Professional Conduct Committee
Initial Hearing

Stage One: 5 to 13 February 2024
Stage Two: 16 to 17 September 2024

Name:	**OSBORNE, Erik Hereward**
Registration number:	**68046**
Case number:	**CAS-202729-L7V9W9**

General Dental Council:	John Greany, Counsel Instructed by Clare Hastie of Kingsley Napley
Registrant:	Present Represented by Simon Cridland, Counsel Instructed by Stephen Hooper of Clyde and Co

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Fitness to practise:	Impaired by reason of misconduct
Outcome:	Conditions imposed (with a review)
Duration:	Nine months
Immediate order:	Immediate order of conditions

Committee members:	Anne Ng	(Chair) (Dental Care Professional)
	Alison Mayell	(Dentist)
	Alastair Smith	(Lay)
Legal Adviser:	Michael Bell	
Committee Secretary:	Paul Carson	

Mr Osborne,

1. This hearing before the Professional Conduct Committee ('the Committee') was convened for the purposes of an inquiry into a charge against you, which was originally set out in the notification of hearing dated 3 January 2024 as follows:

> "*That being registered as a dentist, your fitness to practise is impaired by reason of misconduct in that you;*
>
> *1. In or around April 2019, you said, in respect of a patient, "Is that the horrible one?" or words to that effect.*
>
> *2. In or around April or May 2019, during an appointment, you:*
>
> *a. Confronted a 14-year-old patient, Patient A, about a negative review he had posted online.*
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> *b. Said to Patient A, "Are you the one who put a review on Google, I saw from your profile picture that you had an ice hockey shirt on, and I came to the ice rink to speak to you about it. Do you realise what damage a review like that can do?" or words to that effect.*
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> *3. On one or more occasion between 2017 and 2019, you instructed dental nurses to provide emergency treatment to patients while you were away from the practice and no dentist would be present.*
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> *4. Your conduct at 3 above was an instruction for the dental nurses to work outside their scope of practice.*
>
> *5. Your conduct at 1 and/or 2 and/or 3 and/or 4 above was:*
>
> *a. Inappropriate;*
>
> *b. Unprofessional*

2. You are represented at this hearing by Mr Simon Cridland, Counsel. The Case Presenter for the GDC is Mr John Greany, Counsel.

3. The hearing commenced on 5 February 2024, with the majority of the proceedings having been conducted remotely by Microsoft Teams video-link, save for one day, 9 February 2024. The hearing was conducted in person on 9 February 2024 for the purposes of hearing your oral evidence.

Preliminary Matters

4. At the outset of the hearing on 5 February 2024, the General Dental Council (GDC) applied for an amendment to head of charge 3 under Rule 18 of the *GDC (Fitness to Practise) Rules 2006* ('the Rules') and for joinder under Rule 25 and/or amendment under Rule 18 of head of charge 5.

5. An application was also made on your behalf for a witness statement to be admitted as hearsay.

6. The Committee heard the submissions of both Counsel in respect of each application, and it accepted the advice of the Legal Adviser.

The applications for joinder and/or amendment - 5 February 2024

7. Rule 18 provides that: *"(1) At any stage before making their findings of fact in accordance with rule 19, a Practice Committee may amend the charge set out in the notification of hearing unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice…"*

8. And Rule 25 provides that:

> *"(2) Where—*
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> > *(a) an allegation against a respondent has been referred to a Practice Committee,*
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> > *(b) that allegation has not yet been heard, and*
> >
> > *(c) a new allegation against the respondent which is of a similar kind or is founded on the same alleged facts is received by the Council,*
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> *the Practice Committee may consider the new allegation at the same time as the original allegation, notwithstanding that the new allegation has not been included in the notification of hearing.*
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> *(3) Where it is proposed that a new allegation should be heard by a Practice Committee under paragraph (2), they shall—*
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> > *(a) inform the respondent of the new allegation, and the alleged facts on which it is based; and*
> >
> > *(b) provide the respondent with an opportunity to make written representations on the new allegation and require any such representations to be received within the period of 28 days beginning with the date on which notification of the new allegation was sent to the respondent, or within such period as is otherwise agreed by the parties".*

9. Mr Greany, on behalf of the GDC, applied under Rule 18 to amend head of charge 3 by removing the word *"emergency"* so that it would now read: "*On one or more occasion*

between 2017 and 2019, you instructed dental nurses to provide treatment to patients while you were away from the practice and no dentist would be present." Mr Greany submitted that the application was being pursued to remove argument on whether some of the alleged treatment (the fitting of a retainer) would constitute *"emergency"* treatment.

10. The application was opposed by Mr Cridland on your behalf on the grounds that the amendment would impermissibly widen the scope of the charge so as to encompass a new allegation which therefore engages Rule 25, the 28-day notification requirement of which had not been met and was not waived by you.

11. The first consideration for the Committee was whether the amendment under Rule 18 could be made *"without injustice"*. The Committee noted that an amendment under Rule 18 would normally be confined to the correction of dates or typographical errors which do not alter the substance of the charge. In respect of the present application, the removal of the word *"emergency"* would, in the Committee's judgement, alter the substance of the charge by potentially introducing wider matters. It would allow the charge to be widened so as to encompass a different type of treatment other than that which is pleaded in the notification of hearing.

