Expert Witness Reports

Sample Case Reports
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Regulated by the General Dental Council and Registered with the Care Quality Commission
DENTAL REPORT

NAME: JJJJJJ MMMMMM
ADDRESS: X XXXXXXX XXXXX, XXXXX XXXX XXX
DATE OF BIRTH: XX/XX/XXXX
DATE OF ACCIDENT: YY/YY/YYYY
ON THE INSTRUCTIONS OF: XXXXXXXXXXXXX
SOLICITORS REFERENCE: XXX/XXX/XXXXXXXXXX/XX
REPORT DATED: XX/XX/XXXX
(1) INTRODUCTION

(1.1) THE WRITER

I am Gokhan Baytug. I am a Registered Dental Surgeon (GDC 67802). I have been providing dental services since 1992 following qualification at Liverpool University. I am a general dental surgeon treating both private and NHS sector patients. I have been providing reports specific to the area of personal injury, trauma and assessment since 2003. Full details of my qualifications entitling me to give expert opinion and evidence are set out at the end of this report by way of my curriculum vitae (Appendix A).

(1.2) SUMMARY OF CASE

The case concerns an incident in May 2012 in which the claimant allegedly suffered personal injury. I have been instructed by LLLLL LLLLLLLL, to report whether the claimant has suffered formal dental damage as a result of alleged dental negligence, and the effects and prognosis of this if appropriate. I have been provided with the claimant’s medical records, including historic incidents from RRRRR RRRRR RRRRRRRR. I have been provided with dental practice notes and records that relate to the incident. I have been provided with dental radiographs (x-rays). I have not been provided with a specific medical report to the incident or physiotherapy reports relating to the incident. I have been provided with dental records from RRRRR RRRRRRR in relation to the incident and in addition to the general dental records. I have not examined Mr MMMMMMMM for the purposes of this preliminary report. I have not been asked to provide further treatment recommendations or costs involved.

(1.3) TECHNICAL TERMS

I have indicated any technical terms in bold type. Explanations of such are included in the parentheses as appropriate.

(2) INVESTIGATION

(2.1) EXAMINATION

NOT APPLICABLE

(2.1.1) RECALL OF THE INCIDENT & SUBSEQUENT DEVELOPMENTS

Mr MMMMMMM has prepared a signed witness statement dated 16/09/2012. Generally, there are few variations between his recall of events as disclosed in these documents and those ascertained by reference to his dental and medical records. The only significance between his account and those from his dental notes is the recollection by Mr MMMMMM, that on 29th May 2010 he saw a different dentist rather than his usual dentist CCCCCCCCCC AAAAARGAR yet the notes clearly record the entry that day as being made by Mr AAAAAAA. However, his recollection of the medication prescribed that day corresponds precisely to that recorded by Mr AAAAAAAA that day (namely antibiotics and diclofenac).

(2.2) DISCLOSED MEDICAL & DENTAL HISTORY

Mr MMMMMMM is not disabled and is a retired plant operator. He suffers with chronic bronchitis. He suffers with osteo-arthritis in his knee and he does take medication. He was successfully
treated for the removal of a neoplastic lesion (Squamous Cell Carcinoma) in 2009 and the latest correspondence in August 2012 regarding this matter asserts that the area has been successfully treated.

(2.3) REVIEW OF DOCUMENTS

(2.3.1) MEDICAL & DENTAL RECORDS

DENTAL RECORDS

(A) PRIOR TO THE INCIDENT.

The dental records show that Mr MMMMMM has attended The SSSS DDDDDD CCCCCC in BBBB since 01/10/2010. It is assumed that this would have been his first visit as there are no dental records predating this and there is not supporting evidence that can demonstrate Mr MMMMMM's dental history prior to this date.

On the 01/10/2010, Mr MMMMMM was examined by Mr AAAAAAAA, who discovered he was suffering with moderate periodontal disease. BPE examination records a Code 3 in the lower right quadrant. Mr MMMMMM did not receive detailed periodontal charting, despite the significant BPE finding nor did Mr MMMMMM receive any radiography to determine the extent of any hard tissue damage. It is usual to provide soft tissue charting of the gum tissue and hard tissue radiography in determination of potential periodontal disease and ascertain the quantum of tooth attachment loss: This so-called 'Loss Of Attachment' should be quantified to adequately determine the severity and the prognosis of the periodontal disease diagnosis.

Mr MMMMMM was prescribed a deep scale and polish with the hygienist with recall at three months and he attended this on 29/11/2010. This treatment was concluded by A A

However, following this treatment in November 2010, Mr MMMMMM was sot seen again until May 2011, some six months following his initial treatment. In effect, the three-month review opportunity following the initial treatment was not completed on time but delayed a further three months. There is no adequate explanation why there was a delay in revaluation.

On 18/05/2011, Mr MMMMMM was seen by JJJJJJJJJJJ KKKKKK, who provided an examination and completed scaling and polishing. Appropriate recall was set at three months and on 15/08/2011, Mr MMMMMM attended for treatment provided from A A for scaling and polishing. He was referred back to JJJJJJJJJJJ KKKKKK in November 2011.

At this appointment dated 07/11/2011, Mr KKKKKK performed a BPE and discovered that in addition to the Code 3 finding in the lower right quadrant, the upper right quadrant also now showed a similar score and the lower left quadrant had deteriorated to a BPE Code 4. No further detailed charting or radiography is undertaken at this stage (as would be usual) although Mr MMMMMM received deep scaling of the teeth at this opportunity. The records also recommend a 6-month recall period. However, Mr MMMMMM’s next appointment is three months later on 13/02/2012 with A A who performed scaling and polishing, although the notes written at this appointment deploy a significant number of abbreviations, many of them non-standard.

On 22/05/2012, Mr MMMMMM attended his appointment with Christopher AAAAAAAA, who takes two radiographs and records the requirement for the exposure as ‘caries’. Two ‘Bitewing’ radiographs are taken of the left and right side teeth. For the purpose of diagnosis, the radiography of the left side is acceptable but missing salient data including only partial imaging of the target tissue, namely the Lower Left third molar (LL8). The radiography of the right side Lower Right first molar (LR6) also shows a potential area of radiographic translucency, which is probably secondary caries to the existing amalgam restoration: However, this finding is neglected from Mr
AAAAAAAAA’s radiographic report. Also neglected from Mr AAAAAAAAA’s report is any description of the Lower left second molar tooth (LL7), which very clearly has a deep and compromised amalgam filling. Furthermore, Mr AAAAAAAAA’s report does not include any suitable assessment of the Lower Left third molar condition prior to surgery (such as condition of the crown, orientation of the roots, degree of impaction or any apparent root sclerosis to the bone). Indeed, not only is this particular assessment neglected, but Mr AAAAAAAAA would not have been able to complete an assessment to this standard as the radiography available was inadequate in this aspect.

Despite these analytic requirements being absent from the radiography, Mr AAAAAAAAA’s assesses the quality of his investigations as Grade 1 of three possible grades:

| Faculty of General Dental Practitioners Selection of Radiographic Criteria |
|-----------------------------|----------------------------------|
| GRADE 1 Excellent           | No Errors                        |
| GRADE 2 Diagnostically Acceptable | Some errors but nothing which detracts from the diagnostic utility of the radiograph |
| GRADE 3 Unacceptable        | Errors which render the radiograph diagnostically unusable |

It is quite evident, for the diagnosis of caries, the apparent findings of the right radiograph were not reported and that the quality of the radiography for the diagnosis of caries in the left radiograph is Grade 2 an not Grade 1 because only a partial view of the crown is ascertained and not the full extent of the root. Therefore, in the requirement for a pre-surgical assessment for extraction, the radiography is Grade 3.

At this appointment, Mr AAAAAAAAA ‘discussed options’ with Mr MMMMMMM (although there is not detail what options were discussed), recommended extraction and provided Mr MMMMMMM a hygiene appointment with hygienist LLLLL LLLLLLL, who recommends full periodontal charting due to mobility of the Lower Right first molar (LR6), although there is no evidence that full periodontal was ever completed for Mr MMMMMMM.

On 25/05/2012 Mr MMMMMMM attended for his extraction with Mr AAAAAAAAA. There is no indication that Mr MMMMMMM signed a NHS consent form (‘FP17DC’) and no evidence that his medical history was checked at this particular appointment. There is no evidence that Mr MMMMMMM was warned of possible post-operative complications or that an alternative referral to Specialist services was offered to Mr MMMMMMM. There is no evidence that Mr AAAAAAAAA rechecked the radiography he had taken just 3 days before and there is no evidence that he either considered or offered further radiography, despite obvious deficiencies. The usual radiographic view for third molar assessment is an Ortho Pantomo Graphic exposure: There is no evidence Mr AAAAAAAAA considered this usual form of assessment prior to his surgery, and no evidence that he offered it as an option to Mr MMMMMMM (for him to accept or decline).

It is evident that at this appointment, the surgery of the LL8 was not successful and the notes record that ‘the roots remain in situ’. It is recorded that Mr MMMMMMM was informed of this and that Mr AAAAAAAAA would refer his patient to the RRRRR RRRRRRR RRRRRRRR (RRR). There is no evidence that Mr MMMMMMM was informed of the damage to his LL7 and no evidence that Mr MMMMMMM was discharged appropriately that day without checking that he had formed a sufficient clot (i.e. that bleeding had adequately been arrested). There is no evidence that Mr MMMMMMM was provided with any appropriate and specific written post-operative instructions or aftercare advice.

(B) Subsequent to the incident.

