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BEFORE THE
DENTAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: WILLIAM NIELSEN 3712-C Lone Tree Way Antioch, CA 94509 Dentist's License No. 23743 Oral Conscious Sedation Certificate Number 450 Respondent.	Case No. **DBC 2006-12** **ACCUSATION**

Complainant alleges:

PARTIES

1. Robert Hedrick (Complainant) brings this Accusation solely in his official capacity as the Executive Officer of the Dental Board of California, Department of Consumer Affairs.

2. On or about January 1, 1973, the Dental Board of California issued Dentist's License Number 23743 to William Nielsen (Respondent). The Dentist's License was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2007, unless renewed.

3. On or about September 12, 2001, the Dental Board of California issued Oral Conscious Sedation Certificate Number 450 to Respondent. The Oral Conscious Sedation Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2007, unless renewed.

JURISDICTION

4. This Accusation is brought before the Dental Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

5. Section 1670 states:

Any licentiate may have his license revoked or suspended or be reprimanded or be placed on probation by the board for unprofessional conduct, or incompetence, or gross negligence, or repeated acts of negligence in his or her profession, or for the issuance of a license by mistake, or for any other cause applicable to the licentiate provided in this chapter. The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the board shall have all the powers granted therein.

6. Section 1682 states:

"In addition to other acts constituting unprofessional conduct under this chapter [chapter 4 (commencing with section 1600)], it is unprofessional conduct for:

. . .

"(c) Any dentist with patients who are undergoing conscious sedation to fail to have these patients continuously monitored during the dental procedure with a pulse oximeter or similar or superior monitoring equipment required by the board.

. . .

"(e) Any dentist to fail to obtain the written informed consent of a patient prior to administering general anesthesia or conscious sedation. In the case of a minor, the consent shall be obtained from the child's parent or guardian."

7. Section 118, subdivision (b), of the Code provides that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

8. Section 125.3, subdivision (a), states, in pertinent part:

"Except as otherwise provided by law, in any order issued in resolution of a

disciplinary proceeding before any board within the department . . . the board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case."

FACTUAL BACKGROUND

9. On or about June 21, 2005, three-year old Patient R.C.[1] was taken to Respondent's office by his grandmother for dental work. R.C. was administered one teaspoon of noctec syrup (chloral hydrate) and one teaspoon hydroxyzine hydrochloride orally. R.C. spat out some of the medicine. Approximately 30 minutes later, R.C. fell asleep in his stroller, and was placed on a "papoose" board to immobilize him. R.C. was tightly wrapped on the papoose board and administered nitrous oxide and oxygen analgesia via a nasal mask. Topical anesthetic was applied by cotton swab to R.C.'s gum by dental assistant M.N. Respondent injected Septocaine (the brand name for articaine, a local anesthetic, not recommended for use with pediatric patients under the age of four). Approximately one minute later, R.C. became aroused and started crying, screaming, fighting and yelling. Respondent placed an unguarded mouth prop into R.C.'s mouth, and R.C. bit down on it hard, knocking out one of his teeth. Respondent placed a 4x4 piece of gauze to the area to blot dry the blood from the tooth. With the mouth prop in R.C.'s mouth, Respondent attempted to administer a palatal injection. R.C. continued to cry. Without removing the 4x4 gauze pad from R.C.'s mouth, Respondent used the "Hand over Mouth and Nose[2]"

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1. Patient initials are used herein for privacy. The patient's identifying information will be produced pursuant to a proper request for discovery.

2. Dental schools may have taught the "Hand Over Mouth and Nose" technique before 1988, during which the dentist gets the attention of an uncooperative child by gently covering his or her mouth and nose. However, the child's airway was not to be obstructed during the use of this technique. The Hand Over Mouth and Nose technique is anachronistic, and the teaching of the technique is no longer taught in dental schools. A modification of the technique, "Hand Over Mouth," in which the dentist lightly places his or her hand over the mouth of an uncooperative child, being sure not to obstruct or restrict the child's airway, is not taught in dental schools and has been removed from the guidelines of the American Academy of Pediatric Dentistry because it is rarely taught and not practiced by a significant number of dental practitioners.

technique in which he covered R.C.'s mouth and nose for approximately 30 seconds, impeding R.C.'s air supply. R.C. stopped crying, and Respondent administered additional anesthesia. Respondent noticed R.C. was not breathing, whereupon he sat R.C. upright, believing that R.C.'s tongue had fallen back, causing an airway obstruction. R.C. took one breath. Dental assistant P.R. applied a pulse oximeter to R.C., but was unable to find a pulse. Office Manager C.C. retrieved an oxygen tank and full face mask and assembled it for Respondent. Respondent initiated cardiopulmonary resuscitation (C.P.R.). R.C. was placed upright again, and he vomited. C.P.R. was continued, and Respondent instructed his staff to call 911.

