HEARING HEARD IN PUBLIC

LUGUERA AGUIRRE, Maritza Margarita

Registration No: 200119

PROFESSIONAL CONDUCT COMMITTEE

JANUARY 2018 – JUNE 2020

Most recent outcome: Suspended indefinitely **

** see page 70 for the latest determination

Maritza Margarita LUGUERA AGUIRRE, a dentist, Lic Odont Madrid 2010] was summoned to appear before the Professional Conduct Committee on 4 January 2018 for an inquiry into the following charge:

Charge (as amended on 4, 5, 8, 9 and 10 January 2018)

"That being registered as a dentist, Ms Martiza Luguera Aguirre (200119)

Patient A

1. On or around 10 September 2015 you failed to take an adequate record in relation to radiographs in that you:
    a. did not record the justification for taking the radiographs;
    b. did not grade the radiographs.
2. On or around 10 September 2015 you failed to take an adequate record in that you did not adequately complete the examination template.

Patient B

3. You failed to provide an adequate standard of care including:
    a. You placed and/or repaired a filling at UR6 with inadequate care and/or skill including
        i. on or around 12 November 2012;
        ii. on or around 28 January 2013;
        iii. on or around 15 May 2014.
    b. On or around 23 July 2014 you fitted a crown at UR6 with inadequate care and/or skill.
    c. On or around 23 July 2014 you failed to make any diagnosis in respect of the bone loss which was present.
4. On or around 23 July 2014 you failed to take an adequate record in that you did not adequately complete the examination template.

Patient C

5. On or around 23 June 2015 you failed to take an adequate record in that you did not adequately complete the examination template.
6. On or around 29 June 2015 you failed to take an adequate record in relation to radiographs in that you:
    a. did not record the justification for taking the radiographs;
    b. did not grade the radiographs;
    c. did not report on the radiographs.

Patient D

7. You failed to provide an adequate standard of care in that you issued a prescription without clinical justification including:
    a. on or around 26 March 2013;
    b. [withdrawn];
    c. on or around 15 January 2014 in respect of antibiotics.
8. On or around 16 January 2014 you failed to take an adequate record in relation to radiographs in that you:
    a. [withdrawn];
    b. did not grade the radiograph;
    c. did not report adequately on the radiograph.
9. You failed to take an adequate record in that you did not adequately complete the examination template:
    a. on or around 26 March 2013;
    b. on or around 16 October 2014;
    c. on or around 28 July 2015.

Patient E

10. You failed to provide an adequate standard of care in that you placed a filling at UR4 with inadequate care and/or skill in that:
    a. on or around 17 June 2015;
    b. on or around 17 July 2015;
    c. on or around 13 January 2016.
11. On or around 11 June 2015 you failed to take an adequate record in relation to radiographs in that you:
    a. did not record the justification for taking the radiograph;
    b. did not grade the radiograph;
    c. did not report adequately on the radiograph.
12. On or around 13 May 2015 you failed to take an adequate record in that you did not adequately complete the examination template.

Patient F

13. On or around 14 October 2015 you failed to take an adequate record in relation to radiographs in that you:
    a. did not record the justification for taking the radiograph;
    b. did not grade the radiograph;
    c. did not report adequately on the radiograph.
14. On or around 14 October 2015 you failed to take an adequate record in that you did not adequately complete the examination template.

Patient G

15. On or around 8 July 2015 you failed to take an adequate record in that you did not adequately complete the examination template.
16. On or around 8 July 2015 you failed to take an adequate record in relation to radiographs in that you:
    a. [withdrawn];
    b. did not grade the radiographs.

Patient H

17. You failed to provide an adequate standard of care including:
    a. on or around 17 June 2015 you prescribed amoxicillin without clinical justification;
    b. on or around 23 September 2015 you fitted a crown at UR4 with inadequate care and/or skill.
    c. [withdrawn].
18. On or around 7 October 2015 you failed to take an adequate record in relation to radiographs in that you:
    a. did not record the justification for taking the radiograph;
    b. did not grade the radiograph;
    c. did not report adequately on the radiograph.
19. On or around 7 October 2015 you failed to take an adequate record in that you did not adequately complete the examination template.

Patient I

20. On or around 2 July 2015 you failed to take an adequate record in that you did not adequately complete the examination template.

Patient J

21. You failed to provide an adequate standard of care including:
    a. on or around 24 September 2013 you prescribed erythromycin without clinical justification;
    b. you fitted a crown at UR2 with inadequate care and/or skill including:
        i. on or around 21 November 2013;
        ii. on or around 18 June 2014.

22. You failed to take an adequate record in that you did not adequately complete the examination template:
    a. on or around 30 July 2013;
    b. on or around 13 August 2015.
23. On or around 13 August 2015 you failed to take an adequate record in relation to radiographs in that you:
    a. did not record the justification for taking the radiograph;
    b. did not grade the radiograph;
    c. did not report adequately on the radiograph.

Patient K

24. On or around 16 July 2015 you failed to take an adequate record in that you did not adequately complete the examination template.
25. You failed to provide an adequate standard of care in that on or around 23 September 2015 you performed root canal treatment with inadequate care and/or skill.

Patient L

26. You failed to provide an adequate standard of care in that you placed and/or repaired a filling at UL2 with inadequate care and skill including:
    a. on or around 31 July 2015;
    b. on or around 3 September 2015.
27. [withdrawn]:
    a. [withdrawn];
    b. [withdrawn];
    c. [withdrawn].

Patient M

28. Between around 20 February 2014 and around 5 May 2016 you failed to provide an adequate standard of care including:
    a. On or around 15 July 2014 you prescribed amoxicillin without clinical justification;
    b. you fitted and/or replaced a crown at LR5 with inadequate care and/or skill including:
        i. on or around 2 September 2015;
        ii. on or around 14 October 2015;
        iii. on or around 16 March 2016.
29. You failed to take an adequate record in that you did not adequately complete the examination template:
    a. on or around 13 February 2015;
    b. on or around 13 August 2015.

Patient N

30. On or around 14 August 2015 you failed to take an adequate record in that you did not adequately complete the examination template;

31. On or around 14 August 2015 you failed to take an adequate record in relation to radiographs in that you:

    a. did not record the justification for taking the radiographs;

    b. did not grade the radiographs.

Patient O

32. On or around 30 June 2015 you failed to take an adequate record in relation to radiographs in that you:

    a. did not record the justification for taking the radiographs;

    b. did not grade the radiographs.

33. You failed to take an adequate record in that you:

    a. on or around 30 June 2015 did not adequately complete the examination template;

    b. [withdrawn]:

        i. [withdrawn];

        ii. [withdrawn];

        iii. [withdrawn];

        iv. [withdrawn].

    c. On or around 28 July 2015 you did not record:

        i. the type of local anaesthetic used;

        ii. the quantity of local anaesthetic used;

        iii. the site where local anaesthetic was applied;

        iv. the batch number of the local anaesthetic used.

Patient P

34. You failed to provide an adequate standard of care in that on or around 31 January 2013 you did not take any radiographs when it was clinically indicated to do so.

35. You failed to take an adequate record in that you did not adequately complete the examination template:

    a. on or around 23 February 2012;

    b. on or around 31 January 2013.

Patient Q

36. [withdrawn]:

    a. [withdrawn];

    b. [withdrawn];

    c. [withdrawn];

    d. [withdrawn].

37. On or around 30 July 2015 you failed to take an adequate record in that you did not adequately complete the examination template.

Patient R

38. You failed to provide an adequate standard of care in that you:
    a. on or around 17 July 2015 you prescribed Metronozide and/or Amoxicillin when it was not clinically indicated;
    b. on or around 17 July 2015 you prescribed Metronozide at an inappropriately high dosage, namely 400 mg tablets;
    c. between around 3 September and around 9 September 2015 you carried out root treatment at LL7 with inadequate care and skill.
39. On or around 9 September 2015 you failed to take an adequate record in relation to radiographs in that you:
    a. [withdrawn];
    b. did not grade the radiographs;
    c. did not report on the radiographs.
40. On or around 12 March 2015 you failed to take an adequate record in that you did not adequately complete the examination template.

Patient S

41. On or around 9 September 2015 you failed to take an adequate record in relation to radiographs in that you:
    a. [withdrawn];
    b. did not grade the radiographs.
42. On or around 9 September 2015 you failed to take an adequate record in that you did not adequately complete the examination template.

Patient T

43. On or around 18 July 2015 you failed to take an adequate record in relation to radiographs in that you:
    a. did not grade the radiographs;
    b. did not report adequately on the radiographs.
44. On or around 18 July 2015 you failed to take an adequate record in that you did not adequately complete the examination template.

Patient U

45. You failed to provide an adequate standard of care in that you did not take any radiographs when it was clinically indicated to do so:
    a. on or around 1 October 2015;
    b. on or around 15 October 2015.
46. You failed to take an adequate record in that you did not adequately complete the examination template:

a. on or around 15 July 2015;

b. on or around 1 October 2015.

Patient V

47. On or around 21 July 2015 you failed to take an adequate record in relation to radiographs in that you:

    a. [withdrawn];

    b. did not grade the radiographs;

    c. did not report adequately on the radiographs.

48. You failed to provide an adequate standard of care including:

    a. on or around 23 July 2015 you prescribed amoxicillin when it was not clinically indicated;

    b. on or around 23 July 2015 you prescribed amoxicillin at an inappropriately high dosage, namely 500mg;

    c. on or around 17 February 2016 you placed a filling at UL1 when it was clinically indicated to have carried out root canal treatment.

49. On or around 21 July 2015 you failed to take an adequate record in that you did not adequately complete the examination template.

Patient W

50. On or around 14 July 2015 you failed to take an adequate record in relation to radiographs in that you:

    a. [withdrawn];

    b. did not grade the radiographs;

    c. did not report adequately on the radiographs.

51. You failed to provide an adequate standard of care in that you:

    a. did not take radiographs when it was clinically indicated to do so including:

        i. on or around 16 July 2015;

        ii. on or around 28 July 2015.

    b. on or around 11 August 2015 you fitted a crown at UR6 with inadequate care and/or skill.

52. On or around 14 July 2015 you failed to take an adequate record in that you did not adequately complete the examination template.

Patient X

53. You failed to provide an adequate standard of care in that you:

    a. on or around 7 August 2015 you did not take radiographs when it was clinically indicated to do so;

    b. on or around 27 October 2015 you prescribed antibiotics when it was not clinically indicated to do so.

54. On or around 7 August 2015 you failed to provide an adequate standard of record keeping in that you did not adequately complete the examination template.

Patient Y

55. On or around 5 December 2014 you failed to take an adequate record in relation to radiographs in that you:
    a. [withdrawn];
    b. did not grade the radiographs.
56. You failed to take an adequate record in that you did not adequately complete the examination template:
    a. on or around 18 September 2013;
    b. on or around 31 October 2013;
    c. on or around 19 March 2014;
    d. on or around 24 July 2014;
    e. on or around 5 December 2014.

Patient Z

57. On or around 31 January 2013 you failed to provide an adequate standard of care in that:
    a. you prescribed Amoxicillin when it was not clinically indicated to do so;
    b. you prescribed Amoxicillin at an inappropriately high dosage, namely 500mg.
58. On or around 1 May 2014 you failed to take an adequate record in relation to radiographs in that you::
    a. did not record the justification for taking the radiographs;
    b. did not grade the radiographs.
59. You failed to provide an adequate standard of record keeping in that you did not adequately complete the examination template:
    a. on or around 31 January 2013;
    b. on or around 26 February 2013;
    c. on or around 8 April 2014;
    d. on or around 11 February 2015;
    e. on or around 29 June 2015.

Patient AA

60. On or around 13 August 2015 you failed to take an adequate record in relation to radiographs in that you:
    a. [withdrawn];
    b. did not grade the radiographs;
    c. did not report on the radiographs.

Patient AB

61. You failed to provide an adequate standard of care in that:
    a. on or around 16 December 2014 you prescribed Amoxicillin when it was not clinically indicated to do so;
    b. on or around 16 December 2014 you prescribed Amoxicillin at an inappropriately high dosage, namely 500mg;
    c. you fitted a crown at UR3 with inadequate care and/or skill including:
        i. on or around 22 July 2015;
        ii. on or around 30 July 2015.
62. On or around 16 December 2014 you failed to take an adequate record in relation to radiographs in that you:
    a. did not record the justification for taking the radiographs;
    b. did not grade the radiographs;
    c. did not adequately report on the radiographs.
63. You failed to provide an adequate standard of record keeping in that you did not adequately complete the examination template:
    a. on or around 4 July 2013;
    b. on or around 20 May 2014;
    c. on or around 24 June 2015.

Patient AC

64. On or around 8 October 2015 you failed to take an adequate record in relation to radiographs in that you:
    a. [withdrawn];
    b. did not grade the radiographs;
    c. did not adequately report on the radiographs.
65. You failed to take an adequate record in that you did not adequately complete the examination template:
    a. on or around 22 July 2015;
    b. [withdrawn].

Patient AD

66. On or around 15 July 2015 you failed to take an adequate record in relation to radiographs in that you:
    a. did not record the justification for taking the radiographs;
    b. did not grade the radiographs.
67. On or around 15 July 2015 you failed to take an adequate record in that you did not adequately complete the examination template.

Patient AE

68. On or around 10 September 2015 you failed to provide an adequate standard of care in that you took radiographs which were not of diagnostic quality in that the root apex was not shown.

69. On or around 10 September 2015 you failed to take an adequate record in relation to radiographs in that you:

    a. [withdrawn];

    b. did not grade the radiographs;

    c. did not adequately report on the radiographs.

70. On or around 30 July 2015 you failed to take an adequate record in that you did not adequately complete the examination template.

Patient AF

71. On or around 30 September 2015 you failed to take an adequate record in relation to radiographs in that you:

    a. [withdrawn];

    b. did not grade the radiographs;

    c. did not adequately report on the radiographs in that you did not report on bone loss which was present.

Patient AG

72. You failed to provide an adequate standard of care in that you failed to diagnose a cavity in LL6 prior to 1 October 2014.

73. You failed to take an adequate record in relation to radiographs in that you:

    a. on or around 1 October 2014:

        i. did not record the justification for taking the radiographs;

        ii. did not grade the radiographs;

        iii. [withdrawn].

    b. on or around 28 January 2015:

        i. [withdrawn];

        ii. did not grade the radiographs.

    c. on or around 8 October 2015:

        i. did not grade the radiographs;

        ii. did not adequately report on the radiographs.

74. You failed to take an adequate record in that you did not adequately complete the examination template:

    a. On or around 21 November 2013;

    b. On or around 18 December 2014;

    c. On or around 28 January 2015;

    d. On or around 8 October 2015.

Patient AI

75. On or around 6 August 2015 you failed to take an adequate record in relation to radiographs in that you:
    a. did not grade the radiographs;
    b. did not adequately report on the radiographs in that you did not report on bone loss which was present.
76. On or around 6 August 2015 you failed to take an adequate record in that you did not adequately complete the examination template.

Patient AJ

77. On or around 23 July 2015 you failed to take an adequate record in relation to radiographs in that you:
    a. did not record the justification for taking the radiographs;
    b. did not grade the radiographs;
    c. did not adequately report on the radiographs in that you did not report on bone loss which was present.
78. You failed to provide an adequate standard of care in that:
    a. on or around 7 October 2015 you did not take a radiograph when it was clinically indicated to do so;
    b. [withdrawn].

Patient AK

79. On or around 5 February 2015 you failed to take an adequate record in relation to radiographs in that you:
    a. [withdrawn];
    b. did not grade the radiographs;
    c. did not adequately report on the radiographs.
80. You failed to provide an adequate standard of care in that:
    a. you placed a filling at UR5 with inadequate care and/or skill:
        i. on or around 5 February 2015;
        ii. on or around 9 July 2015.
    b. on or around 13 August 2015 you fitted a Maryland bridge at UR 3 4 5 with inadequate care and/or skill.
81. On or around 16 December 2014 you failed to provide an adequate standard of record keeping in that you did not adequately complete the examination template.

Patient AL

82. On or around 24 September 2015 you failed to take an adequate record in relation to radiographs in that you did not grade the radiographs taken.
83. You failed to take an adequate record in that:

a. on or around 30 July 2015 you did not adequately complete the examination template;

b. on or around 24 September 2015 in respect of root canal treatment you did not record:

i. the method of cleaning;

ii. the rubber dam;

iii. irrigation;

iv. the size of canal;

v. the type of sealant used;

vi. the root filling material.

Patient AM

84. You failed to provide an adequate standard of care in that on or around 2 September 2015 you provided root canal treatment at UL4 without adequate care and/or skill.

85. On or around 16 September 2015 you failed to take an adequate record in relation to radiographs in that you:

a. [withdrawn];

b. did not grade the radiographs;

c. did not adequately report on the radiographs.

86. You failed to take an adequate record in that:

a. on or around 21 July 2015 you did not adequately complete the examination template;

b. on or around 2 September 2015 in respect of root canal treatment you did not record:

i. the method of cleaning;

ii. the rubber dam;

iii. irrigation;

iv. the size of canal;

v. the type of sealant used;

vi. the root filling material.

Patient AN

87. On or around 28 July 2015 you failed to take an adequate record in relation to radiographs in that you:

i. [withdrawn];

ii. did not grade the radiographs;

iii. did not adequately report on the radiographs.

88. On or around 28 July 2015 you failed to take an adequate record in that you did not adequately complete the examination template.

