Safeguarding for the Paediatric Patient

7

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Learning Objectives
By the end of this chapter, readers will:

- Be familiar with signs and symptoms negatively impacting on a child or young person's wellbeing.
- Have heightened awareness of factors that raise the suspicion of safeguarding measures being required and consider the possibility of injuries being caused by physical abuse.
- More fully understand the role of the dentist in safeguarding especially in cases that include dental neglect.
- Know about the underpinning principles of child safeguarding and have insight into the information needed to develop a local safeguarding policy.

7.1 Definitions Within Safeguarding

There are some terms involved in safeguarding that are useful to define. Safeguarding itself is the action that is taken to promote the welfare of all children and young people CYP and protect them from harm. It is defined as protecting children from maltreatment (Table 7.1), preventing impairment of children's health or development, ensuring that children are growing up in circumstances consistent with the provision of safe and effective care and, importantly, acting to enable all children to have the best outcomes.

Child protection is part of safeguarding and includes activities undertaken to protect CYP who have been harmed or are at significant risk of being harmed. It can

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Table 7.1 Forms of child maltreatment

Physical abuse
Domestic violence or abuse
Sexual abuse
Psychological or emotional abuse
Financial or material abuse
Modern slavery
Discriminatory abuse
Organisational or institutional abuse
Neglect or acts of omission
Self-neglect

be defined as preventing and responding to violence, exploitation, neglect and abuse against CYP.

Child wellbeing refers to the quality of a child's life including how well the child is and how their lives are going. It is generally poorly defined but there is some emerging consensus that childhood wellbeing is multi-dimensional, should include dimensions of physical, emotional and social wellbeing; should focus on the immediate lives of children but also consider their future lives; and should incorporate some subjective as well as objective measures. Child wellbeing can be illustrated by the wellbeing wheel (Fig. 7.1) which is a tool originating in Scotland to help professionals understand the term wellbeing.

7.2 General and Dental Neglect

Neglect is the persistent failure to meet a CYP's basic physical and/or psychological needs, likely to result in the serious impairment of their health or development. It is possible that neglect can be overlooked (or neglected) by professionals because it is less incident focused and there is less shared understanding of what it is and how it should be responded to. Neglect is common and CYP who experience neglect can have short-term and long-term effects. In certain circumstances neglect can also kill children e.g. a young child deprived of food and drink or an older child who is inadequately supervised.

CYP maltreatment is a symptom of disordered parenting. Intervention aims to diagnose and, if possible, cure the disordered parenting and abnormal family dynamics. It is not the intention to take children away from their natural parents unless there is serious risk.

Dental teams should be aware of the general markers of neglect which are summarised in Table 7.2 and based on the needs of CYP.

7.2.1 Dental Neglect

Dental neglect is defined as the persistent failure to meet a CYP's basic oral health needs, likely to result in the serious impairment of their oral or general health or development. The number of carious teeth in itself does not indicate the severity of dental neglect due to the multifactorial aetiology of dental caries, variation in individual susceptibility, inequalities in dental health e.g. regional, social class,

Fig. 7.1 The wellbeing wheel

Table 7.2 General markers of neglect based on the need of the child

The child's needs	Effect of neglect
Nutrition	Failure to thrive /short stature
Warmth, clothing, shelter	Inappropriate clothing; cold injury; sunburn
Hygiene and healthcare	Ingrained dirt (finger nails); head lice; dental caries
Stimulation and education	Developmental delay
Affection	Withdrawn or attention seeking behaviour

inequalities in access to dental treatment and differences in treatment philosophies. However, obvious dental disease (especially that which is obvious to a non-dentally trained person) which has an impact on the CYP is concerning particularly if practical care has been offered, yet the child has not returned for treatment, or the child has an irregular attendance pattern and repeated missed (or rescheduled) appointments. Other concerning features include failure to complete planned treatment (where the child is not brought to all appointments necessary to complete a

treatment plan), the child returning in pain at repeated intervals or the child requiring repeated general anaesthesia for dental extractions.

7.2.2 Long-Term Effects

The long term effects of neglect do vary depending on the individual but there is evidence that adults who were neglected (and/or abused) as children have higher rates of mental illness, alcohol and substance misuse, arrest and suicide attempts as well as liver disease, cancer, diabetes and ischemic heart disease. These chronic debilitating conditions not only have an impact on the individuals affected but also on wider society and health services. If neglect could be identified early, and support mechanisms put in place, it is likely that the long-term financial cost to health services would be reduced.