On 29/05/2012 Mr MMMMMMM’s dental records show that Mr AAAAAAAAA prescribed antibiotics and analgesics following the extraction. There is no evidence that Mr AAAAAAAAA examined his patient prior to his prescription.
On 31/05/2012, Mr MMMMMM was seen by Ali AJAJAJ as an emergency patient. Mr AJAJAJ took a appropriate history, performs an appropriate examination and takes an appropriate radiograph (of evident Grade 1 quality) to ascertain that Mr MMMMMM is suffering with a root fracture and that the tooth is of poor prognosis: This tooth being the LL7. Mr AJAJAJ appropriately records that the tooth is not restorable in his opinion as the prognosis is poor and thus it requires extraction. There is however no evidence that Mr AJAJAJ checked Mr MMMMMM’s medical history or completed a NHS FP17DC consent form prior to attempting the extraction and no evidence that Mr AJAJAJ considered referral to a Specialist for its removal prior to his attempt, especially given the difficulty encountered with the extraction of the LL8 and the discovery of root fracture to the LL7 earmarked for extraction.

From the records, it is clear that the extraction did not wholly proceed well and Mr AJAJAJ was only able to extract part of the tooth using forceps: Given the condition of the LL7 prior to his attempted extraction, the use of forces alone would have been inadequate for the removal of the tooth. The retained roots were ‘left behind’ and the patient informed to complete his course of antibiotics that had been prescribed 2 days previously. Mr AJAJAJ appropriately checked that Mr MMMMMM’s wound had arrested in terms of bleeding.

On 19/06/2012, Mr MMMMMM was seen again by Mr AJAJAJ as an emergency patient in relation to on-going swelling and pain form the lower left region following his surgery in May. Mr AJAJAJ investigates the area appropriately and finds that not only are the LL7 roots tender, but they are also extremely sensitive to cold spray. There is no evidence that Mr AJAJAJ checked Mr MMMMMM’s medical history. Mr AJAJAJ proceeds to administer a local anaesthetic and remove the nerves from the LL7, a process referred to as ‘extirpation’. A steroid/antibiotic paste is administered and a prescription issued of further antibiotics.

On 22/06/2012, Mr MMMMMM was seen again by Mr AJAJAJ in relation to continued pain from the dressed LL7. Mr AJAJAJ checks that Mr MMMMMM’s medical history has not changed and gives advice on appropriate analgesic consumption to palliate the symptoms in the understanding that Mr MMMMMM contacts the surgery of the pain worsens,

On 25/07/2012, Mr MMMMMM was seen by JJJJJJJ JKKKKKK relation to a large swelling of the lower left mandible. After appropriate examination of the patient and the previous radiography, Mr KKKKKKK appropriately prescribes antibiotics to treat the infection and makes the recommendation of analgesics, with the advice to visit Accident & Emergency should the symptoms become worse.

**MEDICAL RECORDS**

I was provided with copy of Mr MMMMMM’s medical records from RRRRR RRRRR RRRRRRRR.

(A) **PRIOR TO THE INCIDENT**

Nothing of Note: However it has been noted that the patient attended for the treatment of skin cancer from 2009-2011.

(B) **SUBSEQUENT TO THE INCIDENT.**

A letter dated 25th May 2012 shows that Mr MMMMMM was appropriately referred to a Specialist centre at the [Redacted] by Mr AAAAAAAA for the extraction of the LL8 roots following his unsuccessful attempt that day.

Mr MMMMMM’s hospital records relating to this referral shows he was first examined at the RRRRR RRRRR RRRRRRR on 5th July 2012 at the Oral & Maxillofacial Surgery Department. An Ortho-pantomo-gram (OPG) radiograph was taken and the notes clearly record that the LL8
roots have ‘distal hooks’ and that the treatment recommended was the extraction of the LL7 and LL8 roots.

On 31st July 2012, Mr MMMMM MMM attended for the extraction of the teeth roots and required an ‘MOS’ procedure where following appropriate anaesthetic, an incisional flap was raised, bone removed and the roots elevated. The notes clearly records that the tissue was ‘schlerosed’.

(2.3.2) MEDICAL REPORTS

No reports were available.

(3) DISCUSSION AND OPINION

Mr AAAAAAAA did not adequately examine the LL8 prior to offering an extraction simply because he did not ascertain correctly the true nature of the tooth’s roots. The radiography obtained subsequently at the RRRRR RRRRRRRRRRR following Mr AAAAAAAA’s attempt at extraction evidently describe the roots being hooked. Thus, had Mr AAAAAAAA performed adequate investigations, Mr MMMMM MMM’s tooth could have been adequately assessed and Mr MMMMM MMM offered the opportunity for referral. There is no evidence that Mr AAAAAAAA even considered taking further radiography, let alone offered this to Mr MMMMM MMM to consider.

Therefore, the seminal and significant point of negligence occurs at this point. Simply put, Mr AAAAAAAA neglected to assess the third molar tooth adequately prior to his advice to his patient and thus the patient was not adequately informed of the procedure prior to giving his consent. There is no evidence that the patient was advised of possible and tangible adverse outcomes.

When presented with an adverse outcome following Mr AAAAAAAA’s procedure, Mr AJAJAJ could have referred Mr MMMMM MMM to the Specialist for the extraction of the LL7, given that Mr MMMMM MMM had already been referred by Mr AAAAAAAA for the removal of the retained roots of the LL8 just a few days before. Given the radiographic results obtained by Mr AJAJAJ, and specifically that the root appears fractured, the LL7 had a diminished prospect of being simply an ordinary extraction.

Given the condition of the LL7 prior to Mr AJAJAJ’s attempted extraction, the use of forceps alone would not have been adequate for the removal of the tooth. It is not surprising that the LL7 tooth fractured further in this extraction attempt, with the roots being left behind.

The retained roots of the LL7 and LL8 contributed to the prolonged morbidity experienced by Mr MMMMM MMM in the immediacy of the extraction attempts.

(4) CONCLUSIONS

(4.1) SUMMARY OF DIAGNOSIS

Mr MMMMM MMM required further dental and specialist dental consultations as a direct consequence of the traumatic incident. In addition, Mr MMMMM MMM required further surgery as a consequence of the traumatic incidence. The following diagnoses are made

1. Initially the LL8 had dental caries with poor prognosis
2. Following the attempted extraction of the LL8, LL8 and LL7 suffered catastrophic trauma
(4.2) CAUSATION

Mr MMMMMM’s loss of the LL7 resulted from the poor planning in relation to the LL8 extraction and lack of appropriate surgical technique on both the LL8 and the LL7.

There are fundamental and significant breaches in the duty of care of Mr MMMMMM’s dentist, Mr AAAAAAAAA.

Had Mr AAAAAAAAA taken the appropriate radiography prior to advising Mr MMMMMM his treatment plan, he would have seen that the LL8 roots were hooked and to consider minor oral surgery procedure, either with himself or by referral to the local hospital. Mr AAAAAAAAA’s treatment plan was therefore inadequate and Mr MMMMMM was not advised appropriately. Mr AAAAAAAAA was negligent.

Mr AAAAAAAAA was also negligent in his extraction as his approach was flawed from the outset. Thus, his treatment was negligent.

Mr MMMMMM then suffered loss insofar that during the procedure, he fractured the LL7 tooth so badly that it required extraction. There is no evidence that Mr MMMMMM had any problems with the LL7 prior to the procedure on the LL8. In this aspect, Mr MMMMMM suffered material loss.

In the transfer of Mr MMMMMM’s case from Mr AAAAAAAAA to Mr AJAJAJ, it was discovered by the latter clinician that the LL7 was badly damaged as a result of his predecessor’s procedure a few days prior. At this point, Mr MMMMMM had already been referred by Mr AAAAAAAAA to the local hospital for further surgery in relation to the LL8 tooth. Despite this letter and the clear opportunity for Mr AJAJAJ to augment the extraction of the LL7 to the referral, he decided to extract it. However, Mr AJAJAJ did not apply the appropriate technique as despite its poor condition, he attempted a simple forceps extraction. This unsurprisingly was unsuccessful, leaving LL7 roots behind. Mr AJAJAJ was negligent in his assessment and negligent in his inappropriate surgical technique.

Ironically, the local hospital had to complete the surgery of both the LL8 and the LL7 in any event.

(4.3) PROGNOSIS

Both of the teeth have been extracted. Currently, there is no prognosis as the tissue has been lost.

(4.4) TREATMENT REQUIRED

NOT APPLICABLE

(4.5) COSTS

NOT APPLICABLE

(5) DECLARATION

I understand that my duty as an expert witness is to the court. I have complied with that duty. This report includes all matters relevant to the issues on which my expert evidence is given.

I have given details in this report of matters, which might affect the validity of this report.

I have addressed this report to the court.

I confirm I have used standard textbook evidence as follows:
1. Oral Pathology; Soames & Southam; Oxford Medical 1989
2. Dental Caries; Fejeskov & Kidd; Blackwell Munksgaard 2004
4. Standards In Dentistry; Faculty of General Dental Practitioners 2006

I confirm that I have not entered into any arrangement where the amount or payment of my fees is in any way dependent on the outcome of the case.

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and that the opinions I have expressed represent my true and complete professional opinion.

Gokhan Baytug BDS (Liverpool 1992)
Dental Surgeon
(5) APPENDICES

Appendix A: Curriculum Vitae
G Baytug BDS  
Dental Surgeon

help@dentalangel.com

dentalangel  
61 Highgate  
Kendal LA9 4ED  
01539 722772

DENTAL REPORT

NAME: Mr Y
ADDRESS: XXXXXXXX
DATE OF BIRTH: XX/XX/XXXX
DATE OF ACCIDENT: XX/XX/XXXX
DATE OF INTERVIEW: XX/XX/XXXX
INSTRUCTED BY: XXX
CASE REFERENCE: XXXXXX/XX/XX
REPORT DATED: XX/XX/2011
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**Appendix Details**

- Appendix A: Disclosed Medical & Dental History
- Appendix B: Dental Report of Dr A 2 Z
- Appendix C: Dental images
- Appendix D: curriculum vitae
(1) INTRODUCTION

(1.1) THE WRITER

I am Gokhan Baytug. I am a Registered Dental Surgeon (GDC 67802). I have been providing dental services since 1992 following qualification at Liverpool University. I am a general dental surgeon treating both private and NHS sector patients. I have been providing reports specific to the area of personal injury, trauma and assessment since 2003. Full details of my qualifications entitling me to give expert opinion and evidence are set out at the end of this report by way of my curriculum vitae (Appendix D).

