Dental caries in children: a sign of maltreatment or abuse?

Nurses are often the first to detect distress in young patients. David Heads and colleagues examine whether tooth decay can be an indicator of neglect.

In England, in 2010, there were 35,700 children registered on a child protection plan and 44,500 other substantiated cases of child maltreatment, in total representing 0.54 per cent of the English child population (Childhood Wellbeing Research Centre (CWRC) 2011). These figures are likely to be underestimates and anamnestic reporting by the National Society for the Prevention of Cruelty to Children (NSPCC) found levels of severe child maltreatment in 5.9 per cent of children under 11 years of age, 18.6 per cent of 11-17 year olds and 25.3 per cent of 18-24 year olds (NSPCC 2011).

Many cases go unreported and the issue of safeguarding children was highlighted in England after the death of Victoria Climbié and, more recently, Peter Connelly (Baby P). The enquiry into Victoria Climbié’s case by Lord Laming led to changes in reporting procedures and highlighted the need for better communication between social services, the police and healthcare professionals, culminating in a multiagency approach via local safeguarding children boards (LSCBs) (Laming 2003).

Dental neglect and safeguarding

NHS trusts in the UK require their staff to participate in safeguarding children training and a number of organisations produce guidance, much of which mentions dental caries in children. Safeguarding Children and Young People from the Royal College of Nursing (RCN) (2007) emphasises types of abuse and neglect, although dental caries is not specifically mentioned. The Child Protection Companion, written for doctors in the UK, states that signs of neglect may also be found in the mouth – decayed, unfilled teeth, and poor dental hygiene (Royal College of Paediatrics and Child Health 2006). It suggests that decayed and unfilled teeth in a child are signs of

IN SAFEGUARDING children training, dental caries and poor oral health are often considered as signs of a neglected child. This article examines whether all cases of untreated decay, unfilled teeth or poor oral hygiene in children should be treated as signs of neglect. It also discusses the role of children’s nurses in dealing with child neglect issues.

Child maltreatment constitutes physical, emotional or sexual abuse and neglect. Working together to safeguard children (Department for Education 2013) defines neglect as ‘the persistent failure to meet a child’s basic physical and/or psychological needs, likely to result in the serious impairment of a child’s health or development’. It states that a parent or carer may neglect a child by failing to prevent harm or ensure access to appropriate medical care or treatment.

Abstract

Healthcare professionals are required to complete regular training in safeguarding children and, in this training, dental caries and poor oral hygiene are often cited as potential indicators of neglect. Nurses may be the first healthcare professionals to detect poor oral health in a child, although unfortunately the relationship between neglect and dental caries in children is unclear. Any healthcare professional suspicious of child abuse or neglect has responsibility to follow the appropriate protocol and report their concerns. If dental neglect is suspected then the opinion of a dentist will be required as part of the investigation.

Keywords

Child abuse, child protection, dental caries, oral hygiene, neglect, safeguarding
neglect, but this needs qualification. Child Protection and the Dental Team (Department of Health 2005) provides case reports to work through and discusses examples where dental caries may represent neglect. Lastly, the clinical guideline When to Suspect Child Maltreatment from the National Collaborating Centre for Women’s and Children’s Health (NCCWCH) (2009) is prescriptive, advising readers to consider neglect if parents or carers have access to, but persistently fail to, obtain NHS treatment for their child’s dental caries. It advises healthcare professionals to suspect neglect if parents or carers fail to seek medical advice for their child to the extent that the child’s health and wellbeing are compromised, including if the child is in ongoing pain.

The perception that dental caries is a sign of neglect is embedded in safeguarding children training, but the literature linking dental caries and child maltreatment is scant and difficult to relate to the UK. Two case-control studies have compared the oral health of abused and non-abused children on American military bases (Greene et al 1994, Greene and Chisick 1995). Both found that there were no statistical differences in lifetime dental caries among abused and non-abused children. However, abused children were more likely to have untreated caries in the permanent dentition (Greene et al 1994).

Another study found that early childhood caries is more prevalent among abused children than non-abused children but this latter study lacked controls for confounders, such as socioeconomic factors (Valencia-Rojas et al 2008). It is well known that children from lower socioeconomic classes are more vulnerable to abuse and neglect (NSPCC 2008), however, to our knowledge, there are no published reports describing the association between prevalence of dental caries, socioeconomic status and child maltreatment.

