General Dental Council | protecting patients, regulating the dental team

HEARING HEARD IN PUBLIC

SANTA, Ivan

Registration No: 116026

PROFESSIONAL CONDUCT COMMITTEE

OCTOBER 2018 - NOVEMBER 2020*

Most recent outcome: Suspended Indefinitely

***See page 15 for the latest determination**

Ivan SANTA, a dentist, DMD Semmelweis University 2004, was summoned to appear before the Professional Conduct Committee on 23 October 2018 for an inquiry into the following charge:

Charge

"That being a registered dentist:

1. On 23rd September 2015, you put Patient A's safety at risk in that you provided an amount of local anaesthetic that was in excess of the maximum recommended dose within the manufacturer's guidance.
2. On 27th October 2016, you failed to:
    a. adequately communicate a change in the treatment plan to Patient A;
    b. obtain informed consent from Patient A for treatment to the upper jaw.
3. Between 29th January 2015 and 27th October 2016, you failed to maintain an adequate standard of record keeping in respect of Patient A's appointments, in that:
    a. You did not record details of any clinical examination;
    b. You did not record discussion with Patient A regarding changed in the treatment plan;
    c. You did not record any discussion indicating that you obtained informed consent;
    d. You did not report upon CBCT scans or DBT radiographs, in accordance with the Ionising Radiation Medical Exposure Regulations (IRMER).
4. You failed to make arrangements for the continuity of Patient A's care following your departure from the Practice.
5. You failed to respond adequately to Patient A's complaint regarding his dental treatment.

And that, in consequence of the matters set out above, your fitness to practise is impaired by reason of your misconduct."

Mr Santa was not present and was not represented. On 24 October 2018 the Chairman announced the findings of fact to the Counsel for the GDC:

"This is the Professional Conduct Committee's inquiry into the facts which form the basis of the allegations against Mr Santa that his fitness to practise is impaired by reason of misconduct.

Mr Santa was neither present nor represented in this hearing. Mr Thomas, Counsel and Case Presenter for the General Dental Council's (GDC) case, made an application under Rule 54 of the General Dental Council (Fitness to Practise) Rules 2006 ("the Rules") that the hearing should proceed in Mr Santa's absence. He submitted that the notification of hearing had been served on Mr Santa in accordance with Rules 13 and 65 and that the committee could exercise its discretion to proceed with the hearing.

Decision on service of notification of hearing

The Committee had before it a copy of the notification of hearing letter dated 11 September 2018 which was sent by special delivery and email to Mr Santa's registered address as it appears in the Dentists Register. It was satisfied that the letter contained all the components necessary for a notice of hearing to be valid in accordance with Rule 13. The Committee noted the Royal Mail track and trace report which showed that the letter was returned as it was considered by the German postal service to be incorrectly addressed. The notice of hearing was also sent to Mr Santa via email to an email address which Mr Santa had used to corresponded with the GDC in relation to the investigation of the matters now before the Committee. Having accepted the advice of the Legal Adviser, the Committee was satisfied that the notification of hearing had been served in accordance with Rules 13 and 65.

Decision on proceeding in the Registrant's absence

Mr Thomas then made an application under Rule 54 that the hearing should proceed in Mr Santa's absence. The Committee bore in mind that its discretion to proceed with a hearing in these circumstances should be exercised with the utmost care and caution. It took account of Mr Thomas' submissions and it accepted the advice of the Legal Adviser.

The Committee noted that there was no information from Mr Santa before it in relation to this hearing. Mr Thomas informed the Committee that Mr Santa had not engaged with the GDC since May 2017. The Committee found all reasonable efforts had been made to send notification of the hearing to Mr Santa. There was no request from Mr Santa for an adjournment of the hearing. In considering whether to adjourn the Committee had regard to the public interest in the expeditious disposal of this case, the potential inconvenience to the witnesses called to attend this hearing and fairness to Mr Santa. The Committee was of the view that adjournment was unlikely to secure Mr Santa's attendance at a future hearing given that he has not engaged with these proceedings at all and was satisfied there was no good reason to inconvenience witnesses. For all these reasons the Committee determined to proceed with the hearing in Mr Santa's absence having regard to the public interest in the expeditious disposal of cases.

Background

On 20 December 2016, the GDC received a complaint from Patient A regarding implant treatment undertaken by Mr Santa at the Tracey Bell Clinic ("the Practice") in 2015 and 2016. Patient A underwent a course of treatment which was to include removal of upper and lower teeth, sinus lift and bone augmentation, placement of eight implants, bridges and sandwich veneers on lower teeth. This treatment was incomplete at the time Mr Santa left the Practice, albeit Patient A had paid £17,000 of a £22,000 account. The concerns raised by Patient A included that: (i) only four implants had been placed in his upper jaw, rather

than six as per the treatment plan; (ii) the sinus lift was only partially done and only on one side; and (iii) the implants placed were badly done, and some not into bone. Patient A also stated that he had not received an adequate response when he complained about his treatment.

Witnesses

The Committee received a witness statement dated 18 May 2018 from Patient A. The Committee found Patient A to be a credible witness and accepted his evidence. It considered that Patient A was honest and that his oral evidence was consistent with his statement.

The Committee received a report dated 16 May 2018 from Professor Brook, expert witness for the GDC. His written report and oral evidence were clear. The Committee accepted his evidence and considered that he provided a careful and thorough analysis of the available evidence and presented fair and balanced opinions.

The Committee took account of all the oral and documentary evidence presented in this hearing. It considered the submissions made by Mr Thomas. The Committee drew no adverse inferences from Mr Santa's absence.

