PUBLIC HEARING

Professional Conduct Committee
Initial Hearing

13 – 17 May 2024

Name:	WALKER, Darren Lee
Registration number:	76334
Case number:	CAS-204404-X0V5V6

General Dental Council:	Ashraf Khan, Counsel/Case Presenter. Instructed by Daniel Watson IHLPS
Registrant:	Present and represented by John Cameron.

Fitness to practise:	Impaired by reason of misconduct
Outcome:	Fitness to Practise Impaired. Reprimand Issued

Committee members:	Gill Mullen	(Chair and Lay member)
	Juliette Brouard	(Dentist member)
	Clare McIlwaine	(DCP member)
Legal adviser:	Nicola Bircher	
Committee Secretary:	Gurjeet Dhuper	

1. This is a Professional Conduct Committee hearing. The members of the Committee, as well as the Legal Adviser and the Committee Secretary, conducted the hearing remotely via Microsoft Teams. You are present and represented by Mr John Cameron. Mr Ashraf Khan (Counsel) is the Case Presenter for the GDC.

Admissions

2. Mr Cameron on your behalf made an admission to Charge 1. The Committee accepted your admission and found the charge proved.

Defence application on no case to answer 14 May 2024

3. Mr Cameron on your behalf, has made a submission under Rule 19(3) of the General Dental Council (GDC) (Fitness to Practise) Rules 2006 that there is no case to answer in respect of some of the charges against you.

4. The charges against you, which are all in dispute, are as follows:

2. You failed to provide Patient A with an adequate standard of care between 8 October 2013 and 15 September 2015 by not carrying out sufficient diagnostic assessments, in that you did not:

a. Carry out and/or record Basic Periodontal Examinations; and/or
b. Carry out a soft tissue examination; and/or
c. Carry out an assessment of oral hygiene status.

3. You failed to obtain informed consent for all of the treatment provided to Patient A between 08 October 2013 to 15 September 2015, in that you did not:
a. Carry out and/or record Basic Periodontal Examinations for Patient A; and/or
b. Carry out soft tissue or oral hygiene assessments for Patient A; and/or
c. Adequately discuss the risks and benefits of orthodontic treatment with Patient A; and/or
d. Adequately discuss the expected timeframe and/or retention regime for treatment with Patient A.

4. You failed to maintain an adequate standard of record keeping between 08 October 2013 to 15 September 2015 in respect of Patient A's appointments, in that you did not:

a. Record a soft tissue examination; and/or
b. Record hygiene status; and/or
c. Record a discussion of the risks and benefits of the orthodontic treatment proposed; and/or

d. Record the expected timeframe and/or retention regime for treatment.

5. Mr Cameron made no oral submissions, but provided the Committee with written submissions on the application which are as follows.

   "The GDC's case is based on evidence from its expert, a general dental practitioner with a special interest in orthodontics, not a specialist in either orthodontics or periodontology. The patient was referred to the practice where the registrant was working as an unpaid assistant to the three GDC specialist practitioners who owned that practice and had done so for a considerable time, where treatment was restricted specifically and only to orthodontic treatment. The registrant was working as an assistant in the practice so that he could see and treat orthodontic patients, whilst undergoing a MSc in orthodontics from Warwick University which he had commenced in 2010.

6. *The patient was referred to the orthodontic practice by his general dental practitioner in January 2013; the referral letter was in the bundle; there was no evidence in the referral letter that there were any periodontal concerns; it reported that the patient was concerned about his upper lateral incisors being out of position. The letter back from the administrative staff at the orthodontic practice, accepting the referral, was that the first appointment was not to have treatment but for the registrant to make an assessment; if a second appointment was necessary the fee for that second appointment was included in the quoted price* ***(Page 192 of the Bundle)****. The patient was first seen by the registrant on 8th October 2013 when the records confirm that an orthodontic assessment was carried out, but active treatment did not take place 22/1/2014.*

7. *Allegation 2 states that registrant failed to provide Patient A with an adequate standard of care between 8 October 2013 and 15 September 2015 by not carrying out sufficient diagnostic assessments, in that he did not carry out and / or record Basic Periodontal Examinations; and / or carry out a soft tissue examination; and / or carry out an assessment of oral hygiene status. The GDC's expert relied not just in this charge but in all the three charges that the failure to carry out a BPE represented a gross or significant departure from the standard expected. He presented no evidence to confirm that any other individual or learned society would concur with his view in the circumstances of this case.*

8. *It is the registrant's position that the requirement for a BPE to be included in all orthodontic assessments only became a requirement after the British Society of Periodontology issued the new guidance in 2017 / 2018, a long time after the patient completed treatment; evidence was produced in the defence bundle to support this view. The registrant did not have either the specific perio probes or equipment in the orthodontic practice where he was working to carry out the BPE, or periodontal treatment, so he returned the patient to his GDP to have the required periodontal and restorative treatment carried out. What occurred is entirely in accordance with what regularly happened in 2013 in the United Kingdom, general dental practitioners having close relationships with specialist practitioners to whom they would refer. The general dental practitioner had carried out a BPE in late November 2012 which was not in the expert's report, but was in his instructions from the GDC and was presented to the committee in the defence Bundle. It is the registrant's position that this BPE charting by the general dental practitioner was pertinent, in the GDC expert's knowledge and should have been included in his report; no explanation was given for its omission. The expert agreed that if a dentist did not have the equipment to provide certain treatment, the patient should be referred elsewhere for treatment, which is exactly what the registrant had done. In his evidence the expert mentioned a practitioner not having forceps and therefore not being able to carry out extractions; he agreed with the registrant's representative that it would be appropriate in such a case to refer the patient to a dentist who had the equipment and facilities to carry out the treatment. This was an exact analogy with the patient being referred back to the general dental practitioner for the periodontal*

treatment and care which the registrant recorded in his clinical notes and in his correspondence with the practitioner when he had assessed patient A at his first assessment visit.

