Investigation of a complaint against the Northern Health & Social Care Trust

Report reference: 202004300

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The role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the public interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

TABLE OF CONTENTS

Page

Case Reference: 202004300
Listed Authority: Northern Health and Social Care Trust

SUMMARY

This complaint was about the dental and paediatric care and treatment the Northern Health and Social Care Trust (the Trust) provided to the complainant's son (the patient). The patient is autistic, non-verbal and has other health issues, including epilepsy.

The complainant was concerned that the Trust failed to identify and treat the patient's dental pain within a reasonable timeframe, which caused behavioural changes that were traumatic for the patient and his family. Further, this also impacted the patient's attendance at school and prevented him from engaging with other children for a significant period of time.

The investigation identified the Trust did not provide appropriate and reasonable dental care and treatment. Specifically, the Trust failed to: -

- apply topical fluoride to the patient's teeth in line with relevant guidance;
- recall or review the patient for dental care at appropriate intervals in line with relevant guidance; and
- follow-up with the patient's family about the General Anaesthetic assessment.

The investigation also established the Trust did not provide appropriate paediatric care and treatment to the patient during the period. This is because Paediatrics failed to communicate definitive arrangements for the General Anaesthetic assessment to Community Dental Services. Consequently, the patient did not receive a dental examination as anticipated.

I recommended the Trust provides the patient and his family with an apology for the injustices caused by the failures, to be offered both in writing and in-person. I made further recommendations for the Trust to address under an evidence-supported action plan.

Throughout my consideration of this case, the complainant's concerns for the patient's wellbeing and her desire to ensure his needs and best interests were met were evident. I hope the report provides the complainant with the answers she earnestly sought about the failures in the patient's care and treatment.

THE COMPLAINT

1. This complaint was about the paediatric and dental care and treatment the Northern Health and Social Care Trust provided to the complainant's son (the patient).

Issues of complaint

2. I accepted the following issues of complaint for investigation:

Issue 1: Whether the care and treatment the Trust Community Dental Service provided to the patient between 13 September 2012 and 19 July 2019 was appropriate and reasonable.

Issue 2: Whether the care and treatment the Trust Paediatric Department provided to the patient from January 2018 to July 2019 was appropriate and reasonable.

INVESTIGATION METHODOLOGY

3. To investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised. This documentation included information relating to the Trust's complaints process.

Independent Professional Advice Sought

4. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisors (IPA):
    - A Senior Community Dental Surgeon for Special Care Dentistry with 25 years' experience; BDS, MFDS RCPS, LLM (legal aspects of medical practice), Dip Clin Ed, Pg Cert Cognitive Behavioural Studies (Dental IPA); and
    - A Consultant Paediatrician with 17 years' experience as a consultant; MBBS, MSc, MRCP MD (Paediatric IPA).

I enclose the clinical advice received from the Dental IPA at Appendix three and the Paediatric IPA at Appendix four to this report.

5. The information and advice which informed the findings and conclusions are included within the body of this report. The IPAs provided 'advice.' However, how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

6. To investigate complaints, I must establish a clear understanding of the standards, both of general application and those specific to the circumstances of the case. I also refer to relevant regulatory, professional, and statutory guidance.

   The general standards are the Ombudsman's Principles[1]:

   - The Principles of Good Administration

7. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

   The specific standards and guidance relevant to this complaint are:

   - The Department of Health and Social Care Delivering Better Oral Health: An Evidence-based Toolkit for Prevention, March 2017 (DoH Oral Health Guidance);
   - The National Health Service Children's Teeth Guidance, June 2017 (NHS Fluoride Guidance);
   - The National Institute for Health and Care Excellence Dental Checks: Intervals Between Oral Health Reviews Clinical Guideline 19, 27 October 2004 (NICE Dental Check Guidance); and
   - The General Medical Council's Good Medical Practice, April 2013 (GMC Guidance).

[1] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

8. I did not include all information obtained during the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.

9. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

Issue 1: Whether the care and treatment the Trust Community Dental Service provided to the patient between 13 September 2012 and 19 July 2019 was appropriate and reasonable.

