Dental Surgery

Dentist, Dr C

A Report by the

Deputy Health and Disability Commissioner

(Case 14HDC01267)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. On 14 August 2014, Mr A (aged 87 years at the time of these events) attended a dental appointment with Dr C at a dental surgery, which is owned and operated by a limited company (the Company). Dr C performed a surface amalgam restoration (silver filling) for Mr A's left lower second molar (tooth 37) under local anaesthetic. The procedure took 45 minutes and was "challenging" owing to difficulty with accessing the area and moisture control. Dr C used approximately seven cotton rolls for moisture control during the procedure relating to tooth 37, but he did not keep a record of this.

2. On 15 August 2014, Mr A began to experience discomfort and pain, and had a swollen and sore tongue, which continued to worsen over the following days. He was unable to sleep, and food and fluid intake was difficult. On 17 August 2014, Mr A started taking antibiotics for his sore throat.

3. On 18 August 2014, Mr A's daughter, Ms B, telephoned Dr C. Dr C recorded that Mr A intended to visit a doctor, and advised Mr A to contact him if his symptoms persisted.

4. That afternoon, Ms B took her father to see a general practitioner (GP), who examined Mr A's mouth and neck and concluded that Mr A had an infection. The GP prescribed further antibiotics and recommended that Mr A return to his dentist if there was no improvement over the next two days.

5. On 21 August 2014, Mr A returned to see Dr C. Dr C undertook an examination of Mr A. There was "discomfort/pain on palpation", and Mr A was unable to lift his tongue. Dr C took radiographs of Mr A's lower left mouth for further examination of tooth 37. Dr C considered that Mr A might have had an infection, and prescribed him further antibiotics.

6. On 22 August 2014, Mr A returned to see a doctor. The doctor who saw Mr A on this occasion noted that he had been seen by a GP for the same symptoms four days previously, and was taking antibiotics prescribed by his dentist the previous day, but was still in pain. The doctor considered that as Mr A had started the antibiotics only the previous day, they should wait for their effect.

7. On 26 August 2014, Mr A sought a second opinion from dentist Dr D. Dr D examined Mr A and located and removed a dental cotton roll that was tucked underneath Mr A's back left bottom molar alongside his tongue.

8. Mr A had a large, deep ulcer where the cotton roll had been sitting. Having had the cotton roll removed, Mr A immediately felt better and, two days later, was feeling well.

Findings

9. In failing to account for the number of cotton rolls used during Mr A's procedure on tooth 37, Dr C's care fell below an accepted standard. Dr C's management of Mr A's

condition and concerns following treatment, including the later failure to detect the retained cotton roll, was suboptimal.

10. Dr C failed to provide services to Mr A with reasonable care and skill, and breached Right 4(1)[1] of the Code of Health and Disability Services Consumers' Rights (the Code).

11. Dr C's breach of the Code was due to individual clinical failings. Accordingly, the Company was not directly or vicariously liable for Dr C's breach of the Code.

Complaint and investigation

12. The Commissioner received a complaint from Ms B about the services provided to her father, Mr A, by a dental surgery in August 2014. The following issues were identified for investigation:

- *Whether Dr C provided an appropriate standard of care to Mr A between 14 August 2014 and 26 August 2014.*
- *Whether the dental surgery provided an appropriate standard of care to Mr A between 14 August 2014 and 26 August 2014.*

13. An investigation was commenced on 31 March 2015.

14. This report is the opinion of Deputy Commissioner Ms Rose Wall, and is made in accordance with the power delegated to her by the Commissioner.

15. The parties directly involved in the investigation were:

Mr A	Consumer
Ms B	Complainant/consumer's daughter
Dr C	Dentist/provider
Dental surgery	Provider

Also mentioned in this report:

Dr E	GP
Dr F	Doctor

16. Information from dentist Dr D and Mr A's medical centre was also reviewed.

17. Independent expert advice was obtained from dentist Dr Mary Towers (**Appendix A**).

[1] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

Information gathered during investigation

18. Mr A, aged 87 years at the time of these events, is a resident of a retirement village. Mr A lives in an independent unit and, at the time of these events, had been a resident at the retirement village for four years. This report relates to dental care provided to Mr A by dentist Dr C at the dental surgery, which is owned and operated by a limited company (the Company).[2] Dr C is registered with the Dental Council of New Zealand in a general dental scope of practice.

