NEW ZEALAND
DENTAL ASSOCIATION

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Code of Practice

Child protection

16 April 2016

The New Zealand Dental Association Code of Practice – Child protection is a practical resource for members of the New Zealand Dental Association that outlines the responsibilities of dental practitioners with regard to child protection and provides guidance on how these responsibilities can be met. This Code of Practice should be regarded as a 'reference point' for members and does not constitute legal advice.

This Code of Practice supersedes the NZDA Practice Guideline – Child protection 2006

Contents

Introduction

Maltreatment of children (abuse and neglect) occurs in all socioeconomic levels, across all ethnic and cultural lines, within all religions and at all educational levels in New Zealand society. The maltreatment of a child can have long-term adverse physical, psychological and behavioural consequences for that child. Child maltreatment is a cyclic problem with abused children often becoming abusive parents. Children and young people have the right to be protected from all forms of abuse and neglect.[1]

Child protection means protecting a child from maltreatment. Child protection requires the interaction of services (including dental practitioners), children and families. For child protection to work effectively it is essential that everyone understands and fulfils their ethical, legal and social responsibilities. Dental practitioners and the dental team have a duty of care to consider the wellbeing of their patients, and as part of this, a responsibility in identifying and reporting concerns regarding the wellbeing of children and young people.

Dental practitioners should have the knowledge and skills to identify signs and symptoms that may indicate maltreatment and must know how, and to whom, to share this information. Where a practitioner has reasonable cause to suspect or believe that a child is at risk of significant harm the practitioner has a responsibility to share these concerns with the appropriate authority. The overriding principle is that the child's welfare is paramount.

This Code of Practice outlines the responsibilities of dental practitioners with regard to child protection and provides guidance on how these responsibilities can be met. This Code of Practice does not constitute legal advice.

Definitions

Child and young person

A child is a boy or girl under the age of 14 years. A young person is a person under the age of 18 years who is not married or in a civil union.[a]

Child abuse

Child Abuse is a deliberate act of harming (whether physically, emotionally or sexually), ill-treatment, neglect or deprivation of any child or young person. Child abuse can be categorised as; physical abuse, emotional abuse, sexual abuse, and neglect.

Child neglect

Any serious act or omission or commission that, within the bounds of cultural tradition, constitutes a (*persistent*) failure to provide conditions that are essential for the healthy physical and emotional development of a child.[4] A failure to act.

Dental neglect

Dental neglect is the persistent failure to meet a child's basic oral health needs which is likely to result in the serious impairment of a child's oral or general health or development.[5]

Child Maltreatment

Child abuse and neglect are forms of maltreatment of a child. Child maltreatment can take many forms and can harm a child suddenly or over a period of time. Abusers can be members of the family (parents, siblings), people known to the child (including other children) or more rarely strangers. In New Zealand most perpetrators are parents.[6] The overriding characteristic of abusers is their apparent normality. Risk factors for child maltreatment include, domestic violence, unstable parental relationships, parental misuse of drugs or alcohol or mental illness of a parent.[7] The vulnerability of children to maltreatment is amplified when a child has an increased dependence on a parent/guardian/caregiver and when that child lacks the ability to communicate a need for help (e.g. preschool and disabled children).[5,8]

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[a] The Children, Young Persons and Their Families Act 1989[2] section 2(1) defines a young person as a boy or girl aged 14 years and over, but under 17 years and who is not nor has been married or in a civil union. The Vulnerable Children Act 2014[3] defines a child as a person under the age of 18 years who is not married or in a civil union.

Responsibilities

Dental practitioners and their staff have a responsibility to be mindful of, and vigilant for, signs that a child may be being maltreated. They must be familiar with the perioral signs of child abuse and neglect. If a practitioner has concerns about the welfare of a child they must act (see 'Responding to concerns', page 5).

Dental practitioners have an obligation to ensure that children and young people are not at risk from practice staff members. Safety checking of staff working with children is an important element of this. Concerns and/or allegations about staff members employed in the practice are to be taken seriously. The decision to follow-up an allegation of child maltreatment by a staff member should be made in consultation with Child Youth and Family (CYF) and/or the Police.[9]

Practitioners should note that the statutory responsibility for investigation of allegations of child abuse lies with CYF and the Police and not with them. Practitioner responsibilities are principally recognition and responding appropriately to concerns they may have.

Dental practitioners and their staff are encouraged to seek educational opportunities to improve their knowledge in issues of child protection.

Child protection - Assessment

Concerns about a child or young person may arise over a period of time or in response to a particular incident. Concerns may arise from observations made by dental staff, reports from the child/young person or from a third party. Practitioners should listen, observe and must exercise sound professional judgement in identifying concerns that require child protection actions. The signs of maltreatment can be physical and/or behavioural and are wide and varied in presentation.