7.2.3 Interaction with Rest of 'My World'

When considering the impacts of neglect, it is useful to consider the child holistically and identify their needs. This is illustrated in the 'My world' triangle (Fig. 7.2) which is again taken from the Getting It Right For Every Child policy which originated in Scotland. In the illustration neglect impacts not only on 'What I need from people who look after me' but also on 'How I grow and develop'.

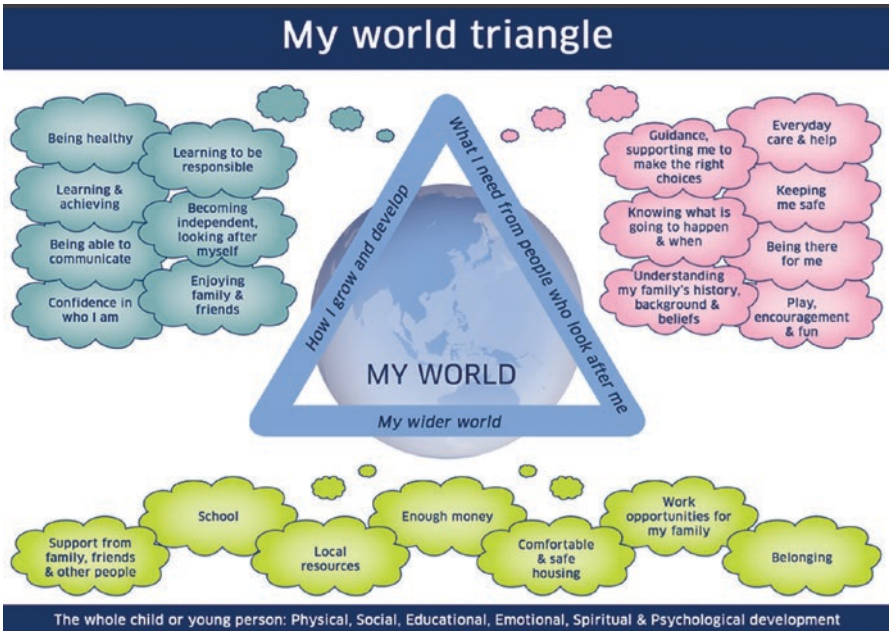

Fig. 7.2 My world triangle

7.3 The Dentists Role in the Management of Dental Neglect

It is important that the dental team recognise dental neglect as part of overall physical neglect.

Studies have concluded that CYP with a welfare concern have a larger proportion of dental caries with much of this caries being untreated. Untreated dental disease can lead to significant pain and sepsis. It has also been shown to contribute to poor overall growth and diminished quality of life.

In most developed countries it may not be unreasonable to expect that families are aware that their children's teeth need to be brushed twice daily with a fluoride containing toothpaste and that sweet foods and beverages should be limited to mealtimes. However, if it cannot be proven that adequate oral care advice has been given to the carer the presence of caries cannot automatically be considered negligent. Once professional advice has been provided and there is failure to obtain appropriate oral care for a CYP (with social support if necessary) this should be considered negligent and should be managed accordingly. It is unacceptable for carers only to seek treatment when their child is in pain and fail to return with the child for follow-up treatment as prescribed by a dentist.

Dental caries is almost always preventable, and this may signify missed potential, it is also entirely treatable once established and failure to access treatment is an act of omission.

When dental neglect is present along with signs of general neglect then a child protection referral should be made as will be discussed later. There may be cases, however, where dental neglect appears to be an isolated issue and there is a lower level of concern for the child's welfare. In cases such as this, a three-stage approach is suggested for dealing with the concerns about dental neglect (Table 7.3):

1. A preventive dental team response.
2. A preventive multi-agency response.
3. Child protection referral.

Table 7.3 Management of dental neglect in three practical stages

The first stage involves:
Raising the dental concerns with parents or carers
Offering support
Setting targets
Keeping records
Monitoring progress
Dental treatment plans need to be realistically achievable (not only the actual treatment planned but also the timescale and when/where appointments will take place and how long they will last) and formulated after discussion with the family
The second stage involves :
Contacting other professionals who you know are involved with the family (e.g. health visitor for pre-school children, school nurse, general medical practitioner or social worker) to see if any of your concerns are shared
The third stage (a child protection referral) would be appropriate at any stage if the situation becomes complex or things and getting worse and there is concern that the child may be suffering significant harm

7.4 Aetiology of Child Physical Abuse

The aetiology of child abuse is complex and multifactorial. Abuse can occur due to a toxic interaction of personality traits (both adult and child), characteristics of the CYP and environmental conditions. There is a wide variation in behavioral characteristics, personality traits and psychiatric symptoms among abusive adults, so no specific parameters exist.

