HEARING HEARD IN PUBLIC

MANAN, Ghafoor

Registration No: 71231

PROFESSIONAL CONDUCT COMMITTEE

JANUARY 2021 – OCTOBER 2022

Outcome: Erased with Immediate Suspension

MANAN, Ghafoor, a dentist, Statutory Exam 1995, was summoned to appear before the Professional Conduct Committee on 4 January 2021 for an inquiry into the following charge:

Charge (as amended on 5 January 2021)

"That being registered as a Dentist, your fitness to practice is impaired by reason of misconduct in that:

1. You failed to provide Patient A (identified in Schedule A[1]) with an appropriate standard of care when treating her at UL5 in that you:
   (a) failed to assess the tooth adequately;
   (b) failed to explain the risks and benefits of the proposed treatment and/or failed to make a note in the clinical records if this was done;
   (c) perforated the root;
   (d) failed to identify a second canal either from a pre-treatment radiograph and/or when carrying out the root canal treatment;
   (e) failed to disinfect and obturate the tooth adequately;
   (f) failed to use a rubber dam when carrying out root canal treatment;
   (g) fractured/separated an instrument in the apical third of the root.
2. In relation to the management of Patient A's UL5, you failed to:
   (a) inform the patient of the fractured/separated instrument and that it had been left in the root canal;
   (b) discuss with the patient the influence of 2(a) above on the expected success of the root canal treatment;
   (c) discuss the available treatment options; and/or
   (d) refer the patient to another dental practitioner.

[1] Please note the Schedules are private documents that cannot be disclosed

3. By your conduct at 2(a) and/or 2(b) you failed to comply with your duty of candour.

4. Your conduct at 2(a) and/or 2(b) and/or 2(c) and/or 2(d):

   (a) was unprofessional; and/or

   (b) lacked integrity.

5. You prescribed antibiotics to the patient with no clinical justification.

6. You provided a poor standard of care in relation to radiographs in that you:

   (a) failed to take one or more radiographs prior to commencing root canal treatment;

   (b) failed to take a radiograph immediately after completing root canal treatment;

   (c) failed to take any radiograph that captured a satisfactory image during root canal treatment.

7. You failed to record:

   (a) whether or not any assessments and/or investigations were carried out on 23 March 2018;

   (b) WITHDRAWN

   (c) the materials used for impressions and/or occlusal registration on 10 May 2018;

   (d) whether or not a temporary crown was used on 10 May 2018 and the material any crown was to be constructed from.

8. You failed to maintain an adequate standard of record keeping in relation to radiographs in that you:

   (a) failed to make a note in the clinical records of two radiographs taken on 13 April 2018;

   (b) failed to make a note in the clinical records of the clinical justification for taking a radiograph on 12 September 2018;

   (c) failed to make a written report of the radiographs taken 13 April 2018 and/or 12 September 2018;

   (d) recorded in the clinical records that a periapical radiograph had been taken on 27 September 2018 when one had not.

9. On 23 May 2019 you provided the GDC with a transcript of your records for Patient A which:

   (a) for an appointment on 13 April 2018:

(i) did not include the words '*inform pt*' when this was recorded in your handwritten notes;

(ii) includes the words '*Leave as in apical 3rd'* when this was not recorded in your handwritten notes;

(b) did not include a transcript for an appointment on 27 September 2018.

10. Your conduct at 9(a)(i) was:

(a) misleading; and/or

(b) unprofessional; and/or

(c) dishonest.

11. Your conduct at 9(a)(ii) was:

(a) misleading, and/or

(b) unprofessional, and/or

(c) dishonest.

12. AMENDED TO READ: You failed to respond adequately to Patient A's complaints about their dental treatment in that you:

(a) failed to have in place and/or to follow an effective complaints procedure;

(b) failed to provide the patient with a copy of the written complaints procedure;

(c) failed to respond to the patient's letter dated 22 November 2018;

(d) failed to provide a substantive response when responding on 18 December 2018.

13. In December 2019 you wrote to Patient A:

(a) by letter dated 3 December 2019 seeking '*an out of court settlement to save time and money*' by paying £7,500 in addition to £2,500 for the costs of an implant;

(b) by email dated 18 December 2019, in terms, asking her to withdraw her allegations of sexual misconduct.

14. Your conduct at 13(a) and/or 13(b):

(a) was unprofessional, and/or

(b) lacked integrity, and/or

(c) was with the objective of influencing the outcome of the GDC's proceedings relating to you.

15. On 23 March 2018 said to Patient A:

(a) '*How do you look so young?'*

(b) '*You're so beautiful.'*

(c) '*Do you have a daughter? Is she more beautiful than you or less beautiful than you?*' or words to that effect

16. On 10 May 2018 said to the patient's partner '*How do you satisfy such a beautiful woman in bed?*' or words to that effect.

17. Your conduct at 15(a) and/or 15(b) and/or 15(c) and/or 16 was:

(a) unprofessional, and/or

(b) sexually motivated.

18. On or around 15 May 2019 and/or 16 January 2020, you caused or allowed the GDC to be provided with what was purported to be a complete set of records of your care of Patient A.

19. On 5 February 2020, you informed the GDC that you had provided it with all the documents relating to Patient A and that there were no documents remaining.

20. Your conduct at 18 and/or 19 was:

(a) Unprofessional; and/or

(b) Misleading; and/or

(c) Lacking in integrity; and/or

(d) Dishonest.

21. In the patients notes you recorded "extremely nervous treat like a baby. (GM) 2 Kids G=30 .B=29.. **[REDACTED]**".

22. Your conduct at 21 was unprofessional."

Mr Manan was present and was represented. On 5 January 2021 the Chairman made a statement regarding the preliminary applications.

On 8 January 2021 the hearing adjourned part heard.

"Mr Manan,

Ms Deignan, on behalf of the General Dental Council (GDC), applied under Rule 25 of the General Dental Council (Fitness to Practise) Rules 2006 (the "Rules") for further allegations to be joined to the those already contained in the notification of hearing dated 26 November 2020. The allegations already contained in the notification of hearing relate to your alleged care and treatment of Patient A and your alleged conduct towards her (charges 1-17).

By letter dated 20 November 2020, the GDC put you and your solicitors on notice of its intention to join the following further allegations:

18. On or around 15 May 2019 and/or 16 January 2020, you caused or allowed the GDC to be provided with what was purported to be a complete set of records of your care of Patient A.

19. On 5 February 2020, you informed the GDC that you had provided it with all the documents relating to Patient A and that there were no documents remaining.

20. Your conduct at 18 and/or 19 was:

    (a) Unprofessional; and/or

    (b) Misleading; and/or

    (c) Lacking in integrity; and/or

    (d) Dishonest.

21. In the patients notes you recorded "extremely nervous treat like a baby. (GM) 2 Kids G=30 .B=29.. **[REDACTED]**".

22. Your conduct at 21 was unprofessional.

The parties were in agreement that the requirements of Rule 25 were met and that the Committee therefore had the discretion to join the further allegations: the issue, having regard to the questions of fairness and prejudice, was whether the Committee should exercise that discretion.

Mr McDonagh, on your behalf, resisted the joinder application on the grounds that the application was made late with no adequate explanation from the GDC for the delay. In his submission your ability to respond to the further allegations is prejudiced by the lateness of the application. The documents on which the GDC relied in formulating the further allegations were already in its possession in early 2020. This hearing was originally listed to be heard in the summer of 2020 but was relisted owing to the pandemic to the current hearing, which was scheduled to commence 4 January 2021. It was not until 20 November 2020 that the GDC served notice of its intention to join the further allegations and not until 30 December 2020 when the GDC identified in full the documents on which it relies in support of the further allegations. The GDC's explanation that its paralegals were all working from home during the first national lockdown and had difficulty comparing documents to identify the further allegations is unpersuasive and is otherwise unsupported by evidence.

Mr McDonagh submitted that you had been out of the country undertaking charity work and did not return to the United Kingdom until a few days ago. The potential charges 18-20 arise from the eventual disclosure of Patient A's records by the new practice owner, following a threat by the GDC to exercise its statutory powers to compel disclosure. You have not had sufficient opportunity to make enquiries with him and to consider whether to seek to call him as a witness.

Mr McDonagh submitted that the same evidence in question will still be admitted before the Committee in support of the existing charges and that the further allegations do not increase the gravamen of the charges you already face. As to the potential charges 21-22, he also submitted that what is alleged here lacks substance in the context of pleading misconduct as part of these regulatory proceedings: the patient was a nervous patient and you made the notes in question to assist you in engaging in conversation with her to put her at ease.

The Committee retired to consider the application and accepted the advice of the Legal Adviser.

The Committee acceded to the joinder application and joined charges 18-22. Whilst there had been considerable delay on the part of the GDC in identifying and disclosing the further allegations it now seeks to pursue, the primary consideration for the Committee was whether the joinder would be unfair to you or prejudicial to your ability to respond to the further allegations.

Charges 18-20 relate to the disclosure of records made to the GDC by the new practice owner, which allegedly contain more records than those which you had identified to the GDC as being the full records for the patient, such that the GDC alleges you had acted in a way which was misleading and dishonest, among other things. Whilst you might wish to make enquiries with the new practice owner and/or seek to call the new practice owner as a witness, on the basis that such enquiries or evidence might potentially be relevant to your defence of these allegations, this does not in the Committee's judgment go to the core your ability to respond to and resist the allegations. In the Committee's judgment, the joinder of these allegations would not be unfair or prejudicial, as the focus of what is alleged is your state of mind: your understanding of the completeness of the records and your understanding in relation to the alleged corresponding assurances to the GDC. That is a matter for your own testimony (if any) to be given as part of the factual inquiry. You are not in the Committee's judgment prejudiced by the lateness of the GDC's application as any evidence or other response from the new practice owner would not be central to the determination of the allegations.

As to charges 21-22, it appears from Mr McDonagh's submission that you accept that fact that you made the notes in question and that you have an explanation for why such notes were made. That is an explanation for you to give as part of the factual inquiry. There is nothing to suggest that your ability to respond to these allegations depends on the need for you to call any further evidence in your defence.

The Committee therefore found that there was no significant prejudice to you in acceding to the joinder application.

Mr McDonagh also applied for clarification in respect of some of the charges which you face. The Committee heard the submissions of both counsel and accepted the advice of the Legal Adviser.

As is uncontroversial and agreed between the parties, charge 12 is amended to correct a typographical error ("Your failed" to "You failed") and charge 7(b) shall be amended by way of deletion, on the basis that it duplicates what is already alleged at charge1(b). Mr McDonagh also submitted that the use of the words "unprofessional" and "integrity" lacked proper definition or context. In respect of the stem of charge 12, Mr McDonagh also submitted that the use of the pleading "failed to respond adequately to Patient A's complaints" is inconsistent with what is then particularised. For example, that you "failed to have in place… an effective complaints procedure". Mr McDonagh also submitted that some of the charges plead matters which are stated in the GDC's expert evidence to only fall below (as opposed to far below) standard, and that some charges fail to attach a professional criticism of your conduct.

Mr McDonagh submitted that without proper definition he is unable to advise you adequately as to whether to admit or deny a charge, notwithstanding that there are a large number of factual matters which you are willing to admit.

In the Committee's judgment, the word "unprofessional", as pleaded throughout the charge, is to be given its ordinary construction. It does not require further definition or clarification, nor does it conflate the considerations to be given at the factual inquiry stage of proceedings with those which are to be given at any subsequent stage. The word "integrity" in the context of these regulatory proceedings has a meaning and significance discussed in the caselaw and is referred to in the Standards. These words are widely understood. There has been full disclosure and you have been given reasonable time to prepare your case. You have been put on sufficient notice of the charges you face and you are in a position to understand and respond to the case against you.

