General
Dental
Council

HEARING HEARD IN PUBLIC

SHIMMIN, Roger William

Registration No: 53695

PROFESSIONAL CONDUCT COMMITTEE

NOVEMBER 2020

Outcome: Erased with Immediate Suspension

Roger William SHIMMIN, a dentist, BDS University of Liverpool 1979, was summoned to appear before the Professional Conduct Committee on 23 November 2020 for an inquiry into the following charge:

Charge (as amended on 24 November 2020)

"That being registered as a dentist, you:

1. Failed to provide an adequate standard of care to Patient A between 29 March 2006 and 7 June 2019, in that you:

Sjogren's Syndrome

a. failed to refer Patient A to, or confirm that Patient A was receiving, appropriate specialist care for the oral symptoms of Sjogren's syndrome, following the appointment on 29 March 2006.

Oral Lichen Planus

b. **Amended to:** failed to make a provisional diagnosis of oral Lichen Planus following the appointment on 24 November 2008;

c. failed to refer Patient A to a specialist in oral medicine or oral and/or maxillofacial surgery regarding the possibility of oral Lichen Planus following the appointment on 24 November 2008;

Oral Cancer

d. inappropriately assessed Patient A to be at low risk of oral cancer between 4 September 2015 and 22 February 2019;

e. failed to adequately assess the lesions present between:

i. 1 December 2015 and 11 March 2016;

ii. 23 April 2019 and 7 June 2019;

f. failed to refer Patient A to a specialist within a reasonable time following the appointment of 1 December 2015;

g. failed to perform timely reviews following the appointments of:

i. 23 April 2019;

ii. 17 May 2019;

h. failed to instigate an urgent referral on the cancer pathway on 7 June 2019.

Caries

i. failed to diagnose caries on 17 May 2019 at:

i. UR3;

ii. UL5;

iii. **Amended to:** UL1

iv. UL4.

Radiographic Monitoring

2. Failed to take sufficient bitewing radiographs between 29 March 2006 and 7 June 2019 in order to adequately monitor Patient A's caries.

3. Failed to adequately monitor Patient A's periodontal bone loss radiographically between 29 March 2006 and 7 June 2019.

Record Keeping

4. Failed to adequately record the appearance of the lesions present between:

a. 1 December 2015 and 11 March 2016;

b. 23 April 2019 and 7 June 2019.

AND that by reason of the matters alleged above your fitness to practise is impaired by reason of misconduct."

Mr Shimmin was not present and was not represented. On 25 November 2020 the Chairman announced the findings of fact to the Counsel for the GDC:

"This is the Professional Conduct Committee's (PCC) inquiry into the charges which form the bases of the allegations against Mr Shimmin that his fitness to practise is impaired by reason of misconduct. 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 Tahta, of Counsel presented the Council's case, and participated via video link. Mr Shimmin was neither present nor represented in his absence.

Preliminary Matters

Submissions on service of notice of hearing

Ms Tahta on behalf of the GDC submitted that notification of this hearing had been served on Mr Shimmin 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 had received a bundle of documents which contained a copy of the notification of today's hearing, dated 13 October 2020, that was sent to Mr Shimmin's registered address by registered post and email. The Committee noted that the notification provided Mr Shimmin 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 Shimmin's absence. An extract from the Register confirms that the address used for posting is Mr Shimmin's current registered address.

The Committee 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 was delivered on 14 October 2020 at 9:40am and signed for in the printed name "CARTER". The notification of hearing letter was also sent to Mr Shimmin and his legal representatives on 13 October 2020 via secure email as an attachment.

The Committee was satisfied that the notification of this hearing had been served on Mr Shimmin in accordance with the Rules.

Application to proceed with the hearing in the absence of the registrant

Ms Tahta then made an application for this hearing to proceed in the absence of Mr Shimmin pursuant to Rule 54 of the Rules. She referred the Committee to the case of *R v Jones*.

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

The Committee noted the email dated 18 November 2020 from Mr Shimmin's legal representatives. In that email they stated that "Mr Shimmin has today confirmed that he will not be attending the forthcoming hearing nor is he likely to be represented at that hearing." The Committee was satisfied that Mr Shimmin is aware of this hearing and has waived his right to attend. There has been no request for an adjournment and there was no indication before the Committee that Mr Shimmin is likely to attend if the hearing was adjourned today. Further, the Committee considered that there is a public interest in the hearing proceeding expeditiously. The Committee concluded that it is appropriate to proceed with the hearing in the absence of Mr Shimmin.

Application to amend the charge

During the course of the hearing, Ms Tahta made an application under Rule 18 to amend charge 1(i)(iii) by replacing "UR1" with "UL1". She submitted that Professor Brook had erroneously noted UR1 in his report instead of UL1 and this error was then reflected in the charge. She submitted that the amendment would cause no injustice to Mr Shimmin and it should be made in order to follow the evidence accurately.

The Committee accepted the advice of the Legal Adviser. It considered that it is in the interest of fairness to the proceedings to make the proposed amendment as it brings clarity to the charge. The Committee therefore granted the application.

Background

Mr Shimmin joined his current practice as a partner in 1984 and subsequently became the Principal of the practice in 2007. Mr Shimmin treated Patient A for a period of over 31 years during which period Patient A was a regular attender at the practice. She was a private patient under Denplan. During the time when Patient A was Mr Shimmin's patient, she developed Sjorgen's Syndrome and Lichen Planus, two conditions which can affect oral care because of the related symptoms. It is alleged that Mr Shimmin failed in numerous ways to deal with Patient A's care appropriately including failed opportunities to refer Patient A to relevant specialists. Patient A was subsequently referred by her GP in June 2019 on an

urgent two-week cancer pathway for oral cancer. Following the referral, Patient A changed dentists and the subsequent treating dentist was so shocked at the state of neglect and the level of caries in Patient A's dentition that he made a complaint to the Council. The Council conducted its own investigations and asked Professor Brook to review Patient A's records. The allegations made against Mr Shimmin arise out of the criticisms made by Professor Brook in his report.

Factual Evidence Received

By way of factual evidence from the Council, the Committee was provided with Patient A's dental records, signed witness statement dated 23 June 2020 from Witness A, signed witness statement dated 26 June 2020 from Witness B and signed witness statement dated 13 July 2020 from Witness C. The Committee was invited to consider whether it wished to hear oral evidence from these witnesses. It considered the matter and decided that given that the focus of the allegations was on the treatment provided by Mr Shimmin and it had the benefit of Professor Brook's detailed report and oral evidence, it would not require further oral evidence from these factual witnesses.

