Parliamentary and Health Service Ombudsman

Report by the Health Service Ombudsman for England of an investigation of a complaint about a dentist in Staffordshire

HC 1079

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Contents

Foreword

This report is of my investigation of a complaint about a dentist who has not put things right after he made mistakes. The dentist has failed to put things right even though he has been told to do so by a number of organisations that he should not ignore. Therefore, I am laying this report before Parliament under section 14 (3) of the *Health Service Commissioners Act* as I have found injustice arising from maladministration that has not and, it appears, will not, be remedied.

This is the first time I have laid a report under section 14 (3) of the Act since I became Health Service Ombudsman for England in 2002. By laying this report I am able to put into the public domain my investigation report, naming the dentist. I am also able to make public my disappointment that anyone providing a NHS service can have such disregard for a patient and her complaint.

The story is a simple one. Mrs D was unhappy about the behaviour of her dentist during an appointment in September 2007. The same month she complained to the Dental Practice.

Dissatisfied with the response to her complaint, she escalated her complaint to the Healthcare Commission, which at that time provided the second stage of the NHS complaints system. The Healthcare Commission investigated, upheld Mrs D's complaint and made recommendations that the dentist should send written apologies to Mrs D about five issues. Mrs D did not receive the apologies so she contacted the General Dental Council, the professional regulatory body for dentists. The General Dental Council warned the dentist to follow recommendations of professional bodies.

Mrs D complained to me that she had not received the apologies from the dentist. I investigated and upheld Mrs D's complaint. I recommended to the dentist that he apologise to Mrs D and pay her £500 compensation. In response to my draft report the dentist maintained that he had apologised to Mrs D. I disagreed. The dentist has told my staff that he will not make any payment to Mrs D. I issued my final report in March 2011, giving the dentist one month to comply with my recommendations. To date, he has not done so.

I considered that the dentist's unwillingness to comply with the recommendations of the Healthcare Commission and the Ombudsman raised questions about his fitness to practise, sufficient to constitute a threat to the health and safety of patients. Therefore, in March 2011 I shared the report of my investigation with the General Dental Council. The General Dental Council is considering what action to take.

South Staffordshire Primary Care Trust urged the dentist to comply with my recommendations and are considering what further action to take.

For anyone who provides a NHS service to ignore recommendations arising from the NHS complaints system is a serious matter. I hope that making this story public provides the catalyst for the dentist to provide the long overdue remedy to Mrs D.

Ann Abraham
Parliamentary and Health Service Ombudsman
June 2011

Health Service Commissioners Act 1993

Report by the Health Service Ombudsman for England
of an investigation into a complaint made by Mrs D

Complaint about: Mr Narendranath
Stone Family Dental Practice, Radford Street, Stone, Staffordshire

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Introduction

1 This is my report of the investigation into Mrs D's complaint about Mr Narendranath (Mr Nath).[1] This report contains my findings, conclusions and recommendations with regard to Mrs D's areas of concern.

The complaint

2 Mrs D made a complaint to the Healthcare Commission[2] in January 2008 about Mr Nath, the dentist at the Stone Family Dental Practice (the Practice), and the Commission recommended that he provide her with five specific apologies. Mrs D complains that Mr Nath has not provided her with the apologies that the Healthcare Commission recommended he make.

3 Mrs D says that because Mr Nath has not apologised she has been left feeling '*offended*' and '*shocked*' and unable to gain closure on her original complaint.

4 Mrs D is seeking the apologies from Mr Nath that were recommended by the Healthcare Commission.

My decision

5 Having considered all the available evidence related to Mrs D's complaint about Mr Nath, and having taken account of the clinical advice we have received, I have reached a decision.

6 I found maladministration in relation to Mr Nath's failure to implement the Healthcare Commission's recommendations. This maladministration led to Mrs D suffering the injustice of feeling '*offended*' and '*shocked*' and unable to gain closure. I uphold the complaint about Mr Nath.

The Health Service Ombudsman's jurisdiction and role

7 The *Health Service Commissioners Act 1993* empowers me to investigate complaints about the NHS in England. In the exercise of my wide discretion I may investigate complaints about NHS bodies such as trusts, family health service providers such as GPs and dentists (like Mr Nath), and independent persons (individuals or bodies) providing a service on behalf of the NHS.

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1 Mr Narendranath is known as Mr Nath.

2 At that time, under *The National Health Service (Complaints) Regulations 2004*, if a complainant was dissatisfied with a dentist's response to a complaint they could refer their complaint to the Healthcare Commission.

