Scottish Parliament Region: Lothian

Case 200503137: Lothian NHS Board

Summary of Investigation

Category

Health: Community Dental, clinical treatment

Overview

The complainant (Mrs C) raised a number of concerns about the dental treatment she received prior to and following surgical extraction of teeth on 3 May 2005. She also raised concerns that she had not given informed consent, there was a lack of communication from staff and poor complaints handling.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the treatment which was provided prior to and following surgical extraction of teeth on 3 May 2005 was inadequate and it was inappropriate to extract an additional tooth (*not upheld*);

(b) staff failed to obtain informed consent from Mrs C (*not upheld*);

(c) communication from staff was poor *(partially upheld)*; and

(d) there were delays and communication failures when handling the complaint (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board remind staff of the timescales in the NHS Complaints Procedure Guidance and offer Mrs C an apology for the failings which have been identified.

The Board have accepted the recommendations and will act on them accordingly

Main Investigation Report

Introduction

1. On 3 April 2006, the Ombudsman received a complaint from Mrs C about the dental treatment she received prior to and following surgical extraction of teeth on 3 May 2005. She also raised concerns that she had not given informed consent, there was a lack of communication from staff and poor complaints handling.

2. The complaints from Mrs C which I have investigated are that:

(a) the treatment which was provided prior to and following surgical extraction of teeth on 3 May 2005 was inadequate and that it was inappropriate to extract an additional tooth;
(b) staff failed to obtain informed consent from Mrs C;
(c) communication from staff was poor; and
(d) there were delays and communication failures when handling the complaint.

Investigation

3. In the course of this investigation, I have examined correspondence between Mrs C and Lothian NHS Board (the Board), Mrs C's dental records and the Board's complaint file on this matter. I also obtained advice from the Ombudsman's professional dental adviser (the Adviser) regarding the clinical aspects of the complaint.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report can be found at Annex 1. A glossary of the clinical terms is at Annex 2. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Background

5. Mrs C had been a patient of the Community Dental Service (CDS) and the Edinburgh Dental Institute since 2001 following a referral from her General Dental Practitioner. A Senior Community Dentist (Dentist 1) at the CDS assumed responsibility for Mrs C's treatment. Between 9 July 2002 and 23 August 2004 Mrs C underwent seven separate procedures which included root treatment, restoration of teeth, radiographs and teeth extractions. On 3 May 2005 Dentist 1 arranged for Mrs C to be admitted to St John's Hospital,

Livingston (the Hospital) as a day patient to undergo allergy testing and dental extractions. Following this treatment on 3 May 2005, Mrs C reported continual mouth pain, pain round her cheeks and eye sockets, hearing loss and tinnitus and could not eat properly. She attended her General Practitioner (the GP) who arranged for her to see a Consultant in maxillofacial surgery at the Hospital (the Consultant).

(a) The treatment which was provided prior to and following the extractions on 3 May 2005 was inadequate and it was inappropriate to extract an additional tooth

6. Mrs C formally complained to the Board that that between 2001 and 2005 Dentist 1 should have arranged allergy testing which would have found a suitable anaesthetic; allowed pro-active dental treatment to start sooner and prevent abscess problems and the loss of teeth. She also felt it was wrong that Dentist 1 allowed another dentist (Dentist 2) to carry out allergy tests prior to surgery[1] on 3 May 2005. Mrs C stated that Dentist 2 had given her an injection in the mouth and this caused her great pain. Mrs C thought that Dentist 2 had administered the injection in the wrong place and had probably injected into a nerve. Mrs C also complained that x-rays and notes were not available prior to the surgery for Dentist 1 to refer to and, therefore, this would have affected her professional judgement. Mrs C felt the removal of a fourth tooth during surgery was also unnecessary and Mrs C thought this happened because Dentist 2 had caused a large piece of bone to break off when extracting a neighbouring tooth and this undermined the fourth tooth. Post-operatively, Mrs C was told the fourth tooth had a hole in it and she wondered if an x-ray had been taken and whether this would have identified the hole which could then have been filled instead of extracted.