Mr Shimmin was not in attendance at this hearing and was not represented. However, the Committee had before it a copy of the written response on behalf of Mr Shimmin dated 14 February 2020 to the Council's Case Examiners. The Committee noted that the allegations which were addressed in that written response, although relating to Mr Shimmin's treatment of Patient A, do not precisely mirror the current charges that the Committee has to consider. The Committee has nevertheless considered those responses in order to understand Mr Shimmin's position (where stated) on the charges before it today.

Also put before the Committee is a copy of the written submissions dated 6 November 2020 on behalf of Mr Shimmin in support of his application for voluntary removal from the Dentists Register. The Committee has also considered those submissions.

Expert Evidence and Assessment of Oral Evidence

The Committee received an expert report dated 29 June 2020 from Professor Brook instructed by the Council. It found him to be knowledgeable in relation to the matters before the Committee and a credible witness. The Committee found his approach to be considered while he was measured in his assessment, with appropriate reflection when a query was put to him.

The Committee's Findings of Fact

The Committee has considered all the evidence presented to it, both oral and documentary. It took account of the submissions made by Ms Tahta on behalf of the Council. The Committee heard and accepted the advice of the Legal Adviser. In accordance with that advice it considered each head of charge separately, bearing in mind that the burden of proof rests with the GDC and that the standard of proof is the civil standard, that is, whether the alleged matters are found proved on the balance of probabilities.

Charge 1(b)

The Committee carefully considered Ms Tahta's submissions in relation to its question of Professor Brook on the wording of charge 1(b) and the use of the word "diagnose" in the charge *"failed to diagnose oral Lichen Planus following the appointment on 24 November 2008".*

In his evidence in chief, Professor Brook told the Committee that it is not Mr Shimmin's duty to make a diagnosis but to make a referral. When asked to clarify this further Professor Brook stated that on the appointment of 24 November 2008 there was sufficient evidence from Mr Shimmin's record in the dental notes of 'gums peeling away' that the gingival condition that Patient A was exhibiting was unusual. Professor Brook's opinion was that there was a duty on Mr Shimmin to make a provisional/differential diagnosis and then to refer the patient to the relevant specialist. Professor Brook stated that it was not Mr Shimmin's duty to actually make a definitive diagnosis. Ms Tahta sought the opinion of Professor Brook on the use of the term 'diagnose' by General Dental Practitioners ("GDP") and whether it could be read to include differential diagnosis. Professor Brook acknowledged that the term 'diagnose' may be used loosely by some GDPs in the course of their practice. Professor Brook stated however that the charge could have been worded differently.

In her closing submissions, Ms Tahta submitted that it is common sense that a GDP could not definitively diagnose oral lichen planus without a biopsy. She submitted that the use of the word "diagnose" included making possible and differential diagnoses.

The Committee was advised by the Legal Adviser that it had the power under Rule 18(1) at any time before making its findings of fact, to amend the charge unless, having regard to the merits of the case and fairness to the proceedings, the required amendment cannot be made without injustice. Rule 18(2) provides that before making any amendment the Committee shall consider any representations from the parties. Ms Tahta confirmed that the Committee had the power to amend the charge but submitted that she would not be making an application to amend charge 1(b).

The Committee determined that it was appropriate to amend the wording of charge 1(b) in order to reflect accurately the criticisms of Professor Brook with regards to identifying oral lichen planus in Patient A on 24 November 2008. While the Committee accepted that GDPs may use the term "diagnose" loosely in practice, it considered that the amendment more accurately reflected the criticism of Mr Shimmin. The charge was therefore amended to read *"failed to make a provisional diagnosis of oral Lichen Planus following the appointment on 24 November 2008".*

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

1.	*Failed to provide an adequate standard of care to Patient A between 29 March 2006 and 7 June 2019, in that you:*
	Sjogren's Syndrome
1.(a)	*failed to refer Patient A to, or confirm that Patient A was receiving, appropriate specialist care for the oral symptoms of Sjogren's syndrome, following the appointment on 29 March 2006.* **Admitted and found proved** The dental records indicate that on 29 March 2006, Mr Shimmin suspected that Patient A was suffering from Sjogren's syndrome. The handwritten records for this date state *"RWS thinks Pt. may have Sjogren's syndrome' – 'Pt has smooth tongue and also dry eyes. Advised to go to GP again".* In his report Professor Brook stated:

	"It is not clear if Mr Shimmin while aware of and doing his best to manage Patient A Sjögren's syndrome checked that Patient A was receiving appropriate specialist care for her dry mouth due to Sjögren's syndrome. Patient A should have benefited from input into her care from appropriate dental specialists (Oral Medicine). If there was failure to ensure appropriate specialist care was facilitated or check it was being received, care would have fallen far below standard." In the document dated 6 November 2020 it was stated on behalf of Mr Shimmin that "Mr Shimmin was aware that [Patient A] was under the care of her GP for Sjogren's syndrome but acknowledges that he should have referred [Patient A] to specialist care for the oral symptoms of her condition; or alternatively confirm that she was receiving the requisite specialist care." The Committee accepted the expert opinion of Professor Brook. It found that Mr Shimmin failed to refer Patient A or confirm that Patient A was receiving appropriate specialist care and that this failure to refer was a failure in his duty to the patient. It therefore found this charge proved.
	Oral Lichen Planus
1.(b)	***Amended to:*** *failed to make a provisional diagnosis of oral Lichen Planus following the appointment on 24 November 2008;* **Found proved** In the dental records for the appointment on 24 November 2008 Mr Shimmin notes: *"Bleeding gums +++ V.RED, RAW MOUTH Esp left quadrant. Surface of gums appear to be "peeling" away? Offer to ?Ref to Manchester Hosp?"* In his report Professor Brook stated: *"Patient A suffered from Lichen Planus affecting the skin and was under the care of dermatologists in secondary care.* *Mr Shimmin was, from her history, aware that Patient A suffered from the skin lesions of Lichen Planus but does not appear to have considered the possibility of Oral Lichen Planus until the visit on 07.06.19 when he notes that Patient A should discuss this with her dermatologist.* *Presentation of Patient A at the appointment on 24.11.08 was related to the signs and symptoms of Oral Lichen Planus the records note 'gums peeling away? offer to ref Manchester Dental Hospital ??'. "Desquamative gingivitis" -red and peeling gums is a well recognised variant of Oral Lichen Planus that GDP should recognise and act upon.* *Failure to refer Patient A on 24.11.08 or at any time after this to investigate her desquamative gingivitis and or the possibility of Oral Lichen Planus prevented Patient A receiving appropriate care over a prolonged period, care falling far below standard."* In his oral evidence, Professor Brook stated that having a potential diagnosis allows the GDP to differentiate it from the normal, discuss the