In the Committee's understanding, the allegation as framed and particularised allows you to make admissions with qualifications to the factual accuracy of particular heads of charge. For example, you could make an admission that a head of charge is factually correct but not that it amounts to misconduct.

Accordingly, the charges as they stand do not require further amendment or clarification and the hearing shall now open with those charges to be put to you."

The hearing resumed on 12 July 2022 and adjourned part heard on 13 July 2022.

The hearing resumed again on 16 September 2022 and the Chairman announced the findings of fact:

"Mr Manan,

The allegations against you relate to your care and treatment of Patient A in 2018-19. You are also alleged to have made unprofessional and sexually motivated comments to Patient A and her partner at the initial appointments in 2018. In addition, you face probity allegations relating to the completeness and accuracy of

your disclosure of Patient A's records to the General Dental Council (GDC) as part of its investigation into your fitness to practise.

The hearing commenced on 4 January 2021 and adjourned part-heard on 8 January 2021, following the conclusion of the GDC's case at Stage One.

On 5 January 2021 the Committee acceded to an uncontested application by the GDC to: (i) delete charge 7(b) as it duplicated what was already alleged under charge 1(b); and (ii) to amend charge 12 to correct a typographical error.

You admitted a number of the charges against you. The Committee noted your admissions but deferred making any findings of fact until all the evidence had been heard.

In support of the GDC's case the Committee heard oral evidence from Patient A and her partner. The Committee also heard oral evidence from Elizabeth Glass, a general dental practitioner instructed by the GDC for her expert opinion.

On 8 January 2021 Mr McDonagh, on your behalf, made a half-time application of no case to answer under Rule 19 of the General Dental Council (Fitness to Practise) Rules 2006 in respect of a number of the charges. For reasons which are set out below, the Committee acceded to the application only in respect of charges 1(c) and 1(g).

The hearing was scheduled to resume with the commencement of your case at Stage One in August 2021 but the hearing did not proceed owing to a Committee member being taken ill.

The hearing resumed on 12 July 2022 when the Committee heard oral evidence from you.

Upon the resumption of the hearing in July 2022 Ms Deignan, on behalf of the GDC, applied for charge 16 to be amended to correct the date of the appointment at which it is alleged that you said to Patient A's partner *"How do you satisfy such a beautiful woman in bed?"* or words to that effect. In drafting the charge, the GDC appeared to have confused or conflated the date of the appointment at which it is alleged that this was said with the date of another appointment. This error should have been apparent to the GDC from the outset of the proceedings, but the GDC did not make any application to amend the charge until some 18 months later. The application was opposed by Mr McDonagh on your behalf. The Committee accepted the advice of the Legal Adviser and retired to consider the application. The Committee noted that it would have been entirely uncontroversial to have amended the charge to correct the date, had the application been made at the outset of the proceedings. The delay on the part of the GDC in identifying the error and applying for the amendment was of concern to the Committee. However, having regard to all the circumstances, including the public interest in the serious allegation pleaded under charge 16 being fully determined, the Committee acceded to the application and amended the charge to correct the date. There was no evidence that the amendment would be prejudicial

to you in terms of your ability to respond to the allegation, as you were not intending to call any witnesses who might have been present at either appointment and your ability to give your own account in response to the charge would be unaffected by the date of the appointment being corrected. In the absence of the amendment, charge 16 would automictically have failed because of the incorrect date being pleaded as a result of what appeared to have been an administrative oversight when drafting the charge. The Committee determined that it would be contrary to the public interest and the overarching objective to allow such a serious charge to fail on purely technical grounds in circumstances where a simple amendment to the charge to correct the date would remedy the issue and would not result in any significant prejudice to your ability to respond to the charge.

The Committee retired in camera at Stage One between 13-15 July 2022 and today 16 September 2022.

The Committee had regard to all the evidence which had been put before it and to the submissions of both counsel.

The Committee accepted the advice of the Legal Adviser.

The burden is on the GDC to prove each allegation on the balance of probabilities.

I shall now announce the Committee's findings of fact as follows.

1.	*You failed to provide Patient A (identified in Schedule A) with an appropriate standard of care when treating her at UL5 in that you:*
1. a)	*failed to assess the tooth adequately;* **Admitted and found proved.** Patient A had been referred to you for root canal treatment at her UL5. The clinical records show that you had identified pathology at the UL5 and that it needed root canal treatment and a crown. However, there is nothing further in the notes to indicate that your assessment of the tooth was adequate. The tooth had a second canal which you had failed to identify as part of your assessment of the tooth. That second canal was not clearly visible in the radiographic image on which you had based your assessment, owing to the angle from which the radiograph had been exposed. The opinion of Ms Glass was that a further radiograph should have been taken to assess the presence of a second canal. You accepted that you should have taken a further radiograph and on that basis admitted that you had failed to assess the tooth adequately. The Committee accepted your admission. Accordingly, the Committee found this charge proved.
1. b)	*failed to explain the risks and benefits of the proposed treatment and/or failed to make a note in the clinical records if this was done;*

	Admitted and found proved in relation to "failed to make a note". **Not proved in relation to "failed to explain".** It was not in dispute that you were under a duty to have explained to Patient A the risks and benefits of the proposed treatment and to have made a note of this in the clinical records. You made no such note and the issue before the Committee was whether you had explained the risks and benefits but failed to make a note of this, or whether the reason there is no note is because the discussion had not in fact taken place. Patient A stated in her witness statement that: "*I do not recall whether any risks or benefits were discussed*". Your evidence was that, whilst you do not have a specific recollection of any such discussion with Patient A, it was your normal practice to explain to your patients the risks and benefits of proposed treatment and that such a discussion would therefore have taken place in Patient A's case. Accordingly, you admitted this charge only in so far as it alleges a failure in record keeping. In deciding whether the risks and benefits had been explained to Patient A, the Committee was mindful that the absence of a corresponding note in the clinical records is not in itself determinative. The Committee also noted that the phrasing of this charge is confined to a failure "*to explain the risks and benefits of the proposed treatment"*. The charge therefore turns on whether you had explained the risks and benefits of the proposed treatment at all and not on whether any such explanation was also adequate. Other than any inferences which could be drawn from the absence of a note in the clinical records, there was no other evidence before the Committee in support of the GDC's case that you had failed to explain the risks and benefits. Patient A does not recall whether or not such a discussion had taken place and your evidence was that the discussion would have taken place in accordance with your normal practice. The Committee considered that the absence of a corresponding note in the clinical records could equally have been the result of poor record keeping. The Committee could not therefore go so far as to properly infer from this that no explanation of the risks and benefits had been given. The Committee considered that what you explained in evidence as being your normal practice was likely to be so, as explaining the risks and benefits of proposed treatment is a basic requirement of obtaining informed consent and is something which dentists would be expected to explain to their patients as a matter of routine. The Committee noted that you are a specialist endodontist with, other than the concerns raised in the present case, some 30 years of unblemished practice.

	Having regard to the totality of the evidence, the Committee could not determine either way whether or not you had explained the risks and benefits of the proposed treatment. The GDC had not therefore discharged its burden of proof. Accordingly, the Committee found this charge proved only in so far as a failure to make a note in the clinical records.
1. c)	*perforated the root;* **No case to answer.** On 8 January 2021 the Committee found that there was no case to answer in respect of this charge. It was not in dispute that you had perforated the root of the UL5 when carrying out the root canal treatment. The issue, as pleaded at the stem of this charge, was whether this amounted to a failure to provide an adequate standard of care to Patient A when treating the tooth. "Failure" in this context means that you were under a duty to have provided an adequate standard of care to Patient A by not perforating the root and that you had failed in that duty. During the course of her oral evidence Ms Glass acknowledged that the root can be perforated during root canal treatment. It is not necessarily the result of negligence or a lack of competence on the part of the treating clinician. The Committee was not satisfied that the GDC had presented any evidence from which it could be concluded that you had failed in your duty to provide an adequate standard of care by perforating the root. Accordingly, the Committee had found no case to answer in respect of this charge.
1. d)	*failed to identify a second canal either from a pre-treatment radiograph and/or when carrying out the root canal treatment;* **Admitted and found proved.** The Committee noted your admission to this charge. You had not identified that a second canal was present at the UL5, both when assessing the tooth using a pre-treatment radiograph and when carrying out the root canal treatment itself. The presence of the second canal was identified by a subsequent treating dentist. The pre-treatment radiograph on which you relied did not clearly show the presence of the second canal. The second canal had been superimposed on the first canal in the radiographic image, owing to the angle from which the radiograph had been exposed. As admitted and found proved under charge 1(a) above, you should have taken a further

	pre-treatment radiograph as part of your assessment of the tooth. In any event, the Committee was satisfied that a reasonably competent general dental practitioner (far less a specialist in endodontics) would have identified that a second canal was present when carrying at the root canal treatment itself, once the pulp chamber of the tooth had been opened up and cleaned out. The Committee was therefore satisfied that you were under a duty to have identified at this stage (if not earlier) the presence of the second canal. You did not do so and therefore only provided treatment to the first canal when the second canal would also have required treatment. The Committee was satisfied that your failure to have identified the presence of the second canal therefore amounted to a failure to provide an adequate standard of care to Patient A, as the second canal was left untreated. Accordingly, the Committee found this charge proved in its entirety.
1. e)	*failed to disinfect and obturate the tooth adequately;* **Found proved.** You were unaware that the UL5 had a second canal and so did not attempt to disinfect and obturate it as part of the root canal treatment you provided to the tooth. As the second root remained untreated it was not in dispute that you had therefore not disinfected and obturated the UL5 adequately. You denied this charge on the basis that you could not have failed in a clinical duty to have disinfected and obturated the second canal if you were unaware of its existence. Your case was that the criticism against you should be limited to the failure to have identified the presence of that second canal, as admitted and found proved under charge 1(d) above, and that the criticism should not extend also to the secondary consequences which flowed from that failure. The Committee was mindful that the word “failed” in the context of this and the other charges means that you were under a duty to have done something and that you did not do it. The Committee rejected your argument that the duty pleaded under this charge to have treated the second canal is not engaged in circumstances where you had failed to identify the presence of that canal. The charge must be read in accordance with its stem, which alleges a failure to have provided an adequate standard of care to Patient A in respect of the treatment you provided at her UL5. The underlying duty pleaded by the stem is not altered by the fact that you were not aware of the second canal: you remained under a duty to have treated that canal in order to have provided an adequate standard of care to Patient A. You

	did not do so. The Committee also accepted the opinion of Ms Glass that you had not disinfected and obturated the tooth adequately by not using a rubber dam during treatment, which exposed the tooth to risk of contamination from the rest of the oral cavity. The Committee was satisfied that this amounted to a failure to have provided an adequate standard of care to Patient A in respect of the treatment at her UL5, as it meant that you had failed to disinfect and obturate the tooth adequately. Accordingly, the Committee found this charge proved.
1. f)	*failed to use a rubber dam when carrying out root canal treatment;* **Admitted and found proved.** You had not used a rubber dam during treatment, as noted by you in the clinical records and as confirmed by you in evidence to the Committee. You explained that the reason you did not use a rubber dam was because you were concerned that the dam would be cut by the metal bur when removing the crown and that once the crown had been removed from the tooth you did not consider there to be enough remaining tooth structure for a clamp to be placed to secure a rubber dam. You accepted in hindsight that you should have attempted to secure a rubber dam to the adjoining teeth, as "*it is a routine procedure and all of my colleagues as well as myself use this*". The Committee also accepted the opinion of Ms Glass that a rubber dam was indicated for this procedure. She referred to guidance from the European Society of Endodontology which stated that root canal procedures should only be carried out where the tooth is accessed by rubber dam. The Committee concluded that the use of a rubber dam during the root canal treatment was required in order to isolate the tooth and to protect it from contamination from other parts of the oral cavity. By not using a rubber dam you exposed the tooth to an increased risk of infection. Accordingly, the Committee found this charge proved.
1. g)	*fractured/separated an instrument in the apical third of the root.* **No case to answer.** It was not in dispute that part of the file fractured during treatment and remained in the apical third of the root. As with charge 1 above, on 8 January 2021 the Committee acceded to a half time application of no case to answer in respect of this charge on the basis that the GDC had not produced any evidence from which it could be established that this in itself amounted to a failure to provide an adequate standard of care to

