Safeguarding Children and Adults at Risk of Harm, Level 1 Part 2

Aims:

To recognise how groups of professionals work together to safeguard children and adults at risk of harm; to understand and recognise the different types of abuse; and, to understand what to do if you have a safeguarding concern. Safeguarding level 1, part 1 also needs to be completed to meet the full learning outcomes required at level 1.

Learning outcomes:

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

- Identify the different forms of abuse, to include emotional abuse; physical abuse; (including fabricated and induced illness); sexual abuse; neglect; forced marriage; modern slavery and grooming; county lines; radicalisation; cyber bullying; discriminatory abuse; financial abuse; and domestic abuse.
- Show an understanding of the Prevent Duty and how to access Government recommended training for healthcare.
- Identify some of the signs and symptoms of the different forms of abuse.
- Know the risks associated with the internet and online social networking.
- Identify the importance between someone not attending a dental appointment and someone not being brought to a dental appointment.
- Know the legal definitions of parental responsibility.
- Understand the main principles of the Mental Capacity Act and the relevance and impact in adult safeguarding.
- Know the role of the Safeguarding Practice Lead.
- Know how to raise concerns about conduct of colleagues.
- Know how to take appropriate action if there are safeguarding concerns
- Identify how to record and share relevant information appropriately with other teams.

Introduction

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

Part one of this CPD covered the key definitions relating to safeguarding of children and safeguarding adults at risk of harm, as well as the training competency framework and the standards, laws and regulations surrounding safeguarding.

This article will describe multi agency working, the main categories and signs and symptoms of abuse and how to report concerns.

Multi Agency Working

Protecting children and adults at risk of harm is:

- Everyone's responsibility - It is shared by all members of society.
- A shared responsibility - It is a responsibility shared by many different groups of professionals.
- The responsibility of every member of the dental team.[2]

Multi agency working is key to effective safeguarding and child protection. Serious case reviews throughout the UK emphasise the importance of information sharing and collaboration between the agencies.[3] Everyone who works with children and adults at risk of harm has a responsibility to share any information appropriately where there is a concern about the child or adult's welfare. Dental practices must have clear procedures and processes in place where it comes to sharing information. Safeguarding is a shared responsibility between:

- Social Care
- Police (including transport police)
- Safeguarding Adults Boards
- Community
- Education
- NSPCC
- Health Care
- Community
- Education
- Integrated Care Boards

The 2019 Safeguarding in General Dental Practice Toolkit states that, "the concept of 'professional curiosity' should lie at the heart of the relationship between the dental team and patients/families/carers. It does not require anyone to be interrogated, but it does involve the critical evaluation of information and the maintenance of an open mind."[1]

Categories of Abuse

The main categories of abuse are: Psychological abuse (including emotional abuse), physical, sexual and neglect.[2] Adults at risk of harm may also be subjected to financial or material abuse or institutional abuse. Other types of abuse described in the Care and Support Statutory Guidance include discriminatory abuse, modern slavery, radicalisation, cyber bullying, and domestic abuse.

Abuse is a violation of an individual's human and civil rights by any other person or persons.

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.

Emotional Abuse

Emotional abuse involves the persistent emotional maltreatment of an individual which can result in severe and persistent adverse effects on the child's emotional development and the adult at risk of harm's health and well-being.
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.[2]

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
- Bullying
- Verbal abuse
- Isolation or withdrawal from service or supportive networks.[4]

Possible indicators of Emotional Abuse

- Poor growth
- Developmental delay
- Being withdrawn
- Education failure
- Not able to do the things they used to
- Showing compulsive behaviour
- Low self esteem
- Social immaturity
- Lack of social responsiveness, aggression or indiscriminate friendliness
- Challenging behaviours
- Excessively good behaviour (trying to please parent or carer)
- Attention difficulties
- Concerning parent-child interaction[2,5]

