©Dan Kenyon/Stone/Getty Images Plus

Looked after children: an overview for the dental team

CPD questions

Read this article then answer four multiple choice questions to earn 1 hour of CPD. Visit the CPD Hub: https://go.nature.com/3Lt0KIC

This *BDJ* paper by **Lucy Ridsdale**,[1] **Laura Johnston**,[2] **Nadya James**[3] and **Richard Balmer**[1] addresses specific issues of consent for looked after children (LAC) and includes a flowchart as a working tool to determine who has consent in a variety of circumstances.

Abstract

Looked after children (LAC) are children and young people (CYP) who have been under the continuous care of the local authority for more than 24 hours. Reasons for becoming looked after include concerns about abuse or neglect, breakdown in family functioning, or absence of a suitable caregiver (for example bereavement, parental illness, or separation, such as for unaccompanied asylum-seeking children). Many LAC live with foster families, extended family, or in residential care homes, but a CYP can be legally 'looked after' and still be living with their original or birth family, or living independently with support. Regardless of the circumstances, the local authority has responsibility for meeting the needs of the CYP, including dental care, usually via a named social worker.

The evidence available suggests that LAC are at higher risk of dental caries and pain. In 2021, Public Health England reported on inequalities in oral health in England and although evidence was limited, found LAC to have poorer oral health and access to care. It is important that LAC are considered for enhanced prevention and reviewed regularly to enable appropriate provision of dental care. Understanding who can consent for dental treatment is essential.

Author information

[1]Paediatric Dentistry, Leeds Teaching Hospitals NHS Trust, Leeds Dental Institute, Leeds, UK; [2]Paediatric Dentistry, Birmingham Community Healthcare NHS Foundation Trust, Birmingham Dental Hospital, Birmingham, UK; [3]Community Paediatrics, Nottingham University Hospitals NHS Trust, Nottingham Children's Hospital, Nottingham, UK.
*Correspondence to: Lucy Ridsdale
Email: lucyridsdale@nhs.net

Who are looked after children?

Looked after children (LAC) are children and young people (CYP) who have been under the continuous care of the local authority for more than 24 hours.[1] LAC may also be called children in care or children looked after. A CYP may be looked after for a few days or their whole childhood, up until their eighteenth birthday.

LAC may be living with a registered foster carer, extended family, in residential care, in respite care, semi-independent living, on remand, or still living in the home with their birth family despite being legally 'in care'.

In 2018/2019, there were approximately 102,000 LAC in the UK and since 2010, the total number of LAC has increased year-on-year.[2] There are lots of reasons why a child may enter the care system and become looked after, including neglect, physical or emotional abuse, breakdown in family functioning, or absence of a suitable caregiver (for example, bereavement, parental illness, or separation which may include unaccompanied asylum-seeking children).[3] For whatever reason, they can no longer remain in the sole care of their original or birth family. Figure 1 summarises the different circumstances in which a child would be described as an LAC.

A child stops being an LAC if they are adopted, return to their original or birth

© The Author(s), under exclusive licence to British Dental Association 2023

family (without being 'looked after'), or turn 18 (although local authorities are required to support children who are leaving care until they are at least 21). Definitions surrounding LAC vary slightly across the UK and it is important that dentists familiarise themselves with the terms used in their area.

Children who are not LAC

There are a range of circumstances where children may have involvement from children's social care or someone other than their birth parents may also hold parental responsibility (PR), but the child is not an LAC. Dentists should be aware of these circumstances, which include the following:

Child in need

Child in need (CIN) applies to CYP who are unlikely to achieve or maintain a reasonable standard of health or development without the provision of services by a local authority. This can be due to disabilities, safeguarding concerns and wider family difficulties. A CIN plan is produced which sets out the support that will be provided to the child and family. Engagement with a CIN plan by the family is voluntary.

Child protection plan

If a CYP is considered to have suffered or be at risk of suffering significant harm due to physical, emotional or sexual abuse or neglect, a legal threshold is met for Section 47 enquiries, which decide what action is required to safeguard and promote the welfare of the child and may lead to an initial child protection conference. This is chaired via social care but routinely involves health, education, the CYP and family, and may involve other agencies such as the police. The outcome may be a child protection plan, which documents responsibilities and actions to be taken to keep the child safe. Failure to engage with a child protection plan by the family can lead to legal proceedings by the local authority.

