General
Dental
Council

HEARING HEARD IN PUBLIC

The Committee has made a determination in this case that includes some private information. That information has been omitted from the text.

MOFFAT, Noel George Robert

Registration No: 60367

PROFESSIONAL CONDUCT COMMITTEE

MAY 2021

Outcome: Erased with immediate suspension

MOFFAT, Noel George Robert, a dentist, BDS Sydney 1972, was summoned to appear before the Professional Conduct Committee on 4 May 2021 for inquiry into the following charge:

Charge (as amended on 5 May 2021)

"That, being a registered dentist:

1. In 2009, you failed to co-operate with a Police investigation into your NHS claiming in that:
   (a) on 2 September 2009, you were asked to attend Basingstoke Police Station on 11 September 2009 for interview in relation to a criminal investigation;
   (b) you indicated that you would attend;
   (c) you were informed that should you not attend you would be circulated as a wanted person and liable to arrest;
   (d) on 3 September 2009 you flew to Australia and did not attend the interview.
2. In an application form to be restored to the GDC register signed by you on 22 September 2010, you ticked '*no*' to the question '*Have you been convicted of a criminal offence or cautioned or are you currently the subject of any police investigations which might lead to a conviction or a caution in the UK or any other country?*', and signed a declaration that the information contained in the application was true to the best of your knowledge and belief.
3. Your conduct in relation to paragraph 2 above was:
   (a) misleading; and/or
   (b) dishonest, in that:
      (i) you knew that your answer to the question as set out above in paragraph 2 was inaccurate and/or untrue;
      (ii) it was intended to mislead as to your suitability for restoration to the General Dental Council's Dentists' Register; and/or to avoid further investigation into your suitability for restoration to that register.
4. In applications to join Southwark and Lambeth PCT Performers Lists dated 2 November 2010 and 3 November 2010, you:

(a) answered '*no*' to the question '*are you currently the subject of any proceedings which might lead to such a conviction, which have not yet been notified to the Primary Care Trust*';

(b) answered '*no*' to the question of whether you had been removed from any list kept by a PCT or equivalent body, despite having been removed from the Performers Lists of West Sussex PCT and Hampshire PCT in January and March 2010;

(c) signed a declaration that the information contained in the application forms was true to the best of your knowledge and belief.

5. Your conduct in relation to paragraph 4 (a), (b) and (c) above was:

(a) misleading, and/or

(b) dishonest, in that:

(i) you knew that your answers to the questions as set out above in paragraphs 4 (a) and (b) were inaccurate and/or untrue;

(ii) it was intended to mislead as to your suitability for admission to the Performers Lists of Southwark and Lambeth PCTs, and/or to avoid further investigation into your suitability for admission to the performers list(s).

6. In an application to join South East London Dental Performers List in October 2012, you:-

(a) answered '*no*' to the question '*are you currently the subject of any proceedings which might lead to such a conviction, which have not yet been notified to the Primary Care Trust*'.

(b) answered '*no*' to the question of whether you had been removed from any list kept by a PCT or equivalent body, despite having been removed from the Performers Lists of West Sussex PCT and Hampshire PCT in January and March 2010.

(c) signed a declaration that the information contained in the application form was true to the best of your knowledge and belief.

7. Your conduct in relation to paragraph 6 (a), (b) and (c) above was:

(a) misleading, and/or

(b) dishonest, in that:

(i) you knew that your answers to the questions as set out above in paragraphs 6 (a) and (b) were inaccurate and/or untrue;

(ii) it was intended to mislead as to your suitability for admission to the South East London Dental Performers List, and/or to avoid further investigation into your suitability for admission to that Performers List.

8. You practised at the dental practice identified in Schedule 1 below between 2011 and 2014, and treated the patients identified in Schedule 2 below.

9. Between 2012 and 2013, you failed to provide an adequate standard of care to:-

(a) As amended - Patient A, in that between 24 July 2012 to 13 March 2013 you failed to create a treatment plan in relation to the provision of crowns for UR1 and UL6.

(b) Patient C, in that between 24 May 2012 and 27 November 2013 you failed to root treat LL6 in a timely manner.

(c) Patient D, in that:-

(i) on 8 August 2012 you failed to review UR6 and UR7 following previous pathology and symptoms;

(ii) As amended - between 13/9/13 and 20/11/13 failed to provide a root treatment to UR5 before restoration of that tooth.

(d) Patient F, in that on 24 January 2013, you failed to discuss and/or record discussion of the risks and/or benefits of leaving the root of UL2 in place when proposing treatment of a cantilever bridge off UL3 to replace UL2.

(e) Patient I, in that:-

(i) on 29 August 2012 and 18 September 2012, you failed to carry out and/or record an adequate examination;

(ii) between 20 November and 12 December 2012, you failed to inform the patient and/or record that the patient had been informed that the root filling done on 20 November 2012 was sub-optimal and that she had the option of being referred for specialist treatment;

(iii) on 5 June, you failed to review and/or record a review of the gum infection previously treated on 10 May 2013.

(f) Patient P, in that between 30 August 2013 and 28 November 2013, you failed to provide root canal treatment for UL2 and UL3 prior to restoring them.

(g) Patient T, in that you did not treat LR5 prior to preparing the tooth for inlay on 26 September 2013.

(h) Patient U, in that on 31 January 2012 and/or 29 May 2013 and/or 31 October 2013, you failed to provide and/or record oral hygiene instruction (OHI) or dietary advice.

10. You failed to record a radiographic report in respect of the patients and appointments set out in Schedule A[1].

11. You failed to provide an adequate standard of care by failing to take necessary pre treatment radiographs in respect of the patients and appointments set out in Schedule B.

12. You failed to provide an adequate standard of care by prescribing antibiotics which were not clinically justified and/or necessary in respect of the patients and appointments set out in Schedule C.

13. You failed to provide an adequate standard of care by failing to adequately diagnose and treat caries in respect of the patients and appointments set out in Schedule D.

[1] The schedules are private and cannot be disclosed

14. You failed to maintain an adequate standard of record keeping between 2012 and 2013 in respect of the patients set out in Schedule E.

15. From 28 November 2018 to 17 January 2019 you failed to fully cooperate with an investigation conducted by the GDC by not agreeing to a health assessment and/or providing the GDC with a health report from your consultant.

16. Between 1 and 24 September 2020, you failed to fully cooperate with an investigation conducted by the GDC's solicitors by not agreeing to a health assessment or to the disclosure of your medical records.

And, by reason of the facts stated, your fitness to practise as a Dentist is impaired by reason of your misconduct."

As Mr Moffat did not attend and was not represented at the hearing, the Chairman made the following statement regarding proof of service on 4 May 2021:

"Decision on service of the Notification of Hearing

The Committee first considered whether notice of the hearing had been served on Mr Moffat in accordance with Rules 13 and 65. It received a bundle of documents containing a copy of the Notification of Hearing letter, dated 18 March 2021. Also contained within the bundle was a Royal Mail 'Track and Trace' receipt confirming that the letter was sent to Mr Moffat's registered address by Special Delivery. The Committee took into account that there is no requirement within the Rules for the GDC to prove receipt of the letter. However, it noted from the 'Track and Trace' information that the letter was delivered and signed for at Mr Moffat's registered address on 19 March 2021. A copy of the letter was also sent to him by email.

The Committee was satisfied that the Notification of Hearing letter of 18 March 2021 contained proper notification of the hearing, including its start date, time and venue, as well as notification that the Committee could proceed with the hearing in Mr Moffat's absence. On the basis of the information provided to it, the Committee was satisfied that notice of the hearing had been served on Mr Moffat in accordance with the Rules.

Decision on whether to proceed with the hearing in the absence of Mr Moffat

The Committee next considered whether to exercise its discretion under Rule 54 of the Rules to proceed with the hearing in the absence of Mr Moffat and/or any representative on his behalf. It approached the issue with the utmost care and caution, noting his right to attend and participate. The Committee had regard to the factors to be considered in reaching its decision as set out in the case of *R v Jones [2003] 1 AC 1HL,* and the public interest considerations referred to in *Adeogba v GMC [2016] EWCA CIV 162* as well as the obligation on professionals to engage with their regulator. It took into account that fairness to Mr Moffat was of primary importance, but also remained mindful of the need to be fair to the GDC. The Committee also took into account the public interest in dealing with Mr Moffat's case expeditiously.

The Committee was mindful that factual allegations relate to issues going back to 2009. This case has a long history involving wide ranging concerns.

The Committee noted that Mr Moffat's son responded on his behalf via an email to the GDC on 8 June 2020 where he stated that *"He is not of age nor health to be able to adequately*

assess or defend these allegations. [PRIVATE]. As well and to re-state, he is not of financial means to be able to hire the necessary legal counsel to be able to advise him and so is further unable to assess properly or adequately defend these allegations. From my perspective, it is disappointing, even wrong that the GDC feel that running a case against someone who is not able to adequately defend themselves is right and proper in this instance."

His son responded on Mr Moffat's behalf in a further email dated 26 February 2021 where he stated "*[PRIVATE]. Additionally, dad has neither the sufficient savings nor necessary funds that would be required for a legal defence of the case brought against him either. He is in no position to adequately defend himself nor afford to be defended in the case the GDC has brought against him and so on that basis, he will not be attending. Should the GDC choose to proceed regardless, then the reasons for my father's non-attendance set out in this letter should be noted on record. Additionally, we have previously made an application on the 5th February 2020 for him to retire permanently and have his name removed from the GDC register and he undertook at that time not to work again*".

The Committee noted that there has not been a request to adjourn these proceedings from the registrant or by his son. The Committee was satisfied from the information before it, that Mr Moffat had been aware of the current hearing and had formal notice of the hearing from at least 18 March 2021. It noted the last communication, made on 26 February 2021, *[PRIVATE].* The Committee also noted that the email from Mr Moffat's son states that his father is now retiring permanently and requests to have his name removed from the register. The Committee however was aware that the GDC has a policy of non-permitting voluntary erasure when the PCC proceedings are in progress.