(1.2) SUMMARY OF CASE

The case concerns an accident in July 2010 in which the claimant allegedly suffered personal injury. I have been instructed by X X X of X, X in X to investigate for the court whether the claimant has suffered dental damage as a result of an alleged accident, and the effects and prognosis of this if appropriate. I have been provided with the claimant's general dental report relating to the incident and I have been provided with the dental records or radiographs (x-rays) of his general dental practitioner.

I have neither been provided with a specific medical report to the incident, physiotherapy reports nor with any hospital records relating to the incident. I have not been provided with any psychological reports.

(1.3) TECHNICAL TERMS

I have indicated any technical terms in bold type. Explanations of such are included in the parentheses as appropriate.

(2) INVESTIGATION

(2.1) EXAMINATION

DATE: XX/XX/XXXX
IDENTITY: I was provided with evidence of the claimant's identity.

ON EXAMINATION:

Mr Y presented appropriately at examination and on interview was able to give me a clear and detailed account of the accident and its impact upon him. His affect was appropriate throughout, although as he was relying solely on his memory of the incident. He was accompanied by his wife.

Mr Y completed his medical and dental history prior to the interview and these are included in Appendix A. His medical history includes hypertension and he takes the medication as listed in Appendix A which includes aspirin.

On examination, Mr Y presented with a DMFT (Decayed Missing Filled Teeth) score of 25 (maximum possible including third molars is 32) and as such, a majority of his permanent dentition would appear treated or extracted.

(2.1.1) RECALL OF THE INCIDENT AND SUBSEQUENT DEVELOPMENTS

At the interview, Mr Y presented as a 66 year old male. He stated that he had been attended his dental practice regularly but had a break in his regular care as his previous dentist had retired and he found himself on the waiting list for a new NHS dentist. He was allocated his new dentist, Dr A 2 Z at XX, X in XXXXXXXXXXXX XXXX, two months after his accident.
Mr Y felt that his discontinuity of dental care was beyond his control and that following his accident, he was required to wear false teeth, of which hitherto he had no previous experience.

Mr Y recalled that the accident occurred on the XXth XX XXXX, being the first day of the school holiday whilst being driven to Birmingham en-route to a holiday. He was a passenger in the centre of the rear seat and the car he was travelling in was in a traffic hold-up. His passengers to his side included his daughter-in-law and his grandson. He recalls that they were just south of Preston when the accident occurred and in the third lane. He recalled the motorway was 'chock-a-block' and with constant 'stop-start' travel. He recalls that whilst in motion, the vehicle two cars in front braked suddenly causing the car in front brake suddenly. This was followed by an immediate response from Mr Y’s car, which was then hit from behind from the car immediately behind his vehicle in the traffic jam. Mr Y was not immediately concerned about his own welfare as the violence of the impact caused such upset that his grandson was ‘covered in blood’ and very upset. His daughter-in-law was also injured. The concern for the injuries not only of his grandson and daughter-in-law but also his son, who was the driver of the vehicle, required hospital treatment and as such, he was unconcerned at the time of any injuries he had suffered.

Shortly afterwards, Mr Y noticed that a front tooth had become loose and this prevented him from eating well due to its looseness. He reverted to using a dental fixative as a remedy, and in his own words, ‘to soldier on’ and continued with his holiday. He did not seek medical advice until after his holiday as he felt generally fine at the time although at this point was aware his tooth was loose.

The holiday lasted for 7 days and on return to his home in Xxxxxxxx, Mr Y contacted the Emergency Dental Centre but could not get an appointment as they were ‘too busy’. He delayed his treatment until allocated a place by NHS Xxxxxxxx with Dr Z.

Mr Y first visited Dr Z on XX/XX/XXXX, who suggested a root filling to the broken tooth. When Mr Y return approximately two weeks later for the treatment, XX/XX/XXXX, Dr Z re-evaluated the condition of the tooth and that it was his opinion that would require an extraction of the tooth and to be provided with a denture at the time of the extraction. As Mr Y was managing to keep the tooth affixed using dental fixative, he delayed this treatment until Xxxxxxxx XXXX but required a solution as his son was getting married.

In Xxxxxxxx XXXX, the tooth was extracted and a denture fitted. However, since this time another tooth has broken on the upper left side.

At his interview, Mr Y consented to a full dental evaluation.

At his dental examination, Mr Y stated that he brushed his teeth daily in the morning and regularly uses dental floss especially after eating meat. He stated that he did not use mouthwash regularly and used a manual toothbrush, rather than an electric type.

Mr Y stated that he did not use tobacco, having ceased some 25 years previously, he did not add sugar to tea or coffee, did not snack ‘graze’ between meals and did not consume soft drink. He reported that he was not aware that he had every ground his teeth at night but that he might do it during the day as part of a habit. He did not report any headaches in the morning or problems with his jaw such as clicking.

A full mouth examination was performed and charted and Mr Y was comfortable throughout and was not suffering any dental pain.

Mr Y’s oral hygiene was fair and the Basic Periodontal Examination (BPE) reflects that there were deposits of plaque with bleeding on probing to the upper and lower left and right rear teeth and deposits of dental calculus (tartar) to the lower front teeth and right hand side. The lower front teeth exhibited staining.

Mr Y’s orthodontic incisal relationship (i.e. the position of the upper front teeth to the lower front teeth) was recorded as Class I (Angle’s Classification) with an overjet (the amount by which the
upper front teeth protrude in front of the lower front teeth) measured in situ of less than 4mm. His dental arches are broad and well aligned, with no imbrication observed (crossing of the teeth).

Mr Y’s oral soft tissues appeared normal with one exception, that being the palate, which showed mild signs of the denture sinking.

Mr Y’s other dental tissues are in good health and there was nothing abnormal recorded facially. His [temperomandibular](https://en.wikipedia.org/wiki/Temperomandibular_joint) (jaw) joints appeared normal and his lymph nodes were not palpable and thus normal.

The site of the extraction, namely upper right central incisor region, showed good healing, with the site scalloped and rounded in facial profile and in relation to the two adjacent teeth, the upper right lateral incisor and the upper left central incisor.

The Upper Right Second Premolar and the Upper Left Second Premolar (Teeth 15 & 25) show fractures to the existing restorations. It is understood that these have occurred following the accident. The Upper Right First Premolar (Tooth 14) has a large Distal Occlusal (rear) amalgam filling which is very significantly guttered and requires replacement. This type of wear is associated with the long term placement of amalgam due to the material property [creep](https://en.wikipedia.org/wiki/Creep_phenomena).

The lower incisors exhibit mild to modest dental [attrition](https://en.wikipedia.org/wiki/Attrition_(dentistry)) (tooth wear due to the action of one tooth grinding against another during jaw movement and compression)

Mr Y’s denture was assessed, being a hard acrylic type with three teeth and supporting rests or clasps. It fitted fairly well and was comfortable, but in compressive loading, the central tooth appeared to travel upwards thus loosing its incisal edge profile with the adjacent central tooth. The crowned teeth were firm and their restorations intact.

Seven 35mm SLR photographs were taken.

Four dental radiographs (xrays) were taken using the Planmeca Dimaxis digital system using a 28lpicture resolution and B Dixi ccd intraoral sensor. The super long cone rectangular collimated beam was aligned using a Schick intraoral sensor holder. Images are presented in this report together with clarified regions of interest (These are presented in Appendix C).

Clarification included noise removal, level equalisation and sharpening to enhance the diagnostic quality.

The exposure times are as follows (8mA at 70kVp):
- Periapical view UR12 & UL12 (2 images in total): 0.04s each
- Periapical view UR5 & UL5 (2 images in total): 0.064s each

Periapical radiography demonstrates no evident deep pathology to the incisor teeth but edge detailing of the Upper Right Lateral Incisor and Upper Right Canine (teeth 13 and 12) shows porcelain bonded crowns whose margins require further investigation. There is no deep pathology associated to these teeth in terms of abscess. Radiography shows the area where the Upper Right Central Incisor (UR1 tooth) was lost, the crest of the dental bone (alveolus) being quite concave, commensurate with the soft tissue profile of an ovate type saddle area. Radiography also shows that the Upper Left Central Incisor (Tooth 21) has a porcelain bonded crown, with good marginal adaptation and with no deep pathology.

**2.2 DISCLOSED MEDICAL & DENTAL HISTORY**

Please refer to Appendix A in which copy of Mr Y’s medical and dental history at the time of examination is disclosed.

Mr Y is not disabled and is retired. He appeared at the time of the examination fit and well.

Mr Y’s dental history record is enclosed in Appendix A and matches that reported at his interview.

**2.3 REVIEW OF DOCUMENTS**
(2.3.1) MEDICAL & DENTAL RECORDS

DENTAL RECORDS

(A) PRIOR TO THE INCIDENT

Not Available.

(B) SUBSEQUENT TO THE INCIDENT (APPENDIX B)

Supplied as separate enclosure to the instructions of the X X X X and comprising three pages (although four pages are cited) of ‘Care Pathway’ and six pages of Clinical Charting & Records.

