Safeguarding Children & Vulnerable Adults Policy

We are committed to safeguarding children and vulnerable adults and to protecting them from harm. Our dental team accepts and recognises our responsibilities to develop awareness of the issues which may cause harm to children and vulnerable adults.

The Child Protection and Adult Safeguarding Lead at our practice is Anastasija Petkevica. Their deputy is Emilia Kalantari-Saghafi.

They are the relevant points of contact for raising concerns. They also have responsibility for ensuring that our policies and procedures for safeguarding children and vulnerable adults are kept up-to-date and operated correctly.

We will endeavour to safeguard children and vulnerable adults by:

- developing an awareness of safeguarding issues;
- promoting good safeguarding practice through all our practice policies and procedures;
- following the guidelines set out below;
- making team members and patients aware that we take child and vulnerable adult protection seriously and respond to concerns about the welfare of children and vulnerable adults;
- sharing information about concerns with agencies who need to know and involving parents and children appropriately;
- following carefully the procedures for staff recruitment and selection (including referencing and DBS disclosure); and
- providing effective management for staff by ensuring access to supervision, support and training.

This policy is underpinned by the following principles:

- patients have access to information and knowledge to ensure that they can make an informed choice
- patients are given the opportunity to consider the various treatment options available to them and are encouraged to fully participate in their care at the practice
- patients are supported to make their own decisions and to give or withhold consent to treatment - unless provided for otherwise by law, no-one can give or withhold consent on behalf of another adult
- information about patients held by the practice is managed appropriately and all members of the team understand the need for confidentiality
- the individual needs of the patient are respected
- the background and culture of all patients is respected
- practice procedures ensure the safety of patients at all times
- recruitment and selection procedures at the practice are followed routinely and ensure that all required checks are carried out.
- We will review this policy and guidance annually.

Safeguarding guidance

Definitions

- **CHILD** - A child is anyone who has not yet reached their 18th Birthday
- **VULNERABLE ADULT** - A vulnerable adult is a person aged 18 or over who is, or may be, in need of community care services or is resident in a continuing care facility by reason of mental or other disability, age or illness or who is, or may be, unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation.

Introduction

Members of the dental team are in a position where they may observe the signs of abuse or neglect or hear something that causes them concern about a child or vulnerable adult. The dental team has an ethical responsibility to follow the procedures for safeguarding set out in this guidance wherever a child or vulnerable adult is or might be at risk of abuse or neglect: this includes a responsibility to ensure that children and vulnerable adults are not at risk from members of the profession itself.

If a team member becomes aware of anything that makes them suspect a child or vulnerable adult is being abused, they must **immediately** refer the matter to the Child Protection and Adult Safeguarding Lead. If it is not possible to refer the matter to them, the team member must refer the matter to the Deputy Lead. They will decide the most appropriate manner in which to deal with the situation. If there is any doubt about how a matter should be handled, they can obtain additional information from the Child Protection and the Dental Team website or the local Safeguarding team.

Any allegations made against or suspicions about a team member must be reported to the Child Protection and Adult Safeguarding Lead in the same way as if they had involved a child's parent, a vulnerable adult's carer or another person. If an allegation is made against or you have suspicions about the Child Protection and Adult Safeguarding Lead, this should be reported to her Deputy. If an allegation is made against or you have suspicions about the Deputy Lead, this should be reported to the Child Protection and Adult Safeguarding Lead in the usual way. Where allegations involve any team member, the Child Protection and Adult Safeguarding Lead or her Deputy (as appropriate) will make decisions about the need for referral in the same manner as in any other case but may also invoke disciplinary procedures.

If neither the Child Protection and Safeguarding Lead nor her Deputy are available to consult, you may have to make a referral yourself.

Forms of abuse & Signs of abuse

The dental team is not responsible for making a diagnosis of abuse or neglect, just for sharing concerns appropriately, but here are some examples of what might amount to abuse, so that you have some idea of what to look for:

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm. It may also be caused by a parent or carer fabricating the symptoms of, or deliberately causing, illness.

Fabricated or Induced illness is where someone, often a parent or carer, exaggerate or deliberately cause symptoms of illness in a child or an adult at risk.