	need for a referral with the patient and refer to the right specialist. The Committee noted that the documents dated 14 February 2020 and 6 November 2020 submitted on behalf of Mr Shimmin addressing the charges are silent on this particular charge. The Committee accepted the opinion of Professor Brook that Mr Shimmin should have recognised the potential diagnosis of Oral Lichen Planus and should have referred Patient A to specialist care, and that the failure to do so fell far below the standard of a reasonably competent General Dental Practitioner. There is no evidence within the records to indicate that Mr Shimmin had made a provisional diagnosis of oral lichen planus in Patient A. The Committee therefore found this charge proved.
1.(c)	*failed to refer Patient A to a specialist in oral medicine or oral and/or maxillofacial surgery regarding the possibility of oral Lichen Planus following the appointment on 24 November 2008;* **Admitted and found proved** In his report Professor Brook stated: *"Failure to refer Patient A on 24.11.08 or at any time after this to investigate her desquamative gingivitis and or the possibility of Oral Lichen Planus prevented Patient A receiving appropriate care over a prolonged period, care falling far below standard."* There was no evidence within the dental records that Mr Shimmin referred the patient to a specialist and indeed the Committee noted that Mr Shimmin accepted that a referral was not made. In the document dated 14 February 2020 it was stated on behalf of Mr Shimmin that: *"Given that there is no supporting documentation regarding a referral, and the use of the words "offer to", … this is not a reference to a referral having been made but simply an offer of a referral to the patient. Therefore, it is Mr Shimmin's position that no referral was made…"* The Committee accepted the opinion of Professor Brook that Mr Shimmin should have recognised the potential diagnosis of Oral Lichen Planus and should have referred Patient A to specialist care, and that the failure to do so fell far below the standard of a reasonably competent General Dental Practitioner. In his oral evidence Professor Brook told the Committee that the standard was that patients should be referred within 2 weeks and anything more than 2 weeks was an inordinate amount of time. The Committee found that Mr Shimmin had a duty to refer the patient and he failed in that duty. It therefore found this charge proved.
	Oral Cancer
1.(d)	*inappropriately assessed Patient A to be at low risk of oral cancer between 4 September 2015 and 22 February 2019;* **Found proved** The dental records indicate that on appointments attended by Patient A on

	4 September 2015, 11 March 2016, 16 September 2016, 17 March 2017, 6 October 2017 and 22 February 2019, Mr Shimmin recorded his assessment of Patient A's cancer risk as low. In his report Professor Brook stated: *"Patient A did not smoke or drink, major risk factors for oral cancer in the UK in respect of squamous cell carcinoma. Patient A was graded by Mr Shimmin as 'Low risk' from Oral Cancer (appointments 04.09.15, 11.03.16, 16.09.16, 17.03.17 and 22.02.19). However, it was known that Patient A suffered from Sjögren's syndrome in which Non-Hodgkin's lymphomas (NHL) occur in approximately 2.7–9.8% of patients, recent data reported that NHL risk increases 2.2% per year of age with a 4.3-fold increased risk in Sjogren's syndrome patients compared with the general population. Patient A was thus high risk for this type of 'cancer'.* *Patient A also suffered from oral Lichen Planus which is a recognised precursor condition for oral cancer (incidence of cancer range 1 in 100 to 1 in 25 patients) and put her at 'high* *risk'. Mr Shimmin should have been aware by 24 11 08 that Patient A was exhibiting signs and symptoms of oral Lichen Planus and was thus high risk. However, although the record of* *07.06.19 is that Mr Shimmin was at that time aware of [sic] that Patient A suffered from skin Lichen Planus the records are unhelpful as to if this was the first time, he knew this. The grading of 'low risk' for oral cancer was thus factually incorrect in view of her oral Lichen Planus and Sjögren's syndrome.* *Mr Shimmin's should have in respect of Sjögren's syndrome alone graded Patient A as 'high risk' for cancer, not to do so fell far below standard."* The Committee found that Mr Shimmin inappropriately assessed Patient A to be at low risk of oral cancer when in fact she should have been graded as high risk based on her medical condition.
1.(e)	*failed to adequately assess the lesions present between:*
1.(e)(i)	*1 December 2015 and 11 March 2016;* **Not admitted but found proved** The dental records indicate that on appointment of 1 December 2015 Mr Shimmin records *"Raised firm growth on RHS of patients cheek,??? Frictional in pats slep – so flattened all the molar off on the RHs to se if this helps the situate=ion. RWS thinks itsa chewing habit rather than anything nasty xxx".* For the appointment of 11 March 2016 the following record is made " Patient's complaints: *"RHS FRICTIONAL AREA TO REF TO RLI FOR 2ND OPINION – PAT HAS VERY DRY MOUTH – RAISED RHS OF CHEEK MORE THAN A SQUARE CM IN SIZE".* In his report, Professor Brook stated:

	"Standard records for recording lesions such as those presented by Patient A in general practice in the periods 01.12.15 to 11.03.16 and 23.04.19 to 07.06.19 should have included the following: *a. the duration of the lesion and its history;* *b. any changes noted by Patient A;* *c. site, size and extent of the lesion;* *d. colour of overlying mucosa - white or red or speckled;* *e. texture - hard soft indurated tethered;* *f. any ulceration or not;* *g. any bleeding or not;* *h. and if possible, a photographic record of the lesion* *The records made by Mr Shimmin related to presentation and examination of Patient A's oral lesions in the periods 01.12.15 to 11.03.16 and 23.04.19 to 07.06.19 fell far below standard."* In the document dated 14 February 2020 it was stated on behalf of Mr Shimmin that: *"Mr Shimmin considered the raised area on [Patient A's] right cheek on 1 December 2015 and requested she attend a two-week review. At that review, he considered the area to have shrunk and therefore advised a further review period to mid-January (although the appointment took place later in the month). When the patient attended again in January 2016, the area had once again shrunk…Mr Shimmin considered that the area was caused by the patient chewing her cheek in her sleep, but still did not dismiss the matter and advised a review period of approximately six weeks. When [Patient A] attended in March 2016, Mr Shimmin advised a referral. Mr Shimmin's course of action was reasonable as he had the patient under active review and found the area to have diminished each time. Nonetheless, he did not let this continue indefinitely and referred her at the third review appointment."* The Committee accepted the opinion of Professor Brook regarding the standard of records of an assessment of lesions such as those presented by Patient A. The Committee was of the view that without a proper recording of observations in relation to the points listed by Professor Brook at (a) – (h) above, it would not be possible for a GDP to track the progress of such lesions. The Committee noted that the records made by Mr Shimmin did not cover all the areas set out by Professor Brook. It found that Mr Shimmin's assessment of Patient A's lesions on 1 December 2015 and 11 March 2016 were not adequate. It therefore found this charge proved.
1.(e)(ii)	*23 April 2019 and 7 June 2019;* **Found proved**