12. The Committee was mindful that the evidence on which the GDC was seeking to rely in respect of the treatment in question was disclosed to you several months ago and that, in response, you have provided evidence denying that you would have instructed the dental nurse to provide that treatment outside of her Scope of Practice. There would not therefore appear to be actual unfairness to you in allowing the amendment, in terms of your practical ability to respond to the charge. However, the Committee recognised that there would in principle be some degree of unfairness in allowing the amendment in circumstances where it would constitute the potential introduction of wider matters and where the 28-day notification requirements under Rule 25 have not been met. On that basis, the Committee was not satisfied that the amendment could be made *"without injustice".*

13. Accordingly, the Committee refused the GDC's application to amend the charge under Rule 18 by removing the word *"emergency".* In reaching its decision, the Committee did not decide whether or not the alleged treatment amounted to emergency treatment. The Committee only decided that charge 3 is confined to *"emergency treatment"* and that it is not to be amended under Rule 18 to refer to any other treatment.

14. The next application pursued by Mr Greany was to join or add the following allegation under Rule 25 (alternatively by way of amendment under Rule 18), so that the charge would read as follows:

> *"5. On one or more occasion, in or around January 2021, you asked Colleague 1, the practice manager and someone who was not a registered GDC dental nurse, to work as a dental nurse.*

6. Your conduct at 1 and/or 2 and/or 3 and/or 4 and/or 5 above was:

a. Inappropriate;

b. Unprofessional."

15. Colleague 1 was a qualified dental nurse but was not registered with the GDC at the time of the alleged events. The GDC's application to join or add the charge arose from her witness statement which was disclosed to you on 4 July 2023. Mr Greany submitted that the additional allegation is of a similar kind or is founded on the same alleged facts as those which had been referred by the Case Examiners in respect of head of charge 3. He submitted that, whilst the timeframe and registration status of Colleague 1 differ from what is already alleged, the allegation is still of a similar kind or is founded on the same alleged facts to those which are pleaded at head of charge 3. It was not in dispute before the Committee that the 28-day notification requirement under Rule 25 had been complied with in respect of this application, as set out in the notice served on 3 January 2024.

16. Mr Cridland opposed the application, mainly on the grounds that the alleged facts are distinct from those which had been referred by the Case Examiners, that this is not a *"new"* allegation but one which the GDC was seeking to introduce late in the proceedings without any explanation for the delay. Mr Cridland submitted that, in doing so, the GDC was effectively circumventing independent scrutiny by the Case Examiners of the additional allegation.

17. Having carefully deliberated on the matter, the Committee determined that the additional allegation is of a similar kind to those already pleaded at head of charge 3. The Committee considered that the gravamen of head of charge 3 is your alleged use of a position of authority to request or instruct subordinate colleagues to perform duties that they were not employed or permitted to do. The Committee was satisfied that the additional allegation was a *"new"* allegation for the purposes of Rule 25 in that, for whatever reason, it had not already been considered by the Case Examiners as part of the referral to this Committee.

18. Accordingly, having had regard to all the circumstances, including the fairness of the proceedings and the GDC's overarching statutory objective, the Committee determined to allow the application under Rule 25 to join or add the additional charge in the terms quoted above.

The application to admit hearsay evidence – 5 February 2024

19. The third preliminary application which the Committee heard on 5 February 2024 was an application made by Mr Cridland for the witness statement of your wife, a General Dental Practitioner who works at the Practice, to be admitted as hearsay. For the purposes of this determination, your wife is referred to as Witness 6.

20. The hearsay application was unopposed by the GDC.

21. The Committee heard in private session under Rule 53 of the Rules details of why Witness 1 was unable to attend to give evidence to the Committee, whether in person or remotely. Any reference to those matters shall remain in private under Rule 53 as part of these proceedings. The Committee was satisfied that this uncontested evidence was cogent and credible. The Committee accepted that there were strong reasons why Witness 6 was unable to attend, and it concluded that it would be unreasonable to expect or require her attendance.

22. The Committee considered that Witness 6's witness statement was relevant to the allegations you faced. It considered that the fact that her witness statement could not be tested by questioning was potentially a matter going to the weight which could be attached to her evidence, but it was not a matter going to admissibility. Hearsay evidence is admissible in these proceedings and the Committee determined that it would be fair to allow Witness 6's witness statement to be admitted as hearsay.

Summary of the case background

23. In his opening submissions for the GDC, Mr Greany outlined the background to the charge against you. He provided the Committee with a copy of his opening in writing and made submissions orally.

24. You are a GDC registered dentist and the principal of a dental practice ('the Practice). The Committee heard that on 11 January 2021, the NHS England Professional Standards Team ('NHS PST') received a referral form raising a performance concern about you.

25. Mr Greany highlighted that the material provided to the NHS PST is summarised within the witness statement of Witness 1, a manager within the NHS PST. This material included complaints and supporting documentation provided by employees at the Practice, a number of whom are also witnesses in this case. Also included in the material received by the NHS PST was your version of alleged events.

26. On 21 April 2021, following the NHS investigation, the Assistant Medical Director NHS England referred the concerns to the GDC.

27. It is the evidence provided to the GDC by NHS PST, and that which was gathered by the Council during its own investigation, which forms the basis of the allegations in this case. The charge brought against you by the GDC encompasses two broad areas of concern, namely your alleged inappropriate and unprofessional conduct towards patients, and your alleged inappropriate and unprofessional instructions to colleagues to undertake work that they were not qualified and/or registered to undertake.