Indicators of child abuse

Disclosure If a child discloses an incident or incidents which may constitute abuse the practitioner's role is not to conduct an investigation to confirm whether or not abuse has occurred, but to observe, document and as necessary refer. The practitioner should take the claim seriously, listen carefully and sympathetically avoiding expressing a 'view' on the matter. Questions should be limited to only those that are needed to clarify the information being provided, and care must be taken to ensure questions are open ended. No in-depth interview of the child should be attempted which is more properly the domain of CYF or the Police. Any disclosure should be carefully recorded at the time.

If a practitioner has concerns about the welfare of a child, based on information given by that child, the practitioner should explain to the child, assuming the child is able to understand, (i.e. is 'competent') that the practitioner may need to share the information. If this is the case the child should be told to whom and when the information will be shared.

Orofacial injuries Children commonly suffer injuries to the mouth and face and these injuries need to be distinguished from those potentially arising from abuse. Suspicious injuries to the head, face, mouth or neck of a child may include; contusions, ecchymosis and bruising, lacerations, fractures, burns, bites and dental trauma. When attempting to distinguish accidental injuries from injuries arising from abuse the following may assist:[10-13]

- Implausible, inadequate or inconsistent explanation as to the cause of the injury
- Discrepancies between the characteristics of the injury and the purported mechanism and timing of the injury for a child of that age. Is the injury consistent with the history given and/or is it unusual for that specific age group?
- Discrepancies between the history provided by the child and that of the parent/guardian.
- A history (or signs) of repeated or previous trauma including injuries at different stages of healing.
- Significant delays a parent/guardian in seeking treatment for a child's injuries.

Behavioral observations Observations of child behaviour and parent-child interaction may assist in the assessment process.

- Unusual behaviour exhibited by the child (e.g. an exaggerated or detached response to questioning, overtly anxious, watchful)
- Parent/guardian who appears withdrawn or unconcerned
- Evidence of neglect or poor supervision of the child

Further detail regarding warning signs of child abuse is contained in Appendix A.

Child neglect

A neglected child may be constantly hungry, listless and fatigued, have poor personal hygiene, inappropriate or inadequate clothing, have unmet medical needs and lack supervision.[13] Neglect is usually appended to abuse.[14]

Dental neglect Untreated oral disease and a neglected dentition are suggestive of dental neglect especially when the child shows signs of general neglect. Whilst research has demonstrated that children confirmed as having suffered abuse or neglect have a higher incidence of untreated dental caries and other oral problems,[15-17] it is unwise to make an automatic assumption regarding general neglect based on the presence of a neglected dentition or suspected dental neglect.[18]

Practitioners should note the distinction between a 'neglected dentition' and dental neglect. A key element is determining this is if the child's presenting dental situation is a result of a parent/guardians lack of knowledge and awareness or a result of a wilful failure to address the child's needs. The child's health and welfare must always be the overriding consideration irrespective of the wilfulness (or otherwise) of the suspected dental neglect.

Signs and symptoms of dental neglect present along a spectrum of severity and may include:[4,5,13,19,20]

- Rampant untreated dental caries easily detected by a lay person
- Untreated orofacial pain, infection, bleeding or trauma. Parent/guardian ignores the child's symptoms.
- Failure of parents/guardian to respond to offers of acceptable and appropriate treatment.
- History of lack of appropriate dental care over time (continuity of care) in the presence of identified dental pathology. Failure to obtain planned treatment when access is available (e.g. repeated failure to attend appointments).

Child protection - Responding to concerns

Abuse and neglect

If a practitioner has concerns that a child is being maltreated they may act on this concern or may first choose to seek advice and council from an appropriate colleague or other professional[b] first. If, having discussed the matter, the concerns remain a key first point of contact is CYF which provide a contact service 24 hours a day, 356 days a year. CYF will be able to help determine the urgency of the concern, whether CYF need to do anything further, or if the child or young person's needs could be better met by another agency.

If at any point there is concern that the child is suffering significant harm from maltreatment, a referral should be made to CYF or to the Police. Timeliness of action is central to effective support of children who may be being maltreated.

If there are **immediate concerns** for the physical safety of a child, contact the Police directly by phoning 111 and asking for 'Police'.

Less immediate referrals of suspected child maltreatment should be made in the first instance to CYF.

[b] An appropriate colleague or other professional may be an experienced dentist, a paediatrician, public health nurse etc.

