Scottish Parliament Region: Mid Scotland and Fife

Case 200501171: A Dentist, Forth Valley NHS Board

Summary of Investigation

Category

Health: Family health services; Dental treatment

Overview

The complainant raised concerns about her dental treatment and the redress she obtained.

Specific complaint and conclusion

The complaints which have been investigated are that:

(a) the treatment provided was inadequate (*upheld*); and

(b) the compensation was insufficient (*upheld*).

Redress and recommendation

The Ombudsman recommends that the dentist makes a payment of £3020 to the complainant and undertakes further training.

The dentist has accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. The complainant (Ms C) complained to her dentist about the dental treatment she had received on her upper right second premolar tooth UR5 which resulted in the unnecessary loss of the tooth and caused unnecessary pain and suffering.

2. Ms C's dentist apologised and refunded the cost of the treatment.

3. Ms C complained to the Ombudsman about the clinical standard of the treatment and the inadequacy of the compensation.

4. The complaints from Ms C which I have investigated are that:
(a) the treatment provided was inadequate; and
(b) the compensation was insufficient.

Investigation

5. In investigating this complaint I have had access to Ms C's dental records. In addition I obtained records and photographs from the dentist Ms C consulted subsequently. I also obtained clinical advice from the Ombudsman's professional adviser (the Adviser) and my conclusions are based on the advice I have received. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the dentist have been given the opportunity to comment on the draft of the Report.

(a) The treatment provided was inadequate

6. Ms C attended her dentist on 13 December 2004. A DO amalgam filling (a filling from the top of the tooth to the back of the tooth) was placed at UR5.

7. On 6 January 2005 Ms C attended the dentist complaining of toothache at UR5. A root canal treatment was carried out on that tooth. A pre-treatment radiograph was taken of UR5 and a further radiograph was taken when the root canal treatment was completed.

8. Ms C said that following this treatment she continued to experience pain in the area of the root canal treatment. Her dentist prescribed a seven day course of antibiotics but the pain persisted.

9. Ms C attended for a further appointment on 20 January 2005 at which time she said the dentist told her the tooth would settle down in time.

10. Ms C said that over the following week she suffered even greater levels of pain. She required large and regular doses of painkillers. She was unable to eat or sleep properly and struggled to attend her work.

11. Ms C lost confidence in her dentist and on 28 January 2005 attended an appointment with a new dentist where she was advised that extraction of UR5 was the only appropriate action because the root of the tooth had been drilled through twice.

12. When Ms C complained to her original dentist he said he was sorry that her treatment had gone awry. He could not understand his failure to recognise her situation at the follow-up appointment. He apologised for failing to examine her x-ray on the new computer. He thought Ms C's tooth could possibly have been saved by further root canal therapy.

(a) Conclusion

13. The post treatment digital radiograph clearly shows that the root filling had not in fact been placed into the root canal of UR5 but that the dentist had perforated the side of the root. This is known as a lateral perforation and is a procedural error by the dentist. The Adviser said that when carrying out root canal treatments there are basic principles to be followed. A diagnostic radiograph should have been taken. That is where the dentist places a root canal instrument file in the tooth and takes a radiograph. If that had been done it would have ensured that the dentist had located the root canal correctly.

14. The Adviser noted the dentist's belief that the tooth could have been saved even after the events described. The Adviser said, however, that although referral to a root canal specialist and surgical intervention can sometimes be carried out to try to save a tooth, the prognosis in this case was very poor and extraction was the appropriate clinical option. I am, therefore, satisfied that the tooth ultimately required to be extracted as a result of shortcomings in the root canal treatment.

15. The Adviser said that the standard of the root canal treatment was clinically unacceptable. I uphold the complaint that the treatment provided to Ms C was inadequate.

(a) Recommendation

16. I am concerned that the dentist can offer no explanation of his failure to look at the post treatment radiograph. He also failed to take a diagnostic radiograph. The Ombudsman recommends that the dentist undertakes 'hands-on' postgraduate endodontics training as part of his continuing professional development. In response to the draft report NHS Forth Valley Board expressed their willingness to use their Dental Practice Advisor to mentor the dentist. A copy of this report will be sent to the Board to allow them to monitor the dentist's progress.

(b) The compensation was insufficient

17. Following her complaint Ms C's dentist sent her a cheque for £93.56. This was a refund of the charges she had paid for dental treatment. Ms C said that she did not consider that to be sufficient. Ms C was unable to find another NHS dentist locally and has already incurred charges for private dental treatment of £124 to have the tooth removed and £95 in respect of a consultation regarding treatment options. She now has to attend the private dentist for a tooth implant at an estimated cost of £2,500. Ms C provided receipts for the expenses which she had paid and an estimate for the work needing to be done. In addition, between 6 January 2005 and 28 January 2005 she suffered unnecessary pain and distress during which period her dentist failed to recognise the problem.

(b) Conclusion

18. Ms C incurred considerable expense as a result of the poor treatment and she suffered pain unnecessarily. A refund of the charges will not adequately compensate her. I uphold the complaint that the redress provided to Ms C was insufficient.

(b) Recommendation

19. The Ombudsman recommends that the dentist pays £3020 to Ms C being £2720 to cover the cost of remedial work and the implant and £300 in respect of her pain and suffering.

20. The dentist has accepted the recommendations. The Ombudsman asks the dentist to notify her when the recommendations set out in paragraphs 16 and 19 have been implemented.

23 May 2007

Annex 1

Explanation of abbreviations used

Ms C	The complainant
UR5	The upper right second premolar tooth

Annex 2

Glossary of terms

Root canal treatment	The treatment of painful or diseased teeth, in which the nerves are removed and the root canal is filled with an inert root filling material
endodontics	A dental specialty concerned with the maintenance of the dental pulp in a state of health and the treatment of the pulp cavity