Patient AO

89. You failed to provide an adequate standard of care in that:
    a. [withdrawn];
    b. on or around 10 December 2013 you prescribed amoxicillin when it was not clinically indicated;
    c. on or around 22 January 2014 you did not take a pre operative radiograph when it was clinically indicated;
    d. you failed to diagnose caries at:
        i. UR3;
        ii. UR4;
        iii. [withdrawn].
90. You failed to provide an adequate standard of record keeping in that you did not adequately complete the examination template:
    a. on or around 12 June 2012;
    b. on or around 19 June 2014;
    c. on or around 14 July 2015.

Patient AP

91. You failed to provide an adequate standard of care in that:
    a. you prescribed Amoxicillin when it was not clinically indicated:
        i. on or around 12 June 2012;
        ii. on or around 18 June 2013;
        iii. [withdrawn];
        iv. on or around 15 August 2013;
        v. on or around 26 November 2013.
    b. Between around 7 October 2014 and 2 March 2016 you failed adequately, or at all, to diagnose and/or treat a swelling at UR2.
92. You failed to provide an adequate standard of record keeping in that you did not adequately complete the examination template:
    a. on or around 12 June 2012;
    b. on or around 18 June 2013;
    c. on or around 1 October 2013;
    d. on or around 22 January 2014;
    e. on or around 19 June 2014.

Patient AQ

93. Between around 17 September 2012 and around 30 April 2015 you failed to provide an adequate standard of care in that you did not adequately diagnose and/or treat caries.

Patient AR

94. You failed to provide an adequate standard of care in that:

    a. on or around 12 April 2014 you did not take radiographs when it was clinically indicated to do so;

    b. between around 16 June 2015 and around 28 July 2016 you failed to adequately diagnose and/or treat caries at:

        i. LR7;

        ii. [withdrawn].

95. You failed to take an adequate record in relation to radiographs in that you:

    a. on or around 27 January 2015 you:

        i. [withdrawn];

        ii. did not grade the radiographs;

        iii. did not report on the radiographs.

    b. on or around 16 June 2015 you:

        i. [withdrawn];

        ii. did not grade the radiographs.

96. You failed to provide an adequate standard of record keeping in that you did not adequately complete the examination template:

    i. on or around 27 January 2015;

    ii. on or around 7 October 2015.

Patient AS

97. You failed to provide an adequate standard of care in that:

    a. you prescribed antibiotics when it was not clinically indicated:

        i. on or around 15 December 2011 you prescribed Metronidazole;

        ii. on or around 16 January 2012 you prescribed Amoxicillin;

        iii. on or around 14 May 2012 you prescribed Metronidazole.

    b. Between around 1 October 2013 and around 13 November 2013 you performed root canal treatment at LL6 with inadequate care and/or skill;

    c. You fitted a crown at LR6 with inadequate care and/or skill:

        i. on or around 16 April 2014;

        ii. on or around 22 May 2014;

        iii. on or around 13 August 2014.

98. From around 8 July 2016 to around 11 November 2016 you failed to comply with conditions imposed on your practice by the Aneurin Bevan University Health Board on 8 July 2016.

99. Between around 16 September 2016 to 19 December 2016 you failed to provide the General Dental Council with any evidence of indemnity.

As a result of the matters set out above your fitness to practise is impaired by reason of deficient professional performance and/or misconduct."

The hearing was adjourned on 11 January 2018 and re-opened on 6 June 2018.

On 6 June 2018 the Chairman made the following statement regarding the finding of facts:

"Miss Luguera Aguirre is not present at this hearing of the Professional Conduct Committee (PCC) and is not represented in her absence. Mr Matthew Corrie of Blake Morgan solicitors appears for the General Dental Council (GDC).

Service of notice

On behalf of the GDC Mr Corrie submitted that service of notice of this hearing has been properly effected in accordance with Rules 13 and 65 of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules'). On 22 November 2017 a notice of hearing was sent to the address that Miss Luguera Aguirre has registered with the GDC, setting out the date, time and location of this hearing. The notice was sent using the Royal Mail's International Track and Signed postal service. A copy of the notice was also sent to Miss Luguera Aguirre by email. The Royal Mail's Track and Trace service records that the notice was delivered on 28 November 2017.

The Committee accepted the advice of the Legal Adviser. The Committee was satisfied that service has been properly effected in accordance with the Rules.

Proceeding in absence

The Committee then went on to consider whether to exercise its discretion to proceed in the absence of Miss Luguera Aguirre in accordance with Rule 54 of the Rules. Mr Corrie invited the Committee to do so on the basis that the GDC had made all reasonable efforts to notify Miss Luguera Aguirre of this hearing, that she appears to have decided not to participate in these proceedings, and that it is in the public interest to proceed.

The Committee accepted the advice provided by the Legal Adviser. The Committee was mindful that its discretion to conduct a hearing in the absence of a registrant should be exercised with the utmost care and caution. After careful consideration the Committee was satisfied that it would be fair and appropriate to proceed in Miss Luguera Aguirre's absence. The Committee considers that all reasonable efforts have been made to inform Miss Luguera Aguirre of this hearing. It appears that Miss Luguera Aguirre has either decided not to attend or has not kept the GDC informed of her current whereabouts. The Committee considers that an adjournment would be unlikely to secure Miss Luguera Aguirre's attendance. The Committee is also mindful of the public interest in proceeding with this hearing and has taken note of the inconvenience that would be caused to the witnesses in this case if the Committee were to decide to postpone the hearing.

The Committee therefore determined to proceed in the absence of Miss Luguera Aguirre.

Preliminary matters

Mr Corrie applied to amend a number of the heads of charge in accordance with Rule 18 of the Rules.

The Committee, having received advice from the Legal Adviser, considered that the proposed amendments could be made without injustice to Miss Luguera Aguirre. The Committee notes that most of the proposed amendments have been communicated to Miss Luguera Aguirre in advance of the hearing and largely concern typographical errors. The Committee also notes that the more

substantive changes that the GDC seeks to make to the allegations would bring the charges into line with the criticisms set out in the report of the GDC's expert witness, namely Mr Simon Jefferies. Miss Luguera Aguirre has previously been provided with a copy of that report. The Committee was therefore satisfied that it was fair for the amendments to be made. The schedule of charge was duly amended.

Further amendments were made to the heads of charge to correct minor discrepancies during the course of the Committee's factual inquiry.

Whilst in camera the Committee identified a potential issue with head of charge 28 (b). Having received written submissions from Mr Corrie, and having accepted the advice of the Legal Adviser, the Committee made a minor change to the wording of that head of charge. The Committee also recalled parties whilst in camera in relation to the meaning of head of charge 68 and heard Mr Corrie's submissions as to how the matter is put by the Council.

The hearing adjourned part-heard on 11 January 2018 due to the lack of available time in which to complete the case.

Upon the resumption of the hearing on 6 June 2018 the Committee considered whether Miss Luguera Aguirre, notwithstanding her earlier absence from the hearing, had been provided with notice of the continuation of the hearing in accordance with Rule 58 (3) of the Rules. Mr Corrie drew the Committee's attention to a copy of a notice dated 12 January 2018 addressed to Miss Luguera Aguirre in relation to the continuation of the hearing. That letter set out that the hearing would continue at a different venue to that at which the Committee has reconvened. Mr Corrie submitted that for administrative reasons the Council is not able to prove that the notice was posted on or around that date. However Mr Corrie submitted that the Council is able to demonstrate that a copy of the notice was subsequently included in a bundle of documents that was posted to Miss Luguera Aguirre on 23 January 2018 and emailed to her on 27 February 2018 in relation to different proceedings. Mr Corrie further submitted that, more recently on 29 May 2018, a further letter was sent to Miss Luguera Aguirre by both post and email to inform her of the correct venue for the continuation of this hearing. Mr Corrie also submitted that enquiries have revealed that Miss Luguera Aguirre has not attended today at either venue.

Mr Corrie submitted that although service of the notice dated 12 January 2018 cannot be proved, the copy of the notice that was later sent to Miss Luguera Aguirre, and the further letter that was sent to Miss Luguera Aguirre on 29 May 2018, comply with the Rules. Mr Corrie submitted that it appears that Miss Luguera Aguirre has continued to absent herself from these proceedings and that there is no indication now that an adjournment would secure her attendance. Mr Corrie invited the Committee to continue with the hearing, and that to do so would be in the public interest and in Miss Luguera Aguirre's own interests.

The Committee accepted the advice of the Legal Adviser. The Committee is satisfied that, notwithstanding the matters referred to above, service of notice of the continuation of the hearing has been properly effected in accordance with the Rules. The Committee is also mindful of the public interest in the continuation of the hearing, and that there is no indication to suggest that Miss Luguera Aguirre now wishes to participate in these proceedings. The Committee concludes that an adjournment would serve no purpose, and that in the circumstances it is fair and appropriate to continue with the hearing.

Background to the case and summary of allegations

The allegations giving rise to these proceedings relate to the standard of care, treatment and record-keeping that Miss Luguera Aguirre provided to 39 patients, referred to for the purposes of this hearing as Patient A to Patient AS, in the overall period of December 2011 to July 2016. Miss Luguera Aguirre was in practice at the relevant times as a general dental practitioner at Oasis

Dental Care in Caerphilly, Glamorgan. Her name also appeared on the dental performers' list administered by the local health board, namely Aneurin Bevan University Health Board.

The Committee has heard that in October 2015 the local health board received concerns about the standard of Miss Luguera Aguirre's practice. The health board shared those concerns with Oasis Dental Care and was informed that Miss Luguera Aguirre had been removed from clinical duties pending retraining. The health board investigated the concerns that had been raised and a review of a sample of 28 patient records was undertaken. A further record-card review was carried out by a dental reference officer in January 2016 involving an audit of a sample of the records of patients who had been treated by Miss Luguera Aguirre following her retraining. The record-card review identified continued concerns about Miss Luguera Aguirre's practice. At a health board meeting in July 2016 conditions were placed upon her entry on the dental performers' list. It is alleged that Miss Luguera Aguirre failed to comply with those conditions. Following her removal from the dental performers' list the local health board referred its concerns about her practice to the GDC for consideration.

As part of its investigation the GDC commissioned an expert report from Mr Stuart Jefferies, who in setting out his findings relies on the same patient records that were used by the local health board for the purposes of the two record-card audits referred to above. In addition, a general dental practitioner who provided treatment to three patients who had previously received care and treatment from Miss Luguera Aguirre, namely Patients AO, AP and AQ, referred concerns about Miss Luguera Aguirre's treatment of those patients to the GDC. The treatment of those concerns is also dealt with by Mr Jefferies and form part of the GDC's case against the registrant. Complaints from two other patients, who are referred to as Patient AR and AS for the purposes of these proceedings, have also given rise to specific allegations.

The allegations that arise out of Ms Luguera Aguirre's care and treatment of the patients involved in this case relate to specific areas of concern. The GDC alleges that certain acts and omissions were repeated within and across individual patient cases, and that these shortcomings amount to a failure to provide an adequate standard of care and record-keeping. The specific areas of concern are providing restorative treatment with inadequate skill or care, failing to diagnose and treat caries, prescribing antibiotics without clinical indication, failing to obtain radiographs when clinically indicated, and failing to make adequate records.

As referred to above, the GDC also contends that, from around 8 July 2016 to 11 November 2016, Miss Luguera Aguirre failed to comply with conditions imposed on her by the health board. It is further alleged that, in the approximate period of 16 September 2016 to 19 December 2016, Miss Luguera Aguirre failed to provide the Council with evidence of her indemnity arrangements.

Evidence

The Committee heard oral evidence from Patient AQ; from Patient AS; from the subsequent treating dentist of Patient AO, Patient AP and Patient AQ; and from the expert instructed by the GDC, namely Mr Jefferies.

The Committee has been provided with documentary material in relation to the heads of charge that Miss Luguera Aguirre faces, including the witness statements and documentary exhibits of Patient AO, Patient AP, Patient AQ, and Patient AS; the witness statement and documentary exhibits of the subsequent treating dentist of Patient AO, Patient AP and Patient AQ; the witness statement and documentary exhibits of the former Head of Quality for Primary Care at the Aneurin Bevan University Health Board; and the witness statement and documentary exhibits of a Senior Caseworker in the GDC's Fitness to Practise Department with knowledge of the Council's investigation. The Committee has also been provided with the expert report of Mr Jefferies, and the clinical records for each of the patients involved in this case.

Committee's findings of fact

The Committee has taken into account all the evidence presented to it, both written and oral, and has considered the submissions made by Mr Corrie on behalf of the GDC.

The Committee has accepted the advice of the Legal Adviser. The Committee is mindful that the burden of proof lies with the GDC, and has considered the heads of charge against the civil standard of proof, that is to say, on the balance of probabilities. The Committee has considered each head of charge separately, although in respect of some of the heads of charge its findings will be given together.

I will now announce the Committee's findings:

	<u>Patient A</u>
1.(a)	Proved
	The Committee finds the facts alleged at head of charge 1 (a) proved. The Committee notes from the clinical records of Patient A that Miss Luguera Aguirre did not record a justification for the taking of the radiographs in question. The Committee accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to do so in accordance with the Ionising Radiation (Medical Exposure) Regulations (2000) ('IRMER regulations'). The Committee finds that this amounts to a failure to take an adequate record in relation to Miss Luguera Aguirre's radiography. Accordingly, the Committee finds the facts alleged at head of charge 1 (a) proved.
1.(b)	Proved
	The Committee finds the facts alleged at head of charge 1 (b) proved. The Committee notes from the clinical records of Patient A that Miss Luguera Aguirre did not record the grading of the radiographs in question. The Committee accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to do so in accordance with the IRMER regulations. The Committee finds that this amounts to a failure to take an adequate record in relation to Miss Luguera Aguirre's radiography. Accordingly, the Committee finds the facts alleged at head of charge 1 (b) proved.
2.	Proved
	The Committee finds the facts alleged at head of charge 2 proved. The Committee notes from Patient A's clinical records that Miss Luguera Aguirre only partially completed what appears to be a template proforma used for patient examinations. This record did not set out key aspects of a patient examination, for instance the extent of the risk of caries and periodontal disease. The Committee accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient A. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 2 proved.
	<u>Patient B</u>

3.(a) (i)	Proved
3.(a) (ii)	Proved
3.(a) (iii)	Proved
	The Committee finds the facts alleged at heads of charge 3 (a) (i), 3 (a) (ii) and 3 (a) (iii) proved. The evidence presented to the Committee demonstrates that the restoration that Miss Luguera Aguirre repaired at Patient B's UR6 only lasted until January 2013. The filling that Miss Luguera Aguirre repaired had originally been placed on 14 November 2011. A second repair to the restoration on 28 January 2013 lasted until May 2014, with a further filling provided on 15 May 2014. The Committee accepts the expert evidence of Mr Jefferies that such work should not need to be repeated on multiple occasions, and it accepts his opinion that this represents the placing and repairing of a filling with inadequate care and skill. The Committee further finds that this amounts to a failure on the part of Miss Luguera Aguirre to provide an adequate standard of care to Patient B. Accordingly the Committee finds the facts alleged at heads of charge 3 (a) (i), 3 (a) (ii) and 3 (a) (iii) proved.
3.(b)	Proved
	The Committee finds the facts alleged at head of charge 3 (b) proved. The evidence presented to the Committee demonstrates that on 23 July 2014 Miss Luguera Aguirre fitted at crown at Patient B's UR6. The crown was subsequently repaired on 29 October 2015. The crown became loose through debonding and the patient attended a further appointment with another registrant on 23 November 2015. The crown that Miss Luguera Aguirre had placed on 23 July 2014 lasted only 15 months. The Committee notes that in his evidence Mr Jefferies stated that there may been good reasons for the failure of a crown, such as grinding, but there is no documented reason for the failure. In any event, the Committee accepts the expert evidence of Mr Jefferies that the crown that Miss Luguera Aguirre placed was inadequate in the first place, as demonstrated by its limited longevity. The Committee accepts that the repeated failure of the crown is indicative of Miss Luguera Aguirre having fitted the crown with inadequate care and skill, and also accepts his view that there was an inherent design problem associated with a three-quarter-length crown. The Committee further finds that Miss Luguera Aguirre's fitting of a crown with inadequate care and skill amounts to a failure to provide an adequate standard of care. The Committee therefore finds the facts alleged at head of charge 3 (b) proved.
3.(c)	Proved
	The Committee finds the facts alleged at head of charge 3 (c) proved. The Committee has heard the expert evidence of Mr Jefferies in this regard, namely that the radiographs taken on 21 March 2016 show bone loss, and that the bone loss was so extensive that it would have been present on the date on which Miss Luguera Aguirre fitted the crown, namely 23 July 2014. The Committee infers from the absence of

	any record to suggest that a diagnosis was made that no diagnosis was in fact made. This conclusion is reinforced by the apparent absence of any periapical radiographs which would have been required to detect the likely bone loss on 23 July 2014. The Committee finds that Miss Luguera Aguirre was under a duty to make a diagnosis of the patient's bone loss, and that as she did not do so this amounts to an inadequate standard of care. The Committee therefore finds the facts alleged at head of charge 3 (c) proved.
4.	Proved
	The Committee finds the facts alleged at head of charge 4 proved. The Committee notes from Patient B's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, for instance by recording that Patient B was a non-smoker but that smoking cessation advice was given. Miss Luguera Aguirre also did not record the results of a basic periodontal examination (BPE) or the extent of the risk of caries and periodontal disease. The Committee accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient B. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 4 proved.
	<u>Patient C</u>
5.	Proved
	The Committee finds the facts alleged at head of charge 5 proved. The Committee notes from Patient C's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by not specifying the patient's caries and periodontal risks. The Committee accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient C. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 5 proved.
6.(a)	Proved
6.(b)	Proved
6.(c)	Proved
	The Committee finds the facts alleged at head of charge 6 (a), 6 (b) and 6 (c) proved. The Committee notes from Patient C's clinical records that Miss Luguera Aguirre did not record the justification for, the grading of and a report on the radiographs that she took on 29 June 2015, and it again accepts the expert evidence of Mr Jefferies that this amounts to a failure to make an adequate record contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at