Care Pathway Document
This document was prepared by Mr Y’s dentist, Dr A 2 Z on XX/XX/XXXX. It states that the patient has no pain, can only eat on one side and with difficulty and that his dental mucosa (soft tissues) are normal. In addition, the report provides indices for Caries (tooth decay), bleeding and plaque deposits. However, there is no accompanying legend to qualify precisely what these indices mean in terms of clinical findings and they are non-standard. A completed Medical Questionnaire is included, which cites in addition to that disclosed in Appendix A that Mr Y also suffers with arthritis, although there is no clarification if this is osteo or rheumatoid types, or if this condition is localised or generalised. Whilst a Social Questionnaire is also included, it appears to be incomplete and scored out in freehand.

Clinical Charting & Records
The clinical chart and records are compiled by Dr A 2 Z (recorded as GSA191), and also an unknown clinician whose identifier is recorded as RXL 191 (XX/XX/XXXX). The clinical records printed XX/XX/XXXX. The clinical records relate to Mr Y’s dental care from XX/XX/XXXX to XX/XX/XXXX inclusive.

In order of chronology:

XX/XX/XXXX
Mr Y attends the clinic of Dr Z for the first time, who undertakes a full dental examination where his medical history is checked. Mr Y’s reason for attendance is cited as being check up and that his main complaint being a lost crown, although this is not directly specified and it is also stated that he smokes 10 cigarettes per day and consumes 10 units of alcohol per week. It is also stated that his previous dental visit was approximately two and a half years previously. Extra oral examination of Mr Y revealed a click on the right side of his jaw and the intra oral examination cites that Mr Y toothbrushes twice daily.

A dental radiograph was taken, and although the qualification as the requirement for ionising radiation exposure is cited, the exact exposure details (for example duration, current and voltage) are not detailed. The results of the radiographic assessment are reported and that the UR1 tooth was of good quality to enable its reconstruction using a post and crown. The dental tissues are also examined with regard to the periodontal (gum) condition and a Basic Periodontal Examination (BPE) concluded, although the details of the BPE are not disclosed. Further evaluations are made in respect of hard tissue fractures, wear and caries (all assessed as nil) and also a risk assessment in terms of caries (low) and periodontal disease (medium).

Dr Z provides his diagnosis and discusses treatment for the UR1 crown, a filling to the UL5 tooth and basic periodontal prophylaxis, namely a S&P (Scale & Polish). A treatment plan is explained and a routine maintenance cycle defined for 6 months.

Mr O’ Hagan also receives a ‘therapy prescription’ which includes S&P of the lower front teeth and upper & lower molar teeth.

XX/XX/XXXX
Dr Z checked that Mr Y’s medical history has not changed and takes a further dental radiograph, although its requirement is not cited, there is no radiography report and the exposure time, current and voltage are not recorded. Neither is the site of the dental radiograph recorded.
Dr Z undertakes the **extirpation** (removal of dental pulp components) of the UR1 tooth and provides a dressing of cotton wool and temporary filling material after irrigating the canal with an antiseptic agent comprising chlorhexidine obtained from Corsodyl mouthwash.

**XX/XX/XXXX**

Dr Z undertakes to complete the root treatment of the UR1 tooth but discovers that the tooth has a suspect fracture to it. Dr Z confirms his diagnosis from his recollection of his clinical findings at the time of dental surgery at Mr Y’s previous appointment, namely that the tooth had bled ‘quite a lot’ despite apparently removing all of the dental pulp. Dr Z takes a dental radiograph of the site, although the exposure details are not recorded in terms of exposure length, current or voltage. Dr Z revises the prognosis of the tooth and advise that the tooth requires extraction and a denture to be made prior to the surgery, to be fitted at the time of surgery (an immediate denture). Dr Z records that he will discuss the cost implications of this treatment with Mr Y as it might be cheaper to have this treatment provided privately.

Dr Z provides dental periodontal prophylaxis, namely a S&P, and also provides a composite type filling to the UL5 tooth which does not require local anaesthetic.

**XX/XX/XXXX**

Dr Z takes alginate impressions of Mr Y’s upper and lower dental arches to fabricate an upper dental removal prosthesis, name an acrylic denture. Dr Z notes that this denture is to be provided as a NHS denture and that the next appointment is for the extraction of the UR1 tooth and the placement of the denture.

**XX/XX/XXXX**

Dr Z checks Mr Y’s medical history and administers local anaesthetic. He then removes Mr Y’s UR1 tooth. The denture is fitted and Dr Z concludes that the denture fits and looks ‘very well’ and that the patient is happy with the result. A recall is set at 3 months to review the extraction site and for Mr Y to consider a bridge.

**XX/XX/XXXX**

Mr Y visits the clinician referred to as ‘RXL191’, who checks his medical history and provides a **BPE** although its reporting is non-standard as ‘all 2’. Mr Y receives dental public health information in terms of care and cleaning advice.

**XX/XX/XXXX**

Mr Y returns to visit Dr Z as his denture is proving uncomfortable. Dr Z adjusts the denture for comfort

**MEDICAL RECORDS**

(A) **PRIOR TO THE INCIDENT**

Not Available.

(B) **SUBSEQUENT TO THE INCIDENT**

Not Available.

(2.3.2) **MEDICAL REPORTS (APPENDIX B)**

A request was made for radiography to the dental practice Mr Y attended for his treatment and his dentist, Dr A 2 Z, kindly supplied this evidence (**XX/XX/XXXX**). In addition, Dr Z also produced reports appended to each radiograph. The radiography was provided by way of greyscale printout and was adequate to assist in the purpose of this report, although Dr Z’ apologies for their quality is accepted.

In order of chronology:

**XX/XX/XXXX**: Periapical Radiograph UR1 showing gingival transverse fracture and loss of tooth crown. Fracture at level of the crestal bone **distally** (to the right of the tooth) whilst fracture site
elevated beyond the height of the crestal bone **mesially** (to the left of the tooth). A small fragment appears impacted within the projecting tooth tissue and this is seen as a **radio-opacity** (white triangular object) mesial to the root canal. The tooth’s pulp canal appears large in bore size and straight. It is not clear if the canal communicates directly to the remaining tooth surface;

XX/XX/XXXX: Periapical Radiograph UR1 showing access to the root canal. The impacted fragment remains clearly visible;

XX/XX/XXXX: Periapical Radiograph UR1 showing that the tooth’s pulp had been removed and access throughout the entire length of the root canal had been achieved;

XX/XX/XXXX: Periapical Radiograph UR1 showing that a dental instrument has been able to deviate from the root canal that had been negotiated previously. The deviation terminates through the apical third (**root tip**). The impacted fragment described in the radiography 16/09/2010 is clearly visible.

(3) **DISCUSSION AND OPINION**

Following the trauma, Mr Y suffered damage to his front incisor teeth as set out by his recollection of events and by the contemporaneous dental report. It has not been possible to correlate the findings of his statement given at the time of his examination in XXXXX XXXX with any other statements he might have provided regarding his accident as these were not supplied with the notes taken that day.

Mr Y visited his new dentist XX/XX/XXXX, two months following his trauma (dated XX/XX/XXXX). During this intervening period, Mr Y apparently did not seek medical or dental attention, despite the trauma to his dental tissue. It has not been possible therefore to provide a correlation to Mr Y’s contemporaneous medical or dental records taken at the time of the trauma.

Whilst Mr Y’s reason for attendance is cited in the clinical records of Dr Z dated XX/XX/XXXX as being for a dental examination and that he was complaining of a lost crown, Dr Z does not record precisely that this is the UR1 tooth and that the crown was lost because of trauma two months previously. Dr Z does not record the event of the Road Traffic Accident.

During the two month intervening period between the Accident and being examined by Dr Z, Mr Y apparently made some effort to contact Xxxxxxxx PCT to arrange emergency care. However, Mr Y states that the Emergency Dental Service was ‘too busy’, despite the trauma being sustained as a result of a Road Traffic Accident. There is no evidence provided that confirms Mr Y’s position in this respect and there is no evidence from the clinical records of Dr Z that would support Mr Y’s position.

However, Mr Y’s recollection appeared lucid and believable, but given the lack of evidence made available for the purposes of this report, the events described are taken as a matter of trust.

In accepting the above, Mr Y suffered damage to his upper right front central incisor tooth and this damage is permanent. He has thus suffered loss.

Mr Y has required treatment to this damaged tooth, the upper right central incisor.

There are a few minor technical inconsistencies with regard to the treatment provided by Dr Z. For the purpose of accuracy, these are:

1. Reporting and recording of radiography;
2. Failure to provide any notification, reason, report or recording of a second radiograph taken XX/XX/XXXX;
3. The treatment plan provided XX/XX/XXXX includes the provision of a post and crown, but does not specify also that this procedure will require a root canal filling. Mr Y’s following appointment XX/XX/XXXX was expressly to provide a root canal filling;
4. The treatment plan provided XX/XX/XXXX includes the filling of the UL5. However, there is not report or diagnosis made regarding this tooth and there are no investigations of this tooth prior to recommending treatment;

5. The treatment plan provided XX/XX/XXXX includes dental periodontal prophylaxis, and although the clinical records state a BPE has been undertaken, the investigation itself is not recorded;

6. There is no qualification as to the type of treatment plan provided for Mr Y in terms of NHS or private provision.

7. It is assumed, although not supported by evidence, that this treatment was NHS treatment and as it included a post and crown, it would have been a ‘Charge Band 3’ item. The cost of Mr Y at this point would have been £198, although a treatment plan detailing costs was not available for the purposes of this report;

8. In returning to Dr Z two weeks later, namely XX/XX/XXXX, Mr Y is advised that the tooth required extraction. Given the report of Dr Z, and as supported by his dental radiography, this treatment is reasonable. Dr Z had attempted the conservation of the UR1 tooth as his first line treatment, but unfortunately the condition of the UR1 was such that despite the efforts of Dr Z, it required extraction. Dr Z prescribes also an immediate denture. However, evidence was not supplied for the purposes of this report detailing this second treatment plan. It is noted that Dr Z recommends private treatment, although extraction and placement of a denture was also available as a NHS treatment plan to Mr Y, also being a ‘Charge Band 3’ item, and the costs already covered by the first treatment plan provided by Dr Z;

9. The issue of NHS provision regarding the denture is qualified at Mr Y’s next appointment. Evidence was not supplied for the purposes of this report detailing the costs;

10. Mr Y receives advice from ‘RXL191’ although there is no evidence provided for the purpose of this report who this clinician is and their dental role and qualification. Clinician RXL191 provides a non-standard BPE report;

It is clear from the dental records that Mr Y required several appointments with his dentist to remedy the effects of his trauma, and had to return, as is sometimes usual for further denture adjustment, which was completed by Dr Z to his satisfaction.

