SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Mid Scotland and Fife

Case ref: 201600216, 201600283 and 201600284 A Dental Practice and two dentists in the Forth Valley NHS Board area
Sector: Health
Subject: Dentists and Dental Practices / Clinical treatment / Diagnosis

Summary
Ms C complained about the treatment she received when she saw a dentist after a bridge that replaced some of her teeth had come off. She said that the dentist had inadvertently fractured the porcelain when cleaning the bridge. She said that they then made a temporary repair, but on the following day, part of the bridge shattered.

We took independent dental advice on Ms C's complaint. The adviser noted the bridge had been in need of replacement, but that there had been a lack of care by the dentist in fracturing the porcelain on the bridge. We therefore upheld this aspect of Mr C's complaint. However, we found that, as this had been an emergency appointment, it had been reasonable for the dentist to carry out a temporary repair and then refer Ms C to her usual dentist for further treatment.

Ms C also complained about the care and treatment she received when she saw her usual dentist. They agreed to refer her to a consultant in restorative dentistry. The consultant sent a report to Ms C's usual dentist with their findings after examining Ms C. In their report, they said that she may need to have some teeth extracted, but they would be quite hopeful that another tooth was relatively sound and could be used to support a bridge. They also suggested that she could have orthodontic treatment for this tooth and implants to replace the teeth that were to be extracted. However, after receiving the report, Ms C's usual dentist extracted this tooth along with the other teeth supporting the bridge.

We also took independent dental advice on this aspect of Ms C's complaint. We found that there was no evidence that Ms C had been adequately advised of her options for replacing the original bridge. Ms C's usual dentist had also failed to record his reasons for extracting what the consultant thought was a relatively sound tooth. We did not consider that there was evidence that Ms C's usual dentist had provided reasonable treatment to Ms C and we also upheld this aspect of her complaint.

Finally, Ms C complained that the dental practice had failed to reasonably respond to her complaint about the dental treatment. We found that the practice had acted in line with their policy for handling patient complaints. In addition, their response about the porcelain fracture on the bridge had been reasonable. However, the practice had failed to respond adequately to Ms C's comments about unnecessary work being carried out. In view of this, we upheld the complaint.

Redress and recommendations

The Ombudsman recommends that Dentist 2:	*Completion date*
(i) issues a written apology to Ms C for the failure to record that they adequately advised her of the reasons for extracting tooth 12 or the options in respect of the replacement of the failed bridge; and;	25 May 2017
(ii) in the event that they are unable to provide an x-ray showing that it was reasonable to remove tooth 12, they should refund Ms C for the cost of having to have an implant fitted to replace tooth 12, due to the failure to record why they did not follow the advice of the dental hospital or that they had fully discussed this with Ms C. This should be done on receipt of appropriate invoices when treatment has been completed.	25 August 2017

The Ombudsman recommends that the Practice:	*Completion date*
(i) issue a written apology to Ms C for the failure to adequately investigate or respond to her comments about unnecessary work being carried out.	25 May 2017

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial

and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Ms C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Ms C complained to this office about the treatment she had received from two dentists at a dental practice (the Practice). She also complained about the Practice's response to her complaint about the treatment. The complaints from Ms C I have investigated are that:

(a) a dentist (Dentist 1) failed to provide Ms C with appropriate dental treatment following reported concerns about dental bridgework (upheld);

(b) another dentist (Dentist 2) failed to provide Ms C with appropriate dental treatment following problems with dental bridgework (upheld); and

(c) the Practice failed to appropriately address Ms C's concerns about her dental treatment following problems with dental bridgework (upheld).

2. When she made her complaint, Ms C said that she wanted the dentists to cover at least some of the costs of dental implant treatment that she subsequently had to have.

Investigation

3. The dentists in this case are self-employed and hold individual contracts with the relevant health board. Under the Scottish Public Service Ombudsman Act 2002, they are treated as individual bodies under the Ombudsman's jurisdiction.

4. In order to investigate Ms C's complaint, my complaints reviewer sought independent advice from a dental adviser (the Adviser). In this case, we have decided to issue a public report on Ms C's complaint because of the injustice we consider she has suffered.

