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Recognising Child Abuse and Neglect in the Dental Practice: An Overview for Malaysian Practitioners

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ABSTRACT

Dental practitioners may face child abuse and neglect in their daily practise. However, such instances usually go unreported due to a lack of appropriate information. Furthermore, practitioners are hesitant to disclose instances for a variety of reasons, creating a vicious circle that confines the victim and has major long-term consequences. This review will emphasise crucial strategies for recognising child abuse in dental settings, how to deal with it, and how dentists can better prepare themselves to deal with such cases if they occur. In addition, this research makes some recommendations for how dental practitioners in general should better prepare for such unforeseen scenarios.

INTRODUCTION

Child abuse, as defined by the World Health Organisation (WHO), is any behaviour that violates a child's rights and jeopardises their ability to live decently and with dignity. According to the Children Act of 2001, a child is defined as someone under the age of 18 (Lembaga Penyelidikan Undang-Undang, 2005). Hence, understanding abuse and characteristics in national populations is crucial for designing and evaluating

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interventions for dental practitioners to recognise child abuse and neglect in dental practises. This review will underline critical measures for recognising child abuse in dental settings, how to deal with it, and how dentists can better prepare themselves to deal with such cases if they occur. The review also makes few recommendations on how dental documentation should be done when reporting suspected child abuse and neglect.

Abuse

Abuse can be in the act of physical or sexual abuse. A child is considered to have been physically abused if they were subjected to any type of physical violence such as, but not limited to burning, hitting, kicking, punching, or shaking (WHO, 1999). On the other hand, subjecting a child to inappropriate sexual activity is considered as an act of sexual abuse. It may involve, but not limited to touching the genitalia of the child or forcing the child to touch an adult's genitalia, having sexual relations with another person, incest, rape, sodomy, exhibitionism, and sexual exploitation. In the legal context, sexual relation with a child under the age of 16 years old is considered committing statutory rape (Lembaga Penyelidikan Undang-Undang, 2005).

Physical abuse or sexual abuse must be carried out by a person who oversees a child's care or who is connected to the child for them to qualify as child abuse (Lembaga Penyelidikan Undang-Undang, 2005). On the other hand, it will be constituted a sexual assault if carried out by a stranger, in which case the police and criminal courts would be the only ones to address it (WHO,1999). However, it is arguably possible that the parent or carer did not mean to harm or injure the child such that the action could be a result of unintentional harsh punishment or excessive physical restriction.

Neglect

On the other hand, a child's basic needs not being met is referred to as neglect (Lembaga Penyelidikan Undang-Undang, 2005). Physical examination may reveal signs of physical abuse as well as neglect (Rontogianni et al., 2023). The general examination may reveal poor oral hygiene with widespread dental cavities, malnutrition with considerable growth failure, untreated nappy dermatitis, or untreated wounds (Rontogianni et al., 2023). Physical, academic, medical needs, or emotional components might all be neglected (WHO, 1999). Child maltreatment refers to any actions, whether deliberate or unintentional, carried out by a parent or caregiver that led to actual harm, the possibility of harm, or a risk of harm to a child, even if harm was not the initial intention (Leeb, 2008). Neglecting to ensure a child receives adequate nutrition, clothing, and shelter is a type of maltreatment that can result in enduring repercussions for their overall well-being (Dubowitz et al., 2000). Identifying and alerting authorities to cases of child maltreatment, which encompass neglecting a child's basic needs, is essential in safeguarding their safety and overall welfare.

Abuse or neglect in Malaysia

There are no current global statistics on the recognition and reporting of child abuse by dentists (Singh & Lehl, 2020). Malaysian children who were physically abused reported an increase of 501 cases and 644 cases in 2020 and 2021, respectively (Department of Statistics Malaysia, 2022). Concurrently, domestic violence in Malaysia has increased, with 5260 and 7468 cases reported in 2020 and 2021, respectively (Department of Statistics Malaysia, 2022). On the other hand, sexual crimes involving children showed an increasing trend of 1468 cases and 1481 cases reported in 2020 and 2021 (Department of Statistics Malaysia, 2022). The Department of Social Welfare reported that 5858 children needed care and protection in 2020 (Department of Social Welfare, 2021). However, the true prevalence of child abuse is difficult to estimate because many cases are never reported/ investigated or simply are not recognised (Singh & Lehl, 2020). Over the years, the number of cases of child maltreatment has increased, with physical abuse being the most common type of abuse, followed by sexual abuse and neglect (Prabhakaran et al. 2020).