7. Following surgery Mrs C said she noticed that her frenulum had been cut and skinned; her tongue was swollen and had red wields; her face was bruised and swollen and the sutures were so tight they cut into the flesh of the gums. Mrs C contacted another dentist (Dentist 3) while she was on holiday. [Note: Mrs C has not divulged the identity of Dentist 3.] Mrs C said Dentist 3 told her it appeared the surgery seemed to have caused a significant area of bone to be cracked off the upper right jaw and lower left jaw during tooth extraction. Mrs C felt Dentist 1 and Dentist 2 must have known about this but had not told her.

[1] The Board have advised that during the surgery itself Dentist 1 and Dentist 2 operated as a team.

Mrs C stated she was never advised that bone might have to be removed (during the operation) and that she would suffer continual pain in her face and frontal area of her head, suffer hearing loss and tinnitus, and that she might require possible reconstructive surgery and suffer myofacial muscle dysfunction and nerve damage due to trauma.

8. The Board's chief operating officer (the Chief Officer) responded to Mrs C. He said that according to the clinical records allergy testing had been carried out in 2001 and 2002. He said that Dentist 2 had also performed allergy testing prior to the general anaesthetic. He continued that Dentist 1 had not mentioned who would carry out the allergy testing but it must have been obvious to Mrs C that Dentist 1 and Dentist 2 were working as a team. The Chief Officer explained that no notes or x-rays were missing prior to surgery, therefore, Dentist 1 and Dentist 2 had consulted the full clinical records and radiographs prior to surgery. He said there were notes missing prior to a previous consultation but the matter was subsequently resolved.

9. The Chief Officer continued that bone was not removed during the surgery and that the teeth were extracted by normal technique without raising a flap or removing a bone. The Chief Officer said that there was no indication that Mrs C was in pain when she received the injection by Dentist 2 and the anaesthetist had confirmed there was no untoward reaction from Mrs C at that time or that she appeared shocked or surprised. The Chief Officer said that both Dentist 1 and Dentist 2 were present when the reason for the extraction of the fourth tooth was explained to Mrs C and she gave no indication that she was dissatisfied with the explanation. It was also explained that an unrestorable cavity was found in the fourth tooth and it was decided to remove the tooth at that time rather than leave it in place which would require another operation under general anaesthetic at a later date.

10. The Adviser read the clinical records in respect of 3 May 2005, and was of the opinion that they recorded a full, accurate and contemporaneous record for Mrs C's care and treatment and were of a high quality. He noted that the initial treatment plan was to extract three teeth from Mrs C – the upper right first molar tooth UR6, the upper left first premolar tooth UL4, and the lower left first molar tooth LL6. This treatment was carried out under a general anaesthetic. He said the clinical records show that at the time of the extractions, it was detected that there was deep decay at the back of the upper right second premolar tooth UR5 and the notes clearly state 'subgingival caries distally'. The notes continue

'heavily restored tooth, decision made by [Dentist 1] to extract UR5'. [Note: the decision was taken after a discussion between Dentist 2 and Dentist 1.] The Adviser commented that as Mrs C was under a general anaesthetic and the clinical decision of Dentist 1 was that this tooth was not saveable, it would be appropriate for Dentist 1 to remove UR5. The Adviser continued that it was quite clear from the written clinical records that no surgical treatment was provided at that time and no bone was removed. The four teeth were extracted by normal technique and the Adviser was satisfied that Mrs C received appropriate treatment in this regard.

11. The Adviser commented that the clinical records dated from 2002 and it appeared that Mrs C had received high quality treatment from the CDS. He noted an OPG of all Mrs C's teeth and jaws which was dated 17 July 2002. The Adviser said it was quite clear from this x-ray that Mrs C already had a heavily restored mouth with very large fillings present. Mrs C was a patient of high treatment need and it did appear from the clinical records that Mrs C was cared for appropriately by the CDS. There is another OPG dated 20 May 2005 (taken by Dentist 3 but not copied to the Board) – this is following the four extractions. The Adviser said this x-ray is quite satisfactory, and showed where the four teeth had been removed.

