HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

A Decision by the Deputy Health and Disability Commissioner

(Cases 22HDC01875, 24HDC00360, 24HDC00361, 24HDC00362, 24HDC00363, 24HDC00364, 24HDC00365, 24HDC00366)

Contents

Introduction

1. This report is the opinion of Dr Vanessa Caldwell, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

2. The report discusses the care provided to multiple consumers by dentist Dr C.

Names (except the advisor) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

3. The following issues were identified for investigation:

- *Whether [Dr C] provided an appropriate standard of care to multiple consumers prior to November 2021 (inclusive) in respect of dental services provided.*
- *The scope of the investigation includes, but is not limited to, the care provided to [Ms D], [Mrs E], [Mr F], [Mr G], [Mrs H], [Mrs I] and [Mr J].*

4. The parties directly involved in the investigation were:

Dr A	Dentist/complainant
Dr B	Dentist/complainant
Dr C	Dentist/registered provider
Ms D	Patient
Mrs E	Patient
Mr F	Patient
Mr G	Patient
Mrs H	Patient
Mrs I	Patient
Mr J	Patient

5. Independent clinical advice was obtained from dentist Dr Angela McKeefry in relation to all patients (Appendix A).

Background

6. Dr C[1] is the sole practitioner at the dental practice (Practice 1) where he has worked since 1995. Dr C told HDC that he has provided dental care to the local population, including after-hours and emergency care to patients from other practices.

7. In November 2021 Dr C ceased practice for a time.[2] During the time he was not practising, Dr A and Dr B, who are practitioners at another dental practice (Practice 2), began to treat Dr C's patients who required emergency care, in addition to Dr C's patients who were unaware that he had ceased practising.

8. Subsequently Dr A and Dr B made a complaint to HDC about the standard of care provided to seven consumers who previously had been Dr C's patients. The Dental Council of New Zealand (DCNZ) was also advised of the concerns regarding Dr C.

9. Below are the relevant standards applicable to my decision, which I have referred to in the relevant paragraphs throughout my report.

[1] Dr C completed a Bachelor of Dental Surgery from the University of Otago in 1986 and was registered with the Dental Council on 1 April 1987. Dr C told HDC that he has attended Dental Association branch meetings, conferences, courses and study groups regularly.
[2] Dr C told HDC that he has since returned to practice.

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Relevant standards and guidelines

DCNZ Standards Framework

10. The DCNZ 'Standards Framework for Oral Health Practitioners' [3] (DCNZ Standards Framework) outlines the professional standards and ethical principles that must be met by oral health practitioners. The five ethical principles to which practitioners must always adhere are to put patients' interests first, ensure safe practice, communicate effectively, provide good care, and maintain public trust and confidence.

DCNZ Practice Standards

11. Practice Standards relate to specific areas of practice that require more detail to enable practitioners to meet the DCNZ Standards Framework. Relevant DCNZ Practice Standards referred to in this decision are as follows:

DCNZ Patient records and privacy of health information practice standard[4]

12. The purpose of this practice standard is to set minimum standards for oral health practitioners in creating and maintaining patient records and maintaining the privacy of patients' health information.

13. The standards outline that 'practitioners have a responsibility to ensure safe practice and put their patients' interests first by maintaining accurate, time-bound and up-to-date patient records and protecting the confidentiality of patients' health information'.

DCNZ Infection Prevention and Control practice standard

14. The purpose of this practice standard is to set minimum standards that must be observed by all practitioners in order to eliminate or reduce the number and quantity of infectious agents in the oral health practice environment and prevent the transmission of infectious agents.

15. Section 14 of the standards outlines that practitioners 'must ensure all critical items are packed and labelled with batch control identification information before sterilisation', including documenting 'the batch control identification information in the record of the patient on whom the sterilised critical item/s is used'.

Responses to provisional opinion

Dr C

16. Dr C was provided with an opportunity to comment on the provisional opinion. Dr C told HDC that he has been providing dental care to the community for 30 years and this complaint has been a source of shame and stress for him. Dr C acknowledged that his record-keeping was significantly below standard for all these patients and that there were deficiencies in the care provided, and he said that he is sorry for this. Dr C told HDC that he has since taken

[3] Whilst the Standards Framework referenced applied from 7 July 2017 to 20 November 2019, there was no change to the five ethical principles referred to in the subsequent versions.
[4] Dated 1 February 2018. Whilst the patient records and privacy of health information standard referenced applied from February 2018 to November 2020, there is no change in the current version.

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steps to improve his practice (discussed further in this report) and he has had no complaints about his practice since 2021.

17. Dr C stated that for many of these patients, the treatment he provided allowed them to keep their teeth for longer than they otherwise would have. Dr C maintains that he discussed treatment plans with his patients and that they were informed of the approach to treatment. However, Dr C accepted that his poor record-keeping means that this cannot be confirmed. Dr C also acknowledged that he should have been more assertive with some patients, setting out holistic, permanent options for treatment as opposed to quick-fix solutions that would only prolong the inevitable.

18. Dr C's additional comments relating to individual consumers have been incorporated throughout this report where relevant.

Dr A

19. Dr A was provided with an opportunity to comment on the 'information gathered' section of the provisional opinion. Dr A told HDC that both she and Dr B have noticed an improvement in Dr C's documentation. However, they are seeing less of Dr C's patients now that he has returned to practice.

20. Dr A told HDC that Dr C has always made himself available to patients at the weekends and after hours. Dr A's remaining concerns relate to the serious consequences arising from Dr C's lack of communication with patients and the lack of treatment options available to them.

Dr B

21. Dr B was provided with an opportunity to comment on the 'information gathered' section of the provisional opinion, and his comments relating to individual consumers have been incorporated throughout this report where relevant.

Opinion: Dr C — breach

22. The investigation focused on the care provided by Dr C to seven consumers. In determining whether the care provided was reasonable, I sought and considered the advice of independent advisor Dr Angela McKeefry.

23. I have undertaken a thorough assessment of the information gathered, and I consider that Dr C breached the Code of Health and Disability Services Consumers' Rights (the Code) when he provided services to the seven consumers. The care provided to each consumer, and the reasons for my decision, are set out below.

24. At the outset, I note that aspects of the investigation were made more challenging because of Dr C's poor standard of documentation for all seven consumers, and I have had to rely on Dr McKeefry's interpretation of Dr C's notes to assist in determining the standard of care provided to these consumers.

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Care provided to Mrs E — breach

Introduction

25. Mrs E[5] had been a patient with Dr C since 2002. The handwritten clinical records provided by Dr C do not contain any further detail of the consultations between 2002 and 2021, although Dr McKeefry notes that Dr C performed eight full mouth examinations and multiple other treatments over this time. There is a record of one X-ray taken on 5 April 2017, and the last date recorded in the records is 4 March 2020, although Mrs E had a consultation with Dr C in November 2021 (discussed below).

26. In response to the provisional opinion, Dr C told HDC that Mrs E's last appointment prior to November 2021 was on 20 March 2018. The recorded date of 4 March 2020 was of a phone message that Dr C's receptionist left for Mrs E.

Appointment — Practice 2

27. On 22 November 2021 Mrs E had a consultation with Dr B, as Dr C had ceased practising.

28. Dr B told HDC that Mrs E presented with a 'lost filling' on tooth 14[6] and that she had seen Dr C a few weeks earlier when he had 'recemented' the filling back on. Dr B told HDC that tooth 14 was root filled[7] and had a 'large and obvious vertical root fracture', which subsequently was confirmed on a PA radiograph,[8] with the only treatment being extraction. The radiograph also showed several pins[9] and a post.[10]

Dr C's response

29. Dr C told HDC that Mrs E presented when the COVID-19 restrictions were in place as she had 'lost a composite crown'.[11] Dr C said that he was at his practice rooms completing paperwork and he informed Mrs E that his practice was closed due to the vaccine mandates.

30. However, Dr C said that he was aware that some patients were having difficulty being treated due to a shortage of practitioners, and so he carried out a visual examination of Mrs E's tooth 14. Dr C said he discovered that the root was fractured, and because it was a simple job, reluctantly he offered to re-cement the tooth for her. In a further response to HDC, Dr C said that he did not anticipate that he would be performing an extraction when he agreed to treat the loose crown.

31. Dr C told HDC that due to the COVID-19 mandates, he was not permitted to use invasive, aerosol-producing treatments, and therefore he did not consider it appropriate to extract

[5] Mrs E was aged 72 years at the time of her first consultation with Dr B.
[6] Upper right first premolar.
[7] Also known as a root canal.
[8] A dental PA radiograph, or periapical X-ray, takes a full tooth picture from the top of the tooth to the tip of the root.
[9] A small metal post used to support and strengthen a tooth that is damaged, has lost a significant amount of structure, or has undergone extensive dental work.
[10] A small metal rod that is inserted into the root space of a tooth. It is used to hold the core or a filling in place. Typically, it is used for teeth that have had root canal treatment.
[11] Dr C did not provide a date for this appointment.

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the tooth or spend longer on treatment than was necessary. He stated that he re-cemented the tooth as a 'temporary measure' and told Mrs E that she would need to return when the mandates were lifted (which he considered would be a relatively short time).

32. Dr C accepted that in retrospect, he should not have seen Mrs E and should have suggested that she seek help elsewhere. He stated that he was only trying to help with what he thought was a simple problem. Dr C accepted that he should have made a record of the visit.

Mrs E's response

33. Mrs E told HDC that while she cannot recollect the treatment that occurred during the COVID-19 mandate, she does recall having a very bad infection after being treated by Dr C. Mrs E said that this 'lasted for several years until [she] enrolled at [Practice 2] when [Dr B] removed the tooth and the infection'.

34. Mrs E also told HDC that after the treatment from Dr C, and the ongoing infection, she 'did not wish for him to carry on any treatment to [her] teeth, hence the change to [Practice 2]'.

Mrs E's response to provisional opinion

35. Mrs E was provided with an opportunity to comment on the 'information gathered' section of the provisional opinion. Mrs E reiterated her comments that the infection took place well before 2021 and recalls having to attend an after-hours medical centre due to the pain. Mrs E maintains that she did not see Dr C at all during the COVID-19 restrictions in 2021.

36. Mrs E told HDC that this is largely irrelevant now, as Dr C has returned to practice and she has had to have the tooth removed, and she cannot afford to have it replaced.

My opinion

37. To determine whether the care provided by Dr C was appropriate, I considered the advice of my independent advisor, Dr McKeefry.

Care provided between 2002 and 2021

38. Dr McKeefry advised that during this time, Dr C performed eight full mouth examinations and multiple other treatments, but only one radiograph was completed, on 5 April 2017.

39. Dr McKeefry said that it is difficult to see any sort of 'holistic care' being provided to Mrs E while she was a patient with Dr C, with no diagnoses or reasons for treatment being documented nor regular diagnostic dental radiographs taken over the 21 years that Mrs E was a patient of Dr C.

40. Dr McKeefry noted a specific example where Mrs E attended Dr C on 5 April 2017 with pain in the upper right first premolar tooth. No diagnosis or reason for treatment was provided by Dr C or shown in the handwritten clinical records, nor was the dose or duration of the Amoxil[12] prescribed for Mrs E. I also note that there appears to have been no follow-up of this treatment, even at the subsequent examination a year later.

[12] Amoxicillin, an antibiotic.

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41. I am concerned that Mrs E was not provided with an appropriate standard of care over this time, particularly given that no regular radiographs were taken despite Mrs E having mouth examinations and multiple treatments. I accept Dr McKeefry's advice and am highly critical of the standard of care provided over this time.

42. I will discuss the issue of the standard of documentation separately.

Consultation November 2021

43. Mrs E's last appointment with Dr C was in November 2021 when Alert Level 2 was in place due to COVID-19. There is no record of this appointment. However, Dr C told HDC that he carried out a visual examination of tooth 14 and discovered that the root was fractured and offered to re-cement the tooth for her. I note that Dr C considered this to be a temporary measure and told Mrs E to return when the COVID-19 mandates were lifted. Due to the COVID-19 mandates in place at the time, Dr C was not permitted to use invasive, aerosol-producing treatments and therefore did not consider it appropriate to extract the tooth or spend longer on treatment than was necessary.[13]

44. In response to the provisional opinion, Dr B told HDC that if Dr C knew that Mrs E had a vertical root fracture, there was no acceptable treatment other than extraction, and this would not have produced any aerosols.

45. I acknowledge that Mrs E maintains that she did not see Dr C in November 2021. However, after reviewing Dr C's account of the treatment provided to Mrs E, combined with Dr B's account of his consultation with Mrs E, I find it more likely than not that Mrs E attended this consultation with Dr C and that he provided the treatment as described above.