Whilst there was no evidence supplied for the purposes of this report regarding appointment schedules and attendance, it is assumed that Mr Y attended all the appointments required of him without failure.

Whilst there is an extended period between the prescription of extraction and denture and their provision, this was due to Mr Y’s personal commitments, citing that his son was married in the autumn of XXXX.

The records of Dr Z clearly state that the extraction and denture fit is to be proceeded by an extended period of convalescence before further restorative treatment can be determined. The denture supplied by Dr Z is thus a transitional prosthesis and was fitted immediately at the completion of surgery. Mr Y is yet to receive his definitive treatment.

There was an inconsistency in tobacco consumption between that stated to Dr Z 16/09/2010 and that stated at interview and also as detailed in the dental history questionnaire completed prior to the interview.

(4) **CONCLUSIONS**

(4.1) **SUMMARY OF DIAGNOSIS**

The diagnosis of Mr Y’s upper right central incisor is gingival transverse fracture and crown loss with probable complex longitudinal root fracture. The cause is trauma. The damage to Mr Y’s upper right central incisor tooth was irreversible and also terminal, requiring its extraction. The prognosis of this tooth was thus poor.
(4.2) CAUSATION

The contemporaneous dental records by Dr Z evidently records that Mr Y presented with a fractured tooth, where the crown of the tooth had broken away from the underlying tooth root, leaving a tooth stump. The contemporaneous radiography shows that the tooth was previously not root filled and there is no evidence that there was any caries. Indeed, it was the opinion of Dr Z that there was no caries at the time of Mr Y’s examination in XXXXXXXXX XXXX.

The type of damage sustained is consistent with a violent blow as it is unusual to sustain such damage in teeth that have neither root fillings nor caries.

Mr Y at interview gave the history of trauma to this tooth as being a Road Traffic Accident, violent enough that warranted the hospital treatment of three of his close family members who were fellow occupants of the vehicle involved in the Accident that day.

Although no evidence was supplied from the time of the Accident itself, namely in XXXX XXXX, evidence has been supplied relating to damage just two months later.

Mr Y cited at interview that in effect he selflessly deferred his own treatment as he was unconcerned about it at the time and was extremely concerned by the ‘horrible’ chain of events unfolding around him that day. His view was to ‘soldier on’ and although at interview he stated that he tried on occasions to access emergency dental care from Xxxxxxx PCT, he did not receive treatment for the broken tooth until XXXXXXXXX XXXX.

Mr Y was on a Xxxxxxx PCT list awaiting allocation for a new NHS dentist. The waiting period for NHS allocation was beyond his control. He was fortunate that this allocation occurred just two months after the Accident, else conceivably could have been waiting longer.

In accepting that it is possible to corroborate his version of events from witnesses involved in the Accident and subsequently thereafter, Mr Y sustained the loss of his tooth crown from the Accident.

Furthermore, the evidence demonstrates that the damage to the tooth was severe enough to warrant the extraction of the remainder.

Mr Y has thus sustained further loss by way of the remedial treatment required as a direct consequence of the trauma.

The remedial treatment included:
1. Examination & Investigation;
2. Root canal extirpation and exploration;
3. Tooth extraction;

The treatment provided to date in respect of the UR1 tooth was in effect ‘emergency’ care and the denture supplied a transitional prosthesis with a view to considering definitive treatment alternatives that would be considered permanent.

Mr Y has suffered irreversible loss in respect of the UR1 and will also require further treatment before the effects of the trauma have been fully concluded.

(4.3) PROGNOSIS

The prognosis for the treatment upper right central tooth is guarded, as it is transitional. The prognosis of any further treatment should be good.

(4.4) TREATMENT REQUIRED

1. Dental Public Health Education;
This includes oral hygiene instruction and understanding the health benefits in reducing oral debris. This also includes using a fluoride mouthwash after his first meal of the day and to use floss regularly.

2. Dental Conservation;

**Tooth UR1:**
This tooth requires a definitive reconstructive solution as currently Mr Y’s status is provisional. Treatment options include either a three unit bridge UR2, UR1; UL1 or the placement of an implant. The option is given to Mr Y as both the UR2 and the UL1 are currently already restored with porcelain bonded crowns and as such, removing the current restorations to provide abutment preparations for a bridge would not prove tooth taxing. However, the restorations currently enjoyed by these teeth are generally satisfactory and as such, Mr Y rightly should consider implant placement. This would involve the fixation of an implant to the UR1 site, into the bone, and allowing healing of the site with the fabrication of a replacement transitional denture. After a period of approximately 3 months, the surgical site would be uncovered and loaded with the provision of a post retained crown. This second treatment option is preferred as it definitively reconstructs the area that has suffered damage and mitigating the reconstruction locally, whereas a bridge would require the reconstruction of the area involved in the damage utilising tissues unaffected by the damage hitherto. Mr Y’s tobacco consumption would require clarification and he would require specialist consultation. Mr Y may also require the addition of a bone graft placement prior to implant fixation. This may required if the bone density, height and width parameters are not ideal for implant fixation but could be made so in a fairly simple, albeit involved, procedure.

### (4.5) COSTS

Mr Y has suffered damage to his upper right first incisor and has suffered loss, in terms of damage, pain, suffering and time required for treatment. He clearly required treatment, the nature of which at best is uncomfortable and at worst distressing and painful.

Mr Y’s trauma and treatment will invariably have resulted in some general loss in his enjoyment of life, but the substantive nature of this is difficult to quantify with precision.

Whilst there is no evidence that the injuries have directly prevented him from continuing to enjoy life, the cosmetic and social impact of the damage to a central incisor tooth is, however, potentially substantial.

To date, Mr Y has spent a number of hours receiving treatment, although I have not been able to verify precisely how much time he has spent in gaining his treatment to date.

I have not been supplied with any treatment plans or costs that Mr Y has been provided with.

Mr Y clearly requires further treatment and this may prove through the years to become vexed in terms of outcomes, thus convoluting treatment pathways further.

It is therefore difficult to precisely state that Mr Y’s conditions will completely resolve as he may suffer eventual further treatment complication, thus mandating further complex reconstructive dental surgery.

However, there are a number of caveats that make the one treatment for life scenario unlikely, and as such Mr Y might be likely to require a number of courses of treatment to the tooth in his lifetime.

Factors include:

**Life Expectancy**
The Office for National Statistics cites that as a simple measure, that whole life expectancy for a male born in England to be 78 years. However, this calculation is prone to misinterpretation as
whole life expectancy at birth, referred to as Period life expectancy, in comparison to Cohort life expectancy can vary widely.


For example, a male living in England can expect to live to be 78 years of age from birth (whole life expectancy).

However, a male living in England who achieves 65 years of age can expect over 17 years of extra life, yielding a life expectancy of approximately 82 years (cohort life expectancy).

Cohort calculation is clearly four extra years in comparison to the whole life expectancy.

In an effort to reconcile simple comparative data, I have used a life expectancy calculator from the University of Wales Institute Cardiff.

(http://www.uwic.ac.uk/shss/dom/newweb/Lifestyle/age_expectancy2.htm).

Using this simple tool, Mr Y’s life expectancy is derived at 79 years.

Accepting some degree of error, Mr Y might survive for an additional 15 years. The implant should not require replacement, although replacement at ten years is not unusual.

**Oral hygiene**

Mr Y must adhere to advice regarding the prevention of oral disease and the maintenance of oral health.

**Tobacco Consumption**

**Permanent Damage**

Mr Y has suffered permanent damage to a hard tissue that is incapable of its own repair or rejuvenation.

**Summary of Costs**

Future and thus ongoing costs for Mr Y are therefore highly probable and it is my opinion inevitable.

1. All disbursements to date in relation to the UR1 tooth, including examination, surgery and provision of a transitional denture;
2. Implant placement UR1 & Post/crown £2200;
3. Bone Graft, Tibial or Mental donation £2000;
4. Transitional denture £200;
5. Award for time, distress, discomfort

NB:

Item (5) cannot be quantified for the purposes of this report and should be a matter for Counsel to determine.

The above does not include the provision of a bridge as this cost is below the award for items (2), (3) & (4)

(5) DECLARATION

I understand that my duty as an expert witness is to the court. I have complied with that duty. This report includes all matters relevant to the issues on which my expert evidence is given.

I have given details in this report of matters, which might affect the validity of this report.

I have addressed this report to the court.

I confirm I have used standard textbook evidence as follows:
1. Oral Pathology; Soames & Southam; Oxford Medical 1989
2. Self Assessment Manual & Standards; Royal College of Surgeons of England 1991
3. Standards In Dentistry; Faculty of General Dental Practitioners 2006
4. Delivering Better Oral Health; Dept. of Health (UK) & BASCD 2009

In addition to the above, I have also researched data from the National Statistics Office and from The University of Wales, and I have recorded their website addresses as appropriate in this document.