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

(a) Dentist 1 failed to provide Ms C with appropriate dental treatment following reported concerns about dental bridgework (201600283)

Background

6. Ms C attended the Practice on 17 September 2013, as a bridge that replaced some of her teeth had come off. The bridge was approximately 20 years old at that time. Ms C asked to see Dentist 2 and said that she would prefer to be treated by them. However, they were busy and she saw Dentist 1

instead. They cleaned and cemented the bridge back on. However, whilst cleaning the bridge, they inadvertently fractured the porcelain from the edge of the bridgework. Dentist 1 recorded that they rebuilt the bridge using dental composite (a white plastic type of filling material) and that they explained the situation to Ms C.

7. Ms C returned to the Practice on 30 September 2013 and said that the porcelain from the bridge had fallen off. She spoke to Dentist 1 and said that the bridge had been fine when she brought it to the last appointment and that they had destroyed it. Dentist 1 said that while it was true that the porcelain had de-bonded when they were cleaning cement Ms C had put on the bridge to repair it, it was the only way to clean the bridge and that it had also previously been weakened. They recorded that they explained to Ms C that there was always a risk of porcelain de-bonding from a bridge when ultrasonic scaler is used to remove the old cement, especially when it is porcelain bonded to non-precious metal.

8. Dentist 1 also recorded that they apologised to Ms C and explained that the bridge had been poorly designed. They stated that the poor design and stresses accumulated in the porcelain were more a cause of the porcelain de-bonding than the ultrasound scaler, which at worst precipitated the de-bonding of the porcelain in an already weakened bridge. They noted that Ms C was to see Dentist 2 for further treatment planning.

9. Dentist 2 subsequently referred Ms C to the dental hospital for new bridgework to be considered.

The Practice's response to Ms C's complaint

10. Ms C wrote to the Practice to complain on 22 January 2016. She said the bridge had been intact when she handed it to Dentist 1 and that they said they could fix it. She said that they started to clean it, but then informed her that they had broken it. They fixed it back in place and told her not to put too much pressure on it. She said that it was clear that the tooth was broken and that it shattered on the following day whilst she was drinking water, exposing a metal tooth. She stated that Dentist 1 patched the tooth up and said that was all they could do.

11. The Practice issued their response to the complaint on 23 February 2016. They said that Dentist 1 had inadvertently fractured the porcelain from the edge

of the bridgework whilst cleaning off the cement Ms C had applied to it. They said that this had no effect on its function or on the underlying teeth or their supporting structures, but it did affect the appearance of the bridge. They stated that whilst they appreciated that the bridgework may have looked unsightly, the clinical notes showed that the bridge was already failing at that point, partly due to the age of the bridge, but primarily due to the condition of the supporting teeth. They said that the teeth supporting the bridgework are important to the longevity of the bridge rather than the porcelain aesthetic element, which was the only fractured element. They added that Dentist 1 had apologised at the time and had repaired the porcelain fracture.

12. The Practice also said that the clinical notes prior to September 2013 suggested that Ms C was aware of the failing bridgework and the issues with the teeth supporting the bridgework. They said that their dentists had been consulted on this for the previous two years and set out the comments in relation to this in the clinical notes. They also stated that following the fracture on 30 September 2013, Ms C was referred to the dental hospital by Dentist 2.

13. In Ms C's complaint to us, she said that it was not true that she had previously cemented the bridge that had fallen out. She also said that the function of the bridge was affected, as the whole tooth had shattered on the following day.

Advice

14. My complaints reviewer asked the Adviser if they considered it had been unreasonable for Dentist 1 to fracture the porcelain whilst trying to clean the bridge when Ms C attended the Practice on 17 September 2013. In their response, the Adviser said that the Practice's response to Ms C's complaint said that it had been necessary to remove excess cement from the bridge prior to re-cementing it. The response said that this excess cement was present because Ms C had attempted to re-cement the bridge herself using an over-the-counter cement she had bought prior to her appointment. The Adviser said that Dentist 1 had recorded this in the notes at that time, although they noted that Ms C denied having used cement to fix the bridge.