	head of charge 6 (a), 6 (b) and 6 (c) above.
	Patient D
7.(a)	Proved
	The Committee finds the facts alleged at head of charge 7 (a) proved. The Committee notes from Patient D's clinical records that Miss Luguera Aguirre did not record a clinical justification for her prescription, and indeed that she did not record what medication she had prescribed. The Committee has heard from Mr Jefferies that the medication that was prescribed may have been antibiotics, given the reference to a failure of RCT at the patient's UL6, but in any event the Committee notes that there is no recorded justification, or any record of what medication was prescribed. The Committee finds that as there was no clinical justification for the prescription, this amounts to a failure on the part of Miss Luguera Aguirre to provide an adequate standard of care to Patient D. Accordingly the Committee finds the facts alleged at head of charge 7 (a) proved.
7.(b)	Withdrawn
7.(c)	Proved
	The Committee finds the facts alleged at head of charge 7 (c) proved. The Committee notes from the clinical records of Patient D that Miss Luguera Aguirre prescribed antibiotics in relation to the patient's pulpitis. The Committee accepts the expert evidence of Mr Jefferies that antibiotics should not be prescribed for pulpitis and that this does not amount to a clinical justification, as set out in the Faculty of General Dental Practitioners' *Standards in Dentistry* (2006) ('FGDP guidelines'). The Committee finds that the prescribing of antibiotics on this occasion without clinical justification amounts to a failure to provide an adequate standard of care to Patient D, and that accordingly the facts alleged at head of charge 7 (c) are proved.
8.(a)	Withdrawn
8.(b)	Proved
8.(c)	Proved
	The Committee finds the facts alleged at heads of charge 8 (b) and 8 (c) proved. The Committee notes that Miss Luguera Aguirre did not grade or report on the radiograph that she took on 16 January 2014, and that this amounts to a failure to make an adequate record in relation to the radiograph contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at heads of charge 8 (b) and 8 (c) proved.
9.(a)	Proved
9.(b)	Proved
9.(c)	Proved
	The Committee finds the facts alleged at heads of charge 9 (a), 9 (b)

	and 9 (c) proved. The Committee notes that, in respect of the records of 26 March 2013 and 28 July 2015, Miss Luguera Aguirre did not record the results of a BPE, or the patient's risk of caries and periodontal disease. In respect of 16 October 2014, Miss Luguera Aguirre recorded that Patient D was a non-smoker, but that smoking cessation advice was given. The Committee considers that each of these omissions and errors amounts to a failure to adequately complete the patient examination template, and that this amounts to a failure to take an adequate record. Accordingly it finds the facts alleged at heads of charge 9 (a), 9 (b) and 9 (c) proved.
	<u>Patient E</u>
10.(a)	Proved
10.(b)	Proved
10.(c)	Proved
	The Committee finds the facts alleged at heads of charge 10 (a), 10 (b) and 10 (c) proved. The information presented to the Committee demonstrates that a filling was initially placed at Patient E's UR4 on 17 June 2015. The filling was repaired on 17 July 2015 and for a second time on 13 January 2016. The filling is recorded as having failed once more on 9 July 2016. As the filling failed three times in the space of one year, the Committee accepts the expert evidence of Mr Jefferies that this amounts to a failure on the part of Miss Luguera Aguirre to place a filling with adequate care and skill. Accordingly the Committee finds the facts alleged at heads of charge 10 (a), 10 (b) and 10 (c) proved.
11.(a)	Proved
11.(b)	Proved
11.(c)	Proved
	The Committee finds the facts alleged at heads of charge 11 (a), 11 (b) and 11 (c) proved. The Committee notes that Miss Luguera Aguirre did not record a justification for, a grading of or a report on the radiograph that she took on 11 June 2015 and that this amounts to a failure to make an adequate record in relation to the radiograph contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at heads of charge 11 (a), 11 (b) and 11 (c) proved.
12.	Proved
	The Committee finds the facts alleged at head of charge 12 proved. The Committee notes from Patient E's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by not specifying the patient's caries and periodontal risks and the results of a BPE. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient E. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The

	Committee therefore finds the facts alleged at head of charge 12 proved.
	Patient F
13.(a)	Proved
13.(b)	Proved
13.(c)	Proved
	The Committee finds the facts alleged at heads of charge 13 (a), 13 (b) and 13 (c) proved. The Committee notes that Miss Luguera Aguirre did not record a justification for, a grading of or a report on the radiograph that she took on 14 October 2015. The Committee finds that this amounts to a failure to make an adequate record in relation to the radiograph contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at heads of charge 13 (a), 13 (b) and 13 (c) proved.
14.	Proved
	The Committee finds the facts alleged at head of charge 14 proved. The Committee notes from Patient F's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by not specifying the patient's caries and periodontal risks and the results of a BPE examination, and by recording that she gave smoking cessation advice to a patient who she also recorded was a non-smoker. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient F. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 14 proved.
	Patient G
15.	Proved
	The Committee finds the facts alleged at head of charge 15 proved. The Committee notes from Patient G's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by not recording the results of a BPE. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient G. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 15 proved.
16.(a)	Withdrawn
16.(b)	Proved

	The Committee finds the facts alleged at head of charge 16 (b) proved. The Committee notes that Miss Luguera Aguirre did not record a grading of the radiographs that she took on 8 July 2015. The Committee finds that this amounts to a failure to make an adequate record in relation to the radiographs contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at head of charge 16 (b) proved.
	<u>Patient H</u>
17.(a)	Proved
	The Committee finds the facts alleged at head of charge 17 (a) proved. The Committee notes from the clinical records of Patient H that Miss Luguera Aguirre appears to have prescribed antibiotics in relation to the patient's abscess. The Committee accepts the expert evidence of Mr Jefferies that antibiotics should not be prescribed for an abscess and that this does not amount to a clinical justification, as set out in the FGDP guidelines. Mr Jefferies stated to the Committee that the FGDP guidelines state that antimicrobials should only be prescribed for serious infection, and where the lymph notes are enlarged, where there is fever, and where the patient's condition is likely to deteriorate. The Committee therefore finds that the prescribing of antibiotics on this occasion without clinical justification amounts to a failure to provide an adequate standard of care to Patient H, and that accordingly the facts alleged at head of charge 17 (a) are proved.
17.(b)	Not proved
	The Committee finds the facts alleged at head of charge 17 (b) not proved. The Committee notes from the evidence presented to it that a crown at Patient H's UR4 was then noted as having broken by 13 September 2016, and was repaired by another registrant on that date. In his evidence to the Committee Mr Jefferies stated that he could not state whether Miss Luguera Aguirre fitted the crown on 23 September 2015 or on 7 October 2015. The Committee finds that the GDC has not demonstrated to the standard required that Miss Luguera Aguirre fitted a crown on the date specified in the charge, namely on or around 23 September 2015. In any event, Mr Jefferies conceded in his evidence that the failure of the crown after approximately 12 months did not amount to a failing. The Committee therefore finds the facts alleged at head of charge 17 (b) not proved.
17.(c)	Withdrawn
18.(a)	Proved
18.(b)	Proved
18.(c)	Proved
	The Committee finds the facts alleged at heads of charge 18 (a), 18 (b) and 18 (c) proved. The Committee notes that Miss Luguera Aguirre did not record a justification for, a grading of or a report on the radiograph that she took on 7 October 2015. The Committee finds that this amounts to a failure to make an adequate record in relation to the

	radiograph contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at heads of charge 18 (a), 18 (b) and 18 (c) proved.
19.	Proved
	The Committee finds the facts alleged at head of charge 19 proved. The Committee notes from Patient H's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by not recording the results of a BPE examination, by omitting the patient's caries risk and by recording that smoking cessation advice had been provided to a non-smoker. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient H. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 19 proved.
	<u>Patient I</u>
20.	Proved
	The Committee finds the facts alleged at head of charge 20 proved. The Committee notes from Patient I's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by not recording the results of a BPE and the patient's caries and periodontal disease risks, and by recording that smoking cessation advice had been provided to a non-smoker. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient I. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 20 proved.
	<u>Patient J</u>
21.(a)	Proved
	The Committee finds the facts alleged at head of charge 21 (a) proved. The Committee notes from the clinical records of Patient J that Miss Luguera Aguirre appears to have prescribed antibiotics to the patient on 24 September 2014. The Committee again accepts the expert evidence of Mr Jefferies. Mr Jefferies stated to the Committee that the FGDP guidelines state that antimicrobials should only be prescribed for serious infection, and where the lymph notes are enlarged, where there is fever, and where the patient's condition is likely to deteriorate. As there is no evidence to suggest the presence of any of these indications, the Committee finds that the prescribing of antibiotics on this occasion was without clinical justification. This in turn amounts to a failure to provide an adequate standard of care to Patient J, and

	accordingly the facts alleged at head of charge 21 (a) are proved.
21.(b) (i)	Proved
21.(b) (ii)	Proved
	The Committee finds the facts alleged at heads of charge 21 (b) (i) and 21 (b) (ii) proved. The Committee notes that Miss Luguera Aguirre fitted a crown at Patient J's UR2 on 21 November 2013. The crown subsequently debonded and was fixed on 18 June 2014. A second debonding then occurred, requiring a further fixing on 13 August 2015. The Committee accepts the expert evidence of Mr Jefferies that this repeated debonding suggests that Miss Luguera Aguirre's crownwork was undertaken with inadequate care and skill, and that this in turn amounts to a failure to provide an adequate standard of care to Patient J. The Committee therefore finds the facts alleged at heads of charge 21 (b) (i) and 21 (b) (ii) proved.
22.(a)	Proved
	The Committee finds the facts alleged at head of charge 22 (a) proved. The Committee notes from Patient J's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by not recording the results of a BPE examination. Although Miss Luguera Aguirre recorded that the patient's caries risk was low, the Committee accepts the expert evidence of Mr Jefferies that this was an incorrect entry, as the patient's dental charting history demonstrates that the patient in fact had a high caries risk. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient J. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 22 (a) proved.
22.(b)	Proved
	The Committee finds the facts alleged at head of charge 22 (b) proved. The Committee notes from Patient J's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by not recording the results of a BPE examination and the patient's caries and periodontal disease risks. Miss Luguera Aguirre also recorded that she gave smoking cessation advice, but did not record whether or not the patient was in fact a smoker. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient J. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 22 (b) proved.
23.(a)	Proved

23.(b)	Proved
23.(c)	Proved
	The Committee finds the facts alleged at heads of charge 23 (a), 23 (b) and 23 (c) proved. The Committee notes that Miss Luguera Aguirre did not record a justification for, a grading of or a report on the radiograph that she took on 13 August 2015. The Committee finds that this amounts to a failure to make an adequate record in relation to the radiograph contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at heads of charge 23 (a), 23 (b) and 23 (c) proved.
	<u>Patient K</u>
24.	Proved
	The Committee finds the facts alleged at head of charge 24 proved. The Committee notes from Patient K's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record a key aspect of the patient examination, namely by not recording the results of a BPE examination. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient K. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 24 proved.
25.	Proved
	The Committee finds the facts alleged at head of charge 25 proved. The evidence presented to the Committee demonstrates that on or around 23 September 2015 Miss Luguera Aguirre provided root canal treatment (RCT) at Patient K's UR4. The Committee has heard expert evidence from Mr Jefferies, who is critical of the standard of the RCT on account of its short length. Mr Jefferies stated that the RCT did not go deep enough into the root canal, and was therefore incomplete and inadequate, as further suggested by the problems that later arose in relation to that tooth. The Committee accepts the expert evidence of Mr Jefferies on this point and finds that Miss Luguera Aguirre's RCT was performed with inadequate care and skill. This in turn amounts to a failure to provide an adequate standard of care to Patient K. The Committee therefore finds the facts alleged at head of charge 25 proved.
	<u>Patient L</u>
26.(a)	Not proved
26.(b)	Not proved
	The Committee finds the facts alleged at heads of charge 26 (a) and 26 (b) not proved. The evidence presented to the Committee demonstrates that Miss Luguera Aguirre placed a filling at Patient L's UL2 on 31 July 2015. The filling is recorded as having been replaced on 3 September

	2015. Although there is some suggestion that the same filling was repaired for a second time on 7 January 2016, the Committee has not been provided with sufficient evidence for it to be satisfied that the replacement in fact related to the same filling. As the Committee finds that the evidence demonstrates that Miss Luguera Aguirre failed on only one occasion, it accepts the expert evidence of Mr Jefferies that one failure does not demonstrate a failure to provide fillings with adequate care and skill. Mr Jefferies is instead critical of repeated failures. The Committee therefore finds the facts alleged at heads of charge 26 (a) and 26 (b) not proved.
27.(a)	Withdrawn
27.(b)	Withdrawn
27.(c)	Withdrawn
	<u>Patient M</u>
28.(a)	Proved
	The Committee finds the facts alleged at head of charge 28 (a) proved. The Committee notes from the clinical records of Patient M that Miss Luguera Aguirre appears to have prescribed antibiotics to the patient on 15 July 2014 for the purposes of alleviating pain at the LR5. Mr Jefferies stated to the Committee that the FGDP guidelines state that antimicrobials should only be prescribed for serious infection, and where the lymph notes are enlarged, where there is fever, and where the patient's condition is likely to deteriorate. As there is no evidence to suggest the presence of any of these indications, and indeed Miss Luguera Aguirre recorded that nothing abnormal was detected in relation to the patient's lymph nodes, the Committee finds that the prescribing of antibiotics on this occasion was without clinical justification. This in turn amounts to a failure to provide an adequate standard of care to Patient M, and accordingly the facts alleged at head of charge 28 (a) are proved.
28.(b) (i)	Proved
28.(b) (ii)	Proved
28.(b) (iii)	Not proved
	The Committee finds the facts alleged at heads of charge 28 (b) (i) and 28 (b) (ii) proved, and the facts alleged at head of charge 28 (b) (iii) not proved. The evidence presented to the Committee demonstrates that Miss Luguera Aguirre fitted a crown at Patient M's LR5 on 2 September 2015. The patient's clinical records state that the onlay came off, and that the patient was seen by a different registrant on 11 September 2015. The crown was then lost and a new one was fitted on 14 October 2015. The crown came off again on 6 January 2016 and a new crown was fitted on 16 March 2016. The porcelain of this crown then fractured on or around 5 May 2016. The Committee finds that the evidence demonstrates that the crownwork on 2 September 2015 and 14 October 2015 was inadequate on account of the repeated failures, and it therefore finds the facts alleged at heads of charge 28 (b) (i) and 28 (b)

	(ii) proved. The Committee however notes that the crownwork of 16 March 2016 has not been demonstrated to have been undertaken with inadequate care and skill, as the fracture that subsequently arose does not mean that the work was undertaken with insufficient care and skill. Therefore, the Committee finds the facts alleged at heads of charge 28 (b) (i) and 28 (b) (ii) proved, and the facts alleged at head of charge 28 (b) (iii) not proved.
29.(a)	Proved
29.(b)	Proved
	The Committee finds the facts alleged at heads of charge 29 (a) and 29 (b) proved. The Committee notes from Patient M's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by not recording the results of a BPE examination, by omitting the patient's risk of caries and periodontal disease, and by recording that smoking cessation advice had been given to a non-smoker. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient M. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at heads of charge 29 (a) and 29 (b) proved.
	<u>Patient N</u>
30.	Proved
	The Committee finds the facts alleged at head of charge 30 proved. The Committee notes from Patient N's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the patient's caries and periodontal disease risks. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient N. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 30 proved.
31.(a)	Proved
31.(b)	Proved
	The Committee finds the facts alleged at heads of charge 31 (a) and 31 (b) proved. The Committee notes that Miss Luguera Aguirre did not record a justification for or grading of the radiographs that she took on 14 August 2015. The Committee finds that this amounts to a failure to make an adequate record in relation to the radiographs contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at heads of charge 31 (a) and 31 (b) proved.
	<u>Patient O</u>

32.(a)	Proved
32.(b)	Proved
	The Committee finds the facts alleged at heads of charge 32 (a) and 32 (b) proved. The Committee notes that Miss Luguera Aguirre did not record a justification for or grading of the radiographs that she took on 30 June 2015. The Committee finds that this amounts to a failure to make an adequate record in relation to the radiographs contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at heads of charge 32 (a) and 32 (b) proved.
33.(a)	Proved
	The Committee finds the facts alleged at head of charge 33 (a) proved. The Committee notes from Patient O's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the patient's caries and periodontal disease risks and the results of a BPE, and by recording that smoking cessation advice had been given to a non-smoker. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient O. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 33 (a) proved.
33.(b) (i)	Withdrawn
33.(b) (ii)	Withdrawn
33.(b) (iii)	Withdrawn
33.(b) (iv)	Withdrawn
33.(c) (i)	Not proved
33.(c) (ii)	Not proved
33.(c) (iiii)	Not proved
33.(c) (iv)	Not proved
	The Committee finds the facts alleged at heads of charge 33 (c) (i), 33 (c) (ii), 33 (c) (iii) and 33 (c) (iv) not proved. The Committee considers that the evidence presented to it is not sufficient to demonstrate that Miss Luguera Aguirre did, in fact, use local anaesthetic on or around 28 July 2015. In his evidence to the Committee Mr Jefferies accepted that Miss Luguera Aguirre may not have used local anaesthetic. It follows that Miss Luguera Aguirre was not under a duty to record the use of local anaesthetic if no such anaesthetic was administered. The Committee therefore finds the facts alleged at heads of charge 33 (c) (i), 33 (c) (ii), 33 (c) (iii) and 33 (c) (iv) not proved.
	<u>Patient P</u>