8 In doing so I consider whether a complainant has suffered injustice or hardship in consequence of a failure in a service provided by the body, a failure by the body to provide a service it was empowered to provide, or maladministration in respect of any other action by or on behalf of the body. Service failure or maladministration may arise from action of the body itself, a person employed by or acting on behalf of the body, or a person to whom the body has delegated any functions.

9 When considering complaints about dentists, I may look at whether a complainant has suffered injustice or hardship in consequence of action taken by the dentist in connection with the services the dentist has undertaken with the NHS to provide. Service failure or maladministration may arise from action taken by the dentist himself or herself, by someone employed by or acting on behalf of the dentist, or by a person to whom the dentist has delegated any functions.

10 If I find that service failure or maladministration has resulted in an injustice, I will uphold the complaint. If the resulting injustice is unremedied, in line with my Principles for Remedy, I may recommend redress to remedy any injustice I have found.

The basis for my determination of the complaint

11 In general terms, when determining complaints that injustice or hardship has been sustained in consequence of service failure and/or maladministration, I generally begin by comparing what actually happened with what should have happened.

12 So, in addition to establishing the facts that are relevant to the complaint, I also need to establish a clear understanding of the standards, both of general application and which are specific to the circumstances of the case, which applied at the time the events complained about occurred, and which governed the exercise of the administrative and clinical functions of those bodies and individuals whose actions are the subject of the complaint. I call this establishing the overall standard.

13 The overall standard has two components: the general standard, which is derived from general principles of good administration and, where applicable, of public law; and the specific standards, which are derived from the legal, policy and administrative framework and the professional standards relevant to the events in question.

14 Having established the overall standard, I then assess the facts in accordance with the standard. Specifically, I assess whether or not an act or omission on the part of the body or individual complained about constitutes a departure from the applicable standard.

15 If so, I then assess whether, in all the circumstances, that act or omission falls so far short of the applicable standard as to constitute service failure or maladministration.

16 The overall standard I have applied to this investigation is set out below.

The general standard – the *Ombudsman's Principles*

17 In February 2009 I republished my *Principles of Good Administration*, *Principles of Good Complaint Handling* and *Principles for Remedy*.[3] These are broad statements of what I consider public bodies should do to deliver good administration and customer service, and how to respond when things go wrong. The same six key Principles apply to each of the three documents. These six Principles are:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right, and
- Seeking continuous improvement.

18 One of the Principles of Good Complaint Handling is particularly relevant to this complaint:

- '*Putting things right*' – which includes acknowledging mistakes and apologising where appropriate.

The investigation

19 We telephoned Mrs D on 24 August 2010 to discuss the nature of her concerns and the way in which we would investigate her complaint. We confirmed our understanding of the complaint and the issues we would investigate in our letter to her dated 1 October.

20 During this investigation we have examined all the relevant documentation. This includes papers provided by Mrs D and Mr Nath and papers relating to the attempted resolution of the complaint both at local level and by the Healthcare Commission. We have taken account of the comments received from Mrs D as set out in her correspondence with this Office. We also met Mr Nath in January 2011 to discuss the complaint and his comments on our draft report.

21 We also obtained specialist advice from one of my clinical advisers, Adviser A BDS(Lond) LDSRCS(Eng) Dip HPM (the Adviser), a dentist. My clinical advisers are specialists in their field, and in their roles as advisers to me they are independent of any NHS body.

22 In this report I have not referred to all the information examined in the course of the investigation, but I am satisfied that nothing significant to the complaint or my findings has been omitted.

23 Mrs D and Mr Nath have both had the opportunity to comment on a draft of this report and their responses have been taken into account in coming to the decision.

[3] The *Ombudsman's Principles* is available at www.ombudsman.org.uk.

Key events

24 Between July and September 2007 Mrs D attended the Practice complaining of a broken crown and toothache. She was seen on a number of occasions by Mr Nath, who took X-rays of her mouth but was unable to identify a cause of the pain. Mrs D says that during her final appointment on 7 September Mr Nath was rough and hurt her whilst trying to conduct further X-rays. She said that when she objected he said he could do nothing more for her, turned his back on her and demanded that she leave the surgery. Mrs D says that she was left '*battered emotionally and in more pain*' from this appointment and she also says: '*I was offended by his rude and unprofessional manner, I was shocked*'.

25 The same day Mrs D made a verbal complaint to the Practice which included that Mr Nath had hurt her and was rude during a consultation when he was attempting to X-ray her teeth.

26 Mr Nath provided a written response to Mrs D and explained why he had needed to take X-rays. He also explained the procedure involved and that this can be uncomfortable. He said he felt that Mrs D had been rude to him and he could not offer her any further help. Mrs D then made a formal written complaint to the local primary care trust (PCT). This complaint included the following: that there was someone present during a consultation and Mrs D did not know who this was; the management of her dental pain; an attempt to take an X-ray was painful; Mr Nath's attitude; and the response to her complaint. The PCT referred the complaint back to the Practice. Mr Nath responded to the PCT and said he had nothing more to add to his original response. The PCT then provided Mrs D with details of the Healthcare Commission.

