INQUIRY COMMITTEE

RECORD OF DECISION

File Reference: DH2101

ELEMENTS OF COMPLAINT

On February 9, 2021, the College of Dental Hygienists of British Columbia (the "College") received a written complaint alleging that the Registrant had provided substandard care by cutting the left side abutment tooth from his bridge and removed bonding from a splint during the provision of dental hygiene care.

The matter was referred to the Inquiry Committee which initiated an investigation under s. 33(4) of the *Health Professions Act*, R.S.B.C. 1996, c. 183 (the "Act") and the Registrant was invited to respond.

On March 17, 2021, the Registrant provided a response denying the allegations. The Registrant advised that during the appointments in question, s/he provided four units of root planing using the cavitron and hand instruments to remove calculus and plaque deposits from the root surface of the Complainant's remaining teeth. The Registrant advised that there were no instruments used that could "cut off" a bridge. The Registrant advised that the Complainant attended for a subsequent dental hygiene treatment on June 9, 2020 and did not express any concerns about his bridge at that time.

COMMITTEE DECISION

After considering the information provided by the Complainant and the Registrant, the inspector's report, and the responses to the inspector's report, the Inquiry Committee concluded that it would not be possible for a dental hygienist to cut a bridge using a cavitron and hand instruments which were the instruments used during the March 4 and June 9, 2020 appointments. It also concluded that there was also no evidence that the Registrant attempted to deliberately take such action. Based on the totality of the evidence, the Inquiry Committee determined that the bridge failed as a result of its age and the presence of carries and heavy occlusal forces. The attending dentist was also of the view that the instruments used by the Registrant during the Complainant's dental hygiene appointment were not capable of cutting sound tooth structure and noted that crowns come off and cement fails sometimes with old dental work.The Inquiry Committee took no further action under s. 33(6)(a) of the Act.

The Complainant filed a request for review with the Health Professions Review Board ("HPRB") under s. 50.6(1) of the Act. The HPRB concluded that the Inquiry Committee had not addressed the second allegation by the Complainant. The Inquiry Committee offered to reconsider the matter and issue a new disposition decision which it did and which was forwarded to the Complainant, Registrant, and the HPRB. In the new disposition decision, the Inquiry Committee concluded that there was still no basis for finding that the Registrant had departed from proper standards of practice and took no further action.

On April 5, 2022, the HPRB issued its decision dismissing the review. The HPRB determined that the Inquiry Committee's investigation was adequate and its disposition was reasonable and addressed the major issues of the complaint. The HPRB confirmed the decision.

RELEVANT PROVISION OF ACT, REGULATION OR BYLAWS

Act, section 33(1); 33(5); 33(6)(a), 50.6(1), and 50.6(8).

STATUS Closed.