Post-adoption

Adoptive parents go through a detailed process of screening and suitability testing before being matched to a CYP. When a CYP is adopted, a new legal identity is created, complete with a new NHS number. The adoptive family assume PR and can legally change the CYPs name to reflect their new life.

Children with a special guardianship order

The process and screening for a special guardianship order is less lengthy than for adoption and this is most often applied for by a connected adult or someone linked by kinship (for example, grandparents). It is usually for long-term placements where fostering or adoption is not felt to be the best option for the individual CYP. The special guardianship order holder shares PR with birth parents, but can exercise their PR to the exclusion of any other PR holder (including birth parents).

Children with a child arrangement order (previously known as residence order)

A child arrangement order is a court order about residency. It may be sought if there is a dispute about living or contact arrangements between estranged parents, but can also be applied for by anyone who can 'claim an interest' for the child (for example, grandparents, siblings, step-parents). The

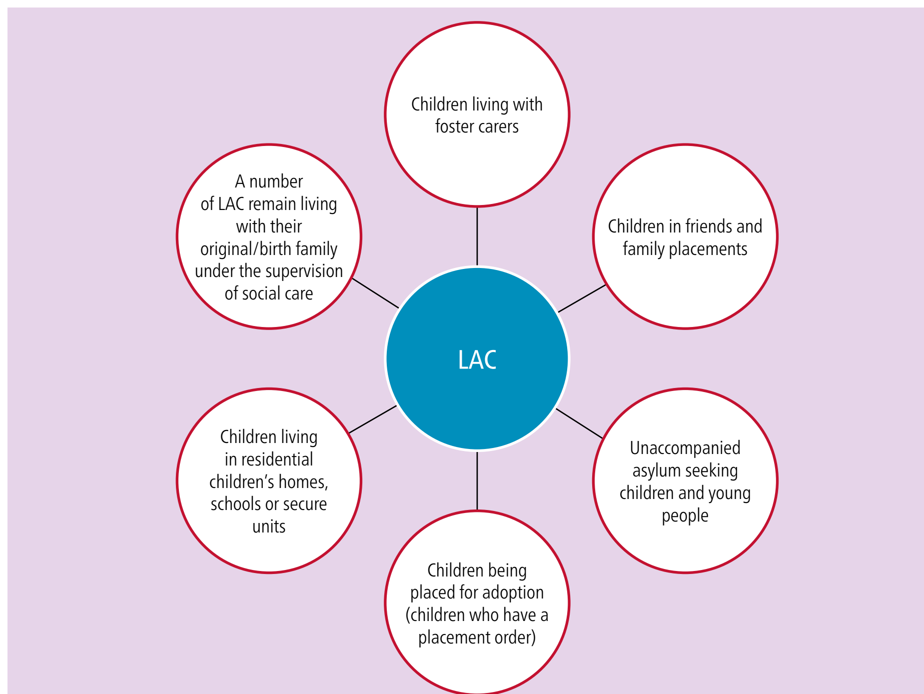

Fig. 1 Summarises the different circumstances in which a child would be described as a looked after child (LAC)

