INQUIRY COMMITTEE
RECORD OF DECISION

FILE NAME: DH1298

FACTS

On August 8, 2012, the Registrar received a written complaint from a dentist, who had provided emergency dental treatment to a patient who had regularly received dental care in a dental office where a number of registrants worked. The dentist alleged that the patient had received dental services so far below accepted standards that any dental hygienist providing dental hygiene care to the patient should have detected this to the patient's dentist and, in the absence of corrective action, to the CDHBC and the CDSBC.

The Inquiry Committee resolved to investigate the matter.

As the dentist did not identify the registrants, the College contacted the patient's regular dental clinic and obtained the names of five dental hygienists who had provided dental hygiene services to the patient over the preceding ten years. The College then notified the five registrants (referred to as Registrant A, B, C, D, and E) of the complaint and invited their responses.

On September 20, 2012, the College received a letter from Registrant E summarizing the dental hygiene treatments (s)he provided to the patient over a three year period. Registrant E provided treatment to the client on four occasions between April 26, 2000 and March 13, 2003. Registrant E also provided a general overview of the client's medical history, which described health issues that may have contributed towards the patient's challenges in maintaining oral health.

On September 21, 2012, the College received a letter from Registrant A summarizing the dental hygiene treatments (s)he provided to the patient over an eighteen month period. Registrant A provided treatment to the client on three occasions between March 5, 2008 and September 14, 2009. Registrant A also provided a general overview of the client's medical history.

On the same day, the College also received a letter from Registrant B summarizing the dental hygiene treatments (s)he provided to the patient over a three year period. Registrant B provided treatment to the client on four occasions between January 7, 2004 and February 5, 2007. Registrant B also provided a general overview of the client's medical history.

On September 25, 2012, the College received a letter from Registrant C summarizing the dental hygiene treatments (s)he provided to the patient over an eighteen month period. Registrant C provided treatment to the client on five occasions between February 10, 2010 and April 4, 2012. Registrant C also provided a general overview of the client's medical history.

On September 26, 2012, the College received a letter from Registrant D summarizing the dental hygiene treatments (s)he provided to the patient. Registrant D provided treatment to the client on August 29, 2007. Registrant C also provided a general overview of the client's medical history.

On December 3, 2012, the Inquiry Committee appointed an inspector to assist with its investigation. The inspector obtained the patient's chart, including copies of the original diagnostic radiographs dating back to 2000. The inspector also conducted interviews to gather information pertaining to the various aspects of the office's paper and electronic files.

On February 21, 2013, the College received a copy of the inspector's report, a copy of which was provided to the dentist who filed the complaint and all five of the registrants for response. The report and respective responses to the report were submitted to the Inquiry Committee for review in consideration of their decision in this matter.

COMMITTEE DECISION

After reviewing the information gathered for this investigation, the Inquiry Committee passed a motion under s. 33(6)(a) of the *Health Professions Act,* R.S.B.C. 1996, c. 183 (the "*Act*") to take no further action.

The Inquiry Committee determined that the evidence established that Registrant A provided dental hygiene treatment to the patient on three occasions, namely March 5, 2008, December 8, 2008 and September 14, 2009. The clinical evidence confirmed that the crown margins were adequate when crowns were first placed and teeth were scheduled for restoration when recurrent decay became visible on the radiographs.

The Inquiry Committee determined that the evidence established that Registrant B provided dental hygiene treatment to the patient on four occasions, namely January 7, 2004, December 19, 2005, July 4, 2006 and February 5, 2007. The clinical evidence indicated that the cerac crowns (which were the focus of the complaint) had not been placed in the patient's mouth until sometime after the last dental hygiene treatment provided by Registrant B.

The Inquiry Committee determined that the evidence established that Registrant C provided dental hygiene treatment to the patient on five occasions, namely February 10, 2010, July 11, 2010, April 6, 2011, October 5, 2011 and April 4, 2012. The clinical evidence indicated that the crown margins were adequate when crowns were first placed and teeth were scheduled for restoration when recurrent decay became visible on the radiographs.

The Inquiry Committee determined that the evidence established that Registrant D provided dental hygiene treatment to the patient on August 29, 2007. The clinical evidence indicated that the cerac crowns had not been placed in the patient's mouth until sometime after the last dental hygiene treatment provided by Registrant D.

The Inquiry Committee determined that the evidence established that Registrant E provided dental hygiene treatment to the patient on four occasions, namely April 26, 2000, June 1, 2001, March 1, 2002 and March 13, 2003. The clinical evidence indicated that the cerac crowns had not been placed in the patient's mouth until sometime after the last dental hygiene treatment provided by Registrant E.

The Inquiry Committee determined that there was insufficient evidence to establish that any of the Registrants observed substandard dental care in relation to the patient or any evidence that the patient was at risk or that the dentistry services she received posed a risk to public safety which would have triggered a duty to report. Based on its review of the clinical documentation, the Inquiry Committee concluded that the evidence did not establish that the patient received substandard dental care from her regular dental clinic or that the Registrants failed to act in accordance with proper standards of dental hygiene practice in relation to this patient.

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

STATUS: **Closed**

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