Physical Abuse

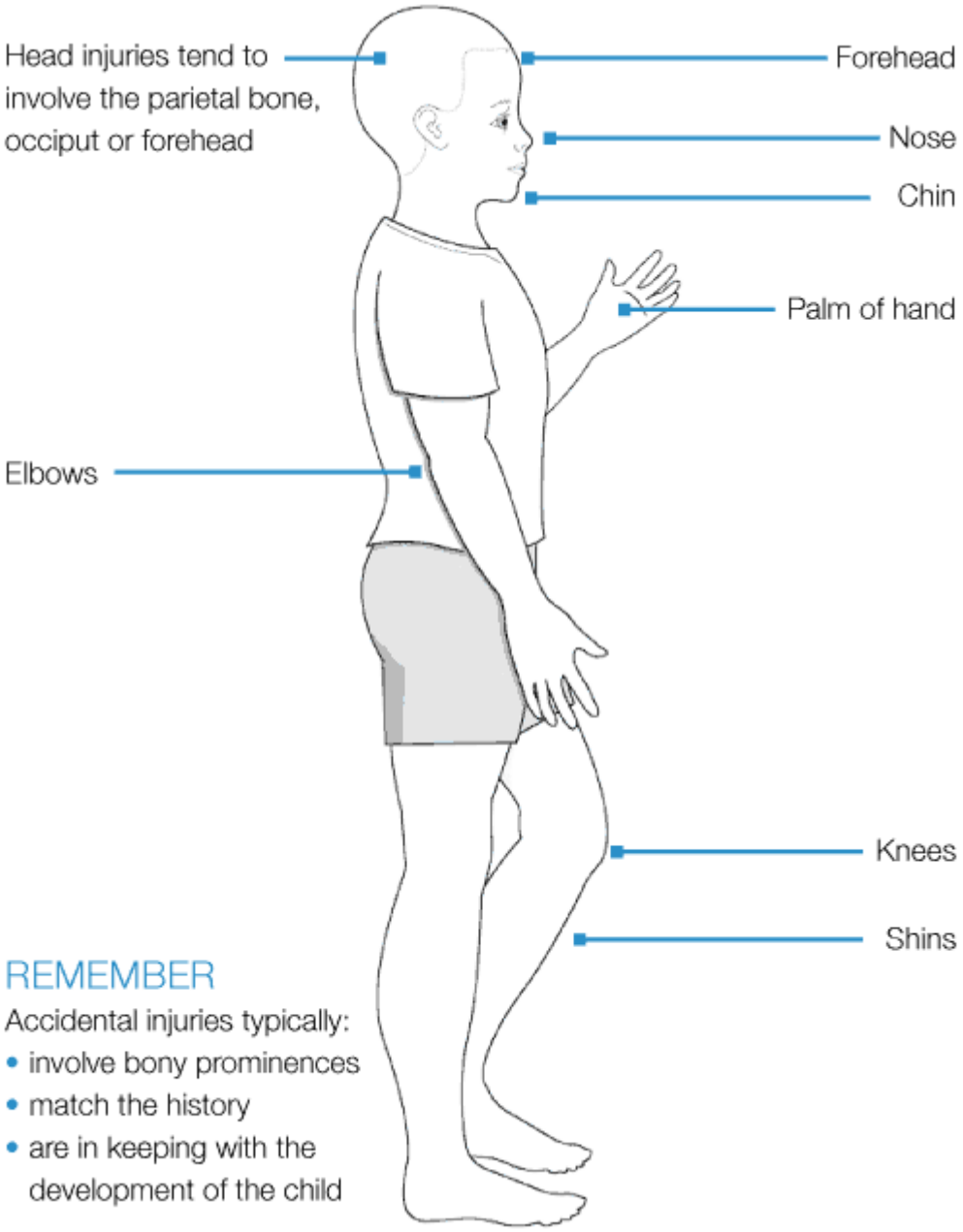
Physical abuse is deliberately hurting a child or adult and may involve hitting, making someone deliberately uncomfortable (for example removing blankets), shaking, throwing, poisoning, burning or scalding, drowning, forcible feeding or withholding food, suffocation, misuse of medication, inappropriate restraint or inappropriate physical sanctions. It also includes fabricated and induced illness.[2,5]