In considering the allegations against Mr Santa the Committee relied on the following evidence –

- Written and oral evidence of Patient A
- The dental records for Patient A from Tracey Bell Clinic
- Written and oral evidence of the expert witness, Professor Brook

The Committee accepted the advice of the Legal Adviser. In accordance with that advice it considered each head and sub-head of charge separately.

The burden of proving the facts alleged is on the General Dental Council (GDC) and the standard of proof is the civil standard which is "on the balance of probabilities". Mr Santa is not required to prove anything.

The Committee's findings in relation to each head and sub-head of charge are as follows:

1.	On 23 September 2015, you put Patient A's safety at risk in that you provided an amount of local anaesthetic that was in excess of the maximum recommended dose within the manufacturer's guidance. **Found Proved** The Committee had sight of Patient A's records. It noted an entry made by Mr Santa on 23 September 2015 stating that 12 cartridges of the local anaesthetic (Articaine) at a 4% concentration were used. The Committee also had sight of the manufacturer's guidance appended to Professor Brook's expert report which indicated that the recommended dosage is no more than 440mg or 5 cartridges. Professor Brook informed the Committee during his evidence that by his calculation, if all 12 cartridges had been used the dosage would amount to a total of 1056mg. Professor Brook acknowledged that it was not possible to ascertain whether all the local anaesthetic within the cartridges was used. The Committee accepted the evidence of Professor Brook and took

	the view that even if only half of the local anaesthetic was used, which Professor Brook considered unlikely, it would still have amounted to more than the manufacturer's recommended maximum dosage. The Committee concluded that Mr Santa, having removed sixteen teeth from all four quadrants in a single appointment and having recorded that he used 12 cartridges it is more likely than not that he had exceeded the manufacturer's maximum recommended dosage. The Committee accepted the evidence of Professor Brook that the toxic effects of exceeding the manufacturer's maximum recommended dosage of local anaesthetic included potential respiratory depression and cardiovascular collapse. The Committee was satisfied that by exceeding the maximum recommended dose Mr Santa put Patient A at risk of harm.
2.	On 27 October 2016, you failed to: a. adequately communicate a change in the treatment plan to Patient A; b. obtain informed consent from Patient A for treatment to the upper jaw. **Found Proved** The Committee had sight of Patient A's records and noted that on 29 January 2015 there was an appointment between Mr Santa and Patient A. Within the records was a treatment plan that was agreed and signed by Patient A. Part of the treatment plan detailed treatment for 6 implants for the upper jaw. The Committee accepted Patient A's evidence. He stated that at the time he underwent surgery he believed that the treatment plan was being adhered to. In fact, as the notes and radiographs show, Mr Santa fitted only four implants in the upper jaw rather than six. He informed the Committee that he first became aware that he had only four implants when he returned to the practice some four weeks after surgery. The Committee accepted Mr Santa had said nothing to him about changing the treatment plan. The Committee accepted Professor Brook's evidence that informed consent requires a dentist to inform the patient of the advantages and disadvantages of alternative treatment options. As the Committee found that Mr Santa failed to communicate any changes to the treatment plan, the Committee was satisfied that informed consent could not have been obtained and was not obtained. Accordingly, the Committee finds this charge proved in its entirety.
3.	Between 29th January 2015 and 27th October 2016, you failed to maintain an adequate standard of record keeping in respect of Patient A's appointments, in that: a. You did not record details of any clinical examination; **Found Proved**

	The Committee had regard to the Standards for Dental Professionals, Standard 4.1.1 which states: *"You must make and keep complete and accurate patient records, including an up-to-date medical history, each time that you treat patients… "* The Committee was satisfied there is a clear duty for Mr Santa to maintain an adequate standard of record keeping and record the details of his clinical examinations of Patient A. The Committee had regard to Professor Brook's expert report which stated that a clinical examination should have been undertaken by Mr Santa at two points; (i) before the extractions and (ii) before the implants were placed. The Committee accepted Professor Brook's opinion that Mr Santa performed both these examinations given the treatment plan and subsequent treatment that was provided. The Committee had sight of Patient A's records and noted that there was no evidence of any records of a clinical examination on either of those occasions. Accordingly, this charge is found proved.
	b. You did not record discussion with Patient A regarding changes in the treatment plan; c. You did not record any discussion indicating that you obtained informed consent; **Found Not Proved** In light of the Committee's findings in charge 2 above, that no discussions took place between Mr Santa and Patient A, there would be nothing to record within the notes.
	d. You did not report upon CBCT scans or DPT radiographs, in accordance with the Ionising Radiation Medical Exposure Regulations (IRMER). **Found Proved** The Committee had sight of the CBCT scans and radiographs within Patient A's records. However, it noted that there is no reference to them in Patient A's records. The Committee accepted Professor Brook's evidence that the radiographs and CBCT scans should have been reported on by Mr Santa in accordance with the regulations. Accordingly, this charge is found proved.
4.	You failed to make arrangements for the continuity of Patient A's care following your departure from the Practice. **Found Not Proved** The Committee had regard to all the evidence. The Committee noted that Patient A was unaware of any arrangements being in place for the continuity of his care and attended the Practice on 22 November 2016 feeling *'confused'* and *'frustrated'*. However, there is no positive evidence as to whether Mr Santa did or did not make any such arrangements. The

	Committee concluded that it would not be appropriate to draw an adverse inference in the absence of any evidence from the Practice. In all the circumstances of this case the Committee finds that the GDC failed to discharge the burden of proof in relation to this matter.
5.	You failed to respond adequately to Patient A's complaint regarding his dental treatment. **Found Proved** The Committee had regard to the Standards for Dental Professionals, Standard 5.1.1 which states: *"It is part of your responsibility as a dental professional to deal with complaints properly and professionally. You must:* • *Ensure that there is an effective written complaints procedure where you work;* • *Follow the complaints procedure at all times;* • *Respond to complaints within the time limits set out in the procedure; and* • *Provide a constructive response to the complaint.* The Committee was satisfied there is a clear duty for dentists to deal with complaints properly and professionally. The Committee had regard to Patient A's evidence. He told the Committee that he emailed Mr Santa expecting an explanation for the dental treatment that was provided to him but has to date still not received any constructive response. Patient A's evidence is supported by the emails between Mr Santa and the Practice, where Mr Santa was asked on more than one occasion to respond to Patient A's concerns. The Committee determined that there was an inadequate response to Patient A's complaint and therefore finds this charge proved.

