

DARTMOUTH DENTAL PRACTICE

24 Victoria Road
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Marian Roberts BDS (Sheffield) GDC 61688
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Health And Safety Policy Statement

Why have a health and safety policy statement?

Every business with five or more workers must by law write down its policy for their health and safety.

An explicit health and safety policy demonstrates to all of us, as employer and employee, that we care for the welfare of all who work at the practice. Writing it down helps us to think through the arrangements we have made and highlight those that have yet to be put in place.

The law requires us to have a written statement of our general policy describing our “organisation and arrangements” for carrying out the policy. As an employer we are obliged to bring the policy, and any revisions, to the attention of all our employees. This health and safety policy statement covers those matters relevant to running the dental practice.

About this policy statement

This policy statement is in three sections:

Section A makes a general declaration based on our obligations under the Health and Safety at Work etc Act 1974. It then shows who is responsible for what within the practice.

Remember that both employer and employee have responsibilities under the law to take care of themselves and others and to cooperate with what we are doing.

Sections B and **C** give our arrangements in greater detail. **Section B** deals with certain general arrangements that apply to most or all workplaces. **Section C** deals with particular hazards that may apply to dental practices.

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Section A

GENERAL STATEMENT OF POLICY

Our policy is to provide and maintain safe and healthy working conditions, equipment and systems of work for all our employees and to provide such information, training and supervision as they need for this purpose. We also accept our responsibility for the health and safety of other people who may be affected by our work activities. This policy applies to all employees of the practice, dental associates, dental hygienists and other contractors providing services to the practice, such as anaesthetists.

The allocation of duties for safety matters and the particular arrangements that we will make to implement the policy are set out below.

This policy will be kept up to date, particularly as changes occur within the practice. To ensure this, the policy and the way in which it has operated will be reviewed every year.

Signed



Practice Owner

Date Thursday, 3 November 2011

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Communication

The practice owner regards communication between staff at the practice as an essential part of health and safety management. Consultation on health and safety matters will be facilitated by means of practice meetings every month or as often as is deemed necessary.

Co-operation between staff at all levels is essential. All staff are expected to cooperate and accept their duties under this health and safety policy. Disciplinary action may be taken against any employee who fails to follow safety rules or carry out duties under this policy.

Responsibilities

1. Overall and final responsibility for health and safety matters within the practice lies with Marian Roberts practice owner
2. Marian Roberts is responsible for this policy being carried out at the practice at Dartmouth Dental Practice. Dr Stephen Pepperrell will be responsible as her deputy.
3. The following are responsible for safety in particular areas:
 - 3.1. Marian Roberts - infection control, including clinical waste
 - 3.2. Marian Roberts - radiation safety
 - 3.3. Marian Roberts - mercury handling/hygiene
 - 3.4. Marian Roberts - risk assessments including COSHH, manual handling, display screen equipment
4. All employees have the responsibility to co-operate with supervisors and managers to achieve a healthy and safe workplace and to take reasonable care of themselves and others.
5. An employee, supervisor or manager who notices a health or safety problem, which s/he is not able to put right, must tell the appropriate person named above.
6. Other people responsible for:
 - 6.1. Safety training - Marian Roberts
 - 6.2. Investigating accidents - Marian Roberts
 - 6.3. Monitoring maintenance of equipment - Keith Roberts

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Section B

General Arrangements

Local Health and Safety Executive:- address

HSE, Ballard House, Weston Lane, Plymouth PL1 8BL Tel 01752 276 300

Accidents

The qualified first-aider / appointed person for the practice is Marian Roberts.

The first-aid box is located in the staff toilet and a list of telephone numbers of doctors and hospitals available to the practice is kept at reception desk. The first-aid box will be maintained by Donna Francis who will ensure that it is adequately stocked at all times.

All accidents and hazardous incidents (such as spills of mercury) must be entered in the accident report book, which is kept at reception and reported to Marian Roberts who will decide whether the accident or incident should be reported to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995. Forms for this purpose are kept at reception and are also now available digitally for completion on screen.

