

# A review of child abuse and the role of the dental team in South Africa



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## INTRODUCTION

Child abuse is a worldwide problem and South Africa is not immune. In Cape Town, violence against children has increased in the last ten years.<sup>2</sup> Children are powerless and cannot protect themselves, and the onus is therefore on adults, caregivers, teachers, health care workers (including dental personnel) and other persons in positions of trust to speak out on their behalf. Just what constitutes abuse is a controversial issue dictated largely by culture and upbringing. However, no violence against a child can be justified even if it is considered to be a form of discipline.<sup>2</sup> Abuse includes any act that negatively affects a child's physical or emotional health and development.<sup>3,4</sup> It can result in 'physical, cognitive and emotional impairment' which could have long-term effects.<sup>5</sup> In broad terms, child abuse can be defined as the 'maltreatment of children.' Such abuse can be inflicted in many ways.<sup>6</sup>

## TYPES OF ABUSE

Various types of abuse have been described,<sup>6</sup> including physical, sexual and emotional abuse, and neglect and exploitation.

**Physical abuse** refers to non-accidental injuries (NAI) which are deliberately inflicted and result in physical injury or death.<sup>6</sup> Physical abuse or use of excessive force can manifest as bruises, scars, fractures, burns or bite marks.

**Sexual abuse** involves "sexually molesting or assaulting a child; allowing a child to be sexually abused or assaulted; encouraging, inducing or forcing a child to be used for the sexual gratification of another person; participating or assisting in the commercial sexual exploitation of a child".<sup>7</sup>

**Emotional abuse** is also known as psychological maltreatment, and includes failure to meet a child's need for affection, attention or stimulation. Constant verbal abuse, rejec-

## ACRONYM

NAI: non-accidental injuries

tion, threats of violence or attempts to frighten the child also constitute emotional abuse,<sup>8,9</sup> as do social isolation and humiliation.<sup>5</sup>

**Neglect:** This is the most common form of maltreatment and involves continuous failure to protect a child from exposure to any danger, cold, starvation or substance abuse.<sup>8</sup> It can also include failure to carry out important aspects of child care which could impact on a child's emotional, psychological or physical development.<sup>5,8,9</sup> Poor supervision of a child could be an indication of neglect.<sup>10</sup> Dental neglect is defined as the "wilful failure of parent or guardian to seek and follow through with treatment necessary to ensure a level of oral health essential for adequate function and freedom from pain and infection".<sup>11</sup>

**Exploitation:** Child labour or exploitation in the workplace is also a form of abuse. This must be reported to a social worker. The Department of Labour will then investigate the case.<sup>8</sup>

## FACTORS WHICH CONTRIBUTE TO ABUSE

Stress, unemployment, poverty, overcrowded living conditions, lack of a support network and substance or alcohol abuse may increase the risk of children being exposed to intentional or non-accidental injuries as well as unintentional injuries.<sup>2,5,9,12,13</sup> It has been reported that children exposed to drugs *in utero* often have developmental problems which make them difficult to manage, thereby increasing their chances of being abused.<sup>14</sup> Sickly children who require constant attention and children with special needs who are more demanding, are also at increased risk for suffering abuse.<sup>15</sup>

Children of single parents,<sup>16</sup> especially when the mother is unmarried and is younger than 20 years of age, are at greater risk of abuse.<sup>17</sup> Mathews *et al.* reported that nearly half of the murdered children in their South African survey were the offspring of single mothers.<sup>1</sup> According to Janssen *et al.*, there is a definite link between poverty and 'child corporal punishment' and there is also an association between domestic violence and child abuse.<sup>2,9</sup> Physical assault by parents or guardians was shown to occur most often in the 10-to-13-year age group with boys constituting 70% of all cases.<sup>2</sup> The reason for this gender predilection is unclear but it is speculated that it could be due to social and cultural views that boys need to be punished more severely.<sup>2,18</sup> Most cases of physical violence occur in the home.<sup>1,2,13</sup> Growing

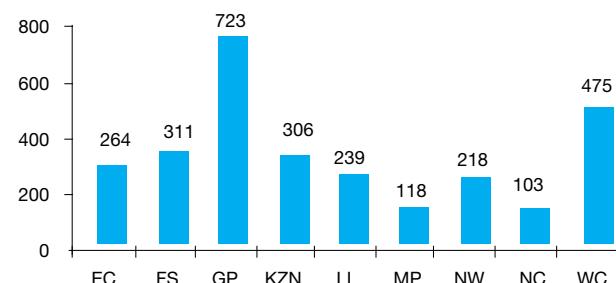
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## Number of reported cases per province



EC: Eastern Cape; FS: Free State; GP: Gauteng Province; KZN: Kwazulu-Natal; LI: Limpopo; NC: Northern Cape; WC: Western Cape.