Having considered all the information before it and the recent response from Mr Moffat's son, it was satisfied that Mr Moffat had voluntarily decided not to attend the hearing. *[PRIVATE].* The Committee considered that Mr Moffat had had several opportunities to ask the GDC for an adjournment, but there was no indication that he made such a request. In the circumstances, the Committee concluded that it was unlikely that an adjournment of the hearing would secure Mr Moffat's attendance on a future occasion.

The Committee was satisfied that in effect that Mr Moffat had chosen to disengage with the process. The Committee was mindful that all professionals have an obligation to engage with their regulator, and that it would run entirely counter to the protection, promotion and maintenance of the health and safety of the public if a practitioner could effectively frustrate the regulatory process. Bearing in mind the age, number and complexity of the allegations and the public interest in the expeditious conduct of the GDC's regulatory function, the Committee had no hesitation that it was fair and in the interests of justice for the hearing to proceed in the absence of Mr Moffat."

On 4 May 2021 Ms Culleton, (Counsel for the GDC) made an application under Rule 25. The Chairman made the following response:

"Ms Culleton on behalf of the GDC made an application under Rule 25 for particulars of allegations relating to these matters to be included in the main set of charges. Ms Culleton submitted that the GDC is of the view that these issues fall within the provisions of Rule 25 of the *General Dental Council (Fitness to Practise) Rules Order of Council 2006* (as amended) ("the Rules"). She submitted that they are matters of a similar kind to the existing concerns, and/or are founded on the same alleged facts as the Case Examiner referral to

the Professional Conduct Committee dated 7 July 2020. These relate to Mr Moffat's 2010 and 2012 applications to join the performers list and associated misleading / dishonest conduct by not disclosing information, and his failure to engage with the GDC's investigations regarding his health.

The allegations that are requested to be joined are as follows:

"That, being a registered dentist:

1. In applications to join Southwark and Lambeth PCT Performers Lists dated 2 November 2010 and 3 November 2010, you:
    (a) answered '*no*' to the question of whether you had been removed from any list kept by a PCT or equivalent body, despite having been removed from the Performers Lists of West Sussex PCT and Hampshire PCT in January and March 2010;
2. Your conduct in relation to paragraph 1 (a) above was:
    (a) misleading, and/or
    (b) dishonest, in that:
        (i) you knew that your answer to the question as set out above in paragraph 1 (a) was inaccurate and/or untrue;
        (ii) it was intended to mislead as to your suitability for admission to the Performers Lists of Southwark and Lambeth PCTs, and/or to avoid further investigation into your suitability for admission to the performers list(s).
3. In an application to join South East London Dental Performers List in October2012, you:
    (a) answered '*no*' to the question of whether you had been removed from any list kept by a PCT or equivalent body, despite having been removed from the Performers Lists of West Sussex PCT and Hampshire PCT in January and March 2010.
4. Your conduct in relation to paragraph 3 (a) above was:
    (a) misleading, and/or
    (b) dishonest, in that:
        (i) you knew that your answer to the question as set out above in paragraph 3 (a) was inaccurate and/or untrue;
        (ii) it was intended to mislead as to your suitability for admission to the South East London Dental Performers List, and/or to avoid further investigation into your suitability for admission to that Performers List.
5. Between 1 and 24 September 2020, you failed to fully cooperate with an investigation conducted by the GDC's solicitors by not agreeing to a health assessment or to the disclosure of your medical records.

The Committee took into account the provisions relating to Joinder that are set out in Rule 25(2) of the Rules. So far as is relevant, they are as follows;

"*Where* –

(a) an allegation against a respondent has been referred to a Practice

Committee,

(b) that allegation has not yet been heard, and

(c) a new allegation against the respondent which is of a similar kind or is founded on the same alleged facts is received by the Council, the Practice Committee may consider the new allegation at the same time as the original allegation, notwithstanding that the new allegation has not been included in the notification of hearing."

The Committee considered the submissions made by Ms Culleton carefully and accepted the advice of the Legal Adviser regarding the general principles to be taken into account when considering this type of application, as well as the relevant provisions set out in the Rules.

The Committee noted that Mr Moffat was served notice on the GDC's Rule 25 application on 18 March 2021 by solicitors acting on behalf of the GDC. To date no response has been received from Mr Moffat. The Committee is satisfied that appropriate notice has been given to Mr Moffat

The Committee is satisfied that joinder of the additional allegations relating to applications to join Southwark and Lambeth PCT Performers Lists and a failure to cooperate with the GDC's solicitors are very similar in nature to the existing allegations and appear to be founded upon the same facts.

The Committee is satisfied that it is appropriate and that the requirements of Rule 25(2)(c) have been met. The Committee therefore considers that it is in the public interest and also in Mr Moffat's own interests for these allegations to be considered at the same time as the original allegations.

Accordingly, the Committee directs that the new referral against Mr Moffat be joined and heard together at this hearing."

On 19 May 2021 the Chairman made the following statement regarding the finding of facts:

"Ms Culleton

Background

This case involves wide ranging allegations including clinical concerns, failure by Mr Moffat to co-operate with the GDC's investigation in respect of enquiries about his health, his failure also to co-operate with a police investigation in 2009 and instead to flee the country and also dishonest representations made on application forms to join the GDC register in 2010 and PCT Performers Lists in 2010 and 2012.

There are also heads of charges relating to his alleged poor care and treatment in respect of 16 patients. On 18 December 2014 [redacted], the principle of Highgate House Dental Practice Bedlington, ("The Practice") reported to the GDC that he had concerns about the clinical care which had been provided by Noel Moffat at the practice where Mr Moffat had been employed between 2011 and 2014. These concerns had only come to light after Mr Moffat left the Practice and were flagged up by the subsequent GDP who took over the care of the patients Mr Moffat had been treating. The complaint was assessed in 2019 by the Fitness to Practise department and the matter referred to the Case Examiners who, in July

2020, determined that the allegations they had considered should be further considered by a Professional Conduct Committee.

Evidence

The Committee received a substantial amount of documentary evidence which included some of the clinical records in respect of the 14 patients and various radiographs where relevant.

The Committee received a written statement and heard oral evidence from 3 Prosecution witnesses, Detective Inspector (DCI) Margrie, DCI Kenny, Mr Joyce Senior Professional Standards Manager for the London region NHS England. The Committee also received expert evidence from Ms Hilary Firestone, called by the GDC. She produced an expert report dated 1 November 2020 and also gave oral evidence.

The Committee received written statements from Ms V Brazier a GDC Case Manager dated 20 November 2020, Ms Dominguez a GDC Registration Case Manager dated 12 November 2020, and Ms Holdsworth Capsticks Solicitor dated 20 November 2020.

Issue of dishonesty

In considering all those charges which allege dishonesty, the Committee has applied the same civil standard of proof namely on the balance of probabilities.

It has applied the test for dishonesty set out at paragraph 74 of the judgement of the Supreme Court in the case of Ivey v Genting Casino (UK) (Ltd (t/a Crockfords) [2017] UKSC 67. "*When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest."*

The Committee has taken into account all the evidence presented to it. It has accepted the advice of the Legal Adviser. In accordance with that advice, it has considered each head of charge separately.

I will now announce the Committee's findings in relation to each head of charge:

1.	*In 2009, you failed to co-operate with a Police investigation into your NHS claiming in that:*
1. a)	*on 2 September 2009, you were asked to attend Basingstoke Police Station on 11 September 2009 for interview in relation to a criminal investigation;* **Found proved.** The Committee accepted the written and oral evidence of DCI Margrie who confirmed that he spoke to Mr Moffat on the telephone on 2 September 2009 requesting him to attend an interview for 11 September 2009. This was acknowledged by Mr Moffat in the letter through his previous representatives, Hempsons dated 6 November 2013.

	The Committee is satisfied that Mr Moffat was asked to attend an interview on 11 September 2009 and therefore finds this head of charge proved.
1. b)	*you indicated that you would attend;* **Found proved.** The Committee accepted the evidence of DCI Magrie and in particular his written statement, confirming that Mr Moffat had informed DCI Magrie that he would attend the interview. DCI Magrie supported this in his oral evidence, which the Committee found to be clear and concise. The Committee is satisfied that Mr Moffat had indicated that he was going to attend the interview and therefore finds this head of charge proved.
1. c)	*you were informed that should you not attend you would be circulated as a wanted person and liable to arrest;* **Found proved.** The Committee noted the written Hampshire Police statement of DCI Margrie, and in particular, "*During this phone call I requested that MOFFATT attend Basingstoke police station on Friday 11th September 2009 between 1000 and 1100 hours to answer questions in relation to a criminal investigation. I informed him at the time that should he not attend we(sic) would be circulated as a wanted person and liable to arrest. He informed me that he would attend*." The Committee also noted the letter from his former representatives, Hempsons Solicitors dated 6 November 2013 stating that Mr Moffat thought it was for a chat. The Committee having considered the evidence before it carefully, notes that when Mr Mofatt was requested to attend a Police interview Mr Moffat flew out to Australia the very next day. The Committee finds Mr Moffat's understanding, that the request was only for a chat, not plausible and therefore accepts the evidence of Detective Inspector Margrie. The Committee is therefore satisfied that Mr Moffat was informed that should he not attend he would be circulated as a wanted person and liable to arrest. The Committee finds this head of charge proved.
1. d)	*on 3 September 2009 you flew to Australia and did not attend the interview.* **Found proved.** The Committee accepted the written and oral evidence of DCI Kenny who confirmed that he checked the aeroplane manifest to confirm that Mr Moffat had flown to Australia on 3 September 2009. He also confirmed that Mr Moffat had not attended the Police interview for 11 September 2009. The Committee is therefore satisfied that Mr Moffat had flown to Australia on 3 September 2009. Accordingly, the Committee finds this head of charge proved.
2.	*In an application form to be restored to the GDC register signed by you on 22 September 2010, you ticked 'no' to the question 'Have you been*

