**Scottish Parliament Region: Glasgow**

**Case 200501652: A Dentist, Greater Glasgow and Clyde NHS Board**

**Summary of Investigation**

***Category***

Health: Dental

***Overview***

The complainant (Ms C) raised a number of concerns regarding the care and treatment provided to her by her dentist (the Dentist).

***Specific complaints and conclusions***

The complaints which have been investigated are that:

(a) the Dentist failed to properly examine Ms C's teeth and overlooked the need for a filling (*upheld*);

(b) the Dentist failed to make an accurate impression of Ms C's teeth (*not upheld*);

(c) the Dentist failed to properly fit a Maryland Bridge (*not upheld*);

(d) there was a delay of two months mid treatment leading to the decay of Ms C's teeth (*not upheld*);

(e) a denture had been fitted improperly which induced Ms C's gag reflex and resulted in the loss of four adjacent teeth (*not upheld*);

(f) appointment times were insufficient to allow for dental work of a reasonable standard (*not upheld*);

(g) the Dentist improperly refitted a crown (*not upheld*); and

(h) the Dentist failed to take into account the radiotherapy and chemotherapy treatment Ms C had had previously which had affected her teeth (*not upheld*).

***Redress and recommendations***

The Ombudsman recommends that the Dentist:

(i) carries out a Clinical Audit of his own x-ray procedures to ensure that any problems with the current system can be identified and removed; and

(ii) carries out a similar audit in respect of his record-keeping to ensure compliance with General Dental Council Standards.

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

## Main Investigation Report

### Introduction

1. On 20 September 2005 the Scottish Public Services Ombudsman's office received a complaint from a member of the public (Ms C) concerning the care and treatment provided to her by her dentist (the Dentist). At this stage it was not clear whether Ms C had raised her concerns with the Family Dental Practice (the Dental Practice) in line with the NHS Complaints procedure. We advised her that she should do so prior to bringing her complaint to the Ombudsman's office. After further contact we formally started our investigation on 3 August 2006.

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

(a) the Dentist failed to properly examine Ms C's teeth and overlooked the need for a filling;
(b) the Dentist failed to make an accurate impression of Ms C's teeth;
(c) the Dentist failed to properly fit a Maryland Bridge;
(d) there was a delay of two months mid treatment leading to the decay of Ms C's teeth;
(e) a denture had been fitted improperly which induced Ms C's gag reflex and resulted in the loss of four adjacent teeth;
(f) appointment times were insufficient to allow for dental work of a reasonable standard;
(g) the Dentist improperly refitted a crown; and
(h) the Dentist failed to take into account the radiotherapy and chemotherapy treatment Ms C had had previously which had affected her teeth.

### Investigation

3. I have examined correspondence including responses to Ms C's complaint. I have made written enquiries of the Dental Practice and have obtained the dental records. I have also sought clinical advice from our independent professional advisers (the Adviser). I have set out, for each of the headings of Ms C's complaint, my findings of fact and conclusions.

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.

**(a) The Dentist failed to properly examine Ms C's teeth and overlooked the need for a filling**

5. Ms C visited her dentist on 28 September 2004 for her initial dental examination. She believes that had this examination been carried out correctly, action could quickly have been taken which would have prevented the further deterioration of her teeth in the following months.

6. From the dental records it is clear that an examination of her teeth did take place on 28 September 2004. The records detail that the patient was complaining of generalised tooth decay following treatment for cancer. It also details the condition of her teeth, what action will be taken at the next visit and includes details of two x-rays.

7. As part of the investigation process the dental records and x-rays have been obtained. The x-rays obtained in connection to this case are not of diagnostic quality. In addition, there is no evidence of a written treatment plan being prepared at the beginning of Ms C's consultations.

*(a) Conclusion*

8. Issues such as a lack of recorded treatment planning are part of a general problem in respect of record-keeping. Although the dental records detailed the Dentist's actions, they were difficult to read and generally fell below the standard which should be expected.

9. From the information held in the dental records, there is no evidence to show that the dentist overlooked the need for a filling. However, the quality of the x-rays and record-keeping is such that when considered along with the lack of a treatment plan, it suggests that the standard of examination falls short of a reasonable standard. For this reason, I uphold this aspect of the complaint.