Emotional abuse is persistent emotional maltreatment causing severe and persistent adverse effects on emotional development. It may involve conveying to children or vulnerable adults that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of the other person. It may feature:

- age or developmentally inappropriate expectations;
- interactions that are beyond the child's or vulnerable adult's developmental capability;
- over protection and limitation of exploration and learning;
- preventing participation in normal social interaction;
- allowing a child or vulnerable adult to see or hear the ill-treatment of another;
- causing a child or vulnerable adult frequently to feel frightened or in danger; and
- exploitation or corruption.

Sexual abuse involves forcing or enticing a child or vulnerable adult to take part in sexual activities, whether or not they are aware of what is happening. The activities may involve physical contact, including penetrative (for example rape, buggery) or non-penetrative acts. They may include non-contact activities, such as involving children or vulnerable adults in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging them to behave in sexually inappropriate ways.

Neglect is the persistent failure to meet basic physical and/or psychological needs, likely to result in the serious impairment of health or development. It may occur in pregnancy as a result of maternal substance abuse. Neglect may also involve a parent or carer:

- failing to provide adequate food, clothing and shelter;
- failing to protect a child or vulnerable adult from physical and emotional harm or danger;
- failure to ensure adequate supervision;
- failure to ensure access to appropriate medical care or treatment; and
- neglect of, or unresponsiveness to, basic emotional needs.

Financial abuse involves stealing from a vulnerable adult by, for example, a carer using benefit money to buy things for themselves.

You may become aware of potential abuse in a number of different ways:

- through a direct allegation (often referred to as a "disclosure") made by a child, vulnerable adult, parent, carer or some other person
- through signs and symptoms which suggest physical abuse or neglect (see above)
- through observations of child behaviour or parent-child interaction
- through observation of a vulnerable adult and the relationship they have with their carer.

If you are worried about a child or vulnerable adult – practical steps

It is uncommon for dentists to see patients with signs of abuse but where you have concerns about a patient who may have been abused and there is no satisfactory explanation, prompt action is important: **immediately** discuss your concerns with the Child Protection and Adult Safeguarding Lead, or their Deputy. They will decide whether a formal referral is required.

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

- a direct allegation (sometimes termed a 'disclosure') made by the child, a parent or some other person
- signs and symptoms which are suggestive of physical abuse or neglect
- or through observations of child behaviour or parent-child interaction
- signs of domestic abuse of a parent, such as bruises or an injury, or the parent (female or male) may disclose domestic abuse to you
- concerns about the mental or general health (alcohol, substance misuse or deteriorating health condition) of the parent.

Because of the frequency of injuries to areas routinely examined during a dental check-up, the dentist has an important role in intervening on behalf of an abused child. It is assumed that the dentist will be examining a child who is fully dressed.

In some instances, the diagnosis of child abuse is clear. However, there are occasions when evidence is inconclusive and the diagnosis merely suspected. Members of the dental team are not responsible for making a diagnosis of child abuse or neglect, just for sharing concerns appropriately.

Extremism is vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty & mutual respect 7 tolerance of different faiths & beliefs.

Discriminatory abuse is harassment, deliberate exclusion or unequal treatment on the grounds of a protected characteristic.

Institutional abuse is the use of systems & routines which neglect a person receiving care. It does not have to be intentional.

Domestic violence & abuse is any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. It includes Honour Based Violence (HBV), an unwritten code of conduct that involves domination, aggression and control by 1 or several members of an individual's extended family or community and may be physical, emotional, sexual or financial. The use of the term 'Honour' or 'Izzat' describes the concept of protecting the prestige and reputation of a family or community. The term embraces a variety of crimes of violence which are mainly, but not exclusively, against women. These include assault, imprisonment and murder, where the person is being punished by their family or community.

FGM (Female Genital Mutilation) Constitutes all procedures which involve partial or total removal of the external female genitalia, or injury to the female genital organs for cultural or non-therapeutic reasons. FGM is illegal in the UK under the Female Genital Mutilation Act (2003) and the Children Act. **PLEASE SEE MORE INFORMATION ABOUT FGM AT THE END OF THIS POLICY**

Forced marriage describes a relationship in which 1 or more of the parties are married without consent or against their will which violates the principle of the freedom and the autonomy of individuals. FM differs from an arranged marriage in which both parties consent to someone helping them to find a partner. FM is illegal under the Forced Marriage Act (2007) which enables victims of forced marriage to apply for court orders for their protection or marriage termination.