I confirm that I have not entered into any arrangement where the amount or payment of my fees is in any way dependent on the outcome of the case.

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and that the opinions I have expressed represent my true and complete professional opinion.

Gokhan Baytug BDS (Liverpool 1992)
Dental Surgeon
Appendix A: Disclosed Medical & Dental History
Appendix B: Dental Report
Appendix C: Dental Images
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<th>IMAGE</th>
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### DENTAL REPORT

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<th><strong>NAME:</strong></th>
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| **ADDRESS:** | 74 SSSSSSS WWW  
NNNN 7XX |
| **DATE OF BIRTH:** | dd/mm/yy |
| **DATE OF ACCIDENT:** | July 2XXX |
| **DATE OF INTERVIEW:** | 27/04/2XXX |
| **ON THE INSTRUCTIONS OF:** | HXXXXX FXXXXX |
| **SOLICITORS REFERENCE:** | LX/LX/0XXXX |
| **REPORT DATED:** | DD/MM/YYYY |
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### Appendix Details
- Appendix A: Disclosed Medical & Dental History
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- Appendix F: curriculum vitae
(1) INTRODUCTION

(1.1) THE WRITER

I am Gokhan Baytug. I am a Registered Dental Surgeon (GDC 67802). I have been providing dental services since 1992 following qualification at Liverpool University. I am a general dental surgeon treating both private and NHS sector patients. I have been providing reports specific to the area of personal injury, trauma and assessment since 2003. Full details of my qualifications entitling me to give expert opinion and evidence are set out at the end of this report by way of my curriculum vitae (Appendix G).

(1.2) SUMMARY OF CASE

The case concerns an incident in July 2009 in which the claimant allegedly suffered personal injury. I have been instructed by HXXXXX FXXXXX, TTTTTTTT, SSSSSSSSS, to investigate for the court whether the claimant has suffered formal dental damage as a result of an alleged road traffic accident, and the effects and prognosis of this if appropriate. I have been provided with the claimant’s general medical records, including historic incidents from SSSS TTTTTTTT District Hospital. I have been provided with dental practice notes and records that relate to the incident. I have not been provided with dental radiographs (x-rays). I have not been provided with a specific medical report to the incident (save for the General Practitioner records), physiotherapy reports or with any hospital records relating to the incident. There appears to me a slight disparity between the letter of instruction from HXXXXX FXXXXX and the dental records supplied by the SSSSS TTTTTTTT Dental Group viz. Date of Incident. The former states the date of incident being the 31st July 2XXX whilst the latter’s first report of the alleged incident is the 24th July 2XXX.

(1.3) TECHNICAL TERMS

I have indicated any technical terms in bold type. Explanations of such are included in the parentheses as appropriate.

(2) INVESTIGATION

(2.1) EXAMINATION

DATE: 27th April 2XXX

IDENTITY: I was provided with evidence of the claimant’s identity and the claimant attended for examination alone.

ON EXAMINATION:

Mr AAAAAAAA presented appropriately at examination and on interview was able to give me a clear and detailed account of the accident and its impact upon him. His affect was appropriate throughout, although as he was relying solely on his memory of the incident and subsequent events, his degree of detail varied.

Mr AAAAAAAA completed his medical and dental history after the interview and returned this by post, which was received at the practice 6th May 2XXX. These are included in Appendix A.

On examination, Mr AAAAAAAA presented with a DMFT (Decayed Missing Filled Teeth) score of 21 (maximum possible including third molars is 32) and as such, a majority of his permanent dentition has either been filled or extracted. Mr AAAAAAAA’s clinical chart and findings are included in Appendix B.
(2.1.1) **RECALL OF THE INCIDENT AND SUBSEQUENT DEVELOPMENTS**

At the interview, Mr AAAAAAAA stated that he had chosen his breakfast cereal and prepared it as normal, and on the first spoonful or thereabout, chewed on something hard at the same time as experiencing a crack. He examined himself and discovered a lot of the tooth was missing on the lower right molar tooth.

Mr AAAAAAAA felt alarmed and concerned and was not aware that the opposing tooth also had some damage to it. He experienced a high degree of shock, which initially overcame any discomfort, but he quickly became aware of pain. He did not notice any damage to his soft tissues (such as cheeks, gums or tongue) but he became quite fixated with the damaged tooth and could not prevent himself probing the damage with his tongue.

Mr AAAAAAAA retained the broken piece of tooth and the material from the cereal he alleges caused the damage (although this was not available for me to examine).

Mr AAAAAAAA’s pain and discomfort included sensitivity to hot and cold and as such, he avoided food and drink that might cause precipitate such. He did not experience any severe pain that either prevented him from sleep or woke him from sleep. He did not experience any swelling and he did not experience any discharge.

Mr AAAAAAAA promptly contacted his dentist and had the tooth examined and discovered two teeth required dressings. He later attended for definitive treatment.

It was noted that there was a delay between the appointments for the treatment of the teeth of approximately six months. When questioned, Mr AAAAAAAA explained that this was due to work commitments: His initial dental appointment following the incident when he received provisional dressings to the teeth proving sufficient until his circumstance enabled him to complete his definitive care.

Following his disclosure, a full mouth examination was performed and charted (Appendix B).

Mr AAAAAAAA’s oral hygiene was adequate and the Basic Periodontal Examination (BPE) reflects that there were deposits of plaque with bleeding on probing to the upper and lower left and right rear teeth and deposits of dental calculus (tartar) to the lower front teeth. The upper front teeth neither had deposits nor bled on probing.

Mr AAAAAAAA’s orthodontic incisal relationship (i.e. the position of the upper front teeth to the lower front teeth) was recorded as Class I (Angle’s Classification) with an overjet (the amount by which the upper front teeth protrude in front of the lower front teeth) measured in situ of less than 4mm.

The two teeth alleged to have been damaged were examined for function. Although in separate arches, both the upper right first permanent molar and lower right second permanent molar function as a masticatory unit (perform a chewing action directly against each other).

Examination visually of the upper right first permanent molar (tooth 16) revealed a very large amalgam filling with an apparent wear facet to the occlusal (chewing) surface. The marginal boundaries of the amalgam filling were deficient in areas and further caries (tooth decay) is visible secondary to the restoration. Additionally, the tooth wall appears to be cracking.

Examination visually of the lower right second permanent molar (tooth 47) revealed a very large amalgam filling with poor adaptation of the mesial (front) part of the filling to conform with the natural anatomy producing deficiency. Caries (tooth decay) is clearly visible secondary to the amalgam restoration and there is a void present on the distolingual-occlusal amalgam margin (rear
chewing surface, tongue side). Ditching of the amalgam is also visible on the mesiolingual-occlusal margin (front chewing surface, tongue side). Additionally, the tooth wall appears to be cracking.

Six intra oral images were retained of tooth 16 and seven intra oral images were retained of tooth 47, using the Planmeca Dimaxis digital system using a 1/3 inch ccd INTRACAM and are presented in Appendix D.

Three dental radiographs (xrays) were taken using the Planmeca Dimaxis digital system using a 28lpi size B Dixi ccd intraoral sensor. The super long cone rectangular collimated beam was aligned using a Schick intraoral sensor holder. Unprocessed (i.e. raw) images are presented in this report together with clarified region of interest images (These are presented side-by-side in Appendix D). Clarification included noise removal, level equalisation and sharpening to enhance the diagnostic quality. The radiographs are also presented in this report by way of CD ROM as attached. The exposure times are as follows (8mA at 70kVp):

Bitewing view: 0.08s
Periapical (Upper Right Quadrant): 0.10s
Periapical (Lower Right Quadrant): 0.06s

Bitewing radiography confirms restorations to both 16 and 47 teeth with coronal radiolucencies (dark area in the tooth’s crowns) evident. These indicate the following:

Tooth 16: Caries (tooth decay) to the distal (rear) and mesial (front) secondary to the existing amalgam;

Tooth 47: Caries (tooth decay) to the distal (rear) secondary to the existing amalgam.

Bitewing radiography also evidently demonstrates that the two teeth together form a functioning masticatory (chewing) unit and this function substantially involves the majority of both teeth.

Periapical radiography demonstrates a radiolucency to the 47 tooth. This indicates the following:

Tooth 16: No evident deep pathology;

Tooth 47: Periapical Periodontitis (an inflammatory reaction at the bone and tooth root junction as a result to infection or trauma to the dental pulp. The dental pulp contains a tooth’s nerve and blood supply) to the mesial (front) root.

(2.2) DISCLOSED MEDICAL & DENTAL HISTORY

Please refer to Appendix A in which copy of Mr AAAAAAAA’s medical and dental history at the time of examination is disclosed.

Mr AAAAAAAA is not disabled and works in employment regularly, his vocation being property maintenance. Although he suffers with osteo-arthritis, he does not require medication. He appeared at the time of the examination fit and well.

Mr AAAAAAAA states on his dental history record that he regularly attends his dentist and his last visit was approximately 3 months ago. He brushes his teeth once daily and uses an electric toothbrush to assist. He does not regularly use mouthwash, dental floss or interdental brushes. He consumes less that 15 units of alcohol and does not smoke, add sugar to tea or coffee or regularly drink soft drink. Mr AAAAAAAA does occasionally snack between meals, but his dietary choice is confined to savoury or fruit foodstuffs. He states that he has pain on a recent filling.

(2.3) REVIEW OF DOCUMENTS

(2.3.1) MEDICAL & DENTAL RECORDS (APPENDIX C)

DENTAL RECORDS
(A) PRIOR TO THE INCIDENT

The dental records show that Mr AAAAAAAA attended for two 30 minute appointments in June 2XXX (18th and 24th) with Mr Mike TTTTTTTT.