Detail of Complaint

10. The complainant said the patient's behaviour changed towards the end of 2017 and, in early 2018, his aggressive behaviour became so concerning that his school first took steps to *'semi-segregate'* him. The complainant said, as the difficulties continued, the school could not cope, and the patient stopped attending school. During this period, the patient was 12 years of age. In mid-2018, the patient's Paediatrician planned a multidisciplinary assessment under general anaesthetic (GA) to ascertain if there was an underlying medical cause for the patient's behavioural changes. The complainant said the patient had previously received multidisciplinary assessments under general anaesthetic (GA). The complainant said she understood the Trust Community Dental Service (CDS) was to be involved in the assessment; however, CDS did not attend the assessment.

11. The complainant said, after the multidisciplinary assessment in August 2018, the patient's difficult behaviour continued. The complainant explained the patient's behaviour included self-harming and aggression, both of which put significant stress on the family, in addition to the impact on the patient. The complainant said the patient's new self injurious behaviours lasted for the entire period, from late 2017 and which manifested *'24 hours a day'.* She explained, the patient and his family became isolated as they could neither go out or receive visitors because of the potential risks to other people from the patient's aggressive behaviour. The complainant said, prior to this period, the patient was '*happy and easy-going'.*

12. On 1 July 2019, the complainant identified that the patient had a broken double tooth and raised this with the patient's key worker who liaised with CDS. On 19 July 2019, CDS carried out dental treatment with the patient under GA.
13. The complainant said, following the dental treatment, the patient's behaviour improved; however, the patient never returned to school and, since the onset of his behavioural change, cannot interact with other children. The complainant said the patient *'lost part of his childhood'.* The complainant also said the patient is now transitioning to adult services and, although his behaviour has improved since he received the dental treatment, he *'was never the same child as before'.* The complainant believed this is because of the trauma he experienced. The complainant believed the patient's behavioural changes were caused by '*significant pai*n' related to dental issues but, because the patient is non-verbal, he could not communicate this.

14. The complainant said neither CDS nor Paediatrics accepted responsibility for this lost opportunity. The complainant said it was important to identify where the responsibility lay, to facilitate an acknowledgement and apology to the patient and his family and to ensure this situation did not recur.

Evidence Considered

Legislation/Policies/Guidance

15. I considered the following guidance:
    - The DoH Oral Health Guidance;
    - The NHS Fluoride Guidance; and
    - The NICE Dental Check Guidance.

    I enclose relevant sections of the guidance considered at Appendix five to this report.

Trust's response to investigation enquiries

16. As part of investigation enquiries, the Trust had an opportunity to respond to the complaint. The Trust's response to the enquiries is at Appendix two to this report.

Relevant Trust records

17. I considered the complainant's dental records for the period of 13 September 2012 to 19 July 2019 and correspondence between and within CDS, as well as correspondence with Paediatrics.

Relevant Independent Professional Advice

18. The Dental IPA provided advice about the care and treatment CDS provided to the patient from 12 September 2012 to 19 July 2019 and CDS' actions in relation to the patient's assessment under GA in August 2018. The Dental IPA's full advice is at Appendix three to this report.

Responses to the Draft Investigation Report

19. The complainant and the Trust were given an opportunity to provide comments on the Draft Investigation Report. The responses to the Draft Report have been considered and, where appropriate, comments have been reflected in the report or changes have been made. Only the Trust CDS provided a response to the Draft Report. Paediatrics did not provide any comments either on the Draft Report or on the Paediatric IPA's further independent professional advice sought after receipt of Draft Report comments, and which further advice, was provided to the Trust for any further comments.

The Trust's CDS response

20. Although the Trust challenged some of the Dental IPA's comments about the detail of the patient's notes, the Trust stated it accepted the notes could contain more specific information, including what it did and did not achieve at each of the patient's appointments and the reasons for any difficulties and decisions, including consideration of risk assessments.

21. The Trust refuted that it could be definitively determined either that the patient experienced dental pain for the period suggested, or this was the source of the patient's behaviour changes.

22. The Trust stated, although the patient presents challenges to the conduct of thorough dental examination and treatments, it recognised the need to further consider approaches and resources required for patients with complex needs.

