Establishing comprehensive oral assessments for children with safeguarding concerns

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VERIFIABLE CPD PAPER

IN BRIEF

- Readers will learn what a comprehensive medical assessment for children with welfare concerns is and what the dental input to these assessments involves.
- Readers will be aware of the challenges they may face when setting up such clinics.
- Readers will see examples of the benefit of dental input in the assessment of children with wellbeing concerns.

GENERAL

The dental profession is well placed to contribute important information in child protection cases but no previous research has been reported that assesses the volume or impact of this information. Comprehensive oral assessment clinics were introduced and established as an integral part of comprehensive medical assessments for children with welfare concerns in Greater Glasgow and Clyde. An assessment protocol and standardised paperwork for comprehensive oral assessments were developed to enhance information sharing and patient access to appropriate care. Two cases are presented and discussed to demonstrate the value of dental input.

INTRODUCTION

Previous research has demonstrated that children confirmed as having suffered abuse or neglect have a higher incidence of untreated dental caries and other oral problems.[1–6] Therefore, the dental profession is well placed to contribute important information in child protection cases but no previous reports have been published that assess the volume or impact of this information. All previous research has been conducted on children who are confirmed cases of abuse/neglect. These children are likely to be the 'tip of the iceberg' as many children may be too young, scared or ashamed to report what is happening to them.[7]

When wellbeing concerns are first highlighted (via health, education, social services or police) dental team members could be invited to share their information regarding oral health and this would add to the body of evidence in these cases. Dentists, dental hygienists and dental therapists are the only health care providers able to diagnose dental and oral disease within their scope of practice.[8,9] In Greater Glasgow & Clyde children with an identified wellbeing or safeguarding concern are referred for comprehensive medical assessments (CMAs) as part of the information gathering process. By the late 1990s it was well recognised that CMAs were necessary to identify health needs and coordinate access to health services for vulnerable and at risk children.[10] The health and welfare needs of children can be overlooked when children are seen by doctors who do not have appropriate training or experience. There is a need to ensure the full involvement of health practitioners, particularly medical staff, in child protection processes.[11]

After many years of work with the NHS policy and planning group the NHS Greater Glasgow & Clyde (NHS GGC) child protection unit set up CMAs for children with welfare concerns. These clinics started in 2009 and involve obtaining a detailed history and account of circumstances leading to referral plus a full medical examination. They are normally requested by social workers but may also be requested by other agencies who contact the child protection advisors.

The most common reason children are referred for a CMA is a concern regarding neglect. The purpose of the CMA is to assess the health of the child and any medical, physical or emotional needs that they may have that are not currently being met by their carer. From December 2009 to March 2012 130 children were seen for a CMA with dental input. The dentists staffing these clinics consisted of a team of three community dental officers and the author (CP). In order to ensure all children received the same standard of dental assessment a training package was developed and training organised to standardise recording of clinical dental information.

ROLE OF THE DENTAL TEAM IN CHILD PROTECTION

Studies of the prevalence of injuries to the head, face and neck of physically abused children have been repeated and it has been consistently shown that 50-75% of physically abused children have orofacial signs of abuse which should be obvious to a dental practitioner.[8,12–15] However the literature also suggests that dentists should be involved in the recognition of neglect[16–18] and sexual abuse.[19,20] Neglect should be considered if parents have access to, but persistently fail to obtain treatment for their child's tooth decay.[21]

The Scottish Government's National Guidance specifically covers the roles and responsibilities of dental care practitioners. In keeping with the General Dental Council's policy[22] the Scottish Government Guidance agrees that the dental team should have the knowledge and skills to be able to identify concerns about a child's welfare and know how and with whom to share that information. The National Guidance also recognises that dental care practitioners often come into contact with vulnerable children and are in a position to identify possible child abuse or neglect from their examination of oral injuries or oral cleanliness (hygiene).[23]

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THE ROLE OF THE DENTIST AT CMAS