CYF contact details:

Phone: 0508 326 459

Fax: 09 914 3820

Email cyfcallcentre@cyf.govt.nz

See: http://www.cyf.govt.nz/about-us/contact-us/

CYF intake social workers deal with contacts concerning child maltreatment and are likely to require the following information:

- Practitioner details, the details of the child and their family/whanau
- The specific concerns and full details of any previous concern
- Opinion regarding the urgency of the matter
- The current location of the child or young person
- Any alleged abuser (if known/suspected) and that person's access to the child
- History of any known violence, stress, substance abuse, mental illness or incapacity, social isolation to which the child may be exposed
- Any physical hazards at the child's home; for example, weapons, threats of violence, dogs
- Any additional information which may assist in determining the appropriate response.

This information should be carefully documented in the child's record. If the information was provided to CYF or the Police verbally it should, as soon as practical, be followed-up in writing.

Practitioners working for a District Health Boards (DHB) should follow the respective DHB child abuse referral protocols, but generally, the first step is to consult with the on-duty paediatrician.

CYF response

In situations where CYF believe further action is required a case/key social worker will contact the referring practitioner about the case. The contact with the practitioner is to ensure the social worker has full and correct information, to receive any update on further developments and to give the practitioner information on action being taken. The timing of this contact will vary depending on the assessed urgency of the case.

At the end of the investigation (which can take 6 to 16 weeks from referral) the case/key social worker has a legal obligation to inform the practitioner that the referral has been investigated and whether any further action has been taken.

Allegation of child maltreatment by a staff member

If concerns and/or allegations of child maltreatment by a staff member[c] are raised, these are to be taken seriously. Interim action may include ensuring that the person concerned does not have unsupervised contact with children until the employer believes on reasonable grounds that there is no risk to children. The decision to follow-up an allegation of abuse by an employee should be made in consultation with CYF and the police.

If, after discussion with CYF and/or the police, there is a need to pursue an allegation as an employment matter the person concerned should be advised as such. Further management of the matter should be taken in the context of the worker's employment contract and legal advice.

Disclosure of information

There are no legal barriers to disclosure of patient information relating to suspected or actual child maltreatment when that information is given in good faith to an appropriate authority (e.g. police, social worker or a Care and Protection Coordinator[d]).[21-23]

[c] Includes paid workers and contractors, volunteers, unpaid workers, people undertaking educational or vocational training

[d] Within the meaning of the Children, Young Persons, and Their Families Act 1989

In most situations a practitioner should explain any concerns about the child to both the parents and to the child. As part of this process the practitioner should inform the parents if there is an intention to refer the child to other agencies (e.g. family support, CYF etc) and the parent's consent for this should be requested. Such conversations can be difficult however open discussion is important.[24,25]

A decision not to discuss concerns with parents is a judgement call. Circumstances where a practitioner may elect not to disclose to parents include: [25]

- Situations where discussion might put the child at increased risk
- Where sexual abuse by a family member, or organised or multiple abuse is suspected
- Where parents are being violent or abusive and discussion would place the practitioner or others at risk
- Where it is not possible to contact parents without undue delay and so would potentially slow down the referral

Dental neglect

Dental neglect should be considered if, following the identification of dental pathology, the careful explanation of treatment and homecare requirements, and the removal of significant barriers to care the parent or guardian continues to fail to follow through with prescribed treatment.

If dental neglect is suspected, practitioners should take a systematic 'stepwise' approach (described below) to intervention noting that most neglect is caused or exacerbated by poverty, ignorance and isolation.[19]

Dental neglect - Step 1 Dental management

Practitioners should work with the child and their family to re-establish good oral health for the child. The primary aim of the intervention is to ensure the child receives the necessary care and not to blame the parent/guardian. A preventive approach is essential if long-term dental health is to be maintained, however, it is recognised that the initial focus needs to be on the management of pain and infection and subsequently restoration of function and appearance. Dental treatment plans must be reasonable and achievable without placing unrealistic demands on the child and their family. A thoughtful follow-up plan is required.

Effective dental management requires the cooperation and participation of the child's parent/guardian. Implicit in this is that the parent/guardian has the knowledge and wherewithal to assist with this management. Individual families may face significant challenges in accessing care and in improving a child's oral heath so the practitioner should make efforts to understand these and find strategies to mitigate such challenges.

Dental neglect - Step 2 Seek assistance

If the interventions undertaken in Step 1 – Dental management, fail to address the underlying issues or if there is a deterioration in the situation practitioners should consider involving other professionals to help. Consideration should be given to involving agencies to support the child and their parent/guardian for example, the child's doctor, public health nurse, social worker etc. See also Useful resources and contacts at Appendix B.

The consent of the child and their parent/guardian should be obtained before such contacts are made although there may be times when it is not possible (e.g. following repeated missed appointments) or when there is an urgent risk to a child's wellbeing. The overriding principle is that the child's welfare is paramount.

Dental neglect - Step 3 Referral

If at any point there is concern that the child is suffering significant harm from dental neglect or showing other signs of neglect or abuse, a referral to CYF or the Police (as above) should be made noting that timeliness of action is central to effective support of children.