	convicted of a criminal offence or cautioned or are you currently the subject of any police investigations which might lead to a conviction or a caution in the UK or any other country?', and signed a declaration that the information contained in the application was true to the best of your knowledge and belief. **Found proved.** The Committee had sight of a copy of Mr Moffat's restoration form to the GDC which Mr Moffat had ticked and signed a declaration on 22 September 2020. This was supported by the written statement of Ms Dominguez the GDC Registration Case Manager. The Committee is satisfied that that Mr Mofffat had ticked '*no*' to the question in section 4 and therefore finds this head of charge proved.
3.	*Your conduct in relation to paragraph 2 above was:*
3. a)	*misleading; and/or* **Found proved.** The Committee having taken into account the meaning of the word misleading, is satisfied that Mr Moffat, an experienced registrant, misled the GDC that he was not the subject of a police investigation when in fact he was. He had already confirmed to the Police that he was aware that he was the subject of a police investigation. This was supported by the oral and written evidence of DCI Margrie. Ms Dominguez stated in her written statement that "*Based on this evidence, the Registrant should have ticked "Yes" on the application form when asked about any ongoing police investigations*." The Committee was satisfied that the GDC would be misled into believing that Mr Moffat was not currently the subject of any police investigations. Accordingly, the Committee finds this head of charge proved.
3. b)	*dishonest, in that:*
3. b) i)	*you knew that your answer to the question as set out above in paragraph 2 was inaccurate and/or untrue;* **Found proved.** The Committee was referred to the case of Ivey v Genting Casinos (UK) Ltd TA Crockfords [2017] UKSC 67. It first considered the actual state of Mr Moffat's knowledge or belief of the facts. Having established that it then went onto determine whether his conduct was dishonest by the standards of ordinary, decent people. The Committee noted that Mr Moffat acknowledged in a telephone call to DCI Magrie that he was required to attend an interview and therefore he must have known that he was subject of a police investigation. He had flown out to Australia the very next day. His representative's letter 6 November 2013 confirmed that Mr Moffat was aware that the police were investigating a matter relating to him. The Committee is satisfied that Mr Moffat's state of

	mind at that time was that he knew that his declaration was inaccurate and untrue. The Committee concludes that it was reasonable to infer that, Mr Moffat who had experience of such applications forms, knew that he was the subject of a police investigation. Considering the content of the application form cumulatively, the Committee was satisfied that Mr Moffat intended to deliberately mislead the GDC. Having made this finding of fact the Committee was satisfied that his conduct was dishonest by the objective standards of ordinary decent people and finds this head of charge proved.
3. b) ii)	*it was intended to mislead as to your suitability for restoration to the General Dental Council's Dentists' Register; and/or to avoid further investigation into your suitability for restoration to that register.* **Found proved.** For the same reasons as given above in head of charge 3.b) i).
4.	*In applications to join Southwark and Lambeth PCT Performers Lists dated 2 November 2010 and 3 November 2010, you:*
4. a)	*answered 'no' to the question 'are you currently the subject of any proceedings which might lead to such a conviction, which have not yet been notified to the Primary Care Trust';* **Found proved.** The Committee had sight of a copy of Mr Moffat's application forms to join Southwark and Lambeth PCT Performers Lists dated 2 November 2010 and 3 November 2010. The forms quite clearly display a box that was ticked no and signed by Mr Moffat. The Committee took into account the comments in Mr Moffat's representative's letter stating that Mr Moffat's understanding was that he was subject to an investigation and not police proceedings. However, the Committee considered that the meaning of both was something that he should have reported on. Mr Moffat had been on the Performers List previously and was familiar with the application process. The Committee accepts the written and oral evidence of Mr Joyce, the Senior Professional Standards Manager NHS England. He confirms in his written statement stated that "*I attach the Performer's application form to join Southwark PCT Performers List dated 3 November 2010. At section 7 of this form, the Performer answered 'no' to the question 'are currently the subject of any proceedings which might lead to such a conviction, which have not yet been notified to the Primary Care Trust.' The Performer signed a declaration form (dated 3 November 2010) confirming that all the information contained in the application was true to the best of his knowledge and belief. As there were no apparent "question marks" or issues over the Performer's applications, he was successfully admitted to join the Dental Performer List of Lambeth PCT."*

	The Committee is therefore satisfied that Mr Moffat has answered no and finds this head of charge proved.
4. b)	*answered 'no' to the question of whether you had been removed from any list kept by a PCT or equivalent body, despite having been removed from the Performers Lists of West Sussex PCT and Hampshire PCT in January and March 2010;* **Found proved.** The Committee had sight of the relevant sections and noted that Mr Moffat had ticked no on both application forms. The Committee had sight of two letters from his Primary Care Trust (PCT) informing him of his removal from the list. The Committee is satisfied that he had a duty to be aware of any developments. The Committee, for the same reasons as given above in head of charge 4.a), finds this head of charge proved.
4. c)	*signed a declaration that the information contained in the application forms was true to the best of your knowledge and belief.* **Found proved.** The Committee had sight of the relevant declaration section to both application forms which clearly displays Mr Moffat's signature. The Committee therefore finds this head of charge proved.
5.	*Your conduct in relation to paragraph 4 (a), (b)and (c) above was:*
5. a)	*misleading, and/or* **Found proved.** The Committee having taken into account the meaning of the word misleading, is satisfied that Mr Moffat, an experienced registrant, misled the GDC that he has not been removed from the Performers List of West Sussex PCT and Hampshire PCT in January and March 2010 and was not subject of any proceedings which might lead to such a conviction. The Committee accepted the written and oral evidence of Mr Joyce. In particular his written statement where he states *"At the time when the Performer completed the above application forms, he was still subject to a police investigation. I am aware of this from the correspondence with the police set out above. In my opinion, the Performer made false declarations on the aforementioned applications to join the PCT Performers lists. This is based on fact that I cannot see him overlooking the fact he was subject to a police investigation and therefore I believe it was a conscious decision on his part not to declare this. In my opinion, the questions on the form are clear and sufficiently wide for the Performer to understand he should disclose the fact he was subject to police investigation*." The Committee is therefore satisfied that Mr Moffat's actions in respect of head of charge 4. a), b) and c) was misleading as it misled the PCT to believe he had not been removed from any other lists or subject to any police investigations. The Committee therefore find this head of charge proved in respect of heads

	of charge 4.a), 4. b) and 4. c)
5. b)	*dishonest, in that:* **Found proved.** The Committee was referred to the case of Ivey v Genting Casinos (UK) Ltd TA Crockfords [2017] UKSC 67. It first considered the actual state of Mr Moffat's knowledge or belief of the facts. Having established that it then went onto determine whether his conduct was dishonest by the standards of ordinary, decent people. The Committee is satisfied that Mr Moffat at that time knew that he was dishonest. It was not the first time he had applied to join the Performers List. In respect of intent, the Committee is satisfied that Mr Moffat knew the purpose of these questions and that his actions were intended to avoid further investigation. The Committee concludes that it was reasonable to infer that, Mr Moffat who had experience of such applications forms, knew that he was the subject of a police investigation and that he had been removed from a PCT list. Considering the content of the application forms cumulatively, the Committee was satisfied that Mr Moffat intended to deliberately mislead Southwark and Lambeth PCT. Having made this finding of fact the Committee was satisfied that his conduct was dishonest by the objective standards of ordinary decent people and finds this head of charge proved.
5. b) i)	*you knew that your answer to the question as set out above in paragraph 4 (a) was inaccurate and/or untrue;* **Found proved.** For the same reasons as given above in head of charge 5.b).
5. b)	*were inaccurate and/or untrue;*
5. b) ii)	*it was intended to mislead as to your suitability for admission to the Performers Lists of Southwark and Lambeth PCTs, and/or to avoid further investigation into your suitability for admission to the performers list(s).* **Found proved.** For the same reasons as given above in head of charge 5.b).
6.	*In an application to join South East London Dental Performers List in October 2012, you:-*
6. a)	*answered 'no' to the question 'are you currently the subject of any proceedings which might lead to such a conviction, which have not yet been notified to the Primary Care Trust'.* **Found proved.** The Committee had sight of the relevant South East London Dental Performers List application form, and in particular section 7 requiring the registrant's declaration. Mr Moffat had ticked the box "*no"* and signed dated

	22 October 2012. The Committee took into Mr Moffat's representative letter dated 6 November 2013 stating that Mr Moffat did not know it was wrong as he interpreted it as being part of proceedings and not a police investigation. The Committee accepted the oral and written evidence of Mr Joyce, and in particular his written statement stating "*The questions are deliberately broad to encompass any investigations a performer is subject to in the world. The response to this question then gives the right for the PCT…, to place the application on hold whilst the investigation is finalised. The performer would not be able entitled to start work for the NHS in the area."* The Committee does not find Mr Moffat's explanation plausible as by that time Mr Moffat had dealt with more than one police officer and also had experience of completing similar application forms. The Committee is satisfied that Mr Moffat knew at the time of completing the application form that he was subject of Police proceedings and that he had ticked "*no*" when asked in the application. The Committee therefore accepts the evidence of Mr Joyce and finds this head of charge proved.
6. b)	*answered 'no' to the question of whether you had been removed from any list kept by a PCT or equivalent body, despite having been removed from the Performers Lists of West Sussex PCT and Hampshire PCT in January and March 2010.* **Found proved.** The Committee had sight of Mr Moffat's South East London Dental Performers List application form, and in particular section 7 question 20 asking whether he had been removed from any PCT lists. The Committee is satisfied that Mr Moffat knew at the time of completing the application form that he was subject of Police proceedings. The form quite clearly shows Mr Moffat ticking the box 'no' when asked in the application on 22 October 2012. The Committee is satisfied that Mr Moffat had signed this application form and therefore finds this head of charge proved.
6. c)	*signed a declaration that the information contained in the application form was true to the best of your knowledge and belief.* **Found proved.** The Committee noted the letter from NHS England to Mr Moffat dated 2 October 2014 where they state "*it is clear that the intention of the regulatory framework under the 2004 PLR was that applicants for inclusion should be open and transparent about incidents relating to concerns in relation to their professional conduct and particularly those where the criminal justice system is engaged."* The Committee is satisfied that the declaration is signed by Mr Moffat dated 22 October 2012 and the Committee therefore finds this head of charge proved.