46. Dr McKeefry acknowledged that Dr C may have been trying to help Mrs E by treating her while the mandate was in place, but she considered that he should not have done so, and he should have treated her in a clinically appropriate manner, which did not occur. Dr McKeefry also advised that Dr C should have documented this treatment. She stated:

> 'In October/November 2021 [the region] was at Level 2 [COVID-19] restrictions which means dental procedures were not limited so long as masks were worn and patients signed in. To say he diagnosed a root fracture but "recemented the tooth as a temporary measure" instead of extracting the tooth to reduce aerosol is ridiculous given the Level 2 restrictions did not require this and there would be similar aerosol for both procedures. This was very subpar treatment and it is fortunate the patient didn't develop a more serious infection.'

47. I accept Dr McKeefry's advice that this was a severe departure from accepted practice. While Dr C may have been trying to help Mrs E, the temporary fix he provided placed Mrs E at risk, and I am highly critical of the care provided at this consultation. I do not accept Dr C's

[13] Guidelines for oral health services at COVID-19 Alert Level 2 (7 September 2021) stated that patients were to be assessed as either low- or high-risk category for care. For low- and high-risk patients, use of aerosols was permitted subject to rules on use.

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reasoning for providing the treatment he did, noting that the restrictions in place did not preclude the use of aerosols (as noted by Dr McKeefry and Dr B above).

Documentation

48. The DCNZ 'Patient records and privacy of health information' practice standard sets out the minimum standards for practitioners in creating and maintaining patient records. This includes the requirement that records are comprehensive, time bound, and up to date.

49. Dr McKeefry stated that Dr C's clinical notes are 'extremely poor' and do not contain a record of treatments or diagnosis and nor is there a record of the treatment provided in November 2021. Dr McKeefry advised that this constitutes a severe departure from accepted practice.

50. I accept this advice. Mrs E had been Dr C's patient for a significant time, but no diagnoses or treatment plans are recorded over this time, and there is no evidence of what was discussed with Mrs E at any stage of her treatment. I consider that Dr C's clinical records fall well short of the practice standard, and I am highly critical of the standard of his documentation.

Infection control

51. The DCNZ 'Infection Prevention and Control practice standards' (referred to in paragraphs 14 and 15 above) set out requirements to be observed by all practitioners to ensure safe practice. These include documenting batch control identification information in the record of the patient on whom the sterilised item is used.

52. Dr McKeefry advised that there is no tracking on Mrs E's file of sterilised critical instruments that were used by Dr C, as required by this standard. I note that it is a legal requirement that practitioners comply with this standard. HDC has not been provided with any evidence that Dr C complied with this practice standard, and I am highly critical of this omission.

Conclusion

53. I consider that Dr C breached Right 4(2) of the Code in failing to keep accurate records and comply with his professional obligations as set out by the Dental Council's standards on infection control and documentation. I also consider that Dr C breached Right 4(1) of the Code by not providing an appropriate standard of care to Mrs E in not conducting regular radiographs over the time she was a patient, in addition to the standard of treatment at the consultation in November 2021.

Care provided to Ms D — breach

Introduction

54. Ms D[14] was Dr C's patient from 1996 until 2021, when Dr C ceased practice.[15] The clinical records provided by Dr C contain brief references to prescriptions for 'amoxil' and to

[14] Ms D was aged 76 years at the time of her first consultation with Dr B.

[15] The last recorded consultation with Dr C was on 10 March 2021 and there are no further recorded consultations with Dr C prior to Ms D attending Practice 2 in February 2022.

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abscesses, in both July 2019 and February 2020. However, there is no record of any treatment plans, diagnosis, discussions, or radiographs over this time.

Appointment — Practice 2

55. On 9 February 2022 Ms D had a consultation with Dr B. Dr B told HDC that Ms D presented because her front teeth were sore to bite on. Dr B performed an examination and diagnosed Ms D with severe periodontal disease.[16] It is documented that an X-ray showed pulpal necrosis[17] and periapical abscess[18] and 'severe bone loss' around the maxillary[19] teeth. Dr B told HDC that Ms D was in 'complete shock' about the diagnoses, as she had been seeing Dr C for regular cleaning. The teeth were not treatable, and a full maxillary clearance[20] was recommended.

Dr C's response

56. Dr C told HDC that Ms D had a history of infrequent attendance at the clinic, and usually she would attend an appointment to fix the acute issue but then not attend a follow-up appointment. He said that Ms D's teeth were 'loose' but would firm up following scaling and root planing.[21] Dr C said that there was quite a bit of recession associated with the teeth, and Ms D's upper partial denture provided a degree of support for the remaining teeth. The teeth were examined using a mirror and probe, which revealed where deep scaling was required, and this would then be performed.

57. Dr C told HDC that the approach he took with Ms D's treatment was 'to try and maintain her teeth for as long as possible, while knowing that she would eventually lose her upper teeth'. Dr C said that to combat this, the treatment plan was to add teeth to her upper partial denture where necessary. Ms D was informed that her upper teeth would eventually need to be removed but that the plan was to make them last as long as possible. Individual teeth could be added to her partial denture if required. Dr C accepted that he 'should have taken more X-rays to record the extent of Ms D's progressive bone loss and made more comprehensive notes'.

58. In a further response to HDC, Dr C stated that he is confident that Ms D did receive benefit from the treatment he provided, but his poor record-keeping meant that this was not documented.

Responses to provisional opinion

Ms D

59. Ms D was provided with an opportunity to comment on the 'information gathered' section of the provisional opinion and has not provided a response.

[16] A serious gum infection that damages the soft tissue and bone supporting the tooth.
[17] Death of the pulp inside the tooth, usually due to tooth decay or trauma.
[18] A pocket of infection around the root of the tooth.
[19] Teeth in the upper jaw.
[20] Removal and replacement of the teeth.
[21] A procedure to smooth out tooth roots by removing tartar, bacteria deposits, and parts of cementum (bony tissue covering tooth roots) from below the gum line.

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Dr B

60. Dr B stated that there is no mention in Dr C's response of offering to refer Ms D to a periodontist if Dr C was unable to manage Ms D's periodontal disease. Dr B accepted that Dr C did what he could but said that he did not manage the disease process. As a result, the only choice left for Ms D was a full clearance, whereas she may have been able to keep her teeth if an appropriate solution had been offered sooner.

Dr C

61. Dr C told HDC that he believes that the treatment he provided to Ms D allowed her to keep her teeth longer than she otherwise would have.

My opinion

62. To determine whether the care provided by Dr C was appropriate, I considered the advice of my independent advisor, Dr McKeefry.

Care provided between 1996 and 2021

63. Ms D was a patient of Dr C between 1996 and 2021. I have serious concerns about the care provided by Dr C during this period.

64. Dr McKeefry advised that the care provided to Ms D by Dr C was a case of 'supervised neglect' over a period of 25 years and that the overall standard of care during this time was a severe departure from accepted practice, for the reasons discussed below.

65. Dr McKeefry accepted that Ms D did not attend regular appointments and was seen approximately 18 times over the period she was Dr C's patient. This included nine examinations. However, no radiographs were taken over this time, not even prior to extractions. Dr McKeefry advised:

> 'There is no record of a diagnosis (advanced adult periodontal disease), a conversation with [Ms D] about the prognosis for her teeth or the advisement of a referral to a periodontist. There is no periodontal charting or radiographs to document the disease. In 1996 when [Dr C] first saw [Ms D], the periodontal disease must have been far less progressed and a referral to a specialist at this time could well have helped to maintain her dentition.
>
> …
>
> The patient may still have lost all her upper teeth, but she was effectively given no opportunity to try and prevent this from happening. The lack of radiographs, periodontal pocket depth charting,[22] diagnosis, offer of specialist referral or satisfactory clinical notes would be found to be shocking by most dentists.'

66. Dr McKeefry said that while it is the responsibility of the patient to attend regularly and receive recommended treatments, 'it is the dentist's responsibility to ensure the patient understands the diagnosis, risks and benefits of treatment and to refer when the care

[22] Measurement of the depth of gum tissue pockets around each tooth.

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required is beyond their scope. If the patient then chooses not to accept treatment or referral, that needs to be clearly documented.' I note that Ms D was neither fully diagnosed nor fully informed of her oral condition or offered a higher level of specialist care.

67. Dr C told HDC that he discussed treatment plans with his patients and that they were informed of the approach to treatment. However, there is no documentation of this. I remain highly critical of the standard of care provided to Ms D while she was Dr C's patient. It appears that no discussion occurred concerning Ms D's periodontal disease, as prior to her consultation with Dr B she had been unaware of this, or of any options for treatment and specialist care.

68. Ms D had the right to the information that a reasonable person in her circumstances would expect to receive regarding her treatment, including an explanation of her condition and of the options available to her. The clinical records also contain no reference to any discussions about consent. Ms D should have been advised of her periodontal condition, with appropriate periodontal charting, referrals, and X-rays completed. I am highly critical of Dr C's management of Ms D's condition.

69. I do not accept Dr C's statement that Ms D received benefit from his treatment, but that poor record-keeping meant that this was not documented. I note Dr McKeefry's advice that Dr C's management of Ms D was 'supervised neglect' that occurred over a significant period, and I accept that this constituted a severe departure from accepted practice.

Documentation

70. The DCNZ 'Patient records and privacy of health information' practice standard sets out the minimum standards for practitioners in creating and maintaining patient records. This includes the requirement that records are comprehensive, time bound, and up to date.

71. Dr McKeefry stated that Dr C's clinical notes fall far short of the accepted standard and do not contain a record of treatments or diagnosis, nor discussions with Ms D.

72. I accept this advice. Ms D was a patient of Dr C for a significant time, but no diagnoses or treatment plans were recorded over this time, and there is no evidence of what was discussed with Ms D at any stage during her treatment. I consider that Dr C's clinical records fall well short of what is required in the practice standard, and I am highly critical of the standard of Dr C's documentation.

Infection control

73. The DCNZ 'Infection Prevention and Control practice standards' (referred to in paragraphs 14 and 15 above) set out the requirements for all practitioners to ensure safe practice. These include the requirement to document batch control identification information in the records of the patient on whom the sterilised item was used.

74. Dr McKeefry advised that there is no tracking on Ms D's file of sterilised critical instruments that were used by Dr C, as required by this practice standard. I note that it is a legal requirement that practitioners comply with this standard. HDC has not been provided with any evidence that Dr C complied with this standard, and I am highly critical of this omission.

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Conclusion

75. I consider that Dr C breached Right 4(1) of the Code by not providing an appropriate standard of care to Ms D in not referring her for specialist treatment and not performing radiographs when Ms D was his patient. In addition, I consider that by not advising her of her periodontal disease and options for treatment, Dr C did not provide Ms D with the information that a reasonable person in her circumstances needed to make an informed choice or give informed consent to the treatment and, accordingly, that Dr C breached Right 6(2) of the Code. It follows that Dr C also breached Right 7(1) of the Code, as Ms D was unable to give informed consent to the treatment he provided. I also consider that Dr C breached Right 4(2) of the Code in failing to keep accurate records and comply with his professional obligations as set out by the Dental Council's standards on infection control and documentation.

Care provided to Mr F — breach

Introduction

76. Mr F[23] was Dr C's patient from 1998 until the last recorded consultation in November 2021. The clinical records provided by Dr C do not contain any record of any treatment plans, diagnosis, or discussions and contain only three radiographs between 2014 and 2021. There is reference to a 'post' in July 2016, as well as prescriptions for antibiotics in 2017, 2018, and 2019, and a reference to formalin[24] in October 2021.

Appointment — Practice 2

77. On 15 December 2021 Mr F had a consultation with Dr B. Dr B told HDC that Mr F presented for a routine examination where tooth 45[25] was identified as being 'root filled'[26]. A periapical radiograph[27] showed an inadequate post placement. Dr B told HDC that Mr F was shocked when he heard this, as he had not been informed about it previously. Subsequently tooth 45 was extracted and the post had perforated the distal tooth.[28]

Dr C's response

78. Dr C told HDC that Mr F had very heavily restored dentition. Tooth 45 was root filled in May 1998 and the coronal[29] portion of the tooth had been restored several times over the years.

79. Dr C stated that 'tooth 45 lacked coronal tissue and had a post placed in July 2016'. Dr C accepted that the post placement was unsatisfactory due to his error but said that the tooth was 'asymptomatic' and appeared quite stable, and as the alternative would have been extracting the tooth, it was decided to leave it until it caused further problems.

[23] Mr F was aged 56 years at the time of his first consultation with Dr B.
[24] A liquid made by mixing formaldehyde and water.
[25] Dr B referred to this as tooth 44 in the complaint, but the clinical notes provided by Practice 2 refer to it as tooth 45.
[26] A procedure to treat an infected or damaged tooth by removing the infected or inflamed dental pulp, cleaning the inside of the roots, and sealing the roots to prevent further infection.
[27] An X-ray to assess areas surrounding the tooth/bony area, in particular the apical (tip) region of the root.
[28] The back surface of the tooth.
[29] Crown of the tooth.