28. You denied all the allegations set out in the charge.

Evidence

29. The factual evidence provided to the Committee by the GDC comprised a number of witness statements along with associated exhibits. The Committee received:

- The witness statement of Witness 1, the NHS PST manager, dated 3 July 2023.
- The witness statement of Witness 2, a dental nurse who worked at the Practice, dated 2 July 2023.
- The witness statement and supplementary witness statement of Colleague 1 who, at the material time was the Practice Manager, dated 4 July 2023 and 27 July 2023.
- The witness statement of Witness 3, a dental nurse who worked at the Practice, dated 3 July 2023.
- The witness statement of Patient A's mother dated 29 June 2023.
- The witness statement of Witness 4, a dental nurse who worked at the Practice, dated 13 July 2023.

30. By way of expert evidence, the GDC provided an expert report prepared by Ms Jo Russell, a qualified dental nurse, teacher, and assessor. In her report dated 26 July 2023, Ms Russell address the scope of practice of a dental nurse with reference to the GDC's *'Scope of Practice (Effective from September 2013)'*

31. In addition to the documentary evidence, the Committee heard oral evidence from Witness 2, Colleague 1, Witness 3, Patient A's mother and Witness 4.

32. The written evidence of Witness 1 was agreed by both parties, as was the expert report of Ms Russell. Neither party nor the Committee required these witnesses to attend the hearing to give oral evidence.

33. The evidence received by the Committee in respect of your case was your main witness statement with associated exhibits dated 12 January 2024.

34. The Committee also admitted into evidence your supplementary witness statement after a successful unopposed application made on your behalf under Rule 57 of the Rules. In admitting your supplementary witness statement, the Committee noted that it related to issues that arisen during the evidence of Colleague 1 and provided further information in relation to these matters. The Committee considered that it was a matter for it to decide what weight to place on your supplementary statement at the fact-finding stage.

35. The further evidence before the Committee in support of your case comprised the following witness statements with their associated exhibits:

- The witness statement of Witness 5 dated 16 February 2024, a Specialist Orthodontist who worked at the Practice intermittently on Saturdays from 2009 to 2018, and also on an ad hoc basis until 2022.
- The witness statements of the parents of a patient who attended the Practice for orthodontic treatment dated 21 January 2024 and 23 January 2024 respectively. In their witness statements, the parents of the patient deal with an appointment for their daughter which took place on 18 October 2019, which was the subject of much discussion during the evidence.
- The witness statement of your wife, General Dental Practitioner, Witness 6.

36. The Committee also heard oral evidence from Witness 5, and from you. You gave your oral evidence in person, as opposed to via the remote video-link.

Findings of Fact – 13 February 2024

37. The Committee considered all the evidence presented to it, both documentary and oral. It took account of the closing submissions on the alleged facts made by Mr Greany on behalf of the GDC and those made by Mr Cridland on your behalf. The Committee accepted the advice of the Legal Adviser.

38. The Committee considered the factual allegations 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 proved on the balance of probabilities.

39. The Committee made the following findings:

1.	*In or around April 2019, you said, in respect of a patient, "Is that the horrible one?" or words to that effect.* **Found not proved.** In bringing this allegation, the GDC relied on the evidence of Witness 2, who first raised the issue as part of her complaint to NHS England in October 2020. In her witness statement prepared for this hearing, Witness 2 stated that she made the complaint to NHS England *"because I was aware that the NHS had been investigating the Practice and I thought they would be interested in what I had to say. I was due to leave the Practice that week and for the first time I felt that I was in a position that I was able to raise my concerns".* One of the concerns raised by Witness 2 with NHS England was that in April 2019, she had heard you say in respect of a patient *"Is that the horrible one?"* (or words to that effect). She recalled being in the surgery with you at the material time, when you were said to have asked Witness 6 this question, allegedly referring to a patient. Witness 2 stated that you then asked the Practice reception to let the patient know that they would not be seen for treatment. In support of the alleged

	matter, Witness 2 provided to NHS England a copy of the log of concerns and diary she had been keeping. In your witness statement you recalled the patient to which this allegation relates. You stated that she was a teenage girl whose orthodontic treatment had been completed at the Practice in November 2017, and who had been discharged from the Practice's care following an incident during a retainer review with Witness 6 on 20 June 2018. You stated that *"Regrettably, the patient's mother had been rude and aggressive toward [Witness 6] at this review appointment and had brought her to tears.* Your account in respect of alleged incident in April 2019 was that you did not say *"Is that the horrible one?"* during the conversation with Witness 6, as alleged. You stated that *"I would not have used such language about this patient, or any patient. I may have said something along the lines of "is she the one who was horrible to you?", which was in reference to the patient's mother and her behaviour on 20 June 2018.* The Committee noted that your account is corroborated by that of Witness 6, as outlined in her witness statement. In considering the written account of Witness 6, the Committee bore in mind that her evidence was not tested through questioning at this hearing. It therefore decided that it could place limited weight on her written account. However, the Committee took into account that the incident involving Witness 6 and the patient's mother on 20 June 2018 is documented in the clinical records for that appointment. The Committee considered that the presence of this contemporaneous evidence supported the contention that you had been referring to the patient's mother during a private conversation with Witness 6 after seeing the patient in the Practice waiting area. Therefore, whilst the Committee was satisfied on the evidence, including your own account, that you used the word "horrible" in conversation with Witness 6, it was not satisfied that this was in reference to a patient. The Committee concluded that it was more likely that what you said was misheard by Witness 2 and taken out of context. Having taken all the evidence into account, the Committee was not satisfied that the GDC proved this allegation on the balance of probabilities.
2a.	*2. In or around April or May 2019, during an appointment, you:* *a. Confronted a 14-year-old patient, Patient A, about a negative review he had posted online.* **Found proved.** The Committee was satisfied from the evidence provided, which included the relevant clinical records in respect of Patient A dated 25 April 2019, that you raised with Patient A the matter of a negative review that he had posted online. The Committee noted that the sole issue between the parties in relation to this allegation was whether in doing so, you *"confronted"* Patient A. In her witness statement, Patient A's mother stated, *"Erik Osborne confronted my son, who was 14 years old at the time…".* The Committee noted that in her oral evidence Patient A's mother was fair and balanced in that she stated that she understood why you had been unhappy with the online review. She also stated