Possible Indicators of Physical Abuse

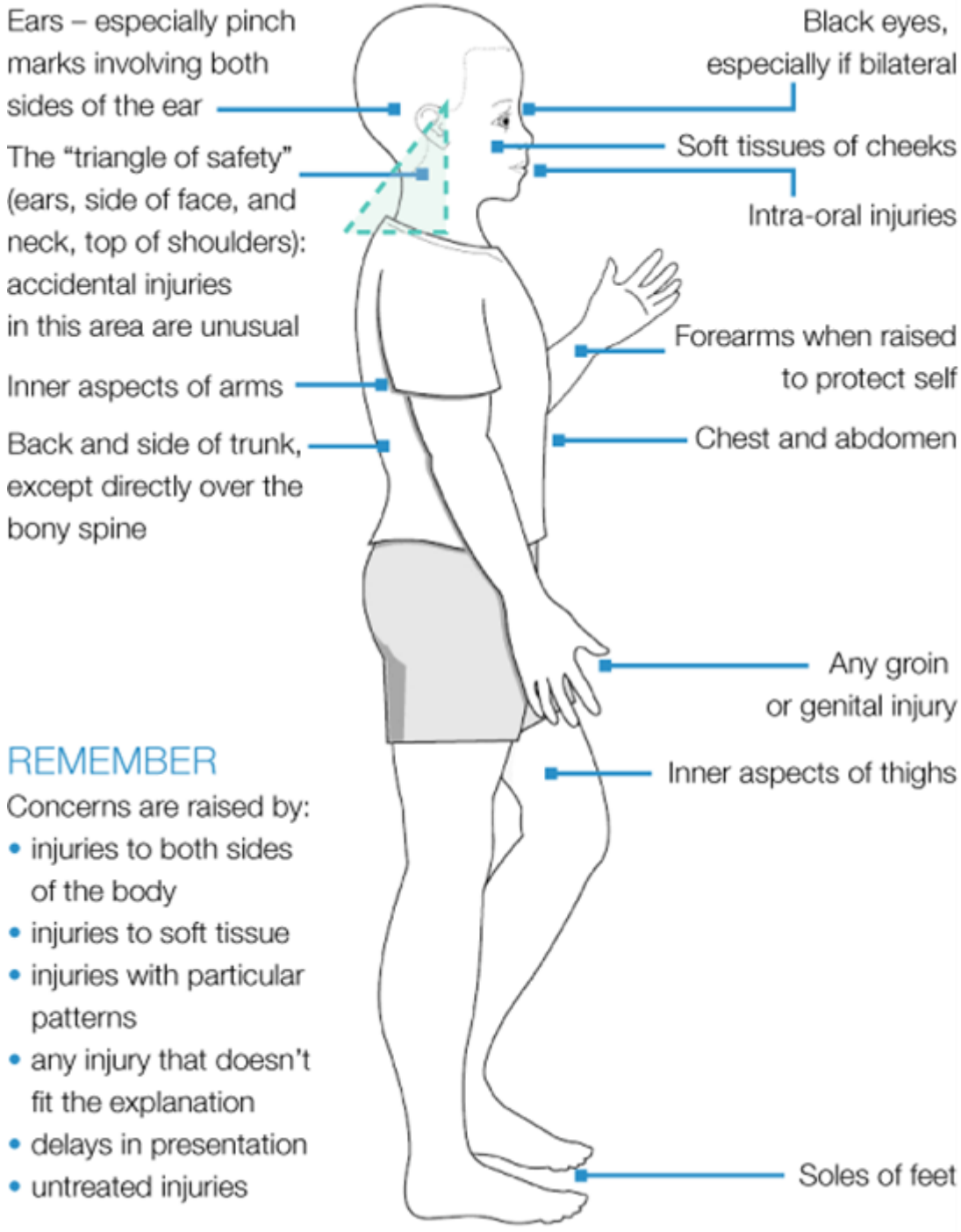
- Bruising, abrasions, lacerations, burns, bite marks, eye injuries, bone fractures, intra-oral injuries
- Frequent injuries
- Unexplained falls
- Signs of malnutrition
- Subdued behaviour in front of a particular person
- Failure to seek medical attention or frequent changes of GP
- Site, size, patterns
- Delay in presentation
- Does not fit the explanation given [5,6]

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 accidental and non-accidental injuries in children.[2] As a vulnerable adult or child attending a dental practice is fully clothed, only some of the injuries may be apparent.

Typical features of accidental injuries



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



Sexual Abuse

Sexual abuse involves forcing or enticing an adult, child, or young person to take part in sexual activities, including prostitution, whether or not the individual is aware of what is happening. It can involve:

- Rape, attempted rape, or sexual assault.
- Inappropriate touch anywhere.
- Any sexual activity that the person lacks the capacity to consent to.
- Inappropriate looking, sexual teasing or innuendo or sexual harassment.
- Sexual photography or forced use of pornography or witnessing of sexual acts
- Indecent exposure.[5]

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.[6]

Possible Indicators of Sexual Abuse

- Direct allegation (disclosure).
- Sexually transmitted infection.
- The uncharacteristic use of explicit sexual language or significant changes in sexual behaviour or attitude.
- Unusual difficulty in walking or sitting.
- Pregnancy in someone who is unable to consent to sexual intercourse.
- Excessive fear/apprehension of, or withdrawal from, relationships.
- Fear of receiving help with personal care.
- Reluctance to be alone with a particular person.
- Trauma such as bruising to thighs, buttocks and upper arms and marks on neck.
- Emotional and behavioural signs e.g., delayed development, anxiety and depression, self-harm, drug, solvent, or alcohol abuse.[6]

Unless there are intraoral signs of sexual abuse or the individual discloses abuse, a dental professional is most likely to detect the problem through emotional or behavioural signs.