7.	*Your conduct in relation to paragraph 6 (a), (b) and (c) above was:*
7. a)	*misleading, and/or* **Found proved.** The Committee having taken into account the meaning of the word misleading, is satisfied that Mr Moffat, an experienced registrant, misled the GDC that he was not the subject of a police investigation nor had been removed from a PCT list. The Committee accepted the written and oral evidence of Mr Joyce, together with the report of NHS England confirming that Mr Moffat has been removed from the PCT Performers List. The Committee was satisfied that Mr Moffat had provided inaccurate information, and therefore the GDC would be misled into believing that Mr Moffat was not the subject of a police investigation nor had been removed from a PCT list. The Committee therefore finds this head of charge proved.
7.b)	*dishonest, in that:*
7. b) i)	*you knew that your answer to the question as set out above in paragraph 6 (a) was inaccurate and/or untrue;* **Found proved** The Committee was referred to the case of Ivey v Genting Casinos (UK) Ltd TA Crockfords [2017] UKSC 67. It first considered the actual state of Mr Moffat's knowledge or belief of the facts. Having established that, it then went onto determine whether his conduct was dishonest by the standards of ordinary, decent people. The Committee is satisfied that it was not the first time Mr Moffat had applied to join the Performers List. In respect of intent, the Committee is satisfied that Mr Moffat knew the purpose of these questions and that his actions were intended to avoid further investigation. The Committee concludes that it was reasonable to infer that, Mr Moffat who had experience of such applications forms, knew that he was the subject of a police investigation and that he had been removed from a PCT list. Considering the content of the application forms cumulatively, the Committee was satisfied that Mr Moffat intended to deliberately mislead Southwark and Lambeth PCT. Having made this finding of fact the Committee was satisfied that his conduct was dishonest by the objective standards of ordinary decent people and finds this head of charge proved.
7. b) ii)	*it was intended to mislead as to your suitability for admission to the South East London Dental Performers List, and/or to avoid further investigation into your suitability for admission to that Performers List.* **Found proved.**

	For the same reasons as given above in head of charge 7. b) i).
8.	*You practised at the dental practice identified in Schedule 1 below between 2011 and 2014, and treated the patients identified in Schedule 2 below.* **Found proved.** The Committee is satisfied based on the evidence before it that Mr Moffat did practise at the dental practice in Schedule 1 and finds this head of charge proved.
9.	*Between 2012 and 2013, you failed to provide an adequate standard of care to:-*
9. a)	*As amended - Patient A, in that between 24 July 2012 and 13 March 2013 you failed to create a treatment plan in relation to the provision of crowns for UR1 and UL6.* **Found proved** The Committee accepted the expert evidence of Ms Firestone. In doing so, it had regard to the following of her report "*It is unknown if this was a planned attendance as part of an overall treatment plan which simply has not been documented… The overall standard of care for Patient A fell far below standard for the following* *reasons:…* *ii) Failure to create a treatment plan or make mention in the records as to why UR 1 and UL 6 required crowns*." The Committee found no other document in the clinical records that could be regarded as a written treatment plan in relation to the provision of crowns for UR1 and UL6. The Committee determined that Mr Moffat failed in his duty to provide Patient A with such a plan and finds this head of charge proved.
9. b)	*Patient C, in that between 24 May 2012 and 27 November 2013 you failed to root treat LL6 in a timely manner.* **Found proved** The Committee noted the expert's report which stated, "*the failure to treat LL6 in a timely manner fell far below standard".* The Committee noted there was a significant period of time when Mr Moffat did not treat the LL6 and should have done so. It accepted the expert's evidence that this was a serious failing. It therefore finds this head of charge proved.
9. c)	*Patient D, in that:-*
9. c) i)	*on 8 August 2012 you failed to review UR6 and UR7 following previous pathology and symptoms;* **Found proved**

	The Committee reviewed Patient D's records and noted the following from the expert report regarding this head of charge: "*no mention is made of a review of the UR6 7 area and whether the area had settled… It was far below standard not to have reviewed UR 6 7 in view of the pathology and symptoms that had been there three months previously.".* The Committee accepted the expert's evidence that this failure to review the UR6 and UR7 was far below the standard expected. It therefore finds this head of charge proved.
9. c) ii)	*Between 13 September 2013 and 20 November 2013 you failed to provide a root treatment to UR5 before restoration of that tooth.* **Found proved** The Committee accepted and agreed with the evidence in the expert report. It noted from that report that "*there was a failure to consider that UR5 had pathology which needed treating prior to restoring the tooth with simply a Composite*". It also noted from the report that "*there was a failure which fell far below the standard by Mr M to have root treated UR 5 in a timely manner*". The Committee is satisfied that Mr Moffatt failed to provide a root treatment to UR5 before the restoration of Patient D's tooth and finds this head of charge proved.
9. d)	*Patient F, in that on 24 January 2013, you failed to discuss and/or record discussion of the risks and/or benefits of leaving the root of UL2 in place when proposing treatment of a cantilever bridge off UL3 to replace UL2.* **Found proved** The Committee accepted the evidence in the expert report which stated that there was no record of any discussion with the patient. In particular, it noted the following from the report: "*If Mr M had not told Patient F that a root was to be left in situ under her new bridge then she was not fully informed or consented and this would be far below standard. However, if Mr M did have the discussion of the risks relating to leaving the root but did not document that discussion then that would be below standard."* The Committee was satisfied that it was more likely than not that a discussion took place with Patient F, as it seemed unlikely that the patient would not have raised this with Mr Moffat as it related to a broken front tooth. However, the Committee determined that any discussion should have been documented in the records and Mr Moffat had failed to do this. It therefore finds this head of charge proved.
9. e)	*Patient I, in that:-*
9. e) i)	*on 29 August 2012 and 18 September 2012, you failed to carry out and/or record an adequate examination;* **Found not proved** The Committee noted the opinion in the expert report that the records "*do*

	not include details of a full examination". However, the Committee carefully reviewed the records and concluded that it was highly likely that an adequate examination was carried out at both appointments. At the first appointment, the Committee noted from the records that Mr Moffat carried out a BPE and an intra-oral and extra oral examination. At the second appointment, the Committee noted that Mr Moffat took radiographs and reported on these. The Committee concluded, therefore, that these were adequate examinations and disagreed with the expert's evidence. The Committee therefore finds this head of charge not proved.
9. e) ii)	*between 20 November and 12 December 2012, you failed to inform the patient and/or record that the patient had been informed that the root filling done on 20 November 2012 was sub-optimal and that she had the option of being referred for specialist treatment;* **Found proved** The Committee accepted the evidence of the expert , and in particular her report which states "*Mr M's standard of care for Patient I fell far below standard because there is no record which states that Patient I had been informed that the root filling was suboptimal or that she had the option at that time of being referred for specialist treatment."* The Committee notes that there was no reference in the patient notes. The Committee is satisfied that the Patient I would be unaware of the quality of the treatment. There is evidence in the patient notes that Mr Moffat knew that the root filling was sub optimal, having reviewed the radiograph. There is no evidence to confirm whether a discussion took place with Patient I, however the Committee notes that there is no recording of such a discussion. The Committee, on the balance of probabilities finds this head of charge proved.
9. e) iii)	*on 5 June, you failed to review and/or record a review of the gum infection previously treated on 10 May 2013.* **Found not proved** The Committee noted the evidence of the expert, and in particular her report which states "*There was no mention of the gum infection treated on 10.05.2013. A failure to have reviewed this area would fall far below standard but the failure to record any review carried out is below standard… There was a failure to arrange a review/ or record that a review had taken place after the LR7 had been treated with antibiotics on 10.05.2013 for a gum infection and then carry out the appropriate operative treatment."* The Committee noted a discrepancy in Patient I's records regarding the exact area of gum infection between the two dates in the charge. The Committee noted that on 5 June 2013 the records show that the patient was "*still sore*" in the upper right quadrant and a radiograph was taken of the UR7 and also all future reference and reviews were of the UR7. The Committee felt that this indicated that the record on 10 May 2013 had

	recorded the problem tooth incorrectly as LR7. The Committee therefore finds on the balance of probabilities that Mr Moffat did review and/or record a review of the gum infection previously treated on 10 May 2013, and finds this head of charge not proved.
9. f)	*Patient P, in that between 30 August 2013 and 28 November 2013, you failed to provide root canal treatment for UL2 and UL3 prior to restoring them.* **Found Proved** The Committee accepted the evidence of the expert witness. In doing so, it had regard to the following of her report; *"I note that on 23.01.2014, a short time after UL 2 and UL 3 were treated, both teeth required root treating as the UL2 was non-vital and UL3 was symptomatic. As the crown at UL2 and the filling at UL3 were placed a short time previously it is unlikely that UL2 was a vital and healthy at the time of tooth/cavity preparation. At the appointment for the root treatment of UL2 (23.01.2014) the treating dentist noted that pus was present in the canal. Pus in a canal maybe suggestive of an acute exacerbation of a chronic lesion. The treatment needed for UL2 and UL3 in January 2014 indicates that these were not healthy teeth when Mr M treated them... There was a failure to provide RCT for UL2 and UL3 prior to definitively restoring them in November 2013."* The Committee is satisfied that the expert report gives clear reasons why the patients teeth should have been root treated. In failing to provide root canal treatment for UL2 and UL3 prior to restoring them, Mr Moffat's standard of care fell far below standard expected. Accordingly, the Committee finds this head of charge proved.
9. g)	*Patient T, in that you did not treat LR5 prior to preparing the tooth for inlay on 26 September 2013.* **Found proved.** The Committee accepted the evidence of the expert witness. In doing so, it had regard to the following of her report; *"It is highly likely that at the inlay preparation at LR 5 on 12.09.2013, LR 5 was cariously exposed and needed root treating prior to placing the inlay. The standard of care provided by Mr M for Patient T fell far below standard because:* *. There was a failure to record a radiographic report.* *. There was a failure to have considered root treating LR5 prior to preparing this tooth for an inlay* *. No PA radiograph of LR 5 was taken prior to preparing it for an inlay."* The Committee notes the wording of this head of charge in relation to Patient T and identified that the failure related to the preparation prior to the fitting of the inlay on 26 September 2013. The Committee reviewed the

