HEARING HEARD IN PUBLIC

GYOREV, Savcho

Registration No: 173888

PROFESSIONAL CONDUCT COMMITTEE

FEBRUARY 2012 – FEBRUARY 2014

Most recent outcome: Indefinite suspension

** See page 10 for the latest determination.

Savcho Borisov Gyorev a dentist; DDM Plovdiv 1994, was summoned to appear before the Professional Conduct Committee on 30 January 2012 for inquiry into the following charge:

Amended: 30 January 2012 and 31 January 2012

"That, being a registered dentist:

1. You were working at the Oasis Dental Practice, Caernarfon ("the Oasis Practice"), between the 1st October 2009 and the 18th November 2009.
2. In relation to Patient A, you provided inappropriate treatment planning in that:
   (a) at an appointment on the 2nd October 2009 you failed to consider the presence and extent of caries in the patient's mouth when you decided to place a crown on UL5;
   (b) you failed to test the vitality of UL5 before placing a crown on it.
3. In relation to Patient A, you provided inappropriate treatment in that:
   (a) at an appointment on the 10th November 2009 you put Coltosol around a tooth which had been prepared for a crown;
   (b) the use of Coltosol as a temporary crown material was unsuitable;
   (c) you failed to treat Patient A's caries.
4. In relation to Patient B, on the 1st October, 10th November and 13th November 2009 you failed to communicate adequately with the patient.
5. In relation to Patient A your record keeping was inadequate in that:
   (a) at an appointment on the 2nd October 2009 you failed to record a periodontal assessment/examination;
   (b) WITHDRAWN
   (c) you failed to record after care advice.
6. In relation to Patient B your record keeping was inadequate in that at an appointment on the 13th November 2009 you failed to record that the patient had left the surgery during an extraction procedure in an upset state.
7. You were working at the Wyndcott Dental Practice, 7 Victoria Square, Abedare ("the Wyndcott Practice") between the 29th March 2010 and the 22nd April 2010.

8. Whilst working at the Wyndcott Practice you did not communicate adequately with Patient C in that:

   (a) you saw Patient C for an emergency appointment on the 16th April 2010;

   (b) when asked by Patient C about some outstanding bridge work on her upper back right teeth you said you were not prepared to carry out the work but did not explain why.

9. Whilst working at the Wyndcott Practice you failed to take radiographs where appropriate in that you:

   (a) failed to take a radiograph during an appointment on the 30th March 2010 with Patient D;

   (b) failed to take a pre operative radiograph during an appointment on the 9th April 2010 with Patient E;

   (c) failed to take a post operative radiograph during an appointment on the 21st April 2010 with Patient F.

10. Whilst working at the Wyndcott Practice you provided an inadequate standard of treatment in that:

   (a) during an appointment on the 30th March 2010, with Patient D, you failed to diagnose chronic adult peridontal disease;

   (b) during the above appointment you made an incorrect BPE assessment;

   (c) WITHDRAWN;

   (d) during the above appointment you failed to anaesthetize the palatal aspect.

11. Whilst working at the Wyndcott Practice your record keeping was inadequate in that:

   (a) WITHDRAWN

      (i) WITHDRAWN;

      (ii) WITHDRAWN;

   (b) at appointments on the 6th and 9th April 2010, with Patient E, you failed to record:
      (i) WITHDRAWN;

      (ii) On 9th April 2010 whether consent was obtained;

      (iii) WITHDRAWN;

      (iv) On 6th April 2010 the dose and duration of the treatment course of Metronidazole;

      (v) On 9th April 2010 after care advice;

   (c) at an appointment on the 14th April 2010, with Patient G, you failed to record:

      (i) the dose, type and batch date of the anaesthesia used;

      (ii) the condition of the tooth being treated;

      (iii) WITHDRAWN;

      (iv) whether consent had been obtained;

      (v) any after care advice;

(d) at appointments on the 14th and/or 21st April 2010, with Patient F, you failed to record:

(i) WITHDRAWN;

(ii) whether consent was obtained;

(iii) after care advice;

(e) at an appointment on the 16th April 2010, with Patient C, you failed to record:

(i) whether the medical history had been checked;

(ii) a periodontal assessment/examination;

(iii) a diagnosis;

(iv) whether consent had been obtained.

12. You were working at the Fountain Dental Practice, 146-147 High Street, Merthyr Tydfil, ("the Fountain Practice") between the 4th May 2010 and the 8th June 2010.