The first pilot CMA clinics in Glasgow had no dental input. The only oral assessment was a comment from a paediatrician on the teeth and a grading of any tooth decay as mild, moderate or severe. There are no texts which grade dental caries in this way and this terminology would not be recognisable to any dental practitioner. Although the attempts that were made were admirable it demonstrated a lack of knowledge in this specialised field and a failure to include the dental profession. As previously noted; the health and welfare needs of children can be overlooked when children are seen by doctors who do not have appropriate training or experience.[11] The same could also be said of children's oral health needs. The child protection unit subsequently agreed that in CMA's the oral examination should be performed by someone highly skilled in the assessment of the oral cavity, namely a dentist.

The aim of this report is to describe the establishment of regular input from paediatric dentistry to the CMAs, to increase interdisciplinary collaborative working, thereby underpinning the importance of interdisciplinary communication.

In turn we hoped that this would help dental services respond to the needs of these vulnerable children and lead to the development of care pathways for management of dental neglect. These plans were designed to meet with the recommendations set out in the British Society of Paediatric Dentistry's policy document on Dental Neglect.[17]

The benefit for the children seen at these clinics would be a holistic approach to the identification of medical and dental needs. This health information would be easily collated and interpreted to provide a comprehensive report for Child Protection Case Conferences. It would also ensure appropriate professionals attended case conferences when required and thus allow the immediate referral of these children into the services they require.

Ethical approval was gained from the West of Scotland Research Ethics Committee. At the clinics the parent or carer with parental responsibility for the child, and the social worker who made the referral attended with the child. This allowed the social worker who made the referral to get immediate verbal feedback. As well as a full verbal opinion provided to the parent/carer and social worker, a standard pro forma clinical data collection sheet and a report of the examination were also completed. A clinical pro forma or check list has been reported to be beneficial in allowing clinicians to concentrate on complex issues while the simple ones are addressed for every patient, every time.[24]

DEVELOPMENT OF ASSESSMENT PAPERWORK AND PROTOCOL

The paperwork was based on a previously established CMA form. From this document a four page comprehensive oral assessment (COA) form was developed and piloted. Input from medical colleagues involved in the pilot allowed the form to be simplified to its current format which is seen in Figure 1.

The clinical examination consisted of a visual inspection for all children in accord with the British Association for the Study of Community Dentistry's criteria[25] and a basic periodontal examination for all of the children aged 7 years and older.[26] The examining dentist then provided a written summary of their findings and a plan for any action required.

DEVELOPMENT OF 'DENTAL APPENDIX TO COMPREHENSIVE MEDICAL ASSESSMENT REPORT'

Following the clinical examination a dental appendix report (Fig. 2) was completed and added to the paediatrician's medical report. This was requested by the paediatricians who wished the results of the dental examination to be reported by a dentist rather than to summarise the findings themselves. The appendix also included details of simple dental targets that were agreed with the accompanying adult as well as the clinic location for future dental appointments (treatment of active caries and a comprehensive preventive treatment plan). Setting targets for improvement is an action derived from multiagency good practice and it has been suggested that this might usefully be undertaken more often by paediatric dentists.[27]

MANAGEMENT SUPPORT

There have been challenges to overcome in the development of COA's for children with a welfare concern. Support from management in the Oral Health Directorate of NHS GGC was essential to start the clinics and to maintain them. This was achieved by regular meetings and update e-mails to management. Understandably management wanted to quantify the clinical involvement that would be required for the clinics from the start, but this has been difficult as the project was in its infancy and is still consistently gathering momentum.

DEVELOPMENT OF ROLES AND RESPONSIBILITIES OF DENTAL COORDINATOR

One of the most challenging aspects of these clinics is ensuring there is a dentist available to attend the CMA's. This led to the development of a 'roles and responsibilities' document for the coordinator of the dental input.