	On 23 April 2019 Patient A presented as an emergency patient with a swelling to her right hand side. The dental records for this appointment record *"C-O PAIN- SWELLING RHS=- LR345 – RAW AND CHEWED APPEARANCE ON THE LIP- LR5 MOBILE- GENERALLY DRY MOUTH."* On the following appointment on 17 May 2019, the notes record the patient's complaint as "VERY DRY MOUTH ALL THE TIME – FL VARNISH APPL. GENERALLY." However, there is no reference to the swelling noted at the previous appointment on 23 April 2019. On the appointment of 7 June 2019 Patient A presented as an emergency appointment and the records state: *"C-O LL2 LL1 SORE GUM- BUT DIDN'T LOOK TOO BAD TODAY- WORSE AROUNF THE LR4 LR5AREA* *RHS LATERAL BORDER OF THE TONGUE- FIBEROIUS OVER GROWTH PLUS WHITE PATCH- NOTHING ON THE LHS- PAT HAS LICHEN PLANUS SKIN LESIONS ANO IS UNDER DERMMAOLOGY= RWS ADVISES TO MENTION THE PROBLEMS IN HER MOUTH AT HER NEXT VISIT."* The Committee noted that the documents dated 14 February 2020 and 6 November 2020 submitted on behalf of Mr Shimmin addressing the charges are silent on this charge. As in charge 1(e)(i), the Committee accepted the opinion of Professor Brook regarding the standard of records of an assessment of lesions such as those presented by Patient A. The Committee was of the view that without a proper recording of observations in relation to the points listed by Professor Brook at (a) – (h) above, it would not be possible for a GDP to track the progress of such lesions. The Committee noted that the records made by Mr Shimmin did not cover all the areas set out by Professor Brook. It found that Mr Shimmin's assessment of Patient A's lesions on 23 April 2019 and 7 June 2019 were not adequate. It therefore found this charge proved.
1.(f)	*failed to refer Patient A to a specialist within a reasonable time following the appointment of 1 December 2015;* **Not admitted but found proved** The dental records for the appointment on 1 December 2015 record *"Raised firm growth on RHS of patients cheek,??? Frictional in pats slep – so flattened all the molar off on the RHs to se if this helps the situate=ion. RWS thinks itsa chewing habit rather than anything nasty xxx".* Patient A attended a review appointment with Mr Shimmin two weeks later on 16 December 2015. Mr Shimmin noted: *"Somms on the RHS is still there but suspected shrunk= measures 12-13mm, its lss raised, less white and less angry looking* *LHS a very small frictional ara which measures=7mm across which looks … After looking at the RHS, suspected frictional but looking lss nasty so*

	advised to patient to come back in mid jan to review again, if it looks the sanme then will refer the patint for second opinion. Patient suffers with very dry mouth so advised a gente MW and occasional sips of water." Two further reviews of Patient A's lesions by Mr Shimmin took place on 29 March 2016 and 11 March 2016. In his report Professor Brook stated: *"There is no consensus on what should be considered excessive delay at each stage. However professional delay (time after patients present in primary care) should not be more than two weeks. [This allowance of time for review by the referring practitioner is in line with guidelines from the BAOMS and BDA and the updated National Institute of Health and Care Excellence (NICE) referral guidelines for suspected cancer published on 23rd June 2015, replacing the 2005 version which states urgent referral on a cancer pathway should be undertaken for any 'unexplained ulceration in the oral cavity lasting for more than 3 weeks' or Consider urgent referral for patients presenting with 'a lump on the lip or in the oral cavity or a red or red and white patch in the oral cavity consistent with erythroplakia or erythroleukoplakia' no grace/delay period specified.* *The two-week guidance is considered sufficient time to permit GMPs and GDPs to consider and evaluate potential confounding factors such as irritation from a denture or local trauma, delay beyond this point for a non-resolved lesion can be considered excessive delay."* In the document dated 6 November 2020 it was stated on behalf of Mr Shimmin that: "*"Mr Shimmin considered the raised area on [Patient A's] right cheek on 1 December 2015 and requested she attend a two-week review. At that review, he considered the area to have shrunk and therefore advised a further review period to mid-January (although the appointment took place later in the month). When the patient attended again in January 2016, the area had once again shrunk…Mr Shimmin considered that the area was caused by the patient chewing her cheek in her sleep, but still did not dismiss the matter and advised a review period of approximately six weeks. When [Patient A] attended in March 2016, Mr Shimmin advised a referral. Mr Shimmin's course of action was reasonable as he had the patient under active review and found the area to have diminished each time. Nonetheless, he did not let this continue indefinitely and referred her at the third review appointment."* The Committee noted that between Patient A's initial presentation on 1 December 2015 with the lesion and Mr Shimmin's decision to make a referral on 11 March 2016, a period of approximately 14 weeks had lapsed. It accepted the opinion of Professor Brook that this amount of time constituted an excessive delay by Mr Shimmin. The Committee found that Mr Shimmin did not refer Patient A to a specialist within a reasonable time following the appointment of 1 December 2015. It also found that he had a duty to refer Patient A and he failed in that duty. The Committee therefore