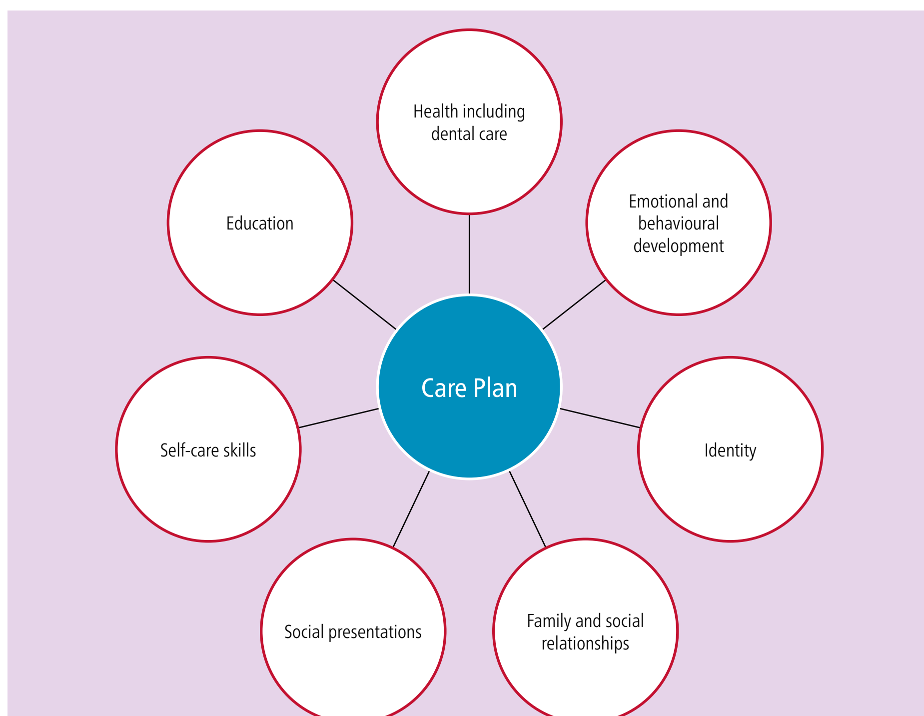

Fig. 2 An LAC's personal care plan sets out how their needs will be met in a wide range of areas. The areas covered as part of the plan are demonstrated here

© The Author(s), under exclusive licence to British Dental Association 2023

child arrangement order can stipulate conditions, such as who can be present when a child stays with another parent. Those with a child arrangement order share PR with birth parents.

'Private fostering'

Private fostering is the term used when a CYP under the age of 16 (or 18 if the young person has a disability) resides for more than 28 days with someone who is not a parent or close relative (sibling, grandparent, aunt/uncle or step-parent). By law, the local authority must be notified so that they can ensure the CYP's welfare and also advise and support the adults caring for them. Private fostering arrangements do not grant PR.

Table 1 Examples of key questions to ask and information to document when providing care for LAC

Key questions to ask	Key information to record
Who is the named social worker?	• Record name, contact number and (if available) secure email
Who has parental responsibility for the child or young person?	• Document who parental responsibility lies with. This may be more than one person • If there is any uncertainty, this should be confirmed with the child's social worker
Who do they live with?	• Document who the child lives with currently • Check if the address is protected and ensure that all team members are aware the address must not be disclosed • The carer may or may not be aware of how long the child will be with them for

Care planning for LAC

When a child becomes an LAC, a personal care plan is formulated for them. This identifies current and predicted needs and how these are to be met in terms of health, education, placement (where they live and with whom) and any other identified areas. A multi-agency approach is taken to ensure the child receives the right care. This is usually led by the LAC social care team, including a named social worker. Figure 2 shows the areas which may be covered as part of a personal care plan.

An essential part of the personal care plan is the initial health assessment (IHA). When a child is taken into care, the local authority must arrange for this statutory health assessment within 20 working days.[4] This is conducted by a paediatrician or specialist doctor and a report and health plan is produced.[5] Oral health needs and a plan for ongoing dental care provision form

