SPSO decision report

Case: **201508897, A Dentist in the Tayside NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Ms C, who works for an advocacy and support agency, complained on behalf of Mrs A about care provided by a dentist. Mrs A attended with a painful front tooth and it was decided that root canal treatment was needed to save it. Mrs A had this treatment over two appointments. However, the tooth later broke while she was eating. Mrs A saw the dentist and emergency treatment was provided. Mrs A experienced pain and swelling following this and saw the dentist about this a few days later. At this meeting, there was a breakdown in the dentist/patient relationship. The dentist completed the treatment and Mrs A later registered with a new dentist.

Ms C complained that Mrs A had not been offered options for treatment and that the risks had not been properly explained. She also raised concerns about the dentist's attitude towards Mrs A, and that the dentist had not followed the proper process as they had threatened to deregister Mrs A. Ms C's final complaint was that the handling of Mrs A's concerns had not been reasonable.

We took independent dental advice. The advice we received was that the treatment provided was appropriate and was the only option to save the tooth. However, the adviser highlighted that there was no evidence that the risks of the treatment had been properly explained to Mrs A. There was also a lack of records for one of her consultations. We therefore upheld Ms C's complaint.

The adviser noted that there was no evidence that steps had been taken to deregister Mrs A and we therefore did not uphold this aspect of Ms C's complaint.

We found that the dentist had not included all appropriate information in the response to the complaint and that there were inconsistencies between the complaints handling procedure and the associated staff guidance document. We therefore upheld Ms C's complaint in relation to this.

Recommendations

We recommended that the dentist:

- apologise for the failings identified in this investigation;
- take steps to ensure that patients are appropriately informed of the risks and benefits of procedures;
- ensure that patient dental records are kept in line with the General Dental Council standard; and
- review the complaints handling procedures for staff and patients for consistency.