	found this charge proved.
1.(g)	*failed to perform timely reviews following the appointments of:*
1.(g)(i)	*23 April 2019;* **Found proved** The dental records indicate that on the appointment of 23 April 2019 Mr Shimmin records: *"C-O PAIN- SWELLING RHS=- LR345 – RAW AND CHEWED APPEARANCE ON THE LIP- LR5 MOBILE- GENERALLY DRY MOUTH."* Following this entry there is no indication of a planned review. The next appointment is almost a month later on 17 May 2019. There is no assessment of the swelling identified in April 2019 and no planned review. The Committee noted Professor Brook's opinion, as quoted earlier under charge 1(f), on the appropriate timeframes for the referral of patients presenting with lesions such as those of Patient A. In his report Professor Brook also stated that: *"In the mouth, there are also associations between potentially malignant disorders such as leucoplakia (white patch), erythroplakia (red patch), lichen planus and mouth cancer.* *Early detection of oral cancers makes them more amenable to treatment, thus reducing morbidity and allowing the greatest chance of cure.* *Examination of the soft tissue to exclude abnormal findings is easy to undertake and should be undertaken routinely at every check up by General Dental Practitioners who should be vigilant and alert to changes in the oral tissues that indicate a departure from the 'normal'...* *Failure to perform timely reviews following presentation of Patient A on 23.04.19 and then again on 17.05.19 [fell] far below standard."* The Committee noted that the documents dated 14 February 2020 and 6 November 2020 submitted on behalf of Mr Shimmin are silent on this charge. The Committee accepted the opinion of Professor Brook. It found that Mr Shimmin failed in his duty to carry out timely reviews of Patient A following the appointments of 23 April 2019 and 17 May 2019. It therefore found this charge proved.
1.(g)(ii)	*17 May 2019;* **Found proved** For the same reasons as in 1(g)(i) above.
1.(h)	*failed to instigate an urgent referral on the cancer pathway on 7 June 2019.* **Found proved**

	The dental records for the appointment of 7 June 2019 state: *"C-O LL2 LL1 SORE GUM- BUT DIDN'T LOOK TOO BAD TODAY- WORSE AROUNF THE LR4 LRSAREA* *RHS LATERAL BORDER OF THE TONGUE- FIBEROIUS OVER GROWTH PLUS WHITE PATCH- NOTHING ON THE LHS- PAT HAS LICHEN PLANUS SKIN LESIONS ANO IS UNDER DERMMAOLOGY= RWS ADVISES TO MENTION THE PROBLEMS IN HER MOUTH AT HER NEXT VISIT."* The Committee noted Professor Brook's opinion, as quoted earlier under charge 1(f), on the appropriate timeframes for the referral of patients presenting with lesions such as those presented by Patient A. In his report, Professor Brook also stated that *"Failure to instigate an urgent referral on the cancer pathway on 07.06.19 fell far below standard."* The Committee noted from the dental records that Mr Shimmin had identified an issue with Patient A's mouth but rather than refer he advised the patient to mention the concerns to her doctor at her next visit. The Committee accepted the opinion of Professor Brook that at this point an urgent referral was required and failing to do so was far below the standard. It found that, at this appointment on 7 June 2019, Mr Shimmin had a duty to instigate an urgent referral of Patient A on the cancer pathway and he failed in that duty. The Committee therefore found this charge proved.
	Caries
1.(i)	*failed to diagnose caries on 17 May 2019 at:*
1.(i)(i) 1.(i)(ii) 1.(i)(iii) 1.(i)(iv)	*UR3;* *UL5;* ***Amended to:*** *UL1* *UL4* **Found proved** On 17 May 2019 Mr Shimmin saw Patient A for a routine dental examination and he noted (as he had since 2014) that Patient A was at high risk of caries. In his report Professor Brook stated: *"The DPT 23 07 19 from [the hospital] only two months after examination by Mr Shimmin 17.05.19 showed gross decay UL5. The subsequent practitioner on 18 07 19 took radiographs which showed decay in UR3, UL5, UR1 and upper UL4 and that fillings were required in:* • *UR3 DBI (distal, buccal and incisal)* • *UL5 MODB (mesial, occlusal, distal and buccal)* • *UR1 D*

	• *UL1 D* • *LL7 B* • *LL4 B* • *UL4 DO…* *Patient A was seen for examination by Mr Shimmin 17.05.19 failures at that time related to lack of radiographic assessment and clinical assessment resulted in failure to detect and diagnose dental decay and fillings that were required.* *Accepting that the subsequent treating dentist as is often the case, when a patient attends for the first time, made a different diagnosis and may have planned care in teeth that Mr Shimmin was monitoring (the notes being unhelpful in this respect) the examination on 17.05.19 fell far below standard related to the diagnosis of dental caries."* The Committee noted that the documents dated 14 February 2020 and 6 November 2020 submitted on behalf of Mr Shimmin are silent on this charge. The Committee accepted the opinion of Professor Brook. It found that Mr Shimmin failed to diagnose caries in Patient A's UR3, UL5, UL1 and UL4 on 17 May 2019. It therefore found this charge proved.
	Radiographic Monitoring
2.	*Failed to take sufficient bitewing radiographs between 29 March 2006 and 7 June 2019 in order to adequately monitor Patient A's caries.* **Found proved** In his report, Professor Brook stated: *"As a result of Oral Lichen Planus (2005-) and Sjögren's syndrome (2006-) Patient A suffered from a sore mouth with concomitant difficulties in eating and performing oral hygiene. Increased susceptibility to dental decay due to the lack of the protective effect of saliva. Patient A was thus at high risk of periodontal disease and caries and this was noted and managed by Mr Shimmin and formally recorded in the improved typewritten computer- based records from 20.05.14. Periodontal care was not adequately recorded in the records from the last century but then the records improved steadily…* *There was a failure to monitor and assess Patient A radiographically. Examinations (such as bitewings) to diagnose caries depends upon an assessment of the caries risk – high,* *moderate and low. For adults' high risk indicates six monthly screening, moderate – annual until no further active lesions, low ~every 2 years.* *In the period 23.12.1987 to 07.06.19 bitewings were taken on only one occasion [on] 17.03.17.* *Patient A was a high risk for dental decay on developing a dry mouth 2006*

