SPSO decision report

Case: **201301139, A Dentist in the Lothian NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C complained that his dentist did not provide a reasonable standard of treatment. At Mr C's initial appointment, the dentist carried out a detailed examination. She noted that there was extensive decay in one of his lower wisdom teeth and that it might require extraction. When Mr C returned to start the treatment, the tooth was drilled to remove the decay, but this led to exposure of the nerve. The dentist covered the exposed nerve by dressing it with a paste to treat inflammation/infection, and a filling material. She told Mr C that the tooth would need to be extracted at a later appointment.

Mr C attended the dentist again two days later as he had pain and swelling around the tooth. The dentist gave him an antibiotic and reduced the filling by cutting it back (this eases symptoms slightly by preventing the patient putting pressure on the tooth when biting). The next day, Mr C contacted NHS 24, as he was concerned about increasing swelling and pain around the tooth. He was referred to an emergency dentist who prescribed a different antibiotic. Mr C saw his dentist again several days later. She was unable to extract the tooth because of the swelling, although she thought that it had gone down slightly. Mr C was later admitted to hospital because the swelling had increased. It was found that he had an abscess and he had an operation to drain the abscess and to extract the tooth.

Mr C complained about the dentist's failure to extract the tooth. As part of our investigation we took independent advice from our dental adviser. We found that the decision to delay the extraction of the tooth until such time as it could be fully assessed was reasonable because of the risks associated with extraction of a lower wisdom tooth. However, the dentist had used a substance called glass ionomer to fill the tooth when the nerve was exposed. Our adviser said that this was not an appropriate choice for an exposed nerve and the dentist should have chosen a more appropriate sedative dressing material. This would have reduced the risk of complications and pain while Mr C was waiting for the tooth to be extracted. In addition, we found that the dentist had failed to ensure that the infection could drain away when the abscess began to develop. This allowed pus to continue to accumulate within the tooth, which then spread into the surrounding tissues and made the swelling worse. In view of this, we found that the dentist had not provided Mr C with a reasonable standard of dental treatment.

Recommendations

We recommended that the dentist:

- ensures that she has learned lessons from this case;
- issues a written apology to Mr C for the failure to use an appropriate sedative dressing material and for the failure to establish drainage in the tooth; and,
- ensures that responses to complaints provide information about how to refer the complaint to the SPSO.