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80. Dr C accepted that he should have told Mr F about what had occurred but said that he was embarrassed as he had had extensive experience placing posts. Dr C also accepted that he should have completed an ACC referral and discussed the remedies with Mr F.

Mr F's response to provisional opinion

81. Mr F was provided with an opportunity to comment on the 'information gathered' section of the provisional opinion. He told HDC that he is pleased that Dr C has acknowledged the shortfalls in the care provided and that Dr C is now receiving professional support.

My opinion

82. To determine whether the care provided by Dr C was appropriate, I considered the advice of my independent advisor, Dr McKeefry.

Posterior radiographs

83. The clinical records for Mr F contain one set of posterior bitewing radiographs taken in 2014.

84. Dr McKeefry advised that radiographs should be done routinely every 12–24 months, and I am concerned that this did not occur. I note that only two other radiographs were completed, in 2019 and 2021.

Post placement

85. Mr F had a post placed by Dr C in July 2016. Dr C accepted that the post placement was inadequate and that he did not inform Mr F of this or complete an ACC referral.

86. Dr McKeefry stated that incorrect post placement that perforates the side of the root is a known risk of post placement, and the issue is that there is no record that Mr F was advised of the risk prior to the procedure. Dr McKeefry advised:

> 'The root perforation (while unfortunate) is not an issue, however the lack of (or at least lack of documentation of) informed consent and informing the patient after the perforation had occurred are problematic. I also note generally poor clinical records again and a lack of diagnostic radiographs. At the post insertion appointment, no record of the perforation is made in the notes. I assume [Dr C] was aware of the perforation as there likely would have been bleeding.'

87. Dr McKeefry concluded that this was a severe departure from accepted practice.

88. I accept this advice. I am highly critical of the standard of care provided to Mr F over this time. Mr F should have been advised of the perforation, and this should have been documented following the procedure. An ACC referral should have been made following the perforation, and I cannot comprehend Dr C failing to do this. As such, this was a missed opportunity, and I note that an ACC referral was completed by Dr B in 2021 — approximately five years after the event.

89. I am also critical that regular posterior radiographs were not completed.

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September–November 2021

90. Mr F had a full dental examination in September 2021. Dr McKeefry stated that the fact that Mr F underwent a full dental examination with Dr C in September 2021 and then subsequently needed remedial treatment with Dr B on 15 December 2021 illustrates a lack of thorough diagnosis at this routine examination.

91. In October/November 2021[30] Mr F underwent a root canal on tooth 46[31] completed by Dr C. There is no record of what was discussed with Mr F about the procedure.

92. Dr McKeefry stated that there are several issues with the root canal treatment completed by Dr C. First, the use of formalin as noted in Mr F's clinical records. Dr McKeefry referred to a position statement issued by the American Association of Endodontists (AAE) on the use of formaldehyde [32] and paraformaldehyde-containing materials in which it was recommended that these should not be used because of their toxicity and carcinogenicity.[33] Dr McKeefry considered the use of formalin to be a moderate departure given that it has not been banned, and potentially other practitioners may still be using these products.

93. In response to the provisional opinion, Dr C told HDC that formalin has not been banned, and Dr McKeefry has accepted that there are likely to be other practitioners who may still be using these products. Dr C told HDC that he ceased using formalin in 2021 and that whenever he administered it, this was recorded. Dr C stated that there has been no publication issued by the Dental Council or any other comparable body in New Zealand addressing the use of formalin and advising against it, and while the AAE may have published a paper on the topic, those findings have not been incorporated into practice here.

94. Dr McKeefry stated that it also appears that an instrument was 'broken' during the root canal procedure. While this is a known risk of the procedure, there is no documentation as to whether Mr F was informed of this.

95. I acknowledge Dr C's comments regarding the use of formalin. However, I consider that Dr McKeefry's advice does take into account that formalin has not been banned and that other practitioners may still use formalin, and I consider that the moderate departure identified by Dr McKeefry reflects these factors. Accordingly, I remain concerned that Dr C used formalin. I am also concerned that there is no evidence to suggest that Mr F was advised of the instrument that was broken during the root canal treatment.

Documentation

96. The DCNZ 'Patient records and privacy of health information practice standard' sets out the minimum standards for practitioners in creating and maintaining patient records. This includes the requirement that records are comprehensive, time bound, and up to date.

[30] The clinical records are difficult to interpret, but Dr McKeefry said that this occurred in October/November 2021.
[31] First molar.
[32] 'A review of the effects of formaldehyde release from endodontic materials' published 5 October 2014.
[33] Having the potential to cause cancer.

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97. Dr McKeefry stated that Dr C's clinical notes fall far short of the accepted standard and do not contain a record of treatments, diagnoses, or discussions with Mr F. Dr McKeefry advised that this is a severe departure from accepted practice. Dr McKeefry also advised that it appears that the root canal was completed without rubber dam isolation,[34] which is standard practice both to limit bacterial contamination and to protect the patient's airway. Dr McKeefry considers this to be a severe departure from accepted practice, although she acknowledged that potentially other practitioners may choose not to use a rubber dam.

98. I accept this advice. I consider that Dr C's clinical records fall well short of what is required in the practice standard, and I am highly critical of this.

Infection control

99. The DCNZ 'Infection Prevention and Control practice standards' (as set out in paragraphs 14 and 15 above) set out requirements to be observed by all practitioners to ensure safe practice. These include the requirement to document batch control identification information in the record of the patient on whom the sterilised item is used.

100. Dr McKeefry advised that there is no tracking on Mr F's file of sterilised critical instruments that were used by Dr C, as required by this practice standard. Dr McKeefry considers this to be a severe departure from accepted practice. I note that it is a legal requirement that practitioners comply with this standard. HDC has not been provided with any evidence that Dr C complied with this standard, and I am highly critical of this omission.

Conclusion

101. I consider that Dr C breached Right 4(1) of the Code by not conducting regular posterior bitewing radiographs, and in the use of formalin when the root canal treatment was provided to Mr F. I also consider that Dr C breached Right 4(2) of the Code in failing to keep accurate records and comply with his professional obligations as set out by the Dental Council's standards on infection control and documentation. I also consider that in not disclosing to Mr F the root perforation and that an instrument was broken during the root canal treatment, Dr C did not provide Mr F with the information that a reasonable person in Mr F's circumstances would expect to receive, and that Dr C breached Right 6(1) of the Code.

Care provided to Mr G — breach

Introduction

102. Mr G[35] was Dr C's patient from 1996 until the last recorded consultation in August 2021. The clinical records provided are handwritten and do not contain details of any treatment plans, diagnoses, or discussions over this time. However, Dr McKeefry noted that several root canals were performed over this time.

[34] A thin square sheet, usually latex or nitrile, used to isolate the operative site (one or more teeth) from the rest of the mouth.

[35] Mr G was aged 75 years at the time of his first consultation with Dr B.

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Appointment — Practice 2

103. On 15 December 2021 Mr G had an emergency appointment with Dr B due to a broken tooth. Dr B told HDC that a PA radiograph showed four pins in tooth 22[36] (which he considered likely to be in the nerve space) and a large periapical radiolucency.[37]

Dr C's response

104. Dr C told HDC that in May 2017 Mr G presented with tooth 22 'broken off at gum level'. It was decided to restore the tooth with a pinned composite[38] due to the lack of tooth structure. Dr C said that this was done on the basis that there was 'nothing to lose by trying this approach'. The restoration was completed in May 2017. However, by May 2020, Mr G had lost this restoration. As the previous restoration had lasted three years, the tooth was restored again with a pinned composite crown. Dr C told HDC that the view was that, if necessary, the tooth could be removed and added to Mr G's upper plastic partial denture that had been made in the intervening period (May 2018).

105. Dr C stated that in July 2021 the pinned composite had come loose, so this was re-cemented in place. Dr C said that he had a further discussion with Mr G about the possibility of adding this tooth to the plastic partial denture at some stage in the future.

106. Dr C accepted that in treating Mr G, he tended to provide 'quick-fix solutions' to problems, and he should have taken a step back and provided an overall treatment plan rather than concentrating on the immediate presenting problem.

107. In response to the provisional opinion, Dr C told HDC that he installed the pins because Mr G did not want to have the tooth extracted at the time. Dr C reiterated that the purpose of the pins was to maintain the tooth while Mr G decided whether to add this to his denture.

Responses to provisional opinion

Mr G

108. Mr G was provided with an opportunity to comment on the 'information gathered' section of the provisional opinion, and he advised that he had no comments to make.

Dr C

109. Dr C told HDC that he believes that the treatment he provided to Mr G allowed him to keep his teeth longer than he otherwise would have.

My opinion

110. I considered Dr McKeefry's advice in determining whether the care provided to Mr G was appropriate.

[36] Upper left lateral incisor.
[37] A hole in the bone formed as a result of inflammation under the root of the tooth.
[38] Used to provide support and stability for a dental restoration.

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Care provided 2018–2021

111. Mr G had a total of 18 recorded appointments between 2018 and 2021. I note that Dr C has accepted that he did not provide an overall treatment plan for Mr G, and Dr McKeefry is critical that Mr G was not fully diagnosed or informed of his oral conditions over this time.

112. Dr McKeefry stated that while obviously Mr G had a heavily filled and broken-down dentition, he was never advised by Dr C to return for a full examination and a comprehensive treatment plan, which may have led to fewer emergency dental appointments and stabilisation of his dentition going forward. Dr McKeefry acknowledged that it can be difficult to balance what a patient wants rather than what is advisable as an educated dental professional. However, Dr McKeefry concluded that Dr C's failure to provide a holistic approach to Mr G's care was a severe departure from the accepted standard of care.

113. I accept this advice. Mr G was entitled to receive care that was not limited to 'quick-fix solutions' and instead addressed his dental care to minimise the need for urgent care. Unfortunately, the notes contain no information about the treatment options discussed with Mr G. I have addressed the issue of documentation below. I am highly critical of Dr C's approach to Mr G's care during this time, and I note that Dr C has accepted that he did not provide Mr G with a comprehensive treatment plan.

Use of pins

114. In 2017 and 2020 Dr C restored Mr G's broken tooth with pinned composite crowns.

115. Dr McKeefry advised that the use of four pins in a lateral incisor under a bonded composite is not advisable due to the risk of perforating the side of the tooth or into the nerve or causing fractures. Dr McKeefry stated that pins 'were designed for use with non-adhesive amalgam[39] restorations, not bonded composites'. She considered this to be a moderate departure from the accepted standard of care.

116. I accept this advice. I acknowledge that Dr C may have meant this to be only a temporary solution. However, I remain critical that potentially Dr C compromised Mr G's oral health by utilising inappropriate methods for the treatment required regardless of whether this was meant to be a temporary solution.

Documentation

117. The DCNZ 'Patient records and privacy of health information practice standard' sets out the minimum standards for practitioners in creating and maintaining patient records. This includes the requirement that records are comprehensive, time bound, and up to date.

118. Dr McKeefry stated that Dr C's clinical notes fall far short of the accepted standard and do not contain a record of treatments, diagnoses, or discussions with Mr G. Dr McKeefry considered this to be a severe departure from accepted practice.

119. Dr McKeefry noted that Mr G had 'multiple' root canals performed over this time but there is no documentation as to whether rubber dams were used. Dr McKeefry advised that the

[39] A mixture of metals used to fill cavities.

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use of rubber dam isolation is standard practice both to limit bacterial contamination and to protect the patient's airway. I am concerned that there is no record of whether this occurred.

120. I am highly critical of the standard of Dr C's documentation, which has made it impossible to assess the diagnoses, treatment plans, and discussions with Mr G, and whether rubber dams were used. I consider that Dr C's clinical records fall well short of what is required in the practice standard.

Infection control

121. The DCNZ 'Infection Prevention and Control practice standards' (as set out in paragraphs 14 and 15 above) set out requirements to be observed by all practitioners to ensure safe practice. These include the requirement to document batch control identification information in the record of the patient on whom a sterilised item is used.

122. Dr McKeefry advised that there is no tracking on Mr G's file of sterilised critical instruments that were used by Dr C, as required by this practice standard, which is a severe departure from accepted practice. I note that it is a legal requirement that practitioners comply with this standard. HDC has not been provided with any evidence that Dr C complied with this standard, and I am highly critical of this omission.

Conclusion

123. I consider that Dr C breached Right 4(1) of the Code by not providing an appropriate standard of care to Mr G. I also consider that Dr C breached Right 4(2) of the Code in failing to keep accurate records and comply with his professional obligations as set out by the Dental Council's standards on infection control and documentation.