	onwards and was recorded as high risk [from] 2014 onward by Mr Shimmin. *Patient A should have been more closely monitored radiographically for dental decay and periodontal bone loss - care fell far below standard."* The Committee noted that the letter dated 14 February 2020 on behalf of Mr Shimmin states "Mr Shimmin is regretful that he did not take radiographs as frequently as he should have done. He admits this part of the allegation and apologises to [Patient A] and the GDC." The Committee noted that Mr Shimmin's admission related to a failure to complete frequent radiographic monitoring of Patient A as expected for patients with Sjorgren's Syndrome and the aspect relating to caries and periodontal bone loss was denied. The Committee accepted the opinion of Professor Brook. It found that taking only one bitewing radiograph over a 30 year period of providing dental care to a patient at high risk of periodontal disease and caries amounted to a failure in his duty to the patient. The Committee therefore found this charge proved.
3.	*Failed to adequately monitor Patient A's periodontal bone loss radiographically between 29 March 2006 and 7 June 2019.* **Found proved** For the same reasons as charge 2 above.
	Record Keeping
4.	*Failed to adequately record the appearance of the lesions present between:*
4.(a)	*1 December 2015 and 11 March 2016;* **Admitted and found proved** The dental records indicate that on the appointment of 1 December 2015 Mr Shimmin records *"Raised firm growth on RHS of patients cheek,??? Frictional in pats slep – so flattened all the molar off on the RHs to se if this helps the situate=ion. RWS thinks itsa chewing habit rather than anything nasty xxx".* For the appointment of 11 March 2016 the following record is made " Patient's complaints: *"RHS FRICTIONAL AREA TO REF TO RLI FOR 2ND OPINION – PAT HAS VERY DRY MOUTH – RAISED RHS OF CHEEK MORE THAN A SQUARE CM IN SIZE".* In his report Professor Brook stated that: *"Standard records for recording lesions such as those presented by Patient A in general practice in the periods 01.12.15 to 11.03.16 and 23.04.19 to 07.06.19 should have included the following:* *a. the duration of the lesion and its history;*

	b. any changes noted by Patient A; *c. site, size and extent of the lesion;* *d. colour of overlying mucosa - white or red or speckled;* *e. texture - hard soft indurated tethered;* *f. any ulceration or not;* *g. any bleeding or not;* *h. and if possible, a photographic record of the lesion* *The records made by Mr Shimmin related to presentation and examination of Patient A's oral lesions in the periods 01.12.15 to 11.03.16 and 23.04.19 to 07.06.19 fell far below standard."* The Committee noted the submissions made on behalf of Mr Shimmin in the document dated 14 February 2020 which is set out above at charge 1(e)(i). It was also stated on Mr Shimmin's behalf that "Mr Shimmin admits and very much regrets that his recordkeeping was not adequate in respect of [Patient A's] notes." The Committee accepted the opinion of Professor Brook regarding the standard of records of an assessment of lesions such as those presented by Patient A. The Committee was of the view that without a proper recording of observations in relation to the points listed by Professor Brook at (a) – (h) above, it would not be possible for a GDP to track the progress of such lesions. The Committee noted that the records made by Mr Shimmin on both appointments did not cover all the areas set out by Professor Brook. It found that Mr Shimmin failed to adequately record the appearance of the lesions on 1 December 2015 and 11 March 2016.
4.(b)	*23 April 2019 and 7 June 2019.* **Admitted and found proved** For the same reasons as charge 4(a) above.

We move to Stage Two."

On 26 November 2020 the Chairman announced the determination as follows:

"Having announced its decision on the facts, in accordance with Rule 20 of the Fitness to Practise Rules 2006, the Committee heard submissions from Ms Tahta, on behalf of the General Dental Council ("the Council") in relation to the matters of misconduct, impairment and sanction. The Committee also received advice from the Legal Adviser which it accepted.

The Committee reminded itself that its decisions on misconduct, impairment and sanction are matters for its own independent judgement. There is no burden or standard of proof at this stage of the proceedings. Where applicable, the Committee took into consideration the GDC's "*Standards for the Dental Team*" (September 2013). The Committee was referred to

the cases of *Roylance v GMC; R (on the application of Remedy) v GMC; Cohen v GMC*; and *CHRE v NMC & Grant*.

Fitness to Practise History

Ms Tahta submitted that Mr Shimmin has no previous fitness to practise history with the Council.

Summary of Findings

This case involves the care provided by Mr Shimmin to Patient A, a patient whom he treated for a period of over 31 years.

The Committee found proved that, between 29 March 2006 and 7 June 2019, Mr Shimmin failed to provide an adequate standard of care to Patient A by:

- Failing to refer Patient A, or confirm that Patient A was receiving appropriate specialist care for the oral symptoms of Sjogren's syndrome, following the appointment on 29 March 2006,
- Failing to make a provisional diagnosis of oral Lichen Planus following the appointment on 24 November 2008,
- Failing to refer Patient A to a specialist in oral medicine or oral and/or maxillofacial surgery regarding the possibility of oral Lichen Planus following the appointment on 24 November 2008,
- Inappropriately assessing Patient A to be at low risk of oral cancer between 4 September 2015 and 22 February 2019,
- Failing to adequately assess the lesions present between 1 December 2015 and 11 March 2016, and 23 April 2019 and 7 June 2019,
- Failing to refer Patient A to a specialist within a reasonable time following the appointment of 1 December 2015,
- Failing to perform timely reviews following the appointments of 23 April 2019 and 17 May 2019,
- Failing to instigate an urgent referral on the cancer pathway on 7 June 2019,
- Failing to diagnose caries on 17 May 2019 at UR3, UL5, UL1 and UL4.

The Committee also found proved that, between 29 March 2006 and 7 June 2019, Mr Shimmin failed to take sufficient bitewing radiographs in order to adequately monitor Patient A's caries, failed to monitor adequately Patient A's periodontal bone loss radiographically and failed to record adequately the appearance of the lesions present between 1 December 2015 and 11 March 2016, and 23 April 2019 and 7 June 2019.

Misconduct

Submissions on behalf of the Council

Ms Tahta submitted that Mr Shimmin's failings occurred over a considerable period of time and in some instances were over a course of 13 years. She submitted that in considering whether the failings amount to misconduct, the Committee should consider the following sections of the GDC's *Standards for the Dental Team* which the Council submitted had been

breached – principle 1, standard 1.4.2, principle 4, standard 4.1, and principle 7, standard 7.1.

Ms Tahta submitted that the facts found proved clearly amount to multiple breaches of the standards and constitute misconduct.