First visit with Dr C — dental procedures

19. On 14 August 2014, Mr A attended a dental appointment at the dental surgery. Dr C performed a surface composite restoration[3] on Mr A's right upper first molar (tooth 16). Dr C advised that this procedure was straightforward, and no anaesthetic was used.

20. Dr C then performed a surface amalgam restoration[4] on Mr A's left lower second molar (tooth 37) under local anaesthetic.[5] Dr C told HDC that this procedure took 45 minutes, and was "challenging" owing to difficulty with accessing the area and with moisture control. Dr C recalls using approximately seven cotton rolls[6] for moisture control during the procedure relating to tooth 37, but he did not keep a record of this. Dr C stated:

> "[T]o achieve adequate moisture control, two of [the cotton rolls] alone were, at the time, placed into the lingual sulcus (into the floor of the mouth, between the teeth and the tongue) and were once replaced bringing the number of cotton rolls used on the lingual side to four. Additionally, three other rolls were used into the buccal sulcus (between the teeth and the cheek) …"

21. Dr C told HDC that, at the time of these events, the dental surgery did not have any policies or practices in place with regard to keeping account of foreign bodies used during dental procedures.

Deterioration post-procedure

22. The next day, Mr A began to experience discomfort and pain, and had a swollen and sore tongue, which continued to worsen over the following days. He was unable to sleep, and food and fluid intake was difficult. Over the next 11 days, as outlined below, the retirement village nurses visited Mr A approximately once a day to monitor him and to offer soft food, fluids and pain relief. Mr A's daughters each took turns staying with their father separately for a few days at a time following his dental procedures.

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[2] Dr C is an employee and sole director and shareholder of the Company.
[3] A white or tooth coloured filling, normally used where there is a small cavity and a large amount of the tooth remaining to support the filling.
[4] A silver coloured filling (a mixture of mercury, silver, tin and copper). Amalgam fillings can be used in larger cavities, where less of the tooth is remaining to support the filling.
[5] Mr A was given 2.2ml Scandonest local anaesthetic.
[6] Absorbent non-sterile rolls of tightly packed cotton used to absorb oral secretions and to facilitate access to the operating field in dental interventions.

23. On 16 August 2014, it is recorded in Mr A's care notes[7] at the retirement village that an enrolled nurse (EN) assessed Mr A, and that he was "complaining of [a] sore throat". The EN noted that she advised Mr A to take paracetamol,[8] and that a "moulied meal"[9] was provided for him. Mr A told the EN that he had antibiotics available to take if necessary.[10]

24. On 17 August 2014, the EN reviewed Mr A again. She noted that he had started taking antibiotics for his sore throat. It is recorded in the care notes: "[Mr A] has low appetite, suggested soft food only."

Telephone consultation with Dr C

25. On 18 August 2014, Ms B telephoned Dr C with concerns about her father's pain and discomfort. Dr C spoke to Mr A and recorded that he had a "swollen tongue on right hand side, difficult to swallow". Dr C recorded that Mr A intended to visit a doctor, noting: "[A]dvised to do so." Dr C told HDC that he advised Mr A to contact him if his symptoms persisted.

26. Ms B told HDC that at this time her father was experiencing "widespread" oral pain, including his throat and tongue.[11]

First consultation with doctor — the medical centre

27. On the afternoon of 18 August 2014, Ms B took her father to the medical centre to see a doctor. Mr A saw general practitioner (GP) Dr E.[12] Dr E recorded that Mr A complained of having had pain in his left throat and neck over the previous three days. Dr E noted that Mr A had had "recent dental work" and was currently taking prednisone[13] and doxycycline.[14] Dr E examined Mr A's mouth and neck and recorded that Mr A was afebrile with tender and swollen lymph nodes in the left side of his neck and a tender lower left molar.

28. Dr E concluded that Mr A had an infection, and prescribed further prednisone, 40mg daily for three days, and doxycycline 100mg twice daily. Dr E also prescribed codeine phosphate[15] 30mg four times daily for pain relief. He recommended that Mr A return to his dentist if there was no improvement over the next two days.