Neglect

THE NSPCC state that 1 in 10 children have experienced neglect[6.] In England, findings from the Safeguarding Adults Collection found that 615,530 concerns of abuse were raised during 2023-2024, which was an increase of 5% on the previous year.[7]

The most common type of risk in Section 42 enquiries was Neglect and Acts of Omission, which accounted for 32% of risks, and the most common location of risk was the person's own home at 46%.[7]

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

Types of Neglect and Acts of Omission

- Failure to provide or allow access to food, shelter, clothing, heating, stimulation, and activity, personal or medical care.
- Substance abuse during pregnancy (for example drugs, alcohol, smoking).
- Providing care in a way that the person dislikes.
- Failure to administer medication as prescribed.
- Refusal of access to visitors.
- Not taking account of individuals' cultural, religious, or ethnic needs.
- Not taking account of educational, social, and recreational needs.
- Ignoring or isolating the person.
- Preventing the person from making their own decisions.
- Preventing access to glasses, hearing aids, dentures, etc.
- Failure to ensure privacy and dignity.[5]

Possible Indicators of Neglect and Acts of Omission

- Failure to thrive.
- Short stature.
- Inappropriate clothing.
- Poor physical condition and/or personal hygiene.
- Pressure sores or ulcers.
- Malnutrition or unexplained weight loss.
- Frequent injuries.
- Ingrained dirt.
- Developmental delay in children.
- Withdrawn or attention seeking behaviour.
- Untreated injuries, medical and dental issues.
- Missed medical appointments (including dental appointments).
- Recurring illness or infections. [5,6]

Signs of self-neglect may also be evident if an adult at risk does not have appropriate access to services.

Types of self-neglect:

- Lack of self-care to an extent that it threatens personal health and safety.
- Neglecting to care for one's personal hygiene, health or surroundings.
- Inability to avoid self-harm.
- Failure to seek help or access services to meet health and social care needs.

- Inability or unwillingness to manage one's personal affairs.[5]

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.

Financial Abuse

Social Care for Clinical excellence describes the many types of financial abuse:

- "Theft of money or possessions.
- Fraud, scamming.
- Preventing a person from accessing their own money, benefits or assets.
- Employees taking a loan from a person using the service.
- Undue pressure, duress, threat, or undue influence put on the person in connection with loans, wills, property, inheritance or financial transactions.
- Arranging less care than is needed to save money to maximise inheritance.
- Denying assistance to manage/monitor financial affairs.
- Denying assistance to access benefits.
- Misuse of personal allowance in a care home.
- Misuse of benefits or direct payments in a family home.
- Someone moving into a person's home and living rent free without agreement or under duress.
- False representation, using another person's bank account, cards or documents.
- Exploitation of a person's money or assets, e.g., unauthorised use of a car.
- Misuse of a power of attorney, deputy, appointeeship or other legal authority.
- Rogue trading – e.g., unnecessary or overpriced property repairs and failure to carry out agreed repairs or poor workmanship."[5]

Possible indicators of Financial or Material Abuse:

- "Missing personal possessions.
- Unexplained lack of money or inability to maintain lifestyle.
- Unexplained withdrawal of funds from accounts.
- Power of attorney or lasting power of attorney (LPA) being obtained after the person has ceased to have mental capacity.
- Failure to register an LPA after the person has ceased to have mental capacity to manage their finances, so that it appears that they are continuing to do so.
- The person allocated to manage financial affairs is evasive or uncooperative.
- The family or others show unusual interest in the assets of the person.
- Signs of financial hardship in cases where the person's financial affairs are being managed by a court appointed deputy, attorney or LPA.
- Recent changes in deeds or title to property.
- Rent arrears and eviction notices.
- A lack of clear financial accounts held by a care home or service.

- Failure to provide receipts for shopping or other financial transactions carried out on behalf of the person.
- Disparity between the person's living conditions and their financial resources, e.g. insufficient food in the house.
- Unnecessary property repairs."[5]

In the dental surgery, a lack of dental care or a care giver questioning the need for treatment (for example, "at his age"), may be an indication of financial abuse.

Other Types of Abuse

Cyber bullying and Grooming

Cyberbullying takes place online and can take place in many forms, including:

- Abusive text messages.
- Sharing videos or images online that are embarrassing to the victim.
- Exclusion of online games of friendships.
- Encouraging self-harming.
- Setting up hate sites or groups about an individual.
- Sending explicit messages (sexting).
- Pressuring individuals in sending explicit images.
- Shaming online.