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Dental neglect

Dental neglect (DN) is described by the American Academy of Pediatric Dentistry, as the "willful failure of parent or guardian, despite appropriate access to care, to seek and complete treatment necessary to provide a level of oral health essential for adequate function and relief from pain and infection" (AAPD, 2017). Kumar et al. (2015) divided dental neglect into two categories: dental treatment neglect (DTN) and dental preventive neglect (DPN). DPN was defined as "the neglect in the prevention of oral disease which results in the experience of dental diseases. On the other hand, DTN is characterised as "the neglect of necessary dental treatment" such as untreated dental caries and/or traumatic dental injuries (Kumar et al., 2015).

Despite having access to dental care, many children have a high frequency of caries that are often left untreated considered as dental neglect (Wulaerhan et al., 2014; Kim et al., 2017). A systematic review of prevalence of dental neglect and associated risk factors in children and adolescents revealed a high frequency of DN and untreated caries from 34% to 56% (Khalid et al., 2022). The results cannot be generalised globally due to under-reporting of dental neglect and only a small number of included studies (Khalid et al., 2022). There is a need for policies that require dental professionals to report dental neglect to higher authorities (Khalid et al., 2022). Untreated dental caries that are visible to the untrained eye, oral ulcers, and extraoral dental issues that directly affect the child can all be oral signs of dental neglect (Bradbury-Jones et al., 2013). Additionally, the child has behavioural issues that point to isolation issues other than just dental ones (Bradbury-Jones et al., 2013).

Thomson et al. (1996) dichotomized a dental neglect scale (DNS) into two groups: a DNS score of 13 or more was considered as the higher dental neglect group, and a DNS score of 12 or less was considered as the lower dental neglect group. 40% of the sample population (n=2659) in South Australia had higher DNS levels when utilising the school's dental services (Thomson et. al., 1996). Child abuse and neglect are possible to be recognised in the dental setting. Between 2014 and 2018, a retrospective study conducted at Hospital Serdang in Selangor, Malaysia revealed a nearly threefold increase in child abuse and neglect cases. Specifically, there were 42 cases in 2014, 116 cases in 2017, and 98 cases in 2018 (Prabhakaran et al. 2020). Two cases of health neglect have been reported in which parents refused basic medical attention for their children, causing the patient's condition to worsen (Prabhakaran et al. 2020). However, no specific data is available regarding dental neglect in Malaysia.

There are some indicators of neglect that aid in the detection of dental neglects such as causing late attendance and recurrent missed appointments for scheduled dental assessments, and attendance for emergency pain relief on several occasions (Ramazani, 2014). Currently there is no available data regarding recognition and reporting of child abuse by dentist in Malaysia. No proper guidelines for dental healthcare professional in managing suspected child abuse and neglect in Malaysia and proper dental documentation is not well recognised.

Recognising dental neglect

It is crucial to distinguish between dental neglect and dental caries to prevent overreporting. There may be a disregard for oral health, but not always a disregardful attitude. A clear definition outlining the grey area for dental caries be regarded as dental neglect is needed to assist the assessment process of child abuse or neglect (Souster & Innes, 2014). Health professionals are accountable for protecting the child from abuse and dental neglect (Harris et al., 2018). Dental neglect is one of the many types of abuse that were stated above that is significant from a dental perspective. However, until today there are still no definite guidelines to differentiate dental neglect due to abuse or neglect due to psychosocial issues (Dubowitz & Bennett, 2007). Dental practitioners in Malaysia play role at the frontline of health services warrants an integral role in managing child abuse and neglect. They may find this review useful in advising them on identifying, reporting, and documenting suspected child abuse and neglect.