Documentation

If child maltreatment is suspected it is important that a detailed record of the observations are made in the child's record. Details should be specific, objective and include the date and who was present. Accounts of

the incident should be recorded verbatim. Injuries should be carefully described and/or photographed. Behavioural observations should be recorded. Document all actions taken, for example, if advice on the case was sought, record from whom and the content of the discussions or if referral to CYF or Police was made.

Information sharing

Other agencies and practitioners may from time-to-time, require information about a patient. Under the Health Information Privacy Code a practitioner normally must not disclose health information other than to the individual concerned (or to the individual's representative). There are however exceptions to this, for example, if the disclosure is authorised by the individual concerned (or the individual's representative).

There may be circumstances where requests for health information are made by other practitioners. The most common situation is where another health care professional makes such a request in order to provide health or disability services to an individual. Such disclosure is permitted by the Health Act 1956[26] and there are only limited circumstances where such a request can be refused. The health care professional making the request does not usually need the patient's consent to request the disclosure but one important ground on which the request may be refused is if the practitioner believes that the individual concerned would not want the information disclosed to the requester.

Under other legislation information can be requested from a practitioner by authorities or other statutory or regulatory bodies. If the law authorises or requires information to be made available (using words like "shall" or "must") the information **must** be made available. Prior to disclosure of such information the practitioner should request in writing exactly what information is required and the statutory provision which requires the practitioner to provide the information.

Other legislation may permit but not 'mandate' the disclosure of information. The Children Young Persons and their Families Act 1989[27] has provisions which allows (rather than requires) disclosure of information to a relevant authority or person in cases of suspected neglect or abuse of a child or young person.

Under the Health Act 1956[28], practitioners are allowed to disclose health information to various agencies (e.g. police), if that information is required for those people to carry out their functions. The disclosure is always discretionary.

Practitioners should ensure their staff are familiar with the rules around disclosure of health information. See also the NZDA Code of Practice – Patient information, privacy and records.[29]

Vulnerable Children Act 2014

The Vulnerable Children Act 2014 (VCA)[3] has as its purpose promoting the best interests of vulnerable children. This Act applies in the dental practice context and includes taking measures aimed at protecting vulnerable children from abuse and neglect, improving their physical and mental health and their cultural and emotional well-being and increasing their participation in decision making about them. The VCA specifically applies to dental practices which provide services as part of State funded schemes such as ACC and the Dental Benefits Scheme.

The VCA requires practices funded by State Services that employ or contract people to work with children to have child protection polices and to 'safety check' staff. These requirements need to be part of practice culture of child protection which is open and accountable, understands the needs of children, and makes their safety and security a priority.[30]

Child protection policies

VCA requires practices to adopt child protection policies that must contain provisions on the identification and reporting of child abuse and neglect. This Code of Practice – Child Protection meets the child protection policy requirements of the VCA.

Safety checking of staff

The VCA requires practices funded by State Services that employ or contract people to work with children to 'safety check' these staff. These requirements apply to dental practices who provide services to children as part of State funded schemes such as ACC and the Dental Benefits Scheme. Safety checking specifically

applies to paid children's workers (including contractors).[e] Safety checking is not required, by law, for people in unpaid work nor for volunteers, however, practitioners are encouraged but not legally obliged to safety check these individuals.

The paid staff in practices who are involved in State funded schemes would normally be considered a:

> '**non-core children's worker'** if they have regular, but limited, child contact and do not work alone with the child.
>
> '**core children's worker'** if they work alone with or have primary responsibility or authority over a child.

It is an employer's responsibility to ensure safety checks are completed for the children's workers they employ or contract. Self-employed practitioners contracted by a State Service (e.g. DHB, ACC) who are children's workers will need to be safety checked by that State Service.

Dates for safety checking compliance
All new non-core children's workers need to be safety checked before starting work in a new role from 1 July 2016. Existing non-core children's workers need to be safety checked by 1 July 2019.

All new core children's workers need to be safety checked before starting work in a new role (with effect 1 July 2015). Existing core children's workers need to be safety checked by 1 July 2018.

Safety checks need to be updated every three years after each check is completed.

Safety checking requirements

Safety checking requirements are detailed in the Vulnerable Children Regulations 2015[31] and must include confirmation of the identity of the person and an assessment of the risk that person would pose to the safety of children if employed or engaged as a children's worker. See Appendix C for detailed safety checking requirements.

Privacy of safety checking information
The privacy of the Information obtained during the safety checking process is to be maintained in accordance with the requirements of the Privacy Act 1993. New Zealand Police may advise employers to destroy the Police-supplied vetting information after a period of time. If the information is destroyed, a record should be kept of the employee who was Police-vetted and the when this was completed.