	that she did not consider that you had been aggressive towards her son, instead that you had raised the issue as a matter of fact. However, Patient A's mother said that Patient A himself had felt confronted. The Committee found that she was clear in her evidence about Patient A's reaction. She said that Patient A had been intimidated by you raising the matter whilst he was in the dental chair awaiting treatment, and that after the appointment he was upset and in tears. The Committee considered Patient A's mother to be a credible witness, and it accepted her evidence on this issue. The Committee noted that in emails to NHS England dated 9 and 15 July 2019, Patient A's mother had made enquiries about changing practice. The Committee further had regard to your oral evidence during cross-examination, when you acknowledged that from a child's point of view, your action could have been regarded as confrontational. In reaching its decision, the Committee considered the matter contextually. It took into account the subjective perspective of Patient A, a child patient who was sitting in the dental chair expecting to be treated, when you the treating dentist, in a position of trust, raised with him the negative online review without warning. The Committee had regard to the imbalance of power involved in this interaction with Patient A, as well as the evidence of the impact on the patient. In all the circumstances, the Committee was satisfied that your action did amount to a confrontation. Accordingly, this head of charge is proved.
2b.	*2. In or around April or May 2019, during an appointment, you:* *b. Said to Patient A, "Are you the one who put a review on Google, I saw from your profile picture that you had an ice hockey shirt on, and I came to the ice rink to speak to you about it. Do you realise what damage a review like that can do?" or words to that effect.* **Found proved.** The evidence in support of this allegation is contained within the witness statement of Patient A's mother, who maintained that you said this to Patient A at the appointment on 25 April 2019 or words to this effect. In addition, Witness 2 stated in her witness statement that, *"Erik Osborne went to the computer and brought up the google review and asked the patient to come over. Whilst pointing to the computer screen he said "are you telling me this isn't you". Erik Osborne was referring to the google account name and picture, which made it obvious the user played ice hockey. Erik Osborne then told the patient that he had been to the ice rink to look for him to fix his brace".* The Committee noted from your evidence that you did not deny that you said to Patient A, *"Are you the one who put a review on Google, I saw from your profile picture that you had an ice hockey shirt on…"* or that you stated "…*Do you realise what damage a review like that can do?".* You did deny, however, that you specifically went to the ice rink to speak to Patient A about the review. Your evidence was that you happened to be at the ice rink for a family social engagement, although you did ask a member of staff whether Patient A was there.

	The Committee considered that Patient A's mother would have remembered you saying something like this to her child during a dental appointment. It was therefore satisfied that her account was reliable. Whilst the Committee acknowledge your explanation that you did not go to the ice rink with the intention of speaking to Patient A, it did not consider that this evidence undermined what is alleged. It noted that the charge states *"words to that effect"* and the Committee was satisfied that words like this were used by you in your confrontation of Patient A during the appointment on 25 April 2019.
3.	*On one or more occasion between 2017 and 2019, you instructed dental nurses to provide emergency treatment to patients while you were away from the practice and no dentist would be present.* **Found proved.** The committee received written and oral evidence from Witnesses 2, 3 4 and Colleague 1, all of whom were consistent in stating that you instructed the dental nurses to deal with emergencies whilst you were away on holiday. Their evidence was that this was common knowledge at the Practice. The Committee took into account that, in relation to this allegation it heard and received a considerable amount of evidence in respect of an appointment that took place on 18 October 2019, and who it was that provided treatment to the patient on that occasion. Whilst the Committee acknowledged that this evidence provided relevant contextual information, it remained mindful that this head of charge is concerned with whether you provided an instruction to the dental nurses to provide emergency treatment in your absence. You denied giving any such instruction, and you provided the Committee with a copy of a Standard Operating Procedure (SOP) as evidence of the formal procedure that was in place at the Practice for the provision of emergency cover. The Committee took into account that you did not mention the existence of the SOP in your witness statement. Further, it found, however, that when questions were put to you about the SOP, including when it was written, how many versions there had been and to whom it applied, your answers were vague and often evasive. The Committee's attention was further drawn to an email dated 26 April 2019 from Witness 5, which you said confirmed the emergency cover arrangement in place at the practice. In the email, Witness 5 appeared to be agreeing to cover holidays. However, the Committee took into account the evidence that at that time, Witness 5 worked at a dental hospital and attended the Practice in the evenings. The Committee considered that Witness 5's email agreeing to cover holidays did not represent anything more than an ad hoc arrangement, as opposed to a formal agreement or policy. Whilst the Committee also heard from Witness 5 about what she said was the arrangement for emergency cover at the Practice, it noted that on several occasions she referred to the arrangement as being an informal one. The Committee also noted that there were inconsistencies between your account and that of Witness 5 in relation to the operation of the arrangement. You told the Committee that the dental nurses had been instructed to telephone you in the event that emergency cover was needed at the Practice, whilst Witness 5 stated that they had been instructed to telephone her.