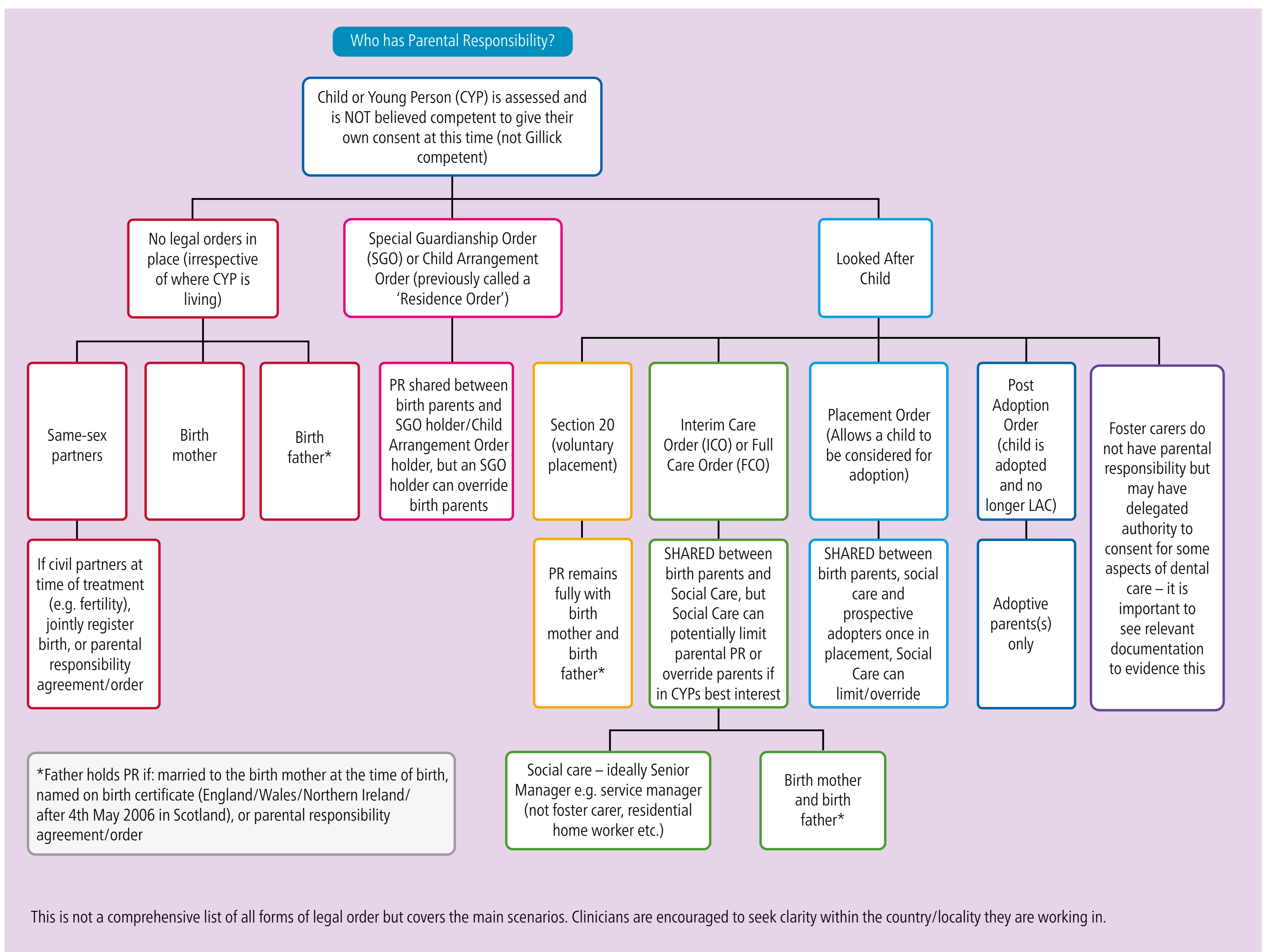

Fig. 3 A flowchart demonstrating who holds parental responsibility for children in a variety of situations, including for LAC

© The Author(s), under exclusive licence to British Dental Association 2023

part of the health plan and report.[6] Social care has overall responsibility for ensuring that CYP receive the health care services they require as set out in their health plan and this will include regular attendance with dental services.

LAC will be under the care of a specific local authority. The local authority that is responsible for the child is usually determined by their original home address. If the child moves to a different region, they will usually remain under the care of the original local authority unless agreed otherwise.

Oral health of LAC

There is little evidence available on the oral health of LAC. They are not identified as an individual group in local or national dental health surveys. Dental checks as part of the IHA may only document if children have had a dental visit and do not always identify the dental health of the child.

The 'Let's talk about teeth' project[7] looked at the dental health needs of LAC in Tower Hamlets, England. They found that 36% of 5 to 11-year-old LAC had experienced tooth decay in their primary teeth. Also, 12 to 15-year-old LAC had a higher number of decayed, extracted and filled permanent teeth than the general 12-year-old population in Tower Hamlets, while 19% had one or more untreated, decayed permanent tooth. They also found that a higher proportion of LAC had a tooth fracture when compared to their peers. Furthermore, 32% of 12–15-year-olds reported that a dental problem had affected their daily lives in the preceding three months.

Sarri *et al.*,[8] conducted a school-based study in East London and found that LAC experienced a higher proportion of neglect in both prevention of oral disease and seeking dental treatment. Keene *et al.*[9] looked at the dental health of children on a child protection plan and found them to have increased levels of dental decay compared to those not on a plan, it may be reasonable to suppose that LAC have a similar experience.

Williams *et al.*[10] found that on entry to care experienced social workers and residential and foster carers reported LAC had poor dental attendance, oral hygiene and diet. They found previous poor dental attendance contributed to high levels of anxiety and appointment refusals for some children. Many older LAC displayed poor attitudes to oral health, with some children having little experience of cleaning their teeth at all. When compared with children living at home, children looked after by local authorities were significantly more likely to receive inadequate dental care.[11]

> *'Oral health needs and a plan for ongoing dental care provision form part of the health plan and report'*

Being informed – caring for LAC

LAC may live with a family member, in the home of a foster carer, or in a residential care home. A carer's role is to provide daily care for the child, including meeting their health needs. It is the responsibility of carers to make sure a child attends their health and dental appointments.