15. The Adviser said that it is always necessary to have clean surfaces prior to re-cementing any bridge and this invariably involves removing any old cement from the bridge and supporting teeth, including any residual cement from when the bridge was originally fitted. They stated that in view of this, it was of no

significance to the process whether some of the cement was applied by Ms C. The Adviser stated that the fracture of the porcelain should not have happened and that the most likely reason for this was that the crown was overheated.

16. That said, the Adviser also stated that the bridge was clearly in need of replacement when Ms C saw Dentist 1. They stated that the porcelain fracture made no direct difference to this, regardless of how annoying or inconvenient it was to Ms C. However, they said that they considered that there had been a lack of care by Dentist 1.

17. We then asked the Adviser if they considered that the action taken by Dentist 1 in response to the porcelain fracture had been reasonable and appropriate. In their response, the Adviser said that the records completed at the time indicated that Dentist 1 repaired the bridge using composite. They stated that it would not be possible to stick this adequately to the metal and porcelain of the bridge, so whilst it might make an adequate temporary repair pending replacement of the bridge, it would not form a satisfactory long-term repair. That said, the Adviser stated that they accepted that this was an emergency appointment. They said that given this, they accepted that Dentist 1's actions in referring Ms C to her normal dentist for further treatment were reasonable.

(a) Decision

18. The advice we received on this aspect of Ms C's complaint was that although the bridge clearly needed to be replaced at that time, it was not reasonable for Dentist 1 to have fractured the porcelain whilst attempting to clean the bridge. I have upheld this aspect of Ms C's complaint. However, I have not made any recommendations, as the dental notes show that Dentist 1 apologised to Ms C at the time. This was also referred to in the Practice's response to the complaint.

(b) Dentist 2 failed to provide Ms C with appropriate dental treatment following problems with dental bridgework (201600284)

Background

19. On 9 October 2013, Dentist 2 discussed the treatment options with Ms C and it was agreed that they would refer her to the dental hospital. In the referral, they suggested a partial denture as the most logical immediate answer with the possibility of implants (depending on the cost) at a later date.

20. A consultant in restorative dentistry from the dental hospital wrote to Dentist 2 on 12 February 2014. They asked that Dentist 2 stabilise the tooth decay and investigate tooth 16. They stated that they would then suggest that consideration was given to an orthodontic referral to assess the feasibility of a number of different treatment options. They suggested that as part of an investigation, that the bridge and veneers be dismantled to assess what remaining tooth substance there was. They stated that it may be that one of the teeth could be endodontically (the branch of dentistry that deals with diseases of the dental pulp) treated to try to improve the bone health in this region for subsequent implant placement. They also stated that they would be quite hopeful that the tooth with the veneer (tooth 12) was relatively sound and could, therefore, be an abutment (support) for future bridgework. They stated that unless certain of the abutment status of tooth 21, they would suggest that it was best dismantled and reassessed at that time. They stated that it may be that one option would be extraction of tooth 21 and tooth 22 and the subsequent implant treatment with possible orthodontic treatment for tooth 12. They stated that that they would be happy to see Ms C to assess her following an orthodontic consultation and dismantling of her bridgework.

21. After receiving this report from the dental hospital, Dentist 2 recommended to Ms C that she have the teeth supporting the bridge and another in-standing tooth (tooth 12) extracted. This was done on 28 May 2014 and a partial denture was fitted. Ms C thought that this would be a temporary measure to be worn for three months and would then be replaced by implants. Ms C was reviewed again on 30 May 2014 and it was recorded that the sockets were healing well.

22. In her complaint to the Practice, Ms C said that after three months, she asked Dentist 2 if she could have her implants fitted, but they told her to wait until six months had passed. She said that she asked again in November 2014 and was told to wait until nine months had passed. She said that she asked Dentist 2 about this again in February 2015 and they said to wait a year, as this would give the bone plenty of time to heal.