34.	Not proved
	The Committee finds the facts alleged at head of charge 34 not proved. The Committee considers that the evidence presented to it is not sufficient to demonstrate to the standard required that Miss Luguera Aguirre was under a duty to take a radiograph on 31 January 2013. The clinical records for Patient P state that there was a retained root at the patient's UR6, but that the patient was not in pain, the root was not causing issues and that the intention was to leave the root *in situ*. The Committee considers that this was a reasonable plan, and that a radiograph was not indicated. Accordingly it finds the facts alleged at head of charge 34 not proved.
35.(a)	Proved
35.(b)	Proved
	The Committee finds the facts alleged at heads of charge 35 (a) and 35 (b) proved. The Committee notes from Patient P's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the results of a BPE and the patient's risk of caries. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient P. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at heads of charge 305 (a) and 35 (b) proved.
	<u>Patient Q</u>
36.(a)	Withdrawn
36.(b)	Withdrawn
36.(c)	Withdrawn
36.(d)	Withdrawn
37.	Proved
	The Committee finds the facts alleged at head of charge 37 proved. The Committee notes from Patient Q's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the patient's caries and periodontal disease risks and the results of a BPE. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient Q. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 37 proved.
	<u>Patient R</u>

38.(a)	Proved
	The Committee finds the facts alleged at head of charge 38 (a) proved. The Committee notes from the clinical records of Patient R that Miss Luguera Aguirre appears to have prescribed antibiotics to the patient on 17 July 2015 for the purposes of alleviating pain. Mr Jefferies stated to the Committee that the FGDP guidelines state that antimicrobials should only be prescribed for serious infection, and where the lymph notes are enlarged, where there is fever, and where the patient's condition is likely to deteriorate. As there is no evidence to suggest the presence of any of these indications, the Committee finds that the prescribing of antibiotics on this occasion was without clinical justification. The pain that the patient was reportedly experiencing is not a sufficient justification for the prescribing of antibiotics. This in turn amounts to a failure to provide an adequate standard of care to Patient R, and accordingly the facts alleged at head of charge 38 (a) are proved.
38.(b)	Not proved
	The Committee finds the facts alleged at head of charge 38 (b) not proved on the basis that this is an alternate charge to be considered in the event that the facts at head of charge 38 (a) above had been found not proved. Having found those facts to be proved, the Committee finds the facts alleged at the alternative head of charge 38 (b) not proved.
38.(c)	Proved
	The Committee finds the facts alleged at head of charge 38 (c) proved. The radiograph presented to the Committee taken on 9 September 2015 demonstrates to the standard required that Miss Luguera Aguirre's RCT was inadequate, in that the root filling was short in the mesial root. The post treatment provided some weeks later also shows that the RCT was incomplete and inadequate. The Committee finds that this amounts to an inadequate standard of care, and accordingly the Committee finds the facts alleged at head of charge 38 (c) proved.
39.(a)	Withdrawn
39.(b)	Proved
39.(c)	Proved
	The Committee finds the facts alleged at heads of charge 39 (b) and 39 (c) proved. The Committee notes that Miss Luguera Aguirre did not record a grading of or a report on the radiographs that she took on 9 September 2015. The Committee finds that this amounts to a failure to make an adequate record in relation to the radiographs contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at heads of charge 39 (b) and 39 (c) proved.
40.	Proved
	The Committee finds the facts alleged at head of charge 40 proved. The Committee notes from Patient R's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not

	properly record key aspects of the patient examination, namely by omitting the patient's periodontal disease risks and the results of a BPE, and by recording that smoking cessation advice was given to a non-smoker. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient R. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 40 proved.
	<u>Patient S</u>
41.(a)	Withdrawn
41.(b)	Proved
	The Committee finds the facts alleged at head of charge 41 (b) proved. The Committee notes that Miss Luguera Aguirre did not record a grading of the radiographs that she took on 9 September 2015. The Committee finds that this amounts to a failure to make an adequate record in relation to the radiographs contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at head of charge 41 (b) proved.
42.	Proved
	The Committee finds the facts alleged at head of charge 42 proved. The Committee notes from Patient S's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by recording that smoking cessation advice was given to a non-smoker. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient S. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 42 proved.
	<u>Patient T</u>
43.(a)	Proved
43.(b)	Proved
	The Committee finds the facts alleged at heads of charge 43 (a) and 43 (b) proved. The Committee notes that Miss Luguera Aguirre did not record a grading of or a report on the radiograph that she took on 18 July 2015. The Committee notes that there are some details in the patient's clinical notes about the radiographs, but the Committee accepts Mr Jefferies' distinction that this relates to a treatment plan rather than to a grading or a report. The Committee finds that this amounts to a failure to make an adequate record in relation to the radiographs contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at heads of charge 43 (a)

	and 43 (b) proved.
44.	Proved
	The Committee finds the facts alleged at head of charge 44 proved. The Committee notes from Patient T's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the patient's caries risk and the results of a BPE. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient R. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 44 proved.
	<u>Patient U</u>
45.(a)	Proved
45.(b)	Proved
	The Committee finds the facts alleged at heads of charge 45 (a) and 45 (b) proved. The Committee notes from the evidence placed before it that Miss Luguera Aguirre provided extractions at the patient's UR4 on 1 October 2015 and at the UL4 on 15 October 2015. The Committee accepts the expert evidence of Mr Jefferies that, in accordance with the IRMER regulations referred to above, radiographs should be taken before extractions are performed. The Committee finds that Miss Luguera Aguirre's omission of radiographs on both dates amounts to a failure to perform her duty in this regard, and that this in turn amounts to an inadequate standard of care. The Committee therefore finds the facts alleged at heads of charge 45 (a) and 45 (b) proved.
46.(a)	Not proved
	The Committee finds the facts alleged at head of charge 46 (a) not proved. Although the evidence of Mr Jefferies is that the record that Miss Luguera Aguirre made of her examination of Patient U on 15 July 2015 was not of an adequate standard, the Committee notes that the head of charge requires the GDC to prove to the standard required that she did not adequately complete the examination template. The Committee finds that she did, on balance, adequately complete the template, and although the template itself leaves much to be desired the Committee therefore finds that this head of charge falls and is not proved.
46.(b)	Proved
	The Committee finds the facts alleged at head of charge 46 (b) proved. The Committee notes from Patient U's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record a key aspect of the patient examination, namely by omitting the patient's risk of caries. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of

	Patient U. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 46 (b) proved.
	Patient V
47.(a)	Withdrawn
47.(b)	Proved
47.(c)	Proved
	The Committee finds the facts alleged at heads of charge 47 (b) and 47 (c) proved. The Committee notes that Miss Luguera Aguirre did not record a grading of or a report on the radiographs that she took on 21 July 2015. The Committee finds that this amounts to a failure to make an adequate record in relation to the radiographs contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at heads of charge 47 (b) and 47 (c) proved.
48.(a)	Proved
	The Committee finds the facts alleged at head of charge 48 (a) proved. The Committee notes from the clinical records of Patient V that Miss Luguera Aguirre appears to have prescribed antibiotics to the patient on 23 July 2015 in relation to a lump, which may have arisen from an infection, in the patient's lower left quadrant. Mr Jefferies stated to the Committee that the FGDP guidelines state that antimicrobials should only be prescribed for serious infection, and where the lymph notes are enlarged, where there is fever, and where the patient's condition is likely to deteriorate. As there is no evidence to suggest the presence of any of these indications, the Committee finds that the prescribing of antibiotics on this occasion was without clinical justification. This in turn amounts to a failure to provide an adequate standard of care to Patient V, and accordingly the facts alleged at head of charge 48 (a) are proved.
48.(b)	Not proved
	The Committee finds the facts alleged at head of charge 48 (b) not proved on the basis that this is an alternate charge to be considered in the event that the facts at head of charge 48 (a) above had been found not proved. Having found those facts to be proved, the Committee finds the facts alleged at the alternative head of charge 48 (b) not proved.
48.(c)	Proved
	The Committee finds the facts alleged at head of charge 48 (c) proved. The Committee notes from the evidence placed before it that on 17 February 2016 Miss Luguera Aguirre placed a filling at Patient V's UL1. The patient's previous treating dentist had, according to the patient's clinical records, identified a root canal infection and had identified the need for RCT, with a temporary dressing having been provided by that registrant. Patient V then attended Miss Luguera Aguirre on 17 February 2016, and instead of providing RCT Miss Luguera Aguirre

	provided a filling. The Committee accepts the expert evidence of Mr Jefferies that this treatment was not indicated, and that the appropriate course of treatment was the RCT planned and proposed by the patient's previous treating dentist. The Committee concludes that this amounts to an inadequate standard of care on the part of Miss Luguera Aguirre, and accordingly it finds the facts alleged at head of charge 28 (c) proved.
49.	Proved
	The Committee finds the facts alleged at head of charge 49 proved. The Committee notes from Patient V's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the results of a BPE. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient V. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 49 proved.
	<u>Patient W</u>
50.(a)	Withdrawn
50.(b)	Proved
50.(c)	Proved
	The Committee finds the facts alleged at heads of charge 50 (b) and 50 (c) proved. The Committee notes that Miss Luguera Aguirre did not record a grading of or a report on the radiographs that she took on 14 July 2015. The Committee considers that her recording of 'as charted' does not constitute a grading or a report. The Committee finds that this amounts to a failure to make an adequate record in relation to the radiographs contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at heads of charge 50 (b) and 50 (c) proved.
51.(a) (i)	Proved
51.(a) (ii)	Proved
	The Committee finds the facts alleged at heads of charge 51 (a) (i) and 51 (a) (ii) proved. The Committee notes that Patient W attended an appointment with Miss Luguera Aguirre on 14 July 2015, and a radiograph was taken. Mr Jefferies is critical of Miss Luguera Aguirre's omission of a mid-treatment radiograph on 16 July 2015 when she was providing RCT to the patient's UR6. Mr Jefferies' evidence is that a radiograph, whilst indicated, might not have been necessary if an apex locator had been used to establish working depth, but as there is no record of an apex locator having been used a radiograph was required. The Committee also accepts Mr Jefferies' evidence that a post-treatment radiograph should have been taken at the next appointment on 28 July 2015 following the completion of RCT. The Committee finds

	that these two omissions amount to an inadequate standard of care, and that the facts alleged at heads of charge 51 (a) (i) and 51 (a) (ii) are therefore proved.
51.(b)	Not proved
	The Committee finds the facts alleged at head of charge 51 (b) not proved. In his evidence to the Committee Mr Jefferies stated that crowns can sometimes fracture. Miss Luguera Aguirre fitted a crown on 11 August 2015, and a fracture was noted on 21 December 2015. The Committee considers that Miss Luguera Aguirre was not necessarily culpable in respect of this fracture and that there is insufficient evidence to suggest that the crown was fitted with inadequate care and skill. Accordingly the Committee finds the facts alleged at head of charge 51 (b) not proved.
52.	Proved
	The Committee finds the facts alleged at head of charge 52 proved. The Committee notes from Patient W's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the results of a BPE. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient W. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 52 proved.
	<u>Patient X</u>
53.(a)	Proved
	The Committee finds the facts alleged at head of charge 53 (a) proved. The Committee notes from the evidence placed before it that Miss Luguera Aguirre performed ten extractions on 7 August 2015. The Committee accepts the expert evidence of Mr Jefferies that, in accordance with the IRMER regulations referred to above, radiographs should be taken before extractions are performed. The Committee finds that Miss Luguera Aguirre's omission of radiographs amounts to a failure to perform her duty in this regard, and that this in turn amounts to an inadequate standard of care. The Committee therefore finds the facts alleged at head of charge 53 (a) proved.
53.(b)	Proved
	The Committee finds the facts alleged at head of charge 53 (b) proved. The Committee notes from the clinical records of Patient X that Miss Luguera Aguirre appears to have prescribed antibiotics to the patient on 27 October 2015 in relation to discomfort at the patient's denture. Mr Jefferies stated to the Committee that the FGDP guidelines state that antimicrobials should only be prescribed for serious infection, and where the lymph notes are enlarged, where there is fever, and where the patient's condition is likely to deteriorate. As there is no evidence to

	suggest the presence of any of these indications, the Committee finds that the prescribing of antibiotics on this occasion was without clinical justification. This in turn amounts to a failure to provide an adequate standard of care to Patient X, and accordingly the facts alleged at head of charge 53 (b) are proved.
54.	Proved
	The Committee finds the facts alleged at head of charge 54 proved. The Committee notes from Patient X's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the patient's periodontal disease risks and the results of a BPE. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient X. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 54 proved.
	<u>Patient Y</u>
55.(a)	Withdrawn
55.(b)	Proved
	The Committee finds the facts alleged at head of charge 55 (b) proved. The Committee notes that Miss Luguera Aguirre did not record a grading of the radiographs that she took on 5 December 2014. The Committee finds that this amounts to a failure to make an adequate record in relation to the radiographs contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at head of charge 55 (b) proved.
56.(a)	Proved
	The Committee finds the facts alleged at head of charge 56 (a) proved. The Committee notes from Patient Y's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the results of a BPE, and a diagnosis following the patient having complained of an abscess at their UL7. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient Y. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 56 (a) proved.
56.(b)	Proved
	The Committee finds the facts alleged at head of charge 56 (b) proved. The Committee notes from Patient Y's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely whether Patient Y smoked and whether she had obtained the patient's

	informed consent. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient Y. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 56 (b) proved.
56.(c)	Proved
	The Committee finds the facts alleged at head of charge 56 (c) proved. The Committee notes from Patient Y's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the results of a BPE. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient Y. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 56 (c) proved.
56.(d)	Proved
	The Committee finds the facts alleged at head of charge 56 (d) proved. The Committee notes from Patient Y's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the results of a BPE and by recording that she had given smoking cessation advice to a non-smoker. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient Y. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 56 (d) proved.
56.(e)	Proved
	The Committee finds the facts alleged at head of charge 56 (e) proved. The Committee notes from Patient Y's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the results of a BPE, the patient's risks of caries and periodontal disease, and whether the patient smoked cigarettes and drank alcohol. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient Y. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 56 (e) proved.
	<u>Patient Z</u>

57.(a)	Proved
	The Committee finds the facts alleged at head of charge 57 (a) proved. The Committee notes from the clinical records of Patient Z that Miss Luguera Aguirre appears to have prescribed antibiotics to the patient on 31 January 2013 in relation to pain at the patient's wisdom teeth. Mr Jefferies stated to the Committee that the FGDP guidelines state that antimicrobials should only be prescribed for serious infection, and where the lymph notes are enlarged, where there is fever, and where the patient's condition is likely to deteriorate. As there is no evidence to suggest the presence of any of these indications, the Committee finds that the prescribing of antibiotics on this occasion was without clinical justification. This in turn amounts to a failure to provide an adequate standard of care to Patient Z, and accordingly the facts alleged at head of charge 57 (a) are proved.
57.(b)	Not proved
	The Committee finds the facts alleged at head of charge 57 (b) not proved on the basis that this is an alternate charge to be considered in the event that the facts at head of charge 57 (a) above had been found not proved. Having found those facts to be proved, the Committee finds the facts alleged at the alternative head of charge 57 (b) not proved.
58.(a)	Proved
58.(b)	Proved
	The Committee finds the facts alleged at heads of charge 58 (a) and 58 (b) proved. The Committee notes that Miss Luguera Aguirre did not record a grading of or a report on the radiograph that she took on 1 May 2014. The Committee finds that this amounts to a failure to make an adequate record in relation to the radiograph contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at heads of charge 58 (a) and 58 (b) proved.
59.(a)	Proved
	The Committee finds the facts alleged at head of charge 59 (a) proved. The Committee notes from Patient Z's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely whether a BPE was undertaken. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient Z. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 59 (a) proved.
59.(b)	Not proved
	The Committee finds the facts alleged at head of charge 59 (b) not proved. The Committee notes from Patient Z's clinical records that Miss Luguera Aguirre did not make adequate records in respect of her

	examination of Patient Z, more particularly that she did not record whether the patient had provided their informed consent. However, the Committee notes that the template used is not a patient examination template, and the Committee is therefore not able to conclude that Miss Luguera Aguirre's record-keeping was inadequate by reason of not properly completing an examination template which was not in fact used. The Committee therefore finds that this head of charge falls, and that the facts alleged are not proved.
59.(c)	Proved
	The Committee finds the facts alleged at head of charge 59 (c) proved. The Committee notes from Patient Z's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the results of a BPE and how many cigarettes the patient smoked each day. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient Z. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 59 (c) proved.
59.(d)	Proved
	The Committee finds the facts alleged at head of charge 59 (d) proved. The Committee notes from Patient Z's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the results of a BPE and the patient's caries and periodontal disease risks. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient Z. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 59 (d) proved.
59.(e)	Proved
	The Committee finds the facts alleged at head of charge 59 (e) proved. The Committee notes from Patient Z's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the results of a BPE and the patient's caries and periodontal disease risks. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient Z. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 59 (e) proved.