All staff receive 6 monthly training in 'Managing Medical Emergencies in the Dental Surgery including Basic Life Support'.

Display screen equipment

All users of display screen equipment (DSE) are given appropriate training on the health and safety aspects of this type of work. Keith Roberts conducts an assessment of all DSE workstations in the practice. Eye and eyesight tests are arranged on request and corrective eye-wear, if required for use with DSE, must be used. A footrest and wrist pad will be provided if required by the user.

Electrical safety

Keith Roberts conducts regular visual inspections on all portable electrical equipment (PAT) at the practice. Records of these inspections is maintained and kept at the practice and on a secure server. A combined inspection and test of the fixed supply is carried out every 3 years by Patey and Rogers - Electrical Contractors, Dartmouth. Records of these inspections and tests are maintained and kept at the practice.

Fire safety

General fire safety within the practice is the responsibility of Marian Roberts.

All staff in the practice have been informed of the action to be taken in the event of a fire, the evacuation procedure and the arrangements for calling the fire brigade. Go [here](#) to see what to do in the event of a fire and the building needs to be evacuated.

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Escape routes must be free from obstruction at all times and adequately sign-posted. Fire alarms and smoke detectors are tested 6 monthly. Fire extinguishers are inspected annually by Dart Fire Protection - 01803 862 416 and 07976 648 898.

If a smoke detector or fire alarm sounds, members of staff should raise awareness within the practice, report the fire (dial 999) and evacuate the building. Staff are only expected to tackle a fire if it poses no threat to their personal safety to do so. Fire drills are conducted annually and a record kept at reception. Smoke alarms in the practice emit a regular beep when their battery is getting low indicating the battery should be changed. Any staff member hearing these beeps should report the matter to Keith Roberts.

Manual handling operations

Where there is a risk of injury, manual handling operations must be avoided. Where they cannot be avoided, an assessment of the task should be undertaken taking into account the load, the working environment and the capability of the individual involved. Assistance should be requested from Marian Roberts or others within the practice.

Personal protective equipment

Personal Protective Equipment (PPE) is provided in those circumstances where employees are exposed to risks to their health that cannot be controlled by other means. Comprehensive training on their use, maintenance and purpose is provided as appropriate. Where appropriate, the practice owner maintains such equipment in good working order.

Training

Marian Roberts is responsible for ensuring all staff receive adequate training to ensure safe working practices and procedures. Training includes advice on the use and maintenance of personal protective equipment appropriate to the task concerned and emergency contingency plans.

The following tasks require special training due to their hazardous nature:

1. Use of the autoclave for the sterilisation of instruments
2. Decontamination of equipment prior to sterilisation
3. Disposal of used local anaesthetic cartridges and needles
4. Taking of any dental radiographs
5. Processing of radiographs

Visitors and contractors

All contractors and visitors to the practice (with the exception of patients) should be referred to Marian Roberts to ensure that they are made aware of the hazards present and what precautions might be required.

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Work equipment

All equipment used in the practice is maintained in good working order and repair. Where appropriate, equipment is clearly marked with health and safety warnings and staff provided with adequate protection. Equipment maintenance is undertaken as recommended by the manufacturer.

Workplace inspections

Marian Roberts conducts regular inspections of the practice. A record of these inspections is kept at reception (as part of the recording of staff meetings). Staff are informed of the significant findings as soon as is reasonably practicable or at the monthly staff meetings, whichever is appropriate.

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Section C

Hazards

Autoclaves and air-receivers

All clinical staff will be trained in the safe use of autoclaves. Staff who have not received training must not attempt to use any autoclave within the practice. At no time should any member of staff mishandle, tamper with or attempt to repair an autoclave. If an autoclave requires attention, it should be reported to Marian Roberts who will arrange for its repair.