Care provided to Mrs H — breach

Introduction

124. Mrs H[40] was Dr C's patient from 2014 until her last recorded consultation with Dr C in March 2021. The clinical notes provided by Dr C do not contain details of any treatment plans, diagnosis, or discussions over this time. There are references to prescriptions for antibiotics in 2017 and 2019, a reference to the use of formalin in 2017, and a note that PA radiographs were taken in 2014 and 2017.

Appointment — Practice 2

125. On 31 March 2022 Mrs H had a consultation with Dr B. Dr B told HDC that Mrs H had a new patient examination with her primary complaint being that a root canal completed three years earlier was still causing her problems.

126. Dr B said that on examination, tooth 47[41] had a very 'ill-fitting' stainless-steel crown. A PA radiograph showed a root canal treatment 10mm short on the mesial root length and 6mm short on the distal root length. The stainless-steel crown was noted to have large

[40] Mrs H was aged 69 years at the time of her first consultation with Dr B.
[41] Second molar.

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overhangs[42] that were 'uncleanable'. Extraction was discussed with Mrs H. However, after a course of antibiotics, the tooth stabilised and Mrs H was advised to consider extraction, which was the only available option.

Dr C's response

127. Dr C told HDC that Mrs H originally presented in September 2014 with pain in tooth 47. The tooth was unrestored and was sore on biting. The tooth was painful when lateral pressure was applied to both buccal[43] and lingual[44] cusps.[45] A PA radiograph did not reveal any problem but showed considerable occlusal[46] wear. Dr C said that he made a diagnosis of a vertical crack in the root and informed Mrs H of this. Dr C stated that Mrs H said that she was 'reluctant' to lose the tooth. Dr C said that as it was unknown how far down the crack went into the root of the tooth, a 'compromise treatment' was proposed on a 'nothing to lose' basis. This involved placing a pre-formed stainless-steel crown on the tooth to hold it together and stop the crack getting worse or opening on biting and causing pain.

128. Dr C said that his diagnosis of a cracked tooth was confirmed by Mrs H's response to the crown placement, which resulted in Mrs H being pain free for three years. He also noted that development of a periapical radiolucency on the distal root three years later in an otherwise unrestored tooth is obvious in the original radiograph (but not the reproduced radiograph provided to HDC as part of the investigation).

129. In response to the provisional opinion, Dr C reiterated his opinion that the original diagnosis of a cracked tooth was correct. This was confirmed as Mrs H was pain free for three years following the placement of the temporary crown and the subsequent appearance of the apical radiolucency in the distal root, which is visible in the original X-ray.

130. Dr C stated that this treatment plan had a degree of success, but three years later Mrs H had pain in her tooth again. A PA radiograph revealed a radiolucency at the root apex,[47] but Mrs H was reluctant to lose the tooth and referred to the crown that had lasted for three years. Dr C said that in order to try to save the tooth, he attempted pulp removal and a root canal treatment. Again, this was done on a 'nothing to lose' basis to make the tooth last a little longer but it only delayed the inevitable. Dr C reiterated that Mrs H was reluctant to lose the tooth and was 'always keen to just try something else'.

131. Dr C told HDC that in retrospect, although he may have helped Mrs H to keep her tooth for longer, he accepts that he should have been more assertive in suggesting an extraction or referring her to someone else, who in his view would 'no doubt' have proposed the same solution, which was extraction.

[42] A restoration that is too bulky in the area where the restoration meets the tooth.
[43] The side of the tooth closest to the cheeks or lips.
[44] The part of the tooth closest to the tongue.
[45] A cusp is an elevation found on the back teeth and canines.
[46] The chewing surface of the tooth.
[47] The tip of the root of a tooth.

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Mrs H's response

132. Mrs H told HDC that she is concerned that Dr C's response does not address the issue, which is that the root canal undertaken by Dr C kept causing her problems.[48]

Mrs H's response to provisional opinion

133. Mrs H was given an opportunity to comment on the 'information gathered' section of the provisional opinion. She told HDC that she had had no complaint regarding Dr C's treatment until she had a root canal. Mrs H stated that she told Dr C that this was sore, but he never took another X-ray.

My opinion

134. To determine whether the care provided to Mrs H was appropriate, I considered the advice of Dr McKeefry.

Diagnosis of vertical root fracture

135. As noted above, Dr C told HDC that in 2014 he made a diagnosis of a vertical crack in tooth 47. He accepts that the subsequent treatment of a stainless-steel crown was a 'compromise' as Mrs H did not want to lose the tooth. Three years later, pulp removal and root canal treatment were performed again to delay the extraction of the tooth.

136. Dr McKeefry stated that there is no evidence to support the initial diagnosis of a vertical crack. She advised:

> 'There is no record of vitality testing to see if the tooth nerve was alive or not. There is no report on the level of pain (intensity, duration, waking at night, painkiller use). There is no mention of periodontal pocket depths (the main indicator of a vertical root fracture is the presence of a deep narrow pocket). The radiograph apparently showed no pathology and I note that even eight years later, on the radiograph taken by [Dr B], there is no evidence of a deep narrow area of bone loss which would be indicative of a vertical root fracture. [Dr C] says the tooth had a lot of occlusal wear which could be the cause of a root fracture in an unrestored tooth, but it could also be indicative of occlusal trauma (which might be relieved with a simple bite adjustment). There were no notes about using transillumination to attempt visualisation of the crack, or even that a crack was detected during the placement of the stainless-steel crown.'

137. Dr McKeefry said that if the diagnosis of a vertical root fracture was correct, the only appropriate treatment would have been extraction. If Dr C had been unsure about the diagnosis, due to the consequences of the diagnosis (extraction) in conjunction with the lack of evidence to support the diagnosis, Mrs H should have been referred to an endodontic specialist. Dr McKeefry does not accept that there was any scientific rationale for the placement of an ill-fitting stainless-steel crown, and she considers this to be a serious

[48] Mrs H also told HDC that a wire had been left in her tooth, and this was not addressed by Dr C in his response. In response to the provisional opinion, Mrs H reiterated that she found out that a wire had broken and was left in her tooth only following an X-ray when she saw Dr B, and she was told that Dr C would have been aware of this.

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departure from accepted practice. However, Dr McKeefry acknowledged that Dr C was likely following Mrs H's instructions.

138. In response to Dr McKeefry's advice, Dr C stated that his diagnosis of a cracked tooth was confirmed by the response to the placement of a pre-formed stainless-steel crown, which resulted in Mrs H being pain free for three years. He also noted that the development of a periapical radiolucency on the distal root three years later in an unrestored tooth is obvious in the original radiograph. In response to the provisional opinion, Dr C reiterated his opinion that his diagnosis of a cracked tooth was correct, as set out above.

139. While I acknowledge Dr C's reasons for his diagnosis and his comments about his observations on the original radiograph, I accept Dr McKeefry's advice that there is no documented evidence to support the initial diagnosis of a vertical root fracture, and that despite Dr C's response above, the subsequent treatment provided was not appropriate. I note that Dr C has accepted that he should have been more assertive in suggesting an extraction or referring Mrs H.

140. Mrs H was entitled to an appropriate diagnosis and treatment, and a referral in the event that Dr C was unsure of his diagnosis. The treatment Dr C provided in the form of an ill-fitting stainless-steel crown, which was noted to be 'uncleanable', was well below the accepted standard of care. Accordingly, I am highly critical of the standard of care provided by Dr C to Mrs H.

Use of formalin

141. Mrs H had a root canal treatment in or around August 2017, and the use of formalin is documented in Dr C's notes.

142. Dr McKeefry referred to the American Association of Endodontists' position statement on the use of formaldehyde and paraformaldehyde-containing materials in which it was recommended that these materials should not be used due to their toxicity and carcinogenicity. Dr McKeefry considered the use of formalin to be a moderate departure, given that it has not been banned, and potentially other practitioners may still be using these products.

143. In response to the provisional opinion, Dr C told HDC that formalin has not been banned, and Dr McKeefry has accepted that there are likely to be other practitioners who may still be using these products. Dr C told HDC that he ceased using formalin in 2021 and that whenever he administered it, this was recorded. Dr C stated that there has been no publication issued by the Dental Council or any other comparable body in New Zealand addressing the use of formalin and advising against it, and while the AAE may have published a paper on the topic, those findings have not been incorporated into practice here.

144. I acknowledge Dr C's comments regarding the use of formalin. However, I consider that Dr McKeefry's advice does take into account that formalin has not been banned and that other practitioners may still be using formalin, and I consider that the moderate departure identified by Dr McKeefry reflects these factors. Accordingly, I accept Dr McKeefry's advice

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and remain concerned that Dr C used formalin, given the concerns about its use highlighted by Dr McKeefry.

Documentation

145. The DCNZ 'Patient records and privacy of health information practice standard' sets out the minimum standards for practitioners in creating and maintaining patient records. This includes the requirement that records are comprehensive, time bound, and up to date.

146. Dr McKeefry stated that Dr C's clinical notes fall far short of the accepted standard and do not contain a record of treatments or diagnoses, or discussions with Mrs H. Dr McKeefry advised that this is a severe departure from accepted practice. Dr McKeefry also stated that the use of rubber dam isolation is standard practice both to limit bacterial contamination and to protect the patient's airway, and I am concerned that there is no record of this when Mrs H had a root canal in August 2017.

147. The standard of documentation has made it impossible to assess the diagnoses, treatment plans, and discussions with Mrs H, and whether rubber dams were used. I consider that Dr C's clinical records fall well short of what is required in the practice standard, and I am highly critical of this.

Infection control

148. The DCNZ 'Infection Prevention and Control practice standards' (as set out in paragraphs 14 and 15 above) set out the requirements to be observed by all practitioners to ensure safe practice. These include the requirement to document batch control identification information in the record of the patient on whom a sterilised item is used.

149. Dr McKeefry advised that there is no tracking on Mrs H's file of sterilised critical instruments that were used by Dr C, as required by this practice standard, which is a severe departure from accepted practice. I note that it is a legal requirement that practitioners comply with this standard. HDC has not been provided with any evidence that Dr C complied with this standard, and I am highly critical of this omission.

Conclusion

150. I consider that Dr C breached Right 4(1) of the Code by not providing an appropriate standard of care to Mrs H in the diagnosis of a vertical root fracture and the subsequent treatment provided, as well as the use of formalin during the root canal treatment. I also consider that Dr C breached Right 4(2) of the Code in failing to keep accurate records and comply with his legal obligations, as set out by the Dental Council's standards on infection control and documentation.

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Care provided to Mr J — breach

Introduction

151. Mr J[49] was Dr C's patient from 1999 until his last recorded appointment in November 2021. The clinical notes provided by Dr C do not contain details of any treatment plans, diagnoses, or discussions over this time. Radiographs were taken in 2013 and 2019, and these were provided with Dr C's records.

Appointment — Practice 2

152. On 22 November 2021 Mr J had a consultation with Dr A. Dr A told HDC that Mr J presented with a large periodontal abscess[50] around tooth 33, along with generalised periodontitis[51] and widespread gingival bleeding.[52] Mr J said that usually he would see Dr C and be prescribed antibiotics with no follow-up. Dr A stated that Mr J was very keen to get on top of his condition and is now under the care of a specialist periodontist.

Dr C's response

153. Dr C told HDC that Mr J was an 'irregular' patient who attended appointments when he had a problem. An example of this is when Mr J attended in 2013 after a five-year absence and presented with pain in tooth 36, which was then root filled. Dr C stated that Mr J then returned in 2018 after another five-year absence presenting with pain and swelling associated with a periodontal abscess on tooth 33. Dr C said that initially this was treated with antibiotics as well as scaling and root planing, and he provided Mr J with a mirror, an examination probe, and a periodontal probe[53] to show Mr J which areas needed deep scaling and root planing.

154. Dr C stated that he tried to get Mr J onto a regular recall programme in order to get on top of his periodontal condition, but this had limited results because of his poor attendance. Dr C said that on-going periodontal conditions can be dealt with only when patients are committed to receiving treatment. As Mr J was not attending the clinic regularly, it was not possible to monitor his periodontal issues or provide on-going treatment. Dr C stated that he felt that he did what he could for Mr J given that his consultations were irregular, but any treatment he was able to provide was less effective than it would have been had he attended regularly.

155. Dr C told HDC that he regrets not being more comprehensive in his note-taking and recording of Mr J's periodontal condition.

Mr J's response

156. Mr J told HDC that he accepts that he was not a regular attendee, but he does not accept that there were five-year gaps between visits. He also does not accept that Dr C wanted him

[49] Mr J was aged 53 years at the time of his first consultation with Dr A.
[50] A pocket of infection that starts in the gums.
[51] Generalised gum disease characterised by ongoing gum inflammation and swelling.
[52] Bleeding gums.
[53] Used to evaluate the depth of the pockets surrounding a tooth in order to determine the periodontium's overall health.