23. The Trust stated, in October 2017, it suggested to the complainant that she ask the patient's GP for an oral sedative to aid dental examination; however, the complainant did not arrange this. The Trust accepted CDS did not follow this up with the complainant. The Trust stated it had offered several other opportunities for dental care to the patient during the period related to the complaint. Specifically: -
    - CDS had arranged to attend the original assessment under GA on 7 June 2018, but the complainant cancelled this assessment;
    - CDS offered a patient review in December 2018, but this received no response. The Trust then renewed the offer of patient review in June 2019; and
    - CDS invited the patient's family to contact CDS if the patient experienced any issues; however, CDS received no contact in the period of June 2018 to July 2019.

24. The Trust stated, although it is not Trust policy to follow-up on patients who do not respond to a review or recall invitation, the Trust would consider how it might incorporate this opportunity for improvement.

25. The Trust stated, when the complainant raised the concern in July 2019, CDS provided a quick response to his need.

Further Independent Professional Advice

26. Following the Trust and complainant's comments on the Draft Investigation Report, and receipt of further records from CDS, we sought further advice from both the Dental and Paediatric IPAs about the roles and responsibilities of CDS and Paediatrics in the organisation of the GA assessment in the summer of 2018.

27. The Dental IPA encompassed his further advice within his original advice, which is at Appendix three to this report. Key aspects of his further advice are detailed in paragraphs 40 and 41 below.

28. The Paediatric IPA incorporated her further advice into a revised advice report. The Paediatric IPA's further advice is at Appendix four to this report. Key aspects are included under Issue two of the complaint at paragraph 54 below.

Analysis and Findings

Application of flouride

29. I note the DoH Oral Health Guidance states '*fluoride varnish … should happen when a child visits a dental surgery and is strongly recommended … applications twice a year produce an average reduction in dental caries*[2] *increment of 37% in the primary and 43% in the permanent dentition'.* Further, the NHS Fluoride Guidance states, *'from the age of 3, children should be offered fluoride varnish application at least twice a year.'*

30. I note CDS applied Duraphat[3] on only two occasions over the relevant period of care, specifically, on 11 August 2015 when the patient was nine, and on 19 July 2019 when he was 13.

31. I note the Dental IPA advised, *'clinical notes are vital records of patient care'* but the patient's CDS notes '*do not record in enough detail what the current oral hygiene practices are, and what oral hygiene techniques have been advised'.* He further advised *'diet analysis appears to be very brief.'*

32. The Dental IPA referenced the DoH Oral Health Guidance. I note his advice dentists should apply topical fluoride twice a year to children in line with guidance. He advised, however, CDS only applied this twice in the seven-year period of 2012 to 2019.

[2] Caries is tooth decay or cavities.

[3] Duraphat is a Topical Fluoride Varnish for decay and cavity control and dental hypersensitivity to be administered by a dental professional.

33. Having considered all relevant information, including the Dental IPA's advice and the patient's records, I find CDS applied topical fluoride to the patient's teeth on only two occasions in the period of September 2012 to July 2019, during which period the patient was aged seven to 13 years. I accept the Dental IPA's advice it would be clinically appropriate for CDS to have applied topical fluoride twice each year. Therefore, I am satisfied CDS did not act in accordance with the DoH Oral Health Guidance or the NHS Fluoride Guidance. I consider this constitutes failures in care and treatment.

Frequency of Dental Checks

34. I note the NICE Dental Check Guidance states, for patients under 18 years old, the agreed interval between dental checks is three, six, nine or twelve months. However, for patients who have difficulty in maintaining oral health, including those with special needs, *'more frequent recalls may be required'.*

35. CDS reviewed the patient at ten appointments from September 2012 until July 2019. This included the appointment on 19 July 2019. I note, within this period, except for two linked appointments in autumn 2012 and two linked appointments in May 2013, CDS reviewed the patient at six appointments at intervals of seven, 11, 16, 14, 12 and 21 months. There is a record of a recall of the patient in December 2018, which did not result in an appointment. However, this recall was 14 months after the previous appointment. There is no evidence of a follow-up to this recall when the patient's parents did not make an appointment. This last interval of 14 months between recalls occurred following a period when the complainant raised concerns about the patient's behaviour with CDS and other clinical professionals. At this time, CDS and the patient's GP had suggested the possibility of patient review under sedation, which I note did not materialise.