23. Ms C was examined by the Scottish Dental Reference Service on 17 February 2015. In their report dated 25 March 2015, they said that the record-keeping in relation to her treatment was poor and that not all of the radiographs and the associated reports had been received. Their report said that although she had been referred to the dental hospital, a treatment plan had not been prepared after this. They commented that the report from the dental

hospital had stated that 'tooth 12 is relatively sound', but this tooth had been extracted on 28 May 2014, with no justification given. They said that the dentist should explain the clinical justification for the provision of the treatment.

The Practice's response to Ms C's complaint

24. In her complaint to the Practice, Ms C said that she was advised to have the healthy tooth (12) removed, as it was not straight. She said that she had told Dentist 2 that she could not afford implants and that they had said not to worry and that they could come to an arrangement. She said that they then told her in June or July 2015 that they were retiring soon from the Practice, but that Dentist 1 had agreed to pay a portion of the costs. She also said that they told her that they would arrange an appointment for her with the implant specialist at the Practice. However, she said that when she called the Practice in January 2016, they informed her that there was no longer an implant specialist at the Practice and she would need to find another practice. She asked what the Practice would do to finish the treatment.

25. On 23 February 2016, the Practice responded to Ms C's complaint. They explained the dental treatment that had been provided since September 2013 and included details of her dental history from 2011. They stated that the dental hospital had suggested two options: either remove the bridgework and treat the abscess with root treatment and utilise for a new bridge; or, extract teeth around the bridgework and supporting it. They said that with Ms C's consent and following lengthy discussions, the abutment teeth and bridge were extracted on 28 May 2014. They said that Dentist 2 had advised that they discussed alternative treatments on several occasions and advised that the removal of the additional in-standing tooth would help to improve the arrangement of the anterior teeth (teeth nearer the front). They said that Ms C, therefore, elected to have the bridgework removed together with the in-standing tooth.

26. In the response, the Practice said that after the extraction, the process of healing of the bone would commence. They stated that the period this would take was not known in May 2014 and the bone and tissue healing were monitored by Dentist 2. They also stated that Dentist 2 had advised that they did not suggest that any treatment with implants would be funded by the Practice or discuss the possibility of Dentist 1 covering the cost of further treatment.

Advice

27. We asked the Adviser if they considered that the treatment provided by Dentist 2 after the fracture of the bridge had been reasonable and appropriate. In their response, the Adviser said that the records made by Dentist 2 were sparse and did not provide adequate detail to fully understand their findings or the rationale behind their actions and treatment planning decisions. They said that this had also been noted in the Dental Reference Officer's report. They also stated that Dentist 2's record-keeping did not appear to meet the standards required by the General Dental Council in either standard 1.4 of the Standards for Dental Professionals or 4.1 of the Standards for the Dental Team, which replaced it on 30 September 2013. This states that the dental team must make and keep contemporaneous, complete and accurate patient records.

28. The Adviser then went on to say that the bridge had failed and required replacement, irrespective of the fractured porcelain. They said that previous patient notes for 21 November 2011 indicated that the bridge had exposed margins, disguised by a composite filling and that Ms C was advised the bridge required replacement. However, Ms C failed to continue with treatment to deal with this at the time. The Adviser commented that it was, therefore, reasonable for Dentist 2 to have concluded that the bridge was no longer adequate for purpose. They said that a referral to the dental hospital for further advice and treatment planning was a reasonable step to take in those circumstances.

29. The Adviser then said that the subsequent letter from the dental hospital confirmed that there were chronic abscesses in two of the teeth supporting the bridge and that one of these teeth had decay. They said that the report recommended that Dentist 2 dismantled the existing bridge and a veneer to assess how much tooth substance remained. It also suggested that it might be possible to treat the supporting tooth with decay endodontically to help improve the health of the bone prior to placement of any implant. In addition, the report said that if the tooth with the veneer was relatively sound, a new bridge could be constructed. As an alternative, the dental hospital suggested that two teeth could be extracted and that the other tooth was repositioned using orthodontics (a brace) prior to placement of implants.

