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Safeguarding and children's oral health:

what to look out for in primary care

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INTRODUCTION

Child neglect or maltreatment can manifest in the oral cavity and present in GP consultations. Even though oral injuries are mentioned in general safeguarding training, and the Royal College of General Practitioners Curriculum makes reference to oral conditions and dental problems, GPs tend to undergo little formal teaching in oral health. Therefore, they tend to be less confident in spotting and acting upon signs of oral maltreatment and neglect than for other areas of the body. This article gives a brief summary of what GPs should look out for, and how they should respond to such concerns.

CASE SCENARIOS

Case 1

A 5-year-old boy is brought by his mother to the GP surgery for behavioural problems. She asks for a Child & Adolescent Mental Health Service (CAMHS) referral. When the boy smiles you notice many decayed teeth. What should you do?

Case 2

A 3-year-old girl presents with a 3-day history of fever and otalgia. The right tympanic membrane is red, the throat normal, but you notice a 1 cm-diameter, clearly demarcated red patch on the hard palate. Is this palatal lesion a concern? What should you do?

DENTAL CARIES

Childhood dental caries is common. In 2019, in England one quarter of 5-year-old children had dental decay.[1] This decay had a greater prevalence among children of 'Other Ethnic Groups', Asian/Asian British groups, and those living in the most deprived areas.[1] Dental decay is also more common in children who are overweight and children of refugees.[2,3] It has been shown that children who are subject to child protection plans have significantly higher levels of dental caries in the primary dentition.[4] Having four or more adverse childhood experiences is associated with a higher likelihood of inadequate dental care in childhood.[5]

Left untreated, childhood caries can cause pain, dental abscesses and facial swelling, difficulties with eating, sleeping, playing, and socialising, and can impact on school attendance. Tooth decay is the most common reason for hospital admission in children aged 6 to 10 years of age.[6] One small study showed that more than one half of the children who are admitted with acute dental abscesses are already known to social services.[7]

It can be difficult to know when dental decay indicates dental neglect. The authors of one systematic review (which represented 1595 children) felt unable to establish from the literature a definitive threshold at which dental caries signals neglect.[8]

The British Society of Paediatric Dentistry defines dental neglect as *'the persistent failure to meet a child's basic oral health needs, likely to result in the serious impairment of a child's oral or general health or development'*.[9] Therefore, it is the suggestion of the present authors that when a GP sees a child with obvious dental decay they ask the parent/carer or child about their frequency of tooth brushing, and whether they have seen a dentist recently. If so, what was the outcome? Did they comply with treatment recommendations? If they have not seen a dentist, the GP should ask why not. If they have found it difficult to access dental care, the GP should consider signposting them to the NHS website 'How to find an NHS dentist' (https://www.nhs.uk/nhs-services/dentists/how-to-find-an-nhs-dentist/), though it must be acknowledged that access to NHS dental services is inconsistent across areas. If they fit the referral criteria of the local community dental service (CDS), the GP should consider referring them there. CDSs provide dental treatment for children, adults, and older people who, because of additional needs (for example, learning disabilities, physical activity limitations, and vulnerabilities), cannot access general dental

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care. Even though access and referral criteria will vary depending on area, most CDSs accept patients who are under the care of a hospital or community-based consultant, or if there are safeguarding concerns. GPs should always ask if they have experienced any pain or other problems with their teeth or mouth, and should enquire about home life and other potential indicators of maltreatment. As with any other safeguarding concerns, safeguarding concerns about oral health should be referred promptly to Children's Social Care (CSC).

ORAL TRAUMA

While accidental intra-oral injuries are common in childhood (once a child is mobilising independently), the oral cavity can be the target or a site of physical abuse. In one study of 2890 child abuse consultations, 3.3% ($n = 96$) of children had an oral injury.[10] Such injuries can include contusions, burns, lacerations of the tongue, lips, buccal mucosa, palate (soft and hard), gingiva, alveolar mucosa, or frenulum, and fractured teeth and facial bones.[11] A torn frenulum has been regarded as pathognomonic of abuse. However, one systematic review concluded that, in isolation, a torn frenulum does not necessarily indicate abuse, but that it should prompt a careful examination of the intra-oral hard and soft tissues and, where concerns arise, appropriate specialist referral.[12] Posterior pharyngeal injuries and retropharyngeal abscesses can be due to fabricated or induced illness (FII) to simulate haemoptysis.[11]

The present authors suggest that, where there are any concerns that abuse could have occurred, a referral should be made to CSC. This would include any intra-oral injury in a non-mobile child, delays in presentation, multiple injuries in different stages of healing, bruising of the palate, or unexplained oral injuries (as listed above).

SEXUAL ABUSE

In children, the oral cavity can be subject to sexual abuse. Though visible oral injuries or infections are rare, unexplained injury or petechiae of the palate, especially at the junction between hard and soft palate, can be the result of forced oral sex.[11] The GP should take a good history and consider the context. For instance, palatal petechiae can occur in acute strep pharyngitis.[13] Any concern of the possibility of sexual abuse must trigger a CSC referral (Box 1).

CONCLUSION

GPs should remain aware of and vigilant to the possibility of oral presentations of maltreatment or neglect in children, and have the confidence to refer to CSC if they are concerned.

Box 1. Reasons to refer to Children's Social Care

Dental caries

- When there is evidence of persistent failure to meet the child's basic oral health needs, which may result in serious impairment of the child's oral health, general health, or development.

Oral trauma

- Intra-oral injury in non-mobile child.
- Delayed presentation or explanation of cause inconsistent with injury.
- Multiple injuries in different stages of healing.
- Bruising of the palate.

Sexual abuse

- Unexplained injury or petechiae of the palate, especially at the junction between the hard and soft palates.
- Oral warts.

Case 1
On further questioning, the boy has seen a dentist and is due to see the community dental service next week. His mother admits it is hard to look after him and her other children. With her consent you ask his school to initiate an early help assessment (CSC referral not indicated).

Case 2
Because no plausible explanation is given for the palatal lesion you obtain consent for clinical photography and refer to CSC.

Useful resources
- Kidsvids at British Society of Paediatric Dentistry (https://www.bspd.co.uk/Kidsvids).
- British Society of Paediatric Dentistry, *A policy document on dental neglect in children* (https://www.bspd.co.uk/Professionals/Resources/Policy-Documents).
- Public Health England, *Health matters: child dental health* (https://www.gov.uk/government/publications/health-matters-child-dental-health/health-matters-child-dental-health).

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