12. The Adviser commented on the issue of Mrs C's allergy to local anaesthetic solution. The notes in the case file show that Mrs C had been tested and there is a letter dated 26 February 2002 from a consultant anaesthetist regarding this issue. In summary, the Adviser felt the care provided for Mrs C was appropriate and in line with accepted clinical practice.

(a) Conclusion

13. Mrs C had concerns about the treatment which she received prior to and following the surgery on 3 May 2005. This included issues such as inadequate allergy testing; poor injection technique of Dentist 2; unnecessary removal of a fourth tooth during surgery; and failings in treatment during the surgery notwithstanding the removal of bone which caused her great discomfort. The advice which I have received and accept is that there is no evidence to substantiate Mrs C's complaints and in fact the records indicate that Mrs C received high quality of treatment from the CDS. I am persuaded that Mrs C received appropriate treatment and the decision to remove the fourth tooth whilst Mrs C was under the anaesthetic was clinically appropriate. I do not uphold this complaint.

(a) Recommendation

14. The Ombudsman has no recommendations to make.

(b) Staff failed to obtain informed consent from Mrs C

15. Mrs C complained to the Board that she was not informed of the risks of surgery; that Dentist 1 only partially read out the consent form and at the time Mrs C was still hurting from anaesthetic and felt pressurised. Mrs C thought that the operation was for the extraction of teeth and that she would experience some discomfort for a few days. Mrs C had originally signed for the removal of two teeth and was persuaded to sign for the removal of a third tooth. At no time did she consent to the extraction of the fourth tooth.

16. The Chief Officer responded to Mrs C that it was incorrect to say that she had not been informed of the potential risks of surgery and of having a general anaesthetic. The records which spanned several years indicated that this was explained to Mrs C. Staff who were present when consent was obtained from Mrs C on 3 May 2005 said that it was not done in an intimidating or pressurised way. The atmosphere in the anaesthetic room was relaxed as there was no other surgery scheduled that morning and there was no time pressure on the procedure. The Chief Officer was content that Mrs C was fully consulted in the process for patients to come to a rational decision regarding consent.

17. The Adviser noted that in the clinical records there are several consent forms (which I have seen) that have been signed by Mrs C, and this appears to be the routine for all patients at the Board. The Adviser had no concerns about the consent forms signed by Mrs C.

18. The consent form signed by Mrs C on 3 May 2005 included 'I … Hereby consent to undergo the operation of … the nature and purpose of which has been explained to me by … I also consent to further or alternative operative measures as may be found necessary during the course of the above named operation … No assurances have been given to me that the operation will be performed by a particular practitioner'.

(b) Conclusion

19. Mrs C complained that she failed to give informed consent in that the consent form was only partially read out and she felt pressurised. The recall from the staff involved was that information about the risks of surgery and consent were explained to Mrs C in line with normal practice. While it is not

always possible to reach conclusions about what was said in conversations between staff and patients, the availability of written documentation is one source of information about the events. In this case, in view of the consent forms which Mrs C signed during the course of her treatment, I am persuaded on the balance of probabilities to accept that reasonable consent was obtained by the staff. Accordingly I do not uphold this aspect of the complaint.

(b) Recommendation

20. The Ombudsman has no recommendation to make.

(c) Communication from staff was poor

21. Mrs C complained that Dentist 1 did not advise her that she would not be performing the surgery on 3 May 2005. Mrs C said at the pre-operative interview Dentist 1 categorically said that the procedures etc would be the same as happened during previous surgery in August 2004 when Dentist 1 performed an operation. Dentist 2 stood in the background and did not volunteer that she would perform the operation. Mrs C said that Dentist 1 also failed to make a post-operative telephone call on 4 May 2005 to Mrs C as promised. Mrs C reported she was in pain and as she had not heard from Dentist 1 by 6 May 2005 she contacted the CDS and was told Dentist 1 would be in touch. Mrs C heard no more and telephoned the CDS again on 20 May 2005 and left a message for Dentist 1 that she required a private appointment as she was in pain and was angry. Mrs C said she then received a voicemail message on 23 May 2005 to say that Dentist 1 was busy but she could see her on 13 July 2005 but if she was in pain she could see another dentist at the CDS.