*(a) Recommendation*

10. The Ombudsman's office has previously highlighted the problem of poor record-keeping in general. There is also an issue in respect of the failure to provide a documented treatment plan for this case.

11. In general it is also clear with this case that there are problems with the diagnostic quality of the x-rays taken over the period of the Dentist's care of Ms C. Clearly, as all x-rays in respect of this case are affected by these quality issues, it is possible that the same may apply to the Dentist's other patients. It

appears possible that there is a problem with the process the Dentist follows when taking and developing x-rays.

12. As a result of this, the Ombudsman recommends that the Dentist carries out a Clinical Audit of his x-ray procedures to ensure that the problems with the current system can be identified and removed. The Adviser has pointed out that it may be possible for the Dentist to obtain assistance in carrying out this audit in conjunction with his professional representative body (such as the Medical and Dental Defence Union for Scotland) (MDDUS).

13. The Ombudsman also recommends that the Dentist carry out a similar audit in respect of his record-keeping, again possibly in conjunction with the MDDUS, to ensure that he complies with the guidance as detailed in the General Dental Council's (GDC) document detailing Standards for Dental Professionals. In both cases it is recommended that the Dentist notifies the Ombudsman when these audits have taken place and provides copies of the audit results.

**(b) The Dentist failed to make an accurate impression of Ms C's teeth**

14. From the dental records it is not possible to establish the accuracy of a clinical impression. However, the Adviser has indicated that if the impression was not of a satisfactory quality, the dental laboratory would advise the dentist and this would be recorded in the records.

*(b) Conclusion*

15. There is no evidence in the records that the dental laboratory raised concerns about the quality of the impression. As such, I do not uphold this aspect of the complaint.

*(b) Recommendation*

16. The Ombudsman makes no recommendations on this point.

**(c) The Dentist failed to properly fit a Maryland bridge**

17. The Dentist decided that Ms C should be fitted with a Maryland Bridge. This is a type of bridge which does not require crowns on neighbouring teeth to support the bridge. Instead it relies on metal wings which are bonded to the back of one or both of the neighbouring teeth.

18. The advantage of this type of bridge is that it does not require the dentist

to remove much healthy tissue from the teeth at either side of the gap when preparing them. They are, however, not as strong as 'conventional' bridges and are only suitable for smaller gaps.

19. The success or failure of a Maryland Bridge relies on a strong bond onto the adjacent teeth. One of the commonest reasons for failure is a de-bonding of the metal wings. It is good practice to advise a patient of the options for, and risks associated with, treatment options including the possibility of de-bonding occurring, and this is reflected in the guidance on Standards for Dental Professionals produced by the GDC. There are no details in the dental notes of any discussion taking place in respect of the possibility of de-bonding occurring.

*(c) Conclusion*

20. Although there is no indication of the dentist discussing the possibility and risk of the de-bonding, there is no evidence to suggest that the bridge was inappropriately fitted. As such I do not uphold this aspect of the complaint.

*(c) Recommendation*

21. The Ombudsman recommends that the Dentist review his record-keeping as detailed in paragraph 12.

**(d) There was a delay of two months mid treatment leading to the decay of Ms C's teeth**

22. In October 2004 Ms C was advised by her dentists that she should return for further treatment in January 2005. She was concerned that this delay had led to the deterioration in the condition of her teeth. The Adviser has reviewed the dental records. He is of the view that a delay of around two months would not lead to any additional decay on Ms C's teeth.

*(d) Conclusion*

23. As a result of this advice I do not uphold this aspect of the complaint.

*(d) Recommendation*

24. The Ombudsman makes no recommendations on this point.

**(e) A denture had been fitted improperly which induced Ms C's gag reflex and resulted in the loss of four adjacent teeth**

25. Ms C had a denture fitted on 21 October 2004 to replace three upper teeth. The type of denture used was an immediate denture, which is one where

teeth are extracted and the new denture with the replacement teeth is fitted over the extraction sockets.