Follow-up care at the retirement village

29. On 19 August 2014, a retirement village health care assistant (HCA) recorded in Mr A's care notes:

[7] The retirement village does not keep clinical notes relating to residents living independently, such as Mr A. Information regarding residents living independently is kept in a care diary.
[8] A painkiller for the relief of mild to moderate pain.
[9] Food is puréed so that it is easier to eat and less likely to cause choking.
[10] Mr A had antibiotics, prednisone and doxycycline, for a chronic chest infection.
[11] Where stated, responses provided by Ms B were provided on behalf of Mr A.
[12] Dr E is vocationally registered in general practice.
[13] A synthetic corticosteroid drug often used to treat inflammatory conditions.
[14] An antibiotic.
[15] A painkiller for the relief of moderate pain.

> "[Mr A] unwell since Saturday … Today also has sore ear and enlarged neck gland on left hand side. Afebrile, miserable, no appetite, wonders if teeth are implicated. Feeling worse despite taking meds as directed. Prompted to re check with [medical centre]."

30. On 20 August 2014, Mr A was reviewed at the retirement village by the HCA and a registered nurse (RN). The RN documented Mr A's observations within the normal range as: "[T]emp 37[16] (but had had panadol one hour previously). Blood pressure 160/82,[17] pulse 84,[18] Oxygen saturation 95%[19] …" The RN contacted the medical centre that day. With regard to the RN's telephone call to the medical centre, it is recorded in the clinical notes at the medical centre that Mr A had an appointment with his dentist the following day, and that Mr A was advised to obtain throat lozenges with pain relief in them. It is further noted that Mr A was unable to eat, as he was unable to swallow, and he was unable to sleep.

Second visit with Dr C

31. On 21 August 2014, Mr A returned for a consultation with Dr C. Dr C recorded that Mr A had "seen a GP" and was taking doxycycline and prednisone. Mr A told Dr C that he still had a sore throat and swollen tongue, and asked him to check tooth 37. Dr C recorded that, on inspection, Mr A presented with moderate trismus,[20] mild halitosis,[21] and moderate bleeding on probing teeth 36 and 37.

32. Dr C told HDC that his examination of Mr A was undertaken with care, as there was "discomfort/pain on palpation". Dr C stated that Mr A was unable to lift his tongue, and was "reluctant to let [him] examine the adjacent soft tissues …". Dr C took radiographs of Mr A's lower left mouth for further examination of tooth 37. Dr C told HDC that "no abnormalities were detected". He considered that Mr A might have had an infection. Dr C prescribed amoxicillin[22] and metronidazole,[23] and recorded that a specialist might need to be consulted for advice if the situation did not improve. Dr C told HDC that he advised Mr A to return in two days' time if there were no signs of improvement. However, this is not documented.

33. Mr A "emphatically" disputes that he was reluctant to allow Dr C to examine him. Mr A also told HDC that "there was no talk of … consulting a specialist" and there was no discussion regarding returning in two days' time for follow-up. However, Mr A acknowledged that Dr C treated him with care because he was "in considerable pain [and] discomfort".

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[16] A normal body temperature is between 36.4°C and 37.6°C (approximately 0.6°C either side of 37°C).
[17] Normal blood pressure in adults is considered to be between 120/80mmHg and 90/60mmHg.
[18] A normal resting heart rate for adults is between 60 and 100 beats per minute.
[19] Normal oxygen saturation for adults is between 95% and 100%.
[20] Often called "lockjaw", trismus refers to reduced opening of the jaws caused by spasm of the muscles.
[21] Bad odour from the mouth.
[22] An antibiotic.
[23] An antibiotic.

34. In response to the provisional opinion, Dr C clarified that when he said that Mr A was "reluctant" to be examined, he meant "in the sense that the procedure was causing [Mr A] pain and discomfort and that the process of palpation and inspection was painful causing him to jerk away". Dr C stated:

> "I therefore saw it fit to prescribe antibiotics, which would have helped with the infection, swelling and pain, and ultimately making possible the detection of the rogue cotton roll in an unusually deep lingual sulcus."

35. Dr C also stated in response to the provisional opinion that "[a]t that stage, to administer local anaesthetic to the inspection site in order to achieve numbness to the site to be examined was simply not an option … ". Dr C did not elaborate on that.