Modern slavery Includes holding a person in a position of slavery, servitude, or forced or compulsory labour. It is illegal under the Modern Slavery Act (2015) which includes human trafficking (the arrangement or facilitation of travel with a view to exploitation). Although human trafficking often involves a cross-border element, it is possible for someone to be a victim within their own country or even where consent has been given to be moved. The Modern

Slavery Helpline on 08000 121 700 can be contacted for any information that could lead to the identification, discovery and recovery of victims in the UK. **PLEASE SEE MORE INFORMATION ABOUT MODERN SLAVERY AT THE END OF THIS POLICY.**

RAISE CONCERNS IF PATIENTS ARE AT RISK

- Always put patients' safety first
- Act promptly if patients or colleagues are at risk 7 take measures to protect them
- Make sure if you employ, manage or lead a team that you encourage and support a culture where staff can raise concerns openly & without fear of reprisal.
- Make sure if you employ manage or lead a team that there is an effective procedure in place for raising concerns, that the procedure is readily available to all staff and that it is followed at all times.
- Take appropriate action if you have concerns about possible abuse of children or vulnerable adults (adults at risk).

Concerns related to a parent/carer

Concerns about the mental or general health (alcohol, substance misuse or deteriorating health condition) of the 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.

In respect of domestic abuse, if a parent makes a disclosure to you or a member of your staff, and requests help, contact your local children's services office. If you suspect domestic abuse, enquire about this with the parent and inform them of your concern for their own and their child's welfare. You are obliged to make a referral to the local children's services office if you have concerns about domestic abuse and to inform the parent you are doing so. This is a very sensitive area and must be dealt with carefully so as not to increase any risks for the parent and child. Take advice from your named nurse or doctor for child protection, your local children's services office or the local police domestic abuse unit.

Permission to refer:

The Child Protection and Adult Safeguarding Lead or their Deputy will consider whether to seek permission to refer. It is good practice to explain concerns to the child or vulnerable adult and their parents or carers, informing them of the intention to refer and seeking their consent – being open and honest from the start results in better outcomes. Wherever possible, patients should be separated from the alleged abuser before such conversations take place.

We will not, however, discuss concerns with the parents or carers where:

- the discussion might put the child or vulnerable adult at greater risk;
- the discussion may impede a police investigation or social work enquiry;
- sexual abuse by a family member/carer, or organised or multiple abuse is suspected;
- fabricated or induced illness is suspected;
- parents or carers are being violent or abusive and discussion would place you or others at risk; and
- it is not possible to contact parents or carers without causing undue delay in making the referral.

Where there is serious physical injury arising from suspected abuse:

- we will refer the individual to the nearest hospital Emergency Department (in the case of a child, with the consent of the person having parental responsibility or care);
- advise the Emergency Department in advance (by telephone) that the patient is coming;
- if consent is not obtained, the Duty Social Worker at the local Social Services Department or the police should be told of the suspected abuse by telephone so that the necessary action can be taken to safeguard the welfare of the individual; and
- a telephone referral to Social Services must be confirmed in writing within 48 hours, repeating all relevant facts of the case and an explicit statement of why there are concerns. The telephone discussion should be clearly documented – who said what, what decisions were made and the agreed unambiguous action plan.

Where less serious injury is recorded or there is concern for the physical or emotional well-being of the individual, the Child Protection and Adult Safeguarding Lead (or her Deputy) will discuss the appropriate reporting procedures and our concerns with local Social Services (contact details below).

Recording and reporting

We will not attempt to investigate any allegations or suspicions ourselves but will instead refer matters to the appropriate authorities. It is important NOT to ask a child or vulnerable adult leading questions but to simply record what they say and what has happened. Asking leading questions may jeopardise any future criminal proceedings arising out of the allegation of abuse.

Where an injury is involved, reports will be restricted to:

- the nature of any injury;
- facts to support the possibility that the injuries are suspicious.

Attendance of the referring dentist may be required by the Social Services Department at a case conference or if there is a court hearing, so comprehensive written records of the injuries and its history (as reported) must be kept together with clinical photographs, where available.