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on a regular recall programme in order to get on top of his periodontal condition. Mr J stated that he did not know what a 'periodontal condition' was, and this was never explained to him by Dr C. Mr J said that he would have followed the treatment advice given by Dr C if this had been explained to him. Mr J said that as a result of Dr C's treatment, he has had three teeth removed, with two other teeth considered to be 'borderline'.

157. Mr J told HDC that he is very happy with the treatment and advice that he has been receiving from Dr A. Dr A has identified and explained the poor condition of his teeth and gums and set out a plan to get on top of his oral health. Since attending Practice 2, Mr J has been provided with a referral to a periodontist and has been receiving treatment for the past year. This has changed his approach to oral health significantly. Mr J told HDC that there has been a significant cost involved with this treatment, and he is disappointed that it had to get this far in the first place. Mr J stated that he was a committed patient, but Dr C did not identify or communicate problems about his periodontal condition, and this responsibility lies with Dr C.

158. Mr J told HDC that he does not bear any animosity towards Dr C but would like Dr C 'to reflect on his poor conduct and get the appropriate help and support so that he does [not] make mistakes like this again'.

Mr J's response to provisional opinion

159. Mr J was provided with an opportunity to comment on the 'information gathered' section of the provisional opinion, and he advised that he did not have any comments to make.

My opinion

160. To determine whether the care provided to Mr J was appropriate, I considered the advice of Dr McKeefry.

Management of Mr J's periodontal disease

161. Mr J had been a patient of Dr C since 1999, and the clinical records show that he attended infrequently between 1999 and 2013. However, from 2018 onwards, Mr J did attend frequently each year until 2021. As noted above, the clinical records do not contain details of any treatment plans, diagnosis of periodontal disease, or discussions over this time.

162. Dr McKeefry stated that while Mr J attended for full mouth examinations from 2019 onwards, there is no record of the diagnosis of periodontal disease nor that this was discussed with Mr J at any time. Dr McKeefry advised:

> '[Mr J] should have been educated on the conditions in his mouth and a referral strongly recommended. Full mouth periodontal charting (pocket depths, recession and bleeding) should have been undertaken on a regular basis as well as comprehensive X-rays.'

163. Dr McKeefry concluded that the fact that none of these things occurred constitutes a severe departure from accepted practice. I accept this advice.

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164. In his response to HDC, Dr C stated that he did attempt to get Mr J on a regular programme to address his periodontal condition, but this did not occur as Mr J did not attend regular appointments. Mr J accepted that he did not attend regular appointments, but he does not accept that there was any mention of him being on a regular recall programme, and he said that he was never advised of his periodontal condition by Dr C.

165. I will address the issue of documentation below. However, due to the absence of evidence that Mr J's periodontal condition was discussed with him, I consider it more likely than not that Mr J was not advised of his periodontal condition. Dr McKeefry also noted that periodontal charting did not occur, and nor were comprehensive X-rays taken.

166. Mr J had the right to the information that a reasonable person in his circumstances would expect to receive regarding his treatment, including an explanation of his condition and of the options available to him. Mr J should have been advised of his periodontal condition, and appropriate periodontal charting, referrals, and X-rays should have been completed. I consider that Dr C had the opportunity to address this at the appointments from 2018 onwards when Mr J began to attend more frequently. In addition, the clinical records contain no reference to any discussions about consent. I am highly critical of Dr C's management of Mr J's condition and that this was left for a significant time.

Documentation

167. The DCNZ 'Patient records and privacy of health information practice standard' sets out the minimum standards for practitioners in creating and maintaining patient records. This includes the requirement that records are comprehensive, time bound, and up to date.

168. Dr McKeefry advised that Dr C's clinical notes fall far short of the accepted standard and do not contain a record of treatments and diagnoses, nor discussions with Mr J, and that this is a severe departure from accepted practice. I also note that Mr J had a root canal treatment in 2013, and there is no record as to whether rubber dam isolation was used.

169. Dr McKeefry advised that the use of rubber dam isolation is standard practice both to limit bacterial contamination and to protect the patient's airway, and I am concerned that there is no record of this.

170. The standard of documentation has made it impossible to assess the diagnoses, treatment plans, and discussions with Mr J, and whether rubber dam isolation was used. I consider that Dr C's clinical records fall well short of what is required in the practice standard, and I am highly critical of this.

Infection control

171. The DCNZ 'Infection Prevention and Control Practice Standards' (as set out above in paragraphs 14 and 15) set out the requirements to be observed by all practitioners to ensure safe practice. These include the requirement to document batch control identification information in the record of the patient on whom a sterilised item is used.

172. Dr McKeefry advised that there is no tracking on Mr J's file of sterilised critical instruments that were used by Dr C, as required by this practice standard, which is a severe departure

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from accepted practice. I note that it is a legal requirement that practitioners comply with this standard. HDC has not been provided with any evidence that Dr C complied with this standard, and I am highly critical of this omission.

Conclusion

173. I consider that Dr C breached Right 4(1) of the Code by not providing an appropriate standard of care to Mr J in not undertaking the required examinations for charting periodontal disease. In addition, I consider that by not advising Mr J of his periodontal disease and options for treatment, Dr C did not provide Mr J with information that a person in Mr J's circumstances would expect to receive and breached Right 6(1) of the Code. I also consider that Dr C breached Right 4(2) of the Code in failing to keep accurate records and comply with his legal obligations as set out by the Dental Council's standards on infection control and documentation.

Care provided to Mrs I — breach

Introduction

174. Mrs I[54] was a patient of Dr C from 2016 until her last recorded appointment in April 2021. The clinical notes provided by Dr C do not contain details of any treatment plans, diagnosis, or discussions over this time.

Appointment — Practice 2

175. On 31 March 2022 Mrs I had a consultation with Dr A. Dr A told HDC that Mrs I was unaware of the internal resorption[55] and caries[56] associated with teeth 21[57] and 35,[58] both of which were treated endodontically.[59] Both teeth were mobile and both required extraction. Dr A recorded that Mrs I had said that tooth 35 had been treated by Dr C several times without any explanation.

Dr C's response

176. Dr C told HDC that he was unaware of the internal resorption associated with tooth 21 and that internal resorption is relatively rare and can be difficult to treat. In terms of the management of tooth 35,[60] he said that the aim was to try to preserve the tooth, as Mrs I suffered from pain due to temporomandibular joint disorder (TMJ),[61] which was not helped by the lack of posterior teeth in the lower arch. Dr C said that he had discussed the option of a lower partial denture with Mrs I, but this was ruled out due to Mrs I's financial situation at the time. Tooth 35 was root filled, and this was repeated when it did not settle. Dr C told

[54] Mrs I was aged 84 years at the time of her first consultation with Dr A.
[55] Occurs when the tissue within a tooth starts to disappear, causing inflammation. The issue beneath the tooth's enamel is absorbed back into the tooth canal, making the tooth hollow and more susceptible to damage and decay.
[56] Tooth decay.
[57] Upper left central incisor.
[58] Lower left second premolar.
[59] Teeth that have undergone root canal treatment.
[60] Dr C accepted that this was incorrectly referred to as tooth 34 in Mrs I's clinical records.
[61] TMJ dysfunction causes pain and tenderness in the jaw joints and surrounding muscles and ligaments.

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HDC that the reasoning for this was that it was better to have the tooth than not until Mrs I was able to reconsider a lower partial denture.

177. Dr C accepted that he should have provided more details in the clinical notes about discussions with Mrs I around treatment options and choices.

178. In response to the provisional opinion, Dr C told HDC that teeth 21 and 35 were not mobile when he saw Mrs I 11 months prior to her appointment with Dr A, and there is no evidence to support this. Dr C stated that extraction of the most posterior tooth in a quadrant when a patient has TMJ is not helpful unless a patient is prepared to get a prosthetic replacement, which Mrs I was not prepared to do.

Mrs I's response to provisional opinion

179. Mrs I was provided with an opportunity to comment on the 'information gathered' section of the provisional opinion, and she advised that she had no comments to make.

My opinion

180. To determine whether the care provided to Mrs I was appropriate, I considered the advice of Dr McKeefry.

Failure to diagnose internal resorption

181. Mrs I's last consultation with Dr C was 11 months prior to the consultation with Dr A. Dr A identified that both teeth 21 and 35 were mobile with large cavities due to both internal resorption and caries.

182. Dr McKeefry stated that it is unlikely that both the mobility of tooth 21 and 35 and cavities were not present to some extent at Mrs I's last consultation with Dr C. Dr McKeefry accepted that it is possible to miss internal resorption until it is quite advanced. However, she stated that further investigations should occur when a tooth is mobile, to find out the cause. Dr McKeefry concluded that Dr C's failure to diagnose internal resorption was a mild to moderate departure from the accepted standard of care.

183. I note that Dr C disputes that teeth 21 and 35 were mobile at Mrs I's last consultation. Unfortunately, there are no clinical notes relating to this consultation. However, I note that these teeth were mobile and had to be extracted at the consultation with Dr A on 31 March 2022, which was 11 months after the consultation with Dr C. Accordingly, I am guided by the advice of Dr McKeefry and consider it is likely that these teeth were mobile and that cavities were present at the time of the last consultation with Dr C.

184. I acknowledge that diagnosing internal resorption may be difficult, but I agree that Dr C should have made further enquiries to ascertain the potential causes of the tooth mobility, and I am critical that this did not occur.

Maintenance of tooth 35

185. Regarding the maintenance of tooth 35, Dr McKeefry stated that Dr C did have sufficient reason to maintain tooth 35, as Mrs I had TMJ due to loss of her back teeth, and he did not

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want her to lose more as she was not able to have a partial denture. The issue is that none of this reasoning is documented in the clinical notes, and Dr McKeefry concluded that in the absence of accurate clinical records, it is difficult to say what was discussed with Mrs I. Whether or not Mrs I opted for a partial denture to provide support for the bite was her decision, but this should have been made after a full discussion regarding her options. Dr McKeefry stated that the maintenance of tooth 35 was compromising the health of the surrounding bone and gum, and it should have been removed if Mrs I had consented to this. Dr McKeefry concluded that the maintenance of tooth 35 in these circumstances is a mild to moderate departure from accepted practice.

186. Dr C stated that extraction of the most posterior tooth in a quadrant when a patient has TMJ is not helpful unless a patient is prepared to get a prosthetic replacement, which Mrs I was not prepared to do.

187. While I acknowledge Dr C's response, there is no documentation of this reasoning nor evidence that this was discussed with Mrs I at any stage. As I have noted above, there were risks in maintaining tooth 35, and there is no documentation to suggest that these risks were discussed with Mrs I, and I accept Dr McKeefry's advice. I am critical of Dr C's decision to maintain tooth 35 in these circumstances and will address the issue of documentation below.

Documentation

188. The DCNZ 'Patient records and privacy of health information practice standard' sets out the minimum standards for practitioners in creating and maintaining patient records. This includes the requirement that records are comprehensive, time bound, and up to date.

189. Dr McKeefry stated that Dr C's clinical notes fall far short of the accepted standard and do not contain a record of treatments, diagnoses, or discussions with Mrs I, and that this is a severe departure from accepted practice. Dr McKeefry also advised that Dr C performed root canal treatments on tooth 35 on two occasions, and I note that there is no record of whether rubber dam isolation was used.

190. Dr McKeefry stated that the use of rubber dam isolation is standard practice to limit bacterial contamination, and I am concerned that there is no record of this.

191. The standard of documentation has made it impossible to assess the diagnoses, treatment plans, and discussions with Mrs I, and whether rubber dam isolation was used. I consider that Dr C's clinical records fall well short of what is required in the practice standard, and I am highly critical of this.

Infection control

192. The DCNZ 'Infection Prevention and Control practice standards' (as set out in paragraphs 14 and 15 above) set out the requirements to be observed by all practitioners to ensure safe practice. These include the requirement to document batch control identification information in the record of the patient on whom a sterilised item is used.

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193. Dr McKeefry advised that there is no tracking on Mrs I's file of sterilised critical instruments that were used by Dr C, as required by this practice standard, which is a severe departure from accepted practice. I note that it is a legal requirement that practitioners comply with this standard. HDC has not been provided with any evidence that Dr C complied with this standard, and I am highly critical of this omission.

Conclusion

194. I consider that Dr C breached Right 4(1) of the Code by not providing an appropriate standard of care to Mrs I, in not conducting appropriate enquiries regarding the potential causes of the mobility of teeth 21 and 35, and the further maintenance of tooth 35. I also consider that Dr C breached Right 4(2) of the Code in failing to keep accurate records and comply with his legal obligations as set out by the Dental Council's standards on infection control and documentation.

Subsequent events

195. Dr C has advised HDC that he has returned to practising dentistry. The Dental Council was advised of the complaint relating to Dr C in October 2023. As a result of the concerns raised, and following a review of Dr C's practice, the Council ordered that Dr C practise under supervision[62] from a dental practitioner, with a competence review to be scheduled.