We move to Stage Two."

On 25 October 2018 the Chairman announced the determination as follows:

"The Committee took account of the submissions made by Mr Thomas on behalf of the General Dental Council (GDC). It accepted the advice of the Legal Adviser.

Decision on Misconduct

The Committee bore in mind that its decisions on misconduct and impairment are matters for its own independent judgement. There is no burden or standard of proof at this stage of the proceedings. Mr Thomas referred the Committee to the cases of *Roylance (no 2) v General Medical Council* [2000] 1 AC 311). He outlined the specific GDC standards, which in his submission, have been breached. He invited the Committee to conclude that the facts found proved are serious and amount to misconduct.

The Committee found proved that Mr Santa put Patient A's safety at risk in that he provided an amount of local anaesthetic that was in excess of the maximum recommended dose

within the manufacturer's guidance. He also failed to adequately communicate to Patient A a change in the treatment plan, failed to obtain informed consent, failed to keep adequate records and failed to adequately respond to Patient A's complaint regarding his dental treatment.

Professor Brook was of the opinion that all of these failings fell far below the standard of a reasonably competent practitioner.

Local anaesthetic

In relation to charge 1 Professor Brook stated that the potential harm to Patient A was significant and included the risk of a serious impact upon his wellbeing. The Committee found that Mr Santa exceeded the maximum safe dose by a substantial margin and the potential consequences according to Professor Brook were severe in that: *"Toxic effects of Articaine or Lignocaine type local anaesthetic agents can be serious and life threatening they include – at low blood levels primarily neurologic signs manifest as light-headedness, slurred speech, mood alteration, diplopia, sensory disturbances, disorientation, muscle twitching; higher blood levels may result in tremors, respiratory depression, tonic - colonic seizures and can result in coma, respiratory arrest and cardiovascular collapse."* The Committee accepted Professor's Brook's opinion that Mr Santa put Patient A at serious risk of harm and that as a consequence his standard of care fell far below the standard expected.

Change in treatment plan/informed consent

In relation to charge 2, Mr Santa's failure to communicate the change in the treatment plan impacted upon Patient A in that he was deprived of the opportunity to provide informed consent. The Committee considered the change to the treatment plan (six to four implants being placed) to be significant as it represented a substantial change and contradicted Mr Santa's previous advice to Patient A that an 'all on four' would be unsuitable. Professor Brook described the change in the treatment plan as *'a potential assault'.* The Committee accepted Professor Brook's opinion that both limbs of the charge taken together fall far below the standard expected.

Record Keeping

The Committee noted that record keeping failures are not always sufficiently serious to amount to misconduct. The Committee had regard for Professor Brook's evidence that the record keeping failures in this case were serious. The lack of examination records made it difficult for subsequent dentists to follow the reasons for the treatment delivered. In addition, the lack of recording meant that the reasons for change in treatment plan remain a mystery. Professor Brook described a duty to report on radiographs as a legal requirement in accordance with IRMER. Failure to report on radiographs could result in diagnostic opportunities being missed. An appropriate report in this case could have shed light on the rationale for the treatment options and this opportunity was also lost. The Committee accepted the opinion pf Professor Brook that Mr Santa's record keeping failures fell far below the standard expected.

Complaint handling

The Committee took the view that in the context of all the other failings Mr Santa's failure to respond adequately to Patient A's complaint was serious. It considered that Patient A deserved an explanation and has been deprived of one to date. According to GDC standards, it notes dentists should be accountable for their choices/actions.

The Committee had regard to the GDC's Standards for the Dental Team (September 2013) and determined Mr Santa's failings breached the following standards below:

1.4.2 you must provide patients with treatment that is in their best interests…

2.1 You must communicate effectively with patients – listen to them, give them time to consider information and take their individual views and communication needs into account.

2.3 You must give patients the information they need, in a way they can understand, so that they can make informed decisions.

3.1 Obtain valid consent before starting treatment, explaining all the relevant options and the possible costs.

3.3 Make sure that the patient's consent remains valid at each stage of investigation or treatment.

4.1 Make and keep contemporaneous, complete and accurate patient records.

5.1 Make sure that there is an effective complaints procedure readily available for patients to use, and follow that procedure at all times.

5.3 Give patients who complain a prompt and constructive response.

The Committee also had regard to the relevant guidance with regard to grading and recording dental x-rays: *The Ionising Radiation (Medical Exposure) Regulations 2000* and determined that Mr Santa's actions breached these regulations.

The Committee determined that Mr Santa's failures, individually and collectively amounted to misconduct.

Decision on Impairment

The Committee next considered whether Mr Santa's fitness to practise is currently impaired by reason of his misconduct. Mr Thomas referred the Committee to the case of *Cohen v General Medical Council* [2008] EWHC 581 (Admin) and the guidance of Dame Janet Smith in her Fifth Report from the Shipman case, set out with approval in the cases of *Zygmunt v General Medical Council* [2008] EWHC 2643 (Admin) and *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council and Paula Grant* [2011] EWHC 927 (Admin). He addressed the Committee on the factors that it must consider, including Mr Santa's level of insight and any remediation. He also addressed the Committee on the need to have regard to protecting the public and the wider public interest, which includes the need the need to declare and maintain proper standards and maintain public confidence in the profession and in the GDC as a regulatory body. He submitted that whilst the failings are remediable, Mr Santa has provided no evidence of remediation and has displayed a disregard for his regulator. He submitted that Mr Santa's fitness to practise is currently impaired by reason of his misconduct.