	patient notes and found that on 23 September 2013 the patient complained of constant pain from the tooth and this was treated with anti-inflammatory medication and fluoride varnish. There is no evidence of further investigations or the need of other treatment to be considered. Subsequently on 27 March 2014 the patient presented with an abscess and buccal sinus. The Committee accepted the evidence in the expert report that confirmed that it was highly likely that the inlay preparation of LR5 on 12 September 2013 was cariously exposed and required root treating. Mr Moffat's standard of care therefore fell far below standard expected. Accordingly, the Committee finds this head of charge proved.
9. h)	*Patient U, in that on 31 January 2012 and/or 29 May 2013 and/or 31 October 2013, you failed to provide and/or record oral hygiene instruction (OHI) or dietary advice.* **Found Proved** The Committee accepted the evidence of the expert witness. In doing so, it had regard to the following of her report; *"There is no record that OHI and dietary advice was given. If OHI and dietary advice were provided, then this is a failure of record keeping which is below standard. If, however, no OHI or dietary advice was provided then this was a failure far below standard. On 29.05.2013 and 31.10.2013 examinations were carried out, and UR 6 and LR 6 were fissure sealed. Fluoride was applied to other teeth. There is no criticism of the above appointments."* The Committee was of the view that as Mr Moffat diligently provided preventive treatment in the form of fissure sealants and fluoride, it is unlikely that he would neglect to provide OHI and dietary advice. The Committee therefore finds this head of charge proved only in respect of failing to record.
10.	*You failed to record a radiographic report in respect of the patients and appointments set out in Schedule A.* Patient A - **Not proved.** The Committee accepted the evidence of the expert witness and in particular her report which stated "*It was noted that there was a deeply buried root at UL 5. In part this information would have been gleaned from the B/W radiograph, so a partial radiographic report was recorded. Mr M referred on 24.07.2012 for the extraction of the UL 5 root."* The Committee acknowledges that this was a partial report and finds this not proved. Patient C - **Found proved.** The Committee accepted the evidence of the expert witness and in particular her report which stated "*There is no radiographic report within the records, which is far below standard*." The Committee is satisfied that there is no report and finds this charge proved. Patient E - **Found proved** for the same reasons above. Patient F – **Found proved** for the same reasons above.

	Patient I 16.10.2012 – **Found proved.** The Committee accepted the evidence of the expert witness and in particular her report which stated "*There was a failure to record a radiographic report which is far below standard*." The Committee is satisfied that there is no report and finds this charge proved. 20.11.2012 – **Found not proved.** The Committee checked the patients records and noted there is a minimal report of radiographs in the record. Mr Moffat refers to a "*kink in apex*" which can only have been visible on the radiograph. The Committee is satisfied that this charge is therefore found not proved. 05.06.2013 - **Found proved.** The Committee accepted the evidence of the expert witness and in particular her report which stated "*There was a failure to report the radiograph taken, which is far below standard*." The Committee is satisfied that there is no report and finds this charge proved. Patient J 02.03.2012 – **Found proved.** The Committee accepted the evidence of the expert witness and in particular her report which stated "*On 20.02.2013 Patient J attended with pain UL7. Mr M diagnosed an infection at UL7 and exposed a PA radiograph. There is no radiographic report. The radiograph available shows UL7 was root treated. Antibiotics were prescribed. Mr M noted that UL7 might need extracting..*" The Committee is satisfied that there is no report and finds this charge proved. 20.02.2013 – **Found proved.** The Committee accepted the evidence of the expert witness and in particular her report which stated "*There was no radiographic report which also fell far below standard*." The Committee is satisfied that there is no report and finds this charge proved. Patient L – 23.08.2013 - **Found proved.** The Committee accepted the evidence of the expert witness and in particular her report which stated "*On 23.08.2013 Mr M carried out an examination and exposed two B/W radiographs. He then advised that LR 5 should be crowned. There was no radiographic report of the B/W's recorded..*" The Committee is satisfied that there is no report and finds this charge proved. Patient M 14.02.2012– **Found proved.** The Committee accepted the evidence of the expert witness and in particular her report which stated "*On 14.02.2012 two B/W radiographs were exposed which were not reported. This fell far below the expected standard.*" The Committee is satisfied that there is no report and finds this charge proved. Patient N - 14.02.2013 – **Found proved.** The Committee accepted the evidence of the expert witness and in particular her report which stated "*There was no radiographic report recorded which falls far below standard.*" The Committee is satisfied that there is no report and finds this charge proved. 01.03.2013 – **Found proved.** The Committee accepted the evidence of the

	expert witness and in particular her report which stated "*There are no radiographic reports of any of the PA's which is far below standard."* The Committee is satisfied that there is no report and finds this charge proved. 28.03.2013 – **Found proved** for the reasons as given above. 18.04.2013 – **Found proved.** The Committee accepted the evidence of the expert witness and in particular her report which stated "*There is no criticism of this appointment apart from the PA radiograph not being reported."* The Committee is satisfied that there is no report and finds this charge proved. Patient O – 27.09.2013 – **Found proved.** The Committee accepted the evidence of the expert witness and in particular her report which stated "*The radiograph was not reported, which is far below standard*." The Committee is satisfied that there is no report and finds this charge proved. 11.10.2013 – **Found proved.** The Committee accepted the evidence of the expert witness and in particular her report which stated "*The radiographs taken were not reported, which is far below standard*." The Committee is satisfied that there is no report and finds this charge proved. 13.11.2013 – **Found proved** for the reasons as given above. 13.12.2013 – **Found proved** for the reasons as given above. Patient Q – **Found proved.** The Committee accepted the evidence of the expert report which stated "*Two B/W radiographs were exposed on 17.02.2012 but not reported. This fell far below the expected standard*." The Committee is satisfied that there is no report and finds this charge proved. Patient T – **Found proved** The Committee accepted the evidence of the expert report which stated "*There was no radiographic report for the B/W radiographs exposed on 04.09.2013*." The Committee is satisfied that there is no report and finds this charge proved.
11.	*You failed to provide an adequate standard of care by failing to take necessary pre-treatment radiographs in respect of the patients and appointments set out in Schedule B.* Patient A 15.08.2012 – **Found proved.** The Committee accepted the evidence of the expert report which stated "*Prior to having prepared UL 6 for a crown which was a perfectly appropriate restoration to provide as UL 6 was root treated, a periapical (PA) radiograph should have been taken to ensure that there was no periapical pathology and that the root filling was satisfactory. The crown was fitted 28.09.2012. Not to have exposed such a radiograph fell far below standard as potentially Mr M was crowning a tooth which was possibly going to need further root treatment (which is more difficult through a crown and can damage the crown) or had features which meant the tooth had a poor prognosis.."* The Committee notes that the report makes no mention of the UR1. The Committee therefore finds this charge proved in respect of UL6

	only. 13.03.2013 – **Found proved.** The Committee accepted the evidence of the expert report which stated "*There was a failure far below standard not to have exposed a PA radiograph for UR 1 prior to preparing the tooth for a crown. Without such a radiograph the overall health of UR 1 could not be assessed."* The Committee is satisfied that there is no pre-treatment radiographs and finds this charge proved. Patient D – **Found proved.** The Committee accepted the evidence of the expert report which stated "*The records inform that the patient would decide if they wanted the crown in metal which would be NHS or with porcelain which would be private. Metal - ceramic crowns are available on the NHS. There was a failure to expose a PA radiograph prior to preparing LR6 for a crown*." The Committee is satisfied that there is no pre-treatment radiographs and finds this charge proved. Patient E – 19.09.2013 – **Found proved.** The Committee accepted the evidence of the expert report which stated "*Patient E had originally been a patient at The Practice in 1989. She first attended Mr M on 19.09.2013 having been living in Australia for several years. Patient E attended for an examination and requesting a crown UR 6. A full examination was recorded, and two B/W radiographs exposed. It was agreed that the crown would be provided on a private basis. In her witness statement (WS) Patient E notes that she attended in the first instance for a check up and because she thought she needed a filling. The records show that B/W's radiographs were taken. A PA of UR6 which was to be crowned was not taken. The records also indicate that a price for the crown was quoted. At para 4 of her WS Patient F says she was not told a price for the crown*." The Committee is satisfied that there is no pre-treatment radiographs and finds this charge proved. 17.10.2013 - **Found proved.** The Committee noted that the report was redacted regarding this appointment. The GDC Case Presenter however read the redacted paragraphs out and these were agreed by the expert witness. It was accepted by the Committee that the report confirms that no pre-treatment radiograph was taken on this occasion, and therefore the Committee finds this charge proved. 31.10.2013 – **Found proved.** The Committee accepted the evidence of the expert report which stated "*Whilst the provision of such restorations as discussed was perfectly satisfactory, Mr M without taking PA radiographs of the teeth in question, was not in a position to plan such treatment as he was unaware of the apical health/bone support/presence of caries. The failure to expose PA radiographs of the relevant teeth fell far below standard. This was particularly relevant as LR 6 had a crown already in situ*." The Committee is satisfied that there were no pre-treatment radiographs and finds this charge proved. 21.11.2013 – **Found proved.** The Committee accepted the evidence of the expert report which stated "*Prior to preparing LR6 was a further opportunity*

	prior to have taken a PA radiograph of the tooth. Not to have taken the PA radiograph fell far below standard." The Committee is satisfied that there were no pre-treatment radiographs and finds this charge proved. Patient J 07.03.2012 – **Found proved.** The Committee accepted the evidence of the expert report which stated "*UL 5 was restored, and an examination carried out. No B/W radiographs were taken as part of the examination which in view of this patient's high dental needs was far below standard. As the patient was new to the practice no previous B/W's were available."* The Committee is satisfied that there were no pre-treatment radiographs and finds this charge proved. 28.0813 – **Found proved.** The Committee accepted the evidence of the expert report which stated "*No B/W radiographs were taken as part of the examination. As the patient had never had them taken and had high dental need, they were necessary. The failure to expose B/W radiographs fell far below standard.."* The Committee is satisfied that there were no pre-treatment radiographs and finds this charge proved. Patient K 19.12.2012 – **Found proved.** The Committee accepted the evidence of the expert report which stated "*No pre-treatment PA radiograph was exposed which falls far below standard*." The Committee is satisfied that there were no pre-treatment radiographs and finds this charge proved. 11.09.2013 – **Found proved.** The Committee accepted the evidence of the expert report which stated "*No pre-treatment PA radiograph was exposed which falls far below standard*." The Committee is satisfied that there were no pre-treatment radiographs and finds this charge proved. 25.09.2013 – **Found proved.** The Committee accepted the evidence of the expert report which stated "*No pre-treatment PA radiograph was exposed which falls far below standard*." The Committee is satisfied that there were no pre-treatment radiographs and finds this charge proved. Patient L - 23.08.2013 – **Found proved.** The Committee accepted the evidence of the expert report which stated "*There was a failure to expose a PA radiograph of LR 5 prior to preparing the tooth for a crown. In this instance as LR5 was a root treated tooth, Mr M particularly needed to have taken a PA to make sure that the root filling was adequate and that there was no apical pathology prior to preparing the LR5 for a crown. The failure was far below standard."* The Committee is satisfied that there were no pre-treatment radiographs and finds this charge proved. 26.09.2013 – **Found proved.** The Committee accepted the evidence of the expert report which stated "*The standard of care that Mr M provided for Patient L fell far below standard because there was a failure to take pre-treatment radiographs on 23.08.2013 and 26.09.2013. These being part of the pre-treatment assessment. No radiographic reports were recorded*." The