Physical abuse and neglect encompass all social classes. In most cases of maltreatment, the perpetrator is the child's parent/s or another person the CYP knows. It is rarely a stranger. Often the mother of the affected CYP may be divorced or single and may introduce an unrelated cohabitant to the home who becomes the perpetrator. Young parents, parents of low intelligence and parents who were once victims of child abuse themselves may be more likely to be perpetrators of maltreatment. Maltreatment may be as much as 20 times more likely for children of a previous victim. Associations exist to parents with a criminal record or those exhibiting violent personality traits. Certain stress factors for the perpetrating adult may also be relevant; these include alcohol and drug abuse, poverty, unemployment and marital problems. Child factors heightening tension include persistent crying, tantrums and soiling clothes. Mentally or physically impaired children, those who are the result of an unwanted pregnancy or those who fail to attain the expectations of their parents could all be at greater risk of maltreatment.

7.5 Signs of Child Physical Abuse

Physical abuse may involve hitting, shaking, throwing, poisoning, burning, drowning, suffocating or any other means of causing physical harm to a child. This includes methods used by a perpetrator to fabricate or exaggerate illness in a child (previously known as Munchausen Syndrome by proxy).

Physical abuse is an international issue and reported in many countries. Social services in the UK have seen a rapid increase in reporting of suspected child abuse but the expectation is that this may still be widely under reported.

Preschool children are the most vulnerable cohort in this category. Easily harmed, small children lack strength for resistance or retaliation. In the UK 0.1% of preschool children suffer severe physical harm such as brain haemorrhage, bone fractures, internal injuries or mutilation. In the USA, 95% of intracranial injuries in children under 1 year of age are caused by intentional harm. In the USA, reporting on intentional injuries in preschool children presenting to emergency departments has been as much as 10% and 1.3 children per 1000 per year in Denmark. As many as 67 British children may die per year from intentional harm.

7.6 Diagnosis of Child Physical Abuse

The dental team must routinely consider whether a child's injuries have been willfully inflicted. If a dentist suspects there are welfare issues it is their responsibility to share this concern. In the case of physical injury, the most appropriate referral is to a Paediatrician with responsibility for the diagnosis of child maltreatment. Failure to identify and refer the possibility of non-accidental injury can have far-reaching consequences for the child.

Diagnosis of physical abuse is complex and there are no definitive signs to confirm that what a dentist sees on examination is due to CYP maltreatment. Several indicators, however, will raise the dentist's index of suspicion.

1. Failure or delay seeking medical/dental attention for injury.
2. History of how the injury occurred is vague, lacks detail or varies between recounts. May vary between people supposedly witnessing the same event.
3. Account of accident/mechanism of injury not compatible with injury observed.
4. A normal parental reaction would be to focus on the child's injury and what the next steps involve; this may not be the case with abusive or neglectful guardians.
5. Abusive or neglectful guardians may become hostile to the dentist's questions or rebut unmade accusations.
6. The child's appearance, behaviour and interaction with their guardian may seem abnormal. Beyond normal dental anxiety, the child may appear sad, withdrawn or fearful of their guardian.
7. The CYP may say something concerning the injury that is a direct contradiction to the story told by their guardian.

7.7 Types of Orofacial Injuries in Physical Child Abuse

At least 50% of cases diagnosed as child physical abuse have orofacial trauma, which may or may not be associated with injury elsewhere. Soft tissue injuries such as bruises are most common. No single type of injury is an absolute indicator of child maltreatment.

The dental team can clearly see injuries to head, neck and face and are in the unique position of being able to examine inside the mouth. It is important that the dentist enquires about how any injury has occurred and consider the explanation along with any other suspicious indicators.