Follow-up care at the retirement village

36. That afternoon at the retirement village, an EN visited Mr A and noted that he had been to the dentist that day. She recorded: "[A]ppetite poor due to facial and tooth pain which continues, spoke about sleep disturbance will contact Medical Centre if continues. Afebrile."

37. On 22 August 2014, the RN contacted the medical centre and reported that Mr A was still in pain, not sleeping, and unable to eat soft foods. An urgent appointment was made for Mr A that day.

Second consultation with doctor — the medical centre

38. At the medical centre Mr A was seen by Dr F.[24] Dr F told HDC that he read Mr A's clinical notes and noted that he had been seen at the medical centre for the same symptoms four days previously. Dr F recorded that on examination he could not find anything abnormal to explain Mr A's pain. Dr F noted that Mr A was taking amoxicillin and metronidazole prescribed by his dentist the previous day, but that he was still in pain. Dr F told HDC that he felt that Mr A was on the appropriate combination of antibiotics for an oral infection. Dr F stated: "[As] he had only started them the day before, I thought we should wait for their effect, but we could do without the pain." Dr F prescribed Acupan[25] for pain, as Mr A reported feeling "woozy" on codeine.

Follow-up care at the retirement village

39. On 23 August 2014, Mr A was assessed at the retirement village by an EN. She noted that Mr A was not feeling well, was still in pain, and had a low appetite.

40. On the morning of 24 August 2014, the EN visited Mr A and noted: "[Mr A] has better colour, still has pain — maybe a bit less, taking medications …"

41. On 25 August 2014, Dr C contacted Mr A to enquire about his condition. Mr A told him that on 22 August 2014 he had visited a doctor, who had given him additional medication, but that his condition had not improved. In response to the provisional opinion, Dr C told HDC that he offered Mr A an appointment to review his condition.

[24] Dr F is registered in general practice. He is not vocationally registered.
[25] Pain relief.

However, according to Dr C, Mr A responded that he was leaving to stay with one of his daughters and would "see how he felt in the next few days with the medication provided by his GP". In this respect, Dr C recorded in the clinical notes:

> "[N]o better & went back to GP on 22nd & he changed medication but that didn't help. Daughters have decided to take him home with them and look after him."

42. Ms B and her sister decided to seek a second dental opinion, and booked an appointment with dentist Dr D. Ms B took her father home to stay with her in order to attend his appointment with Dr D.

43. On 26 August 2014, Ms B took her father to Dr D. Dr D assessed Mr A and recorded:

> "[H]asn't been able to eat much, sore to drink water, does get pain relief from Panadol … pain Q3,[26] to swallow, getting better over the last 2 days, [antibiotics] stopped [3 days] ago as 'gave him the runs' not eating."

44. Dr D examined Mr A and located and removed a dental cotton roll that was tucked underneath Mr A's back left bottom molar alongside his tongue. Dr D recorded: "Cotton roll L [sublingual],[27] ulcer++ saliva gland/duct normal." Ms B told HDC that, according to Dr D, her father had a large, deep ulcer where the cotton roll had been sitting.

45. Ms B said that having had the cotton roll removed, her father immediately started to feel better. On 28 August 2014, Dr D recorded: "[C]alled [patient's] daughter, [Mr A] is feeling great, nil probs."

Further information

46. During the course of this investigation, Dr C told HDC:

> "I want to genuinely acknowledge that [Mr A] has gone through an unfortunate ordeal as a result of a cotton roll being mistakenly left behind after a routine dental procedure and to … offer an apology.
>
> …
>
> It is an unusual and genuine error. Nonetheless, at all times I have acted in the best interest of my patient and all necessary support was offered to speed up my patient's recovery …"

47. Dr C further stated:

> "The initial failure on my part to remove the final cotton roll at the conclusion of [Mr A's] procedure on 14 August can be put down to human error as a result of a lengthy procedure, a fatigued elderly patient and an unusually deep lingual sulcus. Fundamentally, the error occurred in not ensuring the cotton rolls were counted at

[26] "Quadrant three". The mouth is divided into four quadrants: quadrant one is upper right, quadrant two is upper left, quadrant three is lower left and quadrant four is lower right.