Although cyberbullying is often attributed to the young, the incidence of cyberbullying between adults is increasing.[8]

Whilst grooming is most associated with child sexual abuse, it is also possible for adults, especially vulnerable adults, to be groomed for abuse. An individual can be groomed in person or online. Grooming is when someone "builds a relationship, trust and emotional connection with a person so they can manipulate, exploit and abuse them."[6]

County Lines

Criminal exploitation is also known as 'county lines". Gangs and organised crime networks groom and exploit children to sell drugs and are often made to travel across countries, and they use dedicated mobile phone 'lines' to supply drugs. The Children's Clinical Commissioner estimates there are at least 46,000 in England who

are involved in gang activity. Vulnerable children, who may be homeless, living in care homes, experiencing learning difficulties or trapped in poverty are more likely to be targeted. [9]

Forced Marriage

A forced marriage is against the law in the UK and the minimum age of marriage in the UK is 16. It can happen in many religions and nationalities and can affect boys, girls and adults too.[10]

A forced marriage is different to an arranged marriage:

Arranged Marriage	Forced Marriage
Is a cultural tradition	Is an abuse of human rights
You have a choice	You don't have a choice

Modern Slavery

Modern Slavery includes:

- Human trafficking.
- Forced labour.
- Forced marriage.
- Domestic servitude.
- Sexual exploitation (including escort work, prostitution and pornography).
- Debt bondage (working to pay off debts that they may never be able to).[5]

The traffickers usually make a false promise to the children's families for a better future. The Home Office predicts that there may be as many as 10,000 victims in the UK. Victims can be men, women and children of all ages; however, it is more prevalent in the most vulnerable, minority or socially excluded groups.[11]

Radicalisation and the Prevent Duty

Radicalisation is a process by which an individual or group adopts increasingly extreme political, social, or religious ideals and aspirations that reject or undermine the status quo or undermine contemporary ideas and expressions of freedom of choice.

Some organisations in England, Scotland and Wales have a duty, as a specified authority under section 26 of the Counterterrorism and Security Act 2015, to identify vulnerable children and young people and prevent them from being drawn into terrorism. This is known as the Prevent duty. The Prevent Duty is part of the UK Government's counter terrorism strategy, known as CONTEST. Prevent focuses on all forms of terrorism and is focused on providing support and re-direction to individuals at risk of, or in the process of being groomed /radicalised into terrorist activity before any crime is committed.

The Prevent Duty 2015 requires that all specified authorities ensure that there are mechanisms in place to understand the risk of radicalisation. Therefore, healthcare workers need to be trained to recognise the signs of radicalisation.

The Prevent Duty Guidance (2023) is a government document that outlines how specified authorities, such as schools, universities, local councils, healthcare providers, and the police, must comply with their statutory duties under the Counterterrorism and Security Act 2015. There are two versions of the Prevent Duty Guidance:

1. England and Wales - tailored to these regions' specific needs and legal frameworks.
2. Scotland- adapted to reflect Scotland's unique legal and cultural context.[12]

Possible indicators of radicalisation:

- Isolating themselves from family and friends
- Talking as if from a scripted speech
- Unwillingness or inability to discuss their views
- A sudden disrespectful attitude towards others
- Increased levels of anger
- Increased secretiveness, especially around internet use[13]

Gov.UK Prevent Duty Training is available to all healthcare professionals and can be accessed by clicking on the link at the end of this article.

Discriminatory Abuse

Discriminatory abuse is unequal treatment based on one of the protected characteristics (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex or sexual orientation)[14] (A full verifiable article on Equality and Diversity is available for you to complete on the website).

Organisational or Institutional Abuse

Organisational abuse includes neglect and poor practice within an institution or specific care setting such as a hospital or care home. It can be caused through poor neglect or poor professional practice which results from poor structure, policies and practices within an organisation.

Possible indicators of organisational or Institutional abuse:

- Lack of flexibility and choice for people using the service.
- Inadequate staffing levels.
- People being hungry or dehydrated.
- Poor standards of care.
- Lack of personal clothing and possessions and communal use of personal items.
- Lack of adequate procedures.
- Poor record-keeping and missing documents.

- Absence of visitors.
- Few social, recreational, and educational activities.
- Public discussion of personal matters.
- Unnecessary exposure during bathing or using the toilet.
- Absence of individual care plans.
- Lack of management overview and support. [5]

Domestic Abuse

The Domestic Abuse Act 2021 defines domestic abuse in England and Wales as behaviour that is abusive and takes place between two people aged 16 or over who are personally connected to each other. The behaviour is considered abusive if it involves any of the following:

1. Physical or sexual abuse.
2. Violent or threatening behaviour.
3. Controlling or coercive behaviour.
4. Economic abuse – behaviour that has a substantial adverse effect on someone's ability to acquire, use, or maintain money or other property, or to obtain goods or services.
5. Psychological, emotional, or other abuse.