Workforce restrictions (convictions)
The VCA prohibits people with serious convictions from working alone with children. The restrictions apply to people with convictions involving children and/or violent behaviour, including child abuse and sexual offending. The specified offences subject to the Workforce Restriction are listed in Schedule 2 of the VCA.[3]

Non-compliance with the VCA
Employers that employ or engage (or continue to employ or engage) a person as a children's worker beyond the relevant dates specified for compliance, without ensuring that the required checking is done, may be fined up to $10,000 per infraction. An employee that knowingly or recklessly employs a person as a core children's worker who has a specified conviction, and no exemption, beyond the relevant date is liable upon conviction for a fine of up to $50,000 per infraction.

As the requirements of the VCA come into force, the government agencies responsible for enforcing them will be taking an educative approach. This means that in the first years of operation, agencies will place emphasis on offering information, advice and support in the first instance to build the knowledge base and capability of the workforce, rather than prosecuting offences. In cases where the breaches are on-going or particularly serious, charges may still be laid.

Audit
Employers should maintain accurate records about the safety checking process, including when each aspect of the check was completed for each employee or contractor. If relying on checks conducted by other

[e] Also includes individuals undertaking unpaid work as part of an education or vocational training course

individuals or organisations, records will need to provide assurance that the check was adequately conducted, including assessment of the risk the person would pose if employed as a children's worker.

Appendix A Identification of child abuse and neglect

Physical abuse [4,10,13,32,33]

Physical abuse is any non-accidental injury or trauma to the body of a child. Suspicious injuries to the head, face, mouth or neck of a child may include:

Scalp and hair	Isolated traumatic alopecia (bald spots), subgaleal haematomas, bruises behind the ears (Battle's sign)
Eyes	Retinal haemorrhage, ptosis, periorbital bruising (blackened eyes)
Ears	Bruising of the auricle, tympanic membrane damage
Nose	Nasal fractures. Injuries resulting in clotted nostrils
Face	Slap and pinch marks
Orofacial injuries	
	Lips and mouth Contusions, burns, lacerations, tears of the labial or lingual fraenum, mucosa, gingiva, tongue, palate, or floor of the mouth, fractured, luxated and avulsed teeth
	Maxilla or mandible – past or present fractures to facial bones, condyles, mandible Malocclusion may be a result of this type of injury

Any injuries to the face, neck, head or mouth that are burns caused by a specific object (in the shape of the object) such as, for example, an iron, kitchen implement or cigarette; patterned injuries caused by an object (in the shape of that object) such as a belt buckle including bite marks.[33]

Emotional abuse[f]

Emotional abuse can be difficult to identify. A child being emotionally abused may exhibit physical and behavioural indicators. Examples include; frequent psychosomatic complaints, failure to attain significant developmental milestones, severe symptoms of depression, anxiety, withdrawal or aggression, self-destructive behaviours, attention seeking behaviours. Indicators of emotional abuse of children seen in adult behaviours include: unrealistic expectations of the child, constant name calling, labelling the child or public humiliation of the child.

See also: http://www.childmatters.org.nz/86/learn-about-child-abuse/recognise-the-signs/emotional-abuse
How can I tell? Available at http://www.versite.co.nz/~2011/15700/#/8/

Sexual abuse[e]

Detecting sexual abuse by dental practitioners is less likely than the other forms of abuse. There are physical indicators such as sexually transmitted disease manifesting as orofacial symptoms and unexplained injury or petechiae of the palate, particularly at the junction of the hard and soft palate which may be evidence of forced oral sex. Behavioural indicators may be observed that could indicate sexual abuse. Examples include; bizarre, sophisticated or unusual sexual knowledge, fear of certain places e.g. bathroom, eating disorders, promiscuity or prostitution. Indicators of sexual abuse of children seen in adult behaviours include: demonstrations of physical contact or affection to a child which appears sexual in nature or has sexual overtones.

See also: http://www.childmatters.org.nz/85/learn-about-child-abuse/recognise-the-signs/sexual-abuse
How can I tell? Available at http://www.versite.co.nz/~2011/15700/#/8/

Neglect

A neglected child may exhibit physical and behavioural indicators. Examples could include a child; inappropriately dressed for the weather, extremely dirty or unbathed, inadequately supervised, malnourished, demonstrating a lack of attachment to other adults, demonstrating poor social skills, very demanding of affection or attention. Indicators of neglect of children seen in adult behaviours include: failure to provide for the child's basic needs, such as housing, nutrition, medical and psychological care, leaves the child home alone, is overwhelmed with own problems and puts own needs ahead of the child's needs.