> the start and end of the procedure, particularly since the lingual sulcus was deeper and more inaccessible than usual …"

48. With regard to changes made by the dental surgery for keeping account of cotton rolls used during dental procedures, Dr C told HDC:

> "At the beginning of each restorative procedure the instrument tray includes three cotton rolls as standard. In this way, the use of cotton rolls can be carefully monitored and can be accounted for very strictly. In the case that additional cotton rolls are required the previously used rolls are carefully disposed of away from the instrument tray and replaced with three new, unused, cotton rolls. As such, at all times, the tray should include three cotton rolls at the end of a restorative procedure.
>
> All dental chair sides/assistants are briefed on the changes made, as stated above."

Responses to provisional report

49. The parties were given an opportunity to comment on the relevant sections of the provisional report. Both Dr C and Ms B advised HDC that prior to receiving the provisional opinion, Dr C provided a letter of apology to Mr A and enclosed a cheque refunding the cost of his treatment.[28]

50. Dr C advised HDC:

> "[O]ther than the error of misplacing the cotton roll, which was indeed a mistake, I believed that I acted in accordance with the best interests of my patient and provided the best possible care. With regard to the error, we are all susceptible to human error; the important matter is that we learn from it."

51. Further responses have been incorporated into the report where relevant.

Preliminary matters

52. For the avoidance of doubt, I note that during my investigation no concerns were raised regarding the standard of care provided to Mr A by the medical centre or the retirement village. For this reason, this report relates only to the care provided to Mr A by Dr C and the dental surgery.

[28] The apology letter was dated 12 August 2015 and was received by Mr A at the beginning of September 2015, prior to the date of the provisional opinion.

Opinion: Dr C — breach

53. On 14 August 2014, Dr C performed dental procedures for Mr A on teeth 16 and 37. Dr C told HDC that the procedure on tooth 37 was "challenging" owing to difficulty with accessing the area and with moisture control. He said that he recalls using approximately seven cotton rolls for moisture control, but he did not keep a record of this.

54. My expert advisor, dentist Dr Mary Towers, advised:

> "There needs to be more care involved in routine procedures, including accounting for materials placed in the oral cavity, as they are foreign bodies and, as this case shows, can cause serious discomfort and illness."

55. I consider that the care provided by Dr C during Mr A's procedure on tooth 37, in failing to account for the number of cotton rolls used, was below an accepted standard. As the treating practitioner, Dr C had an individual responsibility to ensure that any foreign bodies used during the procedure were removed. Dr C did not account for the number of cotton rolls used during Mr A's procedure and, therefore, could not check that all the rolls had been removed.

56. On 18 August 2014, Dr C spoke with Mr A on the telephone regarding concerns about his ongoing pain and discomfort since his dental procedures. Dr C recorded that Mr A had a "swollen tongue on right hand side, difficult to swallow", and that he intended to visit a doctor. Dr C noted: "[A]dvised to do so." He said that he also advised Mr A to contact him if his symptoms persisted.

57. With regard to the telephone consultation, Dr Towers advised that normal practice would be for the dentist to arrange to see a patient as soon as possible if there were any issues directly following a procedure. I acknowledge the actions taken by Dr C, including advising Mr A to consult with a doctor, and to contact him if his symptoms persisted. However, I accept my expert's advice that it would be normal practice in these circumstances to arrange to see the patient as soon as possible, and I am critical that Dr C did not do so.

58. On 21 August 2014, Mr A returned for a consultation with Dr C. According to Dr C, Mr A told him that he still had a sore throat and swollen tongue, and asked him to check tooth 37. Dr C told HDC that he undertook a careful examination of Mr A as there was "discomfort/pain on palpation". Dr C took radiographs of Mr A's lower left mouth for further examination of tooth 37. Dr C told HDC that "no abnormalities were detected". He considered that Mr A might have an infection, and prescribed further antibiotics. According to Dr C, he advised Mr A to return in two days' time if there were no signs of improvement, although this is not documented.

