SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: South of Scotland

Case ref: 201609138, An Orthodontist in the Dumfries and Galloway NHS Board Area
Sector: Health
Subject: Dentists and Dental Practices / Clinical treatment / Diagnosis

Summary
Mr C complained about orthodontic treatment he received over a number of years to address crowding in both his upper and lower jaws. After he lost one of his upper front teeth due to an injury and infection, the decision was taken to move the remaining upper front tooth across the centre of his mouth to fill the gap, whilst also moving the other teeth to resolve the crowding issues.

Mr C was initially told that the treatment was expected to take between 18 and 24 months. However, after around two and a half years of treatment, his original orthodontist left the practice. The subsequent orthodontist was concerned about the appropriateness of the treatment plan and referred Mr C to an orthodontic consultant after identifying a deterioration of Mr C's bone structure and tooth roots. The decision was taken to cease treatment due to the risk of further damage. Mr C was left with the tooth in the centre of his mouth. A veneer was then required to make the tooth appear more normal.

We took independent advice from an orthodontics adviser on the treatment that Mr C received from the initial orthodontist. The adviser considered the treatment plan was unusual. As such, the adviser would have expected there to be evidence of discussions with restorative dentists, because restorative work would be required after orthodontic treatment was complete in order to make the moved teeth appear normal. However, this did not take place.

The adviser was also critical of the quality of the records, which were unreasonably abbreviated and lacked evidence that alternative treatment options were discussed with Mr C, potentially making the consent he gave for the treatment plan invalid. The notes also failed to confirm whether a previously identified infection had resolved before orthodontic treatment was commenced, meaning this could not be ruled out as a factor in the bone structure and tooth deterioration Mr C experienced.

For these reasons, we considered that the treatment fell below a reasonable standard and we upheld the complaint.

Further to the clinical failures, we also identified concerns with the orthodontist's complaints handling and communication, both with Mr C and the SPSO. Throughout the complaints process, the orthodontist missed 12 deadlines for response, sometimes by a number of weeks or months and often without contact to explain the delay. The orthodontist also failed to provide all of the information requested on a number of occasions.

Redress and Recommendations

The Ombudsman's recommendations are set out below:

What we are asking the Orthodontist to do for Mr C:

What we found	**What the Orthodontist should do**	**Evidence SPSO needs to check that this has happened and the deadline**
The orthodontic treatment provided to Mr C fell below a reasonable standard, as did the subsequent complaints handling	Apologise to Mr C for the failing identified in this report. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance	A copy or record of the apology. By: 25 July 2018

We are asking the Orthodontist to improve the way they do things:

What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
The orthodontic treatment provided to Mr C fell below a reasonable standard, as did the subsequent complaints handling	All treatment should be provided to a reasonable standard. Records should be detailed, complete, and clear; all treatment options and predicted outcomes should be fully discussed with a patient before commencing a treatment plan and details of this should be documented; valid consent should always be recorded; complaints should be responded to in a reasonable timescale	To ensure appropriate professional development, details of this complaint and the learning needs identified as a result should be included in the Orthodontist's Personal Development Plan which is submitted to the General Dental Council under their '*Enhanced CPD guidance'*. A copy of this should then be submitted to SPSO. By: 27 August 2018

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

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

Introduction

1. Mr C complained to my office about the treatment he received from an orthodontist (the Orthodontist). The complaint from Mr C which I have investigated is that the orthodontic treatment he received from the Orthodontist was unreasonable.

Investigation

2. The Orthodontist in this case was working at an orthodontic practice (the Practice). However, orthodontists are self-employed and hold individual contracts with the relevant health board. Under the Scottish Public Services Ombudsman Act 2002, they are treated as individual bodies under my jurisdiction.

3. In order to investigate Mr C's complaint, my complaints reviewer requested copies of Mr C's orthodontic records before seeking independent advice from an orthodontic adviser (the Adviser). In this case, we have decided to issue a public report on Mr C's complaint because of the significant injustice we consider he has suffered, and also because of the Orthodontist's poor complaints handling.