36. The Dental IPA referenced the NICE Dental Check Guidance and advised the frequency of CDS' recall of the patient *'was inconsistent*' and ranged from approximately six to 16 months. The Dental IPA further advised that a standard recall for children is six months. However, recall should take place at least every 12 months. I note his advice, *'good practice would be to endeavour to recall a patient with significant special care needs, hence at a higher risk of developing dental decay (caries), at shorter intervals ie every 3 to 4 months. Many of the patient's recall*

periods exceeded the standard and minimum for children, as well as the recommended for special care needs'.

37. Having considered the frequency of the patient's reviews and recalls documented in his dental records, and the Dental IPA's advice, I am satisfied CDS did not act in accordance with either the NICE Dental Check Guidance or good practice. I consider this constitutes a further failure in care and treatment.

Arrangements for the GA Assessment in summer 2018

38. In the Trust's response to investigation enquiries it stated neither CDS nor the Paediatrician had invitations or evidence of a request to attend on 20 August 2018. I note any correspondence available referred to *'preliminary agreement but not a definitive date'.* The Trust also stated the dental surgeon discussed the patient with a Special Care Dentist in CDS in early August 2018, agreed CDS would be 'a*vailable'* and CDS *'would await contact from Paediatrics'.*

39. The Trust stated CDS was to attend a planned appointment on 6 June 2018, at which it would sedate the patient for blood tests. It stated the complainant cancelled this appointment because of the patient's extreme agitation.

40. Following receipt of additional evidence from CDS, the Dental IPA provided further advice about CDS' involvement in the GA assessment in 2018. He advised that Paediatrics did not follow-through with CDS about the specifics of the proposed GA assessment after the initial invitation. I note his advice, although CDS *'could have followed-up to confirm the GA assessment arrangements',* it was the Paediatrician's role as '*coordinator and key worker'* to confirm the time and date of the assessment with CDS.

41. The Dental IPA also advised, however, there was no evidence CDS followed up with the patient's family about the planned assessment at any point. I note his advice this is '*notable as there were queries about possible dental issues raised at and after the last CDS review with the patient in October 2017 when review under an oral sedative was suggested to be taken forward in conjunction with the GMP but this was not followed up either'.* Further, if CDS had recalled the patient in accordance with the minimum standard required of one year, CDS would have *a*ssessed and, if required, treated the patient *'almost nine months earlier'.*

42. The Dental IPA referenced the patient's records for CDS' treatment on 19 July 2019. I note his advice the x-rays indicated decay and '*infection/ abscess',* with the notes from the final treatment plan stating *'gross'* decay. The Dental IPA advised, in addition to the x-rays, CDS scaled the patient's teeth, applied four fillings and extracted two teeth.

43. The Dental IPA advised, on 31 October 2017, there was '*initial evidence',* from the patient's GP, that the patient's behavioural changes could be due to his teeth. He advised, at that time, CDS *'considered sedation to aid an examination however this was not followed up'*. The Dental IPA advised, the dental treatment in July 2019 *'involved the removal of badly decayed/ infected teeth, including abscess. So it can be strongly suspected that dental issues were present for some time'.* Further, I note the Dental IPA's advice the dental issues could have been the source of, or a contributory factor in, the patient's changed behaviours *'given that after the treatment in July 2019 the patient's behaviour improved or became more manageable. There is certainly evidence the patient could have been in pain arising from dental issues'.*

44. I consider the evidence indicates Paediatrics invited CDS to attend the GA assessment but did not provide any further details of the arrangements. I accept the Dental IPA's advice and am satisfied the Paediatrician was responsible for confirming the details of the assessment with CDS, which he did not do. However, I also accept the Dental IPA's advice and consider CDS should have communicated with the patient's family that their involvement in the GA assessment did not materialise. I further accept the Dental IPA's advice CDS should also have followed up the proposal in October 2017 to review the patient using an oral sedative but did not do so. Therefore, I consider these constitute failures in care and treatment.

Summary

45. I refer to my findings at paragraphs 33, 37 and 44. I consider CDS could have identified, prevented and treated the patient's dental issues, which CDS addressed on 19 July 2019, earlier. Specifically if CDS had:-
    - recalled the patient and applied topical fluoride more regularly in line with guidance, the risk of these dental issues would, at a minimum have been reduced, and may have been prevented;
    - followed up the suggested sedation through the patient's GP in 2017;

- followed up when the patient's recall in December 2018 did not result in an appointment; or
- informed the patient's family that CDS did not participate in the GA assessment.