The Committee adopted the approach formulated by Dame Janet Smith in her Fifth Report from the Shipman case; that is, the PCC should ask itself:

> 'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:
>
> a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or

d. …

Taking the guidance of Dame Janet Smith in turn, the Committee was of the view that Mr Santa's excessive use of local anaesthetic and record keeping failures put Patient A at an unwarranted risk of harm. His failure to adequately respond to Patient A's complaint brought the profession into disrepute and his failure to obtain informed consent breached one of the fundamental tenets of the profession.

The Committee was of the view that Mr Santa's clinical failures are capable of being remedied. However, Mr Santa chose not to engage with these proceedings and as a consequence there was no evidence before the Committee that he has taken any action to remedy his misconduct. He has also failed to take the opportunity to demonstrate insight. Taken together these matters led the Committee to conclude that the risk of repetition was high.

The Committee concluded that in the absence of any positive evidence of insight and remediation Mr Santa presents an ongoing risk to patients. Furthermore, members of the public would be concerned by his acts and omissions and would expect his regulatory body to declare and uphold the standards expected of all registered practitioners. The Committee concluded that a finding of no impairment would undermine public trust and confidence in the profession and in the regulatory process.

The Committee determined that Mr Santa's fitness to practise is currently impaired by reason of his misconduct.

Decision on Sanction

The Committee next considered what action, if any, to take in relation to Mr Santa's registration. Mr Thomas addressed the Committee on the matter of sanction and submitted that it must have regard to Mr Santa's non-engagement when determining the workability of any sanction. He drew to the Committee's attention Mr Santa's previous fitness to practise history which includes two Investigating Committee (IC) warnings and a six-month suspension order. Mr Thomas invited the Committee to consider whether an order of suspension with a review would be appropriate.

The Committee reminded itself that the purpose of a sanction is not to be punitive although it may have that effect. The Committee took into account the GDC's "Guidance for the Practice Committees, including Indicative Sanctions Guidance" (October 2016). The Committee bore in mind the principle of proportionality.

The Committee was provided with documents relating to the previous warnings and adverse findings against Mr Santa. It noted that on 18 June 2008 the IC issued Mr Santa with a written warning in relation to incorrectly completing and signing application forms relating to his inclusion on a Performer's List and on the GDC's register. On 10 May 2012 a further warning was issued by the IC about Mr Santa's conduct in relation to clinical failings similar to those found proved in this hearing including poor standard of communication with patient about their treatment, failing to obtain informed consent. In March 2017 a PCC found failings by Mr Santa in relation to his conviction for drink driving and failing to declare to the GDC his

having been charged and subsequently convicted to the GDC. Mr Santa attended the hearing, was legally represented and that Committee found misconduct and impairment. Mr Santa's registration was suspended for a period of six months.

The Committee noted the previous warnings and findings against Mr Santa. The Committee took the view that Mr Santa's non-engagement, his previous fitness to practise history, together with the current findings of misconduct and impairment strongly indicates that he may have an attitudinal and/or behavioural problem which is difficult to remedy.

The Committee considered the mitigating and aggravating factors in this case. It noted that this is a case involving a single patient during a single course of treatment. Conversely the Committee noted that Patient A suffered harm from the treatment Mr Santa provided. Mr Santa breached the trust placed in him as a professional by failing to adhere to standards of care which are fundamental to the practice of dentistry. Mr Santa's misconduct was sustained and repeated in that he has previous warnings against him, one of which was similar to the findings made in this case. Mr Santa has demonstrated a blatant or wilful disregard of the role of the GDC and the systems regulating the profession by failing to respond to correspondence and requests from the GDC. Mr Santa has also not demonstrated any insight into his actions.

The Committee considered the available sanctions in ascending order starting with the least restrictive.

The Committee was of the view that to conclude this case with no further action or with a reprimand would be inappropriate because neither outcome would manage the risk Mr Santa poses to patients. in addition, neither option would be sufficient to protect the wider public interest.

The Committee then considered whether an order for conditional registration would be appropriate and sufficient in this case. Mr Santa has not engaged with the GDC since May 2017. The Committee was of the view that conditions require a willingness on the part of a registrant to comply with them and in light of Mr Santa's non-engagement the Committee could have no confidence that he would comply even if appropriate and workable conditions could be formulated. Furthermore, the Committee concluded that Mr Santa may have an attitudinal and/or behavioural problem. In these circumstances an order for conditional registration would be insufficient in this case to maintain public confidence in the profession and declare and uphold appropriate standards of conduct and competence among dental professionals.

The Committee has given careful consideration as to whether it is sufficient to direct that Mr Santa's registration be suspended or whether this is a case where an order of erasure is necessary in the wider public interest. It is in no doubt that the findings against Mr Santa are serious. The Committee also has concerns about Mr Santa's lack of insight into the consequences of his conduct and how it impacts on public confidence in the dental profession. The Committee has borne in mind that Mr Santa's conduct was limited to a single complaint originating from one course of treatment.

The Committee considered that a suspension order would protect patients and would send signal to Mr Santa, the profession and the public reaffirming the standards of conduct and behaviour expected of a registered practitioner. A period of suspension would also provide Mr Santa with the opportunity to demonstrate a willingness to reengage with his regulator and work towards a return to the register unrestricted.