	Committee is satisfied that there were no pre-treatment radiographs and finds this charge proved. Patient P – **Found proved.** The Committee accepted the evidence of the expert report which stated "*No PA radiograph was exposed of UL 2 prior to preparing the tooth for a crown. Not to have such a radiograph was far below standard."* The Committee is satisfied that there were no pre-treatment radiographs and finds this charge proved. Patient T – **Found proved.** The Committee accepted the evidence of the expert report which stated "*Prior to the preparation of LR 5 for an inlay on 12.09.2013 there was a failure to expose a periapical radiograph of the tooth*." The Committee is satisfied that there were no pre-treatment radiographs and finds this charge proved.
12.	*You failed to provide an adequate standard of care by prescribing antibiotics which were not clinically justified and/or necessary in respect of the patients and appointments set out in Schedule C.* Ms Firestone stated that in relation to head of charge 12, that it is inappropriate to prescribe antibiotics on occasions other than when patients show systemic signs of infection. Operative treatment is always encouraged as a first choice. However, Mr Moffat sometimes chose to treat with antibiotics. Patient C – 24.05.2012 – **Found proved.** The Committee accepted the evidence of the expert report which stated "*In the absence of systemic signs of infection or swelling, the prescription of antibiotics was inappropriate and far below standard."* The Committee is satisfied that Mr Moffat prescribed antibiotics which were not clinically justified and provided an inadequate standard of care. It therefore finds this charge proved. 31.05.2012 – **Found proved.** The Committee accepted the evidence of the expert report which stated "*If Patient C did have such an abscess, then the treatment of choice was deep scaling and irrigation of the periodontal pocket and not a repeat prescription of Amoxicillin within a short time frame and when Patient C had only just started a course of Metronidazole. It was far below standard to have prescribed antibiotics.."* The Committee is satisfied that Mr Moffat prescribed antibiotics which were not clinically justified and provided an inadequate standard of care. It therefore finds this charge proved. 08.06.2012 – **Found proved.** The Committee accepted the evidence of the expert report which stated *"It was far below standard to have prescribed a third dose of antibiotics."* The Committee is satisfied that Mr Moffat prescribed antibiotics which were not clinically justified and provided an inadequate standard of care. It therefore finds this charge proved. 19.6.2012 – **Found proved.** The Committee accepted the evidence of the expert report which stated *"Under the date written on the record card for the next appointment on 18.06.2012 are the initials "PJ" which suggests that it was not Mr M who attended Patient C on this date. Mr PJ felt that Patient C's*

	symptoms were due to pathology from the retained roots of LL 8 and that Mr M would refer for the extraction of these roots and Mr PJ prescribed Metronidazole. This was the fourth prescription for Amoxicillin in 26 days. If this drug had not worked previously, it was unlikely it was going to work on this occasion. In any event, 24 hours previously Mr PJ had prescribed Metronidazole and rather than prescribing Amoxicillin it would have been sensible to have given the Metronidazole a little longer to work." The Committee is satisfied that Mr Moffat prescribed antibiotics which were not clinically justified and provided an inadequate standard of care. It therefore finds this charge proved. 20.09.2012 – **Found proved.** The Committee accepted the evidence of the expert report which stated *"The prescription was inappropriate and unnecessary as Patient C was comfortable and it had only been three weeks since the last prescription of Amoxicillin. The prescription of Amoxicillin on 20.09.2012 fell far below standard."* The Committee is satisfied that Mr Moffat prescribed antibiotics which were not clinically justified and provided an inadequate standard of care. It therefore finds this charge proved. Patient D – 08.05.2012 – **Found proved.** The Committee accepted the evidence of the expert report which stated *"The same antibiotic as the patient had been taking was prescribed at a higher dose for no recorded reason. This was far below standard.."* The Committee is satisfied that Mr Moffat prescribed antibiotics which were not clinically justified and provided an inadequate standard of care. It therefore finds this charge proved. 15.05.2012 – **Found proved.** The Committee accepted the evidence of the expert report which stated *"This prescription was unnecessary, the patient was better and so fell far below standard*." The Committee is satisfied that Mr Moffat prescribed antibiotics which were not clinically justified and provided an inadequate standard of care. It therefore finds this charge proved. 13.09.2013 – **Found proved.** The Committee accepted the evidence of the expert report which stated "*In the absence of a record describing swelling, pyrexia, lymphadenopathy and malaise, the prescription of Amoxicillin was seemingly unnecessary and far below standard."* The Committee is satisfied that Mr Moffat prescribed antibiotics which were not clinically justified and provided an inadequate standard of care. It therefore finds this charge proved. Patient F – **Found proved.** The Committee accepted the evidence of the expert report which stated "*Localised scaling and irrigation relating to UL 3 4 was the preferred treatment of choice. Antibiotics were not indicated. It was far below standard to have prescribed antibiotics for this clinical scenario. Mr M's overall standard of care for Patient F fell far below standard because the prescription of antibiotics on 28.08.2013 was inappropriate*." The Committee is satisfied that Mr Moffat prescribed antibiotics which were not clinically justified and provided an inadequate standard of care. It therefore finds this charge proved.

	Patient J – 02.03.2012 – **Found not proved.** The Committee noted that the expert witness was not overly critical in respect of this particular date, and she confirmed this in her oral evidence. The Committee having examined the patient records carefully is satisfied that Mr Moffat did provide an overall adequate standard of care on this date and finds this charge not proved. 07.03.2012 – **Found proved.** The Committee accepted the evidence of the expert report which stated "*No diagnosis was made, having thought UR6 was the problem tooth on 02.03.2012, Mr M now considered that the problem tooth was UR 5. The same antibiotic was prescribed within a seven-day period which, together with an antibiotic being prescribed at all falls far below standard.."* The Committee is satisfied that Mr Moffat prescribed antibiotics which were not clinically justified and provided an inadequate standard of care. It therefore finds this charge proved. 20.02.2013 – **Found proved.** The Committee accepted the evidence of the expert report which stated "*There was no recorded diagnosis which indicated a need for the prescription of antibiotics which fell far below standard."* The Committee is satisfied that Mr Moffat prescribed antibiotics which were not clinically justified and provided an inadequate standard of care. It therefore finds this charge proved. 27.03.2013 – **Found proved.** The Committee accepted the evidence of the expert report which stated "*Unless the swelling was large and spreading and as the UL 7 was to be extracted, antibiotics were inappropriate. The prescription fell far below standard."* The Committee is satisfied that Mr Moffat prescribed antibiotics which were not clinically justified and provided an inadequate standard of care. It therefore finds this charge proved. 15.04.2013 – **Found proved.** The Committee accepted the evidence of the expert report which stated "*Dry sockets require local treatment, occasionally antibiotics are required. There is nothing in the records to suggest antibiotics were required, particularly as the same antibiotic had been prescribed less than six weeks previously. It was far below standard to have prescribed antibiotics and not operative treatment on 15.04.2013*."The Committee is satisfied that Mr Moffat prescribed antibiotics which were not clinically justified and provided an inadequate standard of care. It therefore finds this charge proved. 02.05.2013 – **Found proved.** The Committee accepted the evidence of the expert report which stated *"Local means for treating the socket were required. Further prescriptions of antibiotics fell far below standard.* "The Committee is satisfied that Mr Moffat prescribed antibiotics which were not clinically justified and provided an inadequate standard of care. It therefore finds this charge proved. 09.05.2013 – **Found proved** for the same reasons as given above. 11.09.2013 – **Found proved.** The Committee accepted the evidence of the expert report which stated *"There was no diagnosis other than infection, and no record relating to systemic signs being present, therefore the prescription*

	of Amoxicillin was inappropriate and fell far below standard." The Committee is satisfied that Mr Moffat prescribed antibiotics which were not clinically justified and provided an inadequate standard of care. It therefore finds this charge proved. Patient N 14.02.2013 – The Committee accepted the evidence of the expert report which stated *"There was no recorded indication for the prescription of antibiotics. A pain in the jaw is not indicative of a spreading infection. Unless there were systemic signs and symptoms, the prescription of antibiotics was inappropriate and fell far below standard."* The Committee is satisfied that Mr Moffat prescribed antibiotics which were not clinically justified and provided an inadequate standard of care. It therefore finds this charge proved. 10.04.2013 – **Found proved.** The Committee accepted the evidence of the expert report which stated *"Unless the swelling was large and spreading, rather than prescribe antibiotics, reopening of the root canal, cleaning, and irrigation to have allowed drainage would have been preferable. Operative treatment is always preferable to simply prescribing antibiotics. The fact that the Cavit had to be replaced suggests the canal was open which means access to the root canal for the measures described above would have been quick and easy even for a busy GDP. The prescription of antibiotics fell far below standard unless there was a large spreading swollen area.*" The Committee is satisfied that Mr Moffat prescribed antibiotics which were not clinically justified and provided an inadequate standard of care. It therefore finds this charge proved. 12.05.2013 – **Found proved**. The Committee accepted the evidence of the expert report which stated *"In the absence of a recorded diagnosis of infection the prescription of antibiotics was inappropriate and far below standard. The standard of care provided by Mr M for Patient N fell far below standard because there were no radiographic reports. Antibiotics were prescribed inappropriately. Gross caries as explained above was left at LL 5 and to leave caries in such circumstances is far below standard.*" The Committee is satisfied that Mr Moffat prescribed antibiotics which were not clinically justified and provided an inadequate standard of care. It therefore finds this charge proved. Patient O 10.11.2012 – **Found proved**. The Committee accepted the evidence of the expert report which stated "*It was wholly inappropriate and far below standard to have prescribed antibiotics for a "mild gum infection*". The Committee is satisfied that Mr Moffat prescribed antibiotics which were not clinically justified and provided an inadequate standard of care. It therefore finds this charge proved. 27.09. 2013 – **Found not proved.** The Committee noted that the expert witness was not overly critical in respect of this particular date. She confirmed this in her oral evidence. The Committee having examined the patient records carefully is satisfied