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MANAGEMENT OF SUSPECTED, ALLEGED ABUSE OR NEGLECTED CHILDREN IN MALAYSIA

In Malaysia, the management of suspected/alleged abused or neglected children is handled by a team called the Suspected Child Abuse and Neglect (SCAN) team (Ministry of Health Malaysia, 2009). They comprised of a multidisciplinary team of hospital staff, including paediatricians, gynaecologists, child psychiatrist, accident and emergency personnel, forensic pathologists, nurses, and medical social workers. They also collaborate closely with designated Welfare Officers from the Department of Social Welfare, also known as Jabatan Kebajikan Masyarakat (JKM), and police officers. However, dental health professionals, such as Forensic Odontologists, were not included as members of the interdisciplinary SCAN team, even though many oral findings can be found associated with physical and sexual abuse. Each hospital in Malaysia is required or has already identified the SCAN Team hospital members, and they have received the necessary training to assess and handle child abuse situations. The medical team member of the district/state JKM Child Protection Team may also be one of the team's doctors (Lembaga Penyelidikan Undang-Undang, 2005). SCAN teams are categorised into three levels (Ministry of Health Malaysia, 2009).

1) Level A SCAN teams

   (i) Offer advice and assistance to other professionals who are not trained in managing allegations of child abuse and/or neglect.

   (ii) To identify service shortages, take part in long-term planning for child protection services, collaborate with other local agencies, and consult with them.

   (iii) Accept direct recommendations as well as referrals from level B and C hospitals.

2) Level B SCAN teams

The provision of such treatment as in Level A Hospitals, despite the possibility that the child may be referred to a Level A hospital for severe illnesses or with more specialised services.

3) Level C SCAN teams

They are obligated to consult with or refer all SCAN cases to hospitals with specialised facilities. In addition, these SCAN teams can inform the referral hospital with welfare and police investigation findings.

At the moment, the dental professional has no legal role in Malaysia despite the management of suspected child abuse and neglect (CAN) being well-known among healthcare practitioners. Oral or dental injuries or diseases may be linked to alleged physical or sexual abuse, suspicions of child abuse and neglect, and quite often go unreported by dental health professionals. There are currently no clearly established procedures for dental health professionals to document suspected child abuse and neglect in Malaysia. It is also critical to ensure that dental health professionals are well-versed in local child protection referral protocol.

The One Stop Crisis Centre (OSCC), which is open around-the-clock, was established in 1996. This centre is typically situated in the emergency department or unit in the Ministry of Health's hospitals in Malaysia (Ministry of Health Malaysia, 2015). One of its functions is to act as the hospital's entrance point for cases of suspected child abuse among others, offering a quiet space where the child or the family member can be questioned by health professional staff, welfare officers, or police, and an initial medical assessment and evidence collection can be done. The youngster will typically then be admitted to the hospital for additional evaluation, care of any physical wounds, or counselling. The OSCC also acts as a one-stop centre for adult victims of sexual or domestic abuse. A multidisciplinary team of health professionals, police, medical social workers, counsellors, and Non-Governmental Organisations (NGOs) make up the OSCC team (Colombini et al., 2011; Colombini et al., 2012; Ministry of Health Malaysia, 2015).

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Up to 2021, there are only fifty-four (54) Paediatric Dentistry Specialists and three (3) Forensic Odontologists in the Ministry of Health (MOH) Malaysia (Oral Health Programme MOH, 2022). Around 98 729 patients seen by Paediatric Dentistry Specialists in Malaysia (Oral Health Programme MOH, 2022). Forensic Dentistry was first established in Hospital Kuala Lumpur. The total number of cases seen increased from 2020 to 2021 by 157.7% from 163 cases to 420 cases respectively (Oral Health Programme MOH, 2022). Due to the scarcity of Forensic Odontologists in Malaysia, Paediatric Dental Specialists would be the next point of contact for consultation and referrals.