	It was the view of the Committee that your evidence about a formal policy being in place at the Practice between 2017 and 2019 was not corroborated by any contemporaneous or objective evidence. The Committee also noted that the SOP in question contained information relevant to when dental practices re-opened during the covid-19 pandemic, which is a period that post-dates the timeframe within this charge. Witnesses 2, 3, 4, and Colleague 1 all stated that they were unaware of the SOP. The Committee noted the evidence of Witness 3 in particular, who appeared to very uncomfortable in giving her evidence on this matter, and who eventually admitted that she had provided emergency treatment to one patient. The Committee could see no reason why Witness 3 would have done this if not instructed to do so. The Committee also noted your oral evidence that you were contacted by the area team about what emergency cover there was in place while you were on holiday. The Committee considered that it could reasonably infer from the information before it that there were concerns about whether the emergency arrangements at the Practice was adequate. Taking all the evidence into account, the Committee was not satisfied that there was any formal policy in place during the relevant period for emergency cover at the Practice. The Committee concluded that it was more likely than not that you did instruct dental nurses to provide emergency cover while you were away from the Practice and no dentist would be present.
4.	*Your conduct at 3 above was an instruction for the dental nurses to work outside their scope of practice*. **Found proved.** The Committee noted that both parties agreed that its finding in respect of this allegation at head of charge would be reliant on its finding made in respect of head of charge 3 above. The Committee also noted that both parties accepted the evidence of the expert witness in this case, Ms Russell. In her report, Ms Russell referred to the GDC's Scope of Practice in relation to dental nurses. She stated that *"Although the scope of practice for dental nurses is not an exhaustive list of what a dental nurse can and cannot do, page 5 of the document…states further skills a qualified dental nurse could develop are "further skills in assisting in the treatment of orthodontic patients". The key word being assisting – they will, at all times be assisting a dentist or an orthodontic therapist. The scope of practice is furthermore precise in its directive on page 5 that "Dental nurses do not diagnose disease or treatment plan. All other skills are reserved to one or more of the other registrant groups." This, in my opinion, refers to the fact that dental nurses cannot alone decide on a course of treatment appropriate for a patient and then carry that treatment out without any input from a clinician".* Ms Russell went on to outline *"…activities a dental nurse can do without the input of another registrant group"* but she stated that "*everything I have listed is on the prescription of a dentist. The dental nurse does not decide for themselves what is to be done".*

	The Committee accepted the expert opinion of Ms Russell that what the dental nurses describe in their witness statements, about being instructed to provide emergency treatment to patients, was outside of their scope of practice. Ms Russell stated that "*The reason for this is that it is all beyond the scope of practice for any dental nurse. Under no circumstances can a dental [nurse] see or treat patients, … with or without a dentist present".* This head of charge is proved.
5.	*On one or more occasion, in or around January 2021, you asked Colleague 1, the practice manager and someone who was not a registered GDC dental nurse, to work as a dental nurse.* **Found proved.** The evidence before the Committee was that Colleague 1 was not a registered dental nurse at the time, and that you were aware of this. Accordingly, as highlighted in the expert evidence, Colleague 1 was not permitted to carry out any clinical duties. The Committee noted that the issue of contention in relation to the allegation is whether you asked her to work as a dental nurse. Colleague 1's evidence was that this happened on a couple of occasions until she 'put her foot down'. You denied that you asked Colleague 1 to work as a dental nurse and you suggested that she made this complaint when she was asked to leave the Practice. The Committee was provided with two text messages sent by you, both dated 18 January 2021. You sent the first of the messages to the receptionist at the Practice at 08.36, in which you requested that she ask Colleague 1 if she could *"nurse/chaperone"* that day because of a number of staff absences. The second message you sent directly to Colleague 1 at 08.47 asking if she could *"nurse/assist"* on the day in question. Your evidence, as stated in your witness statement, was that you *"received and sent several text messages that morning to and from staff as it appeared that the dental nurse who was assigned to nurse for me would not be able to make it to work and we were going to be extremely short staffed as a result. The text message I sent to [Colleague 1] …was most likely sent quickly or in a rush…I accept that the use of the word "nurse" was a poor choice of words, typed in haste. However, it was never intended that [Colleague 1] would act as a dental nurse as this would have been entirely inappropriate.* It was the Committee's view that the word *'nurse'* has a clearly different meaning to the word *'chaperone'*. It therefore considered that it was not credible that you had used the word *'nurse'* in haste and/or through poor choice. The Committee also took into account Colleague 1's evidence that she worked at the Practice full time and would have been at the surgery in any event if simply needed to chaperone. The Committee was satisfied on the evidence that this allegation is proved.
6a.	*6. Your conduct at 1 and/or 2 and/or 3 and/or 4 and/or 5 above was:* *a. Inappropriate;*