59. With regard to Dr C's examination of Mr A on 21 August 2014, Dr Towers stated:

> "[T]here was a periapical radiograph placed in the area the cotton roll was sited, and still the cotton roll was not noticed. It seems almost unbelievable to me that

> the area worked on in the previous visit was not fully explored and the offending cotton roll found at this stage …"

60. Dr C told HDC that his examination of Mr A was undertaken with care as there was "discomfort/pain on palpation", and Mr A was unable to lift his tongue during the examination. Mr A acknowledges that he was in pain when he visited Dr C on 21 August 2014. I accept that potentially this made examination of Mr A's mouth more difficult; however, taking into consideration the fact that Mr A was in pain, Dr Towers advised that "the duty of care was to fully observe all the oral tissues involved and actively seek out a cause for the problem". Furthermore, having regard to Mr A's age, Dr Towers said: "The duty of care is the same standard for all patients, but in treating those more frail in society, even more care and attention to detail should be observed." Dr Towers advised:

> "My professional opinion is that the standard of care was not adequate at the second visit … I think it was a significant departure from accepted treatment practice. I think it would be viewed as incompetent …"

61. I accept my expert's advice, and consider that the standard of care provided by Dr C to Mr A at his second visit on 21 August 2014 was suboptimal.

62. On 25 August 2014, Dr C contacted Mr A to enquire about his condition. In response to the provisional opinion, Dr C told HDC that during this conversation he offered Mr A an appointment to review his condition. However, Dr C said that Mr A responded that he was leaving to stay with one of his daughters and would "see how he felt in the next few days with the medication provided by his GP". However, this discussion is not documented.

63. It is recorded that Mr A explained that he had visited a doctor three days earlier, that his condition had not improved, and that Mr A's daughter was taking him home to look after him.

64. I note that Dr C appropriately contacted Mr A to enquire about his condition. However, I am concerned that Dr C did not establish that Mr A had stopped taking his antibiotics at that stage.

Conclusion

65. I am concerned by Dr C's failure to account for the number of cotton rolls that he used during Mr A's procedure on tooth 37. I also consider that Dr C's management of Mr A's condition and concerns following treatment, including the later failure to detect the retained cotton roll, was suboptimal.

66. Accordingly, for the reasons stated above, Dr C failed to provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code.

Opinion: The Company — no breach

67. Dr C was an employee of the Company, which owns and operates the dental surgery. In addition to any direct liability for a breach of the Code, under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act), an employing authority may be vicariously liable for any act or omission by an employee. Under section 72(5) of the Act, it is a defence for an employing authority if it can prove that it took such steps as were reasonably practicable to prevent acts or omissions leading to an employee's breach of the Code.

68. This Office has previously found providers not liable for the acts or omissions of staff, when those acts or omissions clearly relate to an individual clinical failure made by the staff member.[29]

69. Dr C advised that at the time of these events the dental surgery did not have in place any procedures with regard to keeping account of foreign bodies used during dental procedures at the dental surgery. Dr Towers advised that for "conservative work on awake adult patients", most dental practices would not have in place any policies regarding keeping account of foreign bodies used.

70. I accept my expert's advice, and am satisfied that Dr C's breaches of the Code were due to his individual clinical failings. Accordingly, I do not consider that the Company is directly or vicariously liable for Dr C's breaches of the Code.

71. Following this incident, the dental surgery made process changes regarding accounting for cotton rolls used during dental procedures.

Recommendation

72. I recommend that the dental surgery implement appropriate written guidelines for staff with regard to accounting for all foreign bodies (including but not limited to cotton rolls) used during all dental procedures, and provide this Office with a copy of these guidelines within **three months** of the date of this report.

73. I have not made a recommendation that Dr C provide an apology to Mr A for his breach of the Code. I have taken into account that prior to my provisional opinion, Dr C provided a letter of apology to Mr A.

[29] Opinion 12HDC01483 (12 July 2013) available at: www.hdc.org.nz.

Follow-up actions

74. • A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Dental Council of New Zealand, and the Council will be asked to give consideration as to whether Dr C should undergo a competency review in light of my report.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the district health board, and it will be advised of Dr C's name.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the New Zealand Dental Association and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent dental advice to the Commissioner

The following expert advice was obtained from dentist Dr Mary Towers:

"Thank you for your request for advice on the standard of care for [Mr A] at [the dental surgery], by [Dr C], in August, 2014. I have no personal or professional conflict of interest in this case as I do not know any of the involved parties, nor have I heard of the case prior to the HDC request.