It is easy to assume an adult accompanying a child is their parent, but this is not always the case. For any child attending a dental appointment, it is wise to make it routine to ask the CYP themselves 'who have you brought with you today?' and ask the adult directly their relationship to the CYP.

All LAC will have a named social worker and their name and contact details should be recorded in the patient record. The social worker can provide a point of contact if a child's appointments are missed, if you have concerns, or to discuss who can consent for treatment. If urgent advice is required, this can be obtained from the children's social care team, either via the child's social worker or the duty social worker.

If a CYP is in care, the address they are living at may be confidential. Extra care must be taken not to inadvertently disclose it to anyone – including birth parents or extended family members. Particular care should be taken when sending appointment letters. If you suspect a breach may have occurred, the social worker or duty team should be notified immediately.

Table 1 provides examples of key questions and information to document in the patient record for LAC.

Providing dental care for LAC

In order to provide the best dental care for LAC, an understanding of their individual needs and situation is essential. LAC may move address frequently, with more than 10% of CYP having three or more placements in a year.[12] It is therefore important to establish LAC's dental needs early and prioritise dental care for this group.

Although providing care in a timely manner is necessary, it is also important to acknowledge that LAC may require more support in order to receive the dental treatment they need. LAC have many of the same health issues as their peers, but the extent of health concerns is often greater because of their past experiences,[6] which may include medical and dental neglect. LAC may have suffered significant emotional trauma and this should be considered when familiarising a child to a new environment or procedure. LAC are almost four times more likely to have special educational needs than children who are not care-experienced and providing tailored support can improve their dental experience and outcome.[13]

Although LAC may have increased dental needs, many of them can and do have oral health care provided in general dental practice. Where treatment is required under general anaesthetic or sedation, or for children with complex medical needs, referral to specialist services may be required. Wherever care is delivered, regular dental review is important and enhanced prevention, in line with the *Delivering better oral health toolkit*,[14] should be provided.

Consent for dental treatment for LAC

Being an LAC does not alter when and if a young person is able to give consent for their own treatment. Once a child reaches the age of 16, they can consent for their own dental care providing they have capacity.[15] Children under the age of 16 can consent if they are considered to be Gillick competent and are able to understand the proposed treatment, including its consequences and alternatives and can retain the information, use it to make a decision and communicate that decision.

For children below the age of 16 and not considered to be Gillick competent, or those aged 16–18 and lacking capacity, it is essential to understand who holds PR and can consent for the child to receive dental care. For those children unable to consent for themselves, it is essential that their wishes and feelings are still considered. Their right to participate in decisions about themselves is enshrined in the *United Nations Convention on the Rights of the Child*.[16]

Figure 3 gives guidance on determining who holds PR in a variety of situations, including for LAC.[17] PR is only fully

© The Author(s), under exclusive licence to British Dental Association 2023

relinquished by birth parents in specific circumstances, such as adoption or once a child reaches age 18. In other circumstances, PR may be shared between adults or adults and social care. In most situations, consent is only needed from one individual with PR. In a few select circumstances (such as changing the name of the child or moving the child abroad), consent does require wider agreement with all who hold PR. In the case of disagreements, or if it is unclear who holds PR for a LAC, contact children's social care to discuss. You may also ask to see copies of any legal consent documents or court orders and may consider contacting your indemnity provider.

A foster carer can have delegated authority. This means that someone with PR (for example, a birth parent) has signed to say that a foster carer can act on their behalf for some specified decisions. This may be to seek 'routine' health care, such as taking the child to the general practitioner for a cough or giving needed medicines, and standard dental check-ups. It does not enable a foster carer to consent for general anaesthetic, immunisations, genetic testing and other specific interventions. It also does not give the foster carer authority to know information about other members of the CYP's family or any 'third party' information in the CYP's past records.

Was not brought

If LAC are not brought to dental appointments, it is important that the social care teams supporting them are made aware of this, if appropriate. A specialised pathway has been developed to help simplify management of missed appointments for LAC.[18] The social worker has a responsibility to ensure the child's dental needs are being appropriately met. Inform the social worker of missed appointments and any concerns you may have around the child's dental care.