Record keeping

Recording physical signs

Dental professionals are likely to observe and identify injuries to the head, eyes, ears, neck, face, mouth and teeth as well as other welfare concerns. Bruising, burns, bite marks and eye injuries are the types of injury that suggest a concern should be raised. Dental professionals are also well placed to identify the risks to oral and general health associated with poor oral hygiene and dental neglect. A patient may also disclose abuse or other indicators of it; such safeguarding concerns should always be recorded.

Accurate record keeping is an essential part of the accountability for safeguarding. Documentation within dental practices should accurately reflect not only the care provided but also any concerns in respect of a child, young person or adult at risk. It may feature information on anyone attending with the patient, any injury observed using diagrams where appropriate and a record of discussions concerning the patient. In cases of abuse records should include:

• description and location of injury

• nature of injury, such as bruise or laceration

• size and shape of injury

• comments and observations made by the patient, parent or carer

• the behaviour or presentation of, or comments concerning, the accompanying parent or carer

Concerns may also be raised in respect of how a parent or carer has related to, or behaves towards, a child or adult at risk. These should be recorded along with any actions taken including seeking advice and noting the advice given. If a decision is taken not to share safeguarding concerns, it is best to discuss this with a defence organisation or professional association.

Recording missed appointments

When a child or adult at risk misses an appointment, it should be recorded as “Was Not Brought” rather than “Did Not Attend”.

The purpose of the appointment and the consequences to the patient of it being missed are important considerations. Where there is a history of “Was Not Brought” for a particular patient it may indicate that action is needed to protect them, to ensure they get the treatment they require. This could involve talking to safeguarding services where there is a risk of neglect.

Recording non-compliance

‘Disguised compliance’ involves a parent or carer giving the appearance of cooperating with a patient’s dental treatment to avoid raising suspicions of unsafe parenting or caring. The aim is to avoid social care interventions by allaying professional concerns. Disguised compliance can make it very difficult for dental teams to maintain an

objective view of the welfare of the patient by preventing an understanding of the severity of harm being experienced by the patient from being gained. Examples of behaviours which indicate disguised compliance include:

- repeated cancelling or rescheduling of appointments
- Sporadic compliance such as attending appointments or engaging with dental professionals for a limited period of time
- Patients or carers agreeing to make the changes needed to improve the patients oral health but then making little or no effort with this

Listening to children and vulnerable adults

We aim to create an environment in which children and vulnerable adults know their concerns will be listened to and taken seriously. We communicate this by:

- asking children for their views when discussing dental treatment options and seeking their consent to dental treatment in addition to parental consent;
- involving children and vulnerable adults when we ask patients for feedback about our practice; and
- listening carefully and taking them seriously if they make a disclosure of abuse.

Providing a safe and friendly environment for children and vulnerable adults

We will provide a safe and friendly environment by:

- taking steps to ensure that areas where patients are seen are welcoming and secure (with facilities for children to play where appropriate);
- considering whether young people or vulnerable adults would wish to be seen alone or accompanied by their parents or carers;
- ensuring that staff never put themselves in vulnerable situations by seeing young people or vulnerable adults without a chaperone; and
- operating safe recruitment procedures (refer to recruitment policy).

Use of interpreters and translators

Where a practitioner does not speak the same language as a patient, a patient has limited proficiency in English or requires British Sign Language, the services of an interpreter, either in person or through a telephone-based service (if appropriate), should be engaged. If an interpreter is not used, the reasons for this should be clearly recorded.

In some cases, patients may request that family members, friends or untrained members of their community interpret for them. However, the risk of relying on someone close to the patient, in what may be a highly personal and confidential situation, is that they may not be able to interpret accurately and may allow their own views of the situation to colour their translation. It may also be difficult, or even impossible, for the patient to disclose issues such as abuse in their presence. Therefore, it is not considered good practice to use family members, friends or untrained members of the community as interpreters as there can be no assurance of exactly what is being said and translated, especially where abuse has occurred.

Not providing an interpreter can affect patient experience and health outcomes, increase missed appointments and make consultations less effective. Under the Equality Act 2010 it can also be considered indirect discrimination. Where a dental practice refuses to provide an interpreter for NHS care, they must have considered their interpreting provision and conclude that fulfils a test of ‘due regard’ under the public-sector equality duty.

