INQUIRY COMMITTEE
RECORD OF DECISION

FILE NAME: DH1179R

FACTS

On January 31, 2011, the Registrar received a written complaint from a member of the public, against a registrant of the College, related to standard of practice. The complainant alleged that a month after receiving an aggressive dental hygiene treatment from the registrant, she noticed that part of her bottom lip remained numb. The Inquiry Committee resolved to investigate the matter.

On May 3, 2011, following completion of its investigation, the Inquiry Committee concluded that there was no evidence that the registrant had engaged in misconduct and passed a motion to take no further action under s. 33(6)(a) of the Health Professions Act (the 'Act'). On May 19, 2011, the complainant filed a request for review with the Health Professions Review Board (the "Review Board"). The Inquiry Committee obtained the consent of the Review Board, the complainant and the registrant to reopen its investigation to consider further information.

On March 5, 2012, the Committee resolved to reopen the investigation and reconsider the disposition following consideration of further evidence brought forward after the complainant filed a request for review, and an inspector was appointed to gather further information for consideration.

COMMITTEE DECISION

The Inquiry Committee reviewed further information including the complainant's dental and medical charts from her family physician, rheumatologist and neurologist. After reviewing all the information the Committee determined that there was insufficient evidence to establish that the dental hygiene treatment was the cause of the complainant's paralysis or paresthesia on her bottom lip.

The Inquiry Committee placed considerable reliance on the opinion of the neurologist who saw the Complainant two years after the dental hygiene treatment. The neurologist indicated that it was possible that the treatment could result in paresthesia if there was deep bruising but that it would be very unusual to have paresthesia if there was no bruising. He further indicated that if the dental hygiene treatment had caused the paresthesia, bruising would have been visible either externally or internally. The Inquiry Committee noted that a dental examination was performed immediately after the hygiene treatment that day and that there were no recorded notes of excessive bleeding, tissue trauma or bruising inside the complainant's mouth. The Committee was unable to find evidence that there was any external or internal bruising following the dental hygiene treatment.

The Inquiry Committee determined that there was insufficient evidence to establish a nexus between the complainant's condition and the dental hygiene treatment that she received and passed a motion to take no further action under s. 33(6)(a) on the basis that the conduct to which the complaint related was satisfactory.

On June 19, 2013, the Complainant filed for a Review of the Decision with the Health Professions Review Board (HPRB). The Complainant, the Registrant and the College were invited to provide written submissions to the HPRB for their consideration, along with the Record submitted by the College. Upon review of all materials, the HPRB determined that the investigation by the College was adequate and the disposition was reasonable. The Complainant's application was dismissed and the disposition of the Inquiry Committee was confirmed.

RELEVANT PROVISION OF ACT, REGULATION, OR BYLAWS: *Act* section 32(1); 32 (2); 33(1); 33(5); 33(6)(a)

STATUS: *Closed*

LEGISLATIVE AUTHORITY: *Health Professions Act, s. 33, 36*