7.7.1 Bruising, Abrasions and Lacerations

Accidental falls cause bruising and injury to the soft tissues overlying the bony prominences of the forehead, cheekbone and chin. Bruising, because of maltreatment, will

also occur in these areas but may also include the soft areas of the cheek, neck and ears. Bruises on the face may indicate their mechanism of production. Grab marks on the cheeks develop as a thumb mark on one side and multiple finger marks on the other, this is a common injury when a child has been force-fed and may be associated with concurrent lacerations of the palate and floor of mouth caused by a spoon or fork. A slap can cause a linear pattern of bruising across the cheek. The soft tissues of the neck are rarely accidentally damaged, typical abusive marks can be as a result of choking with bare hands or show evidence of cord/rope marks, resuscitation attempts do not leave this pattern of bruising. A torn upper labial frenum may be the result of forceful feeding or may accompany carpet burns to the chin and nose if the child were dragged face down across a floor. A frenal tear is easily missed if the upper lip is not everted.

Clinical Tip

It is worth noting that a frenal tear is possible in a young child learning to walk but should be treated with high suspicion in a baby who is not yet mobile.

Predicting the age of a bruise has proven unreliable. The clinical dating of bruises according to colour is inaccurate. Bruises that appear to be of different ages are, however, suggestive of multiple episodes of injury and along with other indicators may greatly increase suspicions. Bruising of the ear is not commonly the result of an accident and may be indicative of a pinch or pull. A corresponding mark may be evident on the opposite side of the ear with accessory bruising over the mastoid process of the skull. Abnormally shaped bruises and lacerations can sometimes help identify the object that caused them such as a large sovereign ring or fingernail, this is known as tattoo bruising.

7.7.2 Burns

Approximately 10% of physical abuse cases involve burns. Intraoral burns can be the result of force feeding hot or caustic substances. Burns can also be inflicted by holding a hot solid object next to the skin, again the object causing the burn is often depicted in the injury such as a cigarette burn or bar of an electric fire.

7.7.3 Bite-Marks

Human bite-marks are identified by their shape and size and most are significantly distorted. The length of time a bite-mark is visible is dependent on the force used to create it, a mark with no broken skin may only be visible for 24 hours so it may be prudent for a dentist to take or request photographs as soon as a bite is detected. Marks may stay longer where the skin is thin, or it has been broken.

As regards bite-mark identification inter-canine distance can clarify whether the perpetrator is in the primary or permanent dentition, beyond that a suspected perpetrator is needed and identification eased if there are irregularities in their dentition. Salivary DNA analysis is clearly far more accurate than bite-mark recognition but is dependent on obtaining an early sample. In infants, bite-marks have been identified on all parts of the body, in older children they tend to occur more in the areas exposed during defense such as the forearm, clothing dependent this area may be visible to the dentist.

7.7.4 Dental Trauma and Facial Fractures

Injuries related to abuse in both the primary and permanent dentitions occur. These injuries are similar to the type and extent seen accidentally so the index of suspicion rises on the presence of other factors. Facial fractures are uncommon in children due to the more elastic nature of their bones. Fractures do occur during severe physical assault, the most common being a broken nose. Management of trauma to the primary and permanent dentitions are covered in Chaps. 6 and 11 respectively.

7.8 Differential Diagnosis

Dentists should be vigilant and consider the possibility of child maltreatment. It is important, however, to leave the full diagnosis to those with appropriate training. If the suspicions of the dental team have been raised this information must be shared. There are, however, several medical conditions which may emulate some of the possible indicators of child maltreatment. In some cases, impetigo can look like a cigarette burn, some forms of haemangioma or birthmark may look like bruising and conjunctivitis of the eye can look like facial trauma. Children who appear to bruise frequently and easily need to be considered for blood analysis to eliminate conditions such as leukaemia, thrombocytopenia or haemophilia.

7.9 The Dentists Role in Safeguarding

The dental practitioner may be the first professional to suspect CYP maltreatment. The primary aim of all professionals involved is to ensure the safety of the child. The secondary aim is facilitating help and support to ensure the child's future well-being. Liaison and referral between dentists and the other safeguarding agencies vary between regions of the UK but all areas have local guidelines and policies. A small number of studies have investigated dentists' views of their child safeguarding role and of possible barriers to taking action. Some dentists felt reluctant to engage in this role due to a lack of knowledge of the signs of child abuse, protocols around how to report and consequences of passing on their concerns. Much has been done

to improve training and increase the profile of safeguarding since many of these studies were completed but there is still likely to be a level of under-reporting.