The document was developed with guidance from 'Protecting Children and Young People: Framework for Standards'[28] which states that professionals who work directly with children should understand child development and be skilled and experienced in communicating with children. They should understand the impact of parent's behaviour on the well-being of their children and know what action to take to protect the interests of each child, and make sure it is taken. They should also be knowledgeable and skilled in making informed assessments, plans and decisions; able to account for their assessments and decisions and competently present these in court, at hearings or in meetings; skilled in interagency working; and understand the role and contribution of other professionals.[28] These skills and attributes are part of the skill set that is acquired through a recognised specialist training pathway in paediatric dentistry, therefore it is sensible that the dental coordinator for these clinics should be someone on the General Dental Council's Specialist List in Paediatric Dentistry.

In addition these professionals should be equipped to deal with difficult situations including conflict and be supported by their colleagues and agencies and have systems in place to monitor this. They should also know the limits of their own knowledge and expertise and call on the skills of others or specialist services when needed. Importantly these professionals need to keep up to date with relevant legislation, research, good practice and guidance and their agencies should support them to do so.[28] There is also the possibility that any of the dental professionals involved in the CMAs may be asked to give evidence in court so it is important that the dental coordinator has training in court skills and can support and advise the other dental team members involved in identifying their training needs.

CASE REPORTS

To illustrate the importance of the COA'S as part of a CMA and to demonstrate the important role that dentistry plays in child protection, selected cases have been included.

Case 1

Case 1 is shown in Table 1.

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Comprehensive Oral Assessment
Of a child where there are welfare concerns

Child's surname:	Forenames:	
Known As:	DOB:	Sex:
Address:	CHI No:	
	Postcode:	
Siblings:	DOB DOB DOB	
GDP:	Date of Examination:	
Address:	Time of Examination:	
Location of Examination:	Emergency ☐	Planned ☐
Person accompanying child		

Consent to Health Assessment and Information Sharing
(source i.e. parent, young person, person holding parental rights)

Parent's signature:

	Name	Relationship	Date
Witnessed by:	Name	Position	Date

Referrer's concern: CSA ☐ Physical injury ☐ Emotional abuse ☐
Physical Neglect ☐ NOFTT ☐

Name:	Date of birth:

Concerns Raised by Child/Parent/Carer/Social Worker

(Tick box if problem raised and discussed)

Mouth pain ☐ Loss of sleep ☐
Diet/feeding ☐ Missed school ☐

Other (specify)

Comments:

Birth Details

Antenatal problems: e.g. maternal drug/alcohol misuse, pregnany induced hypertension, limited/no antenatal care.

Gestation:

Type of delivery:

Any Neonatal Problems:

(Give brief description e.g. SCBU, Jaundice, drug withdrawal etc)

Family Dental History

Include any Significant Family History

Adult attendence at dentist: Regular/Irregular/Only when in pain
How long since last attended

Child attendance at dentist:: Regular/Irregular/Only when in pain
How long since last attended?

Significant Health Problems

Include allergies, current medication if known, Hospital Admissions/A&E Attendances/Appointments

Name:	Date of Birth:

Oral Clinical Examination

Extra-oral:

TMJ

Lymphadenopahty: Y/N

Symmetry

Intra-Oral:

Soft tissues:

Lips

Cheeks

Tongue

Floor of mouth

Oral Hygiene:

BPE:

Teeth present:

Caries present:

Restorations:

Tooth wear:

Hypoplasia/Hypomineralisation:

Miscellaneous:

CONCLUSION/OPINION

Name:		Date of Birth:	
Summary of Findings (please report on each item)	**Yes (Y) or No (N)**	**Newly identified at this assessment (tick)**	**Currently under treatment (tick)**
Untreated Tooth Decay		☐	☐
Oral Sepsis/ Infection		☐	☐
Tooth Wear		☐	☐
Other (specify)		☐	☐