	Having found head of charge 1 not proved, the Committee considered this allegation at 6a in relation to heads of charge 2, 3 4 and 5 only. The Committee made the following decisions: **6a in relation to 2 (a and b) – Found proved.** For the reasons given in respect of its finding at head of charge 2 above, the Committee was satisfied that your behaviour, as found proved, was not suitable behaviour for a registered dentist. The Committee was satisfied that your conduct was inappropriate. **6a in relation to 3 – Found proved.** For the reasons given in respect of its finding at head of charge 3 above, the Committee was satisfied that your behaviour, as found proved, was not suitable behaviour for a registered dentist. The Committee was satisfied that your conduct was inappropriate. **6a in relation to 4 – Found proved.** For the reasons given in respect of its finding at head of charge 4 above, the Committee was satisfied that your behaviour, as found proved, was not suitable behaviour for a registered dentist. The Committee was satisfied that your conduct was inappropriate. **6a in relation to 5 – Found proved.** For the reasons given in respect of its finding at head of charge 5 above, the Committee was satisfied that your behaviour, as found proved, was not suitable behaviour for a registered dentist. The Committee was satisfied that your conduct was inappropriate.
6b.	*6. Your conduct at 1 and/or 2 and/or 3 and/or 4 and/or 5 above was:* *b. Unprofessional* Having found head of charge 1 not proved, the Committee considered this allegation at 6b in relation to heads of charge 2, 3 4 and 5 only. The Committee made the following decisions: **6b in relation to 2 (a and b) – Found proved.** For the reasons given in respect of its finding at head of charge 2 above, the Committee was satisfied that your behaviour, as found proved, was not behaviour expected of a registered dentist. The Committee was satisfied that your conduct was unprofessional. **6b in relation to 3 – Found proved.** For the reasons given in respect of its finding at head of charge 3 above, the Committee was satisfied that your behaviour, as found proved, was not behaviour

	expected of a registered dentist. The Committee was satisfied that your conduct was unprofessional. **6b in relation to 4 – Found proved.** For the reasons given in respect of its finding at head of charge 4 above, the Committee was satisfied that your behaviour, as found proved, was not behaviour expected of a registered dentist. The Committee was satisfied that your conduct was unprofessional. **6b in relation to 5 – Found proved.** For the reasons given in respect of its finding at head of charge 5 above, the Committee was satisfied that your behaviour, as found proved, was not behaviour expected of a registered dentist. The Committee was satisfied that your conduct was unprofessional.

40. The hearing moves to Stage Two.

Stage Two 17 September 2024

Mr Osborne,

41. Between 2017 and 2019, you instructed your dental nurses to deal with emergency patients whilst you were away on holiday, which was beyond their Scope of Practice. In or around January 2021, you also asked your Practice Manager to work as a dental nurse even though she was not registered with the GDC. She was qualified and experienced as a dental nurse but had allowed her GDC registration to lapse. Therefore, she was not permitted to carry out any of the duties of a dental nurse.

42. In addition, in around April or May 2019 you confronted a 14-year old patient about a negative review which he had posted online regarding orthodontic treatment which he was receiving from you. You stated to him words to the effect: "*Are you the one who put a review on Google, I saw from your profile picture that you had an ice hockey shirt on, and I came to the ice rink to speak to you about it. Do you realise what damage a review like that can do?*".

43. This took place during a dental appointment whilst the child patient was seated in the dental chair with his mother present. He initially denied posting the review but admitted doing so after you called him over to your computer and brought up the review, saying to him "*are you telling me this isn't you*" whilst pointing at the computer screen.

44. Your conduct was confrontational. There was an imbalance of power given your seniority as the treating dentist and you raised the issue of the negative review without warning whilst the child patient was seated in the dental chair waiting to be treated by you. The evidence before the Committee was that he felt frightened, was crying after the appointment and no longer wanted to return to the Practice to complete his

orthodontic treatment. His mother instructed him to delete the review in order to maintain a good relationship with the Practice and his orthodontic treatment was completed by another dentist at the Practice.

45. At this stage of the proceedings, the Committee shall decide whether the facts found proved amount to misconduct and, if so, whether your fitness to practise as a dentist is currently impaired by reason of that misconduct. If the Committee finds current impairment, it shall then decide on what action, if any, to take in respect of your registration.

46. The Committee received from you bundles of remediation evidence, consisting of your Continuing Professional Development (CPD) record, records of your mentorship sessions, a Personal Development Plan required by NHS England in order to work towards providing general dental services for the NHS, revised Standard Operating Procedures, testimonials in support of your character and performance as a dentist and a written reflective statement.

47. Mr Greany, on behalf of the GDC, submitted that the facts found proved amount to misconduct, that your fitness to practise is currently impaired and that the appropriate outcome in this case would be a period of suspension for 6-9 months.

48. Mr Cridland, on your behalf, did not contest a finding of misconduct but submitted that your fitness to practise is not currently impaired, given your remediation, insight and what he described as the historical nature of the incidents in question. In the alternative, he submitted that a reprimand would be the appropriate disposal.

49. The Committee accepted the advice of the Legal Adviser.

50. The Committee had regard to the *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016, last revised December 2020).

Misconduct

51. Misconduct connotes a serious departure from the standards reasonably expected of a dentist. It can be characterised as conduct which fellow members of the profession would regard to be deplorable. In assessing whether the facts found proved (or any of them) amount to misconduct, the Committee had regard to the following principles from the GDC's *Standards for the Dental Team* (September 2013):

- 1.2: You must treat every patient with dignity and respect at all times

- 6.3: You must delegate and refer appropriately and effectively

- 6.3.1 …You should only delegate or refer to another member of the team if you are confident that they have been trained and are both competent and indemnified to do what you are asking. For more information, see the 'Scope of Practice' document.