4. This report includes the information that is required for me to explain the reasons for my decision on this case. I have not included every detail of the information considered. My complaints reviewer has reviewed all of the information provided during the course of the investigation. Mr C and the Orthodontist were given an opportunity to comment on a draft of this report.

Background

5. Mr C attended the Practice on 27 January 2012 and was seen by the Orthodontist, who agreed a treatment plan for orthodontic care to address crowding in both his upper and lower jaw. This plan identified that Mr C's first incisor on the upper right of his mouth (Upper Right 1) was in poor condition and likely to be lost. This tooth was later removed by a dentist and the Orthodontist sought to move the corresponding incisor (Upper Left 1) across from the other side of Mr C's mouth to fill the gap that was left. He was fitted with braces for this purpose.

6. Mr C continued receiving orthodontic treatment and adjustment of his braces until the Orthodontist left the Practice in January 2015. Following this, Mr C was seen by another orthodontist at the Practice. That orthodontist had concerns about the original treatment plan and the progress being made. X-rays

taken then showed that Mr C's bone structure and the root of Upper Left 1 had deteriorated.

7. This led to a referral to Dumfries and Galloway Royal Infirmary for orthodontic consultant advice, where Mr C was seen in May 2015. The consultant Mr C saw modified Mr C's treatment plan and resubmitted this to the NHS Dental Practice Board for approval.

8. Mr C's treatment was then transferred to the Orthodontic Department at Glasgow Dental Hospital in August 2015, who sought to return Mr C's Upper Left 1 to its original position. In March 2016, orthodontic consultants recommended termination of the plan due to the risk of further tooth damage or loss, given the weakened condition of Mr C's bone structure and tooth.

9. Following this, Mr C submitted a complaint to the Practice in May 2016. Mr C explained that the Orthodontist's course of treatment had left his Upper Left 1 in the middle of his mouth and that this was irreversible due to his weakened bone structure. This meant veneers would be required to make it appear more normal. Mr C received a response from the Orthodontist in September 2016 and then was referred to the SPSO by the Practice on 12 October 2016.

10. Mr C submitted his complaint to my office on 13 March 2017 and asked me to investigate the treatment he received. He said that the orthodontic treatment he had received took, in total, just under five years to complete, and had resulted in severe deterioration of his tooth and bone structure, which he feared may result in further tooth loss. He explained that, following remedial treatment, he now had a veneer, but was concerned this was not a lifelong solution and would likely need to be replaced in future. Mr C questioned why the alternative option of a dental implant had not been explored before treatment was commenced.

The Orthodontist's response

11. Mr C wrote to the Practice to complain on 9 May 2016. He said that he had originally been fitted with braces around August 2012 and was told that the treatment plan would take around 18 to 24 months. Mr C said that, after the Orthodontist left the Practice, he was seen by a number of other orthodontists, as explained above. He claimed that none of those orthodontists would have suggested the treatment plan attempted and Mr C questioned the suitability of the approach as a result. Mr C said that he had been left with a tooth in the centre

of his upper jaw which could not be further moved, and which would require a veneer.

12. The Practice acknowledged receipt of the complaint on 11 May 2016. They initially said they would aim to respond within 20 working days. However, they wrote to him again on 7 June 2016 to explain that the Orthodontist was still considering the complaint. At that stage, they hoped to respond within a further 10 working days. The Practice wrote to Mr C again on 17 June 2016, 11 July 2016, and 28 July 2016 to advise of further delays in the Orthodontist's investigation.

13. The Orthodontist then wrote to Mr C directly on 27 August 2016 to apologise for the delays in response. They explained that they were in the process of thoroughly reviewing the relevant records and aimed to respond fully within the next two weeks. Mr C received an undated response to his complaint around the middle of September, more than four months after making his complaint.