	Patient AA
60.(a)	Withdrawn
60.(b)	Proved
60.(c)	Proved
	The Committee finds the facts alleged at heads of charge 60 (b) and 60 (c) proved. The Committee notes that Miss Luguera Aguirre did not record a grading of or a report on the radiographs that she took on 13 August 2015. The Committee finds that this amounts to a failure to make an adequate record in relation to the radiographs contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at heads of charge 60 (b) and 60 (c) proved.
	Patient AB
61.(a)	Proved
	The Committee finds the facts alleged at head of charge 61 (a) proved. The Committee notes from the clinical records of Patient AB that Miss Luguera Aguirre appears to have prescribed antibiotics to the patient on 16 December 2014 in relation to pulpitis at the patient's UR3. Mr Jefferies stated to the Committee that the FGDP guidelines state that antimicrobials should only be prescribed for serious infection, and where the lymph notes are enlarged, where there is fever, and where the patient's condition is likely to deteriorate. As there is no evidence to suggest the presence of any of these indications, the Committee finds that the prescribing of antibiotics on this occasion was without clinical justification. This in turn amounts to a failure to provide an adequate standard of care to Patient AB, and accordingly the facts alleged at head of charge 61 (a) are proved.
61.(b)	Not proved
	The Committee finds the facts alleged at head of charge 61 (b) not proved on the basis that this is an alternate charge to be considered in the event that the facts at head of charge 61 (a) above had been found not proved. Having found those facts to be proved, the Committee finds the facts alleged at the alternative head of charge 61 (b) not proved.
61.(c) (i)	Not proved
61.(c) (ii)	Not proved
	The Committee finds the facts alleged at heads of charge 61 (c) (i) and 61 (c) (ii) not proved. The Committee notes from the evidence placed before it that Miss Luguera Aguirre fitted a crown at Patient AB's UR3 on 22 July 2015. The patient returned on 30 July 2015 to report that the crown was too big. The Committee has not been provided with any evidence to suggest that treatment was provided on 30 July 2015. A new crown was fitted on 24 September 2015, and the patient is recorded as having been pleased with the results. The Committee considers that the GDC has not demonstrated to the standard required that the crownwork was performed with inadequate skill and care on

	either occasion, and specifically rejects the argument advanced by the GDC that the treatment provided on 24 September 2015 can properly be considered as having been provided on or around 30 July 2015. In any event, the Committee does not find that the treatment provided on that date, or indeed on the earlier date of 22 July 2015, was inadequate. The Committee therefore finds the facts alleged at heads of charge 61 (c) (i) and 61 (c) (ii) not proved.
62.(a)	Proved
62.(b)	Proved
62.(c)	Proved
	The Committee finds the facts alleged at heads of charge 62 (a), 62 (b) and 62 (c) proved. The Committee notes that Miss Luguera Aguirre did not record a justification for, a grading of or a report on the radiographs that she took on 16 December 2014. The Committee finds that this amounts to a failure to make an adequate record in relation to the radiographs contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at heads of charge 62 (a), 62 (b) and 62 (c) proved.
63.(a)	Proved
	The Committee finds the facts alleged at head of charge 63 (a) proved. The Committee notes from Patient AB's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record a key aspect of the patient examination, namely by omitting the results of a BPE. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient AB. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 63 (a) proved.
63.(b)	Proved
	The Committee finds the facts alleged at head of charge 63 (b) proved. The Committee notes from Patient AB's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the results of a BPE and by recording that smoking cessation advice had been given to a non-smoker. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient AB. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 63 (b) proved.
63.(c)	Proved
	The Committee finds the facts alleged at head of charge 63 (c) proved. The Committee notes from Patient AB's clinical records that Miss

	Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely the omission of the results of a BPE and the patient's caries and periodontal disease risks, and by recording that she had given smoking cessation advice to a non-smoker,. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient AB. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 63 (c) proved.
	<u>Patient AC</u>
64.(a)	Withdrawn
64.(b)	Proved
64.(c)	Proved
	The Committee finds the facts alleged at heads of charge 64 (b) and 64 (c) proved. The Committee notes that Miss Luguera Aguirre did not record a grading of or a report on the radiographs that she took on 8 October 2015. The Committee finds that this amounts to a failure to make an adequate record in relation to the radiographs contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at heads of charge 64 (b) and 64 (c) proved.
65.(a)	Proved
	The Committee finds the facts alleged at head of charge 65 (a) proved. The Committee notes from Patient AC's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the results of a BPE, the patient's alcohol consumption and the patient's caries and periodontal disease risks. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient AC. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 63 (a) proved.
65.(b)	Withdrawn
	<u>Patient AD</u>
66.(a)	Proved
66.(b)	Proved
	The Committee finds the facts alleged at heads of charge 66 (a) and 66 (b) proved. The Committee notes that Miss Luguera Aguirre did not record a justification for or a grading of the radiographs that she took on 15 July 2015. The Committee finds that this amounts to a failure to make an adequate record in relation to the radiographs contrary to the

	IRMER regulations referred to above. The Committee therefore finds the facts alleged at heads of charge 66 (a) and 66 (b) proved.
67.	Proved
	The Committee finds the facts alleged at head of charge 67 proved. The Committee notes from Patient AD's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely the patient's alcohol and cigarette use, if any. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient AD. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 67 proved.
	<u>Patient AE</u>
68.	Proved
	The Committee finds the facts alleged at head of charge 68 proved. Patient AE attended an appointment with Miss Luguera Aguirre on 10 September 2015 for the purposes of RCT at the LL4. The patient's clinical records indicate that the treatment was commenced and completed on that day. Two radiographs which are available are not of diagnostic quality, in that neither show the root apex. The Committee accepts the expert evidence of Mr Jefferies that a radiograph should have shown the root apex before RCT was performed, and that accordingly the radiographs were not of suitable diagnostic quality for that purpose. The Committee finds that this in turn amounts to an inadequate standard of care. It therefore finds the facts alleged at head of charge 68 proved.
69.(a)	Withdrawn
69.(b)	Proved
69.(c)	Proved
	The Committee finds the facts alleged at heads of charge 69 (b) and 69 (c) proved. The Committee notes that Miss Luguera Aguirre did not record a grading of or a report on the radiographs that she took on 10 September 2015. The Committee finds that this amounts to a failure to make an adequate record in relation to the radiographs contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at heads of charge 69 (b) and 69 (c) proved.
70.	Proved
	The Committee finds the facts alleged at head of charge 70 proved. The Committee notes from Patient AE's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the results of a BPE, the patient's caries risk and by recording that smoking cessation advice was given to a non-smoker. The

	Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient AE. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 70 proved.
	<u>Patient AF</u>
71.(a)	Withdrawn
71.(b)	Proved
	The Committee finds the facts alleged at head of charge 71 (b) proved. The Committee notes that Miss Luguera Aguirre did not record a grading of the radiographs that she took on 30 September 2015. The Committee finds that this amounts to a failure to make an adequate record in relation to the radiographs contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at head of charge 71 (b) proved.
71.(c)	Proved
	The Committee finds the facts alleged at head of charge 71 (c) proved. The Committee accepts the expert evidence of Mr Jefferies that the radiographs taken by Miss Luguera Aguirre on 30 September 2015 revealed significant bone loss. It notes that Miss Luguera Aguirre did not report on the presence of such bone loss following the taking of the radiographs, and considers that this amounts to a failure to make an adequate record in relation to the radiographs contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at head of charge 71 (c) proved.
	<u>Patient AG</u>
72.	Proved
	The Committee finds the facts alleged at head of charge 72 proved. The Committee notes that on 1 October 2014 Miss Luguera Aguirre took a radiograph of the patient's LL6, on which a large cavity was visible. The expert evidence of Mr Jefferies is that the cavity was so large that it is likely to have been present for more than 12 months. Patient AG was seen by Miss Luguera Aguirre some 11 months previously on 21 November 2013 for the purposes of a routine examination and a treatment plan. The Committee notes that Miss Luguera Aguirre recorded that nothing abnormal had been detected (NAD), and it infers that she did not diagnose the presence of the cavity. The Committee finds that Miss Luguera Aguirre was under a duty to diagnose the cavity, and that as she did not do so this amounts to an inadequate standard of care. The Committee accordingly finds the facts alleged at head of charge 72 proved.
73.(a) (i)	Proved
73.(a) (ii)	Proved

	The Committee finds the facts alleged at heads of charge 73 (a) (i) and 73 (a) (ii) proved. The Committee notes that Miss Luguera Aguirre did not record a justification for or a grading of the radiographs that she took on 1 October 2014. The Committee finds that this amounts to a failure to make an adequate record in relation to the radiographs contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at heads of charge 73 (a) (i) and 73 (a) (ii) proved.
73.(a) (iii)	Withdrawn
73.(b) (i)	Withdrawn
73.(b) (ii)	Proved
	The Committee finds the facts alleged at head of charge 73 (b) (ii) proved. The Committee notes that Miss Luguera Aguirre did not record a grading of the radiographs that she took on 28 January 2015. The Committee finds that this amounts to a failure to make an adequate record in relation to the radiographs contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at heads of charge 73 (b) (ii) proved.
73.(c) (i)	Proved
73.(c) (ii)	Proved
	The Committee finds the facts alleged at heads of charge 73 (c) (i) and 73 (c) (ii) proved. The Committee notes that Miss Luguera Aguirre did not record a grading of or a report on the radiographs that she took on 8 October 2015. The Committee finds that this amounts to a failure to make an adequate record in relation to the radiographs contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at heads of charge 73 (c) (i) and 73 (c) (ii) proved.
74.(a)	Proved
	The Committee finds the facts alleged at head of charge 74 (a) proved. The Committee notes from Patient AG's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by making contradictory entries about the patient being both a smoker and a non-smoker, and a drinker and a non-drinker. Miss Luguera Aguirre also recorded that the patient had had multiple extractions when that does not in fact appear to be the case. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient AG. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 74 (a) proved.
74.(b)	Proved
	The Committee finds the facts alleged at head of charge 74 (b) proved. The Committee notes from Patient AG's clinical records that Miss

	Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the results of a BPE and the patient's caries and periodontal disease risks. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient AG. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 74 (b) proved.
74.(c)	Proved
	The Committee finds the facts alleged at head of charge 74 (c) proved. The Committee notes from Patient AG's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the results of a BPE and the patient's caries and periodontal disease risks. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient AG. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 74 (c) proved.
74.(d)	Proved
	The Committee finds the facts alleged at head of charge 74 (d) proved. The Committee notes from Patient AG's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the results of a BPE and the patient's caries and periodontal disease risks. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient AG. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 74 (d) proved.
	<u>Patient AI</u>
75.(a)	Proved
	The Committee finds the facts alleged at heads of charge 75 (a) proved. The Committee notes that Miss Luguera Aguirre did not record a grading of the radiographs that she took on 6 August 2015. The Committee finds that this amounts to a failure to make an adequate record in relation to the radiographs contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at head of charge 75 (a) proved.
75.(b)	Proved

	The Committee finds the facts alleged at head of charge 75 (b) proved. The Committee accepts the expert evidence of Mr Jefferies that the radiographs taken by Miss Luguera Aguirre on 6 August 2015 revealed significant bone loss. It notes that Miss Luguera Aguirre did not report on the presence of such bone loss following the taking of the radiograph, and considers that this amounts to a failure to make an adequate record in relation to the radiographs contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at head of charge 75 (b) proved.
76.	Proved
	The Committee finds the facts alleged at head of charge 76 proved. The Committee notes from Patient AI's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the results of a BPE the patient's caries and periodontal disease risks, and recording that there were no dental abnormalities present despite the existence of retained roots and fillings at the patient's LR6. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient AI. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 76 proved.
	<u>Patient AJ</u>
77.(a)	Proved
77.(b)	Proved
77.(c)	Proved
	The Committee finds the facts alleged at heads of charge 77 (a), 77 (b) and 77 (c) proved. The Committee notes that Miss Luguera Aguirre did not record a justification for, a grading of or a report on the bone loss detectable from the radiographs that she took on 23 July 2015. The Committee finds that this amounts to a failure to make an adequate record in relation to the radiographs contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at heads of charge 77 (a), 77 (b) and 77 (c) proved.
78.(a)	Not proved
	The Committee finds the facts alleged at head of charge 78 (a) not proved. The Committee notes from the evidence presented to it that Patient AJ attended an appointment with Miss Luguera Aguirre on 23 September 2015 for the preparation of a crown. The crown was then fitted at an appointment that took place on 7 October 2015. The Committee considers that Miss Luguera was under a duty to take a preoperative radiograph at the crown preparation appointment that took place on 23 September 2015, but not on the later date of 7 October 2015 when the crown was fitted. The GDC has put its case on the basis

	that the failure was in relation to that crown preparation appointment, and the Committee considers that the allegation that the radiograph should have been taken 'on or around 7 October 2015' cannot reasonably include the actual date of 23 September 2015. The Committee considers that the head of charge has not been properly made out, and that the facts alleged are accordingly not proved.
78.(b)	Withdrawn
	<u>Patient AK</u>
79.(a)	Withdrawn
79.(b)	Proved
79.(c)	Proved
	The Committee finds the facts alleged at heads of charge 79 (b) and 79 (c) proved. The Committee notes that Miss Luguera Aguirre did not record a grading of or a report on the radiographs that she took on 5 February 2015. The Committee considers that her recording of 'as charted' does not constitute a grading or a report. The Committee finds that this amounts to a failure to make an adequate record in relation to the radiographs contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at heads of charge 79 (b) and 79 (c) proved.
80.(a) (i)	Not proved
80.(a) (ii)	Proved
	The Committee finds the facts alleged at head of charge 80 (a) (i) not proved, and the facts alleged at head of charge 80 (a) (ii) proved. The Committee notes from the evidence presented to it that on 5 February 2015 Miss Luguera Aguirre provided an amalgam filling to Patient AK's UR5. The filling subsequently fractured, and she performed a repair at an appointment that took place on 9 July 2015. The repair later failed. In his expert evidence Mr Jefferies was not critical of the first attempt made by Miss Luguera Aguirre on 5 February 2015, and the Committee finds the facts alleged at head of charge 80 (a) (i) not proved on that basis. The Committee accepts Mr Jefferies' criticism of the repeated failure, and it finds that the failure of the repaired filling after 9 July 2015 demonstrates that the care provided on that day was not adequate. The Committee therefore finds the facts alleged at head of charge 80 (a) (ii) proved.
80. (b)	Proved
	The Committee finds the facts alleged at head of charge 80 (b) proved. The Committee accepts the evidence of Mr Jefferies that Miss Luguera Aguirre's fitting of the Maryland bridge at Patient AK's UR3, UR4 and UR5 was carried out with inadequate care and skill. Mr Jefferies reaches this conclusion on the basis that the bridge was 'placed on a tooth that was prejudiced and with an uncertain future'. The Committee considers that this amounts to inadequate care, and it accordingly finds the facts alleged at head of charge 80 (b) proved.

81.	Proved
	The Committee finds the facts alleged at head of charge 81 proved. The Committee notes from Patient AK's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the results of a BPE and the patient's caries risk. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient AK. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 81 proved.
	<u>Patient AL</u>
82.	Proved
	The Committee finds the facts alleged at head of charge 82 proved. The Committee notes that Miss Luguera Aguirre did not record a grading of the radiographs that she took on 24 September 2015. The Committee finds that this amounts to a failure to make an adequate record in relation to the radiographs contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at head of charge 82 proved.
83.(a)	Proved
	The Committee finds the facts alleged at head of charge 83 (a) proved. The Committee notes from Patient AL's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the results of a BPE. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient AK. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 83 (a) proved.
83.(b) (i)	Not proved
	The Committee finds the facts alleged at head of charge 83 (b) (i) not proved. The Committee finds that the GDC has not demonstrated to the standard required that Miss Luguera Aguirre was under a duty to record the method of cleaning that she employed when performing RCT on 24 September 2015. It therefore finds the facts alleged at this head of charge not proved.
83.(b) (ii)	Not proved
	The Committee finds the facts alleged at head of charge 83 (b) (ii) not proved. The Committee finds that the GDC has not proved to the standard required that Miss Luguera Aguirre did in fact use rubber dam when providing RCT to Patient AL on 24 September 2015. It follows that she was not under a duty to record that which the Committee is not

	satisfied she used. Accordingly the Committee finds the facts alleged at head of charge 83 (b) (ii) not proved.
83.(b) (iii)	Proved
	The Committee finds the facts alleged at head of charge 83 (b) (iii) proved. The Committee considers that the evidence presented to it demonstrates that it is more likely than not that Miss Luguera Aguirre performed irrigation as part of the RCT on 24 September 2015, and it accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to record that aspect of the treatment. The Committee considers that this amounts to an inadequate record, and accordingly the facts alleged at head of charge 83 (b) (iii) are proved.
83.(b) (iv)	Proved
	The Committee finds the facts alleged at head of charge 83 (b) (iv) proved. The Committee finds that Miss Luguera Aguirre was under a duty to record the size of the canal, and that her failure to do so constitutes an inadequate record. Accordingly that the facts alleged at head of charge 83 (b) (iii) are proved.
83.(b) (v)	Not proved
	The Committee finds the facts alleged at head of charge 83 (b) (v) not proved. The Committee finds that the GDC has not demonstrated to the standard required that Miss Luguera Aguirre was under a duty to record the type of sealant when performing RCT on 24 September 2015. The Committee notes that the GDC has also alleged at head of charge 83 (b) (vi) below that Miss Luguera Aguirre was required to record the root filling material that she used, and the Committee considers that to also record the type of sealant used was not necessary. The Committee therefore finds the facts alleged at this head of charge not proved.
83.(b) (vi)	Proved
	The Committee finds the facts alleged at head of charge 83 (b) (vi) proved. The Committee finds that Miss Luguera Aguirre was under a duty to record the root filling material that she used as part of the RCT. The Committee considers that this amounts to an inadequate record, and accordingly the facts alleged at head of charge 83 (b) (vi) are proved.
	<u>Patient AM</u>
84.	Proved
	The Committee finds the facts alleged at head of charge 84 proved. The Committee accepts the expert evidence of Mr Jefferies that, notwithstanding the absence of a radiograph, the clinical records for Patient AM demonstrate that the RCT that Miss Luguera Aguirre performed at the UL4 was undertaken with inadequate care and skill as the treatment was short in length. The Committee accepts that this execution was inadequate, and that this in turn amounts to an inadequate standard of care. The Committee therefore finds the facts alleged at head of charge 84 proved.