Dental caries The British Association for the Study of Community Dentistry (BASCD) last published statistics for dental caries experience in the UK in 2005. It found that 39.4 per cent of five year olds had a decayed, missing or filled tooth (DMFT) index greater than one (BASCD 2005). The DMFT index pulls together caries prevalence in teeth by counting up the fillings, missing teeth (extracted because of caries) and frank caries. Ideally the score on this index should be 0, so a DMFT score of more than 1 in nearly 40 per cent of the children tested indicates a baseline when looking at abused children.

However, this level of dental caries is much higher than the prevalence of child maltreatment, which is reported to be 0.54-25.3 per cent (CWRC 2011, NSPCC 2011). Not every case of dental caries can be considered to be child abuse. The British Society of Paediatric Dentistry (BSPD) (Harris et al 2009) states that diagnosis of dental neglect cannot be based purely on clinical findings and that several other dental and non-dental factors need to be taken into account.

Unfortunately, widespread inequalities in dental health do still exist in the UK. In fact the average dental disease level of children living in the most deprived regions is three times greater than those living in the least deprived regions (Robertson et al 2011). The NHS provides free dental care for children and so in theory financial inequalities should not exist, although the cost of travel may still provide a barrier. There is also evidence of inequalities in UK dental service provision, with fewer services provided in the areas of greatest need (Harris et al 2009). This may result in vulnerable children in deprived areas of the UK never coming into contact with dental health professionals who can assess their dental needs (Sarri and Marcenes 2012). Children’s nurses and health visitors may be the first healthcare professionals to encounter a child with dental caries or poor oral health. Although there is no responsibility to diagnose dental neglect or even child neglect in this instance, it is still a requirement to raise a concern.

Patterns of behaviour for accessing dental services may be passed from a parent or carer to their child, and it is estimated that 22 per cent of adults in the UK access dental services only when they have dental symptoms and many do not return for necessary treatment. The reasons include phobia, finance, access and a low value of oral health (Nuttall et al 2011). In general, parents are distressed to discover that their child has dental caries, however, in some communities dental caries has become socially acceptable, and there exists a ‘rite of passage’ to extract multiple decayed teeth in children aged around seven under general anaesthetic (Harker and Morris 2005). The BSPD makes the distinction between parents who, once informed of their child’s oral health, subsequently seek treatment and those who do not, in the absence of any barriers (Harris et al 2009). This is an important distinction because not all children with marked caries are neglected. However, neglect should be considered when a child’s parent or guardian is made aware of the need for treatment, which they then fail to act on.

Furthermore, some dental clinicians consider that carious deciduous teeth can be managed conservatively without restorative intervention. Evidence does show that many carious teeth do
not cause pain and infection, and may be observed with a conservative approach using fluoride, diet modification and monitoring (Levine et al 2002). It is therefore possible that a child with apparently untreated dental caries may be following a conservative treatment plan, which was formulated by their dentist. All of the above factors mean it is difficult to identify dental caries or poor oral hygiene as an indicator for neglect, as consideration must be given to dental caries in the population, service provision, parental attitude to oral health and how the patient’s dentist might be managing the case.

Safeguarding protocols

The Nursing and Midwifery Council (NMC) code advises nurses to disclose information, in line with the law, if someone may be at risk of harm (NMC 2008). Safeguarding concerns should be reported according to the local safeguarding board, trust or university policy while bearing in mind responsibilities to inform authorities of any breach in criminal law. Safeguarding guidance from the RCN (2007) also discusses the steps to follow and recommends contacting the organisation’s designated safeguarding nurse for advice, if necessary.

LSCBs are local interagency forums that bring together the local authority, police and health workers to work more effectively in safeguarding children. They will always provide advice and clarify steps to be followed when raising concerns of child abuse and neglect. Flow chart protocols are available from Working Together to Safeguard Children (Department for Education 2013) for referral to safeguarding authorities and the protocol for when urgent action is required for child protection. The document also includes recommendations on the frequency and level of training required by different staff members – including nurses – although clarification should be available from local trust safeguarding representatives with respect to the level and frequency of training.

Conclusion

The clinical finding of dental caries in children is not a reliable indicator of neglect, since consideration should be taken of socioeconomic factors, parental attitudes, barriers to access and whether the dentist is managing the case with a conservative approach. Due to healthcare inequalities, those with highest dental need may never present to a dentist, so children’s nurses may be the first healthcare professionals to encounter a child with dental neglect. Whenever there are concerns that a child is being abused or neglected, whether dental caries or poor oral hygiene are potential indicators or not, local safeguarding protocols should be followed. As part of the investigation into neglect, a child’s dental health may need to be reviewed by a dentist.

References


