with play and socialisation

Dental Neglect: cause for concern

The features that give cause for particular concern after dental problems have been pointed out to parents and appropriate and acceptable treatment offered are:

- Severe untreated dental disease, particularly that which is obvious to a layperson or other non-dental health professional.
- Dental disease resulting in a significant impact on the child.
- Parents or carers have access to but persistently fail to obtain treatment for the child, as may be indicated by:
 - Irregular attendance and repeated missed appointments.
 - Failure to complete planned treatment.
 - Returning in pain at repeated intervals.
 - Requiring repeated general anaesthesia for dental extractions.

Was Not Brought



The term "Was Not Brought" recognises that the responsibility for attendance lies with the caregiver, not the child, and supports early identification of potential neglect.

The dental team need to be vigilant in order to recognise the signs of dental neglect. Where a patient needs to have a parent or caregiver to bring them to an appointment, a person not attending for an appointment should have their failure to attend marked as Was Not Brought, rather than Failed to Attend or Did Not attend. Both reception and clinical staff need to be aware of this since repeated missed or cancelled appointments could indicate neglect. The following video highlights the importance of rethinking [“Did Not Attend”](#).

[Online and Digital Harm](#)



Children and young people are increasingly exposed to safeguarding risks in online and digital environments, including grooming, sexual exploitation, cyberbullying, coercive control, and exposure to harmful or age-inappropriate content. Working Together to Safeguard Children (2023) highlights that abuse can occur both online and offline, and that these environments are often interconnected. Digital harm may not present with visible physical injuries; instead, children may exhibit behavioural or emotional indicators such as anxiety, withdrawal, low mood, changes in behaviour, self-harm, or reluctance to attend appointments.

Dental professionals may be in a unique position to identify these signs during routine care, particularly where a child appears fearful, secretive, or distressed, or where a disclosure is made in a perceived safe environment. The NSPCC emphasises that online abuse should be treated with the same level of seriousness as other forms of maltreatment and that safeguarding responses should follow established local safeguarding procedures, including timely information sharing and escalation where there is concern for a child’s welfare.^{5,11}

[Mandatory Reporting on Female Genital Mutilation Cases \(FGM\)](#)



A mandatory duty to report FGM cases to the police came into effect in England and Wales on 31st October 2015. It applies to all teachers and registered healthcare professionals, including dentists and dental care professionals.

The duty applies where a dental professional, in the course of their work, either: is informed directly by a girl that an act of FGM has been carried out on her or observes physical signs which appear to show an act of FGM has been carried out and has no reason to believe that the act was necessary for the girl's physical or mental health or for purposes connected with labour or birth.

The duty applies only to girls who are under 18 at the time that FGM is observed or disclosed. It does not apply if the health professional only suspects that FGM may have been carried out.

Dental professionals should familiarise themselves with the government's guidance on the duty which includes FAQs and a process map on how the new duty fits with existing safeguarding arrangements. Under the legislation, failure to comply with the new duty may result in an investigation of a dental professional's fitness to practise.¹²

Recognising FGM

A girl or woman who has had FGM may:

- Have difficulty standing, walking, or sitting
- Spend longer in the toilet
- Be anxious or depressed
- Ask for help but may not be explicit about the problem due to fear or embarrassment

Vulnerability Factors



Vulnerability factors are factors that are known to increase the risk of child abuse and neglect. Certain children or groups of children may be more vulnerable to abuse or neglect because of certain risk factors in their environment or because of how they are

perceived by their carers. Whilst acknowledging that the presence of the following factors does not mean that child abuse or neglect will occur, The National Institute for Health and Care Excellence (NICE), advise that practitioners should use their “professional judgment to assess their significance in a particular child, young person or family.”¹³ NICE describe the following vulnerability factors:

Socioeconomic Factors

Socioeconomic vulnerability factors include poverty, poor housing, and deprivation.