26. Prior to the fitting of the denture, however, it is noted in the records that on 28 September 2004 the Dentist was unable to take x-rays 'because the patient had a gag reflex'. This was clearly sometime prior to the denture being fitted.

27. Problems often arise when fitting dentures to people with gag reflexes, this does not indicate that the denture was improperly fitted. Whilst there are sometimes ways around such problems, there is no evidence in this case to suggest that this denture was fitted improperly.

*(e) Conclusion*

28. Because of the above, I do not uphold this aspect of the complaint.

*(e) Recommendation*

29. The Ombudsman has no recommendation to make on this point.

**(f) Appointment times were insufficient to allow for dental work of a reasonable standard**

30. Ms C has complained that her appointment times were of insufficient length to allow for proper treatment. She has suggested that the majority of her appointment times lasted less than 15 minutes. The Dentist has advised that this was not the case. He advised that computer records of all appointments are held and that all but two of the appointments lasted more than 15 minutes.

*(f) Conclusion*

31. There were 16 visits in total from 28 September 2004 until 1 April 2005. The Dentist has supplied the Ombudsman's office with the computer records of the appointment times for all the visits. It was clear from these records that the Dental Practice is a very busy one and that the Dentist was clearly seeing many patients every day. However, the appointment times for Ms C were in line with the general appointment times of the other patients, it appears that the length of the appointments were in line with the Dentist's normal practice. The Adviser considers that these are reasonable. As such, I do not uphold this aspect of the complaint.

*(f) Recommendation*

32. The Ombudsman makes no recommendations on this point.

**(g) The Dentist improperly refitted a crown**

33. At the visit on 28 September 2004 there was a loose crown post on the upper right second incisor UR2. In root filled teeth it is often necessary to fit a post into the tooth root before fitting a crown. This post provides support for the crown. The records show that the dentist re-cemented this crown post at this visit.

34. Ms C has complained that the Dentist 'just stuck the crown back in' but at what she believes was the wrong angle. She feels that it was hanging too low in her mouth and that it interfered with her bite.

35. There is no evidence in the records to suggest that the crown was refitted incorrectly or that Ms C was unhappy with it at the time. Had this been the case, it is likely that this would have been recorded in the records as was the case with similar problems.

*(g) Conclusion*

36. Because of the lack of any evidence to support the view that the crown was improperly cemented, I cannot uphold this aspect of the complaint.

*(g) Recommendation*

37. The Ombudsman makes no recommendations on this point.

**(h) The Dentist failed to take into account the radiotherapy and chemotherapy treatment Ms C had had previously which had affected her teeth**

38. Ms C told the dentist that she had received treatment for cancer as she felt that, as a result of this, she needed emergency dental treatment. The Dentist noted this in the records. She felt that her gums had been damaged as a result of the chemotherapy and radiotherapy and that she had to rinse with Oraldene to numb the pain in her gums. In his response to her complaint the Dentist agreed that he felt that she was right and that the condition of her mouth had suffered as a result of the cancer treatment. He specifically states that he tended to agree with her opinion that the widespread caries (dental decay) was due to the cancer treatment rather than from neglect.

*(h) Conclusion*

39. From the review of the information held on file it is clear that the Dentist

was aware of Ms C's cancer treatment. It is, therefore, likely that he did take account of this when treating Ms C. As such, I do not uphold the complaint.

*(h) Recommendation*

40. The Ombudsman makes no recommendations on this point.

41. The Dentist has accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Dentist notify her when the recommendations have been implemented.

**Annex 1**

**Explanation of abbreviations used**

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| Ms C | The complainant |
| The Dentist | Ms C's dentist |
| The Dental Practice | Ms C's family dental practice |
| The Adviser | A dental adviser to the Ombudsman |
| MDDUS | Medical and Dental Defence Union of Scotland |
| GDC | General Dental Council |

**Annex 2**

## Glossary of terms

| | |
|---|---|
| Crown post | A metal post cemented into the root of a tooth to provide support for a crown |
| Maryland Bridge | This is a type of bridge which does not require crowns on neighbouring teeth to support the bridge. Instead it relies on metal wings which are bonded to the back of one or both of the neighbouring teeth |