Personally connected

People are considered personally connected if they:

- Are (or have been) married or civil partners.
- Are (or have been) in an intimate personal relationship.
- Live (or have lived) together and are family members.
- Share parental responsibility for a child.

Importantly, the Act recognises that domestic abuse is not limited to physical violence; it includes non-physical forms of abuse such as coercive control, economic control, and emotional harm. This broader definition aims to better protect victims and support enforcement efforts.[15]

Long term, children who have witnessed violence and abuse are more likely to become involved in a violent and abusive relationship themselves.[16]

Effects of Historical Abuse

Non recent abuse, otherwise known as historical abuse, is when an adult was abused as a child or young person under the age of 18.

The impact of abuse can last a lifetime, having an effect on health, relationships and education. It can also lead to the development of mental health problems and drug or alcohol issues.

Raising Concerns

Abuse or neglect may present to the dental team in a number of different ways. It could be through a direct allegation made by the child, vulnerable adult, a parent or some other person. Or it could be through signs and symptoms which are suggestive of physical abuse or neglect. The dental team member could also have concerns through observations of child behaviour or parent-child interaction. [5]

The most important thing to remember when you are faced with a child who may have been abused is that you do not need to manage this on your own.

The General Dental Council state "the dental team have an ethical obligation to find out about and follow local procedures for child protection. These procedures should be followed if you suspect a child might be at risk because of abuse or neglect."[17]

Roles and Responsibilities

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 or vulnerable adult 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: Is there a risk of immediate harm? If so, ring the police straight away.

Concerns related to a parent/carer

Concerns about the mental or general health (alcohol, substance misuse or deteriorating health condition) of a parent should prompt a discussion with the parent and a referral to children's services, particularly when other signs of abuse and neglect are present. Children's services will assess the need for child and family support and identify remedial action.[2]

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 adult 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 and adults at risk of harm 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.

There is now an option to subscribe to the DBS's new portability scheme that will allow information from an existing certificate to be checked online. If a new DBS check needs to be done, the system will show "Further information available".

Principle Eight of the General Dental Council's Standards for Dental Professionals is to "Raise Concerns if patients are at risk." They state that if you employ, manage or lead a team you must encourage and support a culture where staff can raise concerns openly without fear of reprisal.

8.3.1 You must promote a culture of openness in the workplace so that staff feel able to raise concerns.

8.3.2 You should embed this culture into your policies and procedures, beginning with staff training and induction.

8.3.3 You should encourage all staff, including temporary staff, staff on different sites and locums, to raise concerns about the safety of patients, including the risks that may be posed by colleagues, premises, equipment or practice policies.[17]
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

All members of the dental team, whether clinical or not, have an ethical and legal responsibility to keep patient information confidential. 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.[17]

It is good practice to ask the child or adult at risk of harm about the cause of any injuries and allow them to talk and volunteer information. Leading questions should be avoided, and notes should be recorded accurately. Any child or adult at risk of harm who makes an accusation of abuse should be taken seriously. If requested to keep a secret, it should be explained that information may need to be shared and with whom and when it will be shared.

Ability to Consent

The Mental Capacity Act 2005 defines a person who lacks capacity as a person who "is unable to make a decision for themselves because of an impairment or disturbance in the functioning of their mind or brain." It does not matter if the impairment or disturbance is permanent or temporary. The Mental Capacity Act 2005 applies to England, Wales and Northern Ireland. In Scotland the Adults with

Incapacity (Scotland) Act 2000 applies. A person lacks capacity if they have an impairment or disturbance (for example a disability, condition or trauma or the effect of drugs or alcohol) that affects the way their mind or brain works, and that impairment or disturbance means that they are unable to make a specific decision at the time it needs to be made.

An assessment of a person's capacity must be based on their ability to make a specific decision at the time it needs to be made, and not their ability to make decisions in general.

The Mental Capacity Act sets out five principles:

- Principle 1. - A presumption of Capacity - every adult has the right to make his/her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
- Principle 2. - Individuals being supported to make their own decisions - people must be given all appropriate help before anyone concludes that they cannot make their own decisions.
- Principle 3. - Unwise decisions - People have the right to make decisions that others might regards as being unwise or eccentric and a person cannot be treated as lacking capacity for these reasons.
- Principle 4. - Best interests - any decisions made, or anything done for or on behalf of a person who lacks capacity must be done in their best interests.
- Principle 5. - Least restrictive alternative - anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms.[18]

Power of Attorney

A Lasting power of attorney (LPA) is a legal document which appoints someone to make decisions on the behalf of someone else. There are two types:

1) **Health and Personal Welfare for England, Scotland and Wales** (called a Welfare Power of Attorney in Scotland)- decisions about whether to receive healthcare or stop a healthcare treatment, moving into a nursing home, where to live. This can only be used when the person is unable to make their own decisions at that particular time. There is no equivalent to a welfare Power of Attorney in Northern Ireland. The law that governs power of attorney and mental capacity in Northern Ireland is known as the Enduring Power of Attorney Order (Northern Ireland) 1987. It's designed to protect and safeguard people who have or may go on to lose capacity.