The association of dental findings with suspected child abuse and neglect

Direct observations, a history of poor dental hygiene and unhealthy eating habits may aid in diagnosis dental neglect (Bradbury-Jones et al., 2013). da Silva et al. (2016) discovered that compared to children in the general population, maltreated children suffered from oral and facial injuries more frequently. Additionally, Maguire et al. (2007) discovered evidence of a greater incidence of intra-oral injuries among abused children, including bites, fractures, invasions, and cuts to the lips, gums, tongue, and palate. An investigation of autopsies performed on deceased children might also reveal abuse or neglect (Maguire et al., 2007). Medical care neglect is defined as the failure of caregivers to offer infants or children with life threatening or other serious/chronic medical illnesses the necessary care (Maguire et al., 2007). Munchausen syndrome by proxy, a rare ailment in which a caregiver—typically the mother—creates or mimics a child's illness-related symptoms, is the exact opposite (Somani et al., 2011). The child may exhibit a broad range of health-related issues or repeatedly unusual symptoms. There have been recorded fatal cases (Somani et al., 2011).

The following are some unusual characteristics of negligent parents that can be used to identify dental neglect (Ramazani, 2014); a) Resulting in missed appointments for the planned dental assessment and delayed attendance. b) No desire to learn about oral hygiene. c) Recurring visits for immediate pain alleviation. d) Not utilising dental care and rehabilitation services. e) Not following through with treatment plans. f) Poor dental health, poor oral health knowledge and attitude. g) Inadequate oral hygiene practiced at home. These qualities of neglectful parents may result in a low quality of life for children.

Child abuse typically has a rationale and is the outcome of a variety of circumstances or causes. In most cases, thorough investigation shows the underlying causes of people's turning to these habits. Among the risk factors that are generally acknowledged (Patil et al., 2017); a) Children that require specialised medical care due to developmental problems, intellectual disabilities, chronic illnesses, or other conditions. When dealing with these types of children, parents often felt burdened. b) Pregnancy with a teenager, unintended, or with twins. Negative connections between early childbearing and several economic, social, and health consequences have been discovered in a variety of data sets over time (. c) Inadequate understanding of parenting and children's health. d) In a family, a depressed parent or partner may use violence. e) Unsafe neighbourhoods or inadequate recreational opportunities. f) Poverty and its burdens that may lead to poor financial and insurance cover indirectly.

Attitudes, knowledge, and practices (AKP) of dental professionals on suspected child abuse and neglect

Dental professionals had little awareness and knowledge of suspected CAN (Cukovic-Bagic et al., 2015; Deshpande et al., 2015). As a result, there was a lot of confusion and reluctance on their part when making diagnoses and reporting suspected cases. This can result in misdiagnosis errors and/or inconsistent documentation of probable abuse and neglect signals (Cukovic-Bagic et al., 2015; Hussein et al., 2016). According to a study in Norway, there is widespread knowledge that recurrent absences from school and serious dental caries may be signs of both dental and general neglect (Brattabo et al., 2018). Over a seven-year period, a sample of dentists showed improved rates of CAN knowledge and reporting (Harris et al., 2013). The understanding of common physical abuse warning signs by Malaysian dentists was reported to

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be adequate. However, this study is among those who are more inclusive as they serve children and significant paediatric oral health (Hussein et al., 2016).

Croatian dental practitioners' knowledge of CAN was reported as inadequate, and as a result, there was a high level of ambiguity and hesitancy among practitioners when diagnosing and reporting suspected cases (Cukovic-Bagic et al., 2015). A survey among Indian dentists found that, while they were aware of the diagnosis of child abuse, they were hesitant to reveal it because they did not know who to report it to. About 55% of the excuses for not reporting were due to ignorance of dentists' reporting obligations for child abuse (Kaur et al. 2017). This could result in diagnostic mistakes and/or uneven reporting of suspected symptoms of abuse and neglect (Cukovic-Bagic et al., 2015; Kvist et al. 2018). A review among dentists in German stated that most dentists' uncertainty regarding the diagnosis, confusion about who to report in the case of a suspected case and worry that the suspected case would turn out to be false were the most often stated excuses for not referring (Pawils et al., 2022). It has also been reported among dentists in Scotland (Crouse & Faust, 2003), the United Kingdom (Harris et al., 2011), Denmark (Uldum et al., 2010), and Nigeria (Bankole et al., 2008). In addition, it has been observed that dentists tend to be reluctant to report situations of child abuse. Ironically, even though most of them acknowledged that they were able to see abuse, the same majority were reluctant to report it to the relevant authorities (Pawils et al., 2022).