I have read and agree to follow the Independent Advisors Guidelines. I graduated from the Otago School of Dentistry in Dunedin in 1978 with a Bachelor of Dental Surgery. I am registered with the New Zealand Dental Council and hold a current practicing Certificate.

I am a current member of the New Zealand Dental Association (NZDA), the NZ Society for Anaesthesiology and Sedation, the NZ Endodontic Society, NZ Periodontal Society and the Nelson Branch of the NZDA.

I have a current Certificate of Continuing Postgraduate Education. I have worked in both Hospital and Private General Dental Practice for over thirty years.

Currently, I own a private Dental Practice in which I work and am employed as a Senior Dental Surgeon at the Nelson Marlborough District Health Board. I have been requested to provide independent advice on the standard of care provided by [Dr C] for [Mr A] in August, 2014.

I have read copies of the following documents provided by the HDC:

— [Ms B's] complaint: (daughter of [Mr A]) (5 September, 2014)

— [Mr A's] relevant dental notes (7/2011 to 21/8/14: hand written and illegible cover page with notes of various phone correspondence)

— [The medical centre's] computer notes from GP (18 to 22 August 2014)

— Dental Practice computer notes from [Dr D's] treatment (26–28/8/2014)

— Paper copies of photographs of cotton roll after removal; and various areas of oral tissue; and cotton roll in situ — black and white; and copy of dental radiograph — not named but presumed to be OPG of patient.

— [Dr C's] response. (20 October, 2014)

According to the information I have been given, my understanding of this case is the following:

On ?/7/2014 [Mr A] attended [the dental surgery] and was seen by [Dr C] for his annual examination. He had a sensitive tooth in the upper left anterior region and had this filled at this appointment and some scaling and polishing done.

According to [Dr C's] report, the date for this was the first of August but the copies of the hand written notes have the 7/14 date. Also I cannot see any notes for the bitewing radiographs or the word examination. The notes have been missed on the copying and there is some shorthand I cannot decipher. The end of the visit states that the next visit, two surfaces will be filled — one upper right first molar (16c) and one lower left second molar (37c).

The second visit was the 14th August, 2014, in which the 16c and 37c surfaces were filled.

The notes are difficult to read but it appears the filling in the lower left tooth (37) was deep as a warning was given over possible root canal treatment and the ledermix lining was placed. 2.2mls of local anaesthetic had been used here.

The next entry in the Dental notes refers to the patient having a swollen tongue on the right hand side, difficulty in swallowing and pain when drinking water — this was recorded from a phone call, not a physical visit — the patient was going to his General Medical Practitioner. There was mention of 37 having a poor prognosis.

On the 21 of August, [Mr A] returned to [Dr C's] surgery — the reasons stated in the notes: 'swollen base of tongue. trismus — 25% loss of mouth opening'. At this appointment [Dr C] did vitality tests on the tooth 37, checked the gingival condition, noted there was halitosis (bad odour from mouth), took a dental PA radiograph (not sighted by me as not enclosed). The dentist prescribed antibiotics and advised the patient to return if there was no improvement.

On 26th August [Mr A] was seen by [Dr D] at [another dental surgery]. On examination [Dr D] discovered a dental cotton roll was in the patient's lingual sulcus (tongue side of lower mouth soft tissue). [Dr D] removed the cotton roll and the patient improved immediately.

Two days later the patient was well.

The facts and assumptions on which my opinion is based, come from my working knowledge and experience of general dentistry and accepted normal procedures in the area of diagnosis of dental and oral diseases; also from evidence based academic publications and advice from peer colleagues.

Advice requested:
From the information available, are there concerns about the care provided by [Dr C] which require further action?

Was the care reasonable in the circumstances, in particular, regarding [Dr C's] assessment and treatment when [Mr A] re-presented on 2l August 2014.

Advice

From the information available, there are concerns about the care provided by [Dr C].

It appears true that the cotton roll located and removed by [Dr D], had been left in place at the treatment appointment on 14 August, 2014. I believe this was a genuine mistake and not a deliberate act. [Dr C] had shown concern and offered support for [Mr A] when there had been phone calls and communication raised, however it is normal to see a patient back as soon as possible if there are any issues directly following a procedure.