2) **Property and Financial Affairs**- paying bills, collecting benefits, selling a home affairs. This LPA can be used as soon as it is registered with the person's permission.

The Mental Capacity Act 2005 introduced the role of the Independent Mental Capacity Advocate (IMCA). IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs are mainly

instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person.[18]

The ability for children under 16 to give valid consent will depend on their maturity and ability to understand what the treatment involves. In England and Wales, this is referred to as being Gillick competent. Other guidelines that exist are 'Fraser guidelines' these specifically relate only to contraception and sexual health.

To be Gillick competent, a child must:

- Understand the nature of the proposed treatment, its consequences, and the alternatives, including no treatment.
- Retain that information.
- Use or weigh up that information in making a decision.
- Communicate that decision.[19]

Parental responsibility

If a child is not Gillick competent, authority to treat or share information may be given by someone with parental responsibility under the Children Act 1989. A mother automatically has parental responsibility for her child from birth. A father usually has parental responsibility if he's either:

- Married to the child's mother.
- Listed on the birth certificate (after a certain date, depending on which part of the UK the child was born in).

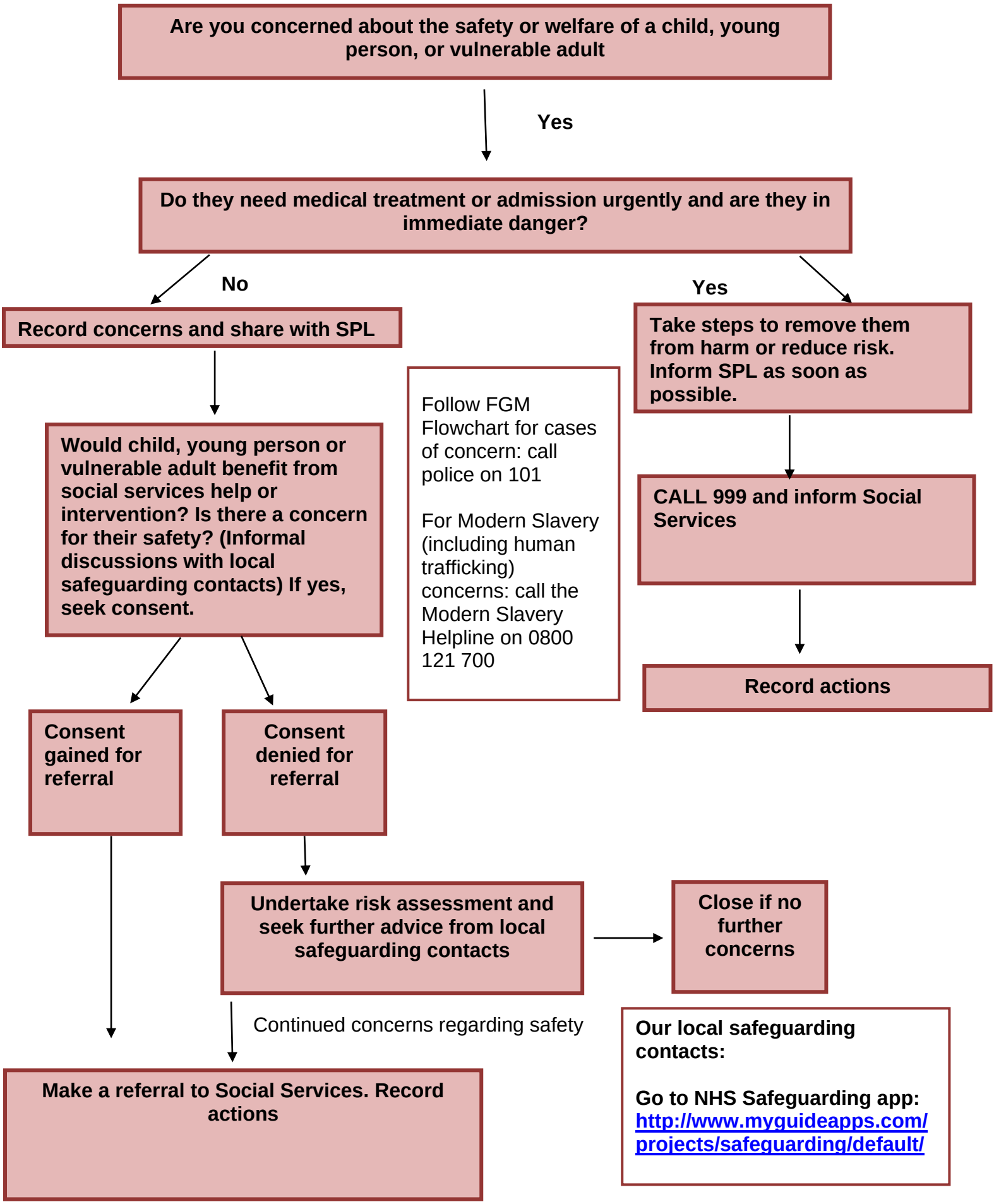
You can apply for parental responsibility if you do not automatically have it.[20]