With regard to the 18th June 2XXX appointment, there are no supportive dental radiographic images although the records evidently disclose his dental examination by Mr TTTTTTTT, and that bitewing radiography (dental x-rays which are used as standard to screen) revealed no evidence of caries (tooth decay). Mr AAAAAAAA’s complaints at this time included worn lower front teeth and food trapping to the lower right teeth and he received some scaling and polishing.

Mr AAAAAAAA returned for treatment with Mr TTTTTTTT on the 24th June 2XXX and received two composite type fillings to the lower left and right lateral incisors, although the reason for these fillings is not made clear.

The NHS “Personal Dental Treatment Plan” FP17DC was not included for this course of treatment although it is a standard Terms of Service requirement to provide one for this type of treatment.

Further scrutiny of the dental records evidently disclose that Mr TTTTTTTT gave advice with regard to food trapping to the lower right teeth which he relates to the way by which the lower right second molar has drifted forwards. Treatment was not required.

Mr AAAAAAAA was discharged for routine recall at six months.

(B) SUBSEQUENT TO THE INCIDENT

The same dental records show that Mr AAAAAAAA’s next dental appointment was with Miss Alexandra TTTTTTTT on 24th July 2XXX.

There is specific mention in the dental records of Mr AAAAAAAA’s alleged damage to two teeth, namely the upper right first molar (recorded as tooth 16) and his lower right second molar (recorded as tooth 47). The damage detailed in these records cite fracture (denoted by the hash symbol) and causation being “eating cereal – chipped two teeth no pain”. The notes also reveal that the upper right molar appeared to have caries (tooth decay) beneath it and that the lower tooth had a ditched amalgam restoration.

Miss TTTTTTTT provided two dressings of GIC (Glass Ionomer Cement) to the teeth and advised that Mr AAAAAAAA return for further treatment.

Miss TTTTTTTT gave advice that the upper right first permanent molar (recorded as tooth 16) would require a dental crown (rather than a filling).

Mr AAAAAAAA’s subsequent appointment was for 65 minutes with Miss NNNNNN EEEEEEs on 14th August 2XXX in which she recorded that the upper right first permanent molar (recorded as tooth 16) was carious (i.e. decayed) and new dental fillings were required to the upper right first premolar and molar (teeth 14 & 16 respectively) and to the lower right second molar (tooth 47).

Miss TTTTTTTT provided the standard NHS “Personal Dental Treatment Plan” FP17DC and provided two fillings to the upper right jaw to the two teeth 14 & 16 as above.

Mr AAAAAAAA required standard local anaesthetic delivered by needle and syringe/dental cartridge for this treatment.

The FP17DC copy provided is dated 14/08/2XXX.
It was noted by Miss TTTTTTTT that the upper right first permanent molar (recorded as tooth 16) had deep caries (tooth decay) and required an extensive filling. Both teeth were filled with amalgam dental restorative material subsequent to having a lining of calcium hydroxide placed (detailed as “Life Lining”) which is standard operative dental technique.

This course of treatment was concluded with a subsequent appointment being recommended for 45 minutes duration.

The dental notes record that on 27/08/2XXX the appointment was cancelled with Miss Nicola EEEEEE. The notes neither detail who cancelled this appointment nor for what reason.

The notes record that a letter was sent 25th January 2XXX although this letter has not been copied through by way of disclosure.

The dental notes next record that on the 08/02/2XXX a diagnosis was apparently made. However, this is detailed solely in the archive of claims and is not recorded as a true patient note. I am unsure thus what the entry 8th February relates to.

In any event, Mr AAAAAAAA’s final appointment is documented on 11th February 2010 where he attended for a 40 minute appointment with Miss EEEEEE.

At this appointment, Miss EEEEEE performed a BPE (examination of Mr AAAAAAAA’s gums as detailed earlier) and completed her work to the lower right second permanent molar (recorded as tooth 47).

With regard to this tooth specifically, Miss EEEEEE’s notes record that the restorations present were removed and dental caries (tooth decay) was removed to the extent of being able to observe the tooth’s pulp. The pulp contains the nerve and blood supply of the tooth. A lining was placed and an amalgam placed, using a proprietary adhesive (Panavia) to enhance its retention and seal.

Mr AAAAAAAA required a standard local anaesthetic via needle and syringe/dental cartridge to enable his treatment.

At the same appointment, Mr AAAAAAAA also received cleaning and polishing and had complained of mobility to one of the front teeth. He received oral hygiene instruction in relation to his complaint.

It is not clear from the notes what recall interval has been set and the notes do not record any further visits from Mr AAAAAAAA to the dental surgery.

MEDICAL RECORDS

I was provided with copy of Mr AAAAAAAA’s medical records from his General Practitioners, the MMMMMM RRRR Health Centre. As detailed, this included records relating to incidents in which Mr AAAAAAAA required care on an outpatient basis at the Accident & Emergency department at SSSSS TTTTTTTT District Hospital.

The medical records were available to me in both paper copy and electronic format, the latter by way of CD ROM.

(A) PRIOR TO THE INCIDENT

Nothing of Note.

(B) SUBSEQUENT TO THE INCIDENT

Nothing of Note.
There is no mention in the medical notes of complaint to the dental structures, namely the jaws and teeth.

(2.3.2) **MEDICAL REPORTS**

No reports were available.

(3) **DISCUSSION AND OPINION**

Following the trauma, Mr AAAAAAAA suffered damage to two teeth as set out by his recollection of events and by the contemporaneous dental records.

Mr AAAAAAAA has retained the piece of material from the cereal he alleges caused the damage.

The teeth form a functioning unit and as such it is consistent that by chewing, similar forces will have been placed on both teeth simultaneously.

I am therefore of the opinion that Mr AAAAAAAA suffered damage to the teeth as a result of chewing.

Mr AAAAAAAA was examined by his dentist just a few weeks before the incident and the dentist records that radiographic examination at the time did not reveal any problems to these teeth. As a result, Mr AAAAAAAA did not require any dental treatment to these teeth prior to the incident.

It is noted that Mr AAAAAAAA had complained of food becoming trapped between teeth 47 and 48 and he received the correct opinion (given the negative findings of radiographic analysis by his dentist) that this was due to the tooth 47 drifting forward due to the loss of tooth 46. It is not clear that Mr AAAAAAAA received appropriate advice that the area needed to be cleaned more thoroughly but it is clear from the contemporaneous notes that a discussion took place. Mr AAAAAAAA was discharged for a routine examination set at six months.

Mr AAAAAAAA attended for his appointment promptly following the incident and both 16 and 47 teeth were dressed using a GIC restoration. This appointment lasted 30 minutes.

There was no supporting radiography or photography taken at the appointment.

As a consequence, Mr AAAAAAAA required two further appointments to receive treatment to these teeth, totalling 1 hour and fifty minutes. Mr AAAAAAAA received a written statement detailing aspects of his treatment. He required local anaesthetic in both treatment courses.

There was no supporting radiography or photography taken at either of these appointments.

The timeline in relation to the 16 and 47 teeth is thus:

**June 2XXX:** Examination and radiographic investigation. Nothing abnormally detected. Discharged for six months.

**July 2XXX:** Time of the incident: Teeth dressed

**August 2XXX:** Tooth 16 restored

**February 2XXX:** Tooth 47 restored

(4) **CONCLUSIONS**
(4.1) **SUMMARY OF DIAGNOSIS**

Mr AAAAAAAA required two replacement fillings as a direct consequence of the traumatic incident.

(4.2) **CAUSATION**

The contemporaneous dental notes evident record that both teeth were restored to an adequate standard and that appropriate investigations were taken by his dentist at the time of the investigation to substantiate this opinion. However, I have not been supplied with a copy of the radiography from this period and rely on the capacity of his dentist at the time, Mr TTTTTTTT.

The teeth damaged reside as posterior teeth (at the back of the mouth) and functionally are required to deal with greater occlusal masticatory (i.e. compressive) forces than anterior teeth (at the front of the mouth). This is due to the leverage force exerted by the masticatory muscles in relation to the mandibular hinge axis, the temperomandibular joint. A simple demonstration of this can be made by considering the chewing of a peanut, by which the rear teeth produce greater force than those at the front.

Chewing food introduces stresses to the natural crowns of teeth and once filled, the restorative material and the remains of the natural crown are thus stressed. As a general rule, chewing forces can vary between the types of food being eaten. For example, blancmange, being soft, requires little or no chewing force whereas nuts and grains require larger forces. Weetabix eaten as a breakfast cereal is softened by soaking it in liquid, usually milk, and the amount of liquid and the time it is exposed to the liquid affects its hardness. Mr AAAAAAAA prepared his cereal in the usual manner and chewed the food accordingly given its hardness when introduced to his mouth.

Mr AAAAAAAA was not aware of anything unusually hard within the cereal, and as a consequence, the material in the cereal did not prepare him in the usual manner. Two teeth suffered damage as a result of trauma.

(4.3) **PROGNOSIS**

The upper right first permanent molar requires further treatment as the restoration placed in August 2XXX is failing. Thus the tooth has a guarded prognosis.

The lower right second permanent molar requires further treatment as the restoration placed February 2XXX is failing. Thus the tooth has a guarded prognosis.

In terms of Mr AAAAAAAA’s own understanding of his dental health, he requires further education and advice as to how he can maintain his mouth to a higher standard. It is evident that he received advice with regard to the build up of dental deposits to his front teeth in February of this year, when he had complained of a tooth feeling loose. By his own admission, he does not use floss, mouthwash or interdental brushes.

(4.4) **TREATMENT REQUIRED**

1. Dental Public Health Education;
   This includes oral hygiene instruction and understanding the health benefits in reducing oral debris.