A child with a severe injury should be referred immediately to a hospital-based consultant paediatrician. Where suspicions are aroused in other cases, the dentist should speak to the designated person in the local guidelines who will advise on the appropriate course of action.

Dental practitioners should ensure that their clinical records are completed immediately with illustrations of the size, position and type of injuries. Photographic documentation would be beneficial. These records may be referred to in any subsequent case conference or legal proceedings.

The needs of the child are always paramount and legal structures are in place to make sure this is facilitated. Dentists need not concern themselves about the usual laws on confidentiality but should still be careful not to disclose more information than is necessary. It is neither in the interest of the child nor the parents for child abuse to be covered up. Failure to follow up suspicions is a form of professional negligence.

A team approach is necessary with multiple specialties collaborating to confirm the need for safeguarding. Successful safeguarding involves the sharing of all pieces of information between the relative parties to obtain a holistic picture of the child and their environment. Without adequate training, dental staff will not feel empowered to take responsibility for referring a child.

Clinical Tips

Dental practitioners should not feel guilty about referring a child in need, they are not accusing either parent; they are simply asking for help and a second opinion on an important and difficult diagnosis.

Any member of the dental team must feel empowered to recognise the possibility of safeguarding issues, provide any essential emergency dental treatment and inform the appropriate authorities of suspicions.

7.10 Policy and Procedure

It is recommended that every dental practice has a safeguarding policy that states their commitment to, and procedures for, protecting children. A safeguarding policy on its own, however, is not sufficient. Dental practices also need to ensure that they listen to CYPs, can provide information for CYPs and families that will support them (e.g. local services for advice/ services/ activities and where to go in times of crisis), that they provide a safe child friendly environment, that they have other relevant policies and procedures in place and that the whole team takes part in appropriate safeguarding training. It may also be useful to appoint a staff member (who does not have to be a dentist) to lead on safeguarding.

The United Kingdom's four nations all have their own child protection systems and laws to protect children. Although they are slightly different, they are all based on the same principles.

7.10.1 When You Have Concerns About a CYP

If you have any concerns about a CYP's welfare it is important to take a good history including any explanations for delays in seeking treatment and whether the history given changes over time or does not adequately explain the presenting complaint. Remember to talk to the child as well as their accompanying parent or carer and record the child's own words. Following this a detailed, well recorded clinical examination is necessary.

You can then discuss your concerns with an experienced colleague (Table 7.4).

This initial discussion may result in you no longer having any safeguarding concerns which may mean that although no further child protection action is needed there are still other actions required (e.g. necessary dental treatment, referral to local support services). On the other hand, after this initial discussion you may still have concerns, or indeed have had your concerns validated or reinforced, and this will necessitate a child protection referral. If this is the case, make every effort to talk to the CYP and their family about why you are concerned and why the referral is necessary. There may be some situations when this is not appropriate or possible such as where discussing your concerns may put the CYP or others in danger or adversely affect a police investigation or alternatively where, despite your best efforts, you cannot get in contact with a family to inform them. If a CYP is in immediate danger call 999 or if you think a crime has been committed but there is no immediate danger call the Police on 101. Otherwise follow your local child protection referral guidelines. These may vary slightly depending on which local authority/ local council area you work in but in general the referral will be to the social services/ children's social care team (England & Wales), social work department (Scotland) or Health and Social Care Trust (HSCT) Gateway Services team (Northern Ireland) in the area in which the CYP lives.

Table 7.4 Who to go to for help if you have concerns about a CYP

Who to go to for help?
Experienced colleague
Named Safeguarding Nurse
Child Protection Adviser
Named Doctor for Safeguarding
Social work / social services (e.g. Social care direct)
Children's Services Department (e.g. First Contact)
NSPCC Helpline 0808 800 5000
Local Safeguarding Children Board (LSCB) or Area Child Protection Committee (ACPC) procedures/ website

7.10.2 Skills Needed in Making the Decision to Refer

Many members of the dental team find making the decision to refer challenging even after informal discussions with more experienced colleagues. Mostly the challenge for dental team members is that there remains an element of fear involved in making this decision, whether that be fear of getting things wrong or fear of consequences. There are skills which the dental team members can develop that may help overcome such fear. This includes skills such as observation, recording, information sharing, breaking bad news and dealing with difficult people.