13. Whilst working at the Fountain Practice your record keeping was inadequate in that:

(a) at an appointment on the 25th May 2010, with Patient H, you failed to record:

(i) WITHDRAWN;

(ii) if a local anaesthetic was used to prepare two teeth for crowns;

(iii) WITHDRAWN;

(iv) whether provisional crowns were placed on UL1 and UL2;

(b) at an appointment on the 2nd June, with Patient I, you failed to record:

(i) a periodontal assessment/examination;

(ii) an intra-oral soft tissue assessment/examination;

(iii) the patient's consent for treatment;

(iv) if a local anaesthetic was used to repair LR5;

(v) WITHDRAWN;

(vi) after care advice;

(c) at an appointment on the 7th June, with Patient J, you failed to record:

(i) the information provided to the patient to decide upon an extraction;

(ii) if consent was obtained;

(iii) if a local anaesthetic was used to extract LR6;

(iv) post operative advice;

(d) at an appointment on 8th June 2010, with Patient K, you failed to record:

(i) WITHDRAWN;

(ii) a periodontal assessment/examination.

And by reason of the facts alleged your fitness to practice is impaired by reason of your misconduct."

Mr Gyorev was not present and was not represented. On 1 February 2012 the Chairman announced the findings of fact to the Counsel for the GDC:

"Ms Norton

Mr Gyorev is neither present nor is he represented at this hearing. The Committee determined that all reasonable efforts had been made to inform him of the hearing, that he was aware of it and that he had chosen not to attend. The Committee determined that it was reasonable to proceed in Mr Gyorev's absence, but it was mindful that he has not present to challenge the charges against him.

The Committee heard oral evidence from three patients, Patients B, C and G, all of whom the Committee found to be credible. It felt able to rely upon their account of events. The Committee was also referred to the dental notes of the various patients referred to in the charges. The Committee felt unable to rely in its entirety upon the expert evidence of Dr Robinson. In some respects Dr Robinson's criticisms seemed to be based upon what he regarded as the ideal standard. The Committee has to consider these charges in the light of the standards that would be applied by the reasonable, competent dentist.

The Committee has taken into account all the evidence presented to it and has assessed the Patient notes carefully. It has accepted the advice of the Legal Adviser. In accordance with that advice it has considered each head of charge separately.

I will now announce the Committee's findings in relation to each head of charge:

1	Proved.
2 (a)	Proved.
2 (b)	Not proved. There is no evidence that Mr Gyorev did not test the vitality of UL5. The notes are silent on the issue.
3 (a)	Proved.
3 (b)	Proved. The Committee, using its own professional expertise in conjunction with the expert evidence, found that this material was inappropriate.
3 (c)	Proved. Mr Gyorev's diagnosis was inadequate, therefore the general caries were insufficiently treated.
4	Proved. The Committee accepted the evidence of Patient B on this matter.
5 (a)	Proved.
5 (c)	Proved. No advice was recorded in the notes. A record of advice is required, in accordance with Faculty of General Dental Practitioners guidelines.
6	Proved. The fact that Patient B was very distressed during the appointment would be relevant to any subsequent treating dentist and Mr Gyorev should have recorded this in the notes.
7	Proved.
8 (a)	Proved.
8 (b)	Proved. The Committee accepts the evidence of Patient C on this matter.
9 (a)	Proved. It had been two years since the patient had had a bitewing radiograph. Such a radiograph should have been carried out or, at least, arranged and recorded in the notes.

9 (b)	Not proved. It was not necessarily appropriate, and perhaps excessive, to take a radiograph in these circumstances.
9 (c)	Proved. It is a standard requirement to take a radiograph in these circumstances.
10 (a)	Proved.
10 (b)	Proved. A different assessment was made the following day which was more consistent with earlier and later assessments by different dentists.
10 (d)	Not proved. Although the notes do not record a reference to a palatal anaesthetic, the Committee was not prepared to regard that omission as establishing that an anaesthetic had not been administered. Dr Robinson agreed that the probability was that, if an anaesthetic had not been administered, the Patient would have been in acute pain, so that the procedure would have been very difficult, if not impossible.
11 (b) (ii)	Proved.
11 (b) (iv)	Proved.
11 (b) (v)	Proved.
11 (c) (i)	Proved. It is a legal requirement to record these details.
11 (c) (ii)	Not proved.
11 (c) (iv)	Proved.
11 (c) (v)	Proved. The Committee accepts the evidence of Patient G that no after care advice was given and therefore it was not recorded.
11 (d) (ii)	Proved.
11 (d) (iii)	Proved.
11 (e) (i)	Proved.
11 (e) (ii)	Proved. Despite the fact that the patient considered this to be an emergency appointment, Mr Gyorev carried out a scale and polish at this appointment. The justification for this should have been recorded by means of a BPE record.
11 (e) (iii)	Not proved. The Committee considers that a diagnosis was in fact recorded in the notes.
11 (e) (iv)	Proved.
12	Proved.
13 (a) (ii)	Proved.
13 (a) (iv)	Proved.
13 (b) (i)	Proved.
13 (b) (ii)	Proved.
13 (b) (iii)	Proved.
13 (b) (iv)	Proved.