Autoclaves in the practice are serviced every 14 months. Eschmann carries out an 14 monthly inspection on all autoclaves according to the written scheme of examination. Eschmann carry out routine and mandatory tests on all autoclaves. Staff are required to monitor individual autoclaves to ensure that the right conditions for sterilisation are being achieved routinely. The results of monitoring should be recorded with the Eschmann.

The air receivers for the practice are serviced/inspected 12 monthly by Edwards Dental Limited - 01803 555 739. They are also be inspected by an Allianz representative according to the written scheme of examination.

Hazardous substances

A number of hazardous substances are used in the day to day activities of the practice. These must be handled with care to avoid skin and eye contact, inhalation or ingestion. Assessments of the hazardous substances used are kept at reception. Staff should familiarise themselves with the hazards associated with each substance and the recommended means of control.

Infection control

The practice infection control policy is displayed in each surgery – it must be adhered to at all times. If any aspect is not clear, please ask Marian Roberts who is responsible for infection control within the practice.

Training in the following areas will be provided for all staff:

- personal protection
- procedures for the cleaning, sterilisation and storage of instruments
- segregation and safe disposal of clinical waste
- cleaning and decontamination of work surfaces and equipment
- decontamination of laboratory items prior to dispatch
- decontamination of instruments and equipment prior to service or repair.

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Medicines

No medicines are stored at the practice

Mercury hygiene

Mercury vaporises at room temperature and can be absorbed into the body through inhalation or contact with the skin. The surgery must be well ventilated to prevent the Occupational Exposure Standard being exceeded and protective gloves worn to reduce skin contact. Any mercury spills must be cleaned up immediately. The mercury spillage kit is kept in the store room. In the event of a mercury spill, Marian Roberts should be informed and will decide what further action is required.

The practice does not use 'free mercury'. Encapsulated mercury is used for amalgam fillings - this represent much less of a risk to staff and patient. The BDA fact file on mercury can be found at the end of this document.

Radiation

A Radiation Protection Adviser Marian Roberts has been appointed for advice in complying with the requirements of IRMER [IRR99].

Marian Roberts is the Radiation Protection Supervisor (RPS) at the practice and is responsible for ensuring that the practice complies with the regulations relating to radiation protection.

All staff are given general training about the radiation equipment used at the practice. Only staff who have received appropriate training and possess the relevant knowledge may take radiographs. Such training is arranged as required. A member of staff who has not undertaken formal approved training must not use radiographic equipment at the practice.

The HPA (Health Protection Agency) carries out a radiation safety survey every 3 years on all radiographic equipment. Servicing is carried out by Health Protection Agency according to the manufacturer's instruction. Local rules are displayed near each machine.

Where individual workloads exceed 100 intra-oral or 50 pan-oral films per week, monitoring badges are provided by the practice owner. Additional monitoring may also take place.

In the event of radiographic equipment malfunctioning, the member of staff involved must immediately switch off the machine (without entering the controlled zone) and report the incident to the RPS.

Waste disposal

All waste generated at the practice is segregated into clinical and non-clinical waste for appropriate disposal. Waste is collected in appropriate containers and stored in locked bins to await collection for disposal. Particular attention is given to the safe disposal of sharps

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waste and designated containers are provided for this purpose. Records of disposal are kept at reception. We use three registered waste disposal agents at the practice:-

- For normal Office Waste South Hams District Council - Totnes
- For Clinical/Hazardous Waste Peake (GB) Limited - Liskeard
- For Clinical/Hazardous Waste Initial Medical Services - Birmingham

Our waste policy can be found [here](#).

Dental Amalgam

Fact file

March 2008

Dental amalgam has been used as a safe, stable and cost effective restorative material for more than 150 years, but there has always been some controversy surrounding its use. A recent review by the EU Commission's Scientific Committee has concluded that no increased risks of adverse systemic effects exist and amalgam is not therefore considered to pose a risk of systemic disease. Alternative materials to dental amalgam do exist, and their use is increasing. This Fact File critically examines the evidence on dental amalgam, and explores the future of dental amalgam and its alternatives.