In comparison, a Malaysian survey among dental health professionals found that incidences of suspected child physical abuse were detected in daily practice, ranging from, “never” (33.3%), “seldom” (51.9%), “occasionally” (13.9%), and “often” (0.9%) (Hussein et al., 2016). However, this may not reflect to the wider dental practitioner in Malaysia. A study among dental students in Universiti Teknologi Mara (UiTM) Sungai Buloh reported that the students did not receive formal training in managing child abuse cases (Abdul Aziz et al, 2020). In addition, the students stated that they had not learned about child abuse through dentistry conferences, dental magazines, literature, or in the dental schools. (Uldum et al., 2010; Cukovic-Bagic et al., 2015; Deshpande et al., 2015; Abdul Aziz et al., 2020). Malaysian dentists wanted training on identifying and reporting child abuse because they felt they had not been given enough information about it (Hussein et al. 2016). Similar findings are also found in other studies (Uldum et al., 2010; Cukovic-Bagic et al., 2015).

Here are a few possibilities as to the barrier to reporting the case (Chopra et al., 2013); a) Fear of legal complications. b) Concern about patient loss. c) Disregard how serious the crime is. d) Apprehensive about being accosted by the family. e) Distrust of child protective services. f) Incorrect instruction and preparation in the area. These dental practitioners' actions and attitudes may result in untreated neglect or abuse of children. Recognising and reporting dental neglect is critical because it can be an early indicator of general physical neglect as well as a source of substantial discomfort and loss of oral function.

When a suspicious case arises, it is crucial to design and adhere to an appropriate protocol. The possible finding of CAN in the head, face, neck area, and oral can be identified in Table 1 (Anees et al., 2022; Sarkar et al., 2021; Sinha et al., 2017). The first stage in identifying and reporting child abuse is interviewing the parents and the child jointly and documenting this activity. 1) A thorough evaluation should start as soon as the child enters the clinic. 2) The interview should take place with a witness present. 3) It is advisable to interview the youngster and parents individually. 4) Questions that are open-ended, non-threatening, and detailed should be asked. 5) The interviewer should be impartial and refrain from making abuse claims.

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Table 1. Possible Findings on Suspected Child Abuse and Neglect in the Head, Face, and Neck region.

Types of Abuse	Area Involves	Findings
Physical Abuse	Neck Chin Cheek Face Ear Eye Hand	Strangulation mark, slap mark, blunt force injury, bruises, lacerations, abrasions, burns, and bite marks, tears, scars.
	Teeth	Missing, fractured, avulsion, mobility, discoloured, residual roots, untreated mild and severe early childhood caries, and rampant caries.
	Mucous membrane Lips Tongue Frenum Gingiva Soft palate Floor of the mouth Buccal Mucosa Mandible Condyle	Laceration, tear, burns, bite marks, scarring, hematoma, contusions, fracture, abrasion, and lacerations.
Sexual Abuse	Lip Tongue Palate	Petechiae, hematoma, erythema, ulcers, and purulent discharge, pseudomembrane and condyloma lesion, papular-vesiculobullous lesion, oral perioral warts

The parents should be reassured of support instead. 6) Before reporting the event or injury to the authorities, take note of any differences between the child's and the parent's descriptions of the incident or injury. 7) The dentist should first alert the relevant authorities about any indicators of abuse and then inform the parents if the dentist believes that one of the parents may attempt to leave the clinic with their child. To improve general knowledge regarding child abuse and neglect among dental practitioners in Malaysia, awareness and continuing dental education should be increased.

RECOMMENDATIONS OF DOCUMENTATION BY DENTAL HEALTH PROFESSIONAL

The Child Protector (Social Welfare Department), which serves as a protector, is required by Malaysian law, Child Act 2001, to receive an immediate report of any suspected physical or emotional harm to children who have been maltreated, neglected, abandoned, or exposed, or who have been sexually abused. If doctors, family members, and childcare providers fail to comply with the reporting requirements, they may be subject to a fine of up to RM 5,000 or imprisonment for up to two years, or both (Lembaga Penyelidikan Undang-Undang, 2005). In Malaysia, Talian Nur, the child abuse hotline (15999) is available to report case if a person prefers to remain anonymous or as mentioned in Table 2.