Therefore, I am satisfied CDS did not provide appropriate and reasonable care to the patient during the period, and I uphold this issue of complaint.

Injustice

46. I considered carefully whether the Trust's failings caused injustice to the patient and his family. I refer to the Dental IPA's advice, the patient's dental records of 19 July 2019 indicated '*gross'* decay and '*infection/ abscess*'; therefore, *'it can be strongly suspected that the dental issues were present for some time'* and '*there is certainly evidence the patient could have been in pain arising from dental issues'.* I also refer to the Dental IPA's advice, if CDS had acted in line with the relevant guidance, it would have reduced the likelihood of these dental issues and facilitated earlier treatment. Therefore, I consider the patient sustained the injustice of a loss of opportunity for optimum and timely care and treatment. I refer to the Trust's comment that the patient's behaviour changes could not be definitively attributed to his dental issues for the entire period. However, in the context that the patient's behaviours improved after his dental treatment in July 2019 and the Dental IPA's advice, I consider, on the balance of probabilities, the patient sustained the injustice of distress from unnecessary pain. Furthermore, I consider the patient's family sustained the injustice of worry and upset at seeing the patient in distress.

Issue 2: Whether the care and treatment the Trust Paediatric Department provided to the patient from January 2018 to July 2019 was appropriate and reasonable.

Detail of Complaint

47. I refer to paragraphs ten to 14 in Issue one of the complaint.

Evidence Considered

Legislation/Policies/Guidance

48. I considered the GMC Guidance. I enclose relevant sections of the guidance considered at Appendix five to this report.

Trust's response to investigation enquiries

49. As part of investigation enquiries, the Trust had an opportunity to respond to the complaint. The Trust's response to the enquiries is at Appendix two to this report.

Relevant Trust records

50. I considered the complainant's paediatric records for the period of January 2018 to July 2019 and correspondence between Paediatrics and CDS.

The complainant's response

51. The complainant said the patient's Paediatrician was the lead clinician within the Multidisciplinary Team (MDT); therefore, he had responsibility for the coordination of input from all required clinicians, including the management of invitations to the proposed assessment. She said the Paediatrician should have presented the invitation to CDS in more formal terms to include the proposed date, time and venue or he should have issued a further follow-up invitation with these details. Further, the complainant said the Paediatrician should have requested confirmation of clinicians' attendance and, in cases when he did not receive a reply, he should have followed these up. The complainant said the *'invite'* the Paediatrician issued was not actually an invitation.

The Trust's CDS response

52. The Trust stated the Paediatrician was the patient's lead clinician. Therefore, although he was responsible for the implementation of all associated procedures related to the proposed assessment, including dissemination of information about this, he did not communicate further details such as the final date and time for the assessment. The Trust also provided further records related to correspondence about the GA assessment of summer 2018.

Analysis and Findings

53. I refer to the GMC Guidance. This states doctors must *'adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological … factors) … where necessary, examine the patient … promptly provide or arrange suitable advice, investigations or treatment where necessary … refer a patient to another practitioner when this serves the patient's needs'.* Further, *'clinical records should include: the decisions made and actions agreed, and who is making the decisions and agreeing the actions … who is making the record and when'.* In relation to continuity and coordination of care, I note the GMC Guidance requires clinicians to '*contribute to the safe transfer of patients between healthcare providers'* which *'means you must: a share all relevant information with colleagues involved in your patients' care within and outside the team, including when you hand over care as you go off duty, and when you delegate care or refer patients to other health or social care providers*'

54. I refer to paragraphs 26 and 28 above under Issue one of the complaint. The Paediatric IPA provided the following advice about the Paediatrician's role in the GA assessment organisation. The Paediatrician was '*the lead clinician'* who was responsible for the *'planning and performance'* of the GA assessment. She advised that the Paediatrician's responsibilities for such an arrangement included decisions about '*what examinations were necessary*', organisation of *'tests for the day'* and to invite '*any other professionals to attend on that day as deemed appropriate*'. I note her advice, *'the Paediatrician should have let CDS know when and where to come'.* She advised the evidence indicates Paediatrics did not inform CDS about the date or time of the proposed procedure. The Paediatric IPA concluded the failure to provide CDS with specific information about the assessment *'was an error on behalf of the Paediatrician'.* Further, Paediatrics should have communicated these details in writing, with CDS' response '*documented in the notes'*. The Paediatric IPA detailed the examinations undertaken at the GA assessment, which did not include any dental examination. She advised there was no indication the GA assessment identified '*a cause for [the patient's] changed behaviour'.*

55. I refer to my finding at paragraph 44 in Issue one of the complaint that Paediatrics did not confirm arrangements for the GA assessment with CDS. I also accept the Paediatric IPA's advice and consider the failure to communicate these arrangements was not appropriate. I consider this does not accord with the GMC Guidance cited in

paragraph 53; therefore, this is a failure in care and treatment. Consequently, I uphold this element of the complaint.