Decision on Misconduct

The Committee found multiple failures in the standard of care provided by Mr Shimmin to Patient A over a period of 13 years, including his radiographic practice and his record keeping practice. Mr Shimmin failed to recognise the potential diagnosis of oral lichen planus in a patient that he was already aware suffered from the skin lesions of lichen planus. He also failed to refer Patient A to a relevant specialist regarding the possibility of oral lichen planus. Mr Shimmin took only one bitewing radiograph in the period he provided dental care to Patient A, a patient at high risk of periodontal disease and caries. Mr Shimmin's assessment and recording of Patient A's lesions was inadequate as he did not follow the required standards for the recording of lesions. Professor Brook was of the opinion that each of Mr Shimmin's failings in relation to Patient A individually fell far below the standard.

The Committee acknowledged that the case involves one patient. However, it considered that there are multiple failings which are serious and span a significant period of time during which there were fundamental failings in relation to specialist referrals, clinical assessments, radiographic monitoring and record keeping. The Committee noted that Patient A was subsequently diagnosed with oral cancer and had to undergo extensive operations but the statement from Patient A's Consultant Oral and Maxillofacial Surgeon made it clear that the failure of Mr Shimmin to instigate an urgent referral of Patient A on a cancer pathway does not appear to have affected the prognosis of Patient A's cancer. The Committee has therefore not taken the fact of Patient A's subsequent cancer treatment into account in this case.

Mr Shimmin's failings fell far short of the standards required to be followed by registered practitioners. A number of standards set out within the *Standards for the Dental Team*, September 2013 are relevant to the findings made in this case. These include:

Principle 1	Put patients' interests first.
Standard 1.4.2	You must provide patients with treatment that is in their best interests, providing appropriate oral health advice and following clinical guidelines relevant to their situation. You may need to balance their oral health needs with their desired outcomes. If their desired outcome is not achievable or is not in the best interests of their oral health, you must explain the risks, benefits and likely outcomes to help them to make a decision.
Principle 4	Maintain and protect patients' information.
Standard 4.1	You must make and keep contemporaneous, complete and accurate patient records.
Principle 6	Work with colleagues in a way that is in patients' best interests
Standard 6.3	You must delegate and refer appropriately and effectively

Guidance 6.3.3	You should refer patients on if the treatment required is outside your scope of practice or competence. You should be clear about the procedure for doing this.
Principle 7	Maintain, develop and work within your professional knowledge and skills.
Standard 7.1	You must provide good quality care based on current evidence and authoritative guidance.
Standard 7.3	You must update and develop your professional knowledge and skills throughout your working life.

The Committee's view is that the multiple omissions found proved in this case are serious and would be regarded as deplorable by fellow practitioners. It noted that Patient A's subsequent treating dentist said in his witness statement of 26 June 2020 that "In [his] experience, [he] had not seen such neglect before in a patient that had attended for regular dental appointments…her teeth were an absolute disaster and it looked like she had not been to a dentist for many years." The Committee concluded that the facts found proved amount to misconduct.

Current impairment

The Committee next considered whether Mr Shimmin's fitness to practise is currently impaired by reason of his misconduct.

Submissions on behalf of the Council

Ms Tahta submitted that all the failings found proved are clinical and therefore remediable. However, she submitted that Mr Shimmin has not remedied his failings and the Committee could not conclude that they were highly unlikely to be repeated. Ms Tahta submitted that Mr Shimmin has shown very little evidence of remediation. She submitted further that Mr Shimmin had made a general apology to Patient A and her family which was welcome but despite his expressions of regret, he made limited admissions to the current charges. Furthermore, she submitted that the evidence of remediation from Mr Shimmin was not all relevant to the misconduct in this case, with the most relevant dated 9 months ago. Ms Tahta submitted that the evidence submitted by Mr Shimmin is insufficient to demonstrate remediation and therefore the public would be at significant risk of harm if a finding of impairment is not made. She also submitted that public confidence would be seriously undermined if a finding of impairment is not made.

Decision on current impairment

The Committee is of the view that the misconduct in this case is remediable. In considering whether it has been remedied, the Committee reviewed the evidence of remediation submitted on Mr Shimmin's behalf. This includes a dental records audit dated 23 January 2020; Continuing Professional Development ("CPD") certificates on Undertreatment; Complaint Handling; Perio Q&As; Case Assessment; Radiographs and Imaging; Clinical Records; Periodontal Disease; Oral Cancer; Core CPD Update; The Relationship between Lifestyle and oral health - Dentistry and Patients with Additional Needs; and Radiology. The Committee considered that the remediation material submitted is limited in scope in contrast to the multiple and serious failings found proved. It noted that the remediation activities actively carried out by Mr Shimmin ended in February 2020. The Committee also noted from the document dated 6 November 2020 that Mr Shimmin has no intention of returning to

dentistry, having ceased all practice in March 2020. The Committee considered the submissions on behalf of Mr Shimmin that the likelihood of repetition is low given that Mr Shimmin has now ceased to practise but concluded that the risk to the public remains high given that the failings have not been addressed. The Committee noted that Mr Shimmin has made a general apology to Patient A and her family for the distress caused. However, there is limited evidence of his insight into the impact of his failings, his reflection on the courses completed and how they have changed his practice and evidence of his remorse. Given the limited remediation and the absence of sufficient evidence of insight and remorse, the Committee concluded that there is a high likelihood of repetition of the failings and a risk to patients and the public. The Committee determined that a finding of impairment is required for the protection of the public.

The Committee then considered whether a finding of impairment is required in the public interest to maintain public confidence in the profession and declare and uphold proper standards. It is of the view that a reasonable and informed member of the public, fully aware of the extent of Mr Shimmin's failings would lose confidence in the profession and the dental regulator if a finding of impairment was not made in the circumstances of this case.

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

Sanction

The Committee next considered what sanction, if any, to impose on Mr Shimmin's registration. It recognises that the purpose of a sanction is not to be punitive although it may have that effect. The Committee applied the principle of proportionality. It also took account of the *Guidance for the Practice Committees including Indicative Sanctions Guidance, October 2016, ("PCC Guidance")*.

Submissions on behalf of the Council

Ms Tahta submitted that the Council's position is that, although this case involves purely clinical failings, the only proportionate sanction is one of erasure. She submitted that misconduct in most clinical cases is considered remediable and in the vast majority a period of conditional registration with a review prior to the expiry of the period is usually the proportionate sanction. However, she submitted that in this case Mr Shimmin's misconduct although easily remediable, has not been remedied and the evidence in the letter sent on his behalf is that, ultimately, he no longer has any interest in remedying his failings. She submitted that he has expressed a decision never to practice dentistry again and has chosen not to attend the hearing to explain his actions to the Committee. Ms Tahta submitted that, for these reasons, the propionate and appropriate sanction is one of erasure.