**Figure 1:** Reported cases of neglect and ill-treatment of children (April 2012- March 2013)

up in the midst of a society where children are exposed to violence, as is the case in many areas in South Africa, inculcates violent behaviour towards others. Often, the perpetrator has him/her-self been a victim of violence or abuse.<sup>2,13</sup>

## THE EXTENT OF THE PROBLEM

Due to the secretive nature of abuse, the exact extent of the problem is difficult to determine as many cases are not reported. Nevertheless, reports gathered from across the country paint a very grim picture.

Figure 1 depicts the crime statistics obtained from the South African Police Service for reported cases of "neglect and ill-treatment of children" between April 2012 and March 2013 at police stations across the country.<sup>19</sup>

A total of 2758 cases of neglect and ill-treatment of children were reported across South Africa during this time period. Spyrelis recorded a total of 1461 cases of child abuse who presented at a safe house in Gauteng between January 2006 and June 2012.<sup>20</sup> More than half involved children under the age of six. Thirty-six percent of these maltreatment cases were classified as "neglect" and 30% as "abandonment".<sup>20</sup> Physical abuse was evident in 19% of the cases and consisted of injuries such as burns, bruises and scars. Twelve percent of the children had been sexually abused.<sup>20</sup>

A survey of child homicides in South Africa found that nearly half of the deaths were due to child abuse and neglect and almost three quarters occurred in children under the age of five years.<sup>1</sup> The estimated rate of child homicides in South Africa for 2009 was double the global rate estimated by the World Health Organization.<sup>1</sup> It was also found that homicides of boys were the most frequent.<sup>1</sup> Data gathered from the trauma unit at Red Cross Children's Hospital, Cape Town, between 2008 and 2010, showed that 78.5% of all suspected cases of non-accidental injuries were due to physical assault.<sup>2</sup> The injuries had been inflicted by assault with objects, by rape/ sexual assault and human bites.<sup>2</sup>

Some of the most common injuries, especially soft tissue trauma, occur on the exposed and easily accessible areas of the face, head and neck.<sup>2,5</sup> Naidoo reported an incidence of 67% of cases.<sup>13</sup> Dentists are therefore in an excellent position to be able to detect abuse. They are also able to observe the relationship between parent and child and to monitor fluctuations in the child's behaviour.<sup>5</sup> Despite this, dentists very rarely report cases of abuse.<sup>5</sup> The records-

based study by Naidoo showed that none had been filed by dentists.<sup>13</sup>

Raising awareness of the warning signs of abuse and educating health care workers, especially dentists, on how to diagnose and report cases of suspected abuse, would empower them to play a more active role in the prevention of child abuse and the protection of vulnerable children.

## RECOGNISING ABUSE

### History and examination

A thorough history should be taken whenever there is a suspected unintentional or accidental injury to determine whether the history and timing of the injury are consistent with the clinical findings.<sup>5,21,22</sup> Details of events surrounding the injury should be noted, especially the accounts given by parents or caregivers of how the injury occurred.<sup>9</sup> A history of prior incidents or hospitalization and reports of "clumsiness" on the child's part could potentially be warning signs of abuse.<sup>9,23</sup> Unexplained or inconsistent injuries or a delay by the parent to seek treatment should be recorded. Varying explanations from one visit to the next should also raise suspicion.<sup>23</sup>

The child and the parent should be interviewed independently, in the presence of a witness.<sup>5</sup> If both parents attend, they should be interviewed separately especially if domestic violence is suspected.<sup>9</sup> Care should be taken to avoid accusatory remarks and open-ended questions should be asked.<sup>5</sup>

In all suspected child abuse cases, a thorough examination of peri-oral and intra-oral structures is necessary. In addition to monitoring signs of oral trauma, oral health problems such as caries should also be noted.<sup>21</sup> As some presentations can often be mistaken for abuse<sup>13</sup>, medical conditions should always be excluded e.g. a history of bleeding disorders should be substantiated by laboratory tests.<sup>9</sup> The clinician should also be mindful of the fact that disorders such as chronic eczema could be mistaken for bruising.<sup>9</sup>