Conclusion

LAC are more likely to present with dental disease and may have little experience of dentistry. They may also be dentally anxious. It is important that their dental needs are identified and managed and care is prioritised. Some LAC may require additional acclimatisation. Identifying who has PR and working with the multidisciplinary health and social care team will help to ensure that these children are supported to receive the best care possible.

This article was originally published in the BDJ *on 13 January 2023 in Volume 234 pages 34–38.*

Ethics declaration

The authors declare no conflicts of interest.

Author contributions

Lucy Ridsdale and Richard Balmer had the original idea for the article. Lucy Ridsdale, Laura Johnston, Nadya James and Richard Balmer were all involved in writing the original draft and reviewing and editing. Nadya James produced the original document on which Figure 3 is based.

References

1. UK Government. Children Act 1989. 1989. Available at https://www.legislation.gov.uk/ukpga/1989/41/part/I (accessed November 2021).
2. National Society for the Prevention of Cruelty to Children. Statistics briefing: looked after children. 2021. Available at https://learning.nspcc.org.uk/media/1622/statistics-briefing-looked-after-children.pdf (accessed October 2021).
3. Hawkey N. Looked-after children and introducing a WNB pathway to support their care. *BDJ In Pract* 2020; **33:** 29.
4. UK Government. The Care Planning, Placement and Case Review (England) Regulations 2010. 2010. Available at https://www.legislation.gov.uk/uksi/2010/959/contents (accessed October 2021).
5. UK Government. IRO Handbook: Statutory guidance for independent reviewing officers and local authorities on their functions in relation to case management and review for looked after children. 2010. Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/337568/iro_statutory_guidance_iros_and_las_march_2010_tagged.pdf (accessed October 2021).
6. UK Government. Promoting the health and well-being of looked after children. Statutory guidance for local authorities, clinical commissioning groups and NHS England. 2015. Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1100188/Promoting_the_health_and_well-being_of_looked-after_children_August_2022_update.pdf (accessed October 2021).
7. Local Government Association. Healthy futures: Supporting and promoting the health needs of looked after children. 2016. Available at https://www.local.gov.uk/sites/default/files/documents/healthy-futures-supportin-9cf.pdf (accessed August 2021).
8. Sarri G, Evans P, Stansfeld S, Marcenes W. A school-based epidemiological study of dental neglect among adolescents in a deprived area of the UK. *Br Dent J* 2012; DOI: 10.1038/sj.bdj.2012.1042.
9. Keene E J, Skelton R, Day P F, Munyombwe T, Balmer R C. The dental health of children subject to a child protection plan. *Int J Paediatr Dent* 2015; **25:** 428–435.
10. Williams A, Mackintosh J, Bateman B *et al.* The development of a designated dental pathway for looked after children. *Br Dent J* 2014; DOI: 10.1038/sj.bdj.2014.51.
11. Williams J, Jackson S, Maddocks A, Cheung W Y, Love A, Hutchings H. Case-control study of the health of those looked after by local authorities. *Arch Dis Child* 2001; **85:** 280–285.
12. UK Government. Improving permanence for looked after children. 2013. Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/264952/final_improving_permanence_data_pack_2013_sept.pdf (accessed October 2021).
13. UK Government. Outcomes for children looked after by local authorities in England. 2018. Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/794535/Main_Text_Outcomes_for_CLA_by_LAs_2018.pdf (accessed October 2021).
14. UK Government. Delivering better oral health: an evidence-based toolkit for prevention. 2014. Available at https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention (accessed August 2021).
15. Dental Defence Union. Consent and Young Patients. 2022. Available at https://www.theddu.com/guidance-and-advice/guides/dental-consent-and-young-patients (accessed November 2022).
16. United Nations Human Rights Office of the High Commissioner. Convention on the Rights of the Child. 1989. Available at https://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx (accessed August 2021).
17. Future NHS. Who has Parental Responsibility? 2020. Available at https://future.nhs.uk/safeguarding/messageshowthread?threadid=8313:326 (accessed December 2021).
18. Kirby J, Harris J C. Development and evaluation of a 'was not brought' pathway: a team approach to managing children's missed dental appointments. *Br Dent J* 2019; **227:** 291–297.

https://doi.org/10.1038/s41407-023-1782-9

© The Author(s), under exclusive licence to British Dental Association 2023