Child factors

The age and gender of a child may impact on their vulnerability. Boys and young men are reported to be less likely to disclose sexual exploitation. Disabled children and young people may be more vulnerable to child abuse or neglect.

Family factors

The following parental factors increase the vulnerability to child abuse and neglect, and these may be compounded if the parent or carer lacks support from family or friends:

- Substance misuse problems.
- A history of domestic violence or having problems managing anger.
- Mental health problems which have a significant impact on the tasks of parenting.

The following are vulnerability factors for recurring or persistent child abuse and neglect:

- The parent or carer does not engage with services.
- There have been one or more previous episodes of child abuse or neglect.
- The parent or carer has a mental health or substance misuse problem which has a significant impact on the tasks of parenting.

Roles and Responsibilities of Dental Professionals

National safeguarding guidance recommends that:

- Each dental practice has a named safeguarding practice lead.
- All members of staff (clinical and non-clinical) undertake the appropriate level of safeguarding training.
- There is a safeguarding reporting system in place and staff are familiar with this.
- All members of staff know how to access the NHS safeguarding app for local safeguarding contact details:
www.myguideapps.com/nhs_safeguarding/default/index.html
- All members of staff read the national safeguarding guidance as part of the induction process- this document does not replace any safeguarding training

but is supplementary to it.¹ (this can be accessed from the further reading section).

National safeguarding guidance states that “professional curiosity should lie at the heart of the relationship between the dental team and patients/families/carers.”¹

In the dental surgery, assessing a child with an injury or with possible signs of abuse or neglect starts with a thorough history, including details from the child and carer of any injury or presenting complaint, past dental history, medical history, family and social circumstances.

A full examination should be carried out, noting in particular: any dental, oral or facial injuries, their site, extent and any specific patterns; 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 (e.g. 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).

Care should be taken to consider relevant factors and to resist making assumptions, however if a dental professional has any concerns, they should share it with a more experienced colleague. Notes should be recorded accurately.

The 5 Rs of Safeguarding lays out the following steps:

Recognise: You must first be able to recognise the signs of abuse.

Respond: Do not respond with shock or surprise but remain calm. Do not ask leading questions but be open. Do not make the child promises but reassure them that they have done the right thing by telling you.

Reporting: Do you have to share this information? Does it have to be done immediately? Follow your practice Safeguarding policy and seek advice from the Safeguarding lead if required.

Record: Record notes accurately.

Refer: If there is concern for a child’s safety, or you think they may be subject to abuse, neglect, or maltreatment, you should report your concerns so that the practice safeguard lead will escalate the concern to the appropriate authority.¹⁵ Is there a risk of immediate harm? If so, ring the police straight away.¹⁴

The NSPCC website has a section that outlines best practice for recognising and responding to abuse. This is available in the further reading section at the end of this article.

Safeguarding Practice Lead



Every dental team should have a designated Safeguarding Practice Lead (SPL). Although the SPL is not required to be an expert in safeguarding or deal with all safeguarding issues, the SPL will be a central person who will have an oversight of safeguarding issues. This will include:

- Ensuring staff are aware of their duty to safeguard.
- Ensuring staff are trained to an appropriate level.
- Providing, within their normal capabilities, practical everyday support and guidance to staff who may have a concern about the welfare and safety of a child or vulnerable adult.
- Ensuring that they and all members of their practice are aware of whom to contact locally in the health service, social services and the police in the event of child protection and protection of vulnerable adults' concerns. Procedures may vary slightly between local authorities and a referral protocol should be obtained from the local social services.
- Being aware of how sources of dental and safeguarding support and advice can be accessed.
- Maintaining an overview of complaints against the practice in order to identify any which might have a safeguarding element and consult with named professionals where there are safeguarding issues.

Adopting a practice policy will help to ensure the safeguarding of children by outlining clear procedures and ensuring staff members are clear about their responsibilities.