14. In response to Mr C's complaint, the Orthodontist appeared to consider that the complaint raised was regarding delays, which they attributed to the decision made by subsequent orthodontists not to pursue the original treatment plan. The Orthodontist defended the original plan, expressing regret that the subsequent orthodontists had chosen to change the approach.

15. Mr C was dissatisfied with this response, so wrote once more to the Practice on 29 September 2016, requesting details of how to progress his complaint to my office. The Practice wrote to him on 12 October 2016, confirming the complaints process was complete and directing him to submit his complaint to my office if he remained dissatisfied. Mr C made his complaint to my office on 13 March 2017.

16. My complaints reviewer notified the Orthodontist of our investigation on 16 May 2017, requested copies of all relevant records, and asked for their comments on Mr C's complaint. A response was requested by 13 June 2017. The complaints reviewer received a telephone call from the Orthodontist on 8 June 2017. They explained that they had only just received our letter from the Practice and they asked for an extension until 27 June 2017, which we agreed. Despite repeated prompts by my complaints reviewer, the records were not received until 2 August 2017 and the Orthodontist failed to provide any covering letter or comments.

Advice

17. On reviewing the records provided by the Orthodontist, the Adviser noted that the clinical notes did not include any details of the initial orthodontic assessment or any discussion with Mr C regarding treatment plan options. There was also no history of the trauma of Mr C's Upper Right 1 or its management. The Adviser also commented that there appeared to be a number of items missing from the records, including study models, as well as some photographs and x-rays they would expect to be taken before starting treatment of this kind. They also said that, in general, the notes were abbreviated to an extent that made them difficult to interpret.

18. The Adviser explained that the decision to move Mr C's Upper Left 1 across to the space left by his Upper Right 1 was unusual and complicated. In particular, they highlighted that central incisors are effectively mirror images of one another. The treatment plan attempted would therefore necessitate some further work to change the form of the relocated tooth to mimic the tooth it replaced. They explained that this may involve removing some of the tooth or adding tooth coloured filling materials to the tooth, work which would normally be done by restorative dentists.

19. The Adviser stated that this sort of complex treatment planning, involving both orthodontic and restorative work, would be best undertaken by specialists. In their view, the absence of evidence of any discussion with either Mr C, or any specialist dental practitioners, about the anticipated outcomes of the treatment plan was unreasonable. They particularly highlighted that they felt the option to fill the gap in Mr C's teeth with a false tooth should have been discussed. They expressed concern that the apparent failure to discuss alternative options with Mr C would likely invalidate his consent for the treatment.

20. The Adviser went on to note that the records for a review appointment on 22 February 2012 make reference to a 'lateral abscess', 'resorption' and 'pus draining' in relation to Mr C's Upper Right 1. They explained that this indicated an active infection being present and made clear that treatment with braces should not be commenced where there is evidence of infection as this can lead to increased deterioration of bone in the infected area. Despite this, there was no entry in the records to confirm that the infection had been resolved before orthodontic treatment began on 20 July 2012. Mr C also informed us that he was not made aware of pus draining from an active infection in his gum. The Adviser made clear that, if treatment with braces was commenced with an infection

present, this would likely have been a significant factor in the loss of bone Mr C experienced.

Further enquiry to the Orthodontist

21. Given the concerns raised by the Adviser, and the Orthodontist's failure to provide us with comments on the complaint, my complaints reviewer wrote to the Orthodontist again on 28 September 2017. They explained the advice we had received and asked the Orthodontist to provide his comments on the failings identified by 12 October 2017. We did not received the Orthodontist's response until 13 November 2017.

22. The response from the Orthodontist provided some further explanation of the original treatment plan and some clarification on areas of the records which were not entirely clear to the adviser. The response also included the following:

The Orthodontist said that:

- whilst unusual, the treatment plan was not unreasonable;
- restorative treatment would have been required after orthodontic treatment was complete;
- the infection in question related to the tooth that was removed prior to commencing orthodontic treatment, by which time no infection was present;
- the treatment plan was fully discussed with the patient, as were alternative options, although the records did not reflect this; and
- the study models, photographs and x-rays missing from the records were taken to aid orthodontic assessment and treatment planning.