See also: http://www.childmatters.org.nz/87/learn-about-child-abuse/recognise-the-signs/neglect
How can I tell? Available at http://www.versite.co.nz/~2011/15700/#/8/

[f] Adapted from Child abuse and neglect: Implications for the dental professional (ref 13)

Appendix B Useful resources and contacts

Organisations that support children and families

Child Youth and Family	http://www.cyf.govt.nz
Barnados	http://www.barnardos.org.nz/
Family Start	https://www.familyservices.govt.nz/working-with-us/programmes-services/early-intervention/new-family-start/
Family Works	https://familyworks.org.nz/
Salvation Army	http://www.salvationarmy.org.nz/
Plunket	http://www.plunket.org.nz/

"Safety checking' staff

Safety checking the children's workforce. Children's Action Plan. May 2015 available at http://www.childrensactionplan.govt.nz/assets/CAP-Uploads/childrens-workforce/20150528-Safety-checking-factsheet-and-QnAs.pdf

Safer Recruitment Safer Children. **Guidance for choosing safe people to work with children**. Children's Action Plan. Available at http://www.childrensactionplan.govt.nz/assets/CAP-Uploads/childrens-workforce/Safer-Recruitment-Safer-Children.pdf

Children's worker safety checking under the Vulnerable Children Act 2014 RC v 1.00 May 2015 available at http://childrensactionplan.govt.nz/assets/CAP-Uploads/childrens-workforce/Childrens-worker-safety-checking-under-the-Vulnerable-Children-Act-RC-v1-02.pdf

Recognising maltreatment

Guideline on oral and dental aspects of child abuse and neglect. American Academy of Pediatric dentistry Reference manual V37 / NO6 15/15 reaffirmed 2010 available at http://www.aapd.org/media/Policies_Guidelines/G_Childabuse.pdf

Harris J, Sidebotham P, Welbury R. *et al*. **Child protection and the dental team**. Committee of Postgraduate Dental Deans and Directors (COPDEND). 2009 available at http://www.cpdt.org.uk/data/files/Resources/Childprotectionandthedentalteam_v1_4_Nov09.pdf

How can I tell? **Recognising child abuse**. Child Matters http://www.versite.co.nz/~2011/15700/#/40/

Child protection education and resources

Child Matters Educating to prevent child abuse http://www.childmatters.org.nz

Child protection and the dental team
http://www.cpdt.org.uk/data/files/Resources/Childprotectionandthedentalteam_v1_4_Nov09.pdf

Appendix C Children's worker safety check

Children's workers[g] must be safety checked. The following checks must have been completed for all new children's workers from 1 July 2015 for core children's workforce roles, and from 1 July 2016 for non-core children's workforce roles. The same checks are required for existing children's workers from 1 July 2018 for core children's workforce roles, and from 1 July 2019 for non-core children's workforce roles.

Safety checking a potential <u>new</u> children's worker

Confirmation of identity

The identity of an employee can be confirmed in one of two ways:

Option 1 The use of an electronic identity credential (e.g., the RealMe identity verification service), and a search of personnel records to check that the identity has not been claimed by someone else.

Option 2 Checking **all** of the following:

- Physically sighting an original primary identity document[h]
- Physically sighting an original secondary identity document[e]
- Physically sighting an original identity document that contains a photo.[i]

'Character' checking

- Conduct and interview (face-to-face, telephone or other communications technology) of the potential children's worker[j]
- Obtain and consider the potential workers work history covering the preceding 5 years
- Obtain and consider information from at least one referee for the potential worker. The referee should not be related to the potential worker or part of their extended family.[g]
- Seeking information from any relevant professional organisation or registration authority, including (but not limited to) confirmation that the potential children's worker is currently a member and/or is currently registered by the relevant organisation or authority.
- Obtaining and considering information from a New Zealand Police vet. Police vetting requires the consent of the children's worker. To obtain a Police vet for a children's worker the employee must first be approved to request and receive 'vets' for employees[e] and contactors. For details go to: http://www.police.govt.nz/advice/businesses-and-organisations/vetting

Risk assessment

Evaluation of the 'identity' and 'character' information is undertaken to assess the risk the potential children's worker would pose to the safety of children if employed or engaged, taking into account the children's workers role.

Professional judgement needs to be used to identify patterns of concerning character, attitudes or behaviours. These patterns can be subtle so should be considered holistically, rather than only looking for narrow indicators like the presence (or absence) of relevant criminal convictions. Indicators should always be considered in context. A criminal conviction, gaps in employment history, or a negative reference can have different significance depending on the context. It may be necessary to seek expert advice, further referees (or seek more information from previously contacted referees) and to raise any issues with the children's worker, including where information is unclear or inconsistent. People should be given the opportunity to respond to concerns about their suitability.

The employer should be satisfied that the children's worker would pose no undue risk to the safety of children if employed or engaged. The final decision about whether a person is safe to work with children remains the sole responsibility of the employer, who should act at all times in the best interests of children accessing the service.