30. The Adviser commented that the Practice's response to Ms C's complaint suggested that lengthy discussions were held with Ms C about her options on 28 May 2014. The Adviser said that in Ms C's complaint to the Board, she had indicated that Dentist 2 advised her to have the teeth supporting the bridge

extracted and also to have the in-standing tooth supporting the bridge extracted as well, prior to placement of a temporary denture followed by implants. The Adviser stated that there was no record of these discussions in the clinical notes, which was a failure to comply with standard 4.1 of Standards for the Dental Team.

31. The Adviser also stated that it did not appear to them to have been reasonable for Dentist 2 to ignore the recommendations provided by the dental hospital, which were to initially dismantle the bridge and veneer in order to better assess the situation. They said that instead, Dentist 2 proceeded straight to extraction, including extraction of a sound, if mis-positioned tooth.

32. We asked the Adviser if they considered it had been reasonable for Dentist 2 to advise removal of this tooth. The Adviser stated that this was contrary to the recommendations given in the letter from the dental hospital. They added that there was no justification given for this in the clinical records, although Ms C's complaint and the response to this suggested that it was done to make it easier to align implants. The Adviser stated that this was a sound tooth and according to the consultant report from the dental hospital, it could have been repositioned orthodontically. They stated that the extraction did not, therefore, seem reasonable.

33. Next, we asked the Adviser if Dentist 2 should have referred Ms C to the implant specialist in the Practice. In their response, the Adviser said that if the Practice had an implant specialist working there at that time, it would certainly have been reasonable to arrange a referral for an opinion.

Comments received from Dentist 2

34. In line with our normal practice, we sent a copy of our draft report on the complaint to Ms C and Dentist 2 for comment. In their response to the draft report, Dentist 2 said that they had taken x-rays in May 2014, which showed that tooth 12 had a short root, was being used to support the bridge in some manner and had an area of infection in the root. They also referred to its overall poor position in relation to the other teeth and clear bone loss. They said that they appreciated that the clinical notes were lacking in detail, but the issues were fully discussed with Ms C and treatment was consented by her.

35. Dentist 2 also said that they failed to see how an orthodontic realignment of tooth 12 would in any way give Ms C a better result. They said that they

attempted to telephone the consultant at the dental hospital on several occasions to discuss how the proposed treatment of a partial denture and orthodontic realignment would work, but the consultant did not return their calls. They told us that they explained to Ms C the problems and difficulties with each of the options available and that she opted for and consented to the extraction of tooth 12 and the other teeth. They said that they did not accept that the extraction of tooth 12 was an unnecessary extraction. During my investigation, I asked Dentist 2 if they could provide the x-rays taken in May 2014, but they were unable to do so.

36. I discussed these comments with the Adviser. They stated that Dentist 2 had not acted in line with the advice of the consultant at the dental hospital in relation to tooth 12 and had not recorded their reasons for this at the time. They said that the consultant felt that this tooth was not a necessary extraction and if Dentist 2 considered that it had to come out, they needed to record the reasons for this, but had failed to do so.

(b) Decision

37. The advice I have received is that there is no evidence that Dentist 2 adequately advised Ms C of her options in respect of the replacement of the failed bridge. They also failed to record his reasons for extracting what the consultant thought was a relatively sound tooth. In view of this, I do not consider that there is evidence in the dental records that the treatment provided to Ms C was reasonable. I have, therefore, upheld Ms C's complaint that Dentist 2 failed to provide her with appropriate dental treatment following problems with dental bridgework.

(b) Recommendations

38. I recommend that Dentist 2:	*Completion date*
(i) issues a written apology to Ms C for the failure to record that they adequately advised her of the reasons for extracting tooth 12 or the options in respect of the replacement of the failed bridge; and	25 May 2017
(ii) in the event that they are unable to provide an x-ray showing that it was reasonable to remove tooth 12, they should refund Ms C for the cost of having to have an implant fitted to replace tooth 12, due to the failure to record why they did not follow the	25 August 2017

advice of the dental hospital or that they had fully discussed this with Ms C. This should be done on receipt of appropriate invoices when treatment has been completed.