7.10.3 How Do I Make a Child Protection Referral?

In most cases the referral will be to the child's local social services/ social work department/ HSCT Gateway Services team. This will be by telephone initially. During the telephone call take a note of the name of the person you are speaking to, their job title and contact details. This referral should usually be followed up in writing within 48 h. In many areas the written follow-up will be on a proforma. This is sometimes called a 'Notification of Concern Form'.

7.10.3.1 What Happens After You Refer?

In general after you refer child protection professionals may take immediate action to secure the safety of the child, provide support, help or advice to the family, provide a service such as childcare to the family, conduct criminal proceedings or record the concern but take no further action at this time. The action taken can vary slightly depending where you are based (Table 7.5).

In general after referral if a CYP is in immediate danger then a 'Child Protection order', 'Exclusion order' or 'Child assessment order' may be issued or the CYP may be removed from their parents/ carers by police or on the authority of a Justice of the Peace, depending on which part of the country they are reside.

Otherwise the usual course of action is investigation, initial assessment and discussion. This is when the relevant authorities and services begin to decide if a CYP is at risk of significant harm. If following this it is decided that no further child protection action is required the family may get additional support (England/ Wales/ Northern Ireland/ Scotland all similar) or a 'Joint Investigation' may be started (Scotland only). Other possible outcomes are noted in the table below and are specific to the devolved nation of the UK.

Table 7.5 List of possible outcomes following a child protection referral

Outcome	Devolved Nation/s applicable
Designate as child in need	England / Wales/ Northern Ireland
Section 47 assessment	England / Wales
Strategy discussion	England
Core assessment	Wales
Pathway assessment	Northern Ireland
Only limited intervention needed	Northern Ireland

7.11 Case Scenarios

The next part of this chapter consists of case scenarios for your consideration. A description is given along with aspects to consider and key learning points.

7.11.1 Results of an Unmet Treatment Need

You are working at the emergency dental service and a 3.5-year-old child is brought in to see you. He has rampant caries with pus draining from both lower second primary molars. He is distressed but looks a bit limp as he clings to his mother. Mum tells you he has had nothing at all to eat or drink for 3 days. The child looks obviously dehydrated. You take his temperature which is 39 °C in his right ear and he feels hot and dry to touch. Mum says he is not registered with a dentist, but when you check your electronic records you realise he attended a community dentist 6 months ago who referred the child for extraction of 14 teeth, the family failed the appointment for general anaesthetic (GA) and did not respond to subsequent follow-up. The family have not been in contact with dental services since the GA referral appointment.

7.11.1.1 Learning Points

In this case your immediate priority is for the medical stabilisation of the child, they are clearly pyrexic, dehydrated and at risk of sepsis. They require urgent admission to hospital for intravenous fluids, antibiotics, antipyrexics and management of the nidus of infection which in this case will involve the extraction of teeth under GA.

A good dental history is essential and where possible you should use whatever possible means you have at your disposal to check that the information you have received from a parent in this type of situation is true.

Once a dental need has been identified, discussed with a parent or care giver, and plans put in place for treatment it is negligent of a parent or care giver not to follow through with the care plan.

After stabilisation of the child you will want to ask the parent why they did not disclose this dental history and why they did not bring their child back for treatment. Make it transparently clear to the parent that, for whatever the reason, this is a case of neglect and you are duty bound to share this information with social services. Make future arrangements for regular dental review and enhanced prevention.

7.11.2 Family with Well Looked After Baby

You are examining a family of three siblings aged 8 years old, 6 years old and 6 months old. The older siblings have previously been registered with another dentist in your practice. This is the first dental visit for the 6 month old. The children have had a social worker appointed to them because of concerns about their care, you obtain the social worker's contact details.

