SPSO decision report

SPSO Scottish Public Services Ombudsman

Case:	**201700458, A Dentist in the Lothian NHS Board area**
Sector:	health
Subject:	clinical treatment / diagnosis
Decision:	upheld, recommendations

Summary

Mr C attended his dentist over a period of months for treatment for severe tooth pain. The dentist extracted one tooth and referred Mr C to the dental hospital to have a second tooth extracted. When Mr C attended the hospital, they identified a number of issues regarding his teeth. Mr C complained that his dentist had failed to provide the appropriate dental treatment and that, as a result, he had suffered with severe pain over a prolonged period of time.

We took independent dental advice. The adviser noted that the dentist did not keep adequate clinical notes in accordance with the guidance published by the General Dental Council. The dentist also did not appear to carry out some of the more basic investigations available for determining the cause of dental pain, and he did not report the findings of an x-ray he took of his Mr C's teeth, which is a requirement of the Ionising Radiation (Medical Exposure) Regulations (2000). We upheld Mr C's complaint and made recommendations.

Recommendations

What we said should change to put things right in future:

- The dentist should consider the requirements for good clinical records as stipulated in the General Dental Council Standards and should consider the available guidance for good note taking.
- The dentist should consult Clinical Examination and Record Keeping Standards (FGDP RCS (Eng)), Key Skills in Primary Dental Care (FGDP RCS (Eng)) and the Management of Acute Dental Problems (SDCEP) for guidance on carrying out the more basic investigations available for determining the cause of dental pain and the treatments that are available.
- The dentist should make themselves aware of the requirements for reporting the findings of x-rays under the Ionising Radiation (Medical Exposure) Regulations (2000).
- The dentist should write up this incident as an Enhanced Significant Event Analysis and should include the incident as an agenda item in the next in-house dental practice team meeting so that learning can be shared among the practice.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.