One should also determine whether the type of injury is unusual for a particular age group e.g. torn frenula in immobile children.<sup>10</sup> Bruising over bony prominences such as the forehead, elbows and lower legs are normal in children who are mobile.<sup>24</sup> Accidental injuries such as falls usually occur in one plane i.e. the presenting surface of the body. Injuries that result from abuse can occur in more than one plane as is the case with penetrating injuries.<sup>5</sup> Any inconsistencies in the history should sound alarm bells for suspected abuse.<sup>21,25</sup>

### Behavioural signs

It is important to remember that children who are abused are often too scared to speak and do not know who to trust. People/ professionals with whom the child comes into contact with on a daily basis have an important role to play in recognizing potential abuse cases as they may be the first to be aware of any behavioural changes. Any warning signs which are noted should be meticulously documented.

Warning signs in a child that is abused may include the following:

- Withdrawal<sup>5,9,23</sup>
- Lack of eye contact
- Refusal to speak/communicate
- Fear of being touched
- Wariness of the parent/ guardian
- Misses school often

- Displays behaviour that parents cannot cope with or control<sup>9</sup>
- Inappropriate aggression and temper tantrums<sup>5,9</sup>
- Child displays extremes in behaviour.<sup>5</sup>
- Child is over-anxious<sup>23</sup>
- Child wears inappropriate clothing<sup>5</sup> e.g. long sleeves in hot weather to cover up bruises/ injuries.

Unusual behaviour patterns and bruising on the child's face or body can be observed while the child is waiting to be consulted.<sup>5</sup> Particular attention should be paid to the child's outward appearance and interaction with others.

A potential abuser may show the following signs:

- an exaggerated, defensive response to questioning<sup>10</sup> i.e. hostile or aggressive attitude.
- Delay in seeking medical or dental care for the child.<sup>23</sup>
- Provides an inconsistent explanation of the injury or injuries.<sup>23</sup>
- A history that changes with time.<sup>23</sup>
- A 'vague' account with few details of the reason for the injury.
- Detachment i.e. plays down the incident and comes across as being indifferent.<sup>9</sup>
- Presence of a "live-in" boyfriend.<sup>16</sup>
- Inflexible, controlling parent.
- A domineering male partner who does not want the mother to be left alone with the examiner and who answers questions on her behalf.<sup>9</sup>

### Clinical signs

Abuse can manifest in a variety of ways and some of the clinical signs are discussed below.

#### Bruising

This is the most common presentation of physical abuse.<sup>9</sup> Bruising or injuries on the buttocks, extremities and ears are highly suggestive of abuse,<sup>13,26</sup> as are injuries of soft tissue which do not cover bone.<sup>13</sup> Naidoo reported that the cheek was the most frequently traumatised part of the face.<sup>13</sup>

Bruises in the shape of a finger-tip especially in the neck region are usually indicative of a "gripping" action.<sup>10</sup> Objects such as belts often leave distinctive marks on the skin.<sup>5</sup> A handprint may present as parallel linear spaced marks.<sup>9</sup> Multiple bruises of different colours are indicative of various stages of healing and could be as a result of protracted abuse.<sup>5,21</sup>

#### Bite marks

Bite marks, whether healed or not, may be an indicator of abuse<sup>21</sup> especially when they occur in areas where it is unlikely that the wound is self-inflicted.<sup>5</sup> Sometimes a bite mark is not clearly distinguishable but should be suspected in the presence of lacerations, contusions or bruises in an elliptical or oval pattern.<sup>21</sup> Bites caused by humans usually do not tear flesh as is the case with animal bite marks.<sup>21</sup> If the "inter-canine" distance is more than 3cm, it is more than likely that the bite was caused by an adult.<sup>27</sup> Severe human bite marks should be managed appropriately as they could result in serious complications ranging from recurrent infections to the need for amputation of extremities.<sup>10</sup> Administration of antibiotics and tetanus toxoid is recommended.<sup>10</sup>

#### Peri-oral injuries

Injuries, bruising or the leathery appearance of skin near the corners of the mouth may indicate 'gagging with a cloth or rope'.<sup>5,21</sup>