13 (b) (vi)	Not proved. It was not necessary to record after care advice in the circumstances of a routine filling.
13 (c) (i)	Not proved. The Committee considers that the information recorded in the notes is adequate in this case.
13 (c) (ii)	Proved.
13 (c) (iii)	Proved.
13 (c) (iv)	Proved.
13 (d) (ii)	Not proved. The Committee could not be satisfied on the balance of probabilities that the patient saw Mr Gyorev or whether this was an emergency appointment, where a BPE would not normally be required.

Heads of Charge 5(b), 10(c), 11(a)(i), 11(a)(ii), 11(b)(i), 11(b)(iii), 11(c)(iii), 11(d)(i), 13(a)(i), 13(a)(iii), 13(b)(v) and 13(d)(i) were withdrawn.

We move to Stage Two."

On 1 February 2012 the Chairman announced the determination as follows:

"Ms Norton

The Committee has considered all of the information before it, including the submissions you have made on behalf of the General Dental Council (GDC). It has accepted the advice of the Legal Adviser.

The allegations against Mr Gyorev concern his practice in relation to 11 patients, treated at three dental practices in Wales between October 2009 and June 2010: the Oasis Dental Practice, Caernarfon, the Wyndcott Dental Practice, 7 Victoria Square, Aberdare and the Fountain Dental Practice, 146-147 High Street, Merthyr Tydfil. The Committee found allegations proved in respect of ten patients.

The Committee has found numerous failings, many repetitive, in Mr Gyorev's clinical practice. These failings included poor communication with patients, failing to obtain the informed consent to treatment and failing to make satisfactory assessment of patients' condition. They also included poor treatment planning, poor treatment and failing to maintain satisfactory records. In respect of the last matter, there was a pattern of omission which was worrying.

Relevant provisions from *Standards for Dental Professionals,* include the following requirements that dentists should:

1.4 Make and keep accurate and complete patient records including a medical history, at the time you treat them. Make sure that patients have easy access to their records.

2.4 Listen to patients and give them the information they need, in a way they can use, so that they can make decisions. This will include:

- communicating effectively with patients;
- explaining options (including risks and benefits); and
- giving full information on proposed treatment and possible costs.

Principles of Patient Consent, the guidance issued by the GDC relating specifically to patient consent, advises dentists that:

1.2 You should give patients the information they want and need, in a way they can use, so that they are able to make informed decisions about their care.

The lapses identified were not all of the most serious kind when viewed in isolation. However, the Committee was concerned that Mr Gyorev's deficiencies spanned three different practices, and occurred in a remarkably compressed space of time. The failings were often similar in nature. They could not be regarded simply as individual events.

The three patients who gave oral evidence to the Committee told the Committee, in their various ways, that their experience of being treated by Mr Gyorev had left them feeling very uneasy. The Committee was satisfied that his behaviour fell far short of that which is expected from dentists and represented consistent and sustained underperformance. The Committee had no difficulty in concluding that Mr Gyorev's various departures from good practice and mandatory standards amounted to misconduct.

The Committee next considered whether Mr Gyorev's fitness to practise is impaired by reason of his misconduct. The Committee considered that, whilst Mr Gyorev's conduct is capable of remedy, he has failed to engage at all with either the NHS or the GDC in respect of these matters. He has therefore demonstrated no insight and offered no evidence to suggest that he has remedied his failings. The Committee considered that there was a high likelihood of Mr Gyorev repeating his misconduct. The Committee therefore determined that Mr Gyorev's fitness to practise is impaired by reason of his misconduct.

In considering sanction, the Committee considered that it would be inappropriate to conclude this case with no order and that a reprimand would be an insufficient sanction.

The Committee went on to consider whether conditions could be imposed which would protect the public. However it was mindful that conditions must be measurable, relevant, achievable and workable. Mr Gyorev was suspended from the Performers List by the local Health Board on 7 December 2010. He was offered a contingent removal on 10 December 2010. His presence on the list was made conditional upon compliance with conditions relating to his retraining and supervision. He failed to comply with these conditions or to undertake retraining and emigrated to the USA. He is now the subject of a national disqualification.