23. As the Orthodontist had made clear that we were not in possession of the full records, my complaints reviewer wrote to him again and asked that the records be provided, in full, no later than 12 January 2018. They explained that, due to the previous delays in receiving a response, if these were not received by the deadline, we would proceed to reach a decision on the complaint based on the information we currently held. To date, the Orthodontist has not provided any further records. They also failed to respond to a request for their comments on a draft of this report.

Decision

24. The advice we have received, and which we accept, has highlighted a number of concerns in the treatment Mr C received from the Orthodontist.

25. The Orthodontist has accepted that the decision to move Mr C's tooth across the dental midline was unusual and it is clear that this was going to require extensive orthodontic treatment over a prolonged period. Given this, I would have expected the Orthodontist to place a higher than usual priority on exploring alternatives. While the Orthodontist claims that alternatives were discussed, I have seen no evidence of this. Both Mr C and the Adviser have questioned whether a dental implant may have been a more appropriate solution. Mr C has made clear that this option was not presented to him, and there is no evidence that this was discussed.

26. Once the treatment plan was decided upon, the Orthodontist should have had discussions with restorative dentists to identify what further treatment would have been necessary after orthodontic treatment was complete. I have seen no evidence that this took place, or that the need for further treatment was discussed with Mr C.

27. While a consent form was signed on 22 February 2012, this is in no way specific. This means there is no evidence that Mr C was made aware of the potential risks or impact of the treatment plan he was agreeing to. This means it is likely the consent is invalid.

28. The Orthodontist failed to clearly record whether a previously documented infection had fully resolved before starting Mr C's orthodontic treatment. This means there is no way to definitively rule this out as a significant factor in the bone structure deterioration Mr C has experienced.

29. The general quality of the records is also poor. The notes are abbreviated to an unreasonable extent, which made them very difficult for the Adviser to interpret.

30. Based on the advice we have received, I have significant concerns about the orthodontic treatment Mr C received and I consider it fell below a reasonable standard. It resulted in a far from satisfactory outcome for Mr C. I have, therefore, upheld Mr C's complaint.

Complaints handling concerns

31. I also have concerns about the Orthodontist's complaints handling and communication, both with Mr C, and with my complaints reviewer. At each stage

of the complaints process, the Orthodontist failed to meet the deadline for response, sometimes by a number of months and often without contact to explain the delay. The Orthodontist consistently apologised for each delay and has, at times, provided an explanation.

32. Overall though, I consider they have demonstrated an unreasonable lack of commitment to providing responses within specified deadlines and to communicating delays effectively. While I appreciate there will always be times when it is not possible to meet deadlines, I do not consider the explanations that the Orthodontist offered justify the delay of over six months caused by missing 12 separate deadlines. This is particularly concerning given the relatively straightforward nature of most of the enquiries and the poor quality of some of the responses provided.

33. Normally, we would expect direct communication from a public body about whether or not they accept the recommendations made in a report. However, in this case, the Orthodontist did provide confirmation. As such, we made clear that, if confirmation was not provided by an extended deadline, we would consider this an acceptance of the recommendations proposed. As such, we will follow-up on these recommendations to ensure they are implemented. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Recommendations

Learning from complaints

The Ombudsman expects all organisations to learn from complaints and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

What we are asking the Orthodontist to do for Mr C:

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Terms used in the report **Annex 1**

Orthodontics	The branch of dentistry concerned with the correction and preventions of irregularities such as crooked, crowded, or protruding teeth.
Orthodontist	A dentist who specialises in orthodontics.
Incisor	One of the four front teeth in the top and bottom of the jaw.
Veneer	A casing applied to the front of a tooth to alter its appearance.
Implant	An artificial replacement for a tooth's root.

List of legislation and policies considered **Annex 2**

General Dental Council's '*Enhanced CPD guidance*'