	Patient A. There was no evidence that the file fracturing was the result of any negligence or lack of competence on your part. Rather, it was a complication which can occur during treatment and which does not in itself mean that you had failed in a duty to provide an adequate standard of care.
2.	*In relation to the management of Patient A's UL5, you failed to:*
2. a)	*inform the patient of the fractured/separated instrument and that it had been left in the root canal;* **Admitted and found proved.** The instrument in question was a file which had fractured during treatment and with the fractured part being left in the root canal of Patient A's UL5. You made a note of this in the clinical records but did not inform Patient A, who only became aware of the matter when she attended another dentist. In a letter to you dated 5 December 2018, she complained that: Since I wrote to you I have had remedial treatment from another specialist. As a result I have discovered that there was a second root that you did not treat and that you left part of an instrument inside the root that you did treat. The latter was clearly visible on an x-ray. You did not tell me about either. Your evidence was that Patient A was a nervous patient with a chronic health condition which you felt could have been made worse by stress: you had decided not to inform her of the fractured file because you were concerned that doing so would be distressing to her and that this might worsen her health. You stated that in your clinical judgment there was a low risk of complications developing and that you therefore decided to monitor the situation over subsequent appointments. You stated that you intended to inform Patient A of the fractured file only if complications were to develop and that to otherwise inform would cause her unnecessary distress. The Committee had regard to the professional duty of candour to which all dental professionals, among other healthcare professionals, are subject. The GDC's guidance document on the duty of candour: *Being open and honest with patients when something goes wrong* (July 2016) states that: Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress. This means that healthcare professionals must:

- tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong;…

…

Telling the patient:

As soon as you realise that something has gone wrong with a patient's care which has caused them harm or distress, or which could do so in the future, you must tell them clearly, in a way that they can understand.

Most patients will want to know what has happened, what has been done or can be done to put matters right and what it means for them. You should answer any questions fully and honestly.

If the patient makes clear that they do not want to know the details, you should respect their decision. However, you should let them know that they can have further information later if they change their mind…

The Committee considered the professional duty of candour to be of fundamental importance. It is a basic right of patients to be informed of when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress. Patients must be able to trust their treating clinicians to give them full and complete information relating to their treatment. In that regard, the professional duty of candour serves to increase patient confidence in the information which they are given by dentists and other dental professionals. Therefore it exists as a duty within the profession and not simply as a matter of good practice.

The Committee accepted that your intention in not informing Patient A of the fractured file appears to have been well-meaning, in that your intention was to protect her from feeling distressed by a situation which you were actively monitoring and which was not likely in your clinical judgment to have resulted in any complications. You did not want to worry her unnecessarily. There did not appear to have been any intention on your part to have concealed information from Patient A in order to protect your own interests, or to avoid criticism or embarrassment. Neither did there appear to have been any conscious disregard by you for Patient A's rights and dignity as a patient: your judgment was that it was in her best interests not to inform her unless complications were to arise, so as not to cause her to experience stress which might worsen her health condition.

However, in the Committee's judgment, it was not for you to decide whether Patient A should be informed. A dental instrument fracturing during treatment, with the fractured part being left in the root canal is a significant clinical incident which could have caused harm (whether or

	not this risk was considered by you to be low) and which, on your own account, would in any event have been distressing to Patient A. The professional duty of candour required you to inform her of the situation. She had a basic right to know that a fractured part of a dental instrument had been left in the root canal of her tooth and that there was a risk of long-term complications arising from this in respect of the tooth. The professional duty of candour involves communicating information to patients which might be distressing or disappointing to them. That information must be communicated sensitively and in a way which is appropriate, but the fact that a nervous patient might find the information to be distressing is not a reason to depart from the duty to communicate that information to them. The Committee observed that there might hypothetically be rare and exceptional circumstances where protecting the vital interests of the patient means that a practitioner is not required to comply with the duty of candour, but there is nothing to suggest that such a threshold would have been met in any way whatsoever in the present case. Neither was this a case where Patient A had made clear to you that she did not want to be informed of the detail of anything which had gone wrong with the treatment. Even if she had, you would still have been under a duty to have informed her of the fact that something had gone wrong with the treatment. In the Committee's judgment, you were under a clear duty to have informed Patient A of the fractured instrument and that it had been left in the root canal and (however well-meaning your intention) you failed in that duty. Accordingly, the Committee found this charge proved.
2. b)	*discuss with the patient the influence of 2(a) above on the expected success of the root canal treatment;* **Found proved.** The Committee accepted the opinion of Ms Glass that the fractured part of the file being left in the root canal had the potential to affect the expected success of the root canal treatment. On your own evidence and that of Patient A, you did not discuss this with her: as admitted and found proved under charge 2(a) above, you had failed even to have informed Patient A that the file had fractured during treatment and that the fractured part of the file had been left in the root canal. You were aware that the fractured part of the file left in the tooth had the potential to influence the expected success of the root canal treatment (although you considered the risk to be low). The Committee accepted

	the opinion of Ms Glass that you were under a duty to have discussed this with Patient A. The Committee also considered this to fall squarely within the terms of the GDC's guidance document on the professional duty of candour referred to at charge 2(a) above. The guidance states that: "*When something goes wrong with a patient's care, you must: …explain fully the short and long term effects of what has happened.*" The Committee was therefore satisfied that you were under a duty to discuss these matters with Patient A to empower her to make an informed decision regarding her treatment and that you did not do so. Accordingly, the Committee found this charge proved.
2. c)	*discuss the available treatment options; and/or* **Proved** For the same reasons as under charge 2(b) above. Accordingly, the Committee found this charge proved.
2. d)	*refer the patient to another dental practitioner.* **Not proved.** As a matter of fact you did not refer Patient A to another practitioner. The issue before the Committee was whether you were under a duty to do so. No evidence had been presented to the committee that you would have been incapable of dealing with this situation in your role as the treating practitioner and as a specialist endodontist. As found proved under charges 2(a)-(c) above, your failure to have informed patient A of the instrument fracturing in her tooth and the potential consequences of this meant that you had not empowered to make her own decision about what was to happen next with her treatment, including referral to another practitioner. However, that does not go to charge 2(d) which effectively pleads that you were otherwise under a duty to refer. In the committee's judgement, you were not under such a duty in the absence of any request from Patient A. Accordingly, the Committee found this charge not proved.
3.	*By your conduct at 2(a) and/or 2(b) you failed to comply with your duty of candour.* **Found proved.** For the reasons given under charges 2(a)-(b) above. Accordingly, the Committee found this charge proved on both limbs.
4.	*Your conduct at 2(a) and/or 2(b) and/or 2(c) and/or 2(d):*

4. a)	*was unprofessional; and/or* **Proved.** The Committee determined that the word "unprofessional" is one of ordinary English usage. Whether a failing or a breach of a standard amounts to conduct which is unprofessional is a question of fact and degree for the judgment of the Committee. Charge 2(d) fell away from the scope of this charge in light of it not being found proved. The Committee was satisfied that your conduct in respect of the remaining charges 2(a)-(c) was clearly unprofessional. As a dentist you were required to adhere to the standards of the profession. Not every breach of the standards will amount to conduct which is unprofessional, but the breach here engaged the basic duties of professionalism to which all clinicians are subject when dealing with circumstances where treatment has gone wrong. The professional duty of candour is, as the Committee has previously stated, of fundamental importance to public confidence in the profession and to the right of patients to make informed decisions regarding their treatment. Your breach of the professional duty of candour amounted to conduct which was unprofessional. Whether your intention in not informing Patient A was well-meaning is irrelevant to the question of whether that conduct was unprofessional. Professionalism requires objectivity and adherence to fundamental standards. It was not open to you to decide for Patient A whether she should be informed that you had left a fractured file in her tooth and whether the potential clinical consequences and treatment options relating to this should be discussed with her. Basic standards of professionalism required you to have informed her of the matter and to have discussed the clinical consequences and the treatment options with her. Accordingly, the Committee found this charge proved in relation to charges 2(a)-(c).
4. b)	*lacked integrity.* **Proved.** The Committee considered the definition of integrity in the context of these proceedings. The Committee considered that a lack of integrity ordinarily refers to conduct which has some element of moral blameworthiness or moral culpability. In the present case, your conduct would clearly have lacked integrity if your intention had been to protect your own interests, or to avoid embarrassment or criticism. Your conduct would also clearly have lacked integrity if you had deliberately not taken

the duty of candour seriously or had otherwise flouted your professional obligations. This is because the concept of integrity requires professional people to adhere to the standards of their profession.

The difficulty for the Committee was that your conduct appears to have been motivated from a well-meaning desire to prevent Patient A from experiencing unnecessary distress and worry. As the Committee has already found proved, your conduct was nonetheless unprofessional and in breach of your duties towards Patient A. However, it does not automatically follow in the Committee's view that such conduct also lacked integrity.

The Committee received further legal advice from the Legal Adviser that integrity in the context of these proceedings refers to objective compliance with the standards of the profession and that it is not necessary to establish an element of moral blameworthiness or moral culpability for conduct to be lacking in integrity. Thus a failure to adhere to a professional standard, however well-meaning, is capable of amounting to a lack of integrity. The Legal Adviser referred the Committee to the following dictum of Rupert Jackson LJ at paragraphs 95 to 103 in *Wingate & Anor v The Solicitors Regulation Authority* [2018] EWCA Civ 366 and suggested that the Committee might be assisted by substituting references to "integrity" with the phrase "professional integrity":

> 95. Let me now turn to integrity. As a matter of common parlance and as a matter of law, integrity is a broader concept than honesty. In this regard, I agree with the observations of the Divisional Court in *Williams* and I disagree with the observations of Mostyn J in *Malins*.
>
> 96. Integrity is a more nebulous concept than honesty. Hence it is less easy to define, as a number of judges have noted.
>
> 97. In professional codes of conduct, the term "integrity" is a useful shorthand to express the higher standards which society expects from professional persons and which the professions expect from their own members. See the judgment of Sir Brian Leveson P in *Williams* at [130]. The underlying rationale is that the professions have a privileged and trusted role in society. In return they are required to live up to their own professional standards.
>
> 98. I agree with Davis LJ in *Chan* that it is not possible to formulate an all-purpose, comprehensive definition of integrity. On the other hand, it is a counsel of despair to say: "Well you can always recognise it, but you can never describe it."
>
> 99. The broad contours of what integrity means, at least in the context

of professional conduct, are now becoming clearer. The observations of the Financial Services and Markets Tribunal in *Hoodless* have met with general approbation.

100. Integrity connotes adherence to the ethical standards of one's own profession. That involves more than mere honesty. To take one example, a solicitor conducting negotiations or a barrister making submissions to a judge or arbitrator will take particular care not to mislead. Such a professional person is expected to be even more scrupulous about accuracy than a member of the general public in daily discourse.

101. The duty to act with integrity applies not only to what professional persons say, but also to what they do. It is possible to give many illustrations of what constitutes acting without integrity. For example, in the case of solicitors:

17) A sole practice giving the appearance of being a partnership and deliberately flouting the conduct rules (*Emeana*);

ii) Recklessly, but not dishonestly, allowing a court to be misled (*Brett*);

iii) Subordinating the interests of the clients to the solicitors' own financial interests (*Chan*);

iv) Making improper payments out of the client account (*Scott*);

v) Allowing the firm to become involved in conveyancing transactions which bear the hallmarks mortgage fraud (*Newell-Austin*);

vi) Making false representations on behalf of the client (*Williams*).