Changes made since events

196. Dr C accepted that some of his records were not up to standard and said that he has made changes to his practice as a result, to ensure that his records are more comprehensive and include the following:

- Discussions as to treatment options/approaches with patients and any concerns patients may have;
- Greater detail about the treatment provided;
- Discussions around consent and consent forms;
- Follow-up actions; and
- Allocation of more time to note-taking and writing up of clinical records.

197. Dr C told HDC that he is now practising under a supervisor and that he has made significant changes to his practice as a result of the complaint.

198. Dr C stated that he is now much more mindful of his record-keeping and dedicates more time to this, and as a result he has 'noticed marked improvements'.

[62] Dr C was ordered to practise under indirect supervision, meaning that the supervisor is easily contactable and available to observe and discuss clinical management. Indirect supervision must include a review of records, treatment planning and diagnosis, and treatment outcomes.

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199. In response to the provisional opinion, Dr C told HDC that he has since taken the following steps to improve his practice:

- Attended an Infection Prevention and Sterilisation course run by the New Zealand Dental Association (NZDA);
- Completed a half-day observation in a specialist endodontist's clinic;
- Completed an endodontics course and attended the NZDA annual conference in addition to attending several endodontics lectures;
- Attended a full-day oral surgery course;
- Reflected on how to be more assertive with patients, and he spends more time discussing treatment options and the advantages and disadvantages of these options, as well as making more referrals for specialist care;
- Installed EXACT software and computerised records, including digital radiographs. Digital X-rays are now taken more frequently, and these are shown to patients during consultations to explain treatment options;
- Enrolled two staff members in the NZDA certificate in dental assisting, which both staff members have since completed;
- Hired more staff to assist with administrative tasks;
- Established regular staff meetings to ensure that all staff are aware of the Dental Council practice guidelines;
- Reduced the number of patient consultations per day to allow time for treatment and recording of clinical notes;
- Regularly attended Dental Association branch meetings, conferences, and courses; and
- Engaged with a Dental Council approved supervisor for the previous 11 months, which involves meeting twice weekly to discuss patient treatments and plans.

Recommendations

200. I recommend that Dr C:

a) Undertake an audit of his clinical records using the DCNZ 'Patient records and privacy of health information practice standard' as guidance to determine the degree of compliance with the following:

   - Documentation of any medical history changes for patients
   - Record of consent for treatments along with a record of any treatments declined and reasons for this
   - Record of sterilisation batch tracking
   - Record of list of materials used, including local anaesthetic and the type of injection and rubber dam used

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- Record of diagnoses
- Documentation of findings at the examination, including items checked (including if no abnormalities noted)
- Records of a basic gum chart for every examination (with more comprehensive charting if treating patients with pockets beyond 3mm)
- Record of recommended recall period and what treatment the patient needs to return for

The summary of findings from the audit, along with corrective actions, is to be provided to HDC within three months of the date of this report.

b) Complete HDC's online learning course on informed consent (Module 2: what you need to know about informed consent). Evidence of completion is to be provided to HDC within two months of the date of this report.

c) Undertake further education and training on courses that cover the following and provide evidence of completion within eight months of the date of this report:

- Clinical record-keeping
- Cross-infection and sterilisation
- Composite restorations
- Communication with patients (including the education of patients)
- Toothache diagnoses
- Minimum standards of care
- Periodontal disease

201. In the provisional opinion, I recommended that Dr C provide apologies to all the consumers mentioned in this report for the breaches of the Code. These apologies were received in response to the provisional opinion and have since been provided to these consumers.

Follow-up actions

202. Due to the severity of the departures identified and the number of patients impacted by these breaches, which are indicative of a pattern of significantly sub-standard care, I considered making a referral to the Director of Proceedings to consider further legal remedies. However, given the measures that have since been put in place by the Dental Council, the time that has elapsed since these events, and that some of the consumers did not support a referral, I have decided not to proceed with a referral to the Director of Proceedings in this instance.

203. A copy of this report will be sent to the Dental Council of New Zealand to communicate my decision about Dr C.

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204. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to the Dental Council of New Zealand, the New Zealand Dental Association, and the Health Quality & Safety Commission.

205. A copy of this report with details identifying the parties removed, except the advisor on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from Dr Angela McKeefry:

'**Independent clinical advice to Health and Disability Commissioner**

Complaint:	**[Dr C]**
Our ref:	**22HDC01875**
Independent advisor:	**Dr Angela McKeefry**

I have been asked to provide clinical advice to HDC on case number **22HDC01875**. I have read and agree to follow HDC's Guidelines for Independent Advisors.

I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint.

I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved:	• Bachelor of Dental Surgery (Otago) 1993 • Fellow of the International College of Continuing Dental Education (In Orthodontics) • Have been a general dentist doing a wide scope of dental procedures in the same practice for 29 years until I recently shifted to a new practice • Have served on several dental committees over my career including running the Wellington branch of the recent graduate program for several years
Documents provided by HDC:	Bundle of Documents consisting of the following: - 1. Letters of complaint from [Drs A and B] dated 1 August 2022 2. [Dr C's] response dated 3 July 2023 and 7 April 2024 3. Clinical records provided by [Dr C] in relation to [Mrs E], [Ms D], [Mr F], [Mr G], [Mrs H], [Mr J] and [Mrs I]. 4. Clinical records from [Drs A and B] in relation to those patients referred to in 3 above. 5. Response from [Mr J] dated 22 March 2024.

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Referral instructions from HDC:	[Dr C] 1. Whether [Dr C] provided an appropriate standard of care to [Ms E] (Case B …) prior to her seeking treatment from [Dr B] in November 2021; 2. Whether [Dr C] provided an appropriate standard of care to [Ms D] (Case D …) prior to her seeking treatment from [Dr B] in February 2022; 3. Whether [Dr C] provided an appropriate standard of care to [Mr F] (Case E …) prior to him seeking treatment from [Dr B] in December 2021; 4. Whether [Dr C] provided an appropriate standard of care to [Mr G] (Case F …) prior to him seeking treatment from [Dr B] in December 2021; 5. Whether [Dr C] provided an appropriate standard of care to [Mrs H] (Case G …) prior to her seeking treatment from [Dr B] in March 2022; 6. Whether [Dr C] provided an appropriate standard of care to Mr J (Case 1 …) prior to him seeking treatment from [Dr A] in November 2021; 7. Whether [Dr C] provided an appropriate standard of care to [Mrs I] (Case 2 …) prior to her seeking treatment from [Dr A] in March 2022; 8. The standard of [Dr C]'s documentation; 9. Any other matters in this case that you consider warrant comment.

Factual summary of clinical care provided complaint:

Brief summary of clinical events:	[Drs A and B] saw multiple patients of [Dr C] after he had to cease treatment due to the COVID 19 vaccination mandate. The standard of dentistry they observed in these patients was unsatisfactory. They are also concerned that [Dr C] treated at least one patient after the mandate was in effect. They are concerned about the quality of his clinical notes and that he is working in a solo practice which is isolated from dental peers. [Dr C] has stated he has been a regular attender of peer events and continuing education. He acknowledges his clinical notes could have been better and that he shouldn't have treated the patient during the COVID 19 mandate. [Dr C] said he was generally trying to help his patients by

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	providing "stop gap" dentistry to avoid extracting otherwise unsavable teeth. [Dr C] comments it was hard to provide comprehensive care when the patients failed to attend regularly.

Question 1: Whether [Dr C] provided an appropriate standard of care to [Ms E] (Case B …) prior to her seeking treatment from [Dr B] in November 2021.	
List any sources of information reviewed other than the documents provided by HDC:	Standards Framework for Oral Health Practitioners — DCNZ Code of Health and Disability Services Consumers' Rights Infection Prevention and Control Practice Standard — DCNZ
Advisor's opinion:	[Mrs E] looks to have been a patient of [Dr C] from 2002–2021. During this time [Dr C] performed eight full mouth exams and multiple other treatments. There seems to have only been one radiograph taken and the clinical notes are extremely poor. [Dr C], although trying to help [Mrs E], should not have treated her during the COVID 19 mandate. Having decided to treat her, he should have done so in a clinically appropriate manner. He should also have documented this treatment. In October/ November 2021 [the region] was at Level 2 COVID restrictions which means dental procedures were not limited so long as masks were worn and patients signed in. To say he diagnosed a root fracture but "recemented the tooth as a temporary measure" instead of extracting the tooth to reduce aerosol is ridiculous given the Level 2 restrictions did not require this and there would be similar aerosol for both procedures. This was very subpar treatment and it is fortunate the patient didn't develop a more serious infection. There is no tracking on the patient's file, of sterilized critical instruments which became mandatory in 2016.
What was the standard of care/accepted practice at	From: Code of Health and Disability Services Consumers' Rights

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the time of events? Please refer to relevant standards/material.	Right 4 *Right to services of an appropriate standard* Right 6 *Right to be fully informed* Right 7 *Right to make an informed choice and give informed consent* **Advisor comments: [Mrs E] should not have been treated by [Dr C] during the COVID 19 mandate, but since she was, it should have been done to an acceptable standard.** From: Standards Framework for Oral Health Practitioners — DCNZ Patients have the right to: • have services provided with reasonable care and skill; • have services provided that comply with legal, professional, ethical, and other relevant standards; • have services provided in a manner consistent with their needs; • have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer; • co-operation among providers to ensure quality and continuity of services. ***(In the above bullet points, all have been breached in this case — [Dr C] should have made arrangements for ALL his patients' care to be taken over by other dentists in the area)*** Standard 10 You must maintain accurate, time-bound and up-to-date patient records Standard 20 You must provide care that is clinically justified and based on the best available evidence

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	Standard 24 You must be familiar, and comply, with your legal and professional obligations From: Infection Prevention and Control Practice Standard — DCNZ 14 — You must ensure all critical items are packaged and labelled with batch control identification information before sterilisation. Label the outside of the pack of all critical items, before sterilisation, with the following batch control identification information: • Steriliser identification number or code, if there is more than one steriliser in use. • Date of sterilisation. • Cycle or load number. Batch control identification (tracking/tracing) links the reprocessed critical item/s to a particular sterilisation cycle with documented performance data demonstrating sterilisation parameters were met. **Document the batch control identification information in the record of the patient on whom the sterilised critical item/s is used.**
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	There was a severe departure from accepted practice.

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How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	Our peers would view this very poorly. • The clinical notes are nothing more than a list of items to be invoiced for. They resemble clinical records from the 1970s. • The clinical notes are missing the final entry when the patient was treated during the COVID 19 Mandate. • [Dr C] treated the patient while in breach of the COVID 19 Vaccination Order. • The patient had not been provided with regular diagnostic dental radiographs over the 21 years they were a patient of [Dr C]. • It's hard to see any sort of holistic care being provided with no diagnoses or reason for treatment ever being provided, e.g. [Mrs E] attended on the 5/4/17 with pain in the 14 (upper right first premolar tooth). There was no diagnosis, 'amoxil' (no record of dose or duration stated) was prescribed and no follow up occurred (even at the subsequent exam a year later). • The treatment provided during the COVID 19 mandate was inappropriate and sub-standard. A root fracture was diagnosed and yet the restoration was recemented temporarily. The only suitable treatment in this instance was extraction or referral for extraction.
Please outline any factors that may limit your assessment of the events.	The clinical records are so poor [Dr C] has probably done himself a disservice as it is quite likely more care and thought went into the treatment than is reflected there.
Recommendations for improvement that may help to prevent a similar occurrence in future.	A course on clinical record keeping. A course on minimum standards of care. A very close or even supervisory relationship with one or more respected dental practitioners. An audit of [Dr C's] "new" record keeping and likely an assessment of the overall functioning of the dental practice.

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	Cross infection and sterilization course for ALL staff.

Question 2: Whether [Dr C] provided an appropriate standard of care to [Ms D] (Case D …) prior to her seeking treatment from [Dr B] in February 2022.	
List any sources of information reviewed other than the documents provided by HDC:	Standards Framework for Oral Health Practitioners — DCNZ Code of Health and Disability Services Consumers' Rights Infection Prevention and Control Practice Standard — DCNZ
Advisor's opinion:	[Ms D] was a patient of [Dr C] from 1996–2021. An appropriate standard of care was not provided to [Ms D]. The patient was not a regular attender but was seen about 18 times in that 25 year period, including nine examinations. At no time were any radiographs taken, not even prior to extractions. The clinical records fall far short of the standard. There is no record of a diagnosis (advanced adult periodontal disease), a conversation with [Ms D] about the prognosis for her teeth or the advisement of a referral to a periodontist. There is no periodontal charting or radiographs to document the disease. In 1996 when [Dr C] first saw [Ms D], the periodontal disease must have been far less progressed and a referral to a specialist at this time could well have helped to maintain her dentition. It is the responsibility for the patient to attend regularly and undergo advised treatments, but it is the dentist's responsibility to ensure the patient understands the diagnosis, risks and benefits of treatment and to refer when the care required is beyond their scope. If the patient then chooses not to accept treatment or referral, that needs to be clearly documented. There is no tracking on the patient's file, of sterilized critical instruments which became mandatory in 2016.