ACTION BY THE UNDERSIGNED CLINICIAN

1. Need for further assessment/treatment of medical/developmental problems. Refer child to:

Community Dentist ☐ Hospital Dental dept ☐
GDP ☐

Signed Date Time

Name in block letters	Designation	Review	Weeks

Copy this assessment to:

File ☐ Police ☐ School Nurse ☐
Parents ☐ GP ☐ Audit Office ☐
Social Work ☐ HV ☐ Other ☐ (please state)
Paediatrician ☐

Fig. 1 Comprehensive oral assessment (COA) form

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Name:	Date of birth:	Date of assessment:

DENTAL APPENDIX TO COMPREHENSIVE MEDICAL ASSESSMENT
FOR A CHILD WHERE THERE IS A WELFARE CONCERN
(to be completed by a qualified dentist)

Concerns raised

This child currently:
- Is registered/unregistered with a dentist
- Attends regularly/irregularly only when in pain

The last reported visit was _____
This child brushes _____ times per day with _____ ppm fluoride toothpaste which is appropriate/inappropriate for thier age.

CONCLUSION/OPINION (delete as required)

This child is in the _____ dentition.

They have untreated decay in _____ primary teeth and _____ permanent teeth.

There is/is no evidence of current oral sepsis

Oral cleanliness is _____

They are at low/medium/high risk of developing dental decay.

They have erosion affecting _____ primary teeth and _____ permanent teeth, which is mild/moderate/severe.

It is/is not likely that this child will have suffered considerable pain.

CARE PLAN

The child requires:
1. Full preventivedental plan including toothbrushing instruction, diet and oral hygiene advice, use of fluoride mouthwash/fluoride supplements, applications of fluoride varnish___times per year, fissure sealants on non-decayed back teeth and dental radiographs every ___months.
2. Further dental examination including radiographic examination
3. Treatment/urgent treatment of oral disease including restorations and/or extractions which may require local anaesthetic/general anaesthetic

TARGETS

The following targets have been agreed with _____
- Teeth have to be brushed twice per day with fluoride toothpaste.
- _____ has to be taken regularly to the dentist (this means every 3-6 months) for check ups as well as any treatment required.
- Advice from dental staff regarding diet and oral hygiene will be listened to and taken on board.

It has been agreed that appointments will be made at _____ for dental treatment.

Reasonably attainable targets have been set.
Failure to comply wiht these measures will result in _____ experiencing considerable pain and suffering.

SIGNATURES

_____ **(signature)** _____ (name) _____ (position)_____(date)

The social worker involved with this family contacted the Child Protection Unit requesting a CMA for this child and their siblings. The social worker advised the Child Protection Unit that there was an accumulation of various concerns for the family which included missed health appointments for the children, particularly dental appointments. Apart from the dental concerns no other health issues were identified. Following the CMA a remedial dental treatment plan was developed and implemented following direct referral to the Dental Hospital with very close support for the child from social services. Without the dental input in the CMA, many of the child's wellbeing needs may have been overlooked, and certainly the treatment she required would not have been as efficiently organised. This case highlighted numerous learning points for those working in both primary dental care and secondary (hospital) dental care including:

- Long standing problems with missed health appointments (most notably dental in this case) can be the main wellbeing concern for vulnerable children.
- After the block of missed appointments following 'social issues' were noted, however after this the child then failed to attend again and only a standard letter was sent out to the family telling them they had been discharged according to hospital policy. The BSPD policy document[17] recommends that missed appointment policies should not be punitive. This was an opportunity missed to help this family and safeguard this child's wellbeing.
- The child's siblings had also missed appointments for both assessment at the dental hospital and later for dental extractions under general anaesthesia. In a large dental hospital there is often no way of knowing the attendance history of a child's siblings and this is different from a general dental practice where the practice dental team may know the family more closely. In this case it should have raised alarm bells with the child's previous GDP when they received letters saying the children had failed to attend their appointments. These specific issues are mentioned in the 'Child Protection and the Dental Team' document[16] that was sent to all dental practices in 2006 and is also available online (www.cpdt.org.uk). It may be that the original GDP for this child was one of nearly half of GDPs in Scotland who have not read this document.[29]

Case 2

Case 2 is shown in Table 2.