27 In January 2008 Mrs D complained to the Healthcare Commission. In March 2008 Mr Nath wrote to the Healthcare Commission in response to its enquiries. Mr Nath said:

> *'I am sorry that Mrs D felt that I had not treated her in a gentle manner ... I can only apologise if the patient felt that I was uncaring ... I can only apologise if Mrs D felt uneasy with the presence of my second nurse ... I am sorry that the patient feels I have not handled this complaint appropriately but I believe I have carried out the complaint handling in an appropriate way.'*

28 In response to the complaint regarding the management of Mrs D's dental pain, Mr Nath wrote:

> *'I am sure that any dental professional will confirm that if one is unable to identify the cause of the problem then one cannot carry out treatment. I believe that I looked carefully at the patient and considered the various options that I had. It would have been inappropriate for me to have advised on a diagnosis and treatment as I had not been able to take the appropriate X-rays.'*

29 The Healthcare Commission upheld Mrs D's complaint in April 2008 and made 13 recommendations to the Practice regarding the treatment Mr Nath had provided for her. Among other things, the Healthcare Commission recommended that the Practice should, by 16 May 2008, send a written response to Mrs D including:

- an apology for the pain and distress caused to Mrs D when Mr Nath attempted to insert an X-ray sensor during a consultation on 7 September 2007;

- an apology that Mrs D found Mr Nath's attitude at this consultation uncaring;

- an apology for any concern caused to Mrs D by the unexpected presence of an additional dental nurse at a consultation on 3 July 2007;

- an apology for the fact that Mr Nath was not following professionally accepted guidelines when he chose to take X-rays on 16 July, and did not conduct appropriate investigations following this, and for the distress that this had caused Mrs D; and

- an apology for the Practice's failure to adequately respond to Mrs D's complaint, and for the additional inconvenience and distress this caused.

30 Mr Nath disputed the Healthcare Commission's decision to uphold the complaint. On his behalf, the Dental Defence Union (DDU) forwarded his objections to the Healthcare Commission. Mr Nath considered that some aspects of Mrs D's complaint had not been raised with him prior to her approaching the Healthcare Commission. He maintained his position that he could not add any more to his original response to resolve the complaint and questioned the clinical advice that the Healthcare Commission had received. The Healthcare Commission responded to the DDU and said that all of Mrs D's complaint was laid out in her letter of 26 September 2007 and the Practice had acknowledged receipt of it on 1 October. It also addressed Mr Nath's concerns about the clinical advice referred to in its report and requested that he comply with the recommendations by 18 July 2008.

31 On 19 August 2008 Mr Nath wrote to Mrs D. The letter simply said:

> *'I reiterate the points made in all my previous correspondence to you and the* [Healthcare Commission] *in relation to your treatment. Our practice adheres to all the practice procedures seen as good practice by an acceptable body of general dental practitioners. I am still awaiting an apology from you for your rude and insulting behaviour.'*

32 In September 2008 Mrs D wrote to the Healthcare Commission as Mr Nath had not provided her with any apologies. The Healthcare Commission subsequently asked Mr Nath to comply with the recommendations; informed the PCT that he had not complied with its recommendations; and asked the PCT to consider whether it was appropriate to refer him to the General Dental Council (GDC).[4]

33 In November 2008 Mrs D wrote to the GDC regarding her complaint about Mr Nath. In February 2009 the PCT wrote to Mrs D and explained that it had also contacted the GDC about him.

34 In April 2010 Mr Nath's representative (now from the Medical Defence Union) wrote to the GDC. This letter set out Mr Nath's position in

[4] The GDC is the regulatory body for dentists.

relation to the GDC's investigation into Mrs D's complaint. It said that Mr Nath had addressed the issue regarding the management of Mrs D's dental treatment in his letter to the Healthcare Commission in March 2008. It also said the letter to the Healthcare Commission included Mr Nath's apologies for: his poor attitude; the unexpected presence of an additional dental nurse; pain caused while attempting to insert an X-ray sensor; and poor complaint handling. Mr Nath's representative said he reiterated these apologies in his letter to Mrs D in August 2008 and '*Dr* [Nath] *repeats this apology*'. A copy of the letter to the GDC was sent to Mrs D.

35 In May 2010 the GDC wrote to Mrs D and said it was extremely concerned to note that she had still not received a letter of apology and it had issued a warning to Mr Nath which included: '*... Mr Nath is also warned in future to follow recommendations of professional bodies when issued with them*'.