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[g] Also includes individuals undertaking unpaid work as part of an education or vocational training course

[h] The list of suitable documents can be found in Children's worker safety checking under the VCA[34]

[i] An identity referee may be used in the absence of a photo IF, for details see Children's worker safety checking under the Vulnerable Children Act 2014 RC v 1.00 May 2015[34]

[j] For guidelines on carrying out interviews and reference checks, including sample questions relevant to the VCA, see Children's worker safety checking under the Vulnerable Children Act 2014 RC v 1.00 May 2015[34]

All aspects of the safety check must be completed before a person commences work as a children's worker. For additional information see: Safer Recruitment Safer Children. Guidance for choosing safe people to work with children.[30]

Safety checking an existing children's worker

Confirmation of identity

The identity of an employee can be confirmed in one of two ways:

Option 1 The use of an electronic identity credential (e.g., the RealMe identity verification service), and a search of personnel records to check that the identity has not been claimed by someone else.

Option 2 Checking **all** of the following:

- Physically sighting an original primary identity document[k]
- Physically sighting an original secondary identity document[e]
- Physically sighting an original identity document that contains a photo.[l]

'Character' checking

Seeking information from any relevant professional organisation or registration authority, including (but not limited to) confirmation that the potential children's worker is currently a member and/or is currently registered by the relevant organisation or authority.

Obtaining and considering information from a New Zealand Police vet.

Risk assessment

The employer should be satisfied that the children's worker poses no undue risk to the safety of children. The final decision about whether a person is safe to work with children remains the sole responsibility of the employer, who should act at all times in the best interests of children accessing the service.

Periodic rechecking of children's workers

Safety checks need to be updated every three years after each check is completed. The rechecking process requires confirmation that the children's worker has not changed their name from the name on the documents produced during the initial identity confirmation. If there has been a change to the person's name since he or she was last safety checked, the person must reconfirm his or her identity by producing a supporting name change document relating to his or her name change.

Character' checking

Seeking information from any relevant professional organisation or registration authority, including (but not limited to) confirmation that the potential children's worker is currently a member and/or is currently registered by the relevant organisation or authority.

Obtaining and considering information from a New Zealand Police vet.

[k] The list of suitable documents can be found in Children's worker safety checking under the VCA[34]

[l] An identity referee may be used in the absence of a photo IF, for details see Children's worker safety checking under the Vulnerable Children Act 2014 RC v 1.00 May 2015[34]

References

1. United Nations High Commissioner for Human Rights. United Nations Convention on the Rights of the Child. Geneva, Switzerland: Office of the United Nations High Commissioner for Human Rights, 1989 available at http://www.un-documents.net/crc.htm accessed 26 Jan 2016.
2. Children, Young Person and Their Families Act 1989
3. Vulnerable Children Act 2014
4. Kilpatrick NM, Scott J, Robinson S. Child protection: a survey of experience and knowledge within the dental profession of New South Wales, Australia. Int J Paed Dent 1999;9:153-159
5. Harris JC, Balmer RC, Sidebothan PD. British Society of Paediatric Dentistry: a policy document on dental neglect in children. Int J Paediatric Dent 14 May 2009; DOI:10.1111/j.1365-263X.2009.00996.x
6. Lievore D, Mayhew P The scale and nature of family violence in New Zealand: A review and evaluation of knowledge. Ministry of Social Development, 2007 available at https://www.msd.govt.nz/.../about.../scale-nature/scale-and-nature.doc accessed 23 Feb 2016
7. Protecting children – A shared responsibility. The Scottish Government March 2003 available at http://www.gov.scot/Publications/2003/03/16909/21128 accessed 29 Jan 2016
8. Millar D, Brown J 'We have the right to be safe' Protecting disabled children from abuse. Final report. NSPCC. October 2014 available at https://www.nspcc.org.uk/services-and-resources/research-and-resources/2014/right-to-be-safe/ accessed 6 Feb 2016
9. Safety checking the children's workforce. Children's Action Plan. May 2015 available at http://www.childrensactionplan.govt.nz/assets/CAP-Uploads/childrens-workforce/20150528-Safety-checking-factsheet-and-QnAs.pdf accessed 22 Feb 2016
10. Becker DB, Needleman HL, Kotelchuck M. Child abuse and dentistry: orofacial trauma and its recognition by dentists. J Am Dent Assoc 1978;97:24-28
11. Needleman HL. Orofacial trauma in child abuse: types, prevalence, management, and the dental profession's involvement. J Am Dent Assoc 1986;8(1);71-80
12. Guideline on oral and dental aspects of child abuse and neglect. American Academy of Pediatric dentistry Reference manual V37 / NO6 15/15 reaffirmed 2010 available at http://www.aapd.org/media/Policies_Guidelines/G_Childabuse.pdf accessed 22 Feb 2016
13. Jessie SA, Deinard AS. Child abuse and neglect: Implications for the dental professional available at http://www.dentalcare.com/en-US/dental-education/continuing-education/ce49/ce49.aspx accessed 9 Feb 2016
14. The nature of economic costs from child abuse and neglect in New Zealand. A report prepared by Infometics Ltd for Every Child Counts Discussion paper number 1 June 2010 available at http://everychildcounts.org.nz/404.php accessed 27 Jan 2016
15. Greene PE, Chisick MC, Aaron GR. A comparison of oral health status and need for dental care between abused/neglected children and non-abused/non- neglected children. Pediatr Dent 1994;16:41–45
16. Montecchi PP, Di Trani M, Sarzi Amade D, Bufacchi C, Montecchi F, Polimeni A. The dentist's role in recognizing childhood abuses: study on the dental health of children victims of abuse and witnesses to violence. Eur J Paediatr Dent 2009;10:185–187
17. Valencia-Rojas N, Lawrence HP, Goodman D. Prevalence of early childhood caries in a population of children with history of maltreatment. J Public Health Dent 2008;68:94–101
18. Harris JC, Elcock C, Sidebotham PD, Welbury RR. Safeguarding children in dentistry: 2. Do paediatric dentists neglect child dental neglect? Brit Dent J 2009;206(9):465-470
19. Loochtan RM, Bross DC, Domoto PK. Dental neglect in children: definition, legal aspects and challenges. Pediatric Dent 1986;8(1):113-116