This family consisted of three children aged 8 years, 6 years and 6 months respectively. Both older children were very compliant for dental examination. The children

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Table 1 Case 1: A 13-year-old	
Concerns raised before CMA	Issues identified during preparatory investigation and dental exam at CMA
Multiple missed health appointments, especially dental	Significant previous dental treatment including exposure and bonding under general anaesthesia
Bereavement issues in family	Multiple missed appointments at Dental Hospital in paediatrics and orthodontics in 2 blocks.
Poor school attendance	After the first block of missed appointments "social issues" were noted as the reason for missed appointments
Poor home conditions	Gold chain visible in mouth, with unerupted tooth still unerupted and loss of space for unerupted tooth
	Siblings had missed dental general anaesthetic appointments
	Previous discharge letters sent to previous GDP who had not raised any concerns

Table 2 Case 2: Siblings in one family
Issues identified during preparatory investigation and dental exam at CMA
Parent focused solely on baby (who has freshly laundered clothes, clean skin and hair and good oral hygiene), not interested in older children
Ingrained dirt on school uniforms
Skin and hair visibly dirty
Older children smelt unclean
Older children have active gross dental caries and poor oral hygiene
Parent blames children for oral condition "they never brush when I tell them to"
Poor attenders at GDP- fail to complete treatment although compliant

were registered with a general dental practitioner.

The children's parent was made aware of the dental needs of the children and targets were set. The parent elected to take the children back to their own dentist for treatment. A copy of the dental appendix to was sent to the children's general dental practitioner and a telephone call with the dentist confirmed they were registered but had failed to complete treatment. A few weeks later the dentist contacted the examining COA dentist as the children had not returned for their dental treatment. The COA dentist contacted the children's social worker who was able to inform them that the older children had been removed from the home and accommodated by social services. The CMA had played a role in the decision to remove the children from their parents. Without the dental input the children's wellbeing needs would not have been fully assessed. In addition the social worker asked permission to pass the dental report onto the new family GDP that the children would be attending.

Once again learning points were raised and included:

The older siblings in the family were obviously dirty and smelly on extra-oral examination and intra-oral examination revealed gross caries. The children were registered with a GDP, but the family were irregular attendees. The children were very compliant during the examination and the GDP agreed that they had also been compliant with previous treatment. Despite this, and coupled with their appearance, no concerns had been raised by the GDP. Again these alerting issues are mentioned in 'Child Protection and the Dental Team'.[16]

The use of target setting in this case was helpful in that it made clear to the family what was expected. As the targets had been set both the family and GDP knew what was expected so the GDP had a lower tolerance for future missed dental appointments.

This case highlighted the importance of information sharing. Without informing the GDP that their patients had been subject to a CMA and required dental treatment, the GDP would not have been aware of the increased importance of adequate follow up for these children. Additionally if the GDP hadn't contacted the examining COA dentist to share the information of the subsequent failure to attend it may never have been discovered that the children had been accommodated.

DISCUSSION

Setting up clinics to include a COA as part of a CMA has never been reported in the literature. The idea for CMA's has been around since the late 1990s and it is recognised that medical staff should have more of a role in informing those who make the decisions on the welfare of children. The model we have produced can be replicated elsewhere and it adds to the information available to those making the very difficult decisions with regard to what is best for children with identified wellbeing concerns.

CONCLUSION

Comprehensive oral assessment clinics have been successfully introduced and established as an integral part of CMAs for children with a welfare concern in Greater Glasgow and Clyde. An assessment protocol and standardised paperwork for COA's has been developed to enhance information sharing and patient access to appropriate care. This included a 'dental appendix' to the established CMA report. Discussion of cases from the COAs demonstrates the usefulness of dental input in these cases.

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