This is not, in the Committee opinion, a case where the evidence of a professional attitudinal problem is currently so strong as to be incompatible with Mr Santa remaining on the register. Consequently, the Committee concluded that the sanction of erasure would not be appropriate or proportionate in this time as it is not the only option that would adequate protect the wider public interest. Taking all these factors into account, the Committee is satisfied that the public interest concerns in this case are sufficiently met by a period of suspension.

Accordingly, the Committee directs that Mr Santa's registration on the Dentists Register be suspended for a period of 12 months. The Committee is satisfied that this period of time is appropriate to mark the seriousness of Mr Santa's misconduct and to send a message to the profession and the public that this type of conduct is not acceptable.

The Committee considers that Mr Santa's case should be reviewed at a resumed hearing to be held shortly before the end of the period of suspension. That Committee will consider what action it should take in relation to Mr Santa's registration.

The Committee considered that a Committee reviewing Mr Santa's case may find it helpful to receive the following:

- evidence of his meaningful engagement with the GDC;
- evidence of CPD and training relevant to the clinical risks identified; and
- a reflective piece demonstrating his insight and understanding of the impact of his behaviour upon Patient A and the wider public in the dental profession

The Committee now invites submissions as to whether Mr Santa's registration should be suspended immediately.

Decision on immediate order

The Committee has considered whether to make an order for the immediate suspension of Mr Santa's registration. Mr Thomas made an application for an immediate order. The Committee has considered the submissions made by Mr Thomas. It has accepted the advice of the Legal Adviser.

The Committee has had regard to its reasons for finding that Mr Santa's fitness to practise is impaired, including its view that there remains a real risk of repetition, as well as its consideration that public confidence would be undermined if a finding of current impairment were not made. It has also had regard to its reasons for directing that Mr Santa's registration be suspended. In these circumstances, the Committee has concluded that not imposing an immediate order and allowing Mr Santa to practise during the period before the substantive order takes effect would place the public at risk. It was also satisfied that it would be contrary to the public interest and inconsistent with its findings not to impose an immediate order to cover the appeal period or, if an appeal is lodged, until it has been disposed of.

The Committee has determined that it is necessary for the protection of the public and is otherwise in the public interest that Mr Santa's registration be suspended forthwith.

The effect of this direction is that Mr Santa's registration will be suspended immediately. Unless Mr Santa exercises his right of appeal, the substantive order of suspension will come

into effect 28 days from the date on which notice of this decision is deemed to have been served on him. Should Mr Santa exercise his right of appeal, this immediate order for suspension will remain in place until the resolution of any appeal.

The Committee noted that there was currently an interim order of suspension on Mr Santa's registration. However, it considered that the serious nature of the impairment found in this case justifies the imposition of an immediate order. The interim order of suspension currently on Mr Santa's registration is revoked.

That concludes the hearing of Mr Santa's case."

At a review hearing on 7 November 2019 the Chairman announced the determination as follows:

"Mr Santa is neither present nor represented at this resumed hearing of the Professional Conduct Committee (PCC). Ms Headley is the Case Presenter for the General Dental Council (GDC).

At the outset, Ms Headley made an application under Rule 54 of the GDC (Fitness to Practise) Rules 2006 Order of Council (the Rules), to proceed with the hearing notwithstanding Mr Santa's absence. The Committee took account of Ms Headley's submissions in respect of the application and had regard to the supporting documentation provided. It accepted the advice of the Legal Adviser.

Decision on service of the Notification of Hearing

The Committee considered whether notice of the hearing had been served on Mr Santa in accordance with Rules 28 and 65 of the Rules. It received a bundle of documents containing a copy of the Notification of Hearing letter, dated 26 September 2019, and a Royal Mail 'Track and Trace' receipt confirming that delivery had been attempted to Mr Santa's registered address by Special Delivery. A copy of the letter was also sent to him by email.

The Committee was satisfied that the letter contained proper notification of today's review hearing, including its time, date and venue, as well as notification that the Committee had the power to proceed with the hearing in Mr Santa's absence. Track and trace information indicated that the letter could not be delivered and may have been returned to sender however, the Committee noted that it had been posted to Mr Santa's registered address and that the rules do not require proof of delivery. On the basis of the information provided, the Committee was satisfied that notice of the hearing had been served on Mr Santa in accordance with the Rules.

Decision on proceeding with the hearing in the absence of Mr Santa

The Committee next considered whether to exercise its discretion under Rule 54 of the Rules to proceed with the hearing in the absence of Mr Santa. It approached this issue with the utmost care and caution. The Committee took into account the factors to be considered in reaching its decision as set out in the case of *R v Jones [2003] 1 AC 1HL*. It remained mindful of the need to be fair to both Mr Santa and the GDC, and it had regard to the public interest in the expeditious review of the suspension order in place on Mr Santa's registration. The Committee took into account that the current order is due to expire on 27 November 2019.

The Committee noted from the Notification of Hearing letter of 26 September 2019 that Mr Santa was asked to confirm by 03 October 2019, whether he would be attending today's

hearing and/or whether he would be represented. The information before the Committee indicates that there has been no response from Mr Santa. He has not provided a reason for his non-attendance, either in person or remotely, nor has he requested an adjournment. The Committee therefore concluded that Mr Santa had voluntarily absented himself from today's proceedings. It decided that an adjournment was unlikely to secure his attendance on a future date. The Committee also noted that Mr Santa did not attend and was not represented at the initial PCC hearing of his case in October 2018.

In all the circumstances, the Committee determined that it was fair and in the public interest to proceed with the hearing in the absence of Mr Santa and/or any representative on his behalf.