102. Obviously, neither courts nor professional tribunals must set unrealistically high standards, as was observed during argument. The duty of integrity does not require professional people to be paragons of virtue. In every instance, professional integrity is linked to the manner in which that particular profession professes to serve the public. Having accepted that principle, it is not necessary for this court to reach a view on whether *Howd* was correctly decided.

103. A jury in a criminal trial is drawn from the wider community and is well able to identify what constitutes dishonesty. A professional disciplinary tribunal has specialist knowledge of the profession to which the respondent belongs and of the ethical standards of that

	profession. Accordingly such a body is well placed to identify want of integrity. The decisions of such a body must be respected, unless it has erred in law. The Committee accepted the further advice of the Legal Adviser and determined that the concept of integrity in the context of professional practice is wider than the concept of integrity in an everyday context. The Committee determined that your conduct lacked integrity as the duty of candour is a fundamental standard of the profession to which you were subject and there had been a significant failure by you to comply with that duty. Accordingly, the Committee found this charge proved in relation to charges 2(a)-(c).
5.	*You prescribed antibiotics to the patient with no clinical justification.* **Not proved.** Patient A had not presented with symptoms of spreading or systemic infection. In those circumstances, the prescribing of antibiotics would not normally be clinically justified. However, the Committee accepted that this was an emergency appointment where Patient A had attended complaining of pain and where she was about to go on holiday before treatment could be commenced. In those circumstances, the Committee accepted that it was within the scope of your clinical judgment to have prescribed antibiotics as a precaution to manage the infection in the intervening period, in the event that Patient A's pain worsened. Ms Glass accepted in oral evidence that the prescription of antibiotics is reasonable if the dentist reasonably believes there to be a possibility of infection. The Committee was satisfied that, in the circumstances, you had sufficient clinical justification to prescribe the antibiotics. Accordingly, the Committee found this charge not proved.
6.	*You provided a poor standard of care in relation to radiographs in that you:*
6. a)	*failed to take one or more radiographs prior to commencing root canal treatment;* **Admitted and found proved.**
6. b)	*failed to take a radiograph immediately after completing root canal treatment;* **Admitted and found proved.**

6. c)	*failed to take any radiograph that captured a satisfactory image during root canal treatment.* **Not proved.** The copy of the radiograph before the Committee does not contain a satisfactory image. However, the Committee accepted that this was a copy of what appears to be the original analogue radiograph, which is not available, and that the image may have been clearer in that original radiograph. The Committee accepted your evidence that during the root canal treatment you had used an apex locator in conjunction with the original radiograph and that you would have considered this to be sufficient in your clinical judgment. The Committee was not satisfied that the GDC has proved that the original radiograph used by you did not contain a satisfactory image, particularly when the radiograph was used by you in conjunction with an apex locator. Accordingly, the Committee found this charge not proved.
7.	*You failed to record:*
7. a)	*whether or not any assessments and/or investigations were carried out on 23 March 2018;* **Admitted and found proved.**
7. b)	WITHDRAWN
7. c)	*the materials used for impressions and/or occlusal registration on 10 May 2018;* **Admitted and found proved.**
7. d)	*whether or not a temporary crown was used on 10 May 2018 and the material any crown was to be constructed from.* **Admitted and found proved.**
8.	*You failed to maintain an adequate standard of record keeping in relation to radiographs in that you:*
8. a)	*failed to make a note in the clinical records of two radiographs taken on 13 April 2018;* **Admitted and found proved.**
8. b)	*failed to make a note in the clinical records of the clinical justification for taking a radiograph on 12 September 2018;* **Found proved.**

	You were under a duty to record a justification for taking the radiograph. You made the following entry in the clinical records for 12 September 2018: "*UL5 I root treated in Morden. 1 PA Infected now. Going for 1 week holidays in 3 days time. Metro 400mg TDS x5 days (GM)*" Your case was that this was an emergency appointment and reference to infection and to Patient A about to go on holiday recorded sufficient justification for the taking of the radiograph. The Committee accepted the opinion of Ms Glass that this did not amount to a justification for the taking of the radiograph. Reference to infection was your interpretation of the radiograph and not the justification for the taking the radiograph. Accordingly, the Committee found this charge proved.
8. c)	*failed to make a written report of the radiographs taken 13 April 2018 and/or 12 September 2018;* **Admitted and found proved.**
8. d)	*recorded in the clinical records that a periapical radiograph had been taken on 27 September 2018 when one had not.* **Not proved.** The clinical records show that a radiograph was taken by you at the Wandsworth Practice on 12 September 2018. You did not make a note of this until 27 September 2018, when you recorded in the notes at the Morden Practice: "*1 PA taken at Wandsworth*". The criticism advanced by the GDC is that the radiograph should have been recorded on 12 September 2018 and that writing up the note two weeks later on the 27 September 2018 gave the misleading impression that the radiograph had instead been taken that same day. In the Committee's judgement, the entry is not misleading when the records are read as a whole. The note at Morden on 27 September 2018 refers to the radiograph having been taken at the Wandsworth and the records show that the appointment at Wandsworth was on 12 September 2018. The Committee considered that a discrepancy of two weeks because of the way in which the notes had been written up would not in any event amount to a significant record keeping error. The error would not have affected Patient A's continuity of care, as the radiograph itself was still available to any subsequent treating dentist. At most, they would have misread the clinical records as recording the radiograph being taken two weeks later than it actually was, which would not have been a material discrepancy in terms of Patient A's clinical care. Accordingly, the Committee found this charge not proved.
9.	*On 23 May 2019 you provided the GDC with a transcript of your records*

	for Patient A which:
9. a)	*for an appointment on 13 April 2018:*
9. a) i)	*did not include the words 'inform pt' when this was recorded in your handwritten notes;* **Admitted and found proved.**
9. a) ii)	*includes the words 'Leave as in apical 3rd' when this was not recorded in your handwritten notes;* **Admitted and found proved.**
9. b)	*did not include a transcript for an appointment on 27 September 2018.* **Admitted and found proved.**
10.	*Your conduct at 9(a)(i) was:*
10. a)	*misleading; and/or* **Found proved.** Misleading in the context of this charge refers to the objective effect of the conduct, regardless of whether it had been your intention to mislead. The Committee was satisfied that your conduct was plainly misleading to the GDC, as the GDC would have assumed that the typed transcript was an accurate reflection of the handwritten notes. The GDC would therefore have been misled into concluding that the words "inform pt" were not recorded in the handwritten notes when in fact they were. The GDC had requested the typed transcript as it was having difficulty reading the handwritten notes as part of its investigation into the concerns reported by Patient A. The GDC would therefore have relied on the typed transcript rather than cross referencing the transcript with the handwritten notes. Accordingly, the Committee found this charge proved.
10. b)	*unprofessional; and/or* **Found proved.** You were asked by your regulatory body to produce a typed transcript of a small number of your handwritten clinical records. The transcript was requested as part of a formal investigation into your fitness to practise. You failed for whatever reason to produce an accurate transcript and this was unprofessional in the Committee's judgment, given the context in which the transcript had been requested and importance of that document. Accordingly, the Committee found this charge proved.

10. c)	*dishonest.* **Not proved.** Whether your conduct was also dishonest depended on your state of mind in providing the transcript. In particular, whether it had been your intention to mislead the GDC into concluding that the words in question had not formed part of the original handwritten record, or whether there was another reason for the discrepancy between the handwritten notes and the typed transcripts. Your explanation for why the words were missing from the typed transcript was that this was simply an oversight. The Committee considered that if it had been your intention to deliberately mislead, then this would have been a high risk activity as you knew the GDC already had in its possession the original handwritten notes (previously supplied by you) and that, were it to cross reference those notes, the discrepancy would be discovered. The words “inform pt” were clearly legible in the handwritten notes. The Committee also had regard to other irrelevant errors in the transcript which point towards carelessness rather than an intention to mislead. There were discrepancies between the original handwritten notes and the typed transcript, where more detail or comment had been added to the typed transcripts than was contained in the handwritten notes. It appeared to the Committee that you had either misunderstood the GDC’s request of you and assumed that it was requesting an enhanced version of the handwritten notes, with added detail and narrative typed up to make the handwritten notes easier to understand in context; or you were otherwise trying to be helpful to the GDC by including such detail and narrative. The Committee also had regard to your good character in determining your propensity or otherwise to have acted dishonestly. You have an unblemished career of some 30 years practice. Having regard to all the circumstances, the Committee concluded that it was more likely than not that your omission of the words in question from the typed transcript was an oversight on your part in circumstances where you were not in any event trying to produce a verbatim typed transcript but were instead providing a typed transcript summarising the handwritten notes with additional comments and detail, so as to assist the reader in understanding the handwritten notes more easily. The matter here is characterised by a failure to have performed the relatively simple task that was required of you and to instead have typed up a narrative of the handwritten notes (rather than a verbatim transcript). In

	the process of doing so you omitted the words in question. The Committee was therefore satisfied that there was no ill intent in his supplying the typed transcript, as you were trying to assist rather than obfuscate or conceal. Such conduct would not be regarded as dishonest by the ordinary standards of decent honest people. Accordingly, the Committee found this charge not proved.
11.	*Your conduct at 9(a)(ii) was:*
11. a)	*misleading, and/or* **Not proved.** The discrepancy here, the addition of detail in the typed transcript to make the handwritten note clearer, was technically misleading in one sense but was not materially misleading to the extent that the Committee would find your conduct to have been misleading. The addition of the words "Leave as in apical 3rd" were not themselves included in the handwritten notes but the information which those words conveyed (referred to the fractured file being left in the root canal) was clearly documented in the handwritten notes. Accordingly, the addition of the words in the typed transcript did not convey any new or additional information to the reader. It was misleading only in the sense that the words had not themselves formed part of the original handwritten note. There were numerous other additions to the typed transcript from which (in contrast to charge 10(a) above which involved the omission of text) it would have been apparent to the GDC that the typed transcript contained more text than was contained in the handwritten notes. The question of whether your conduct was misleading under this charge turned on the impact the typed transcript would have had on the GDC when reading the typed transcript and not simply on the verbatim accuracy of the transcript. In context, the GDC would not have been misled first because the transcript was not materially misleading and secondly because it would have been apparent that the transcript contained additional detail. Accordingly, the Committee found this charge not proved.
11. b)	*unprofessional, and/or* **Proved.** For the same reasons as under charge 10(b) above. Accordingly, the Committee found this charge proved.
11. c)	*dishonest.*

	Not proved. For the same reasons as under charge 10(c) above. Accordingly, the Committee found this charge not proved.
12.	AMENDED TO READ: *You failed to respond adequately to Patient A's complaints about their dental treatment in that you:*
12. a)	*failed to have in place and/or to follow an effective complaints procedure;* **Proved in relation to failed to follow an effective complaints procedure.** There was no evidence before the Committee establishing that you did not in fact have in place an effective complaints procedure. Accordingly, the Committee found that aspect of the charge not proved. The Committee noted from the terms of Patient A's complaint that she appeared to be aware of how to complain to the practice regarding the treatment you had provided. The clinical records contain an entry recording that you responded to Patient A's initial complaint dated 22 November 2018 two days later, sending to her a cheque refunding her the £400.00 she had paid for the treatment. Patient A's evidence was that she did not receive this response. She submitted a follow up complaint on 18 December 2018 in response to which you sent her another cheque on or around 06 January 2019 with "my apologies for any inconvenience caused GM" written on a compliments slip. Patient A received this response. Accordingly, the Committee was satisfied that you did attempt to respond to the complaint and seek resolution by issuing Patient A with a refund, albeit you did not appear to have given any formal or structured response to the complaint. There was no evidence to suggest that in responding to Patient A's complaint you had sent her a copy of your complaints procedure (if any). The GDC's *Standards for the Dental Team* (September 2013) states: Standard 5.3: You must give patients who complain a prompt and constructive response 5.3.1 You should give the patient a copy of the complaints procedure when you acknowledge their complaint so that they understand the stages involved and the timescales. The Committee therefore found that in this regard that you had failed to follow an effective complaints procedure, as your response to Patient A's complaint was not in accordance with the procedure described under the