(c) The Practice failed to appropriately address Ms C's concerns about her dental treatment following problems with dental bridgework

Ms C's complaint

39. Ms C submitted her complaint to the Practice on 22 January 2016. In this, she said that she had already complained to them at the time, but felt they had dismissed her complaint and had never taken it seriously. She said that she had contacted the NHS and they had told her to submit a complaint in writing.

40. Ms C said that she had asked for compensation for the remedial work that needed to be carried out due to a broken bridge and it had been agreed that this would be discussed with the owners of the Practice, although it was unlikely that they would pay anything, as the bridge was old and needed to be replaced anyway. Ms C complained that she had never been informed of the outcome of this conversation. She also said that the Dental Reference Officer had told her that she was definitely due compensation from the Practice, as a dentist had broken her bridge, which led to four front teeth being removed. She also stated that their report said that a lot of unnecessary work had been carried out.

The Practice's response to Ms C's complaint

41. The Practice have told us that they received the complaint on 9 February 2016. They acknowledged receipt of the complaint on 11 February 2016, stating that they would be in touch with a full response within 21 working days. The Practice then issued a response to Ms C's complaint on 23 February 2016. In this, they said that the bridgework was already in poor condition and was failing prior to the date on which the porcelain was fractured. They stated that this was not only due to the age of the bridge, but also because of decay and abscesses in the supporting teeth. They stated that it would, therefore, have always required remedial treatment at that stage and that further remedial treatment had in fact been recommended to Ms C as early as April 2011.

42. In the response to Ms C, the Practice said that they considered that the advice and treatment provided to her had been appropriate and that further

remedial work would always have been required due to the poor condition of the supporting teeth causing the failing bridgework.

The Practice's Policy for Handling Patient Complaints

43. This states that if a complaint is about any aspect of clinical care or associated charges, it will normally be referred to the dentist unless the patient does not want this to happen. It states that they will acknowledge the complaint in writing and enclose a copy of the Code of Practice as soon as possible, normally within three working days. The policy states that they will seek to investigate the complaint within ten working days of receipt to give an explanation of the circumstances that led to the complaint. It states that if the patient does not wish to meet them, they will attempt to talk to them on the telephone. If they are unable to investigate the complaint within ten working days, the policy states that they will notify the patient, giving the reasons for the delay and a likely period within which the investigation will be completed.

(c) Decision

44. The Practice have told us that they received Ms C's complaint on 9 February 2016. I have noted that it was acknowledged within three working days and, although this referred to a full response being issued within 21 days, a response was then issued within ten working days of receipt of the complaint in line with the Practice's policy for handling patient complaints. The complaints about clinical care and charges were also referred to the relevant dentists in line with the policy.

45. I consider it was reasonable for the Practice to state in their response that the bridgework was failing prior to the date on which the porcelain was fractured and would have always required further remedial treatment. However, Ms C had also complained in her letter that the Practice had a copy of the report from the Dental Reference Officer. Ms C stated that this report said that a lot of unnecessary work had been carried out on her. I do not consider that the Practice adequately investigated or responded to this part of Ms C's complaint and, for that reason, I have also upheld this aspect of her complaint.

(c) Recommendation

46. I recommend that the Practice:	*Completion date*
(i) issue a written apology to Ms C for the failure to adequately investigate or respond to her comments	25 May 2017

about unnecessary work being carried out.

47. We will follow-up on the recommendations. Dentist 2 and the Practice are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Ms C	the complainant
the Practice	the dental practice
Dentist 1	the dentist who fractured the porcelain on the bridge
Dentist 2	the dentist who provided treatment to Ms C
the Adviser	the dental adviser

Annex 2

Glossary of terms

abutment	support(ing)
anterior teeth	teeth nearer the front
dental composite	a white plastic type of filling material
endodontically	the branch of dentistry that deals with diseases of the dental pulp
orthodontics	a brace

Annex 3

List of legislation and policies considered

Standards for Dental Professionals (2009) (General Dental Council)

Standards for the Dental Team (2013) (General Dental Council)