What is dental amalgam?

Dental amalgam has been used as a safe, durable, stable and cost effective restorative material for more than 150 years. Mercury is unique in its ability to form solid amalgams with other metals and dental amalgam comprises approximately 50% mercury, combined with silver and small amounts of copper, tin or zinc. There has always been a certain amount of controversy surrounding the use of dental amalgam as a restorative material. This has increased over the past 25 years and there has been much research into the health effects of amalgam over this time.

How widely is dental amalgam used?

Amalgam remains a valuable tooth restorative material in dentistry for practical and realistic reasons. Other filling materials are available but amalgam is cost effective and durable material with predictable outcomes and is still a commonly used filling material in many countries.

What other sources of exposure to mercury exist?

Human exposure to mercury is mainly from three sources:^{1,2}

- Methyl mercury in fish

- Mercury vapour from amalgam tooth fillings
- Ethyl mercury in thiomerosal (used as a preservative in vaccines).³

The main source of human exposure to methyl mercury is through the consumption of fish. The highest concentrations are found in long-lived predatory fish such as tuna, swordfish, shark and bass. Thiomerosal, which contains ethyl mercury, has been used as a vaccine preservative since 1930. Ethylmercury has a similar toxicology pattern to methylmercury but is metabolised more rapidly and in 2002 WHO concluded that it was safe to use thiomerosal in vaccines.

What are the health effects of dental amalgam?

In the mouth, mercury is amalgamated with other metals and is therefore rendered inert. Chewing can release some mercury vapour but this is very minimal.¹

There have been concerns in the past of amalgam being associated with a variety of systemic conditions such as Alzheimer's, Parkinson's Disease, and Multiple Sclerosis. However, several major studies have failed to reveal such effects. A recent epidemiological assessment⁴ found that evidence for the role of dental amalgam in multiple sclerosis, Parkinson's disease and Alzheimer's disease was inconclusive. Evidence that dental amalgam can be a causative factor for effects on neuropsychological function, chronic fatigue syndrome and non-specific symptom complexes was also inconclusive. It is perhaps worth noting that many studies of patients with alleged "amalgam illness" have shown that these patients often have a tendency towards psychosomatic disorders, anxiety and depression, panic disorder and the inability to perceive and understand threatening situations.⁵ The recent preliminary report by the Scientific Committee on Emerging and Newly Identified

Health risks (SCENIHR)⁶ concluded that no increased risks of adverse systemic effects exist and they do not therefore consider that the current use of dental amalgam poses a risk of systemic disease.

Two recent studies on the health effects of dental amalgam in children concluded that it should remain a viable restorative treatment option for children. The first⁷ showed that there were no statistically significant differences in adverse neuropsychological or renal effects observed over the 5-year period in children whose caries were restored using dental amalgam or composite materials. The second⁸ indicated that children who received dental restorative treatment with amalgam did not, on average, have statistically significant differences in neurobehavioural assessments or in nerve conduction velocity when compared with children who received resin composite materials without amalgam. The SCENIHR preliminary report also concludes that the most recent studies have failed to find any association between the use of amalgam and neuropsychological development in children.

Allergic reactions to mercury in dental amalgam have also been reported but these are very rare.⁵ The SCENIHR report recognises that some local adverse effects are occasionally seen with amalgam fillings, including allergic reactions, but the incidence is low and normally readily managed.

Is amalgam safe?

The SCENIHR report concludes that dental amalgam is a safe material to use in restorative dentistry with respect to patients.

Should dental amalgam fillings be removed?

Several studies on the release of mercury vapour during the removal of dental amalgams have been carried out, including some of



patients who had all their amalgams removed in one session.⁵ Most studies showed a slight transient increase in blood and urine levels during removal. No evidence supporting amalgam removal for supposed health benefits has been found. There is no clinical justification for removing clinically satisfactory amalgam restorations, except in those patients suspected of having allergic reactions to one of the amalgam constituents.