20. Bhatia SK, Maguire SA, Chadwick BL, Hunter ML, Harris JC, Tempest V, Mann MK, Kemp AM. Characteristics of child dental neglect: A systematic review. J Dent 2014;42;229-239
21. Children, Young Person and Their Families Act 1989 sections 15 and 16
22. The Health Act 1956 section 22C
23. Health Information Privacy Code 1994 Rule 11 2d (II)
24. Sidebotham PD, Harris JC Protecting children. Brit Dent J 2007;202:422-423
25. Harris J, Sidebotham P, Welbury R. *et al*. Child protection and the dental team. Committee of Postgraduate Dental Deans and Directors (COPDEND). 2009 available at http://www.cpdt.org.uk/data/files/Resources/Childprotectionandthedentalteam_v1_4_Nov09.pdf accessed 21 Jan 2016
26. Heath Act 1956 Section 22F Communication of information for diagnostic and other purposes
27. Children, young persons, and their families Act 1989 Section 15 Reporting of ill-treatment or neglect of child or young person.
28. Heath Act 1956 Section 22C Disclosure of health information
29. NZDA Code of Practice – Patient information, privacy and records (16 Apr 2016)
30. Safer Recruitment Safer Children. Guidance for choosing safe people to work with children. Children's Action Plan. Available at http://www.childrensactionplan.govt.nz/assets/CAP-Uploads/childrens-workforce/Safer-Recruitment-Safer-Children.pdf accessed 2 Mar 2016
31. Vulnerable Children (Requirements for Safety Checks of Children's Workers) Regulations 2015
32. Jessie A Child abuse and neglect: Implications for the dental professional. Texas Dent J 1999;Feb;40-46
33. Senn DR, McDowell JD, Alder ME. Dentistry's role in the recognition and reporting of domestic violence, abuse and neglect. Dent Clin North Am 2001;45(2):343-363
34. Children's worker safety checking under the Vulnerable Children Act 2014 RC v 1.00 May 2015 available at http://childrensactionplan.govt.nz/assets/CAP-Uploads/childrens-workforce/Childrens-worker-safety-checking-under-the-Vulnerable-Children-Act-RC-v1-02.pdf accessed 2 Mar 2016

Child protection

Code of Practice Advisory Group

The Code of Practice – Child protection aims to combine available information regarding the role of dental practitioners and the dental team in matters related to child protection in the New Zealand practice environment. This Code of Practice is the result of work by the Code of Practice Advisory Group (Child Protection) who donated their time, technical and professional knowledge and expertise in the provision of advice that informs this Code of Practice.

The NZDA wishes to acknowledge and thank the members of the Code of Practice Advisory Group for their significant contribution to the development of this Code of Practice.

Code of Practice Advisory Group Membership (2016)
Child protection

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Disclaimer

Practitioners are individually responsible for complaints against them and must exercise professional judgment when using the information contained in this Code of Practice.

This document's sole aim is to summarise the available evidence in the context of current practice environment to assist members of the NZDA in matters relating to child protection.

The members of the Code of Practice Advisory Group and the NZDA shall not be liable for any actions arising from the use of, or reliance on, this document.

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