In the light of this history, his non-appearance before this Committee and his failure to engage with the GDC, it cannot be said that conditions would be workable.

The Committee went on to consider the sanction of suspension. It concluded that this sanction was appropriate. It is sufficiently serious to bring home to Mr Gyorev the need to improve his practice and will protect the public. The Committee believed that this was the appropriate response to the various failings which have been found.

The period of suspension should be one of twelve months and there should be a review before the end of that period.

The interim suspension order currently applying to Mr Gyorev's name is hereby revoked.

The Committee is minded to consider imposing an order for Mr Gyorev's immediate suspension from the Dentists Register, but first invites your submissions on this matter.

The Committee has determined that it is necessary for the protection of the public and otherwise in the public interest that Mr Gyorev's name is suspended with immediate effect.

The effect of the foregoing direction and order is that the name of Savcho Borisov Gyorev is suspended from the Dentists Register from when notice of this decision is deemed to have been served upon him and, unless he exercises his right of appeal, his name will be suspended for a further twelve months after 28 days have elapsed.

That concludes the case."

At a review hearing on 25 February 2013, the Chairman announced the determination as follows:

"Ms Bruce,

The Committee has carefully considered the documents placed before it, and has accepted the advice of the Legal Adviser.

Mr Gyorev is neither present nor represented today. On behalf of the General Dental Council (GDC) you made an application to proceed in his absence. The Committee has been referred to *'The General Dental Council (Fitness to Practise) Rules Order of Council 2006'* (the Rules), in particular Rule 54.

The Committee is satisfied that all reasonable steps have been taken by the Council to effect service. Letters containing notification of this hearing were sent to Mr Gyorev on 14 February 2012, 19 July 2012, 20 September 2012 and 22 January 2013. These were sent to his last known registered address in the USA. The letters were sent using an international signed-for service and also by e-mail using an address previously provided by the registrant. There is no evidence that the letters sent by international mail were delivered and signed for, however the Committee noted that the e-mail did not produce a 'failure to deliver' reply. The Committee noted that details of this hearing were sent to Mr Gyorev more than 28 days prior to this hearing.

In line with Rule 54, the Committee is satisfied that all reasonable efforts have been made to serve the notice of review. The Committee is aware of the fact that if this hearing did not go ahead today it would not be possible to re-list the matter before the expiry of the order and comply with the 28 day rule of notice. The Committee considered that an adjournment would be unlikely to secure the attendance of Mr Gyorev given his failure to engage at any stage of the regulatory process. The Committee was of the view that Mr Gyorev has voluntarily absented himself from these proceedings and determined that it is in the interests of justice to proceed in Mr Gyorev's absence.

This is a resumed hearing held pursuant to Section 27(C) of the Dentists Act 1984 (as amended) (the Act). On 1 February 2012 a Professional Conduct Committee of the GDC found facts proved in relation to a wide range of clinical failings relating to ten patients covering three separate dental practices across a period of approximately eight months. The previous Committee found numerous failings, many repetitive, in Mr Gyorev's clinical practice. These failings included poor communication with patients, failing to obtain the informed consent to treatment and failing to make satisfactory assessment of patients' condition. They also included poor treatment planning, poor treatment and failing to maintain satisfactory records.

These facts were found to amount to misconduct and his fitness to practise was found to be impaired. A suspension order was imposed on Mr Gyorev's registration for a period of 12 months. This Committee is convened to review that order.

The Committee has reviewed Mr Gyorev's case and considered whether his fitness to practise remains impaired and whether any sanction continues to be necessary. It has taken

into account all the documents presented to it and the submissions made by you on behalf of the GDC.

You invited the Committee to extend the period of the suspension order for a further 12 months. You submitted that there had been no contact with or from Mr Gyorev since the imposition of the suspension order.

The Committee found that there was nothing to suggest that the failures identified in the last hearing have been remedied, or that Mr Gyorev has any insight into his actions and the serious implications that they have for patients and the public. It noted that the facts found proved were serious and wide-ranging, and they are capable of damaging the trust patients are entitled to have in the dental profession. Mr Gyorev has not provided any evidence of remorse or a willingness to address his deficiencies. In the absence of any evidence that Mr Gyorev's clinical skills have improved, the Committee finds that his fitness to practise remains currently impaired.

The Committee first considered whether to lift the suspension order and take no further action. It determined that Mr Gyorev's clinical and professional failings have not been remedied and the risks to the public identified at the last hearing remain a matter of serious concern. The Committee determined that it would not be appropriate to lift the suspension order currently in place.