Is amalgam safe for use in pregnant women?

It is known that mercury can cross the placenta from mother to foetus – but there is no evidence of any link between amalgam use and birth defects or stillbirths. In 1997 UK Committee on Toxicity report said that there was no reason to think that the placement or removal of amalgam fillings during pregnancy was harmful.⁹ Nevertheless, COT did say as follows:

“There is no available evidence to indicate that the placement or removal of dental amalgam fillings during pregnancy is harmful. We are of the opinion, however, that the toxicological and epidemiological data are inadequate to assess fully the likelihood of harm occurring in such circumstances. Until appropriate data are available we concur with the view that it may be prudent to avoid, where clinically reasonable, the placement or removal of amalgam fillings during pregnancy.”

Following the publication of advice from COT, the Chief Dental Officer and Deputy Chief Medical Officer (April 1998) produced concise precautionary advice with respect to amalgam fillings and pregnancy. It remains the Department’s advice that dentists should continue to avoid or delay any dental intervention or medication during pregnancy; however a dental emergency where treatment with dental amalgam is required can outweigh any, as yet, theoretical risk of systemic toxicity.¹⁰

The 2008 SCENIHR preliminary report states there is a lack of information about the effects of amalgam in pregnant women. There is no evidence to suggest that pre-existing amalgam restorations pose any risk as far as the health of such women and the developing foetus is concerned, and any removal of restorations during this time would present a greater exposure to mercury. Caution should be exercised when considering the placement of any dental restorative material in pregnant women.

What about the safety of dentists?

Dentists have far more mercury exposure than

the general populations. Health and morbidity studies, however, have indicated that dentists have no unusual diseases and live longer than physician colleagues who generally are not exposed to mercury in the workplace.⁵

What do the regulatory agencies say?

According to the Medicines and Healthcare Regulatory Agency (MHRA),¹¹ there are three major uses for mercury in medical devices:

- Blood pressure measurement devices
- Body temperature thermometers
- Dental amalgam

At present there are no plans to further restrict addition of mercury to dental amalgam. However, the MHRA suggests that it may be prudent not to remove or place fillings during pregnancy where clinically reasonable (although it points out that there is no evidence to suggest that this is harmful) and advises that alternatives should be used in cases of allergy and hypersensitivity. The MHRA considers that “the safety of dental amalgam has been reviewed nationally and internationally over last 10 years – concluding that it is safe to use.”

The SCENIHR report concludes that dental amalgam is a safe material to use in restorative dentistry with respect to patients. A report released at the same time by the Scientific Committee on Health and Environmental Risks (SCHER)¹² entitled Preliminary report on the environmental risks and indirect health effects of mercury in dental amalgam, states that the predicted indirect exposures of humans to methylmercury resulting from emissions due to dental amalgams are much lower than the tolerable limits indicating a low risk for serious health effects.

What do governing bodies say?

In 1997, the Department of Health’s Committee on Toxicity of Chemicals in Food, Consumer Products and the Environment (COT) was asked to advise the former Medical Devices Agency (now the MHRA) on the toxicity of dental amalgam, in order to inform the UK’s response to the report of the Ad Hoc Working Group of experts established by the European Commission. COT saw no reason to revise the view of amalgam that it had taken in 1986: “that the use of dental amalgam is free from risk of systemic toxicity...”⁹

The World Dental Federation (FDI) and the World Health Organisation (WHO) consensus statement on dental amalgam¹³ was issued in 1997. This concludes that Dental amalgam restorations are considered safe, but

components of amalgam and other dental restorative materials may, in rare instances, cause local side-effects or allergic reactions. The small amount of mercury released from amalgam restorations, especially during placement and removal, has not been shown to cause any other adverse health effects.