#### Intra-oral injuries

Oral injuries could be caused by forcing hands or fingers into the mouth, forced feeding using bottles or eating utensils and the use of caustic substances or scalding liquids.<sup>21</sup>

Intra-oral injuries may occur on the tongue, lips, hard or soft palates, mucosa, frenum or gingiva.<sup>21</sup> Tears near the frenum of the upper lip often occur in children between the ages of 6 and 18 months who fall while learning to walk. However, in children younger than a year old who are not mobile or in children older than 2 years, a frenum tear is a strong indicator of non-accidental injury.<sup>5</sup> This type of injury could result from force feeding where a spoon or bottle is shoved into the mouth. It may also be due to a blow to the mouth<sup>10</sup> or could be caused by oral sexual assault.<sup>9</sup>

Other less common oral injuries include:

- Contusions<sup>21</sup>
- Lacerations<sup>21</sup>
- Fractures of teeth<sup>5,21</sup>
- Discoloured teeth that test non-vital could be indicative of previous trauma<sup>28</sup>
- Displaced or avulsed teeth<sup>21</sup>

#### Burns

Burns can be electrical, thermal or chemical.<sup>9,21</sup> Many burns are accidental and therefore the age and development of the child should be taken into consideration when determining the cause.<sup>9</sup> Cigarette burns are very distinctive in appearance<sup>5</sup> and can present as a round or oval lesion 5mm to 10mm in diameter.<sup>29</sup> However, other lesions such as those caused by varicella or impetigo could have a similar appearance and those options should be excluded.<sup>9</sup> A cigarette that has been stubbed out on the body can leave a scar or injury with an irregular outline.<sup>29</sup> Minor burn injuries may be managed with topical antibiotics but major burn injuries must be referred.<sup>10</sup>

#### Fractures of the jaws/ skull<sup>5,10,21</sup>

Occasional discrepancies and paraesthesia are usually indicative of mandibular fractures.<sup>30</sup> A sublingual haematoma may also result from a mandibular fracture.<sup>30</sup> Base of the skull fractures can present as cerebrospinal fluid leaking from the ear or nose.<sup>31</sup> Children with osteogenesis imperfecta are prone to fractures of the limbs and this should be excluded as a possible cause.<sup>9</sup>

#### "Battered child syndrome"

The term "Battered Child Syndrome" was coined by Dr Kemp in 1962 and highlighted the fact that child abuse was not a rare occurrence, but something that happens often in everyday family situations. The term describes "a clinical condition in young children who have received serious physical abuse" and should be "considered in any child exhibiting evidence of fracture of any bone, subdural haematoma, failure to thrive, soft tissue swelling or skin bruising".<sup>32</sup> This syndrome has been seen in children of all ages but in most cases the child is younger than three years.<sup>32</sup>

#### "Shaken baby/ infant syndrome"

In young children, intracranial trauma often occurs as a result of "shaken baby syndrome"<sup>9</sup> which, along with the possibility of other side effects, can result in impaired brain development.<sup>33</sup> Naidoo found that children younger than two years were most at risk for abuse.<sup>13</sup> This type of non-accidental injury as first described by radiologist John Caffey in 1974 who referred to it was "whiplash shaken infant syndrome",

but it was later renamed. Injuries occur as a result of the child being grabbed around the chest and violently shaken, causing brain movement within the skull.<sup>9</sup> This is usually an attempt to silence him/her. "Shaken baby syndrome" is diagnosed by the presence of a triad of features, namely, retinal haemorrhage, subdural haematoma and rib fractures-- the first two markers being the most important.<sup>34</sup>

#### Sexual abuse (including oral sexual abuse)

In South Africa, all forms of sexual abuse including child rape are very prevalent<sup>1</sup> and sexual assault was found to more commonly occur in children below the age of four.<sup>2</sup>

Sexually transmitted diseases include gonorrhoea, syphilis, chlamydia, human papilloma virus (HPV) and human immunodeficiency virus (HIV). Oral injuries or infections such as oral and peri-oral gonorrhoea or oro-genital warts may be indicative of sexual abuse.<sup>32</sup> There is a paucity of studies differentiating between infections that exist prior to abuse and those that are caused by abuse.<sup>33</sup> In adults, pre-existing infections can be due to prior sexual activity. However, in children, infections can be acquired vertically, horizontally or through previous sexual activity or abuse.<sup>35</sup>