Other relevant policies and procedures

Clinical governance policies that we already have in place contribute to the practice being effective in safeguarding children and vulnerable adults. Relevant policies and procedures include:

- safe staff recruitment procedures: carrying out checks with the DBS, making job applicants aware of our policy on child protection and safeguarding vulnerable adults, checking gaps in employment history, requesting proof of identity, taking up references;
- our complaints procedure: so that children or parents attending our practice can raise any concerns about the actions of team members that may put children at risk of harm;

- whistleblowing policy (underperformance policy): so that team members can raise concerns if practice procedures or the action of colleagues put patients at risk of harm.
- confidentiality policy, consent policy, equal opportunities policy, equality and diversity policy, patient safety policy, etc.

More information re: FGM (Female Genital Mutilation)

On the 31st October 2015, a new mandatory duty to report FGM cases to the police came into force.

Who does it apply to?

- All registered healthcare professionals and social workers in England, and Wales, including all dental professionals registered with the GDC who practice in England & Wales
- This is a personal duty: the health professional who first identifies FGM or is told by a girl under 18 years of age, that she has been subject to FGM, must report it to the police.

What does it involve?

The new duty applies where a dental professional, in the course of their work, either:

- Is informed directly by a girl under the age of 18 that an act of FGM has been carried out on her, or
- Observes physical signs which appear to show FGM – due to the nature of their work this aspect of the duty will apply principally to doctors, nurses and midwives.

There are 4 main types of FGM

- Type 1 – CLITORIDECTOMY – removing part or all of the clitoris
- Type 2 – EXCISION – removing part or all of the clitoris and the inner labia, with or without removal of the labia majora.
- Type 3 – INFIBULATION – narrowing of the vaginal opening by creating a seal, formed by cutting & repositioning the labia.
- OTHER HARMFUL PROCEDURES – to the female genitals, which include pricking, piercing, cutting, scraping and burning the area.

Effects of FGM

There are no health benefits to FGM. Removing and damaging healthy and normal female genital tissue interferes with the natural functions of girls' and women's bodies.

Immediate effects

- severe pain
- shock
- bleeding
- wound infections, including tetanus and gangrene, as well as blood-borne viruses such as HIV, hepatitis B and hepatitis C
- inability to urinate
- injury to vulval tissues surrounding the entrance to the vagina
- damage to other organs nearby, such as the urethra (where urine passes) and the bowel FGM can sometimes cause death.
- Long-term consequences
- chronic vaginal and pelvic infections
- abnormal periods
- difficulty passing urine, and persistent urine infections
- kidney impairment and possible kidney failure
- damage to the reproductive system, including infertility
- cysts and the formation of scar tissue
- complications in pregnancy and newborn deaths
- pain during sex and lack of pleasurable sensation
- psychological damage, including low libido, depression and anxiety (see below)
- flashbacks during pregnancy and childbirth
- the need for later surgery to open the lower vagina for sexual intercourse and childbirth

- Psychological and mental health problems

Case histories and personal accounts taken from women indicate that FGM is an extremely traumatic experience for girls and women, which stays with them for the rest of their lives. Young women receiving psychological counselling in the UK report feelings of betrayal by parents, as well as regret and anger.

More information re: Modern slavery

Modern slavery – Including; slavery, human trafficking, forced labour & domestic servitude, Traffickers & slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude & inhumane treatment

- **PHYSICAL APPEARANCE**: victims may show signs of physical or psychological abuse, look malnourished or unkempt, appear withdrawn
- **ISOLATION:** Victims will rarely be allowed to travel on their own, may seem under the control of others, rarely interact, may seem unfamiliar with their neighbourhood
- **POOR LIVING:** May be living in dirty, cramped, overcrowded accommodation. May be living and working at the same address.
- **FEW OR NO PERSONAL EFFECTS:** They may have no identification or documents, few personal possessions, wear same clothes day in & day out.
- **RESTRICTED FREESOM OF MOVEMENT:** Victims may have little opportunity to move freely, may have had passports taken away.
- **UNUSUAL TRAVEL TIMES:** May require strange/unusual appointment times
- **RELUCTANT TO SEEK HELP:** May avoid eye contact, appear frightened or hesitant to talk.