Staff Recruitment and 'whistle blowing'



All staff that are recruited must be deemed to be suitable to work with children and vulnerable adults. The home office requires all dental professionals to have an enhanced Disclosure and Barring Service (DBS) checks.

It is recommended that the dental practice has adequate safeguards in place when appointing a new member of staff. The following should be checked:

- References and CV
- Validation of date of birth and name
- Professional registration and qualifications
- DBS checks

The Public Interest Disclosure Act 1998 (PIDA) protects workers who 'blow the whistle' about wrongdoing, providing the allegation was made in good faith and with genuine concern.

Confidentiality and Information Sharing



Dental professionals have an ethical and legal duty to protect patient confidentiality; however, this duty is not absolute. Where there are safeguarding concerns, information must be shared appropriately and in a timely way to protect children and promote their welfare.

When a patient allows you to share information about them, make sure the patient understands:

- What you will be releasing;
- the reasons you will be releasing it; and
- the likely consequences of releasing such information.¹⁵

It is important to remember that UK GDPR and the Data Protection Act 2018 are not barriers to sharing information but provide a framework to ensure that personal information is shared lawfully, proportionately and appropriately, securely, and on a need-to-know basis. Information sharing may be justified without consent where there is a concern that a child is at risk of harm, where seeking consent may place the child at further risk, or where it would prejudice the prevention or detection of serious crime.

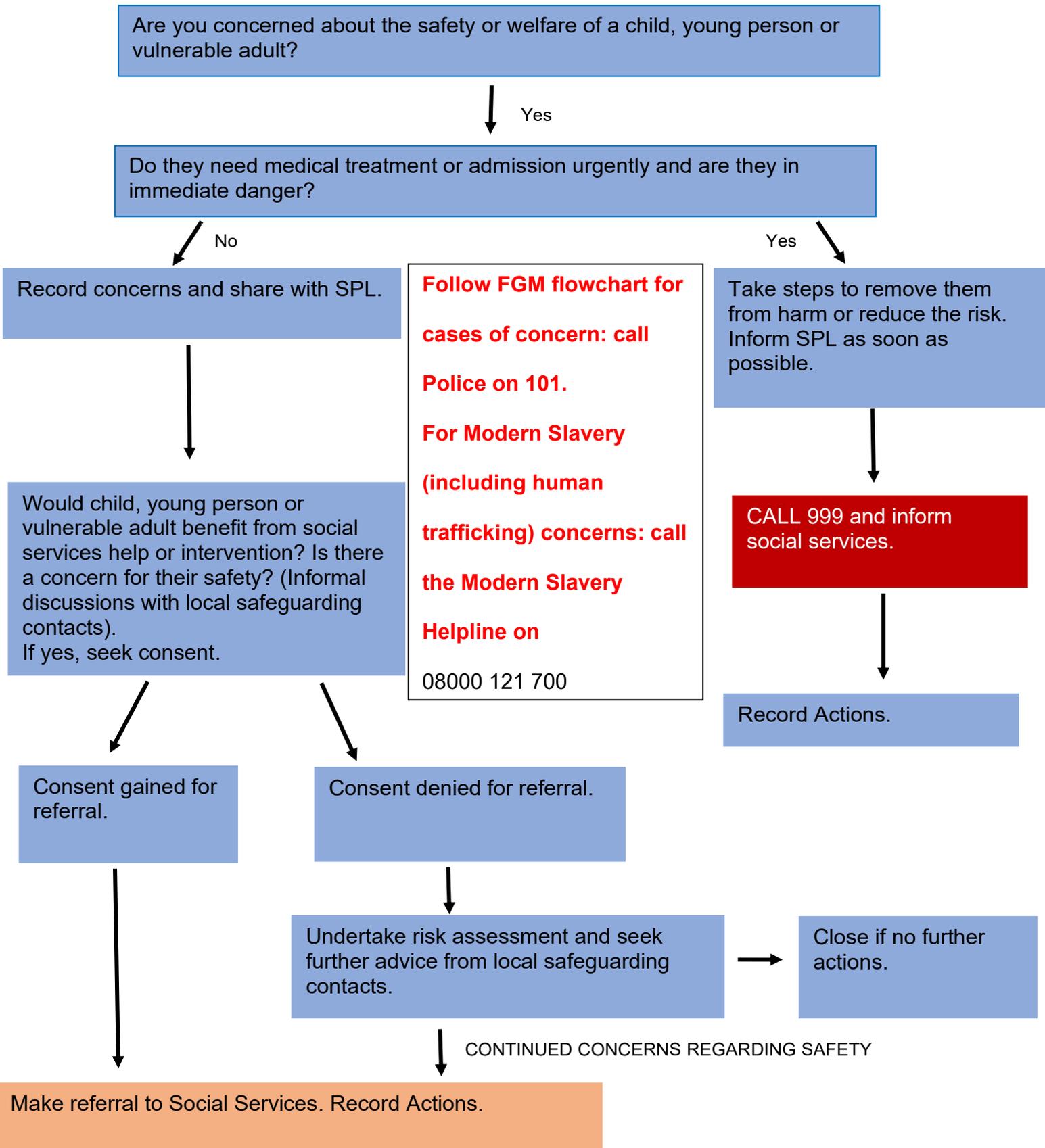
The Department for Education's Information sharing: Advice for practitioners (2024) emphasises that effective safeguarding depends on confident, timely information sharing, supported by professional judgement. Dental professionals should be clear about what information is being shared, why it is necessary, who it is being shared with, and how it will be recorded. Where possible and appropriate, children and their parents or carers should be informed that information will be shared, unless doing so would increase the risk of harm.¹⁶