HPV can be transmitted through sexual and non-sexual contact. It can be transmitted to the oral cavity through direct oro-genital contact or through non-sexual contact where the virus is transmitted through contact with the lesion and then the mouth i.e. horizontal transmission.<sup>36,37,38</sup> Vertical transmission occurs between mother and child during birth.<sup>36,37,38</sup> History taking is therefore very important. In cases where oro-genital contact is suspected, verification by means of laboratory investigations is recommended.<sup>22</sup> Isolation of an organism in children may be the first indication that abuse has occurred.<sup>35</sup>

Unexplained injuries or petechiae at the junction of the hard and soft palate may also be indicative of sexual abuse.<sup>39</sup>

Appendix 1 provides additional information for recognising abuse.

#### DOCUMENTATION AND RECORD KEEPING

Any inconsistent history of an injury should be documented in the patient's records along with photographs and radiographs of the injuries.<sup>5,9</sup> The date and time should be recorded on all images i.e. photographs and radiographs.<sup>9</sup> When photographing injuries or bite marks for record keeping purposes, a scale ruler should be placed next to the wound. The camera lens should be held directly over the bite and perpendicular to the plane of the bite mark so as to avoid distortion and to give a more accurate representation of the actual size of the injury.<sup>5,21</sup> It is important that consent be obtained before photographs are taken. The child has a right to refuse that photographs be taken and this should be respected. However, such a refusal should be recorded in the folder.<sup>9</sup>

The location, appearance, stage of healing and severity of the injury should be recorded in detail.<sup>5,6,9</sup> Each entry should be dated and signed. Diagrams for recording purposes are also useful.<sup>9</sup> It is important that handwriting on written documents is legible and that no abbreviations are used. Wherever possible, the child/ parent's own words should be recorded.<sup>9</sup>

Appropriate referrals should be made for the management of any lesions or injuries that are beyond the scope of the den-

tist.<sup>10</sup> If child abuse is suspected, referrals should be made prior to discussing the issue of abuse with the parents. Doing so later might jeopardize the care that the child receives as parents might feel threatened.<sup>10</sup> Doctors and dentists are required to detect cases of abuse, to document and keep good records, to refer for appropriate treatment and to notify the relevant authorities.<sup>40</sup>

#### THE RIGHTS OF THE CHILD<sup>8</sup>

The Hague Convention is an international law that guides the law of South Africa where child protection is concerned. Child protection services are provided by three different groups:

1. The National Department of Social Development
2. Social Development in the Provinces
3. Non-government organizations such as Child Welfare or private social workers. In cases where the safety of children is a concern, the social worker plays a very important role as he/ she has to make sure that the child is not living in a dangerous environment.

When investigating the possibility of abuse, it is important to note that the child has the right to:

- be addressed in a language that he/ she can understand
- be accompanied by a support person of their choice (unless he/ she is of sufficient maturity and wishes not to be accompanied by such a person)
- privacy and confidentiality
- be assessed in a child-friendly environment
- not be given the impression that they are being scrutinized

##### Appendix 1: Hints and tips

###### Questions to ask yourself:

1. Is the child clean and is he/ she wearing clean clothes?
2. Is the child appropriately dressed for the weather conditions?
3. Does the child appear to be nutritionally healthy?
4. Is there evidence of neglect or poor supervision?
5. Does the parent or child display any unusual behaviour?
6. Does the child display any obvious physical problems such as unexplained difficulties in standing upright, walking or climbing onto the dental chair?
7. If there are injuries present, are they consistent with the history given/ age of the child? Could the injuries have been caused accidentally?
8. Is there any evidence of previous repeated trauma and hospitalisation?
9. Are there multiple skin lesions or bruises suggestive of abuse?
10. If there has been a delay in seeking treatment, is there a plausible reason?

###### Five key observations

1. The nature of the relationship between child and parent/ caregiver
2. The child's reaction and behaviour towards other people
3. The child's reaction to medical or dental examination
4. The general demeanour of the child or parent/ caregiver
5. Any comments made by the child or parent/ caregiver that may raise concern over the child's upbringing or lifestyle.