Decision on sanction

The Committee is of the view that to conclude this case with no further action would be inappropriate and would not satisfy the public interest. In light of the nature of the serious misconduct and current impairment found in this case, some form of sanction on Mr Shimmin's registration is required.

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

In relation to a reprimand the Committee noted that the PCC Guidance states that:

"*A reprimand may be suitable where most of the following factors are present (this list should not be taken to be exhaustive):*

- *there is no evidence to suggest that the dental professional poses any danger to the public;*
- *the dental professional has shown insight into his/her failings;*
- *the behaviour was an isolated incident;*
- *the behaviour was not deliberate;*
- *the dental professional acted under duress;*
- *the dental professional has genuinely expressed remorse;*
- *there is evidence that the dental professional has taken rehabilitative/corrective steps;*
- *the dental professional has no previous history."*

The Committee noted that there was no evidence that Mr Shimmin's behaviour was deliberate and he has no previous fitness to practise history with the Council. There is also no evidence to suggest that he acted under duress. Mr Shimmin's failings in relation to his failure to diagnose and monitor Patient A's caries and periodontal bone loss put Patient A at risk of harm. Furthermore, he has demonstrated only limited insight or remorse and very limited corrective steps in relation to his failings. Having reviewed the relevant factors for a reprimand, it concluded that a reprimand was inappropriate.

The Committee considered whether a conditions of practice order would be appropriate. It noted from the PCC Guidance that:

"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…

Conditions may be appropriate when all or most of the following factors are present (this list is not exhaustive):

- *there are discrete aspects of the registrant's practice that are problematic;*
- *any deficiencies are not so significant that patients will be put at risk directly or indirectly as a result of continued – albeit restricted – registration;*
- *the registrant has shown evidence of insight and willingness to respond positively to conditions;*
- *it is possible to formulate conditions that will protect the public during the period they are in force;*
- *it is possible to formulate conditions that satisfy the requirements set out at 7.19."*

Mr Shimmin's attitude by not engaging with his regulator at this time leaves the Committee with little confidence that conditions would be complied with. In addition, the areas where

concerns were identified are not discrete but wide ranging and significant such that patients would be put at risk if Mr Shimmin's registration remains unrestricted particularly in the absence of adequate remediation. Furthermore, Mr Shimmin submitted that he has ceased all practice and has indicated that he has no intention of returning to dentistry. The Committee determined that conditions are neither sufficient, workable nor appropriate to address the seriousness of the findings and safeguard the wider public interest.

The Committee next considered whether suspension would be sufficient to mark the serious misconduct and safeguard the public interest. The PCC guidance states:

"Suspension is appropriate for more serious cases and may be appropriate when all or some of the following factors are present (this list is not exhaustive):

- *there is evidence of repetition of the behaviour;*
- *the registrant has not shown insight and/or poses a significant risk of repeating the behaviour;*
- *patients' interests would be insufficiently protected by a lesser sanction;*
- *public confidence in the profession would be insufficiently protected by a lesser sanction;*
- *there is no evidence of harmful deep-seated personality or professional attitudinal problems (which might make erasure the appropriate order)."*

The Committee noted that Mr Shimmin submits that he does not want to continue in the profession, and concludes that he does not want to remedy his failings and does not wish to engage in a meaningful way with his regulator. For these reasons, the Committee concluded that suspension is not appropriate in this case.

In relation to the sanction of erasure, the PCC Guidance states:

"The ability to erase exists because certain behaviours are so damaging to a registrant's fitness to practise and to public confidence in the dental profession that removal of their professional status is the only appropriate outcome. Erasure is the most severe sanction that can be applied by the PCC and should be used only where there is no other means of protecting the public and/or maintaining confidence in the profession. Erasure from the register is not intended to last for a particular or specified term of time. However, a registrant may apply for restoration only after the expiry of five years from the date of erasure.

Erasure will be appropriate when the behaviour is fundamentally incompatible with being a dental professional: any of the following factors, or a combination of them, may point to such a conclusion:

- *serious departure(s) from the relevant professional standards,*
- *where serious harm to patients or other persons has occurred, either deliberately or through incompetence,*
- *where a continuing risk of serious harm to patients or other persons is identified,*
- *a persistent lack of insight into the seriousness of actions or their consequences."*

The findings made against Mr Shimmin were failings which spanned a long period of 13 years, individually fell far below the standards expected, and collectively amounted to

serious breaches of the standards of the profession. There has been limited remediation, limited insight into the seriousness of the failings, actual harm caused to Patient A and a continuing risk of harm to patients in the absence of sufficient remediation. The Committee acknowledged that Patient A's cancer was not a direct result of Mr Shimmin's failings but it considered that there was still serious harm caused to Patient A in the form of the extensive decay found in multiple teeth by her subsequent treating dentist.

The Committee therefore determined that erasure is the proportionate outcome in this case. The Committee has considered the impact of erasure upon Mr Shimmin but determined that the public interest outweighs Mr Shimmin's interest in this regard.

The Committee determined, pursuant to Section 27B(6)(a) of the Dentists Act 1984, as amended, to direct that Mr Shimmin's name be erased from the Register.

Any interim order currently in place is hereby revoked.

The Committee now invites submissions on whether an immediate order of suspension should be imposed on Mr Shimmin's registration.

Submissions on immediate order of suspension

Ms Tahta submitted on behalf of the Council that an immediate order should be imposed on Mr Shimmin's registration. She submitted that the interim order in place is revoked now that a substantive decision has been made. She submitted further that an immediate order is necessary to ensure that Mr Shimmin cannot return to unrestricted practice in the intervening period pending the substantive order taking effect.

Decision on immediate order of suspension

The Committee considered the submissions made and accepted the advice of the Legal Adviser. It was of the view that not to make an immediate order would be inconsistent with its previous findings on misconduct, impairment and sanction. The Committee determined that an immediate order is necessary for the protection of the public. It determined that an immediate order is also in the public interest in order to maintain public confidence in the dental profession.

The effect of the foregoing direction and this order is that Mr Shimmin's registration will be suspended with immediate effect and unless he exercises his right to appeal, the substantive direction of erasure will take effect as indicated in the notice to be served on him. Should he exercise his right to appeal, this order for immediate suspension will remain in place pending the resolution of any appeal proceedings.

That concludes this determination."