Paramedics arrived and continued C.P.R., and transported R.C. to Sutter Delta Medical Center, where he was subsequently pronounced brain dead. R.C. died on June 22, 2005. The Coroner's Report indicated that a 4x4 gauze pad was lodged in the throat of R.C., and listed the cause of death as "anoxic encephalopathy due to asphyxia by combined smothering and gagging on gauze pad during dental procedure."

FIRST CAUSE FOR DISCIPLINE

(GROSS NEGLIGENCE)

10. Respondent is subject to disciplinary action under section 1670 in that he was grossly negligent when he:

a. Utilized the "Hand Over Mouth and Nose" technique on R.C., without first obtaining informed consent;

b. Failed to remove the 4x4 gauze pad from R.C.'s mouth before employing the Hand Over Mouth and Nose technique on R.C.; and

c. Failed to remove the 4x4 gauze pad from R.C.'s throat before initiating C.P.R.

SECOND CAUSE FOR DISCIPLINE

(REPEATED ACTS OF NEGLIGENCE)

11. Respondent is subject to disciplinary action under section 1670 in that he committed the following repeated acts of negligence:

a. Failing to recognize the signs and symptoms of cardiac and respiratory

failure;

b. Failing to provide adequate resuscitation;

c. In causing the patient's airway to be obstructed by failing to remove the 4x4 piece of gauze before employing the Hand Over Mouth and Nose technique;

d. In obstructing the patient's airway with the Hand Over Mouth and Nose technique;

e. In using an unprotected mouth prop and causing injury to the patient.

f. In tightly securing the immobilization device and obstructing the breathing of the patient;

g. In not using a neck and shoulder roll;

h. In failing to obtain informed consent for the Hand Over Mouth and Nose technique;

i. In failing to maintain adequate sedation records including pre- and post-operative instructions; and

j. In failing to exercise correct basic life support principles of airway visualization and airway management.

THIRD CAUSE FOR DISCIPLINE

(INCOMPETENCE)

12. Respondent is subject to disciplinary action under section 1670 in that he was incompetent:

a. In failing to recognize the signs and symptoms of cardiac and respiratory failure;

b. In failing to provide adequate resuscitation;

c. In causing the patient's airway to become obstructed with a 4x4 piece of gauze;

d. In obstructing the patient's airway with the Hand Over Mouth and Nose technique;

e. In using an unprotected mouth prop and causing injury to the patient.

f. In tightly securing the immobilization device and obstructing the breathing of the patient;

g. In not using a neck and shoulder roll;

h. In failing to obtain informed consent for the Hand Over Mouth and Nose technique;

i. In failing to maintain adequate sedation records including pre and post-operative instructions;

j. In failing to exercise correct basic life support principles of airway visualization and airway management;

k. In failing to identify alternative treatments;

l. In failing to identify risks specific to R.C.;

m. In failing to identify risks of the technique of oral conscious sedation used with R.C.;

n. In using unacceptable techniques of behavior management;

o. In failing to use correct basic life support and pediatric life support techniques, and

p. In using Septocaine on a three year old patient.

FOURTH CAUSE FOR DISCIPLINE

(USE OF CONSCIOUS SEDATION WITHOUT A PULSE OXIMETER)

13. Respondent is subject to disciplinary action under section 1682(c) in that he failed to have R.C., who underwent conscious sedation, continuously monitored during the dental procedure with a pulse oximeter or similar or superior monitoring equipment.

FIFTH CAUSE FOR DISCIPLINE

(FAILURE TO OBTAIN WRITTEN INFORMED CONSENT BEFORE CONSCIOUS SEDATION)

14. Respondent is subject to disciplinary action under section 1682(e) in that he failed to obtain the written informed consent of R.C.'s parent or guardian prior to administering conscious sedation.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Dental Board of California issue a decision:

1. Revoking or suspending Dentist's License Number 23743, issued to William Nielsen;

2. Ordering William Nielsen to pay the Dental Board of California the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 7/27/06

ROBERT HEDRICK
Executive Officer
Dental Board of California
Department of Consumer Affairs
State of California
Complainant

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