[Mr A] saw his GP who was treating him for a problem which had originated at his dental appointment. Interestingly, the GP did not see the cotton roll left in [Mr A's] mouth; there are no notes in the GP's assessment to say if the GP looked in [Mr A's] mouth or throat.

When [Mr A] presented for a dental visit, solely about the ongoing problem, … [Dr C] states in the notes that the teeth in the lower left were tested for vitality and percussion sensitivity; there was a periapical radiograph placed in the area the cotton roll was sited, and still the cotton roll was not noticed.

It seems almost unbelievable to me that the area worked on in the previous visit, was not fully explored and the offending cotton roll found at this stage.

There is a very important aspect to this complaint. [Mr A] is an older patient with his own dentition. He is in some form of assisted living but also it appears he is quite independent.

Dentistry is an invasive procedure and local anaesthetic is used. At the treatment visit (14/8/14) [Dr C] states later that it was a difficult procedure and required a lot of cotton rolls to achieve adequate moisture control; the patient was numb when he left and would not have been able to tell if there was something foreign in his mouth. When the local anaesthetic wore off, he was aware of discomfort and as the time went on this became worse.

The duty of care is the same standard for all patients, but in treating those more frail in society, even more care and attention to detail should be observed.

[Mr A] was in pain when he returned on 21/08/14 and [Dr C] may have been hesitant about lifting his tongue or being overly invasive in his mouth without using local anaesthetic, BUT the duty of care was to fully observe all the oral tissues involved and actively seek out a cause for the problem.

When [Mr A] visited [Dr D] later, this was done immediately.

My professional opinion is that the standard of care was not adequate at the second visit. I think it was a significant departure from accepted treatment practice. I think it would be viewed as incompetent.

There needs to be more care involved in routine procedures, including accounting for materials placed in the oral cavity, as they are foreign bodies and as this case shows can cause serious discomfort and illness."

Further advice

On 30 June 2015, Dr Towers provided the following further advice:

> "Further to my report in November, 2014, I have now sighted three dental radiographs of [Mr A], taken 01/07/14 and one on 21/08/14.
>
> These are two standard dental radiographic views, right and left, taken to aid diagnosis of dental caries (decay) and bone levels relating to periodontal disease. They are a two dimensional representation of a moment in time of the said patient. They show heavily restored posterior teeth in [Mr A]. The third and last radiograph is a deeper view of the patient's lower left molars and includes a view of the roots of the posterior teeth. Soft tissues are not seen nor are cotton rolls — only hard tissues like bone, teeth and restorations are visible.
>
> The sighting of the radiographs does not change my opinion from my previous report. I had no reason to question the diagnosis and treatment of [Mr A]. Once again, I am surprised that in placing a radiograph physically into the same place the cotton roll had been left, and then removing the radiograph, the dentist did not notice the retained cotton roll. But he didn't. The patient complained of pain in this area. The dentist should have at least physically looked in this area.
>
> The General Practitioner also did not look but the next dentist did look and immediately found the problem and resolved the issue."

On 27 July 2015, Dr Towers provided the following further advice:

> "1) The statement from [Dr C]: 'There were no specific procedures or policies in place' with regard to the accounting for foreign bodies used in Dental procedures.
>
> I think this is normal in most practices for conservative work on awake adult patients. Most patients would be aware if a cotton roll had been left in place after the procedure, and it may even flush out when they rinse out. However, [Mr A] was numb and may not have been aware of any foreign body until his tongue came back to normal feeling. He still did not realise at that stage which is where the problem became worse as it was an irritation and created pain and swelling, which then further made it difficult to do an easy examination.
>
> 2) Advice regarding the changes made by [the dental surgery] in this respect, since these events.
>
> See 7 and 8 of letter to the Commissioner 17 April 2015:
>
> I think the policy of accounting for the cotton rolls by staff and dentist is an excellent response. Involving the staff in the accounting is important and always provides a safeguard against such incidents recurring. Perhaps it could be extended to include all small items such as burs, wedges, bands etc. The awareness raised by such an event is huge. Mistakes are often our best teachers and [Dr C] has thought through the problem and worked out a procedure to try to eliminate the problem from recurring. Also the awareness of a vulnerable patient and the effects of local anaesthetic cannot be understated.
>
> I hope this is helpful in the resolution of this case."