The Committee next considered whether replacing the suspension order with conditions would be sufficient for public protection. It noted that no conditions could be formed that would be workable, practicable and measurable so as to adequately protect the safety of patients and preserve public confidence in the profession. In any event, Mr Gyorev's lack of engagement means that his compliance with conditions could not be assured.

The Committee then considered whether continuing the period of the suspension order would be appropriate and proportionate in all the circumstances of this case. Mr Gyorev has not provided the Committee with any evidence of remediation or insight into his failings. He has not engaged with these regulatory proceedings. In fact, there has been no contact of any kind.

In light of the above, the Committee concludes that Mr Gyorev remains a real risk to patients and to the reputation of the dental profession. It determined that the only proportionate and appropriate sanction is an order for a further period of suspension. This is necessary for the protection of the public and is in public interest in the light of the seriousness of Mr Gyorev's failings and his lack of engagement. The registration of Savcho Borisov Gyorev will therefore be suspended for 12 months commencing upon expiry of the current period of suspension. This order will be reviewed before the end of the 12 month period."

At a review hearing on 17 February 2014 the Chairman announced the determination as follows:

"Mr Warrington

This is a resumed hearing pursuant to Section 27C of the Dentists Act 1984 (as amended).

The Committee has considered all the information before it, including the submissions you have made on behalf of the General Dental Council (GDC). It has accepted the advice of the Legal Adviser.

Mr Gyorev was neither present nor was he represented at today's hearing. The Committee was satisfied on the basis of the documents put before it that service had been effected in accordance with the rules.

You drew the Committee's attention to the extensive history of Mr Gyorev failing to engage with the GDC's investigations and his non attendance at the associated hearings. The Committee heard that the last communication the GDC received from Mr Gyorev was an email he sent in April 2011 indicating that he did not wish to attend an Interim Orders Committee meeting due to take place the same month. In light of this history, the Committee considered that there would be nothing to be gained by adjourning the case today as Mr Gyorev appears to have voluntarily disengaged entirely from proceedings. It therefore determined that it was fair and appropriate to proceed with this resumed hearing in his absence.

On 1 February 2012 a Professional Conduct Committee of the GDC found facts proved in relation to a wide range of clinical failings relating to ten patients covering three separate dental practices across a period of approximately eight months. That Committee found numerous failings, many repetitive, in Mr Gyorev's clinical practice. These failings included poor communication with patients, failing to obtain the informed consent to treatment and failing to make satisfactory assessment of patients' condition. They also included poor treatment planning, poor treatment and failing to maintain satisfactory records.

These facts were found to amount to misconduct and his fitness to practise was found to be impaired. An immediate suspension order was imposed on 1 February 2012 suspending Mr Gyorev's registration for a period of 12 months.

A Committee convened on 25 February 2013 to review the order for suspension which had been imposed at the previous hearing. Mr Gyorev failed to attend this hearing. That Committee did not have the benefit of any information to suggest that Mr Gyorev's practice had improved in any way. It found that there was nothing to suggest that the failures identified at the previous hearing had been remedied, or that Mr Gyorev had any insight into his actions or the serious implications that they had for patients and the public. In the absence of any evidence of an improvement in the situation, the Committee found that Mr Gyorev's fitness to practise remained impaired at that point and determined that an order for suspension remained appropriate. The Committee of February 2013 therefore extended the period of suspension by a further period of 12 months.

Today the Committee has heard that in late 2012 and early 2013 Mr Gyorev was written to by the Case Review Team. The team were inviting Mr Gyorev to apply for voluntary removal from the Register in light of his on-going non-engagement. The team has not received any reply to these invitations. Otherwise, the Committee has heard that the situation has remained materially unchanged since the last resumption of the hearing. In the circumstances you invited the Committee to suspend indefinitely Mr Gyorev's name from the Register.

The Committee considered that in light of Mr Gyorev's continued non-engagement, it has no evidence that could satisfy it that any of the failures identified by previous Committees have been in any way ameliorated. The Committee therefore determined that Mr Gyorev's fitness to practise remains impaired.

The Committee further considered that the risk that Mr Gyorev continues to pose necessitates the continuation of the order for suspension. It considered that Mr Gyorev's wholesale lack of engagement means that it is appropriate at this point that the suspension is imposed indefinitely, as further annual reviews are neither in the public interest nor Mr Gyorev's interests.

The effect of the foregoing direction and order is that Mr Gyorev's name is hereby suspended indefinitely.

Mr Gyorev has 28 days from when notice of this decision is deemed served upon him to make an appeal.

That concludes the case."