22. The Chief Officer responded to Mrs C that it was Dentist 1's custom and practice to make it quite clear to patients and Mrs C, that her treatment was to be carried out by a team of staff. Dentist 1 wrote to Mrs C before she had made her formal complaint. Dentist 1 said she explained that she was sorry but she had tried to contact Mrs C with a post-operative call on 4 May 2005 but heard a BT recorded message and for reasons of confidentiality she decided not to leave a message. Dentist 1 was willing to meet Mrs C to discuss her complaint but wished details of what issues required to be addressed in advance so she could obtain the required information. Dentist 1 also wished to know what comments Dentist 3 had made about the surgery so that she could address them. Dentist 1 had no concerns about the treatment which was provided to Mrs C. The Chief Officer told Mrs C that he had noted Dentist 1 had apologised both verbally and in writing for the failure to follow-up the telephone call to

Mrs C on 4 May 2005 and that he did not think this indicated an administrative failure in the system. [Note: The Chief Officer subsequently advised me that the telephone follow-up call by the clinician is a procedure followed by the clinicians as a matter of courtesy. It would not be routine policy in any field of surgery to contact patients by telephone.]

23. The Adviser said there was an entry in the clinical notes dated 4 May 2005 that reads 'post-op phone call … no answer'. This is signed by Dentist 1 and the Adviser accepted this as a written record.

(c) Conclusion

24. Mrs C complained about a lack of communication from staff as to who would perform the operation and the failure of Dentist 1 to make a post-operative telephone call to her on 4 May 2005 as promised. Paragraph 18 has set out that the consent form included advice that no assurances had been given that the operation would be performed by a particular practitioner.

25. I note from the records that Dentist 1 attempted to contact Mrs C on 4 May 2004 but chose not to leave a message on the grounds of confidentiality. While I fully accept Dentist 1's reasons for doing so I am critical that she did not make further efforts to contact Mrs C. I note that Mrs C said she contacted the CDS on 6 May 2005 and asked that Dentist 1 should return her call and again on 20 May 2005. Although appropriate apologies have been provided for Dentist 1 not telephoning Mrs C, the fact that Mrs C left a message on 6 May 2005 for Dentist 1 to return her call and this was not actioned is a concern. As a result I have decided to partially uphold the complaint to this limited extent.

(c) Recommendation

26. The Ombudsman has no recommendations to make.

(d) Delays and communication failures when handling the complaint

27. The sequence of events following Mrs C's formal complaint to the Board were:

20 July 2005

Mrs C met with the Complaints Manager (the Manager) to discuss her complaint.

28 July 2005
The Manager sent Mrs C a letter. It was agreed an independent opinion from outside the Board could be an option and further enquiries would be made in that regard. It was also suggested that information could be obtained from other health professionals within the Board area, who had treated Mrs C since her surgery, might be required, therefore, could Mrs C sign a mandate.

9 August 2005
The Manager sought comments from the Consultant about what information he gave to Mrs C about the cause of her problems (i.e. the surgery).

17 August and 18 August 2005
Mr and Mrs C sent emails to the Board asking for an update. They were advised there was no trace of Mrs C's complaint and could they provide additional details. They were also told the Manager was on leave and would return on 29 August 2005. Mr and Mrs C decided they would wait for the Manager's return.

5 September 2005
The Consultant responded to the Board. He had not noticed anything untoward in terms of Mrs C's surgery and enclosed a copy of a letter he had sent to the GP following him seeing Mrs C on 22 June 2005.

8 September 2005
Mr and Mrs C ask for an update on the investigation.

14 September 2005
The Manager advised Mrs C that a response would be issued soon.

3 October 2005
The Chief Officer formally responded to the complaint.

National guidance
28. The NHS Complaints Procedure Guidance (the Guidance) was reviewed on 1 April 2005. The Guidance states that complaints should be acknowledged within three working days of receipt. Responses to complaints should be made within 20 working days with a further extension of 20 working days as long as

the complainant is advised of the delay and given the option to contact the Ombudsman if required.