Background to Mr Santa's case

Mr Santa's case was first considered by the PCC at a hearing in October 2018. That Committee found proved that:

"Mr Santa put Patient A's safety at risk in that he provided an amount of local anaesthetic that was in excess of the maximum recommended dose within the manufacturer's guidance. He also failed to adequately communicate to Patient A a change in the treatment plan, failed to obtain informed consent, failed to keep adequate records and failed to adequately respond to Patient A's complaint regarding his dental treatment. Professor Brook was of the opinion that all of these failings fell far below the standard of a reasonably competent practitioner."

The Committee that sat in October 2018 considered that the breaches of the GDC's standards, as highlighted by its findings, were serious and were capable of undermining public confidence in the profession. That Committee found that the facts found proved against Mr Santa amounted to misconduct and it determined that his fitness to practise was impaired by reason of that misconduct. In its determination on impairment, that Committee stated that Mr Santa's misconduct was remediable. However, the Committee received no evidence from him in relation to any steps he had taken to address the concerns raised in this case. Nor had the Committee been provided with any evidence of insight. In the absence of such evidence and in view of his lack of engagement with the GDC, the Committee concluded that Mr Santa's fitness to practise was impaired.

That Committee determined to suspend Mr Santa's registration for a period of 12 months and imposed an immediate order of suspension. It directed a review of his case prior to the end of the 12 month period.

Today's review

In comprehensively reviewing Mr Santa's case today, the Committee considered all the evidence before it. It took account of the submissions made by Ms Headley on behalf of the GDC and accepted the advice of the Legal Adviser. No material or written submissions were received from, or on behalf of, Mr Santa.

Ms Headley submitted that to date, there is no evidence that Mr Santa has remedied any of the failings identified by the previous Committee or demonstrated any insight. Neither had he engaged with GDC since the last hearing or provided any of the evidence recommended by the Committee on the last occasion. In relation to the matters before the Committee today she invited the Committee to find that Mr Santa's fitness to practise remains impaired. Ms Headley further invited the Committee, if it found current impairment, to extend the period of Ms Santa's suspension order by a period of 12 months with a review.

Decision on impairment

In reaching its decision on whether Mr Santa's fitness to practise remains impaired, the Committee exercised its own judgement. It had regard to the over-arching objective of the GDC, which involves: the protection, promotion and maintenance of the health, safety and well-being of the public; the promotion and maintenance of public confidence in the dental profession; and the promotion and maintenance of proper professional standards and conduct for the members of the dental profession.

Mr Santa's misconduct, as found by the initial PCC, was serious, put members of public at risk of harm, and was capable of undermining public confidence in the dental profession. This Committee accepted the submissions of Ms Headley and the advice of the Legal Adviser.

The information before this reviewing Committee today indicates that Mr Santa has failed to engage in any way with the GDC since the last hearing. Consequently, it has received no evidence to indicate that he has made any efforts to fulfil the recommendations made by the Committee in October 2018.

In this Committee's view, because of Mr Santa's ongoing failure to engage effectively with the GDC, he has not demonstrated any insight into the concerns identified at the hearing in October 2018, or any efforts taken to address the concerns identified at that hearing. Taking into account this lack of evidence of insight, and the absence of any evidence of remediation, this Committee concluded that the serious concerns remain.

Having taken all the information before it into account, the Committee continues to be concerned about the serious risk of repetition. In all the circumstances, the Committee decided that a finding of current impairment is necessary for the protection of the public. The Committee also decided that public confidence in the dental profession would be undermined if such a finding were not made in the circumstances of this case.

Accordingly, the Committee has determined that Mr Santa's fitness to practise remains impaired by reason of his misconduct.

Decision on Sanction

The Committee considered what action, if any, to take in respect of Mr Santa's registration. It had regard to its powers under Section 27C(1) of the *Dentists Act 1984 (as amended)*, which sets out the options available to it. The Committee took into account that the purpose of any sanction is not to be punitive, although it may have that effect, but to protect patients and the wider public interest.

The Committee had regard to the '*Guidance for the Practice Committees including Indicative Sanctions Guidance (effective from October 2016 revised May 2019)*'. It applied the principle of proportionality, balancing the public interest with Mr Santa's own interests. It considered the available sanctions in ascending order.

In the light of the Committee's outstanding concerns about public safety, it determined that it would be wholly inappropriate to terminate the current suspension order or to allow it to lapse. It decided that some ongoing restriction of Mr Santa's registration is necessary to safeguard the public and to uphold the wider public interest.

The Committee next considered whether to terminate Mr Santa's suspension order and replace it with an order of conditions. However, the Committee concluded that conditional registration would not be suitable in this case, where the registrant has failed to engage

meaningfully in the regulatory process in any way and nothing is known about his current situation. It also took into account the serious nature of Mr Santa's failings, which have yet to be addressed. It therefore determined that the imposition of conditions would not be appropriate, workable or proportionate.

In all the circumstances, the Committee determined to extend the period of the suspension order on Mr Santa's registration. This Committee has found that he has failed to engage with the GDC and the remedial process. As a result, the failings identified remain a real concern. In view of this, the Committee concluded that members of the public and the wider public interest would not be sufficiently protected by a lesser sanction than suspension.

The Committee has decided to extend the suspension order by a period of 12 months. In deciding on this period, the Committee took into account the absence of any evidence of progress made by Mr Santa since the findings made against him in October 2018. It considered that a significant amount of engagement and remediation will now be required on his part to address all the identified failings. The Committee concluded that a 12-month suspension would afford him such an opportunity, whilst ensuring that members of the public and the wider public interest remain protected adequately.

