Scottish Parliament Region: Glasgow

Case 200603028: A Dentist, Greater Glasgow and Clyde NHS Board[1]

Summary of Investigation

Category

Health: Dental Services, clinical treatment and diagnosis

Overview

The complainant (Ms C) complained about the standard of treatment she received from a dental practitioner which, she felt, had led to further problems with her dental health.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) a root was perforated during treatment, but this was not identified (*not upheld*); and

(b) the fitting of a crown was done poorly, leading to periodontal damage (*not upheld*).

Redress and recommendations

The Ombudsman has no recommendations to make.

[1] The dentist who was involved in this complaint was working in a practice in Lothian NHS Board area at the time of this complaint and thereafter moved to the area covered by Greater Glasgow and Clyde NHS Board

Main Investigation Report

Introduction

1. In the course of this treatment, Ms C believes that a root was perforated during root canal treatment (RCT) on 2 June 2003, and that a crown was poorly fitted on 22 October 2004, leading to further damage. She complained to the dental practice on 27 September 2006 about these issues along with some other concerns and received a response from the Dentist dated 8 November 2006. She remained dissatisfied with the Dentist's response to her complaint and referred the matter to the Ombudsman's office on 4 January 2007.

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

(a) a root was perforated during treatment, but this was not identified; and

(b) the fitting of a crown was done poorly, leading to periodontal damage.

Investigation

3. In order to investigate this complaint, I reviewed the correspondence between Ms C and the Dentist and examined the dental records and radiographs relevant to this period of treatment. In response to an inquiry letter of 16 March 2007, the Dentist sent her comments on the complaint on 9 April 2007. I sought the advice of an independent adviser on dental treatment (the Adviser) and received his comments on 6 July 2007.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C and the Dentist were given an opportunity to comment on a draft of this report.

Background

5. Ms C received dental care from the Dentist over the period 24 June 2002 to 16 August 2005. The Adviser noted that Ms C had, and continues to have 'a very high treatment need' and my reading of her dental records for this period confirms this view.

(a) A root was perforated during treatment, but this was not identified

6. On 23 May 2003, Ms C attended the dental surgery to seek treatment for pain she was experiencing in her lower left side. An x-ray showed a large area of infection at the tip of the root of her lower left first premolar tooth (LL4). To treat this, RCT was carried out and was completed on 2 June 2003. The

Dentist informed Ms C at that time that the prognosis for this tooth was not good and that it would be kept under observation.

7. In her complaint letter to the practice of 27 September 2006, Ms C said that an x-ray of LL4 taken by her new dentists on 27 August 2006 had indicated that the root canal had been perforated during treatment. While she noted that such perforations can happen in the course of RCT, she felt that the Dentist was obliged to 'advise the patient of the mistake at the time'. The tooth was now in a poor state and would require extraction.

8. In her response to Ms C's complaint, the Dentist said that x-rays from June 2003 to May 2005 had not indicated a perforation. She explained that infections of the sort she identified did not always respond well to conventional RCT.

9. The Adviser reviewed the radiographs of LL4 for the period of Ms C's treatment. He noted that the infection was significant and that 'the likelihood of a successful outcome has to be guarded in this type of infected root situation'. He considered that the Dentist had prepared the canal well and that the filling was also well done.

10. The Adviser explained that perforations do sometimes occur when the instrument accidentally deviates from the path of the root canal and perforates the side of the root of a tooth. He said that when a perforation does occur, patients usually experience pain and bleeding as a result. There was no written evidence in the clinical notes that this happened in this case. In conclusion, he considered that the RCT was of a good standard and that there was not enough x-ray evidence to say categorically that there had ever been a perforation.

(a) Conclusion

11. It is clear that Ms C's LL4 tooth had had significant infection and that by August 2006, its condition had deteriorated to the extent that it could not be saved. Given the poor prognosis for this tooth before the RCT, it is not necessary to look to that treatment for a possible cause of the deterioration. Indeed, the evidence is that the Dentist's work had been of a good quality and there was no evidence to suggest a perforation in the period following the RCT. In these circumstances, I do not uphold this complaint.

(b) The fitting of a crown was done poorly, leading to periodontal damage

12. The Dentist fitted a crown on Ms C's upper right first molar tooth (UR7) on 22 October 2004. When she attended her new dental practice in August 2006, Ms C was informed that there was an overhang on the crown of this tooth creating a plaque trap and periodontal pocket which was the cause of her pain. The tooth was healthy but the crown was replaced.

13. In her response to Ms C's complaint letter, the Dentist expressed her opinion that the loss of bone in the area around this tooth was due to chronic adult periodontal disease and not any overhang of the crown. In her submission to this office, the Dentist further commented that the crown 'may have had a distal [ie at the back of the crown] overhang evident on the radiograph [but] such overhangs can be exaggerated on radiographs due to film angulation.' She noted that such overhangs can be corrected.

14. The Adviser examined x-rays taken before (10/9/04) and after (30/3/05) the fitting of the crown and noted that there had been no change in the periodontal condition of UR7. He was aware of the suggestion of an overhang at the back of the crown and was of the opinion that any overhang in this area could easily be adjusted. He believed that the Dentist's treatment of this tooth was 'entirely reasonable'.

(b) Conclusion

15. I am conscious that Ms C incurred significant additional costs by replacing the crown fitted by the Dentist and she believes that this had been necessary due to damage resulting from inadequacies in the way it was fitted. The Adviser's review of the radiographic evidence led him to conclude that there had not been periodontal damage around UR7 in the months following the fitting of the crown. It was also his view that if there had been an overhang in this area, it would have been possible to correct it if Ms C had returned to the Dentist with further concerns about this tooth. In the light of this, I do not consider that there is evidence to suggest that the Dentist's treatment had been deficient, leading to periodontal damage, and there is evidence of other probable causes of such damage. In all these circumstances, I do not uphold this complaint.

19 December 2007

Annex 1

Explanation of abbreviations used

Ms C	The complainant
RCT	Root Canal Treatment
The Dentist	A dental practitioner who treated Ms C
The Adviser	A dental adviser to the Ombudsman
LL4	Lower left first premolar tooth
UR7	Upper right first molar tooth