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	This looks to be a case of supervised neglect.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	From: Code of Health and Disability Services Consumers' Rights Right 4 *Right to services of an appropriate standard* Right 6 *Right to be fully informed* Right 7 *Right to make an informed choice and give informed consent* **Advisor comments: [Ms D] was not fully diagnosed, nor fully informed of her oral conditions. She was not given the option of a higher level of specialist care.** From: Standards Framework for Oral Health Practitioners — DCNZ Patients have the right to: • have services provided with reasonable care and skill; • have services provided that comply with legal, professional, ethical, and other relevant standards; • have services provided in a manner consistent with their needs; • have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer; • co-operation among providers to ensure quality and continuity of services. ***(In the above bullet points, all but the final one have been breached in this case)*** Standard 1 You must ensure the health needs and safe care of your patients are your primary concerns

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	Standard 8 You must practise within your professional knowledge, skills and competence, or refer to another health practitioner Standard 10 You must maintain accurate, time-bound and up-to-date patient records Standard 15 You must give patients the information they need or request, in a way they can understand, so they can make informed decisions Standard 16 You must ensure informed consent remains valid at all times Standard 19 You must take a holistic approach to care appropriate to the individual patient Standard 20 You must provide care that is clinically justified and based on the best available evidence Standard 24 You must be familiar, and comply, with your legal and professional obligations From: Infection Prevention and Control Practice Standard — DCNZ 14 — You must ensure all critical items are packaged and labelled with batch control identification information before sterilisation. Label the outside of the pack of all critical items, before sterilisation, with the following batch control identification information: • Steriliser identification number or code, if there is more than one steriliser in use. • Date of sterilisation.

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	• Cycle or load number. Batch control identification (tracking/tracing) links the reprocessed critical item/s to a particular sterilisation cycle with documented performance data demonstrating sterilisation parameters were met. **Document the batch control identification information in the record of the patient on whom the sterilised critical item/s is used.**
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	There was a severe departure from accepted practice.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	This care would be viewed very poorly. This has been supervised neglect over a period of 25 years. The patient may still have lost all her upper teeth, but she was effectively given no opportunity to try and prevent this from happening. The lack of radiographs, periodontal pocket depth charting, diagnosis, offer of specialist referral or satisfactory clinical notes would be found to be shocking by most dentists.
Please outline any factors that may limit your assessment of the events.	I have no access to non-recorded patient-dentist discussions.
Recommendations for improvement that may help to prevent a similar occurrence in future.	I think a full audit of the practice needs to occur followed with appropriate upskilling and mentoring or supervision. Cross infection and sterilization course for ALL staff.

Question 3: Whether [Dr C] provided an appropriate standard of care to [Mr F] (Case E) prior to him seeking treatment from [Dr B] in December 2021.	
List any sources of information reviewed other than the documents provided by HDC:	Standards Framework for Oral Health Practitioners — DCNZ Code of Health and Disability Services Consumers' Rights

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	Infection Prevention and Control Practice Standard — DCNZ American Association of Endodontists 2013 position statement advising against the use of formaldehyde and paraformaldehyde containing materials
Advisor's opinion:	The specific problem highlighted in this case is the post [Dr C] placed in [Mr F's] lower right second premolar in 2016 which perforated through the side of the root. This is a known risk of post placement treatment. There is no record of the patient having been warned of this as part of informed consent prior to the procedure. [Dr C] admits he failed to inform [Mr F] that the root had been perforated due to embarrassment and that is also likely why no ACC claim was filed. The root perforation (while unfortunate) is not an issue, however the lack of (or at least lack of documentation of) informed consent and informing the patient after the perforation had occurred are problematic. I also note generally poor clinical records again and a lack of diagnostic radiographs. At the post insertion appointment, no record of the perforation is made in the notes. I assume [Dr C] was aware of the perforation as there likely would have been bleeding. That [Mr F] had a full dental exam with [Dr C] on 14/09/2021 and then needed so much remedial treatment only three months later speaks to a lack of thorough diagnoses at his routine examination. Routine posterior bitewing radiographs had not been taken since 2014 when they should be done every 12–24 months. Also of note is the root canal on the 46 (lower right first molar) done in Oct/Nov 2021. There was again no noted informed consent, during the process Formalin was used which has been advised against since at least 2013 (when the American Association of Endodontists issued a position statement on the use of formaldehyde and paraformaldehyde containing materials in which they recommended that they should not be used due to their toxicity and

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	carcinogenicity) and an instrument looks to have been broken in one of the canals (which is another known risk of root canals) without documenting the patient being informed (if they were). It also appears the root canal was done without rubber dam isolation which is standard practice to both limit bacterial contamination and to protect the patient's airway. There is no tracking on the patient's file, of sterilized critical instruments which became mandatory in 2016.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	From: Code of Health and Disability Services Consumers' Rights Right 4 *Right to services of an appropriate standard* Right 6 *Right to be fully informed* Right 7 *Right to make an informed choice and give informed consent* **Advisor comments: [Mr F] was not fully diagnosed, nor informed of his oral conditions. He was not informed about the root perforation and did not have this event registered with ACC.** From: Standards Framework for Oral Health Practitioners — DCNZ Patients have the right to: • have services provided with reasonable care and skill; • have services provided that comply with legal, professional, ethical, and other relevant standards; • have services provided in a manner consistent with their needs; • have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer;

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	• co-operation among providers to ensure quality and continuity of services. ***(In the above bullet points, all but the final one have been breached in this case)*** Standard 1 You must ensure the health needs and safe care of your patients are your primary concerns Standard 8 You must practise within your professional knowledge, skills and competence, or refer to another health practitioner Standard 10 You must maintain accurate, time-bound and up-to-date patient records Standard 11 You must keep your professional knowledge and skills up-to-date through ongoing learning and professional interaction Standard 13 You must communicate honestly, factually and without exaggeration Standard 15 You must give patients the information they need or request, in a way they can understand, so they can make informed decisions Standard 16 You must ensure informed consent remains valid at all times Standard 19 You must take a holistic approach to care appropriate to the individual patient Standard 20 You must provide care that is clinically justified and based on the best available evidence

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	Standard 24 You must be familiar, and comply, with your legal and professional obligations From: Infection Prevention and Control Practice Standard — DCNZ 14 — You must ensure all critical items are packaged and labelled with batch control identification information before sterilisation. Label the outside of the pack of all critical items, before sterilisation, with the following batch control identification information: • Steriliser identification number or code, if there is more than one steriliser in use. • Date of sterilisation. • Cycle or load number. Batch control identification (tracking/tracing) links the reprocessed critical item/s to a particular sterilisation cycle with documented performance data demonstrating sterilisation parameters were met. **Document the batch control identification information in the record of the patient on whom the sterilised critical item/s is used.**
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	There was a severe departure from accepted practice. With regards the use of Formalin, this is more a moderate departure as it has not been banned and there are likely other practitioners who may still be using these products. With regards the failure to use rubber dam for the root canal treatment, this was a severe departure (although I suspect there are other dentists who also choose not to).
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	The treatment in [Mr F's] case would be viewed very poorly.

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Please outline any factors that may limit your assessment of the events.	Lack of clinical notes to understand what actually was discussed with the patient.
Recommendations for improvement that may help to prevent a similar occurrence in future.	Clinical records course Informed consent course Endodontic (root canal) course. Cross infection and sterilization course for ALL staff. Mentorship and practice audit.

Question 4: Whether [Dr C] provided an appropriate standard of care to [Mr G] (Case F …) prior to him seeking treatment from [Dr B] in December 2021.	
List any sources of information reviewed other than the documents provided by HDC:	Standards Framework for Oral Health Practitioners — DCNZ Code of Health and Disability Services Consumers' Rights Infection Prevention and Control Practice Standard — DCNZ Are Dental Pins Obsolete? By Stephen J Bonsor Restorative Dentistry Vol 40, Issue 4, May 2013 Pg 253–258
Advisor's opinion:	[Dr C] did not provide an acceptable standard of care to [Mr G]. The clinical records are deficient. The use of four pins in a lateral incisor under a bonded composite is ill advised (due to risk of perforating out the side of the tooth or into the nerve or causing fractures). Pins were designed for use with non-adhesive amalgam restorations, not bonded composites. Many practitioners today say pins are obsolete (e.g. Stephen Bonsor article in Restorative Dentistry 2013). [Dr C] states "In treating [Mr G] I tended to provide quick-fix solutions to presenting problems and I should have had a step-back and provided an overall treatment plan for [Mr G] rather than concentrating on the immediate presenting problem." This comment is correct. When seeing a patient with an emergency, obviously it is necessary to focus on the presenting complaint, however the patient should

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	always be advised to return for a full dental examination (unless one has been done in the last six months) and this recorded in their notes. Unfortunately, it is too easy to get caught up in just doing what the patient wants rather than advising them as an educated dental professional. [Mr G] had 18 dental appointments between August 2018 and August 2021 and while he obviously had a heavily filled and broken-down dentition, was never advised to return for a full examination and treatment plan. Also of note (as with the case above) is the lack of rubber dam isolation for the numerous root canals performed. There is no tracking on the patient's file, of sterilized critical instruments which became mandatory in 2016.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	From: Code of Health and Disability Services Consumers' Rights Right 4 *Right to services of an appropriate standard* Right 6 *Right to be fully informed* Right 7 *Right to make an informed choice and give informed consent* **Advisor comments: [Mr G] was not fully diagnosed, nor informed of his oral conditions. He was not advised to have a full dental examination with a view to creating a comprehensive plan which would hopefully lead to far less emergency dental appointments and stabilise his dentition going forwards.** From: Standards Framework for Oral Health Practitioners — DCNZ Patients have the right to: • have services provided with reasonable care and skill;

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	• have services provided that comply with legal, professional, ethical, and other relevant standards; • have services provided in a manner consistent with their needs; • have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer; • co-operation among providers to ensure quality and continuity of services. ***(In the above bullet points, all but the final one have been breached in this case)*** Standard 1 You must ensure the health needs and safe care of your patients are your primary concerns Standard 8 You must practise within your professional knowledge, skills and competence, or refer to another health practitioner Standard 10 You must maintain accurate, time-bound and up-to-date patient records Standard 15 You must give patients the information they need or request, in a way they can understand, so they can make informed decisions Standard 19 You must take a holistic approach to care appropriate to the individual patient Standard 20 You must provide care that is clinically justified and based on the best available evidence From: Infection Prevention and Control Practice Standard — DCNZ

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Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	There was a severe departure from standard of care in record keeping and providing holistic care (strongly advising the need for a full examination) and lack of rubber dam use for root canal treatment (no clamps visible on the radiographs). There was a moderate departure of care in placing four pins into an upper lateral incisor under a bonded composite (this is not conforming to evidence based dentistry).
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	Our peers would view the records, no rubber dam use for root canals and failure to advise the need for a full exam as very poor. The heavily pinned composite would be less frowned upon, but still considered less than ideal.
Please outline any factors that may limit your assessment of the events.	Lack of clinical notes documenting the actual conversations had about potential treatment.
Recommendations for improvement that may	Record Keeping course Cross infection and sterilization course for ALL staff

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help to prevent a similar occurrence in future.	Continuing education on composite restorations Audit of the practice — how many other patients are unknowingly being delivered "bottom of the cliff" dentistry. Endodontic (root canal) course. I do understand the pressures many practitioners are under, especially in solo, rural practices. They are very busy and many patients only want quick fixes that are as cheap as possible. Maybe some communication skills around educating patients and saying no to patients when they make ill-advised demands would be appropriate also.