- 6.3.2 If you delegate a task to another member of the team who does not feel that they are trained or competent to carry it out, you must not take advantage of your position by pressurising them into accepting the task.

- 8.1: You must always put patients' safety first.

52. The Committee determined that, although an isolated incident, your confrontational behaviour towards the 14-year old patient about the negative review was wholly inappropriate and demonstrated a serious lapse of professional judgment. Regardless of whether you intended to be confrontational, it should have been plain to you that this is how you were likely to come across to a child who was seated in the dental chair awaiting treatment. If there was any legitimate reason for you to have challenged or discussed the negative review, you should have done so tactfully and with restraint, in accordance with the standards of courtesy and respect which are expected of the dental profession.

53. The Committee determined that this incident represented a serious breach of Standard 1.2 and that it amounts to misconduct.

54. Your conduct between 2017 and 2019 in requesting your dental nurses to deal with emergency patients in breach of their Scope of Practice whilst you were away on holiday was a clear breach of fundamental professional standards. Some of the dental nurses were uneasy about this arrangement but felt unable to challenge it given your seniority as the principal dentist and their employer. The uncontested expert opinion evidence before the Committee was that allowing the dental nurses to deal with emergency patients beyond their Scope of Practice put those patients, most of whom would have been child patients, at a risk of harm. You abused your position of trust and authority at the Practice and flouted fundamental professional standards over a period of years.

55. Your request in or around January 2021 to the Practice Manager that she work as a dental nurse even though she was no longer registered with the GDC was also a clear breach of fundamental professional standards. The fact that she was qualified and experienced as a dental nurse was irrelevant. She needed to be registered with the GDC to carry out the duties of a dental nurse and, as you knew, her registration had lapsed. By requesting that she work as a dental nurse without being registered with the GDC you flouted fundamental professional standards, undermined the regulatory regime of the GDC and put patients at risk of harm.

56. The Committee determined that your inappropriate and unprofessional conduct in requesting that your dental nurses work beyond their Scope of Practice, and in requesting that your Practice Manager work as a dental nurse when she was not registered with the GDC, represented serious breaches of Standards 6.3.1, 6.3.2 and 8.1 and amounts to misconduct.

Impairment

57. The Committee considered whether your misconduct is remediable, whether it had been remedied and the risk of repetition. The Committee also had regard to the wider public interest, which includes the need to uphold and declare appropriate standards of conduct and behaviour, so as to maintain public confidence in the profession and its regulation.

58. The Committee acknowledged the substantial targeted CPD activity which you have undertaken, some of which was to address the concerns raised in these proceedings. It also took account of the professional mentorship required by NHS England in relation to you providing further NHS dental treatment. You have made significant changes to your working practices, including a reduction in hours and the introduction of Standard Operating Procedures. Your Personal Development Plan sets out your intention to return to general dentistry in addition to orthodontic practice. You provided the Committee with a reflective written statement in which you accepted the Committee's findings of fact and apologised to the GDC and the Committee.

59. Whilst there was therefore evidence of remorse and an apology, your apology was confined to the GDC and the Committee. There was no evidence of any apology, whether expressed directly or as part of these proceedings, to: (i) the 14-year old patient; (ii) the patients who were to be treated by members of staff who were either not registered with the GDC or would be acting beyond their Scope of Practice; and (iii) those members of staff who were put in such an invidious position by your requests that they do this and whose consistent and corroborated evidence was disputed by you during the factual inquiry.

60. The Committee also considered that your reflective written piece was lacking in any meaningful reflection or acknowledgement on why you had acted in the way which has been found proved. There was no reflection on how your actions affected Patient A, patients who were put at risk or members of staff who were asked to work out of scope. You only reflected on how these proceedings have impacted you. You have not acknowledged why you requested your dental nurses work beyond their Scope of Practice and how this could have put patients at a risk of harm. You have not acknowledged why you requested your Practice Manager to work as a dental nurse when she was not registered with the GDC and how this could have put patients at a risk of harm. There was also no evidence of any current Standard Operating Procedure in relation to out-of-hours care and holiday cover.

61. The Committee rejected Mr Cridland's submission that the index events are so historical in nature that your fitness to practise is not currently impaired in relation to them. Whilst there is no evidence of any repetition, the index events are not in context so historic that they no longer engage the question of your current fitness to practise.

62. In the Committee's judgment, you have undertaken significant remedial steps and demonstrate developing insight. Whilst the Committee does not consider there to be a

high risk of repetition, it cannot be satisfied that the risk of repetition is low and there therefore remains some risk to the public.

63. The Committee also had regard to the seriousness of your misconduct. You breached fundamental tenets of the profession and put patients at a risk of harm. Your misconduct brings the profession into disrepute. Having regard to all the circumstances, the Committee determined that public confidence in the profession and its regulation would be undermined if no finding of impairment were to be made to mark the seriousness of your misconduct.

64. Accordingly, the Committee determined that your fitness to practise is currently impaired by reason of misconduct.

Sanction

65. The Committee next considered what action, if any, to take in respect of your registration. The purpose of a sanction is not to be punitive, although it might have that effect, but to protect the public and the wider public interest.

