SPECIAL FEATURE

Paediatric dental neglect: a pathway for information sharing

Danielle Brown,[1] Sanford Grossman[1] and Matthew Heming[1] highlight a local policy on when to share information about children undergoing dental extractions.

Abstract

This article describes the development of a local trust policy which aims to protect children undergoing treatment in an oral and maxillofacial surgery department who may be at risk of dental neglect. Children with high caries rates are frequently managed under day case general anaesthesia for dental extractions. Our local policy identifies those who are most at risk of dental neglect and outlines a pathway for information sharing with community services. Enhancing processes for information sharing is not only beneficial for safeguarding purposes but can also enable vulnerable families to access additional support.

Background

Despite neglect being one of the most common forms of child abuse, it still often goes unrecognised.[1] Dental neglect can have a significant impact on the wellbeing of a child. Ofsted (the Office for Standards in Education, Children's Services and Skill) (2014) reported that 'the pervasive and long-term cumulative impact of neglect on the well-being of children of all ages is well documented'.[2] A 2017 report from the Torbay Safeguarding Children Board highlighted high rates of neglect in our locality; they found a higher proportion of children on child protection plans as well as increased proportions of looked-after children when compared to national averages.[3] Thirty-six percent of children in the Torbay area were subject to a child protection plan due to neglect.

Dental neglect is defined as a persistent failure to meet a child's oral health needs.[4] Many factors can raise concerns of dental neglect; one common indicator may be the presence of rampant untreated childhood caries.[5] Children with extensive tooth decay are often referred to secondary care services for dental extractions under general anaesthesia (GA). In fact, tooth extraction under day case GA is now the leading cause of hospital admission for children aged 5–9 years old.[6] Research has shown that there is an increased proportion of children suffering from dental neglect who have treatment under GA.[7] Despite this, there is currently no national guidance available to inform the clinician as to which children may benefit from additional information sharing. The importance of recognising and raising concerns of dental neglect should not be undervalued; sharing information on dental neglect can help inform healthcare professionals in identifying wider patterns of abuse. Although the majority of children having dental extractions under GA will not be victims of dental neglect, it is vital that there are robust processes in place to help detect and protect those in need.

Safeguarding children is everyone's responsibility: 'everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action'.[1] The importance of optimising every contact with professionals has been emphasised during the coronavirus (COVID-19) pandemic. The combined impact of reduced contact with healthcare professionals such as general medical practitioners (GMPs) and general dental practitioners (GDPs), as well as school closures, has resulted in reduced opportunities to identify families who may benefit from additional support to meet their child's needs. This includes both oral health support and education as well as safeguarding. The COVID-19 pandemic has also resulted in many elective theatre lists being cancelled or postponed due to pressures on hospital services, which has increased day case GA waiting times and therefore further stretched opportunities for support and intervention. Overall, this is recognised to have contributed to further health inequalities in children.[8]

> 'The importance of recognising and raising concerns of dental neglect should not be undervalued'

Changes to our practice

Our department noticed that although many children treated on the day case GA list may be at risk of dental neglect due to high caries rates, very little information was being shared with other teams involved in the child's care in the community. Discharge

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summaries were completed and sent to the patients' GMPs; however, they only provide limited clinical information such as operational coding and do not include details of how many teeth were extracted or the indication for dental extractions.

Our findings raised concerns that there is a risk that cases of child neglect may be missed by healthcare professionals due to a lack of communication between primary care, secondary care and community services. To address this, we have developed a new protocol to ensure there is appropriate information sharing for children who are considered most at risk of dental neglect. The protocol was developed and agreed through collaborative working with the Children Safeguarding Operational Group and Paediatric Liaison team. We determined a set of criteria (Box 1) to support clinicians in identifying high-risk cases and established a simple pathway for children to be referred to Paediatric Liaison. If a child meets the criteria for a referral, this is discussed with the parents and consent is obtained to share relevant information. We have evaluated the implementation of this pathway through clinical audit and made a few minor adjustments to the criteria to aid clarity and improve compliance.

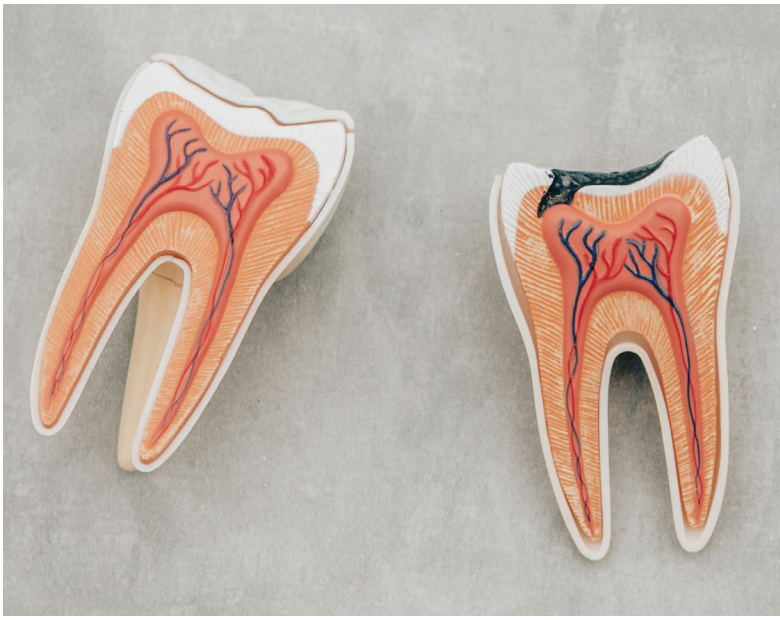
Paediatric Liaison services are well placed to collate information relating to a child's hospital attendance and share it with appropriate community services such as the public health team. They also have a role in sharing information with safeguarding teams for a child that is thought to be at risk. In some cases, information may be shared with other healthcare teams such as paediatrics. For example, it is recognised that children showing signs of a sensory processing disorder such as autism, a contributing factor to their poor oral health, often attend with a significant number of decayed teeth. Although this is related to the challenges surrounding their acceptance of oral hygiene measures, sharing relevant information can make a positive difference to the care and support a child or parent receives and could help with future disease prevention. *Working together to safeguard children* (2018) states: 'Local organisations and agencies should have in place effective ways to identify emerging problems and potential unmet needs of individual children and families'.[1] This includes children under universal services and therefore highlights our responsibility to arrange for further support for all children at risk of dental neglect.

Box 1 Referral criteria for information sharing with the Paediatric Liaison Team for children at risk of dental neglect

Information Sharing with Paediatric Liaison Team referral criteria:

- Age six or older children undergoing removal of six or more teeth
- Age five and under children undergoing removal of four or more teeth
- Children undergoing a second general anaesthetic procedure in their lifetime for removal of at least two or more decayed teeth
- Children currently on a child protection plan/looked-after child undergoing removal of one or more decayed teeth
- Failure to attend two consultation or operation appointments (Trust 'Was Not Brought' [WNB] policy followed in addition).

NB: Exemptions include children undergoing extractions of healthy teeth (eg orthodontic referrals) or due to a developmental dental defect (eg molar incisor hypomineralisation [MIH]).



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Conclusions

Secondary care services have a responsibility to identify and act upon cases of dental neglect. The high frequency of children having multiple extractions under GA presents challenges for clinicians in identifying cases most at risk. Our simple protocol highlights one method of identifying cases and ensuring appropriate information is shared. By working together with Paediatric Liaison services and community teams we can continue to improve our practice, identify opportunities for additional support for vulnerable families and protect children at need of safeguarding. ■

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Ethics declaration

The authors have no conflicts of interest to declare.

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