	that Mr Moffat did provide an overall adequate standard of care and finds this charge not proved.
13.	*You failed to provide an adequate standard of care by failing to adequately diagnose and treat caries in respect of the patients and appointments set out in Schedule D.* Patient A – **Found proved**. The Committee accepted the evidence of the expert report which stated "*However, this radiographic report did not include other radiographic findings, which included…iii) Caries was present distal LL 6, mesial UR 7, distal UR 5, mesial UL4. There was a failure far below standard to diagnose and plan to treat caries at LL6, UR 5, UR 7 and UL 4. There was a failure far below standard to record a full radiographic report and to identify on the charting the carious teeth. The extent of the caries seen on the radiographs, suggests that this caries could have been diagnosed clinically at UR 5 and LL 6 and would have been evident on examination of these 2 teeth.*" The Committee is satisfied that Mr Moffat failed to adequately diagnose and treat caries in respect of this patient and therefore failed to provide an adequate standard of care. It therefore finds this charge proved. Patient K – The Committee accepted the evidence of the expert report which stated "*Mr M's standard of care for Patient K fell far below standard because... Without such radiographs Mr M failed to diagnose and treat the caries at LR 5 and LR 7. These carious lesions were seen on the B/W radiograph taken on 23.04.2014 and then treated by the subsequent GDP. Had these carious lesions been treated by Mr M they would in 2012/2013 been smaller and less damaging to the tooth.*" The Committee is satisfied that Mr Moffat failed to adequately diagnose and treat caries in respect of this patient and therefore failed to provide an adequate standard of care. It therefore finds this charge proved. Patient N – The Committee accepted the evidence of the expert report which stated "*It was noted on 31.03.2014 by the subsequent GDP that the inlay fitted ten months previously had fallen out and beneath LL 5 was grossly carious. LL5 was restored with an inlay on 02.05.2013. Gross caries does not develop in 10 months from nothing. So, the fact gross caries was present indicates that caries must have been left in the cavity at the time of inlay preparation and fit in April/May 2013… The standard of care provided by Mr M for Patient N fell far below standard because: -* *. There were no radiographic reports.* *. Antibiotics were prescribed inappropriately* *. Gross caries as explained above was left at LL 5 and to leave caries in* *such circumstances is far below standard."* The Committee is satisfied that Mr Moffat failed to adequately diagnose and treat caries in respect of this patient and therefore failed to provide an adequate standard of care. It therefore finds this charge proved.
14.	*You failed to maintain an adequate standard of record keeping between*

	2012 and 2013 in respect of the patients set out in Schedule E. Patient A – **Found proved**. The Committee accepted the evidence of the expert report which stated "*The records are legible, but minimal and as such fall below standard.*" The Committee is satisfied that Mr Moffat failed to maintain an adequate standard of record keeping. It therefore finds this charge proved. Patient C – **Found proved**. The Committee accepted the evidence of the expert report which stated "*The records for attendances, with the exception of examinations, are minimal but understandable. As such they are below standard…Records as stated previously should be contemporaneous and should tell the reader a story as to what problems were present and all symptoms and signs, the treatment that was considered, or carried out and any options, risks, benefits which may have been discussed. The lack of a detailed record often reflects the lack of time available to write such information. Generally, if the story is not told in sufficient detail, little harm will flow, so I therefore consider for an individual entry that any failures are below the standard expected of a reasonably competent. GDP. However, when that failure is repeated and is seemingly the norm for a GDP then the failure is cumulative and becomes far below the standard expected of a GDP. Mr M's records for all the patients considered were consistently lacking in detail and information in respect of presenting complaints, the treatment carried out, discussions with the patients, clinical signs although symptoms were recorded briefly but without any detailed or additional information. Mr M's writing is not clear but can be deciphered even if on occasion a magnifying glass was required. I am therefore not critical with respect to their legibility.*" The Committee is satisfied that Mr Moffat failed to maintain an adequate standard of record keeping. It therefore finds this charge proved. Patient I – **Found proved**. The Committee accepted the evidence of the expert report which stated "*The records for this patient are with a little effort legible. Unusually the examination on 29.09.2012 was not fully recorded. This was below standard… Records as stated previously should be contemporaneous and should tell the reader a story as to what problems were present and all symptoms and signs, the treatment that was considered, or carried out and any options, risks, benefits which may have been discussed. The lack of a detailed record often reflects the lack of time available to write such information. Generally, if the story is not told in sufficient detail, little harm will flow, so I therefore consider for an individual entry that any failures are below the standard expected of a reasonably competent GDP."* The Committee is satisfied that Mr Moffat failed to maintain an adequate standard of record keeping. It therefore finds this charge proved. Patient J – **Found proved.** The Committee accepted the evidence of the expert report which stated "*The records for 16.10.2013 are minimal but understandable, they are below standard."* The Committee is satisfied that Mr Moffat failed to maintain an adequate standard of record keeping. It therefore finds this charge proved.

	Patient N – **Found proved.** The Committee accepted the evidence of the expert report which stated "*The records of 10.04.2013 (they simply say LL5 blow up, buccal swelling) and 12.05.2013 (simply says swollen) are minimal and as such are below standard. There was a failure on 27.09.2013 to record a radiographic report which falls far below standard. Records as stated previously should be contemporaneous and should tell the reader a story as to what problems were present and all symptoms and signs, the treatment that was considered, or carried out and any options, risks, benefits which may have been discussed. The lack of a detailed record often reflects the lack of time available to write such information. Generally, if the story is not told in sufficient detail, little harm will flow, so I therefore consider for an individual entry that any failures are below the standard expected of a reasonably competent GDP."* The Committee is satisfied that Mr Moffat failed to maintain an adequate standard of record keeping. It therefore finds this charge proved.
15.	*From 28 November 2018 to 17 January 2019 you failed to fully cooperate with an investigation conducted by the GDC by not agreeing to a health assessment and/or providing the GDC with a health report from your consultant.* **Found proved.** The Committee accepted the oral and written evidence of Ms Brazier, the GDC Case Manager, and in particular her written statement dated 20 November 2020 where she states "*I confirm that I have reviewed the GDC's database and I am not aware of any further records of correspondence between the Registrant and the GDC in relation to the GDC's request for him to consent to a health assessment or either providing a copy of a report from his consultant, or the contact details for the consultant (so that the GDC could contact them directly). The Registrant did not consent to a health assessment or either provide a copy of a report from his consultant, or the contact details for the consultant (so that the GDC could request this from them)."* The Committee noted Mr Moffat's email dated 4 May 2018 to the GDC stating "*As to your demand that I sign a consent form allowing your nominated outside health facility to make an assessment of my health on your behalf I most certainly do not agree to at this stage of my recovery for a number of reasons. It is most patronising of you to enclose a consent form in your communication. Has the GDC not heard of the definition of "informed consent " ?* The Committee having carefully considered all the evidence before it is satisfied that Mr Moffat had failed to fully cooperate with an investigation conducted by the GDC by not agreeing to a health assessment. Accordingly, the Committee finds this head of charge proved.
16.	*Between 1 and 24 September 2020, you failed to fully cooperate with an investigation conducted by the GDC's solicitors by not agreeing to a health assessment or to the disclosure of your medical records.*

	Found proved. The Committee noted the written statement of Ms Holdsworth's written statement where she states "*I have checked our case file, and confirm that the Registrant has not responded to any of our correspondence. He has not provided his consent to attend a health assessment or provided consent for the release of his medical records*." Her statement is exhibited with various letters from the GDC solicitors, all of which received no response from Mr Moffat. The Committee is satisfied that Mr Moffat did not cooperate with the GDC's investigation during this specific time period, and therefore finds this head of charge proved.

We move to Stage Two."

On 20 May 2021 the Chairman announced the determination as follows:

Submissions

"In accordance with Rule 20 (1) (a) Ms Culleton informed the Committee that Mr Moffat has no fitness to practise history.

When addressing the Committee on misconduct, Ms Culleton submitted that the clinical failings found proved in this case were repeated, involved a large number of patients and included basic aspects of dental care and treatment which breached a number of the GDC standards. Ms Firestone's report concluded that these failings fell far below the standards expected. With regard to the completion of the application forms for both NHS England and the GDC, Mr Moffat acted dishonestly in the way he answered to the questions regarding declarations. She submitted that this conduct was mirrored in his non-co-operation with the Police investigation. Ms Culleton submitted that his conduct was sustained and repeated and amounted to very serious dishonesty. She informed the Committee that there has been no insight which might reassure the Committee going forward. Ms Culleton concluded that Mr Moffat's conduct amounted to a very serious failing over a protracted period of time of just over 4 years, which covered a broad spectrum, including an abuse of trust. She submitted that this clearly amounted to misconduct.

Ms Culleton then moved on to the issue of current impairment. She submitted that given the gravity of the misconduct and the absence of insight from Mr Moffat, this amounted to current impairment. She referred the Committee to the test of impairment mentioned in Dame Janet Smith's Fifth Shipman Report of The Shipman Inquiry and submitted that there was no evidence to suggest that Mr Moffat perceived the need for any remedial training and that he may have an attitudinal problem that prevents him from doing so. In relation to the charges of repeated dishonesty, Ms Culleton submitted that nothing gave cause for re-assurance that Mr Moffat's conduct will not be repeated. She stated that there was every indication that Mr Moffat's absence of insight will continue, and it was clear that Mr Moffat had behaved in a manner that put self-interest above patients and the wider public interest. She further submitted that confidence in the dental profession would be seriously undermined if a finding of impairment was not made in this case.