A Committee will review Mr Santa's case at a resumed hearing to be held shortly before the end of the extended period of suspension. That Committee will consider whether it should take any further action in relation to his registration. He will be informed of the date and time of that resumed hearing. The Committee wish to emphasise to Mr Santa that the powers available to the next reviewing Committee will include the discretion to suspend Mr Santa's registration indefinitely.

The Committee considers that a reviewing Committee would be assisted by the same evidence identified at the initial hearing, in other words:

- *evidence of his meaningful engagement with the GDC;*
- *evidence of CPD and training relevant to the clinical risks identified; and*
- *a reflective piece demonstrating his insight and understanding of the impact of his behaviour upon Patient A and the wider public in the dental profession*

Unless Mr Santa exercises his right of appeal, his current suspension order will be extended by a period of 12 months, from the date of which when it would have otherwise expired. If Mr Santa does lodge an appeal against this decision, the current suspension order will continue to remain in force until the appeal has been decided.

That concludes this determination."

At a review hearing on 19 November 2020 the Chairman announced the determination as follows:

"Members of the Committee, as well as the Legal Adviser, and the Committee Secretary, are conducting the hearing remotely via video link in line with the General Dental Council's ("the Council") current practice. Ms Headley, case presenter for the GDC participated via video link. Mr Santa was neither present in the hearing nor represented in his absence.

This is a resumed hearing pursuant to section 27C of the Dentists Act 1984 (as amended) ('the Act') to review the order of suspension for 12 months which was imposed on Mr Santa's registration by a previous Professional Conduct Committee ("the PCC") in October 2018.

Submissions on service of notice of hearing

Ms Headley submitted that the notification of this hearing had been served on Mr Santa in accordance with Rules 28 and 65 of the General Dental Council (Fitness to Practise) Rules Order of Council 2006 ("the Rules").

Decision on service of notice of hearing

The Committee received a bundle of documents which contained a copy of the notification of today's review hearing, dated 8 October 2020, that was sent to Mr Santa's registered address by 'International Tracked and Signed' and via email. The letter also included a tracking number. The Committee noted that the notification provided Mr Santa with more than the 28 days required by the Rules. It was satisfied that the letter contained proper notification of today's hearing, including its time, date and location, as well as notification that the Committee has the power to proceed with the hearing in Mr Santa's absence. A screenshot of the entry in the Register shows that the address used is Mr Santa's current registered address. The Committee noted that the Council is not obliged to prove that the notice was delivered or received only that it was posted. It also noted that Rule 65 permitted the notification to be sent by post and proof of service to be confirmed by Royal Mail. The Committee had sight of the extract from the Royal Mail Track and Trace service, regarding the notice of hearing. This showed that the notification letter with the same tracking number was sent on 8 October 2020. A copy of the notice of hearing was also sent as an attachment in a secure email to Mr Santa on 8 October 2020.

The Committee was satisfied that the notice of this review hearing had been served on Mr Santa in accordance with the rules.

Application on proceeding with the hearing in the absence of the registrant

Ms Headley made an application for this hearing to proceed in Mr Santa's absence pursuant to Rule 54 of the Rules. She submitted that the Council had made all reasonable efforts to notify Mr Santa of this hearing. She referred the Committee to the cases of *R v Jones*, *Tate v Royal College of Surgeons, GMC v Adeogba*.

Decision on proceeding with the hearing in the absence of the registrant

The Committee noted that Mr Santa has not attended the last two review hearings. There is no evidence to show that there has been any engagement by Mr Santa or that he wishes to attend this hearing. There has been no request for an adjournment and there is no indication before the Committee that an adjournment would facilitate Mr Santa's attendance at a future date if the hearing were to be adjourned today. Further, the Committee considered that there is a public interest in the hearing proceeding expeditiously given that the order is due to expire on 27 November 2020 and an adjournment today could lead to the order lapsing, leaving the public and patients without protection and the Committee without jurisdiction on the matter. The Committee concluded that it is appropriate to proceed with the review hearing in the absence of Mr Santa.

Background and Summary of Findings

This case was first considered by the PCC in October 2018. The charge before that PCC related to Mr Santa's treatment of Patient A between 2015 and 2016. Patient A underwent a course of treatment which was to include removal of upper and lower teeth, sinus lift and bone augmentation, placement of eight implants, bridges and sandwich veneers on lower teeth. The PCC found proved that Mr Santa put Patient A's safety at risk in that he provided an amount of local anaesthetic that was in excess of the maximum recommended dose

within the manufacturer's guidance. Mr Santa failed to adequately communicate a change in the treatment plan to Patient A and failed to obtain informed consent from Patient A for treatment to the upper jaw. Mr Santa also failed to maintain an adequate standard of record keeping in respect of Patient A's appointments by not recording details of any clinical examination and by not reporting on CBCT scans or DPT radiographs, in accordance with the Ionising Radiation Medical Exposure Regulations (IRMER). It was also found proved that Mr Santa failed to respond adequately to Patient A's complaint regarding his dental treatment.

The PCC in October 2018 considered that Mr Santa's failings were serious, fell far below the standard expected and, individually and cumulatively, amounted to misconduct. It considered that although the failings were remediable, there was no evidence to show that Mr Santa had taken any action to remedy his misconduct and there was no evidence of his insight. The PCC determined that Mr Santa's fitness to practise was impaired by reason of his misconduct and directed that his registration be suspended for a period of 12 months with a review prior to the end of the period of suspension.

First Review

On 7 November 2019 the case was reviewed by the PCC. It determined that Mr Santa's fitness to practise remained impaired. This was due to the lack of evidence of his insight, the absence of any evidence of remediation, his ongoing failure to engage effectively with the GDC which led the PCC to conclude that the serious concerns found by the initial Committee remained as well as a risk of repetition. The PCC also concluded that a finding of current impairment was necessary for the protection of the public and to maintain public confidence in the dental profession. The PCC determined that Mr Santa's fitness to practise remained impaired by reason of his misconduct and directed that his registration be suspended for a further period of 12 months.