Question 5: Whether [Dr C] provided an appropriate standard of care to [Mrs H] (Case G …) prior to her seeking treatment from [Dr B] in March 2022.	
List any sources of information reviewed other than the documents provided by HDC:	Standards Framework for Oral Health Practitioners — DCNZ Code of Health and Disability Services Consumers' Rights Infection Prevention and Control Practice Standard — DCNZ
Advisor's opinion:	I am unsure how [Dr C] can elaborate on clinical appointments which happened over 6 years prior with such limited notes to refer to. The clinical notes are extremely poor. The diagnosis of a "vertical crack in the root" seems to have been made without any sound scientific evidence. There is no record of vitality testing to see if the tooth nerve was alive or not. There is no report on the level of pain (intensity, duration, waking at night, painkiller use). There is no mention of periodontal pocket depths (the main indicator of a vertical root fracture is the presence of a deep narrow pocket). The radiograph apparently showed no pathology and I note that even eight years later, on the radiograph taken by [Dr B], there is no evidence of a deep narrow area of bone loss which would be indicative of a vertical root fracture. [Dr C]

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	says the tooth had a lot of occlusal wear which could be the cause of a root fracture in an unrestored tooth, but it could also be indicative of occlusal trauma (which might be relieved with a simple bite adjustment). There were no notes about using transillumination to attempt visualisation of the crack, or even that a crack was detected during the placement of the stainless-steel crown. If the diagnosis of a vertical root fracture was correct, the ONLY treatment is tooth extraction. There is no scientific rationale for the placement of an ill-fitting stainless-steel crown (which are normally reserved for use in children). Given the consequences of a root fracture diagnosis (tooth loss), if [Dr C] was unsure (though he doesn't say this, I question how any dentist could be sure given the lack of diagnostic criteria discussed above), he should have referred [Ms H] to an endodontic specialist. I do note that [Dr C] was trying to do "stop gap" dentistry to "help" the patient by providing treatments that aimed to delay an extraction and that [Ms H] was clearly pushing him for these treatments. [Ms H] has now been told she either needs an extraction or retreatment of the existing root canal filling. She has opted for extraction rather than potentially saving the tooth (since it seems there is likely no root fracture) and now some antibiotics have settled the tooth, has cancelled the extraction appointment. I note also, as in the above two cases, there is no rubber dam isolation used for the root canal. At an appointment on 16/8/17 Formalin was used in the lower right molar, which has been advised against since at least 2013 (when the American Association of Endodontists issued a position statement on the use of formaldehyde and paraformaldehyde containing materials in which they recommended that they should not be used due to their toxicity and carcinogenicity).

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	There is no tracking on the patient's file, of sterilized critical instruments which became mandatory in 2016.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	From: Code of Health and Disability Services Consumers' Rights Right 4 *Right to services of an appropriate standard* Right 6 *Right to be fully informed* Right 7 *Right to make an informed choice and give informed consent* **Advisor comments: [Ms H] was not fully/correctly (?) diagnosed, nor informed of her oral conditions. She was not given the option of a higher level of specialist care.** From: Standards Framework for Oral Health Practitioners — DCNZ Patients have the right to: • have services provided with reasonable care and skill; • have services provided that comply with legal, professional, ethical, and other relevant standards; • have services provided in a manner consistent with their needs; • have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer; • co-operation among providers to ensure quality and continuity of services. ***(In the above bullet points, all but the final one have been breached in this case)***

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	Standard 1 You must ensure the health needs and safe care of your patients are your primary concerns Standard 8 You must practise within your professional knowledge, skills and competence, or refer to another health practitioner Standard 10 You must maintain accurate, time-bound and up-to-date patient records Standard 11 You must keep your professional knowledge and skills up-to-date through ongoing learning and professional interaction Standard 13 You must communicate honestly, factually and without exaggeration Standard 15 You must give patients the information they need or request, in a way they can understand, so they can make informed decisions Standard 16 You must ensure informed consent remains valid at all times Standard 19 You must take a holistic approach to care appropriate to the individual patient Standard 20 You must provide care that is clinically justified and based on the best available evidence From: Infection Prevention and Control Practice Standard — DCNZ

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Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	There was a severe departure from accepted practice in quality of clinical records, in diagnostic processes in the treatment provided and in the failure to use rubber dam. With regards the use of Formalin, this is more a moderate departure as it has not been banned and there are likely other practitioners who may still be using these products.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	The care provided would be viewed poorly by our peers. However, many dentists would recognise and sympathise with the situation where a patient pressures them into providing less than optimal treatment to save money and/or save an otherwise hopeless tooth. This is a slippery slope and once on it, very hard to change tack with the patient after years of giving in to them.
Please outline any factors that may limit your assessment of the events.	Insufficient clinical records
Recommendations for improvement that may	Clinical Records course

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help to prevent a similar occurrence in future.	Continuing education on toothache diagnoses Communication course Endodontic (root canal) course. Cross infection and sterilization course for ALL staff

Question 6: Whether [Dr C] provided an appropriate standard of care to [Mr J] (Case 1 …) prior to him seeking treatment from [Dr A] in November 2021.	
List any sources of information reviewed other than the documents provided by HDC:	Standards Framework for Oral Health Practitioners — DCNZ Code of Health and Disability Services Consumers' Rights Infection Prevention and Control Practice Standard — DCNZ
Advisor's opinion:	Going by the clinical records which are substandard the care provided by [Dr C] to [Mr J] was not of an acceptable standard. [Mr J] was an irregular attender but came more frequently in recent years. In the years 2019, 2020 and 2021 [Mr J] attended for a full mouth exam each year. According to [Dr C's] records, no periodontal condition was diagnosed and the patient was unaware of the gum disease in his mouth. [Mr J] should have been educated on the conditions in his mouth and a referral strongly recommended. Full mouth periodontal charting (pocket depths, recession and bleeding) should have been undertaken on a regular basis as well as comprehensive X-rays. I also note again no rubber dam isolation was used for this patient's root canal. There is no tracking on the patient's file, of sterilized critical instruments which became mandatory in 2016.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	From: Code of Health and Disability Services Consumers' Rights Right 4 *Right to services of an appropriate standard*

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	Right 6 *Right to be fully informed* Right 7 *Right to make an informed choice and give informed consent* **Advisor comments: [Mr J] was not fully diagnosed, nor informed of his oral conditions. He was not given the option of a higher level of specialist care.** From: Standards Framework for Oral Health Practitioners — DCNZ Patients have the right to: • have services provided with reasonable care and skill; • have services provided that comply with legal, professional, ethical, and other relevant standards; • have services provided in a manner consistent with their needs; • have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer; • co-operation among providers to ensure quality and continuity of services. ***(In the above bullet points, all but the final one have been breached in this case)*** Standard 8 You must practise within your professional knowledge, skills and competence, or refer to another health practitioner Standard 10 You must maintain accurate, time-bound and up-to-date patient records

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	Standard 15 You must give patients the information they need or request, in a way they can understand, so they can make informed decisions Standard 19 You must take a holistic approach to care appropriate to the individual patient Standard 20 You must provide care that is clinically justified and based on the best available evidence From: Infection Prevention and Control Practice Standard — DCNZ 14 — You must ensure all critical items are packaged and labelled with batch control identification information before sterilisation. Label the outside of the pack of all critical items, before sterilisation, with the following batch control identification information: • Steriliser identification number or code, if there is more than one steriliser in use. • Date of sterilisation. • Cycle or load number. Batch control identification (tracking/tracing) links the reprocessed critical item/s to a particular sterilisation cycle with documented performance data demonstrating sterilisation parameters were met. **Document the batch control identification information in the record of the patient on whom the sterilised critical item/s is used.**
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	There was a severe departure from the accepted standard of care.

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How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	This would be viewed very poorly by our peers. Undiagnosed/untreated periodontal disease has been a high level of concern for many many years now.
Please outline any factors that may limit your assessment of the events.	Lack of adequate clinical records
Recommendations for improvement that may help to prevent a similar occurrence in future.	Clinical record keeping course Informed consent course Communication course Endodontic (root canal) course. Cross infection and sterilization course for ALL staff Periodontal disease continuing education Full practice audit as there is likely to be other patients in the same situation (some I have seen included in this report) Peer mentoring/supervision

Question 7: Whether [Dr C] provided an appropriate standard of care to [Ms I] (Case 2 …) prior to her seeking treatment from [Dr A] in March 2022.	
List any sources of information reviewed other than the documents provided by HDC:	Standards Framework for Oral Health Practitioners — DCNZ Code of Health and Disability Services Consumers' Rights Infection Prevention and Control Practice Standard — DCNZ
Advisor's opinion:	[Mrs I's] last full mouth exam by [Dr C] was 11 months prior to the patient seeing [Dr A]. At this point, both teeth 21 and 35 are mobile and have very large cavities in them from internal resorption and caries respectively. It seems unlikely the cavities and mobility would not have been present to some degree just 11 months earlier. It is possible to miss internal resorption until it is quite advanced, but if a tooth becomes mobile, more investigations should be done to ascertain why. With

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	regards tooth 35, it is likely [Mrs I] has confused the replacing of the restoration "a myriad of times" with the numerous appointments needed for the root canal filling which was done twice (second time at no charge). [Dr C] has a reason to maintain the 35, stating [Mrs I] has TMJ issues due to loss of back teeth and he didn't want her to lose more since she wasn't going to have a partial denture. Unfortunately, none of this is recorded in the clinical notes. Maintaining that tooth was compromising the health of the surrounding bone and gum and it should have been removed so long as the patient consented. Whether or not the patient opts for a partial denture to provide support for the bite is then up to her AFTER having a full and frank informed consent discussion. I also note again no rubber dam isolation was used for this patient's root canals. There is no tracking on the patient's file, of sterilized critical instruments which became mandatory in 2016.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	From: Code of Health and Disability Services Consumers' Rights Right 4 *Right to services of an appropriate standard* Right 6 *Right to be fully informed* Right 7 *Right to make an informed choice and give informed consent* **Advisor comments: It doesn't seem like [Mrs I] was given full information about her case. In the absence of good clinical records it is hard to say what was discussed. This can be a particular issue in some older patients who may have hearing or memory issues.** From: Standards Framework for Oral Health Practitioners — DCNZ

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Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	There was a severe departure from accepted practice regarding the clinical notes and a mild–moderate departure in choosing to maintain tooth 35 and failing to diagnose the 21 internal resorption.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	Our peers would view the clinical records and lack of rubber dam use poorly and the treatment/lack of diagnosis as unfortunate.
Please outline any factors that may limit your assessment of the events.	Lack of good clinical records
Recommendations for improvement that may help to prevent a similar occurrence in future.	Clinical records course Informed consent course Endodontic course Cross infection and sterilization course for ALL staff

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Question 8: The standard of [Dr C's] documentation.	
List any sources of information reviewed other than the documents provided by HDC:	Standards Framework for Oral Health Practitioners — DCNZ Infection Prevention and Control Practice Standard — DCNZ
Advisor's opinion:	The documentation for these cases are all consistently poor. There is: 1. rarely a chief presenting complaint recorded 2. no recorded medical history or updates of this 3. no diagnoses 4. no sterilization batch tracking of critical items 5. no options presented or discussions noted 6. no informed consent recorded 7. no periodontal pocket charting 8. no comment on the health of the intra and extra oral tissues 9. no base charting recorded 10. no dosages/durations of medication prescribed 11. no local anaesthetic recorded 12. no types of materials, techniques or isolation methods recorded 13. insufficient radiographs taken for full examinations and proper diagnoses 14. no post op instructions that may have been given to the patient listed
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	From: Standards Framework for Oral Health Practitioners — DCNZ Number 9 You must identify and manage health and safety risks within your practice environment

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	Number 10 You must maintain accurate, time-bound and up-to-date patient records Number 24 You must be familiar, and comply, with your legal and professional obligations From: Infection Prevention and Control Practice Standard — DCNZ 14 — You must ensure all critical items are packaged and labelled with batch control identification information before sterilisation. Label the outside of the pack of all critical items, before sterilisation, with the following batch control identification information: • Steriliser identification number or code, if there is more than one steriliser in use. • Date of sterilisation. • Cycle or load number. Batch control identification (tracking/tracing) links the reprocessed critical item/s to a particular sterilisation cycle with documented performance data demonstrating sterilisation parameters were met. **Document the batch control identification information in the record of the patient on whom the sterilised critical item/s is used.**
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	There was a severe departure from accepted practice.
How would the care provided be viewed by your peers? Please reference the	The documentation would be viewed very poorly by our peers.

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views of any peers who were consulted.	
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	Record keeping course Cross infection and sterilization course for ALL staff Practice audit

Question 9: Any other matters in this case that you consider warrant comment.	
List any sources of information reviewed other than the documents provided by HDC:	
Advisor's opinion:	I am concerned when I read [Dr C's] comments around his record keeping. For him to say "I do recognise that some records may not be up to standard" is an understatement in the extreme. None of the records I have seen are anywhere near the accepted standard. The changes he says he has made are a good start but will still fall short. He also needs to: • Update and record medical history changes at every appointment • Include a record of patient consent at every treatment • Record the sterilization batch tracking • Provide a thorough list of materials used including local anaesthetic and the type of injection • State diagnoses made • Note a justification for not taking regular X-rays (if there are any e.g. patient declined and the conversation around that) • List findings at the examination including items checked even if nothing abnormal is found and include a basic gum chart for every exam (with a

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	more comprehensive charting if treating patients with pockets beyond 3mm • Note what the recommended recall period is and what treatment the patient needs to return for

Signature: *Angela McKeefry*
Name: Dr Angela McKeefry (BDS) Date of Advice: 29 May 2024’

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