Both older siblings have obvious ingrained dirt on their school uniforms, their skin and hair is visibly dirty, and they smell bad. They both have poor oral hygiene and active dental caries. The 6 month old has clean freshly laundered clothes, their hair and skin appear clean and they have two lower incisors present and good oral hygiene. You raise your concerns about the oral health of the children with their father who blames the children saying, 'They never brush their teeth when I tell them to'. You make their father aware of the children's dental needs and the family elects to return for treatment. When you talk to the children's previous dentist they confirm that the older children were always compliant but they failed to complete treatment and were irregular attenders. A few weeks later the older siblings are not brought to their agreed treatment appointments.

7.11.2.1 Learning Points

- Extra oral appearance is important.
- Children need assistance with toothbrushing until at least 7 years of age.
- Sometimes not all children in a family are abused/ neglected.
- Irregular attendance and failure to complete treatment are alerting features.
- Dentists hold key information which may not be known to other healthcare professionals.
- Information sharing is essential.

7.11.2.2 Outcome

Children's social worker contacted regarding further failure to attend dental appointments. Social services working with family on several issues as well as facilitating attendance of the children at healthcare appointments.

7.11.3 Teenager (Expose and Bond)

A 13-year-old patient registers as a new patient at your practice and attends with a social worker. The child has already been placed on the Child Protection Register due to chronic neglect but has come to see you because of dental concerns. When you examine her, you note that she is missing a central incisor and the space has closed. You note a gold chain hanging through the attached gingivae. The patient tells you she had some dental treatment completed a few years ago under general anaesthetic. Otherwise the patient is well and healthy looking. You are concerned and refer the patient to your local specialist in paediatric dentistry as well as raising concerns about the child's welfare with their social worker.

7.11.3.1 Background/Results of Investigation

This child had missed a lot of health appointments, including dental appointments. When social services investigated after the new dentist raised concerns, they found the child had 84% school attendance, was proving a caring role for younger siblings and there had been many calls to Police from neighbours. When the home was visited the conditions were described as having 'very poor cleanliness'. The family

were already known to social services because of bereavement issues, but it was thought they were coping.

After investigation it was found that the child had undergone significant dental treatment including exposure and bonding of gold chain to an unerupted tooth. She had then not been brought to multiple orthodontic appointments. A standard letter had been sent to the family and the original referring dentist stating no further hospital appointments would be made. The new dentist was also able to tell social services that a younger sibling had missed a GA appointment for exodontia.

7.11.3.2 Learning Points

- Missed dental appointments is one concern of many but the main concern in this case.
- It was not until the child had been seen by a new dentist that concerns were appropriately raised with social services.
- Input from health services including dental teams is essential in assessment of a child's circumstances.
- Social history is important, as is rigorous follow-up.
- Dentists may hold information regarding family situations that are not apparent on dental hospital visits.

7.11.3.3 Outcome

Child and siblings accommodated with foster family.

Close contact with social worker to ensure attendance at health appointments, especially for dental care.

7.11.4 Hidden Trauma

A family attends your practice for a check-up, mother with a 7-year-old son and 22-month-old daughter. On charting for the 22-month-old girl you note that LRA and LRB are missing. You discuss this with the mother who informs you that they fell out. On questioning further you learn that the mother's partner lives with the family, he had been babysitting one night and when he went in to check on the little girl before he went to bed at midnight he found the two teeth lying in her cot with blood on her pillow, she was asleep.

This scenario would clearly cause you some concern and although her medical history is clear you would be concerned about underlying medical conditions which can cause premature tooth loss as well as the possibility of unexplained trauma.

In this case the dentist made an urgent referral to a Consultant in Paediatric Dentistry under the assumption that perhaps the child had an underlying medical condition. In the meanwhile the family were actually referred to the police as a member of the public was uncomfortable after witnessing an incident in a supermarket. The male adult was seen to physically chastise the 7-year-old boy in a rough and unacceptable manner, he was also using inappropriate language. The member of the public was able to follow the family around the supermarket until the police

arrived. When the police arrived one of the things they noted was that the little girl was wearing a woollen hat in a warm environment, when they asked for the hat to be removed they were able to see multiple areas of bruising on her head. Following investigation the children were removed to live with their grandmother whilst awaiting court proceedings.

7.11.4.1 Learning Points

Perpetrators of physical abuse are often unrelated people who have been brought into a family and in this case the child was physically assaulted by the mother's partner.

It is important to check for other injuries on exposed areas of the body.

Marks and symptoms of what can appear as trauma may be the result of a medical condition and this should always be considered. Always refer when unsure or where things just don't add up!

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