The American Dental Association (ADA) continues to believe that amalgam is a valuable, viable and safe choice for dental patients¹⁴ and in 2002 the Federal Drugs Administration (FDA) published a Consumer Update on dental amalgam which stated that “FDA and other organisations of the U.S. Public Health Service (USPHS) continue to investigate the safety of amalgams used in dental restorations (fillings). However, no valid scientific evidence has shown that amalgams cause harm to patients with dental restorations, except in the rare case of allergy”.

What are the alternatives to dental amalgam?

Alternatives to dental amalgam do exist and are often used for cosmetic reasons. These include resin composite materials, glass ionomer cements, ceramic inlays and onlays and gold alloys.

Issues to consider when looking at alternative restorative materials include longevity, durability, sensitivity, allergenicity and cost effectiveness. For patients desiring an alternative for cosmetic reasons, resin composites are usually the best choice, but glass ionomer cements have been advocated in patients prone to caries. Ceramic and gold restorations are also used in dentistry where an indirectly custom manufactured restoration is necessary or chosen.

Current research suggests that resin modified glass ionomer cements (and compomers) have comparable durability to amalgams for occlusal and moderate sized class II cavities in primary molars,¹⁵ while Preformed Metal Crowns are actually superior for larger restorations in primary molars.^{16,17} However, the evidence on restoration longevity from primary care settings is not as convincing with restorations failing more quickly.

What is the future of dental amalgam as a restorative material?

As dental amalgam is not tooth-coloured and does not adhere to remaining tissues, its use has been decreasing in recent years, and tooth-coloured filling materials have increased in popularity.⁸ This trend restorations shows some variation within and between countries. There is a significant reduction of training in the



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placement of dental amalgam restorations and a corresponding increase in training in the use of alternatives in a growing number of European dental schools. A sustained reduction in the use of dental amalgam in oral health care provision is expected across the European Union. This is dependant on trends in dental education towards increasing use of alternative materials in place of amalgam and the possible reduced availability of mercury products in general.

Are there mercury emissions from crematoria?

Crematoria are currently responsible for a rising proportion of UK mercury emissions to air. This is partly because the number of amalgam fillings present at cremation is rising and partly that other mercury emissions are falling or are steady.¹⁸ However, it has been predicted that mercury emissions from crematoria will only continue to increase until 2020. This will be followed by a slight rise or plateau until 2035 and then a decrease back to 2000 levels by 2055. These predictions have been made based on dental data to 1998¹⁹ and actuarial data and can be explained by considering the population of the UK as three cohorts:

- the very old with few or no teeth
- those with heavily restored teeth
- the fluoride toothpaste generation

The aim in the UK is to cut emissions of mercury from crematoria by half by the end of 2012. This figure was determined after extensive consultation by DEFRA to achieve a balance between costs to the sector and environmental benefits.²⁰ To help achieve this target, an experimental initiative called 'burden sharing' has been introduced. Under this initiative, crematoria operators can choose whether to fit mercury abatement equipment or contribute to the costs of others doing so. The scheme is being organised at a national level by the umbrella organisation CAMEO and more information about it can be found on the Federation of British Cremation Authorities website.²¹

All crematoria were required to notify their local authority regulator by 31 December 2005 whether they would be fitting abatement equipment, sharing the cost of abatement fitted by other crematoria (burden sharing), or using a combination of the two approaches. All new crematoria should be fitted with mercury abatement equipment but those conducting fewer than 750 cremations have until 2012 to do this.^{22,23}

Is amalgam disposed of safely?

Article 4 of the Waste Directive (75/442/EEC) requires that waste must be disposed of without endangering human health or the environment. This includes amalgam waste from dental practices. In order to meet these requirements, DEFRA issued new guidance in December 2005 which stated that amalgam separators should be fitted in all dental practices in England where amalgam is used²⁴. Dentists were asked to take steps to ensure that suitable separators were fitted as soon as reasonably practicable. The guidance also advised that amalgam waste would need to be kept separate from other waste and collected by a waste management facility with a licence or permit to handle amalgam waste. Similar guidance exists for Scotland, Wales and Northern Ireland.

**British Dental Association
February 2008**



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