Submissions on behalf of the GDC

Ms Headley informed the Committee of Mr Santa's fitness to practise history. She submitted that in June 2008 the Council's Investigating Committee ("the IC") issued Mr Santa with a written warning in relation to incorrectly completing and signing application forms relating to his inclusion on a Performer's List and on the GDC register. In May 2012 another warning was issued by the IC to Mr Santa regarding clinical failings around poor standard of communication about treatment and informed consent, which are similar to those found proved in this case. In May 2017 a PCC made findings against Mr Santa in relation to his conviction for drink driving and failing to declare to the GDC that he had been charged and subsequently convicted. Mr Santa's registration was suspended for a period of 6 months.

Ms Headley also informed the Committee of an ongoing investigation by the Council in relation to a complaint made against Mr Santa. However, she submitted that the case was still being investigated and the allegations had not been proven. The Committee was advised that it should be cautious about placing any weight on this information as they remained mere allegations until an inquiry had been carried out at a substantive hearing.

In respect of compliance, Ms Headley submitted that there is no information to suggest that Mr Santa has breached the order of suspension or that he is working in the UK or at all. However, she submitted that the previous PCC had considered that this review Committee would be assisted by receiving evidence of meaningful engagement with the GDC, evidence of Continuing Professional Development ("CPD") and training relevant to the clinical risks identified and a reflective piece. Ms Headley submitted that Mr Santa has not been engaging with the Council at all. He has not provided a reflective piece as recommended by the

previous PCC. She submitted that the current cycle of CPD began in 2018 and no evidence of CPD has been provided to the Council to date.

In relation to current impairment, Ms Headley submitted that the Committee should consider the cases of *Abrahaem v GMC* and *Bamgbelu v GDC*, *CHRE v NMC and Grant, Cohen v GMC*, and *Kimmance v GMC*. She submitted that having been given a further opportunity by the last review PCC to demonstrate remediation along with specific guidance on what the remediation should look like, Mr Santa has not engaged with the process and he has not attended any of the hearings. Ms Headley submitted that Mr Santa has done nothing to satisfy this Committee that his fitness to practise is no longer impaired. She submitted that in light of the non-engagement, the appropriate sanction should be one of indefinite suspension. She further submitted that Mr Santa would be able to request a review at 2-year intervals should he wish to re-engage with the Council. She submitted that in the interim, an indefinite suspension would remove the need for yearly reviews.

Decision of the Committee

Current Impairment

In considering whether Mr Santa's fitness to practise is currently impaired, the Committee bore in mind that this is a matter for its own independent judgement. It also had regard to its duty to protect the public, declare and uphold proper standards of conduct and competence and maintain public confidence in the profession. The Committee accepted the advice of the Legal Adviser.

The Committee noted the findings made at the initial hearing. It also noted that Mr Santa has not engaged with the Council since May 2017. There is no evidence from Mr Santa before the Committee today and therefore a complete absence of any information upon which it could assess the degree of any remediation, insight developed and ultimately his current fitness to practise. In the absence of any evidence, the Committee had to conclude that there remained a risk to the safety of patients and a risk of repetition. It determined that a finding of current impairment is required for the protection of the public.

Furthermore, the Committee determined that a finding of current impairment is in the public interest in order to uphold the standards of the profession. A fully informed member of the public knowing the nature of the facts found proved and Mr Santa's complete disengagement with the Council and these proceedings, would be shocked if a finding of current impairment was not made. The Committee determined that Mr Santa's fitness to practise remains currently impaired by reason of his misconduct.

Sanction

The Committee considered what sanction to impose on Mr Santa's registration. It reminded itself that the purpose of any sanction is not to be punitive although it may have that effect. The Committee bore in mind the principle of proportionality.

The Committee first considered whether to terminate the suspension direction currently in place or allow it to lapse and leave Mr Santa's registration unrestricted. It was of the view that this course of action would be wholly inappropriate given that Mr Santa has completely disengaged with the Council and has not demonstrated any remediation of his misconduct.

The Committee considered whether to replace the suspension with a direction for conditional registration. The Committee noted paragraph 7.12 of the *Guidance for the Practice Committees including Indicative Sanctions Guidance, October 2016*:

"Conditions can only be considered to provide adequate public protection if the panel can reasonably be confident in the registrant's capacity to comply with them. If the panel is

concerned that a registrant may not comply with the conditions they are minded to impose, suspension may be a more appropriate sanction to ensure public protection. This applies equally if concerns about non-compliance are due to circumstances, rather than due to the registrant."

The Committee has seen no evidence from Mr Santa in relation to the findings made against him in this case. It therefore was not confident that Mr Santa would comply with any conditions imposed on his registration. The Committee concluded that conditions would neither be workable nor appropriate at this stage.

The Committee then considered whether to extend the current suspension for a further period of 12 months. However, in the absence of any engagement by Mr Santa, a further period of suspension for 12 months with a review would be an unnecessary expense for the Council. Furthermore, Mr Santa appears to have completely disengaged with the Council and these fitness to practise proceedings. The Committee noted that at the expiry of the current period of suspension, Mr Santa would have been suspended for a period of 2 years.

The Committee therefore directs that Mr Santa's registration in the Register be suspended indefinitely pursuant to section 27C (1)(d) of the Dentists Act 1984, as amended.

Mr Santa is able to request a review of this decision under section 27C (4) of the Dentists Act 1984, as amended after a period of 2 years should he wish to establish meaningful engagement with the Council.

That concludes this determination."