85.(a)	Withdrawn
85.(b)	Proved
85.(c)	Proved
	The Committee finds the facts alleged at heads of charge 85 (b) and 85 (c) proved. The Committee notes that Miss Luguera Aguirre did not record a grading of or a report on the radiographs that she took on 16 September 2015. The Committee finds that this amounts to a failure to make an adequate record in relation to the radiographs contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at heads of charge 85 (b) and 85 (c) proved.
86.(a)	Proved
	The Committee finds the facts alleged at head of charge 86 (a) proved. The Committee notes from Patient MK's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the results of a BPE and the patient's caries and periodontal disease risks, and by recording that she had given smoking cessation advice to a non-smoker. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient AM. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 86 (a) proved.
86.(b) (i)	Not proved
	The Committee finds the facts alleged at head of charge 86 (b) (i) not proved. The Committee finds that the GDC has not demonstrated to the standard required that Miss Luguera Aguirre was under a duty to record the method of cleaning that she employed when performing RCT on 2 September 2015. It therefore finds the facts alleged at this head of charge not proved.
86.(b) (ii)	Not proved
	The Committee finds the facts alleged at head of charge 86 (b) (ii) not proved. The Committee finds that the GDC has not proved to the standard required that Miss Luguera Aguirre did in fact use rubber dam when providing RCT to Patient AL on 2 September 2015. It follows that she was not under a duty to record that which the Committee is not satisfied she used. Accordingly the Committee finds the facts alleged at head of charge 83 (b) (ii) not proved.
86.(b) (iii)	Proved
	The Committee finds the facts alleged at head of charge 86 (b) (iii) proved. The Committee considers that the evidence presented to it demonstrates that it is more likely than not that Miss Luguera Aguirre performed irrigation as part of the RCT on 2 September 2015, and it accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre

	was under a duty to record that aspect of the treatment. The Committee considers that this amounts to an inadequate record, and accordingly the facts alleged at head of charge 83 (b) (iii) are proved.
86.(b) (iv)	Proved
	The Committee finds the facts alleged at head of charge 86 (b) (iv) proved. The Committee finds that Miss Luguera Aguirre was under a duty to record the size of the canal, and that her failure to do so constitutes an inadequate record. Accordingly the facts alleged at head of charge 83 (b) (iv) are proved.
86.(b) (v)	Not proved
	The Committee finds the facts alleged at head of charge 86 (b) (v) not proved. The Committee finds that the GDC has not demonstrated to the standard required that Miss Luguera Aguirre was under a duty to record the type of sealant when performing RCT on 2 September 2015. The Committee notes that the GDC has also alleged at head of charge 86 (b) (vi) below that Miss Luguera Aguirre was required to record the root filling material that she used, and the Committee considers that to also record the type of sealant used was not necessary. The Committee therefore finds the facts alleged at this head of charge not proved.
86.(b) (vi)	Proved
	The Committee finds the facts alleged at head of charge 86 (b) (vi) proved. The Committee finds that Miss Luguera Aguirre was under a duty to record the root filling material that she used as part of the RCT. The Committee considers that this amounts to an inadequate record, and accordingly the facts alleged at head of charge 86 (b) (vi) are proved.
	<u>Patient AN</u>
87.(i)	Withdrawn
87.(ii)	Proved
	The Committee finds the facts alleged at head of charge 87 (ii) proved. The Committee notes that Miss Luguera Aguirre did not record a grading of the radiographs that she took on 28 July 2015. The Committee finds that this amounts to a failure to make an adequate record in relation to the radiographs contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at head of charge 87 (ii) proved.
87.(iii)	Not proved
	The Committee finds the facts alleged at head of charge 87 (iii) not proved. In his expert evidence to the Committee Mr Jefferies accepted that a report of 'nothing abnormal detected' would constitute an adequate report on a radiograph. The Committee notes that Miss Luguera Aguirre recorded 'nil' in the patient's clinical notes in relation to the radiographs, and it considers that this was an acceptable report. The Committee accordingly finds the facts alleged at head of charge 87

	(iii) not proved.
88.	Proved
	The Committee finds the facts alleged at head of charge 88 proved. The Committee notes from Patient AN's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the results of a BPE, the patient's caries and periodontal disease risks, and whether the patient used cigarettes and alcohol. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient AN. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 88 proved.
	<u>Patient AO</u>
89.(a)	Withdrawn
89.(b)	Proved
	The Committee finds the facts alleged at head of charge 89 (b) proved. The Committee notes from the clinical records of Patient AO that Miss Luguera Aguirre appears to have prescribed antibiotics to the patient on 10 December 2013 in relation to a cracked crown which was causing pain. Mr Jefferies stated to the Committee that the FGDP guidelines state that antimicrobials should only be prescribed for serious infection, and where the lymph notes are enlarged, where there is fever, and where the patient's condition is likely to deteriorate. As there is no evidence to suggest the presence of any of these indications, and indeed Miss Luguera Aguirre recorded NAD, meaning 'nothing abnormal detected', in relation to the patient's lymph nodes, the Committee finds that the prescribing of antibiotics on this occasion was without clinical justification. This in turn amounts to a failure to provide an adequate standard of care to Patient AO, and accordingly the facts alleged at head of charge 89 (b) are proved.
89.(c)	Proved
	The Committee finds the facts alleged at head of charge 89 (c) proved. The Committee notes from the evidence placed before it that Miss Luguera Aguirre performed an extraction of Patient AO's UL6 on 22 January 2014. The Committee accepts the expert evidence of Mr Jefferies that, in accordance with the IRMER regulations referred to above, radiographs should be taken before extractions are performed. The Committee finds that Miss Luguera Aguirre's omission of a preoperative radiograph amounts to a failure to perform her duty in this regard, and that this in turn amounts to an inadequate standard of care. The Committee therefore finds the facts alleged at head of charge 89 (c) proved.
89.(d) (i)	Proved

	The Committee finds the facts alleged at head of charge 89 (d) (i) proved. The evidence presented to the Committee demonstrates that Patient AO last saw Miss Luguera Aguirre on 27 January 2016. A radiograph taken by the patient's subsequent treating dentist on 14 April 2016 reveals the presence of gross distal caries at the patient's UR3. The Committee accepts the expert evidence of Mr Jefferies that caries would have been detectable both clinically and radiographically during the course of Miss Luguera Aguirre's treatment of the patient. The Committee infers from the absence of a record to indicate otherwise that Miss Luguera Aguirre did not detect the presence of caries at the UR3. The Committee considers that she was under a duty to do so, and that her failure to do so amounts to an inadequate standard of care. Accordingly the Committee finds the facts alleged at head of charge 89 (d) (i) proved.
89.(d) (ii)	Proved
	The Committee finds the facts alleged at head of charge 89 (d) (ii) proved. As set out above in respect of head of charge 89 (d) (i) Patient AO last saw Miss Luguera Aguirre on 27 January 2016. A radiograph taken by the patient's subsequent treating dentist on 14 April 2016 reveals the presence of mesial caries at the patient's UR4. The Committee accepts the expert evidence of Mr Jefferies that caries would have been detectable both clinically and radiographically during the course of Miss Luguera Aguirre's treatment of the patient. Indeed, Miss Luguera Aguirre took a radiograph at her last appointment with Patient AO which reveals the presence of caries at the UR4. The Committee infers from the absence of a record to indicate otherwise that Miss Luguera Aguirre did not detect the presence of caries at the UR4. The Committee considers that she was under a duty to do so, and that her failure to do so amounts to an inadequate standard of care. Accordingly the Committee finds the facts alleged at head of charge 89 (d) (ii) proved.
89.(d) (iii)	Withdrawn
90.(a)	Proved
	The Committee finds the facts alleged at head of charge 90 (a) proved. The Committee notes from Patient AO's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record a key aspect of the patient examination, namely by omitting the results of a BPE. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient AO. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 90 (a) proved.
90.(b)	Proved
	The Committee finds the facts alleged at head of charge 90 (b) proved. The Committee notes from Patient AO's clinical records that Miss

	Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the results of a BPE, and by recording that smoking cessation advice had been given to a non-smoker. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient AO. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 90 (b) proved.
90.(c)	Proved
	The Committee finds the facts alleged at head of charge 90 (c) proved. The Committee notes from Patient AO's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the results of a BPE, information about the patient's use of cigarettes and alcohol, and the patient's caries and periodontal disease risks. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient AO. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 90 (c) proved.
	<u>Patient AP</u>
91.(a) (i)	Proved
	The Committee finds the facts alleged at head of charge 91 (a) (i) proved. The Committee notes from the clinical records of Patient AP that Miss Luguera Aguirre appears to have prescribed antibiotics to the patient on 12 June 2012 for reasons which she did not record. Mr Jefferies stated to the Committee that the FGDP guidelines state that antimicrobials should only be prescribed for serious infection, and where the lymph notes are enlarged, where there is fever, and where the patient's condition is likely to deteriorate. As there is no evidence to suggest the presence of any of these indications, the Committee finds that the prescribing of antibiotics on this occasion was without clinical justification. This in turn amounts to a failure to provide an adequate standard of care to Patient AP, and accordingly the facts alleged at head of charge 91 (a) (i) are proved.
91.(a) (ii)	Proved
	The Committee finds the facts alleged at head of charge 91 (a) (ii) proved. The Committee notes from the clinical records of Patient AP that Miss Luguera Aguirre appears to have prescribed antibiotics to the patient on 12 June 2012 in relation to a small swelling at the patient's LR8. Mr Jefferies stated to the Committee that the FGDP guidelines state that antimicrobials should only be prescribed for serious infection, and where the lymph notes are enlarged, where there is fever, and

	where the patient's condition is likely to deteriorate. As there is no evidence to suggest the presence of any of these indications, the Committee finds that the prescribing of antibiotics on this occasion was without clinical justification. This in turn amounts to a failure to provide an adequate standard of care to Patient AP, and accordingly the facts alleged at head of charge 91 (a) (ii) are proved.
91.(a) (iii)	Withdrawn
91.(a) (iv)	Proved
	The Committee finds the facts alleged at head of charge 91 (a) (iv) proved. The Committee notes from the evidence presented to it that on 15 August 2013 Miss Luguera Aguirre drained an abscess that had formed at the patient's UR2. Miss Luguera Aguirre then appears to have prescribed antibiotics to the patient. Mr Jefferies stated to the Committee that the FGDP guidelines state that antimicrobials should only be prescribed for serious infection, and where the lymph notes are enlarged, where there is fever, and where the patient's condition is likely to deteriorate. As there is no evidence to suggest the presence of any of these indications, the Committee finds that the prescribing of antibiotics on this occasion was without clinical justification. This in turn amounts to a failure to provide an adequate standard of care to Patient AP, and accordingly the facts alleged at head of charge 91 (a) (iv) are proved.
91.(a) (v)	Proved
	The Committee finds the facts alleged at head of charge 91 (a) (v) proved. The Committee notes from the evidence presented to it that on 26 November 2013 Miss Luguera Aguirre drained an abscess that had formed at the patient's LR8. Miss Luguera Aguirre then appears to have prescribed antibiotics to the patient. Mr Jefferies stated to the Committee that the FGDP guidelines state that antimicrobials should only be prescribed for serious infection, and where the lymph notes are enlarged, where there is fever, and where the patient's condition is likely to deteriorate. As there is no evidence to suggest the presence of any of these indications, the Committee finds that the prescribing of antibiotics on this occasion was without clinical justification. This in turn amounts to a failure to provide an adequate standard of care to Patient AP, and accordingly the facts alleged at head of charge 91 (a) (v) are proved.
91.(b)	Proved
	The Committee finds the facts alleged at head of charge 91 (b) proved. The Committee notes from the evidence presented to it that Patient AP was seen by another treating dentist on 8 September 2014. Around a month later on 7 October 2014 the patient was seen by Miss Luguera Aguirre and a veneer was prepared at the patient's UR2. Mr Jefferies' expert evidence to the Committee is that, if the swelling at the UR2 was no longer present, he would have expected Miss Luguera Aguirre to make an entry in the patient's clinical notes to that effect. The only indication that Miss Luguera Aguirre was aware of the swelling arises

	from a comment that Patient AP is reported to have made to the patient's subsequent treating dentist to the effect that Miss Luguera Aguirre had stated that the lump was normal and could take some time to go down after RCT. On 27 April 2017 the subsequent treating dentist noticed the swelling when replacing the veneer. The Committee considers that the evidence presented to it is sufficient to demonstrate to the standard required that Miss Luguera Aguirre did not adequately diagnose and treat the swelling at the patient's UR2. It further accepts the expert evidence of Mr Jefferies that she was under a duty to do so, and that as she did not do so she failed to provide an adequate standard of care to the patient. Accordingly the Committee finds the facts alleged at head of charge 91 (b) proved.
92.(a)	Proved
92.(b)	Proved
92.(c)	Proved
92.(d)	Proved
	The Committee finds the facts alleged at heads of charge 92 (a), 92 (b), 92 (c) and 92 (d) proved. The Committee notes from Patient AP's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record a key aspect of the patient examination, namely by omitting the results of a BPE. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examinations of Patient AP. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at heads of charge 92 (a), 92 (b), 92 (c) and 92 (d) proved.
92.(e)	Proved
	The Committee finds the facts alleged at head of charge 92 (e) proved. The Committee notes from Patient AP's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the results of a BPE and the patient's caries risk, and by recording that smoking cessation advice had been given to a non-smoker. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examinations of Patient AP. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 92 (e) proved.
	<u>Patient AQ</u>
93.	Proved

	The Committee finds the facts alleged at head of charge 93 proved. The Committee notes from the evidence presented to it that Miss Luguera Aguirre did undertake some diagnosis and treatment of Patient AQ's caries, but that this care was far from adequate and did not adequately address the caries with which the patient continued to present for some two-and-a-half years. The Committee notes from the evidence of the patient's subsequent treating dentist that fillings were required at the majority of the patient's remaining teeth, with only seven of those 24 teeth not requiring such treatment. The Committee notes that in her clinical records for the patient Miss Luguera Aguirre recorded on 8 February 2014 that the patient's caries risk was low, which indicates that she did not adequately diagnose or treat the caries which on the evidence of Mr Jefferies and the subsequent treating dentist would have been obviously present for quite some time. The Committee finds that this amounts to an inadequate standard of care, and accordingly it finds the facts alleged at head of charge 93 proved.
	<u>Patient AR</u>
94.(a)	Proved
	The Committee finds the facts alleged at head of charge 94 (a) proved. The Committee accepts the expert evidence of Mr Jefferies that, as Patient AR had a history of caries, Miss Luguera Aguirre was under a duty to take radiographs at the examination appointment that took place on 12 April 2014. The Committee considers that Miss Luguera Aguirre's failure to do so amounts to an inadequate standard of care, and as such it finds the facts alleged at head of charge 94 (a) proved.
94.(b) (i)	Proved
	The Committee finds the facts alleged at head of charge 94 (b) (i) proved. The Committee notes from the evidence presented to it that Patient AR's subsequent treating dentist identified the presence of gross caries at the patient's broken filling at an appointment that took place on 18 August 2016. At the patient's final appointment with Miss Luguera Aguirre on 28 July 2016 Miss Luguera Aguirre recorded that no caries was present when providing the filling at the patient's LR7. Miss Luguera Aguirre had earlier provided a composite filling at the same site on 7 October 2015. The Committee accepts the expert evidence of Mr Jefferies that caries was likely to have been present for quite some time, and that the fact that the filling broke connotes the presence of caries. The Committee is satisfied that the evidence presented to it demonstrates that Miss Luguera Aguirre did not diagnose and treat caries at the patient's LR7 over the period in question, and that her failure to do so amounts to an inadequate standard of care. Accordingly the Committee finds the facts alleged at head of charge 94 (b) (i) proved.
94.(b) (ii)	Withdrawn
95.(a) (i)	Withdrawn
95.(a) (ii)	Proved

95.(a) (iii)	Proved
	The Committee finds the facts alleged at heads of charge 95 (a) (ii) and 95 (a) (iii) proved. The Committee notes that Miss Luguera Aguirre did not record a grading of or a report on the radiographs that she took on 27 January 2015. The Committee finds that this amounts to a failure to make an adequate record in relation to the radiographs contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at heads of charge 95 (a) (ii) and 95 (a) (iii) proved.
95.(b) (i)	Withdrawn
95.(b) (ii)	Proved
	The Committee finds the facts alleged at head of charge 95 (b) (ii) proved. The Committee notes that Miss Luguera Aguirre did not record a grading of the radiographs that she took on 16 June 2015. The Committee finds that this amounts to a failure to make an adequate record in relation to the radiographs contrary to the IRMER regulations referred to above. The Committee therefore finds the facts alleged at head of charge 95 (b) (ii) proved.
96.(i)	Proved
	The Committee finds the facts alleged at head of charge 96 (i) proved. The Committee notes from Patient AR's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the results of a BPE and the patient's caries and periodontal disease risks, and by recording that she gave smoking cessation advice to a patient who she had not recorded was in fact a smoker. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient AR. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 96 (i) proved.
96.(ii)	Proved
	The Committee finds the facts alleged at head of charge 96 (ii) proved. The Committee notes from Patient AR's clinical records that Miss Luguera Aguirre only partially completed the template proforma, and did not properly record key aspects of the patient examination, namely by omitting the results of a BPE, the patient's caries and periodontal disease risks, and the patient's alcohol consumption, and by recording that she had given smoking cessation advice to a patient who she had not recorded was in fact a smoker. The Committee again accepts the expert evidence of Mr Jefferies that Miss Luguera Aguirre was under a duty to make accurate and complete records of her examination of Patient AR. As Miss Luguera Aguirre did not complete the examination template adequately, her record of her examination of the patient was not adequate. The Committee therefore finds the facts alleged at head of charge 96 (ii) proved.