Ms Culleton next addressed the Committee on the matter of sanction. She made reference to the GDC's Guidance. She submitted that the most appropriate and proportionate sanction in this case was one of erasure as Mr Moffat was unsuitable for continued membership of the dental profession.

Misconduct

The Committee first considered whether the facts found proved against Mr Moffat amounted to misconduct. In doing so it had regard to the GDC publication *Standards for Dental Professionals (2005)* which was applicable to the heads of charge that relate to the time prior to 2013. It was satisfied that Mr Moffat's failings included a breach of the following standards:

1.4 Make and keep accurate and complete patient records, including a medical history, at the time you treat them. Make sure that patients have easy access to their records.

5.3 Find out about current best practice in the fields in which you work. Provide a good standard of care based on available up-to-date evidence and reliable guidance.

6.1 Justify the trust that your patients, the public and your colleagues have in you by always acting honestly and fairly.

6.3 Maintain appropriate standards of behaviour in all walks of life so that patients have confidence in you and the public have confidence in the dental profession.

It also had regard to the GDC standards for the periods beyond 2013 and which was applicable at the time. The Committee has concluded that Mr Moffat's conduct was in breach of the following *Standards for the Dental Team* (2013). It was satisfied that Mr Moffat's failings included a breach of the following standards:

1.3 You must be honest and act with integrity

2.3.6 You must give patients a written treatment plan, or plans, before their treatment starts and you should retain a copy in their notes. You should also ask patients to sign the treatment plan.

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

7.1 Provide good quality care based on current evidence and authoritative guidance.

9.1 Ensure that your conduct, both at work and in your personal life, justifies patients' trust in you and the public's trust in the dental profession.

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

With regard to the clinical concerns, the Committee noted that these involved multiple patients. There were repeated examples of antibiotics being issued inappropriately and delayed operative intervention. Also, it was found proved that Mr Moffat has failed on numerous occasions to take pre-operative radiographs and also failed to report on these radiographs The Committee considered the failings to be serious, sustained and wide-ranging. The Committee also noted that the view of Ms Firestone upon review of the patient records was that these failings fall far below the standards expected.

With regard to the inappropriate completion of the application forms, there were repeated incidents of Mr Moffat being dishonest to NHS England, Southwark and Lambeth PCTs and

the GDC. Mr Moffat had experience of being on the Performers List and how to complete similar application forms. The Committee considers that his conduct was a deliberate act of dishonesty, which was repeated. The Committee is satisfied that Mr Moffat had breached the trust of NHS England, Southwark and Lambeth PCTs and the GDC.

Mr Moffat also failed to cooperate with a Police investigation and fled the country, which the Committee considers is a serious failing of the GDC Standards expected.

The Committee noted that Mr Moffat's actions were a serious departure from, and a clear breach of, the recognised GDC Standards and they brought the profession into disrepute. The Committee was satisfied that his behaviour would be considered deplorable by fellow dental professionals and the public alike.

The Committee therefore concluded that Mr Moffat's behaviour had fallen far short of the standards of conduct that were proper in these circumstances and amounted to misconduct.

Impairment

The Committee then considered whether Mr Moffat's fitness to practise was currently impaired by reason of his misconduct.

The Committee was mindful of its statutory over-arching objective to protect the public and of the public interest, which included the need to maintain proper standards of conduct and competence among dental professionals, and to protect patients from risk of harm. In reaching its decision on impairment, the Committee had regard to the GDC Guidance section on impairment and the relevant case law, including the cases of *Cohen v General Medical Council [2008] EWCH 581 (Admin)* and *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council and Grant [2011] EWHC 927 (Admin).* In addition, it reviewed the Fifth Shipman report by Dame Janet Smith which set out the following four potential grounds to consider when determining current impairment:

1. *He/she has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm;*
2. *He/she has in the past brought and/or is liable in the future to bring the medical profession into disrepute;*
3. *He/she has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession;*
4. *He/she has in the past acted dishonestly and/or is liable to act dishonestly in the future.*

The Committee considered that all the grounds were engaged in this case.

The Committee next considered whether Mr Moffat's misconduct was remediable. It noted that dishonesty was very difficult to remediate but the clinical failings could be remedied with the correct attitude. It notes that he has not practised since 2015, however, Mr Moffat has provided no evidence of remediation or insight into his clinical failings. The Committee has also seen no evidence of Continuing Professional Development (CPD). Mr Moffat made no admissions to the heads of charge. The Committee concluded therefore that in the absence of any meaningful remediation or insight, it was very likely that Mr Moffat will repeat his clinical failings and that this will put patients at risk.

The Committee further noted that Mr Moffat has not apologised for his clinical failures or his dishonest conduct. The Committee also considered the pattern of his behaviour during the

completion of his application forms and also during the Police investigation. For these reasons, the Committee considered that there is a high risk that Mr Moffat could repeat the misconduct it has found. It therefore concluded that a finding of impairment is necessary in the interest of public protection.

The Committee also determined that a finding of impairment was necessary in the wider public interest to maintain public confidence and uphold proper standards of conduct and behaviour. Mr Moffat has breached fundamental standards of conduct and co-operation required by the GDC and other organisations and has to date shown no insight into this serious matter. The Committee considered that public confidence in the dental profession and in the GDC as regulator would be severely undermined if a finding of impairment in relation to misconduct was not made in the circumstances of this case.

Sanction

The Committee next considered what sanction, if any, to impose on Mr Moffat's registration. It recognised that the purpose of a sanction was not to be punitive although it may have that effect. The Committee applied the principle of proportionality balancing Mr Moffat's interest with the public interest.

The Committee considered the mitigating and aggravating factors in this case.

The mitigating factors in this case include:

- Mr Moffat's health concerns;
- No evidence of previous FTP history.

The aggravating factors in this case include:

- Risk of harm to patients;
- Serious dishonesty;
- Premeditated misconduct;
- Breach of trust at all levels, including patients, the wider community, the NHS and GDC;
- Misconduct sustained and repeated over a period of time;
- Blatant and wilful disregard of the role of the GDC and the systems regulating the profession;
- No meaningful insight regarding misconduct.

The Committee decided that it would be inappropriate to conclude this case with no further action. It would not satisfy the public interest given the serious nature of Mr Moffat's misconduct.

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

The Committee concluded that misconduct of this nature could not be adequately addressed by way of a reprimand. It cannot be said to be at the lower end of the spectrum. The public interest would not be sufficiently protected by the imposition of such a sanction. The Committee therefore determined that a reprimand would be inappropriate and inadequate.

The Committee then considered whether a conditions of practice order would be appropriate. However, it noted that it would be difficult if not impossible to formulate conditions to address the issue of Mr Moffat's dishonesty. Furthermore, Mr Moffat has not attended this hearing and has failed to co-operate with the GDC's investigation and has a history of not engaging with investigations into his conduct by other organisations. The Committee also noted Mr Moffat's stated intention that he no longer wishes to practise dentistry. The Committee was of the view that conditions would not therefore be workable and were neither sufficient nor appropriate to address the seriousness of the misconduct and safeguard the wider public interest.

The Committee next considered whether to suspend Mr Moffat's registration for a specified period. It questioned whether a suspension would be sufficient in all the circumstances regarding the misconduct that it had found. In reaching its decision, the Committee had regard to the factors listed under paragraph 6.28 of the Guidance, which dealt with the sanction of suspension, and considered that most of the factors listed applied. However, this paragraph made clear that a suspension may be appropriate where there is "*no evidence of harmful deep-seated personality or professional attitudinal problems*". The Committee considered that there was evidence that Mr Moffat did have a professional attitudinal problem. The Committee noted that Mr Moffat has shown no meaningful remorse or insight into his misconduct. This dishonest and non-co-operative behaviour has been sustained over a period of time. In these circumstances, the Committee concluded that the suspension of Mr Moffat's registration would not be sufficient or proportionate to protect the public and maintain the public's confidence in the dental profession.

In considering whether the sanction of erasure was proportionate and appropriate, the Committee had regard to paragraph 6.34 of the Guidance, which states:

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

The Committee considered the following factors applied in this case:

- *"serious departure(s) from the relevant professional standards;*
- *Where a continuing risk of serious harm to patients or other persons is identified;*
- *the abuse of a position of trust or violation of the rights of patients, particularly if involving vulnerable persons;*
- *serious dishonesty, particularly where persistent or covered up;*
- *a persistent lack of insight into the seriousness of actions or their consequences."*

It noted that Mr Moffat had shown a persistent lack of insight into his behaviour and his conduct was a serious departure from the standards expected of dental professionals. His dishonest conduct dishonest was repeated over a protracted period of time. Given these reasons, the Committee concluded that his behaviour was fundamentally incompatible with being a dental professional.

In all the circumstances, the Committee has determined to erase Mr Moffat's name from the Dentists' Register.

The Committee will now consider whether an immediate order should be imposed on Mr Moffat's registration, pending the taking effect of its determination for erasure.

Decision on immediate order

The Committee has considered whether to make an order for the immediate suspension of Mr Moffat's registration in accordance with Section 30(1) of the Dentists Act 1984 (as amended).

Ms Culleton, on behalf of the GDC, submitted that such an order is necessary for the protection of the public and is otherwise in the public interest.

The Committee has considered the submission made. It has accepted the advice of the Legal Adviser.

The Committee was satisfied that an immediate order of suspension was necessary for the protection of the public and was otherwise in the public interest. The Committee concluded that given the seriousness and the nature of its findings and its reasons for the substantive order of erasure, it was necessary to direct that an immediate order of suspension be imposed on both of these grounds. The Committee considered that, given its findings, if an immediate order was not made in the circumstances, there would be a risk to public safety and public confidence in the profession and in the GDC as its regulator would be undermined.

The effect of this direction is that Mr Moffat's registration will be suspended immediately.

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

That concludes today's hearing."