	GDC's own standards. Accordingly, the Committee found this charge proved in relation to failed to follow an effective complaints procedure.
12. b)	*failed to provide the patient with a copy of the written complaints procedure;* **Found proved.** For the same reasons as under charge 12(a) above. Accordingly, the Committee found this charge proved.
12. c)	*failed to respond to the patient's letter dated 22 November 2018;* **Not proved.** Whilst Patient A did not receive the first response you sent to her, the clinical records state that a letter of apology had been sent out to her with a refund for £400.00. The Committee had no reason to doubt that the response had in fact been sent, albeit it was not received by Patient A. Accordingly, the Committee found this charge not proved.
12. d)	*failed to provide a substantive response when responding on 18 December 2018.* **Found proved.** You responded with a cheque refunding Patient A the £400.00 she had paid for the treatment. The cheque was attached to a compliments slip with "my apologies for any inconvenience caused GM" written across it. Nothing further was provided. Mr McDonagh submitted that this response consisted of issuing an apology, a recognition of inconvenience and a cheque refunding Patient A £400.00. He further submitted that the charge does not plead the adequacy or otherwise of the substantive response, only that you had failed to provide one. Accordingly, your position in relation to the charge was that what you had provided amount to a substantive response. The Committee determined that, in context, this could not have amounted to a substantive response to Patient A's complaint. You had failed to provide an adequate standard of care to her in respect of root canal treatment. She complained to you that it was only after she consulted another dentist that she became aware that you had failed to treat a second canal at the tooth and had left a fractured instrument in the canal that you did treat. Whilst there was an attempt at resolution to her complaint by issuing her with a refund cheque, she was entitled to a more substantive response and explanation from you, beyond "my

	apologies for any inconvenience caused GM" written on a compliments slip. Accordingly, the Committee found this charge proved.
13.	*In December 2019 you wrote to Patient A:*
13. a)	*by letter dated 3 December 2019 seeking 'an out of court settlement to save time and money' by paying £7,500 in addition to £2,500 for the costs of an implant;* **Admitted and found proved.**
13. b)	*by email dated 18 December 2019, in terms, asking her to withdraw her allegations of sexual misconduct.* **Proved.** The email in question was before the Committee. It reads: Thank you for your acknowledgement. Now coming back to the wider matter, are you happy to take your allegations against me back, which come under the heading of sexual misconduct. As you know very well that they are not true? And there was nothing of this nature at all. Mr McDonagh submitted that, rather than plead "or words to that effect", the charge is confined to the clause "in terms". He submitted that the email does not "in terms" ask Patient A to her withdraw her allegations of sexual misconduct. The Committee rejected Mr McDonagh's submission. The use of the phrase "in terms" does not in the Committee's view create a dichotomy with "or words to that effect". A natural reading of the phrase "in terms" is wide enough to encompass what was intended or conveyed by the terms of the email. It is abundantly clear on any view that in the email you requested Patient A withdraw her allegations of sexual misconduct. Accordingly, the Committee found this charge proved.
	Your conduct at 13(a) and/or 13(b):
14. a)	*was unprofessional, and/or* **Found not proved in relation to 13(a) and proved in relation to 13(b).** The Committee was not satisfied that the letter of 3 December 2019 offering a financial "out of court settlement" was unprofessional. It constituted a commercial offer to settle pending litigation. Offering a financial settlement in resolution of a complaint is not in itself

	unprofessional conduct. The terms of the offer letter might have been more formally worded but they were not unprofessional. The Committee determined that your email dated 18 December 2019 was unprofessional. It was inappropriate in the circumstances, as it applied pressure on Patient A (or gave the appearance of doing so) to withdraw her complaint to the GDC. Whether or not you considered the allegations of sexual misconduct she made against you to be false, it was unprofessional of you to have asked her to withdraw those allegations. Accordingly, the Committee found this charge not proved in respect of 13(a) and proved in respect of 13(b).
14. b)	*lacked integrity, and/or* **Found not proved in relation to 13(a). Found proved in relation to 13(b).** As with charge 14(a) above, the Committee was not satisfied that your conduct in respect of the letter of 3 December 2019 was lacking in integrity. It was a legitimate attempt to resolve pending litigation by means of a financial settlement. Ms Glass acknowledged in evidence that offering a financial settlement can sometimes be the most appropriate way of resolving complaints about dental treatment. The Committee determined that your conduct in respect of the email on 18 December 2018 was lacking in integrity. It was unprofessional and inappropriate for you to have communicated with Patient A in that way. She had made serious allegations of sexual misconduct against you which were being investigated by your regulatory body. Adherence to the higher standards of the profession would have compelled you not to attempt to communicate with her directly to ask her to withdraw those allegations whilst the GDC's investigation was continuing. Accordingly, the Committee found this charge not proved in respect of 13(a) and proved in respect of 13(b).
14. c)	*was with the objective of influencing the outcome of the GDC's proceedings relating to you.* **Admitted but found not proved in relation to 13(a). Found proved in relation to 13(b).** The Committee was not satisfied that the letter dated 3 December 2019 was with the primary objective of influencing the outcome of the GDC's proceedings against you. It appears to have been a pragmatic attempt to reach a commercial settlement with Patient A in relation to any civil proceedings she might bring against you regarding the dental treatment

	you had provided. The letter made no reference to Patient A withdrawing her allegations to the GDC or of otherwise changing her complaint to the GDC. There was nothing to suggest that reaching a commercial settlement with Patient A on the terms proposed in the letter would have had any bearing on the GDC's regulatory proceedings. The Committee determined that your conduct in respect of the email on 18 December 2018 was self-evidently with the intention of influencing the outcome of the GDC's proceedings relating to you, in so far as those proceedings related to her allegations of sexual misconduct. Had she withdrawn her allegations as requested by you then that would likely have affected the outcome of the GDC's proceedings, with the GDC in all likelihood no longer pursuing those allegations. Accordingly, the Committee found this charge not proved in respect of 13(a) and proved in respect of 13(b).
15.	*On 23 March 2018 said to Patient A:*
15. a)	*'How do you look so young?* **Admitted and found proved.**
15. b)	*'You're so beautiful.'* **Not proved.**
15. c)	*'Do you have a daughter? Is she more beautiful than you or less beautiful than you?'* **Not proved.**
16.	AMENDED TO READ: *On 13 April 2018 said to the patient's partner 'How do you satisfy such a beautiful woman in bed?' or words to that effect.* **Not proved.** Patient A's initial appointment with you was on 23 March 2018. She was referred to you for endodontic treatment and presented as a nervous patient. Patient A's evidence was that you said to her at this appointment: "*how do you look so young?*", "*You're so beautiful*" (three or four times), "*Do you have a daughter? Is she more beautiful than you or less beautiful than you?*". Patient A's evidence was that she was shocked at these comments and did not know how to respond. Patient A subsequently attended an appointment with you on 13 April 2018 with her partner. Patient A's evidence, and that of her partner, was that you said to the partner words to the effect of *"How do you satisfy*

	such a beautiful woman in bed?". Patient A attended a follow up appointment with you on 10 May 2018. Her evidence was that at the end of this appointment she asked that the dental nurse leave the room so that she could speak with you privately. Patient A stated that she informed you that the comments you had previously made were unacceptable to which she stated you replied "*I am a friendly chap*" and that you smiled and shrugged. Patient A stated that when she challenged you further, referencing the comment you allegedly made to her partner, you twice asked "*Did I really say that?*", cupping your head in your hands on the second occasion. Your evidence was that you asked Patient A "*How do you look so young?*" at the initial appointment on 23 March 2018 because she had presented as a nervous patient and you wanted to make her feel at ease. You had noticed that you were both the same age with your birthdays being two months apart. You deny that you had said the other comments to her. In respect of allegedly repeatedly telling Patient A that she was beautiful, you stated in your witness statement that: "*I am aware that Patient A has alleged that I told her "you're so beautiful" and that I repeated this three or four times. This, I believe, is not true what I referred to is that she looked younger than her age.*" In respect of allegedly asking Patient A "*Do you have a daughter? Is she more beautiful than you or less beautiful than you?*", you stated in your witness statement that: "*[Patient A] claimed she was very nervous and I wanted reassure her, and so I asked her about her family and she told me that she had two children a son and daughter, I think that I asked her if they were good children and if they were good looking children (I sometimes say this as this disarms patients and makes* *them smile and most of them say yes they are). It has been alleged by Patient A that I asked her if the daughter was more beautiful than her, I do not believe that I asked her that, it is not correct.*" In respect of allegedly saying to Patient A's partner words to the effect of *"How do you satisfy such a beautiful woman in bed?"*, you stated in your witness statement that: "*I introduced myself and I started chatting with him [the partner]. I actually thought that they were husband & wife at that time. I was generally joking I think I was talking about wives and I asked him: 'I have a good wife. Is she (i.e. Patient A) a good wife?" This is what I said and her partner [who] was sitting at the foot of the dental chair. As she has some disability I asked him if she could cook or not or something to that effect, & "is she a good wife". I* *think she was taken aback suddenly, as she did not like me asking her*

partner about this.

I am aware that it is alleged that I asked: Is she good in bed?", which is preposterous. How could any dentist in his right mind say a thing like this to a patient sitting in the chair with a nurse present, and

the partner sitting right beside her. I did not say this.

Patient A also alleges that I said "'how do you satisfy such a beautiful woman in bed?" to [the partner]. I completely deny saying a thing like that to her or her partner."

You stated in evidence that Patient A did request that the dental nurse leave the room and that Patient A then challenged you in respect of the comments you had allegedly previously made. You stated that you had denied making such comments to her and that you apologised to her if she thought that you had done so.

Neither party has called the dental nurse(s) allegedly present at any of the appointments to give evidence. There was otherwise no statement from those individuals before the Committee. Patient A's evidence was that the dental nurse present at the appointments on 23 March 2018 and 13 April 2018 could not speak English and that you spoke with her using a different language. You denied that the dental nurse could not speak English and stated in evidence that she was UK qualified, although you acknowledged that you may on occasion have spoken to her in a different language in front of Patient A.

The Committee did receive an uncontested witness statement from Ms Malik, a dental nurse and Practice Manager. In her statement she stated that she was present at reception when Patient A attended the practice for her appointments, including when she attended with her partner. Ms Malik states that nothing was said to her on any of those occasions about any conversation of a sexual nature taking place between Patient A or her partner and you. Ms Malik further stated in her statement:

I have been working with Dr Manan for more than eleven years now. I can say that to the best of my knowledge Dr Ghafoor [sic] has not made sexual comments to any patient and I have not heard of anyone saying that he has done so. In particular, during my time as manager I can say that no similar complaint has been raised with me by a patient at either the Morden or Wandsworth practices. I was involved in dealing with [Patient A's] complaint in relation to her treatment, meeting with her and Dr Manan on one occasion. As far as I can recall she made no complaint of a sexual nature at that time against Dr Manan.