	Patient AS
97.(a) (i)	Proved
97.(a) (ii)	Proved
97.(a) (iii)	Proved
	The Committee finds the facts alleged at head of charge 97 (a) (i), 97 (a) (ii) and 97 (a) (iii) proved. The Committee notes from the evidence presented to it that Miss Luguera Aguirre prescribed antibiotics to Patient AS on 15 December 2011, 16 January 2012 and 14 May 2012 in relation to abscesses, and latterly following RCT, at the patient's LR6. Mr Jefferies stated to the Committee that the FGDP guidelines state that antimicrobials should only be prescribed for serious infection, and where the lymph notes are enlarged, where there is fever, and where the patient's condition is likely to deteriorate. As there is no evidence to suggest the presence of any of these indications, the Committee finds that the prescribing of antibiotics on this occasion was without clinical justification. This in turn amounts to a failure to provide an adequate standard of care to Patient AS, and accordingly the facts alleged at heads of charge 97 (a) (i), 97 (a) (ii) and 97 (a) (iii) are proved.
97.(b)	Proved
	The Committee finds the facts alleged at head of charge 97 (b) proved. The Committee notes from the evidence presented to it that RCT was commenced on Patient AS's LL6 on 17 October 2013, and that the treatment was completed on 13 November 2013. The Committee notes that Miss Luguera Aguirre perforated the root, and as she had not obtained a preoperative working length radiograph she was not able to properly identify the perforation and made suitable adjustments. These shortcomings were compounded by her placing of a root canal filling, and also by the absence of a post-operative radiograph. The Committee finds that this amounts to RCT of inadequate care and skill, and accordingly it finds the facts alleged at head of charge 97 (b) proved.
97.(c) (i)	Not proved
97.(c) (ii)	Not proved
97.(c) (iii)	Proved
	The Committee finds the facts alleged at heads of charge 97 (c) (i) and 97 (c) (ii) not proved, and the facts alleged at head of charge 97 (c) (iii) proved. The Committee notes from the evidence presented to it that Patient AS lost a filling at LR6 on 14 January 2014, and that Miss Luguera Aguirre crowned that tooth at an appointment that took place on 16 April 2014. The patient reattended for an appointment with Miss Luguera Aguirre on 8 May 2014 in relation to a fracturing of that crown. Miss Luguera Aguirre is recorded as having sent away for a new crown on that date. The crown was fitted temporarily on 22 May 2014, but was redone on 25 July 2014 as it had fractured. Subsequently on 11 September 2014 the patient's subsequent treating dentist noted that the crown had again fractured. The patient's LR6 was extracted on 26

	February 2015. The Committee considers that the GDC has not established to the standard required that Miss Luguera Aguirre fitted a crown at LR6 with inadequate care and skill at the first two appointments, namely on 16 April 2014 and 22 May 2014. The first appointment was a first attempt which may have failed for good reason, and the second appointment related to the initial fitting of a temporary crown, again in relation to which the Committee attaches no culpability. The Committee does however accept the evidence of Mr Jefferies that the repeated failure of the crown indicates crownwork of inadequate care and skill, and that the facts relating to the appointment on 13 August 2014 at head of charge 97 (c) (iii) are therefore proved.
98.	Proved
	The Committee finds the facts alleged at head of charge 98 proved. The evidence presented from the former Head of Quality for Primary Care at the Aneurin Bevan University Health Board demonstrates that Miss Luguera Aguirre did not comply with specific conditions imposed on her practice, more particularly that she failed to produce a personal development plan (PDP) or arrange a mentor within 28 days of the extended deadline. The Committee finds that Miss Luguera Aguirre was under a duty to do so, and that as she failed to do so the facts alleged at head of charge 98 are proved.
99.	Not proved
	The Committee finds the facts alleged at head of charge 99 not proved. The Committee has paid careful regard to the evidence presented to it in the form of the witness statement and documentary exhibits of the Senior Caseworker in the GDC's Fitness to Practise (FtP) Department with knowledge of the Council's investigation. The Committee considers that Miss Luguera Aguirre was under a duty to provide the information about her indemnity arrangements that was requested, but the Committee is not able to be satisfied from the evidence presented to it that Miss Luguera Aguirre was aware of the request that was made. Accordingly the Committee finds the facts alleged at head of charge 99 not proved.

We move to stage two."

On 7 June 2018 the Chairman announced the determination as follows:

"Proceedings at stage two

The Committee has considered all of the evidence presented to it, both written and oral. The Committee has taken into account the submissions made by Mr Corrie on behalf of the GDC. The Committee has accepted the advice of the Legal Adviser, and has paid careful regard to the GDC's *Guidance for the Practice Committees including Indicative Sanctions Guidance* (October 2016).

Fitness to practise history

In accordance with Rule 20 (1) (a) of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules') Mr Corrie informed the Committee that Miss Luguera Aguirre has no fitness to practise history with the GDC.

Misconduct

The Committee first considered whether the facts that it has found proved constitute misconduct. In considering this matter, the Committee has exercised its own independent judgement.

In its deliberations the Committee has had regard to the GDC's *Standards for Dental Professionals* (May 2005) in place at the time of the earlier incidents giving rise to some of the facts that the Committee has found proved. These paragraphs state that as a dentist you must:

1 Put patients' interest first and act to protect them.

5 Maintain your professional knowledge and competence.

1.3 Work within your knowledge, professional competence and physical abilities […].

1.4 Make and keep accurate and complete patient records, including a medical history, at the time you treat them […].

The Committee has also had regard to the following paragraphs of the GDC's *Standards for the Dental Team* (September 2013) in place at the time of the later incidents giving rise to the remaining facts. These paragraphs state that as a dentist you must:

1.9 […] find out about, and follow, laws and regulations affecting your work […].

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

7 Maintain, develop and work within your professional knowledge and skills.

In light of its findings of fact, the Committee has concluded that Miss Luguera Aguirre's care and treatment of the patients involved in this case fell far short of the standards reasonably expected of a general dental practitioner. The Committee has found serious, repeated and sustained departures from proper professional practice in a wide range of basic and fundamental areas within and across a considerable number of individual patient cases over a significant number of years. The Committee notes, and concurs with, the view of Mr Jefferies that 'the cumulative and individual care to the patients fell far below the standard reasonably expected of a competent general dental practitioner'.

The Committee considers that many of the acts and omissions that it has found proved constitute misconduct in themselves, namely Miss Luguera Aguirre's failures in relation to complying with IRMER regulations governing safe and appropriate radiography, her inappropriate antibiotic prescribing practice, the deficiencies in her record-keeping, her carrying out work with inadequate care and skill, and her failures in diagnosing and treating caries and bone loss. Such acts and omissions resulted in actual harm to patients, and otherwise placed patients at considerable risk of harm. More particularly, in his evidence to the Committee, the subsequent treating dentist of Patient AQ stated that the patient's presentation was as if the patient had never before seen a dentist, or at least had not done so for a number of years.

The Committee finds that the seriousness of the failings that it has found, the protracted period of time over which these acts and omissions were repeated, the wide-ranging nature of the clinical shortcomings and the number of patients involved constitutes conduct that would be considered to be deplorable by Miss Luguera Aguirre's fellow professionals. The Committee finds that the facts that it has found proved, both cumulatively and in many cases individually, amount to misconduct.

Deficient professional performance

The Committee, having considered that the facts that it has found proved amount to misconduct, determined that it was unnecessary to address the question of deficient professional performance in respect of the same facts.

Impairment

The Committee then went on to consider whether Miss Luguera Aguirre's fitness to practise is currently impaired by reason of the misconduct that it has found. In doing so, the Committee has again exercised its independent judgement. Throughout its deliberations, it has borne in mind that its primary duty is to address the public interest, which includes the protection of patients, the maintenance of public confidence in the profession and in the regulatory process, and the declaring and upholding of proper standards of conduct and behaviour.

The Committee considers that the facts which it has found amount to misconduct are capable of being remedied. Although the proven conduct arises out of serious and sustained departures from acceptable practice, the Committee finds that Miss Luguera Aguirre's shortcomings relate to identifiable, basic and fundamental aspects of the practice of dentistry, and are therefore able to be addressed and remedied. However, the Committee has not been provided with any evidence whatsoever to suggest that Miss Luguera Aguirre has taken steps to acknowledge, identify, address or remediate the acts and omissions that have given rise to these proceedings. The Committee further notes that Miss Luguera Aguirre has not given any indication of a desire or intention to do so in the future. The Committee is particularly struck by the complete absence of any evidence of insight into matters which are so damaging to her fitness to practise. Indeed, the Committee's finding of fact in relation to Miss Luguera Aguirre's failure to comply with conditions imposed on her practice by her local health board in relation to the matters that have since been referred to this Committee in itself connotes a lack of appreciation of the seriousness of those issues.

The Committee therefore finds that there is an ongoing risk of Miss Luguera Aguirre repeating the conduct that has precipitated these proceedings, and that any such repetition may cause harm to patients and would otherwise place them at the risk of unwarranted harm. Given the complete absence of any remediation of, or insight into, the serious, wide-ranging and repeated departures from proper professional standards, and the associated risks of repetition, the Committee finds that Miss Luguera Aguirre's fitness to practise is currently impaired.

The Committee also considers that a finding of impairment is required to maintain public confidence in the profession and in the regulatory process, and to declare and uphold proper professional standards. It determines that trust and confidence in the profession would be undermined and that the profession would be brought into disrepute if a finding of impairment were not made in the particular circumstances of this case.

Sanction

The Committee then determined what sanction, if any, would be appropriate in light of the findings of facts, misconduct and impairment that it has made. The Committee recognises that the purpose of a sanction is not to be punitive, although it may have that effect, but is instead imposed in order to protect patients and safeguard the wider public interest referred to above.

In reaching its decision the Committee has again taken into account the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016). The Committee has applied the principle of proportionality, balancing the public interest with Miss Luguera Aguirre's own interests.

The Committee has had regard to the mitigating and aggravating factors in this case. In terms of mitigation, the Committee notes that Miss Luguera Aguirre has had no previous regulatory findings

recorded against her. The Committee also notes that there have been no other reported incidents since the matters giving rise to this case. The Committee also took into account that the matters in question did not result in, and were not motivated by, any financial gain for Miss Luguera Aguirre. There are, however, a number of aggravating factors in this case. As set out above Miss Luguera Aguirre's acts and omissions caused actual harm to patients and otherwise placed a considerable number of patients at unwarranted risk of harm. Miss Luguera Aguirre's conduct was sustained and repeated across multiple patient cases and over a considerable period of time. The Committee's findings relating to Miss Luguera Aguirre's failure to comply with conditions imposed on her by her local health board suggest a disregard for the systems regulating the profession, and as noted above Miss Luguera Aguirre has also not shown any evidence of remorse form or insight into her conduct.

The Committee has considered the range of sanctions available to it, starting with the least serious. In the light of the findings made against Miss Luguera Aguirre, the Committee has determined that it would not be appropriate to conclude this case with no action or with a reprimand. The serious, repeated and wide-ranging departures from acceptable clinical practice that the Committee has identified are considered by the Committee to be liable to be repeated given the absence of any information from Miss Luguera Aguirre that she has taken steps to acknowledge, address and remedy her acts and omissions, or that she is minded to do so in the future. As there is no suggestion that such conduct has been remedied, the Committee concludes that Miss Luguera Aguirre's misconduct is likely to recur. Therefore, the Committee has determined that no action or a reprimand would not provide the necessary degree of protection for the public and would undermine public trust and confidence in the profession.

The Committee next considered whether a period of conditional registration would be appropriate. The misconduct that the Committee has found relates to specific and identifiable clinical acts and omissions. These shortcomings are capable of being remedied, and conditions of practice might be capable of meeting the risks arising from Miss Luguera Aguirre's acts and omissions. However, Miss Luguera Aguirre has not engaged in any way with these proceedings and has not provided any information about her current whereabouts and employment circumstances. Furthermore, as noted above, the Committee has made findings of fact in relation to Miss Luguera Aguirre's failure to comply with previous conditions imposed on her by her local health board. Therefore, the Committee is not able to formulate conditions which would be workable, capable of being monitored and, importantly, with which Miss Luguera Aguirre would engage and comply.

The Committee went on to consider whether to suspend Miss Luguera Aguirre's registration. Miss Luguera Aguirre's conduct was repeated across multiple patient cases over a considerable period of time. Miss Luguera Aguirre has not shown any insight into her misconduct, and she continues to pose a significant risk to patients. The Committee considers that public confidence in the profession, and the safety and interests of patients, would be insufficiently protected by a sanction less than suspension.

The Committee has given careful consideration as to whether a higher sanction of erasure is appropriate. The Committee notes that there are a number of factors which suggest that erasure might be the appropriate and proportionate sanction to impose, namely Miss Luguera Aguirre's persistent lack of insight into her misconduct, and the continuing risk of harm to patients. However, although Miss Luguera Aguirre's conduct was sustained over a considerable period of time, and whilst she has not engaged with these proceedings or provided any evidence of insight and remediation, the Committee does not consider that Miss Luguera Aguirre has a deep-seated professional or attitudinal problem which might make erasure the appropriate sanction.

The Committee therefore considers that, in the particular circumstances of this case, the protection of the public and public trust and confidence in the profession can be adequately secured by a

period of suspension. The Committee has therefore determined, and hereby directs, that Miss Luguera Aguirre's name should be suspended from the register. Although Miss Luguera Aguirre appears to be currently residing outside of the UK, she may return to practise in the UK at any time and if she were to do so the public would, in the Committee's judgement, be insufficiently protected if an order of suspension were not in place.

The Committee has determined, and hereby directs, that Miss Luguera Aguirre's registration be suspended for a period of 12 months. It considers that this period of time is necessary to mark the Committee's findings of facts, misconduct and impairment and is further required to allow Miss Luguera Aguirre to develop and demonstrate appropriate insight into, and suitable remediation of, her misconduct. Such a period is likely to be required given that Miss Luguera Aguirre does not appear to have yet taken any such rehabilitative steps in these numerous and fundamental aspects of her practice. The Committee further directs that this period of suspension be reviewed prior to its expiry.

Although the Committee in no way wishes to bind or fetter the Committee which will review this suspension, it considers that the reviewing Committee may be assisted by seeing evidence of Miss Luguera Aguirre having reflected upon and demonstrated insight into the matters that have culminated in this Committee's findings of fact, misconduct, impairment and sanction. The reviewing Committee may also be assisted if presented with evidence of any steps that Miss Luguera Aguirre has taken to remediate the shortcomings that have been identified. Miss Luguera Aguirre may wish to seek appropriate professional guidance and assistance in taking steps to address her misconduct, including but not limited to personal development plans (PDPs) and targeted learning and continuing professional development (CPD).

Existing interim order

In accordance with Rule 21 (3) of the General Dental Council (Fitness to Practise) Rules 2006 and section 27B (9) of the Dentists Act 1984 (as amended) the interim order of suspension in place on Miss Luguera Aguirre's registration is hereby revoked."

Immediate order of suspension

"Having directed that Miss Luguera Aguirre's registration be suspended, the Committee then invited submissions as to whether it should impose an order for her immediate suspension in accordance with section 30 (1) of the Dentists Act 1984 (as amended).

The Committee has heard the submissions made by Mr Corrie on behalf of the GDC that an order is necessary for the purposes of protecting the public, and that an order is otherwise in the public interest.

In the circumstances, the Committee has determined that it is necessary for the protection of the public and is otherwise in the public interest to impose an order for immediate suspension on Miss Luguera Aguirre's registration. The Committee has decided that, given the risks of harm that it has identified, it would not be acceptable to permit the possibility that Miss Luguera Aguirre could practise before the substantive direction of suspension takes effect. The Committee considers that an immediate order for suspension is proportionate, and is consistent with the findings that it has set out in its determination.

The effect of the foregoing determination and this immediate order is that Miss Luguera Aguirre's registration will be suspended from the date on which notice of this decision is deemed served upon her. Unless she exercises her right of appeal, the substantive direction of suspension will be recorded in the Dentists' Register 28 days from the date of deemed service. Should she so decide

to exercise her right of appeal, this immediate order of suspension will remain in place until the resolution of any appeal.

That concludes this case."

At a review hearing on 17 June 2019 the Chair announced the determination as follows:

"**Service and Proceeding in absence**

This is the first review hearing of Miss Luguera Aguirre's case before the Professional Conduct Committee (PCC). The hearing is being held pursuant to section 27C of the *Dentists Act 1984 (as amended)* (the Act). Miss Luguera Aguirre was neither present nor represented.