66. The Committee considered the aggravating and mitigating features present in this case.

67. The aggravating factors include a risk of harm to patients, with such patients being predominantly children and therefore vulnerable; your misconduct was premeditated and was sustained and repeated over a period of years; you took advantage of your position as a senior member of staff and breached the trust of your patients; and you showed a disregard for the role of the GDC and the systems regulating the profession.

68. In mitigation, the Committee recognised that you are otherwise of good character with no other fitness to practise history and with no evidence of repetition of the matters which have been found proved. You have undertaken significant remedial steps with developing insight and express genuine remorse (albeit only to the GDC and the Committee).

69. The Committee heard in private under Rule 53 of the General Dental Council (Fitness to Practise) Rules 2006 submissions relating to the difficult personal circumstances which have been a significant part of your life during these proceedings and which have become even more so over recent months. The Committee acknowledges and expresses its deep sympathy for those extremely challenging and sad personal circumstances. In deciding sanction, the Committee had regard to those circumstances.

70. The Committee considered sanction in ascending order of severity.

71. To conclude this case with no further action would be inappropriate in the Committee's judgment, as no further action would be insufficient to protect the public or to meet the wider public interest.

72. The Committee next considered whether to direct that you be reprimanded for your misconduct. In assessing whether a reprimand would be sufficient to protect the public and to maintain wider public confidence in the profession. The Committee recognised that a reprimand could achieve a declaratory effect to mark your misconduct but that it would not result in any mechanism through which your continued remediation could be reviewed and it would not have any restrictive effect on your registration in terms of public protection. The Committee considered that a reprimand would not address the risk of repetition identified and consequent risk of harm to patients.

73. The Committee next considered conditional registration and determined that this would serve as a proportionate framework which would protect the public and maintain wider public confidence in the profession whilst you continue in your remediation. The Committee considered that to direct that your registration be suspended would be disproportionate.

74. Accordingly, the Committee directs that your registration be made subject to your compliance with conditions for a period of 9 months to allow you sufficient time to demonstrate embedded improvement in your practice.

75. The conditions shall appear against your name in the Register in the following terms:

1. Within 28 days of these conditions becoming effective, he shall provide the GDC with an updated Standard Operating Procedure for emergency cover within his Practice.

2. Within 28 days of these conditions becoming effective, he shall provide the GDC with an updated Standard Operating Procedure for managing staff shortages within his Practice.

3. He must formulate a Personal Development Plan specifically designed to address the deficiencies in the following areas of his practice:

    - communication with patients and staff;
    - managing staff, specifically in relation to roles and responsibilities;
    - complaints handling.

4. He must forward a copy of his Personal Development Plan to the GDC within three months of the date on which these conditions become effective.

5. He must notify the GDC promptly of any professional appointment he accepts and provide the contact details of his employer or any organisation for which he is contracted to provide dental services and the Commissioning Body on whose

Dental Performers List he is included or Local Health Board if in Wales, Scotland or Northern Ireland.

6. He must allow the GDC to exchange information with his employer or any organisation for which he is contracted to provide dental services.

7. At any time he is providing dental services, which require him to be registered with the GDC, he must agree to the appointment of a reporter nominated by him and approved by the GDC. The reporter shall be a GDC registrant.

8. He must allow the reporter to provide reports to the GDC at intervals of not more than three months covering:

    - the agenda and minutes of monthly staff meetings;
    - details of the provision of emergency cover provided to patients whilst he is away from the Practice and no other dentists are present;
    - complaints received, how complaints were handled and details of any complaints resolved.

9. He must inform the GDC of any formal disciplinary proceedings taken against him, from the date of this determination.

10. He must inform the GDC if he applies for dental employment outside the UK.

11. He must inform within one week the following parties that his registration is subject to the conditions, listed at (1) to (10), above:

    - Any organisation or person employing or contracting with him to undertake dental work
    - Any locum agency or out-of-hours service he is registered with or applies to be registered with (at the time of application)
    - Any prospective employer (at the time of application)
    - The Commissioning Body on whose Dental Performers List he is included or seeking inclusion, or Local Health Board if in Wales, Scotland or Northern Ireland (at the time of application)

12. He must permit the GDC to disclose the above conditions, (1) to (11), to any person requesting information about his registration status.

76. The period of conditional registration shall be reviewed prior to its expiry. The reviewing Committee might be assisted by a further reflective statement from you.

77. The Committee now invites submissions on the question of an immediate order.

78. Mr Greany submitted that an immediate order should be made in light of the Committee's findings on impairment relating to public protection and the wider public interest.

79. Mr Cridland submitted that those findings do not suggest that an immediate order is necessary for the protection of the public or is otherwise in the public interest. He submitted that no immediate order should be made.

80. The Committee accepted the advice of the Legal Adviser.

81. The Committee retired to consider its decision.

82. The Committee determined that it is necessary for the protection of the public to order under section 30(2) of the Dentists Act 1984 that your registration be made subject to your compliance with the above conditions immediately. It would be inconsistent with the above determination not to make an immediate order. You had placed patients at a risk of harm and there remains a risk of repetition.

83. The effect of this order is that your registration is now subject to your compliance with the above conditions. Unless you exercise your right of appeal, the substantive direction for conditional registration shall take effect upon the expiry of the 28-day appeal period. Should you exercise your right of appeal, this immediate order shall remain in force pending the resolution of the appeal.

84. That concludes this determination.