My impression is that Dr Manan has a warm friendly approach to his patients, joking with them and paying them compliments which tends to

	put them at ease. He has patients who have been coming to see him for many many years and they only want to see him. Patient A also stated in evidence that in the summer of 2018 she attended her regular dentist for a check up. That dentist was the practitioner who had referred her to you for endodontic treatment. Patient A stated that she informed him of the comments you had made to her and that in response he laughed and said "*oh Ghafoor*". That dentist had also not been called by either party to give evidence and no statement from him was otherwise before the Committee. The only direct evidence before the Committee in support of the comments you are alleged to have made is the account of Patient A and, in respect of the appointment on 13 April 2018, the account also of her partner. There was a gap of some 18 months between the Committee hearing Patient A's evidence and that of her partner and then hearing your evidence. This was because of the hearing adjourning part-heard in the intervening period and delays for various reasons beyond the control of the Committee and the parties in resuming the hearing. The delay of 18 months between hearing the evidence is deeply regrettable. Whilst the Committee had available to it the transcripts of Patient A's evidence and that of her partner, the Committee struggled to recall the nuance of their oral evidence. This affected the ability of the Committee to decide the conflicting accounts given in oral evidence by each witness. The Committee also noted that, notwithstanding your alleged comments towards Patient A at the initial appointment, she elected to proceed to receive treatment from you and attended you at subsequent appointments. The Committee had regard to the chronology of Patient A's complaint. The allegations now before the Committee under charges 15-16 were not contained in Patient A's original complaint to the GDC but were instead introduced by her at a later stage of the GDC's investigation. Patient A also had not made reference to the alleged comments in her written complaints to you regarding the dental treatment she had received. However, it was not in dispute that she had asked the dental nurse to leave the room at one of the earlier appointments when she then verbally challenged you on comments you had allegedly previously made. The Committee also noted that Patient A maintained her allegations against you even after receiving a financial settlement to her complaint: she continued to allege as part of these regulatory proceedings that you had made the comments in question and she attended the hearing to

	give evidence to the Committee. There was no obvious motive for why she would do so if she knew the allegations she made were false or exaggerated. Rather, she continued to stand by the allegations after receiving a financial settlement in which she had refused to withdraw her allegations suggests that she is motivated either by a sense of injustice and/or a desire to protect other patients from being subjected to such comments. The Committee considered the allegations at length and ultimately determined that the GDC has not discharged its burden of proving that the disputed comments were more likely than not to have been said. The standard of proof is the balance of probabilities. The Committee was mindful that the allegations involve clearly inappropriate comments made casually and repeatedly to Patient A, including on an occasion when her partner was also present. This suggests a pattern of behaviour where comments of this nature would be made routinely by you to patients in an overfamiliar manner. However, there was no evidence of any other complaint or concern being raised against you over a very long practising career. It must have been apparent to you that such comments, if found proved, were likely have serious far-reaching consequences for you in terms of your professional registration. This, in the Committee's judgment, makes it less likely that you would have said such comments. Having regard to the totality of the evidence and applying the burden of proof, the Committee could not be satisfied that it is more likely than not that the comments at charges 15(b)-(c) and 16 were said by you. In reaching this decision, the Committee wishes to emphasise that it has not disbelieved Patient A or found her account to be untrue. Rather, the Committee has been unable to determine one way or the other from the evidence whether the comments were said, owing in part to the considerable passage of time which has elapsed since it had the benefit of hearing Patient A's evidence and that of her partner, and also to the fact that the allegations now made were not contained in the original complaint to the GDC but were added at a later stage and there being no evidence of any other similar complaint being made in respect of you over a long practising career. Accordingly, the Committee found charge 15(a) proved and charges 15(b)-(c) and 16 not proved. You admitted in evidence that you might have made comments which may have offended Patient A or which may have been misinterpreted by her, such as asking her partner whether she was a good wife and whether she could cook, and asking her whether her children were good

	looking. The Committee was not asked to determine the appropriateness or otherwise of such comments.
17.	*Your conduct at 15(a) and/or 15(b) and/or 15(c) and/or 16 was:*
17. a)	*unprofessional, and/or* **Not proved.** Charges 15(b), 15(c) and 16 were found not proved. The alleged unprofessional conduct was therefore confined to the matter found proved under charge 15(a), namely your saying to Patient A at the initial appointment on 23 March 2018 “How do you look so young?”. You stated that you said this to put her at ease, as she was a nervous patient and you had noticed that you were both the same age, your birthdays being two months apart. The Committee accepted that it was likely to have been an innocuous attempt by you at “breaking the ice” and putting Patient A at ease. However, commenting to a patient on their appearance in this way, whether or not well-intended, is generally unwise and better avoided. It is a clumsy style of communication which is likely to be overfamiliar for a clinical environment, where professional boundaries are to be maintained between the dentist and the patient. In deciding whether your comment amounted to unprofessional conduct, the Committee considered how the comment would have been perceived by other dental professionals and by patients. The Committee considered that, in context, other dental professionals generally are unlikely to have regarded the comment in itself as being unprofessional, inappropriate or otherwise of concern, even if they would not make such a comment themselves to a patient. Rather, they are likely to have seen the comment as nothing more than friendly and conversational, to help the patient feel at ease. Likewise, the Committee considered that, in context, patients generally would treat the comment as a compliment and would regard it as an act of friendliness. Importantly, they are not likely in the Committee’s judgment to view it as unprofessional or of otherwise overstepping professional boundaries. The Committee therefore determined that the comment in and of itself did not go so far to be unprofessional. Accordingly, the Committee found this charge not proved.
17. b)	*sexually motivated.* **Not proved.**

	Sexually motivated for the purposes of this charge means that you would have said *'How do you look so young?'* to Patient A either for your own sexual gratification or in pursuance of a sexual relationship with her. You denied that you had any sexual motivation in making the comment. You stated that it would be against your belief system to have made a sexual advance on Patient A, as you are married. The Committee considered that the comment is unlikely in isolation to have had any sexual connotation. It may have been clumsy, unwise and overfamiliar attempt at putting her at ease, but it was not, on the balance of the evidence, likely to have been sexually motivated in the Committee's view. Accordingly, the Committee found this charge not proved.

18.	*On or around 15 May 2019 and/or 16 January 2020, you caused or allowed the GDC to be provided with what was purported to be a complete set of records of your care of Patient A.* **Admitted and found proved.**
19.	*On 5 February 2020, you informed the GDC that you had provided it with all the documents relating to Patient A and that there were no documents remaining.* **Admitted and found proved.**
20.	Your conduct at 18 and/or 19 was:
20. a)	Unprofessional; and/or **Found proved in relation to both charges 18 and 19.**
20. b)	*Misleading; and/or* **Admitted and found proved in relation to both charges 18 and 19.**
20. c)	*Lacking in integrity; and/or* **Found proved in relation to both charges 18 and 19.**
20. d)	*Dishonest.* **Not proved.** On 7 January 2019 the GDC wrote to you to inform you of its investigation into Patient A's complaint, enclosing a copy of Patient A's complaint and her signed consent for the disclosure of her dental records. The GDC requested that you provide it with those records by 21 January 2019.

	In her uncontested witness statement, YG stated that the GDC received Patient A's records from you on 15 May 2019. However, the Committee has not itself had sight of any correspondence recording when those records were received. The Committee also noted that the document exhibited to YG's witness statement headed "CHRONOLOGY OF REQUESTS FOR DISCLOSURE OF RECORDS OF TREATMENT" appeared to incorrectly state that the records were received from you on 18 February 2020. It was clear however that, as of 15 May 2019, the GDC had received Patient A's records from you. This is because it emailed you on that day thanking you for supplying those records and to ask that you provide a typed transcript of the handwritten dental records between 23 March 2018 and 6 January 2019. The GDC also emailed you on 16 May 2019 to state that it did not appear to have been provided with the records for an appointment with Patient A on 12 September 2018 at Wandsworth. The GDC asked you to confirm that the appointment had taken place and to provide the records by 23 May 2019, including a typed transcript of any handwritten notes for that appointment along with the typed transcript which had already been requested. On 23 May 2019 you provided a typed transcript of your handwritten notes. You did not however provide the GDC with a copy of the records which had been requested for the appointment on 12 September 2018 or otherwise respond to the GDC's request for clarification on whether that appointment had taken place. On 25 September 2019 the Case Examiners considered Patient A's complaint and referred the case to the Professional Conduct Committee. On 18 December 2019 the GDC wrote to you by email and Special Delivery post to request that you send a copy of Patient A's original dental records, explaining that the records you had previously supplied had been returned to you but were required again as the case had now been referred. The letter requested that you provide the original records by 3 January 2020. On 8 January 2020 the GDC wrote to you by email and Special Delivery post to state that it was yet to receive a response from you and asked you to respond "*as soon as possible*". On 16 January 2020 the GDC received the original records from you, with a handwritten cover note from you dated 15 January 2020 stating: "*Please find the original documents as requested".* On 3 February 2020 one of the GDC's lawyers stated in email correspondence to a Hearings Case Management Officer at the GDC regarding the readiness of the case for a hearing that: "*our expert has*

	identified that the records provided by Mr Manan's practice still appear to be incomplete, despite us having made several requests for the full records." You replied on 5 February 2020 to state: "'*I have sent all the original documents required to the GDC by registered mail including the Xrays which are digital (so only a copy can be sent), & all the correspondence between* [Patient A] *& myself in original . I can assure you that there nothing remaining.'* [sic] The GDC had also contacted the practices at Morden and Wandsworth to request disclosure of Patient A's records. The disclosures made by these practices included records which you had not previously supplied to the GDC, consisting of a note made by you for Patient A at Morden, stating: *"extremely nervous treat like a baby. (GM) 2 Kids G=30 .B=29.. **[REDACTED]**"*. That note is now the subject of charges 21 and 22 below, which allege that your conduct in making the note was unprofessional. The Committee was satisfied that you caused or allowed the GDC to be provided with what was purported to be a complete set of records of your care of Patient A in respect of the notes which you provided to it on or by 15 May 2019 and on 16 January 2020 (**charge 18**). These records were provided in response to formal requests from the GDC for the records so that it could perform its regulatory functions of investigating Patient A's complaint (the 15 May 2019 disclosure) and of presenting the case before the Professional Conduct Committee (the disclosure of 16 January 2020). The Committee was further satisfied that on 5 February 2020 you informed the GDC that you had provided it with all the documents relating to Patient A and that there were no documents remaining (**charge 19**). In response to the suggestion that the provided records "*still appear to be incomplete*" you had stated in your email to the GDC on 5 February 2020: "*I can assure you that there* [is] *nothing remaining.'* As a matter of fact, the records which had been provided were not a complete set of records of your care of Patient A. The Committee acknowledged that by 16 January 2020 the outstanding records might not have been under your direct control, as you had sold the Practice in Morden on 22 November 2019. This meant that you might not have been in a position at the stage to have accessed those records to disclose to the GDC. However, the records were under your control at the time of your initial disclosure to the GDC's investigation on or by 15 May 2019. In any event, you were likely to have known throughout that such records existed and that they fell within the scope of the GDC's request. It was your duty to have identified to the GDC that those other

	records existed. The Committee had regard to the following from *Standards for the Dental Team* (September 2013): 9.4 You must co-operate with any relevant formal or informal inquiry and give full and truthful information 9.4.1 If you receive a letter from the GDC in connection with concerns about your fitness to practise, you must respond fully within the time specified in the letter… In the Committee's judgment, the GDC was clearly misled By failing to identify to the GDC the existence of the other records, including by positively "assuring" the GDC on 5 February 2020 that there was "nothing remaining", your conduct was both unprofessional (**charge 20(a)**) and misleading (**charge 20(b)**). Misleading in this context refers to the objective effect of your conduct, regardless of whether it had been your intention to mislead. The GDC is entitled to expect its registrants to exercise care and diligence when responding to requests for the disclosure patient records as part of any regulatory investigation or proceeding, and to ensure that the responses they provide are accurate and complete. It is a basic expectation of any professional. The failure of the professional to respond appropriately in this way is capable of undermining the scheme of professional regulation. Your duty here was simply to identify to the GDC that the notes which you had provided were not complete, as other records existed regarding your care of Patient A which had not been included. By not including this caveat your conduct was misleading to the GDC, as it gave the impression that the disclosed records were complete. For these same reasons, the Committee considered that your conduct was lacking in integrity (**charge 20(c)**), co-operating with the GDC's investigation being a fundamental professional standard and one which you breached by acting in a way which was misleading to it in respect of the completeness of the disclosed records. The question whether your conduct was also dishonest (**charge 20(d)**) turns on your state of mind and whether you had deliberately intended to mislead the GDC as to the existence of the other records, or whether you had simply not taken the matter as seriously as you should have and responded without exercising the level of care and diligence which was expected of you. The Committee found there to be insufficient evidence to establish that it was more likely than not that you had deliberately intended to mislead the GDC. The Committee considered whether and to what extent there