2. Dental Conservation;

Tooth 16:
Requires the existing amalgam and caries to be removed. Ideally a provisional restoration, such as GIC, should be placed to this tooth and following a reasonable period of convalescence to facilitate
healing (for example six months), the tooth requires a definitive restorative solution. This would be subject to radiographic assay (x-ray analysis) to confirm that the tooth roots have not become infected. If this is so, then at this opportunity, the tooth would require a root filling.

The definitive restoration of choice would be a gold alloy crown that would provide support to the natural tooth crown and the remains of the provisional restoration. The provisional restoration would not be removed, but prepared as part of the tooth as a resultant crown prep. If the gold alloy proves to be a cosmetic issue for Mr AAAAAAAA, he should receive a porcelain bonded to precious alloy crown. The porcelain would provide a good cosmetic match and the alloy substructure would reinforce the porcelain against fracture.

Despite the best intentions, treatment can be prone to failure. Given the condition of the tooth presently, it is not unforeseen that a root filling might be required and as such, the long-term prognosis of this tooth might be deemed poor. Success rates vary for many confounding reasons and for this reason, I have attached a memorandum submitted by the British Endodontic Society to the UK Parliament in respect of this issue (Highlighted textbox in Appendix E).

Should Mr AAAAAAAA suffer outright loss, he would be entitled to pursue definitive reconstruction using a dental implant system. He does not consume tobacco and as such, the prognosis of such a restoration would be good.

**Tooth 47:**
This requires root canal treatment to provide a root filling and the placement of a gold alloy crown to provide a ferrule against masticatory compression. The caveats regarding such treatment are detailed above

(4.5) **COSTS**

Mr AAAAAAAA has suffered damage to two teeth and has suffered loss, in terms of damage, pain, suffering and time required for treatment. He clearly required treatment, which at best is uncomfortable and required local anaesthetic injections and drilling.

Mr AAAAAAAA’s trauma and treatment will invariably have resulted in some general loss in his enjoyment of life, but the substantive nature of this is difficult to quantify with precision.

There is no evidence that the injuries have directly prevent him from continuing his employment.

To date, he has spent 2 hours and twenty minutes in treatment and this does not include the time required to get to and from the treatment centre and the impact this would have on his work.

Mr AAAAAAAA clearly requires further treatment and this may prove through the years to become vexed in terms of outcomes, thus convoluting treatment pathways further. It is therefore difficult to precisely state that Mr AAAAAAAA’s conditions will completely resolve as he may suffer eventual loss of these teeth requiring further complex reconstructive dental surgery.

With regard to initial treatment costs, I cannot assume that he will be entitled to NHS care, as the ability of practitioners to conclude the treatment set out varies across the dental profession. As such, Mr AAAAAAAA may require Specialist dental care performed by dental care providers given Specialist status by the General Dental Council. In all probability, this would result in Mr AAAAAAAA requiring non-NHS (i.e. “Private”) dental care.

Thus, future costs vary between Specialist care providers and the following is given as a simple guidance only:
1. Tooth 16:  
   GIC provisional restoration, examination and radiography £150  
   Crown placement, examination and radiography £400  
   Tooth extraction, implant placement and sundries £2500

2. Tooth 47:  
   Molar root canal treatment and radiography £600  
   Crown placement and radiography £400  
   Tooth extraction, implant placement and sundries £2500

(5) DECLARATION

I understand that my duty as an expert witness is to the court. I have complied with that duty. This report includes all matters relevant to the issues on which my expert evidence is given.

I have given details in this report of matters, which might affect the validity of this report.

I have addressed this report to the court.

I confirm I have used standard textbook evidence as follows:
   1. Oral Pathology; Soames & Southam; Oxford Medical 1989
   2. Dental Caries; Fejeskov & Kidd; Blackwell Munksgaard 2004
   4. Standards In Dentistry; Faculty of General Dental Practitioners 2006

I confirm that the evidence contained in Appendix E is available from the following website: http://www.publications.parliament.uk/pa/cm200708/cmselect/cmhealth/289/289we06.htm

I confirm that I have not entered into any arrangement where the amount or payment of my fees is in any way dependent on the outcome of the case.

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and that the opinions I have expressed represent my true and complete professional opinion.

Gokhan Baytug BDS (Liverpool 1992)  
Dental Surgeon
Appendix A: Disclosed Medical & Dental History
Appendix B: Clinical Charting
Appendix C: Contemporaneous Medical & Dental Records
Appendix D: Dental Images
Appendix E: British Endodontic Memorandum
NHS DENTAL AND ORTHODONTIC SERVICES

The British Endodontic Society (BES) welcomes the opportunity to submit evidence to the Health Select Committee inquiry into the new GDS and PDS contracts. Root canal treatment is a therapy aimed at preventing or treating apical periodontitis, a prevalent disease process caused by infection of the root canal system within a tooth. The complexity of root canal treatment varies from a straightforward single root canal to complicated molar teeth with four or five root canals. This is precise and fine work which requires time in order to achieve a quality result, the instruments are also costly and disposable. Many practitioners have made a significant investment in equipment (eg magnification loupes, microscopes, electronic devices to help measure the length of teeth, endodontic motors etc) in order to carry out this treatment to modern standards.

The dental health of our younger population has improved, however the restorative and endodontic needs of older adults are
likely to increase. This reflects the fact that people are retaining an increasing number of teeth for longer. In 1998, 50% of middle aged adults in the UK had teeth with fillings (Pine et al, 2000). There will be an ongoing need for complex restorative care of this aging population, despite a younger, healthier cohort following through. Future decennial surveys of adult dental health will be important in monitoring this trend.

The 2001 Health Committee report raised several important issues in regard to dental provision, including access to NHS Dentistry and the remuneration system. The introduction of the nGDS contract April 2006 saw significant changes in the way NHS dental services were commissioned. The British Endodontic Society is concerned that the introduction of the UDA monitoring system does not recognise the time, skill and expense of providing root canal therapy procedures.

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BACKGROUND, QUOTED FROM THE 2001 HEALTH COMMITTEE REPORT

"Para 27 under quality of care considered written evidence from one GDS dentisregarding details of the low success rate of NHS endodontic (root canal) treatment (10%), as measured against European radiographic standards. He noted additional costs to the service this sub-standard care imposed and discussed the reasons why it occurred, which he ascribed to the lack of time and the use of ineffective and outdated techniques and materials. His comment sums up the problems:

"What is required is more time and the use of adequate equipment that is inexpensive, neither of these can be funded by the very low NHS fees."

"Para 28. The DoH did not accept that there was hard evidence to suggest that the quality of NHS dentistry is not up to the standard they expect. They pointed to the regulatory system; the comprehensive inspections undertaken each year by the Dental Reference Service, and the introduction within the GDS of clinical governance and clinical audit. In response to the evidence quoted above, Dame Margaret Seward, the Chief Dental Officer, told us;"

"the report . . . actually was saying that the way the filling was put into the root canal failed against European endodontic standards and, as you quite rightly quoted, [the success rate] was 10%. What it did not actually say was that the whole root filling had failed, it was the way that the root canal had been filled with the material. As we call it. In the report it did admit that the technical quality of the root filling does not necessarily affect the outcome. There are a million canals rootfilled and we do not have great numbers of them failing."

THE BRITISH ENDODONTIC SOCIETY COMMENTS

We believe Dame Margaret is referring to the survival rate of teeth treated by root canal therapy in the NHS, such information has not been available until recently. Lumley, Lucarotti and Burke (submitted for publication) have demonstrated a 74% survival rate of teeth treated by root canal therapy in oGDS without any further intervention over a ten year period. This work demonstrates the value of such therapy to patients and the NHS. Although considerably higher than 10% this figure does remain 23% lower than survival rates reported through the Delta insurance scheme in the USA, an alternative remuneration system (Salehrabi R, Rotstein I. 2004).
All parties are concerned about quality of care and outcome for the patient. A GDS dentist in 2001 raised the issue of low fees in regard to root canal therapy which can be complex and time consuming to deliver. The nGDS contract has seen significant changes in the way dentists are remunerated moving from fee per item to a contract with a PCT monitored against a number of UDAs which are calculated from bands of treatment. Root canal therapy may be performed as part of a band 2 or band 3 course of treatment and is completed by definitive restoration of the crown of the tooth. In the current monitoring system the dentist receives the same number of UDA's for restoring the tooth regardless of whether a root canal filling has been placed or not. Root canal therapy involves preparation and disinfection of the root canal and placement of a root filling. This will normally take between 1/2 and 13/4 hours in routine cases depending on tooth position. More complex tooth anatomy and heavily infected teeth require more time. The British Endodontic Society suggest that this additional time and care is not recognised under the current UDA monitoring system.

This situation has been compounded by the recent introduction of single use instruments which places an additional financial burden on the nGDS dentist.

Many infected teeth can be retained by root canal therapy, the alternative way of rendering patients dentally fit is to eliminate pain and remove infection by extracting the tooth. The preliminary results of the dental treatment band analysis in England from April to July 2007 demonstrate that there has been a reduction in approximately 45% of adult courses of treatment that contain a root-filling episode from 2003-04 to 2007 and an increase in extractions.

The British Endodontic Society is concerned that the UDA monitoring system does not appear to recognise the placement of a root filling and that the introduction of single use instruments may result in teeth which could be reasonably saved being extracted. Extraction is a simpler procedure, takes less time and has the same recognition under the UDA monitoring system. Extraction of a tooth and replacement with a single tooth partial denture carries four times the recognition (12 as opposed to three UDA's), takes less time to deliver but does involve laboratory work.

In summary the British Endodontic Society requests the UDA monitoring system be reviewed in and modified in order to recognise the time and skill required to perform root canal therapy in nGDS to appropriate standards.
Ten year survival of root canal fillings in the general dental services in England and Wales. Lumley PJ, Lucarotti PSK and Burke FJT (submitted for publication)


Appendix F: curriculum vitae

Dr G Baytug BDS