###### Important points to remember

1. Do not ignore any child who makes a statement about abuse
2. Do not promise a child who confides in you that you won't tell anyone what he/ she has said.
3. Do not ask the child's parent if the allegations are true.
4. Do not attempt to examine areas of the child's body that are normally clothed.
5. Do not try to investigate the complaint yourself.
6. Do not wait a few weeks for the situation to improve.
7. Your suspicions should be discussed with nobody but your staff.
8. Do not let anyone else make your decision about whether or not to file a report.

When addressing a child who is suspected of being abused it is important to consider the following:

- The child should be put at ease. He/ she should feel comfortable with you.
- The child should not be addressed or treated in the presence of a possible abuser as their presence could hamper communication with the child.<sup>10</sup>
- It is preferable that another health care worker be present when the child is being interviewed.
- Questions should be phrased in a non-judgmental way.
- Open-ended questions rather than ones with a yes or no response should be used.

Follow-up dental visits may not be possible due to delays in the investigative proceedings or failure on the parent's part to comply.<sup>2,10</sup> Therefore, if possible, all dental treatment should be completed at the initial visit and pain or any need for emergency treatment must be dealt with immediately.<sup>10</sup>

### REPORTING CASES OF SUSPECTED ABUSE/ NEGLECT

All professionals (including dentists) or indeed anyone who comes into contact with children, have a moral and legal responsibility to report cases of suspected child abuse/ neglect. There are numerous laws in the South African Constitution that address the issue of reporting cases of suspected abuse, namely:

- Prevention of Family Violence Act<sup>41</sup> (Appendix 2)
- Domestic Violence Act<sup>42</sup> (Appendix 2)
- The Children's Act<sup>7</sup> (Act 38 of 2005, as amended by Act 41 of 2007). This is a comprehensive law which deals with all matters which affect children. It has replaced the Child Care Act of 1983 and Section 4 of the Prevention of Family Violence Act of 1993.<sup>41</sup>

Section 110 of the amended Children's Act states that:

"Any correctional official, dentist, homeopath, immigration official, labour inspector, legal practitioner, medical practitioner, midwife, minister of religion, nurse, occupational therapist, physiotherapist, psychologist, religious leader, social service professional, social worker, speech therapist, teacher, traditional health practitioner, traditional leader or member of staff or volunteer worker at a partial care facility, drop-in centre or child youth and care centre who on reasonable grounds concludes that a child has been abused in a manner causing physical injury, sexually abused or deliberately neglected, must report that conclusion in the prescribed form (Form 22) to a designated child protection organization, the provincial department of social development or a police official".

The Children's Act also states that: "failure to report a reasonable conclusion that a child has been abused or deliberately neglected would make the health professional liable to be found guilty of an offence and liable to conviction...." It is important to note that there must be more than a suspicion of abuse and the conclusion must be reached on reasonable grounds. However, proof of abuse is not required.

The literature has shown that dentists do not often report cases of abuse<sup>5</sup> and there are many reasons for this including:

- Fear of getting involved<sup>5,13</sup>
- Fear of confrontation with an angry parent<sup>5,13</sup>
- Fear of legal involvement<sup>13,43</sup>
- Fear of losing patients and subsequent income<sup>5,13</sup>
- Fear of offending patients<sup>43</sup>

### Appendix 2: Legislation

#### No. 133 of 1993: Prevention of Family Violence Act, 1993

Any person who examines, treats, attends to, advises, instructs or cares for any child in circumstances which ought to give rise to the reasonable suspicion that such child has been ill-treated, or suffers from any injury the probable cause of which was deliberate, shall immediately report such circumstances:

- (a) to a police official;
- (b) to a commissioner of child welfare or a social worker referred to in section 1 of the Child Care Act, 1983 (Act No. 74 of 1983).

#### Domestic Violence Act 116 of 1998

Notwithstanding the provisions of any other law, the application may be brought on behalf of the complainant by any other person, including a counsellor, health service provider, a member of the South African Police Service, social worker or teacher, who has a material interest in the wellbeing of the complainant: Provided that the application must be brought with the written consent of the complainant, except in circumstances where the complainant is:

- a minor
- Mentally retarded
- Unconscious
- A person whom the court is satisfied is unable to provide the required consent

- Embarrassment about broaching the subject<sup>43</sup>
- Fear of fracturing the family<sup>13</sup>
- Suspicions are often difficult to confirm<sup>10</sup>
- The presence of children or partner<sup>43</sup>
- Inadequate training on how to manage child abuse cases<sup>13,43</sup>
- Not knowing how to intervene appropriately<sup>43</sup>