Injustice

56. I considered carefully whether the Trust's failing caused injustice to the patient and his family. I refer to paragraph 46 above related to Issue one of the complaint and the injustice ascribed to this aspect of the patient's care and treatment. Therefore, because on the balance of probabilities by July 2019 the patient's dental issues had been present for some time and he was in pain, I consider the patient sustained the injustice of a loss of opportunity for optimum and timely care and treatment and distress from unnecessary pain. I also consider the patient's family sustained the injustice of worry and upset at seeing the patient in distress.

CONCLUSION

57. I received a complaint about the paediatric and dental care and treatment the Trust provided to the patient. For the reasons outlined in this report, I upheld both issues of complaint.

58. Specifically, in relation to issue one, the Trust did not: -

- apply topical fluoride to the patient's teeth in line with relevant guidance;
- recall or review the patient for dental care as frequently as required by relevant guidance; and
- follow-up with the patient's family about the GA assessment.

59. I recognise these failings caused the patient to sustain the injustice of a loss of opportunity for optimum and timely care and treatment. Further I recognise, on the balance of probabilities, the failings caused the patient to sustain the injustice of distress arising from unnecessary pain. I also recognise the failings caused the patient's family to sustain the injustice of worry and upset at seeing the patient in distress.

60. Throughout my consideration of this case, the complainant's concerns about the patient's wellbeing and her desire to ensure his needs and best interests were met were clearly evident. I hope this report gives the complainant some reassurance in

providing answers to her questions about the failures in the patient's care and treatment.

Recommendations

61. I recommend the Trust provides a written apology to the complainant in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustices caused because of the failures identified (within **one month** of the date of this report). Further, in recognition of the great distress the patient and his family experienced because of the omission of CDS from the GA assessment, I recommend the Trust considers facilitating a face-to-face meeting between a Paediatric representative and the patient and complainant to communicate the apology in-person.

62. I further recommend the Trust should remind relevant staff of the importance of the DoH Oral Health Guidance; the NHS Fluoride Guidance; the NICE Dental Check Guidance; and the GMC Guidance, paragraphs 15, 21 and 44. The Trust should evidence this through records of information sharing.

63. I recommend the Trust should give relevant staff the opportunity to reflect on the findings of this report and the full Dental and Paediatric IPA's advice, in consideration of their own practice and which the Trust should note in appraisal documentation. The Trust should evidence this through records of information sharing.

64. I further recommend the Trust should review Paediatrics' process for management of potential joint investigations. The Trust should consider how these are documented and progressed. The Trust should evidence the review and any outcomes.

65. I recommend the Trust should carry out sample audits of the following:
    - The frequency of recall of children in line with the NICE Dental Check Guidance, including follow-ups where appointments do not materialise. Both of these should be reviewed with particular reference to children with special care needs;
    - The application of topical fluoride in line with the DoH Oral Health and NHS Fluoride Guidance; and
    - The formal documentation and communications around multidisciplinary clinical assessments coordinated by Paediatrics.

The Trust should evidence the audit outcomes, with an associated action plan for any shortcomings identified.

66. I refer to paragraphs 20, 22 and 24. I welcome the Trust's engagement with learning and opportunities for improvement related to records, approaches to care of patients with complex needs and follow-up with recalls in the absence of patient responses. I recommend the Trust provides this office with details of the outcomes of any process or documentation reviews and revision.

67. I recommend the Trust should provide me with an update on recommendations at paragraphs 62 to 66 within **six months** of the date of my final report. The Trust should evidence the implementation of appropriate actions to address the recommendations (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff read and understood any related policies).

MARGARET KELLY **September 2025**
Ombudsman

Appendix One

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.