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Table 2. How to Report Child Abuse in Malaysia

How to Report Child Abuse?
1. Please provide specifics regarding any suspicions of abuse or neglect via the Talian Nur hotline 15999 so that the JKM officer can determine the severity of the case and take the proper and expedient action
2. For the child and caregiver to be transferred directly to the hospital's One Stop Crisis Centre, the person who brings the child to the hospital should mention at the Emergency Department/Outpatient Department that the child may have been abused.
3. This is better when done through the police since it will allow the doctor to undertake an urgent physical examination for new instances of suspected sexual abuse.

Roles of dental practitioners in dealing with suspected child abuse and neglect.

(i) To investigate and assess potential child abuse and neglect.

(ii) To manage oral and bodily harm brought on by maltreatment or neglect.

(iii) To collaborate with the police and a welfare official to protect the child.

(iv) To satisfy the requirements of the criminal justice and child protection systems through meticulous injury documentation, evidence gathering, and findings interpretation.

(v) To provide dental examination reports and opinions that can be utilised as evidence in criminal prosecutions.

(vi) To participate as the hospital's representative in The Child Protection teams if needed.

(vii) An immediate consultation/referral to a forensic odontologist (FO) is highly recommended.

(viii) Certain suspected child abuse cases are preferably referred/consulted with a forensic odontologist to ensure continuity and integrity of the chain of custody.

(ix) Referral to the medical team. It is critical to understand that abused children might arrive at the clinic/hospital in a variety of ways.

The first referral for a child who had been mistreated or neglected might have been issued as (Lembaga Penyelidikan Undang-Undang, 2005); 1) A medical condition (such as a convulsion or fracture). 2) Behavioural issues. 3) Psychiatric issues (e. g. depression, anxiety attacks). 4) Requesting a genital examination. 5) The disclosure of sexual interaction. 6) Concern from parents over "loss of virginity". 7) In a custody case, there is alleged sexual abuse. 8) Alleged assault or abuse. 9) Found wandering unattended in public spaces or abandoned (as in abandoned babies).

Recommended Documentation on Suspected Child Abuse and Neglect for Dental Health Professionals (Ministry of Health Malaysia, 2009; Singh & Lehl 2020).

History Taking

(i) Names and addresses of the child and its parents.

(ii) The child’s present condition.

(iii) Their age.

(iv) Other relevant information that could be used to determine what led to the abuse.

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(v) The name(s) of the person(s) who allegedly committed abuse or neglect, if known.

General Condition

(i) Nature, scope, and evidence of the harm, as well as any prior harm (Size, shape, colour, location, number, and radiographs).

(ii) Individual's behaviour both alone and with parents/caregiver (if alarming).

(iii) Record all interviews with the child and parent and similar information about other children in the home.

(iv) Get a witness to testify to the injuries and interview, then sign and date the report.

Dental Documentation Must Include

(i) Complete necessary investigation. To avoid medical jargon, Include both the positive physical examination results and any pertinent negative findings.

(ii) Should consider any negative psychological or emotional effects on the child, as well as any disabilities brought on by the abuse, if applicable.

(iii) Maintain an accurate record of all significant physical findings, both favourable and negative.

(iv) Record the time and date the patient was seen and examined.

(v) In cases of physical or sexual abuse, photographs (with the patient's name, RN, the date, and time they were taken, and the photographer's identity) are typically maintained for the doctor's records rather than handed over to the authorities. (Photos must be labelled with the roll of the film's number or, if they are in digital format, with the name and date of the photo).

(vi) All staff members' names must be written legibly, or they may use name chops.

(vii) Unless the history is supplied in the context of a report on whether the young child's history is consistent and if the child is "fantasising or not," do not record a complete history as given by the patient but rather the cause for examination, such as alleged sexual assault, as an introduction.

(viii) Where examination results are normal, do not state "no signs of sexual abuse" because the child's background may strongly imply sexual assault. Even though there might not be any obvious injuries at the time of the assessment, a physical examination cannot rule out sexual abuse.

(ix) If a psychiatrist's assessment is judged helpful, such as in custody cases, to include one.

