SPSO decision report

Case: **202501635, A Dentist in the Greater Glasgow and Clyde NHS Board area**
Sector: Health
Subject: Diagnosis
Decision: upheld, recommendations

Summary

C complained about the dental treatment provided to their adult child (A). C said that A requested a replacement upper retainer (a custom-made device used to maintain the position of teeth after orthodontic treatment) after theirs broke. The dentist provided A with an upper soft splint (a protective device designed to stabilise teeth and reduce the effects of grinding). C said that A's orthodontic work had relapsed, and that they raised this at A's next appointment but felt their concerns were dismissed. C also complained about the handling of their complaint.

We took independent advice from a dentist. We found that the records made by the dentist at the time of A's initial appointment were sparse and lacking in detail and that there was insufficient information detailed to suggest that an upper soft splint was appropriate in A's case and that informed consent for this treatment was obtained. There was also a lack of detail in the clinical records in relation to the dentist's handling of A's concerns about orthodontic relapse at their subsequent appointment. While both A and the dentist agreed that A raised the issue of spacing at A's appointment, we could not conclude that this was dealt with appropriately due to the lack of records in this regard. Therefore we upheld this part for C's complaint.

In relation to complaint handling, we noted that C and A were offered an informal meeting with the dentist by the practice manager. We found that the reasons for the meeting with C and A should have been made clear to them and that the informal tone and the lack of structure did not fully align with expected standards. We noted that a copy of the written record of the meeting should have been provided to C and the wording used in the complaint response to signpost C to this office was not in line with the standard wording set out in the NHS Model Complaint Handling Procedure. Therefore, we upheld this part of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A for the failings identified. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/meaningful-apologies.

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

- Dentists should document a patient's presenting concerns, relevant dental and orthodontic history, findings from clinical examination (including occlusal assessment where relevant), an assessment or diagnosis, the clinical rationale for any proposed treatment, the treatment options discussed, material risks and consequences, and the patient's consent, in accordance with the Scottish Dental Clinical Effectiveness Programme – Oral Health Assessment and Review guidance and the General Dental Council Standards for the Dental Team. Where orthodontic relapse was a consideration, there should be a structured occlusal assessment and clear recording of potential contributing factors, including referral where indicated.

In relation to complaints handling, we recommended:

- Complaints should be dealt with in accordance with the NHS Model Complaints Handling Procedure and expected standards. Complainants should be clearly signposted to the SPSO in all stage 2 complaint responses in line with the standard wording at page 30 of the NHS Model Complaints Handling Procedure. We offer SPSO accredited Complaints Handling training. Details and registration forms for our online self-guided Good Complaints Handling course (Stage 1) and our online trainer-led Complaints Investigation Skills course (Stage 2) are available at https://www.spso.org.uk/training-courses.

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.