The complaint to the Ombudsman

36 Mrs D complains that Mr Nath has not provided her with the apologies that the Healthcare Commission recommended he make.

Specialist advice

37 We asked our Adviser to comment on the recommendations made by the Healthcare Commission in relation to Mrs D's complaint. He said that the recommendations were appropriate and proportionate to the issues in the complaint.

Mr Nath's comments on our draft report

38 Mr Nath told us he considered that Mrs D had had an apology and that his representative's letter to the GDC (paragraph 34) constituted an apology. He said he had tried to address his shortcomings and he had sent more than one apology. He also said that he would not pay Mrs D any compensation.

My findings

39 I have explained the approach I take to determining complaints in paragraphs 11 to 16. Taking into account the *Ombudsman's Principles* (paragraph 17), I begin my consideration of Mrs D's case by establishing what should have happened following the Healthcare Commission's review of her complaint.

40 In line with my Principles of Good Complaint Handling (paragraph 18) Mr Nath should have 'put things right' and provided apologies where appropriate. The Healthcare Commission recommended that Mr Nath provide Mrs D with five separate apologies. Taking into account our Adviser's comments, I consider that the recommendation to apologise was appropriate. In addition, the GDC has warned Mr Nath that he should follow the recommendations of professional bodies. However, Mr Nath showed disregard for the recommendations made by the Healthcare Commission in April 2008 and for the GDC's warning. Although Mr Nath has said that he considers he has apologised to Mrs D, he has not. He has provided some apologies to the Healthcare Commission and reiterated these to the GDC. Mr Nath has not provided any apology to Mrs D, instead he has requested that she apologise to him. In short, he did not 'put things right'. Mr Nath's actions fell so far short of the applicable standard as to amount to maladministration.

Injustice

41 I have found maladministration in relation to Mr Nath's failure to implement the Healthcare Commission's recommendations. I have therefore considered whether an injustice was suffered in consequence of the maladministration.

42 The maladministration caused by Mr Nath led to Mrs D not receiving the apologies that the Healthcare Commission recommended. This is in itself an injustice. Mrs D has said that because Mr Nath has not apologised she has been left feeling '*offended*' and '*shocked*' and unable to gain closure on her original complaint. I can understand that the lack of apology would leave Mrs D feeling that her complaint has not been taken seriously and therefore her original feelings of offence and shock would remain.

43 Moreover, Mrs D has had the inconvenience of bringing her complaint to the Ombudsman, when it could and should have been resolved much sooner.

Conclusions

44 Having studied the available evidence and taken account of the advice provided by our Adviser, I find shortcomings in the way Mr Nath responded to the Healthcare Commission's recommendations and that these shortcomings amounted to maladministration. I have assessed whether the injustice, in this case being left feeling '*offended*' and '*shocked*' and unable to gain closure, arose in consequence of the maladministration I have identified and have concluded that it did.

45 Therefore, I uphold Mrs D's complaint about Mr Nath.

Recommendations

46 In making recommendations I am guided by my Principles for Remedy. '*Putting things right*' states that, if possible, the complainant should be returned to the position they would have been in if the maladministration had not occurred. If that is not possible, then the complainant should be compensated. Public bodies should also consider seriously all forms of remedy, for example, an apology, an explanation, remedial action or financial compensation. With this in mind, I recommend that within one month Mr Nath should:

- provide Mrs D with a full acknowledgement and apology for the failings identified in our report;
- provide Mrs D with the apologies recommended by the Healthcare Commission; and
- provide Mrs D with a sum of £500 as compensation for the feelings of shock and offence she has suffered as a consequence of the maladministration and the inconvenience of bringing her complaint to the Ombudsman, when it could and should have been resolved much sooner.

47 A copy of the acknowledgement and apologies, and confirmation that the compensation has been paid to Mrs D, should be sent to me.

Final remarks

48 In this report I have set out our investigation, findings, conclusions and decision with regard to Mrs D's complaint about Mr Nath. This complaint should have been very simple and straightforward to resolve. However, Mr Nath's failure to apologise has prolonged the complaints process and with it the frustration and upset experienced by Mrs D. I hope that this report will draw what has been a long and complex complaints process to a close.

49 I have taken the decision, in light of Mr Nath's response to our draft report, to share the findings of our investigation into Mrs D's complaint with the GDC. I consider Mr Nath's unwillingness to comply with recommendations of professional bodies raises concerns about his fitness to practise, sufficient to constitute a risk to the health and safety of patients.

Ann Abraham
Parliamentary and Health Service Ombudsman

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