29. Mrs C complained to the Ombudsman that the Board had failed to arrange an independent opinion as previously agreed and that the opinion they accepted was not completely independent as the Consultant was a Board employee. She was also concerned that during the investigation, the Board continued to ask for details of information which she had obtained privately from Dentist 3 despite being told it would not be provided. Mrs C was also dissatisfied about the Board's handling of her complaint. She said the Board had received her signed mandate on 30 July 2005 and had sent their final response on 3 October 2005 which was 66 days. Mrs C said the Board failed to keep her updated on developments with the complaint.

30. The Chief Officer wrote to Mrs C and explained that at the meeting with the Manager on 20 July 2005 it was agreed that a second opinion would be a sensible way forward to attempt to resolve Mrs C's concerns and the Manager would make enquiries. However, it was subsequently noticed that the GP had referred Mrs C to the Consultant whom she saw on 23 June 2005 (see paragraph 5). It was with Mrs C's permission that the Board had approached the Consultant for a report on the condition of Mrs C's mouth. The Consultant had stated to the Manager that he 'noticed nothing untoward in terms of the surgery that had been taken intra-orally, but I did note there was pain on palpation of the temporalis and masseter muscles. …This is unlikely to have risen as a direct result of the surgical procedure and certainly does not reflect any negligence on the part of the surgeon'. The Chief Officer viewed the Consultant's report as independent from the complaint as it had been arranged by the GP and that a further opinion was unlikely to reveal further information. The Chief Officer also thought that sight of x-rays which Mrs C had obtained from Dentist 3 would have been helpful to his clinical advisers and he asked that she reconsider her decision not to produce the x-rays for inspection.

(d) Conclusion

31. Mrs C complained that the Board failed to seek an independent opinion as promised. To an extent I can understand why the Board contacted the Consultant as his involvement was instigated by the GP and was independent of the complaint. However, at that time it would have been appropriate to have clarified with Mrs C the extent of the 'independent' opinion sought (i.e. that the Consultant was independent of the complaint but not the Board). It would also

have been appropriate following this to inform Mrs C that a further opinion would not be sought and to have allowed her to make comments if she felt they were required. I can also understand the logic that sight of Dentist 3's report could have been helpful in the Board's consideration of the complaint and could have afforded the opportunity for them to address any clinical issues which had been raised. I am also conscious of Mrs C's reluctance to name Dentist 3, however, there may have been scope to anonymise Dentist 3's comments.

32. It is also clear that the timescales in the Guidance were not adhered to and updates were not provided to Mrs C on the progress of the investigation. Accordingly, in all the circumstances I uphold this complaint.

(d) Recommendation

33. The Ombudsman recommends that the Board remind staff of the timescales in the NHS Complaints procedure Guidance and offer Mrs C an apology for the failings which have been identified.

34. The Board have accepted the recommendations and will act on them accordingly

18 July 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
The Board	Lothian NHS Board
The Adviser	The Ombudsman's dental adviser
CDS	Community Dental Service
The Consultant	Consultant in maxillofacial surgery
Dentist 1	A Senior Community Dentist
The Hospital	St John's Hospital, Livingston
The GP	Mrs C's General Practitioner
Dentist 2	Dentist who performed the surgery on 3 May 2005
The Chief Officer	The Board's Chief Operating Officer
Dentist 3	A dentist Mrs C attended following the surgery
The Manager	The Board's complaints manager
The Guidance	NHS Complaints Procedure guidance issued 1 April 2005

Annex 2

Glossary of terms

Caries	Decay
Distally	At the back of the tooth
Frenulum	Mucus membrane extending from the floor of the mouth to the underside of the tongue
Heavily restored	Extensively restored
OPG	Orthopantomogram – x-ray image of the upper and lower jaws and entire arrangement of teeth
Subgingival	Under the Gum
Tinnitus	Ringing, buzzing or whistling sound in the ears