Any decision to share or withhold information should be clearly documented, including the rationale for the decision, who was consulted (such as the Safeguarding Practice Lead), and the outcome.

The General Dental Guidance for dental professionals' states that you may share confidential information without consent if it is in the public interest. This may be the case if a patient discloses, or if you suspect, that the patient's health or safety is at risk or if you have confidential information which would help prevent or detect a serious crime. It is recommended that you consult with a senior colleague and your defence union for further advice. If you decide to release confidential information, it is important to document your reasons why so that you are able to explain and justify your actions.¹⁵

[Flowchart for Action](#)

National safeguarding guidance provides the following flowchart as a summary for dental healthcare professionals to use if they are worried about a child or young person.¹



Follow FGM flowchart for cases of concern: call Police on 101.

For Modern Slavery (including human trafficking) concerns: call the Modern Slavery Helpline on 08000 121 700

Our Local Safeguarding Contacts:

Go to NHS safeguarding app: http://www.myguideapps.com/nhs_safeguarding/default/index.html to find local contact details

Personal Development Plan and Reflective Learning

This CPD is linked to the following GDC Enhanced CPD Development Outcomes:

- A. Effective communication with patients, the dental team, and others across dentistry, including when obtaining consent, dealing with complaints, and raising concerns when patients are at risk.**
- D. Maintenance of skills, behaviours and attitudes which maintain patient confidence in you and the dental profession and put patients' interests first.**

Reflective learning is now a requirement of the GDC Enhanced Professional Development Scheme. As such, you will be given the option to answer some reflective learning questions, before your certificate is generated. Examples will be provided. Please remember that you can update this at any time from your CPD log. If you take a few moments to write your reflection on completion, you will have fulfilled the Enhanced CPD requirements.

Further reading

[Public Health England \(2019\) Safeguarding in general dental practice: A tool kit for dental teams.](#)

[Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff. Intercollegiate Document \(2025\)](#)

[NSPCC \(2023\) Recognising and responding to abuse](#)

[Working Together to Safeguard Children 2023](#)

[Children's Social Care National Framework 2023](#)

[Child Protection System UK \(England, Scotland, Wales and Northern Ireland\)](#)

References

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