Examination

Keeping detailed records of all bruises and external injuries, as well as the guardian's explanation of the incident's circumstances: -

(i) Describe the wound's quantity, location, size, shape, surrounding tissue (bruising, swelling), colour, course (such as the direction of the force exerted), and any foreign objects found

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inside the wound. Look for patterns of injuries, such as bite marks, cane markings, cigarette burns, and bruises on the fingertip.

(ii) Bruises - It must be emphasised that the general agreement is that it is impossible to estimate the age of a bruise accurately. Tenderness, edema, and lacerations that are also present are more indicative of recent injury.

(iii) Skin pigmentation may have an impact on the apparent colour.

(iv) The location of bruising is not always the location of trauma; for example, bruising may spread beyond the area of contact, develop at a location far from the impact, or be missing despite significant force.

(v) The amount of force applied does not always correlate with the size of the bruise.

(vi) Bruises heal more quickly on areas of the body with superior vascular supply, such as the face, than they do on the buttocks. As a result, bruises on the buttocks last longer than a comparable bruise on the face.

(vii) Instead of relying solely on colour, dating a bruise should consider any accompanying soreness or swelling.

(viii) Examine ears, mouth, and frenulum for any injuries or hemorrhages.

(ix) Evaluation of development and growth, emotional and physical maturity, personal hygiene, and signs of abuse

(x) In cases of suspected sexual abuse, the examination should be limited to the head and neck region. Medical healthcare should do more examinations in the hospital.

The limitation of this review is that the suggested approach of reporting and documentation of suspected child abuse and neglect cases is tailored for Malaysian dentists. There may be differences in the reporting procedure in other countries. However, this current review offers reference materials for identifying child abuse and abuse. This review also strongly recommends that awareness of identifying child abuse and reporting should be included in Malaysia's undergraduate dentistry curriculum in dental schools and throughout compulsory paediatric dentistry training for the New Dental Officer Program (NDOP), Ministry of Health Malaysia. Continuous professional development (CPD) activities can be done among dental professionals to increase the awareness of suspected CAN. More research should be planned to provide dental practitioners with accurate evidence-based data on child abuse and neglect. Therefore, a standardised tool or diagnostic scale for dental neglect needs to be developed. There is a need to investigate the associations between oral health and child abuse as well as prevention methods for severe untreated dental caries or dental neglect. More research is required in Malaysia to assess the attitudes, knowledge, and practices across the country among Malaysian dental health professionals.

This study also recommends future studies on dental neglect in high- and low-income areas in Malaysia. Managing child abuse and neglect requires a multidisciplinary approach. With the limited Forensic Odontologists in the country, Paediatric Dentistry Specialists would be the next point of contact for consultation. Therefore, when considerable evidence is observed, immediate referral to proper specialties, such as Forensic Odontologists and Paediatric Dentistry Specialists, must be done to ensure any legal implications are managed accordingly. It is advised for multidisciplinary child abuse and neglect teams in Malaysia to identify oral health professionals such as Forensic Odontologist Specialist and Peadiatric Dentistry Specialist in their community to act as consultants for these teams. This will improve our ability to prevent and detect suspected child abuse and neglect, as well as care for and safeguard children.

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CONCLUSIONS

The role of dental professionals does not involve determining whether abuse or neglect has happened. However, recognizing and reporting suspicious cases is required so that further investigation by relevant authorities can be conducted. Standardised dental documentation should be emphasized to report suspected child abuse and neglect. General practitioners must refer the suspected cases to the SCAN team, Forensic Odontology specialists, or Paediatric Dentistry specialists for consultation. This review has provided dentists with information on reporting possible child abuse and neglect in Malaysia.

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CONFLICT OF INTEREST STATEMENT

The authors agree that this research was conducted in the absence of any self-benefits, commercial or financial conflicts and declare the absence of conflicting interests with the funders.

AUTHORS' CONTRIBUTIONS

Abdul Rauf Badrul Hisham: Conceptualization, writing—original draft preparation, data curation, investigation, methodology, writing-review & editing and project administration. Hairuladha Abdul Razak: methodology, writing—review and editing, supervision, and validation. Atika Ashar: writing—review and editing, supervision, and validation. Leong Kei Joe: Conceptualization, writing—review and editing, supervision, and validation. All authors have read and agreed to the published version of the manuscript.

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