	would have been an advantage to you in acting dishonestly. Had the GDC not gone on to obtain the further records, then the following note made by you would not have come to its attention and you would not now be facing additional charges that your conduct in making the note was unprofessional: *"extremely nervous treat like a baby. (GM) 2 Kids G=30 .B=29.. **[REDACTED]**".* There was therefore a potential advantage to you in that regard. The Committee could not identify any other potential advantage to you in deliberately not informing the GDC that the additional records existed, as there was nothing additional contained in those records which would have been adverse to you. In the Committee's view, if you had engaged in thought processes of deliberately misleading the GDC it would have been apparent to you that the GDC was likely to have ultimately obtained the records anyway by contacting the practices directly. When you emailed the GDC on 5 February 2020 you knew that the GDC doubted the completeness of the records you had supplied. You would have known, or should have known, that further records existed which had not been disclosed: you would have known that those computer records had not been destroyed but were still being held by the Practice in Morden. You knew that the GDC was already aware that Patient A had been treated by you at that Practice. You knew that you would have no control over the disclosure of those records, which were now in the possession of the new practice owner. It would therefore have been apparent to you that you would not have succeeded in deliberately misleading the GDC and that any attempt to have done so would have had far more serious regulatory consequences for you. In the Committee's judgment, it is more likely that you simply did not take the GDC's requests as seriously as you should have done and that you did not exercise the care and diligence expected of you when responding to the GDC to disclose the records and when later "assuring" the GDC that all the records had been provided. You should have taken more care to ensure that the records which you were providing to the GDC were complete, or in any event to have identified to the GDC that further records existed. As the Committee has found proved, this raises issues regarding your professionalism and integrity. Dishonesty is not however established on the evidence before the Committee as being any more likely than carelessness and a lack of professionalism. Accordingly, the Committee this charge not proved.
21.	*In the patients [sic] notes you recorded "extremely nervous treat like a baby. (GM) 2 Kids G=30 .B=29.. **[REDACTED]**".*

	Admitted and found proved.
22.	*Your conduct at 21 was unprofessional.* **Found proved.** You explained that you had made this note to remind yourself that Patient A was a nervous patient and to prompt you in respect of matters which you could use to engage in conversation with her, to make her feel at ease. In the Committee's judgment, there was nothing objectionable about recording "*extremely nervous*", as this was information which was relevant to her clinical care. Recording the fact that she had two children (and their gender and ages) and the first name of her boyfriend was also capable of having a legitimate purpose of being information which could be used to initiate conversation with her, so as to put her at ease. In the Committee's judgment, your note "*treat like a baby*" was however objectionable. It was a statement which was open to interpretation and which a patient was in any event likely to be offensive to the patient. Patient A was indeed offended to learn that this had been recorded in her clinical notes. The Committee accepted that English is not your first language and the note you made was a clumsy attempt at recording that the patient should be treated gently and with care. The note however was inappropriate and unnecessary in terms of Patient A's clinical care, as it added nothing to the note already entered that she was "*extremely nervous*". Any clinical note made by a dental professional must be phrased appropriately and be relevant to the clinical care of the patient. In the Committee's judgment, your conduct in recording "*treat like a baby*" in Patient A's clinical notes was unprofessional. Accordingly, the Committee found this charge proved.

We move to Stage"

On 4 October 2022 the Chairman announced the determination as follows:

"Mr Manan,

Patient A attended you in 2018 for root canal treatment at her UL5, having been referred to you by her general dental practitioner. You failed to provide an appropriate standard of care to her in respect of the tooth. You failed to disinfect and obturate the tooth adequately, you failed to use a rubber dam during treatment to protect the tooth from contamination from other parts of the oral cavity, and you failed to identify (both at the pre-treatment investigation stage and during the

treatment itself) the presence of a second canal. That second canal therefore remained untreated. There were also failings in your radiography and record keeping.

In respect of the canal which you attempted to treat, part of an instrument fractured during the treatment and remained in the tooth. The Committee recognised that an instrument fracturing during treatment and remaining in the tooth was a clinical incident which can simply occur during treatment: it is not necessarily the result of any act of negligence or lack of competence from the practitioner. The Committee was therefore not critical of you in respect of this clinical incident itself. However, you had failed to inform Patient A that the instrument had fractured during treatment and that the fractured piece remained stuck inside her tooth. You therefore did not inform her of the influence this would have on the expected success of the root canal treatment (and did not also discuss the available treatment options). This was in breach of the professional duty of candour to which you were subject.

You stated that the reason you did not inform Patient A of the fractured instrument was because she was a nervous patient with a chronic health condition which would have been made worse by stress. You considered the risk of any complications arising from the fractured instrument to be low and did want not to cause her unnecessary worry and distress. You instead decided to monitor the tooth and only to inform her of the situation if complications were to develop. However, this in no sense whatsoever would have provided any justification for not complying with the duty of candour. Patient A had the fundamental right to know that an instrument had fractured in her tooth during the treatment and that the fractured part of the instrument remained stuck inside her tooth. She had the right to be informed of the influence this would have on the expected success of the root canal treatment and the available treatment options. She had the right to decide on the next steps she wanted to take, including whether to continue to be treated by you. Your conduct in not informing her was unprofessional and lacked integrity.

Patient A later consulted another dentist who identified that you had failed to treat a second canal at the tooth and had left a fractured instrument in the canal that you did treat. Patient A submitted a written complaint to you regarding these matters. You failed to respond to her complaint in accordance with the GDC's standards on complaints handling, as you had failed to provide her with a copy of your complaints procedure when responding to the complaint. You also failed to provide her with a substantive response to the complaint, as the response you ultimately provided (an earlier response appeared to have been sent by you but was not received by Patient A) was simply a compliments slip with "my apologies for any inconvenience caused GM" written across it and attaching a cheque refunding the £400 she had paid for the treatment.

Patient A escalated her concerns to the General Dental Council (GDC). In addition to the clinical matters, the concerns also included allegations of inappropriate comments of a sexual nature which she alleged you had made to her and to her

partner at the initial appointments with you. The GDC commenced an investigation into your fitness to practise.

By letter dated 3 December 2019 you wrote to Patient A seeking 'an out of court settlement to save time and money' by paying £7,500 in addition to £2,500 for the costs of an implant. In related email correspondence on 18 December 2019 you asked her to withdraw her allegations of sexual misconduct as part of that financial settlement.

It was open to you to seek to reach a financial settlement with Patient A in respect of pending civil litigation over the clinical matters. However, it was unprofessional and lacking in integrity for you to have also asked Patient A to withdraw her allegations of sexual misconduct as part of that financial settlement. She had made serious allegations of sexual misconduct against you which, as you knew, were being investigated by your regulatory body. You had communicated with her in this way with the objective of influencing the outcome of the GDC's proceedings relating to you.

The inappropriate comments of a sexual nature which Patient A alleged you had made were considered by the Committee as part of the factual inquiry. The Committee found proved (as admitted by you) that you had said to Patient A "*How do you look so young?*" but did not find proved the more serious comments she alleged against you.

You had also recorded in Patient A's notes for the initial appointment: *"extremely nervous treat like a baby…".* Your part of the note "*treat like a baby*" was unprofessional. As stated by the Committee in its findings of fact determination: "*Any clinical note made by a dental professional must be phrased appropriately and be relevant to the clinical care of the patient.*"

As part of its investigation into your fitness to practise, the GDC asked you to provide typed transcripts of your handwritten clinical notes, as your handwritten notes were difficult to read. The typed transcripts you provided on or around May 2019 and January 2020 were inaccurate, as they either omitted text contained in the handwritten notes or added text which was not contained in the handwritten notes. This was objectively misleading to the GDC, as it had the potential to cause the GDC to conclude as part of its investigation into your fitness to practise that the typed transcripts were an accurate transcript of the original notes. In February 2020 you had also informed the GDC that you had provided it with all the documents relating to Patient A and that there were no documents remaining, when in fact you knew there would have existed a set of records which had not been disclosed to the GDC.

The Committee accepted that your conduct when responding to the GDC on these matters was not dishonest but was instead the result of recklessness and a failure to have treated the GDC's requests as seriously as you should. When responding to the GDC you had failed to exercise the level of care and diligence which was expected of you as a professional. In that regard, the Committee found that you had

therefore failed in your duty to cooperate with the GDC's investigation and that your conduct was therefore unprofessional and lacking in integrity.

Stage two of the hearing 3-4 October 2022

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

The Committee had regard to the remediation evidence which you put before it, consisting of your Continuing Professional Development (CPD) record, two supportive references from professional peers and a reflective statement. You did not give oral evidence to the Committee at this stage of the proceedings.

During the course of these proceedings, you had lawfully practised dentistry in Ghana, where you had also undertaken charitable work in relation to the provision of healthcare services in this region.

Fitness to practise history

Your GDC registration was subject to an order for interim suspension pending the determination of this case which, for reasons beyond your control, has regrettably taken nearly 2 years longer than initially envisaged.

On 9 February 2021 you were convicted in the Lavender Hill Magistrates' Court of eight counts relating to the unlawful practice of dentistry when your registration was suspended as a result of the order for interim suspension.

The fact of your convictions was before the Committee at this stage of the proceedings because it forms part of your regulatory history. It was the GDC's submission that your convictions mean that you can no longer be trusted to comply with any restriction on your registration and that, if the Committee were to find current impairment in respect of the facts which it has determined, erasure would be the appropriate sanction in all the circumstances of this case.

The Committee is not asked to consider your convictions as being in themselves a ground of impairment, or to otherwise impose a sanction directly in response to those convictions. These would be matters for another Practice Committee to decide in due course, were those convictions to be referred under the GDC's fitness to practise procedures. At present, the convictions have not been referred and are only before the Committee as a factor to consider when deciding (if it reaches that stage) the questions of impairment and sanction in respect of the facts found proved relating to your care and treatment of Patient A and your responses to her complaint and to the GDC's ensuing investigation.

The certified memorandum of conviction was the only document before the Committee relating to the convictions. It records that six of the counts in respect of

which you were convicted were for carrying out dental treatment on a total of three patients at the Morden and Wandsworth Practices (and potentially a third address), contrary to section 38 of the Dentists Act 1984. The date(s) on which these offences were committed is not specified in the terms of the memorandum of conviction. The remaining two counts were recorded as being for receiving cash payments for dental treatment from two people on 5 November 2019, thus carrying on the business of dentistry contrary to section 41 of the Dentists Act 1984. You were fined £500.00 for each of the eight counts, ordered to pay costs totalling £5000.00, a victim surcharge of £181.00 and compensation to two victims totalling £320.00.

Mr McDonagh (who had not acted for you in the criminal proceedings) initially submitted to the Committee that, as instructed by you, your convictions involved an "isolated" incident where you had booked a family for the completion of their treatment with a locum, but that the locum did not "turn up" and so you treated the family yourself in response to pressure from them. When referred by the Committee to the terms of the memorandum of conviction, which refers to the patients being treated from more than one practice address, Mr McDonagh said he was unable to provide the Committee with any further detail or clarity as to the nature of the offending for which you were convicted.