When reporting a case, Form 22<sup>44</sup> must be completed and one of the following people should be contacted:

- the appropriate child protection organization e.g. Child Welfare
- the Provincial Department of Social Development
- police official
- social worker

Usually, a police official is contacted first. He/ she must then make sure that the child is safe before contacting the Department of Social Development or Child Welfare within a 24 hour period. It is not the responsibility of the person who reports the case to identify the perpetrator—this is for the police or social services to follow-up on.<sup>8</sup>

The following information is required when a report is filed:<sup>45</sup>

- the name, address and telephone number of the child
- the name, address and telephone number of the parent or guardian
- reasons for concern
- documentation of indications/ suspicions of abuse
- documentation of relevant statements made by the child

In all instances as much information as possible should be provided.

The person reporting the incident should also submit the following data:

- full name
- contact details
- profession
- relationship to the child
- circumstances surrounding the case
- whether or not information was imparted by a third party
- the identity of witnesses where applicable

After the report has been filed, the social worker must ensure the safety of the child and confirm that the information in the report is truthful.<sup>8</sup> Children are not always removed from the family, but certainly if the child's life is in danger. The National Child Protection register keeps a record of all situations of child abuse or neglect. Children whose names appear in the register are then followed-up on a regular basis to ensure that they are safe and that the abuse does not continue. The information contained in this register is strictly confidential. Parental rights are not affected by the Child Protection register. The parent's legal responsibilities towards the child are only affected if legal action has to be taken e.g. when the child has to be removed from the home or when the court feels that assistance should be provided to the child and/ or family.<sup>8</sup>

Appendix 3 provides a list of useful contact numbers.

#### Appendix 3: Useful contact numbers

**Childline:** 080 005 5555

**Child Welfare South Africa: Bellville** 021 9453111/ **Athlone** 021 6383127

**Crime Stop:** 086 001 0111

**Department of Labour (Pretoria Head Office):** 012 309 4000

**South African Human Rights Commission:** 021 426 2277

**South African Police Service emergency number:** 10111

**Street Law (National Office):** 031 260 1291

#### Provincial Departments of Social Development:

**Eastern Cape:** 041 406 5700

**Free State:** 051 409 0590

**Gauteng:** 011 355 7843/7823

**KwaZulu-Natal:** 033 341 9600

**Limpopo:** 015 293 6331

**Mpumalanga:** 013 766 3156/3120

**Northern Cape:** 053 874 9100

**North West:** 018 387 3434

**Western Cape:** 021 483 4153/ 3858

## ASSESSMENT/ EVALUATION OF SUSPECTED ABUSE CASES<sup>8</sup>

The evaluation of child abuse cases should be multidisciplinary and should be geared towards the child as well as the family.<sup>21</sup> By including law enforcement, child protective services, medical professions, counselling and other related fields in this multidisciplinary team, the quality of the investigations can be improved. Better communication between these stakeholders and sharing of information would speed up the investigative process and minimize further trauma to the child.<sup>46</sup>

Only after questioning the child or investigating the situation through medical assessments/ radiographs or physical assessment can a conclusion be reached regarding the possibility of abuse.<sup>8,9</sup> The child must consent to these investigations either verbally or in writing. However, if it is in the best interest of the child or the child is too young to give informed consent, assessment may proceed without consent but cogent reasons for proceeding should be noted in writing.<sup>8</sup> According to the Children's Act,<sup>8</sup> this should be explained to the parents/ caregivers. If parents refuse to allow the child to undergo the assessment, it might be necessary to override this decision by applying to the court or referring the matter to the police or the Department of Social Development.

## CONCLUDING REMARKS

There is a need for an increased awareness among dental personnel about child abuse and neglect and their legal and ethical responsibilities to report cases of suspected or known abuse should be emphasised.<sup>10</sup> The primary goal is to "detect child abuse and prevent further injury". Dentists will not be held liable if reports of suspected abuse are fair and based on reasonable grounds but if they fail to report a suspected case of abuse, they can be held legally responsible by the victim.<sup>5</sup> According to the Children's Act, reporting cases of suspected abuse is considered mandatory and "failure to report is a breach of the law". Raising awareness about the signs and symptoms of abuse will probably result in an increase in the number of reported cases.

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