The Committee first considered whether notice of the hearing had been served on Miss Luguera Aguirre in accordance with the Rules. It was provided with a copy of the Notification of Hearing letter, dated 2 May 2019. A copy of the letter was also sent to her by email. The Committee had sight of a download receipt indicating that the Notification of Hearing had been downloaded.

The Committee was satisfied that the letter contained proper notification of today's hearing, including its date, time and location, as well as notification that the Committee may proceed with the hearing in the absence of Miss Luguera Aguirre. The Committee was satisfied that notice of the hearing had been served on Miss Luguera Aguirre in accordance with the Rules.

The Committee then went on to consider whether to proceed in the absence of Miss Luguera Aguirre and on the papers. It has considered the GDC's written submissions dated 5 June 2019 which invites the Committee to do so. The Committee notes Miss Luguera Aguirre has not responded.

There is nothing before the Committee today to suggest that Miss Luguera Aguirre might attend the hearing on a future occasion. In these circumstances, the Committee concluded that Miss Luguera Aguirre has voluntarily absented herself from today's hearing. In addition, the Committee considers that there is a clear public interest in reviewing the order today, given its imminent expiry. Accordingly, the Committee has determined that it is fair to proceed with today's review hearing on the basis of the papers and in the absence of both parties. The GDC reminds the Committee that the current suspension order needs to be reviewed before its expiry on 9 July 2019.

Background

This is the first review of a suspension order that was imposed on Miss Luguera Aguirre's registration for a period of 12 months by the PCC in June 2018. Miss Luguera Aguirre did not attend that hearing. At that hearing the PCC determined that:

> *The Committee considers that many of the acts and omissions that it has found proved constitute misconduct in themselves, namely Miss Luguera Aguirre's failures in relation to complying with IRMER regulations governing safe and appropriate radiography, her inappropriate antibiotic prescribing practice, the deficiencies in her record-keeping, her carrying out work with inadequate care and skill, and her failures in diagnosing and treating caries and bone loss. Such acts and omissions resulted in actual harm to patients, and otherwise placed patients at considerable risk of harm. More particularly, in his evidence to the Committee, the subsequent treating dentist of Patient AQ stated that the patient's presentation was as if the patient had never before seen a dentist, or at least had not done so for a number of years.*

The PCC considered Miss Luguera Aguirre's misconduct and determined the following:

The Committee finds that the seriousness of the failings that it has found, the protracted period of time over which these acts and omissions were repeated, the wide-ranging nature of the clinical shortcomings and the number of patients involved constitutes conduct that would be considered to be deplorable by Miss Luguera Aguirre's fellow professionals. The Committee finds that the facts that it has found proved, both cumulatively and in many cases individually, amount to misconduct.

Having found there was misconduct the PCC considered whether Miss Luguera Aguirre's fitness to practise was impaired and determined the following:

The Committee therefore finds that there is an ongoing risk of Miss Luguera Aguirre repeating the conduct that has precipitated these proceedings, and that any such repetition may cause harm to patients and would otherwise place them at the risk of unwarranted harm. Given the complete absence of any remediation of, or insight into, the serious, wide-ranging and repeated departures from proper professional standards, and the associated risks of repetition, the Committee finds that Miss Luguera Aguirre's fitness to practise is currently impaired.

Having found Miss Luguera Aguirre's fitness to practise impaired the PCC considered the matter of sanction and determined the following:

The Committee has given careful consideration as to whether a higher sanction of erasure is appropriate. The Committee notes that there are a number of factors which suggest that erasure might be the appropriate and proportionate sanction to impose, namely Miss Luguera Aguirre's persistent lack of insight into her misconduct, and the continuing risk of harm to patients. However, although Miss Luguera Aguirre's conduct was sustained over a considerable period of time, and whilst she has not engaged with these proceedings or provided any evidence of insight and remediation, the Committee does not consider that Miss Luguera Aguirre has a deep-seated professional or attitudinal problem which might make erasure the appropriate sanction.

The Committee therefore considers that, in the particular circumstances of this case, the protection of the public and public trust and confidence in the profession can be adequately secured by a period of suspension. The Committee has therefore determined, and hereby directs, that Miss Luguera Aguirre's name should be suspended from the register. Although Miss Luguera Aguirre appears to be currently residing outside of the UK, she may return to practise in the UK at any time and if she were to do so the public would, in the Committee's judgement, be insufficiently protected if an order of suspension were not in place.

Decision of review

The Committee has considered whether Miss Luguera Aguirre's fitness to practise remains impaired. In doing so, the Committee has exercised its independent judgement. Throughout its deliberations, it has borne in mind that its primary duty is to address the public interest, which includes the protection of patients, the maintenance of public confidence in the profession and the declaring and upholding of proper standards of conduct and behaviour.

The Committee was of the view that the misconduct identified was remediable, but there was no evidence that Miss Luguera Aguirre had taken any steps to address the identified misconduct. Miss Luguera Aguirre has not engaged with her regulatory body.

The Committee noted that she has failed to provide any evidence of insight or remediation. The Committee is therefore satisfied that Miss Luguera Aguirre continues to present a risk to patients and her fitness to practise remains impaired. The Committee considers that a finding of impairment is also required for wider public interest reasons, namely, to declare and uphold proper

professional standards of conduct and behaviour and to maintain public trust and confidence in the profession.

Sanction

The Committee then considered what, if any, sanction to impose in this case.

The Committee noted its powers under section 27C(1) the Dentists Act 1984 (the Act). The Committee had the power to extend the current suspension order for a maximum period of 12 months. Alternatively, it could revoke the suspension order or replace the order with a conditions of practice order for up to 3 years.

The Committee was aware that it should have regard to the principle of proportionality, balancing the public interest against Miss Luguera Aguirre's own interests. The public interest includes the protection of the public, the maintenance of public confidence in the profession, and declaring and upholding standards of conduct and performance within the profession.

The Committee first considered whether it would be appropriate to allow the current order to lapse at its expiry on 9 July 2019 or to revoke it with immediate effect. The Committee considered that given all of the information before it, and for all the reasons outlined above, it would not be appropriate to revoke the current order or to allow it to lapse, as this would not protect the public nor would it be in the public interest.

The Committee next considered whether a period of conditional registration would be appropriate in this case. The Committee was mindful that any conditions imposed must be proportionate, measurable and workable. The Committee was aware that in order for conditions to be appropriate and workable there would need to be some measure of positive engagement from Miss Luguera Aguirre, which is noticeably absent in this case. The Committee concluded that replacing the suspension order with a conditions of practice order would not be workable or appropriate at this stage.

The Committee concluded that in all the circumstances of this case a further period of suspension on Miss Luguera Aguirre's registration would protect the public, uphold the public interest and give Miss Luguera Aguirre a further opportunity to address the identified deficiencies and shortcomings in her practice and re-engage in the GDC process. The Committee concluded that for these reasons the appropriate order is 12 month suspension, with a review. This period will be sufficient to enable her to provide evidence of remediation and insight for the next review hearing.

The Committee therefore directs that Miss Luguera Aguirre registration be suspended for a further period of 12 months pursuant to Section 27C(1)(b) of the Act. Section 33(3) of the Act comes into operation to cover any period between the expiry of the current suspension and the date when the direction ordered by this Committee comes into force.

That concludes this hearing."

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

This is a resumed hearing pursuant to Section 27C of the Dentists Act 1984, as amended ('the Act'). The purpose of this hearing has been for the Professional Conduct Committee (PCC) to review Miss Luguera Aguirre's case and determine what action to take in relation to her registration.

The members of the Committee, as well as the Legal Adviser and the Committee Secretary, conducted the hearing remotely via Skype in line with Her Majesty's Government's current advice concerning COVID-19.

Neither party is present nor represented today. The General Dental Council (GDC) has requested that the hearing be conducted on the papers and has provided written submissions dated June 2020.

Service and Proceeding in absence and on the papers

This is the second review hearing of Miss Luguera Aguirre's case before the Professional Conduct Committee (PCC). The hearing is being held pursuant to section 27C of the *Dentists Act 1984 (as amended)* (the Act). Miss Luguera Aguirre was neither present nor represented.

The Committee first considered whether notice of the hearing had been served on Miss Luguera Aguirre in accordance with Rules 28 and 65 of the GDC's Fitness to Practise Rules 2006 ('the Rules') and Section 50A of the Dentists Act 1984 (as amended) ('the Act'). The Committee received from the GDC an indexed hearing bundle of 98 pages, which contained a copy of the Notice of Hearing ('the notice'), dated 14 May 2020, thereby complying with the 28-day notice period. The hearing bundle also contained a Royal Mail International 'Track and Trace' receipt confirming that attempted delivery of the notice was made to Miss Luguera Aguirre registered address in Spain stating 'Your item is now leaving the UK. More information will be available when it arrives in the destination country'. The Notice was also sent by first class post to her last known address. A copy of the notice was also emailed to Miss Luguera Aguirre on 22 May 2020.

The Committee was satisfied that the notice sent to Miss Luguera Aguirre contained proper notification of today's hearing, including its time, date and that it will be conducted remotely by video link, and the other prescribed information including notification that the Committee had the power to proceed with the hearing in Miss Luguera Aguirre's absence. On the basis of the information provided, the Committee was satisfied that notice of the hearing had been served on Miss Luguera Aguirre in accordance with the Rules and the Act.

The Committee next considered whether to exercise its discretion under Rule 54 of the Rules to proceed with the hearing in the absence of Miss Luguera Aguirre. It first concluded that all reasonable efforts had been taken to send the notification of the hearing to Miss Luguera Aguirre in accordance with the Rules. It noted that the GDC has emailed her 22 May and 1 June 2020, and to date has not received a response from the Registrant.

The Committee approached the issue of proceeding in absence with the utmost care and caution. It took into account the factors to be considered in reaching its decision, as set out in the case of GMC v Adeogba & Visvardis [2016] EWCA Civ 162. It remained mindful of the need to be fair to both Miss Luguera Aguirre and the GDC, taking into account the public interest and Miss Luguera Aguirre's own interests in the expeditious review of the suspension order imposed. In those circumstances, the Committee determined that it was fair and appropriate to proceed with the hearing in the absence of Miss Luguera Aguirre and to conduct the hearing on the papers.

Background

This is the second review of a suspension order that was imposed on Miss Luguera Aguirre's registration for a period of 12 months by the PCC in June 2018. Miss Luguera Aguirre did not attend that hearing. At that hearing the PCC determined that:

> *The Committee considers that many of the acts and omissions that it has found proved constitute misconduct in themselves, namely Miss Luguera Aguirre's failures in relation to complying with IRMER regulations governing safe and appropriate radiography, her inappropriate antibiotic prescribing practice, the deficiencies in her record-keeping, her carrying out work with inadequate care and skill, and her failures in diagnosing and treating caries and bone loss. Such acts and omissions resulted in actual harm to patients, and otherwise placed patients at considerable risk of harm. More particularly, in his evidence to*

the Committee, the subsequent treating dentist of Patient AQ stated that the patient's presentation was as if the patient had never before seen a dentist, or at least had not done so for a number of years.

The PCC considered Miss Luguera Aguirre's misconduct and determined the following:

The Committee finds that the seriousness of the failings that it has found, the protracted period of time over which these acts and omissions were repeated, the wide-ranging nature of the clinical shortcomings and the number of patients involved constitutes conduct that would be considered to be deplorable by Miss Luguera Aguirre's fellow professionals. The Committee finds that the facts that it has found proved, both cumulatively and in many cases individually, amount to misconduct.

Having found there was misconduct the PCC considered whether Miss Luguera Aguirre's fitness to practise was impaired and determined the following:

The Committee therefore finds that there is an ongoing risk of Miss Luguera Aguirre repeating the conduct that has precipitated these proceedings, and that any such repetition may cause harm to patients and would otherwise place them at the risk of unwarranted harm. Given the complete absence of any remediation of, or insight into, the serious, wide-ranging and repeated departures from proper professional standards, and the associated risks of repetition, the Committee finds that Miss Luguera Aguirre's fitness to practise is currently impaired.

Having found Miss Luguera Aguirre's fitness to practise impaired the PCC considered the matter of sanction and determined the following:

The Committee has given careful consideration as to whether a higher sanction of erasure is appropriate. The Committee notes that there are a number of factors which suggest that erasure might be the appropriate and proportionate sanction to impose, namely Miss Luguera Aguirre's persistent lack of insight into her misconduct, and the continuing risk of harm to patients. However, although Miss Luguera Aguirre's conduct was sustained over a considerable period of time, and whilst she has not engaged with these proceedings or provided any evidence of insight and remediation, the Committee does not consider that Miss Luguera Aguirre has a deep-seated professional or attitudinal problem which might make erasure the appropriate sanction.

The Committee therefore considers that, in the particular circumstances of this case, the protection of the public and public trust and confidence in the profession can be adequately secured by a period of suspension. The Committee has therefore determined, and hereby directs, that Miss Luguera Aguirre's name should be suspended from the register. Although Miss Luguera Aguirre appears to be currently residing outside of the UK, she may return to practise in the UK at any time and if she were to do so the public would, in the Committee's judgement, be insufficiently protected if an order of suspension were not in place.

The matter was reviewed on 17 June 2019, where that Committee found that Miss Luguera Aguirre's fitness to practice continued to be impaired and determined the following:

The Committee was of the view that the misconduct identified was remediable, but there was no evidence that Miss Luguera Aguirre had taken any steps to address the identified misconduct. Miss Luguera Aguirre has not engaged with her regulatory body.

That Committee found that the appropriate sanction was a further period of suspension for 12 months and determined:

The Committee concluded that in all the circumstances of this case a further period of suspension on Miss Luguera Aguirre's registration would protect the public, uphold the

public interest and give Miss Luguera Aguirre a further opportunity to address the identified deficiencies and shortcomings in her practice and re-engage in the GDC process. The Committee concluded that for these reasons the appropriate order is 12-month suspension, with a review. This period will be sufficient to enable her to provide evidence of remediation and insight for the next review hearing.

Decision of review

This Committee has comprehensively reviewed Miss Luguera Aguirre's case today. In doing so, it has considered all the evidence presented to it. It has taken account of the written submissions made by the GDC. It has accepted the advice of the Legal Adviser.

The GDC has stated that there has been no material change since the previous hearing. The GDC further stated that Miss Luguera Aguirre has not provided any evidence of insight or remediation to date and has not engaged with the GDC. The GDC submitted that Miss Luguera Aguirre's fitness to practise remains impaired by reason of misconduct. In terms of sanction, the GDC submitted that as Miss Luguera Aguirre has not engaged with the process since the initial hearing in June 2018, it would be appropriate and proportionate to impose an indefinite order of suspension on her registration.

Decision on Impairment

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

The Committee noted that Miss Luguera Aguirre has not fully engaged with the GDC with regard to this process. The Committee has not seen any evidence of Miss Luguera Aguirre's insight or learning in relation to the failings identified at the initial hearing in June 2018, despite being given the opportunity to do so. The absence of evidence to show that Miss Luguera Aguirre has sufficient insight means that the Committee cannot say that such conduct is highly unlikely to be repeated. The Committee concluded that there has been no material change in the circumstances of this case. In the absence of any evidence to show the widespread and clinical concerns identified by the PCC at the hearing in June 2018 have been addressed, the Committee considers that Miss Luguera Aguirre remains a risk to the public. In such circumstances a finding of impairment was also necessary on public interest grounds in order to maintain standards and public confidence in the profession. Accordingly, it has determined that Miss Luguera Aguirre's fitness to practise remains impaired by reason of misconduct on both public protection and public interest grounds.

Decision on Sanction

The Committee next considered what sanction to impose on Miss Luguera Aguirre's registration. It has had regard to the GDC's "Guidance for the Practice Committees including Indicative Sanctions Guidance" (October 2016, updated May 2019) as well as the GDC's submissions.

The Committee has found that Miss Luguera Aguirre's fitness to practise remains impaired. In these circumstances, the Committee concluded that terminating the current suspension order would not be appropriate or sufficient for the protection of the public.

The Committee considered whether to replace the current suspension order with one of conditions. In so doing, it had regard to the absence of any evidence of remediation from Miss Luguera Aguirre. She has been given an opportunity to remediate her deficiencies and engage

with the GDC over a long period of time but has chosen not to do so. In these circumstances, the Committee is not satisfied that conditions are appropriate, workable or sufficient for the protection of the public.

The Committee then went on to consider whether to direct that the current period of suspension be extended for a further period. It has borne in mind Miss Luguera Aguirre's continuing lack of engagement with the GDC over a long period of time, despite being given the opportunity to do so, as well as the absence of any insight or remediation. Indeed, Miss Luguera Aguirre's decision not to participate at any of these proceedings over the last two years has exacerbated the situation. In these circumstances, the Committee has concluded that a further period of suspension of 12 months would serve no useful purpose and not be in Miss Luguera Aguirre's interests.

Accordingly, the Committee directs that Miss Luguera Aguirre's registration be indefinitely suspended. It is satisfied that the provisions of section 27C(1)(d)(i) and (ii) of the Act are met. It notes that this direction means that a review of the order can only take place if Miss Luguera Aguirre requests a review and a minimum of two years has elapsed since the direction took effect. It is satisfied that this direction is appropriate and proportionate.

The effect of the foregoing direction is that, unless Miss Luguera Aguirre exercises her right of appeal, her registration will be suspended indefinitely from the date on which the direction takes effect.

That concludes this case for today."