The Committee had regard to Rule 57 of the General Dental Council (Fitness to Practise) Rules 2006, which provides that:

(5) Where a respondent has been convicted of a criminal offence—

(a) a copy of the certificate of conviction, certified by a competent officer of a court in the United Kingdom (or, in Scotland, an extract conviction) shall be conclusive proof of the conviction; and

(b) the findings of fact upon which the conviction is based shall be admissible as proof of those facts

There was no dispute that you were the person referred to in the memorandum conviction and that you had received the convictions in question. You pled guilty to all eight charges. The Committee accepted the terms of the memorandum of conviction as establishing that you had been convicted of six counts providing dental treatment to three patients from at least two different practice addresses and that you had unlawfully received cash payments for dental treatment from two people on 5 November 2019. The Committee therefore did not accept that your criminal offending related to an isolated occasion when a locum did not "turn up" to treat a family, as your offending took place in at least two different dental practices.

Prior to these regulatory proceedings and your convictions, you had an unblemished record over a long practising career.

The Committee heard the submissions of both counsel in respect of Stage Two of these proceedings. Ms Deignan, on behalf of the GDC, submitted that the facts found proved amount to misconduct, that your fitness to practise as a dentist is

currently impaired by reason of that misconduct and that the appropriate outcome in this case is erasure. Mr McDonagh, on your behalf, did not resist a finding of misconduct and impairment and submitted that conditions of practice, with a review, would be the appropriate outcome in this case, with conditions requiring you to work under supervision to complete your remediation. He provided a reference from another practitioner who would be willing to act as your supervisor.

Decision

The Committee accepted the advice of the Legal Adviser.

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

Misconduct

The first consideration for the Committee was whether the facts found proved amount to misconduct. Misconduct connotes a serious departure from the standards reasonably expected of a dental professional. In assessing whether the facts found proved meet this threshold, the Committee had regard to the following principles from the GDC's *Standards for the Dental Team* (September 2013)

1.1 You must listen to your patients

1.1.1 You must discuss treatment options with patients and listen carefully to what they say. Give them the opportunity to have a discussion and to ask questions.

1.3 You must be honest and act with integrity

1.3.1 You must justify the trust that patients, the public and your colleagues place in you by always acting honestly and fairly in your dealings with them. This applies to any business or education activities in which you are involved as well as to your professional dealings.

1.3.2 You must make sure you do not bring the profession into disrepute

4.1 You must make and keep contemporaneous, complete and accurate patient records

4.1.1 You must make and keep complete and accurate patient records, including an up-to-date medical history, each time that you treat patients.

Radiographs, consent forms, photographs, models, audio or visual recordings of consultations, laboratory prescriptions, statements of conformity and referral letters all form part of patients records where they are available.

4.1.2 You should record as much detail as possible about the discussions you have with your patients, including evidence that valid consent has been obtained. You should also include details of any particular patient's treatment needs where appropriate.

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

5.1.1 It is part of your responsibility as a dental professional to deal with complaints properly and professionally. You must:

- ensure that there is an effective written complaints procedure where you work;
- follow the complaints procedure at all times;
- respond to complaints within the time limits set out in the procedure; and
- provide a constructive response to the complaint.

5.3 You must give patients who complain a prompt and constructive response

5.3.1 You should give the patient a copy of the complaints procedure when you acknowledge their complaint so that they understand the stages involved and the timescales.

7.1 You must provide good quality care based on current evidence and authoritative guidance

7.1.1 You must find out about current evidence and best practice which affect your work, premises, equipment and business and follow them.

9.4 You must co-operate with any relevant formal or informal inquiry and give full and truthful information.

The Committee also had regard to the professional duty of candour, as discussed in the findings of fact determination.

Your clinical failings resulted in actual harm to Patient A and are compounded by your breach of your duty of candour with her and your ensuing failure to have responded to her complaint adequately and in accordance with the GDC's standards on complaints handling. The duty of candour is a fundamental tenet of the profession and your breach of it was unprofessional and lacking integrity, as was your conduct in relation to asking Patient A to withdraw her allegations of sexual misconduct and also when responding to the GDC's requests in relation to Patient A's dental records. Such conduct is a serious departure from basic professional standards and has the potential to bring the profession into disrepute. A lack of integrity in any professional person is a serious matter, as it undermines the confidence the public and the profession can place in the practitioner in terms of compliance with the higher ethical and professional standards to which they are subject.

The Committee was satisfied that the facts found proved were serious and amounted to serious breaches of the above quoted standards.

The Committee determined that the facts found proved amount to misconduct.

Impairment

The Committee next considered whether your fitness to practise as a dentist is currently impaired by reason of your misconduct.

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

The Committee considered that you have demonstrated only very limited insight into the failings which the Committee had found proved, notwithstanding the period of time which has passed since the commencement of these proceedings and also since the Committee's announcement of the findings of fact on 16 September 2022. Your reflective statement is cursory and does not provide any detailed or meaningful reflection on your failings. Your CPD record is only partially targeted towards the issues raised in this case and there was minimal or no evidence of any reflection by you on your learning from each activity. For each CPD activity you were invited to record your reflection and learning as part of your CPD record, but had left these sections almost completely blank. The electronic log of the time spent on an online CPD activity shows that you had only spent a matter of seconds on some of the lessons for that CPD activity, suggesting that any benefit you gained from it would have been limited. The Committee judged your CPD record to be poor in the context of the remediation required.

The CPD activities you had undertaken were also not recent.

The Committee rejected the submission made on your behalf that your ability to undertake and complete CPD was hindered by your practising mainly in Ghana. The Committee was not persuaded that there was anything that prevented you from continuing to complete CPD online and from setting out detailed and meaningful written reflections on your learning from each activity and how you would it embed it in your practice. Nothing would have prevented you from completing attended CPD events on the occasions you had returned to the United Kingdom during the course of your interim suspension. As to that, the Committee noted you instead received eight convictions for the unlawful practice of dentistry.

The Committee also identified a lack of any audits on your practice demonstrating any embedded improvement in your practice. You could have undertaken such audits yourself whilst practising in Ghana, as evidence of steps towards your remediation in relation to your clinical, record keeping and radiography failings. The Committee considered such failings to be clearly remediable with targeted learning, reflection and evidence of embedded improvement in practice, but there is a lack of adequate evidence of any such remediation.

Your attitudinal failings, relating to your unprofessional conduct and your lack of integrity, are more difficult to remedy in the Committee's judgment. These matters go

to your character and encompassed both your interactions with Patient A and also with your regulatory body. There is no evidence of any structured steps towards remediation, such as mentorship or peer-based discussion. There is little evidence of any meaningful reflection by you on your unprofessional conduct and lack of integrity and the impact this had on Patient A and on the GDC's ability to discharge its regulatory functions. There has been no meaningful reflection by you on how your actions had the potential to bring the profession into disrepute and to otherwise undermine public confidence in the profession and in the GDC's regulatory role. The Committee noted that rather than provide adequate evidence of remediation you had instead received eight convictions relating to the unlawful practice of dentistry by breaching the interim suspension order imposed on you during the course of these proceedings.

In the Committee's judgment, the lack of evidence of full remediation means that there is a risk of harm to the public should you be allowed to practise without restriction. Public confidence in the profession and in this regulatory process would also be seriously undermined if no finding of impairment were to be made. The Committee considered you had put Patient A at an unwarranted risk of harm and had caused actual harm to her and that you are liable to do so again with patients in the future. You had also acted in a way which was liable to bring the profession into disrepute through your lack of integrity, particularly in relation to your failure to comply with the duty of candour, and that you are liable to demonstrate a lack of integrity again in the future.

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

Sanction

The purpose of a sanction is not to be punitive, although it may have that effect, but to protect the public and the wider public interest.

In deciding on what sanction, if any, to impose on your registration, the Committee had regard to the aggravating and mitigating features present in this case.

The aggravating features present include actual harm caused to Patient A, a breach of her trust in respect of your failure to have complied with the duty of candour, limited remediation and insight demonstrated at this stage of the proceedings and a blatant or wilful disregard of the role of the GDC and the systems regulating the profession. Your convictions for unlawful practice that took place whilst these proceedings were ongoing are also an aggravating factor, undermining your trustworthiness, and demonstrating a disregard for regulatory orders.

In mitigation the Committee recognised that there has been some expression of remorse by you, that you have taken some steps towards remediation, that you had attended and engaged fully in the hearing, and that you have no previous fitness to practise history.

The Committee considered the question of sanction in ascending order of severity.

To conclude this case with no action and reprimand would be wholly inappropriate in the Committee's judgment, given the seriousness of your misconduct and the lack of remediation which you demonstrate. Taking no further action or issuing a reprimand would not protect the public and meet the wider public interest.

The Committee next considered whether conditions of practice could be formulated which would be workable, measurable and proportionate. The Committee considered that conditions of practice might be appropriate to address the clinical concerns in this case. However, the Committee could not identify conditions of practice which could be formulated to address the behavioural issues identified in this case. The Committee determined that conditions of practice would not in any event be sufficient to mark the seriousness of those non-clinical aspects of your misconduct. Further, the Committee could not place its trust in you to comply with conditions on your practice in light of your convictions for illegally practising dentistry in breach of the interim suspension order which was made as part of these proceedings. In the Committee's judgment there appear to be deep seated underlying professional attitudinal problems relating to your failure to take the role of the GDC seriously.

The Committee next considered whether to direct that your registration be suspended for a period of up to 12 months, with or without a review. In the Committee's judgment, suspension would not be sufficient to maintain public confidence in the profession and this regulatory process. This is because of your breaches of the interim suspension order which resulted in your receiving eight convictions relating to the unlawful practice of dentistry. Such conduct, whatever the precise details of your offending, was truly extraordinary and wholly unacceptable from a regulatory perspective. It is conduct which destroys the ability of the public, the profession and the GDC as regulator to trust you to comply with any restriction on your registration, including a period of suspension. In reaching its decision, the Committee was mindful that protecting the reputation of the profession outweighs your personal interests. The Committee considered the facts relating to your misconduct would not in themselves ordinarily result in the ultimate sanction of erasure. However, the consequence of your criminal convictions, coupled with your misconduct in the present case, where you had repeatedly acted with a lack of integrity, along with your lack of any full or meaningful remediation, makes erasure the only appropriate and proportionate outcome. In the Committee's judgment no lesser sanction would be sufficient to protect the public and to maintain public confidence in the profession and in this regulatory process.

Accordingly, the Committee directs that your name be erased from the Register.

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

"Mr Manan,

In reaching its decision on whether to impose an immediate order of suspension on your registration, the Committee took account of the application of Ms Deignan that such an order should be imposed. Mr McDonagh made no submissions in response to the GDC's application but asked the Committee to note that consistency was not a basis for imposing an immediate order. The Committee accepted the advice of the Legal Adviser.

The Committee determined that it is necessary for the protection of the public, and is otherwise in the public interest, to impose an immediate order of suspension on your registration. In its substantive determination, the Committee identified a lack of full remediation on your part, and also raised serious concerns about your integrity and your trustworthiness in complying with regulatory orders. It therefore considered that there would be a risk to the safety of patients if you were to return to unrestricted practice. The substantive order of erasure, as directed by the Committee, will not come into effect until after the 28-day appeal period, or longer, in the event of an appeal. In the circumstances, the Committee was satisfied that an immediate order of suspension is necessary for the protection of the public.

The Committee also considered that the imposition of an immediate order is in the wider public interest. Serious findings have been made against you, and the Committee has imposed the highest sanction, to erase your name from the Dentists Register. The Committee considered that, in these circumstances, public confidence in the dental profession and the regulatory process would be undermined in the absence of an order suspending your registration immediately.

The effect of the foregoing determination and this order is that your registration will be suspended to cover the appeal period. Unless you exercise your right of appeal, the substantive direction for erasure, will take effect 28 days from the date of deemed service. Should you exercise your right of appeal, this immediate order will remain in place until the resolution of the appeal.

The interim order currently on your registration is hereby revoked.

That concludes this determination."