It is important to remember that the Data Protection Act, 2018, is not a barrier to sharing information, but provides a framework to ensure that personal information about living persons is shared appropriately.

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.[17]

Public Health, England, have produced the following flow chart in their Safeguarding Toolkit for Dental Teams.[1] The original flow chart can be accessed through this Document which is available to download at the end of this article as further reading.


Are you concerned about the safety or welfare of a child, young person, or vulnerable adult
Yes
Do they need medical treatment or admission urgently and are they in immediate danger?
No
Yes
Record concerns and share with SPL
Take steps to remove them from harm or reduce risk. Inform SPL as soon as possible.
Follow FGM Flowchart for cases of concern: call police on 101
For Modern Slavery (including human trafficking) concerns: call the Modern Slavery Helpline on 0800 121 700
Would child, young person or vulnerable adult benefit from social services help or intervention? Is there a concern for their safety? (Informal discussions with local safeguarding contacts) If yes, seek consent.
CALL 999 and inform Social Services
Record actions
Consent gained for referral
Consent denied for referral
Undertake risk assessment and seek further advice from local safeguarding contacts
Close if no further concerns
Continued concerns regarding safety
Our local safeguarding contacts:
Go to NHS Safeguarding app: http://www.myguideapps.com/projects/safeguarding/default/
Make a referral to Social Services. Record actions

Tips for best practice

Safeguarding is not just about referring them when you have concerns but is about changing the environment to ensure that risks to their welfare are minimised. These tips for best practice will help a dental practice to not only fulfil the responsibilities of current legislation and ethical guidance but also to take an active role in safeguarding:

1. Identify a member of staff to take the lead on Safeguarding
2. Adopt a Safeguarding policy
3. Work out a step-by-step guide of what to do if you have concerns
4. Follow best practice in record keeping
5. Undertake regular team training
6. Practice safe staff recruitment[2]

Questions to Consider

1. Has there been delay in seeking dental advice, for which there is no satisfactory explanation?
   YES / NO

2. Does the history change over time or not explain the injury or illness?
   YES / NO

3. When you examine the child or vulnerable adult, are there any injuries that cannot be explained?
   YES / NO

4. Are you concerned about the child or vulnerable adult's behaviour and interaction with the parent/carer?
   YES / NO

If the answer to any of these questions is YES, you should discuss with a senior colleague and follow local child protection procedures.

If all the answers are NO, then diagnose and treat as normal.

Conclusion

Clinical and non-clinical staff within the dental practice must fulfil the responsibilities of current legislation and ethical guidance and take an active role in safeguarding children. If in doubt, raise your concerns with a more experienced colleague.

Remember, safeguarding is everybody's responsibility, a shared responsibility, and the responsibility of every member of the dental team.

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 now have the option to answer some reflective learning questions for the CPD you complete. Please remember that you can complete and update this at any time. If you take a few moments to write your reflection on completion, you will have fulfilled the Enhanced CPD requirements.

Further reading
We recommend that you read the following documents to enhance your learning on the subject and ensure that you are happy that you have met the learning outcomes required for level 1. These can be accessed from the intercollegiate documents below. We invite your feedback.

Intercollegiate Document (2019) Safeguarding Children and Young People: Roles and Competences for Health Care Staff.

Intercollegiate Document (2024) Adult Safeguarding: Roles and Competencies for Health Care Staff

No Secrets: Guidance on protecting Vulnerable Adults in Care This has now been superseded by Care and Support Statutory Guidance

Safeguarding in General Dental Practice: a toolkit for dental teams

HM Government (2023) Working together to safeguard children

Children's Social Care National Framework 2023

NSPCC Child Protection in England.

NSPCC Child Protection in Northern Ireland.

NSPCC Child Protection in Wales.

NSPCC Child Protection in Scotland

Gov.Uk Prevent Training for Healthcare Professionals

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