9. *The expert's evidence was that that the registrant failed to carry out a soft tissue exam, when it was clear from the records in the bundle where there was an orthodontic assessment form for the patient that he had specific soft tissue sections and confirmed that the registrant had in fact carried out a soft tissue examination. Additionally, the record and the letter to the general dental practitioner from the registrant confirm that the registrant had carried out a periodontal assessment and referred the patient back to his GDP to have this dealt with; it is his position that he did not commence orthodontic treatment for approximately 3 months after his initial appointment. The expert confirmed that was a satisfactory period on questioning and was this was the appropriate period to delay after a 222 over 222 BPE. When challenged about the fact that it was possible, without a BPE, to determine that there was a need for intensive oral hygiene and a scale and polish by reference to the plaque, calculus, inflamed gums etc the GDC's expert started talking about not being able to identify pocket depths – there was no evidence that the patient had any periodontal pockets or false pockets at that time.*

10. *Similarly in relation to charge 3, the GDC's expert stated that without a BPE it was impossible for the patient to give consent for the treatment. That charge states, informed consent for all of the treatment provided to Patient A between 08 October 2013 to 15 September 2015 was not consented for because the registrant had not carried out and / or recorded a Basic Periodontal Examinations for Patient A; and / or carried out a soft tissue or oral hygiene assessment for Patient A; and / or adequately discussed the risks and benefits of orthodontic treatment with Patient A; and / or adequately discussed the expected timeframe and/or retention regime for treatment with Patient A. It was clear from the letters which are part of the patient's clinical record that the registrant had provided a form confirming the costs of the proposed treatment and a letter referred to a consent form which the registrant sent to the patient confirming that it should be signed dated and returned. It is the registrant's position that he would not have commenced treatment without the consent form being presented signed and dated; the form was not in the bundle. The clinical records confirm that the registrant had a full conversation with the patient about the alternative treatments which it was put to GDC's expert that this must have included the risks and benefits of each treatment rationale as well as the time frame, the GDC's expert rebutted this suggestion but did not provide evidence to show how the information recorded on the clinical record could have been given without covering risks, benefits, time frames.*

11. *It was exactly the same with allegation 4, which states that the Registrant failed to maintain an adequate standard of record keeping between 08 October 2013 to 15 September 2015 in respect of Patient A's appointments. Paper notes, particularly in orthodontic practices were very common in 2013; the expert's assertion regarding the clinical notes alleged that he did not record a soft tissue examination; and / or record hygiene status; and / or record a discussion of the risks and benefits of the orthodontic treatment proposed; and / or record the expected time frame and / or retention regime for treatment. Neither the expert nor the GDC provided any evidence to support the allegations, confirmation that the discussions had taken place did appear on the clinical record and associated letters and documentation which all form part of the clinical records.*

12. *The GDC publication, Standards for the Dental Team came out a week before the patient started treatment; that was the only document, of those documents relied upon by the GDC's expert that was published either before or during the period that the registrant treated the patient. Standard 7.1 confirms that registrants MUST provide good quality care based on current evidence and authoritative guidance. In his report and in his evidence the expert relied upon the General Dental Council's Guidance on Indemnity published in 2016, almost a year after the registrant had finished treating the patient, no documentation was provided regarding what was on the GDC's website at the time the registrant treated the patient. Therefore, there was no document in the bundle or referred to by the*

expert advising on the GDC's guidance on indemnity in 2014. Standards for Dental Teams makes no mention of the specific need for "run off cover". The Expert was also shown documentation in the defence bundle confirming that the Dentists Act 1984 had been amended in 2014, 2020 and also a BDA document confirming further changes in 2024, which exhibited that things were not static but changed, and advice needed to be updated, the expert did not comment according to my notes.

13. *With regard to the mandatory requirement for BPEs, contents of clinical records, consent, etc as alleged by the GDC's expert in his evidence and also contained within the allegations; the expert relied upon the following. The Faculty of General Dental Practice, Standards in Dentistry second edition 2018; the College of General Dentistry, Clinical Examination and Record Keeping Good Practice Guidelines (published apparently in 2016 according to the expert report), which it cannot be correct as the College was not established until 2021. The GDC expert stated that the second date 10/4/2022 was the date he accessed the document. Other documents that the GDC's expert relied upon were The British Orthodontic Society Safety Advice Sheet, Orthodontic Records Collection and Management 2022. The British Orthodontic Society Advice Sheet, Risks of Orthodontic Treatment – Guidance on Informing Patients 2023.*

14. *All of the above documents were published after the registrant treated the patient and they therefore cannot be regarded by any reasonable individual to be documents that the registrant could have accessed prior to and when he treated the patient. The expert's position was, that the BPE and the other requirements which he stated were the basis of the allegations, were mandatory and basic. It is quite clear from the documents above which are advice documents that the requirements are not mandatory but advisory. Other than the GDC's Standards document, not a single document was produced by the GDC or its expert to confirm what the expert was stating about what was mandatory. The expert is not on the GDC's specialist list for orthodontics nor for periodontology he is a general dental practitioner. The GDC's expert made comments that the documents that he produced were exactly the same as earlier documents that were available at the time the patient was treated as they were basic requirements but produced no evidence to support this. The expert's position must be irrational, why would new editions of documents be produced if they were the same as the previous documents, I suggest that is clearly a bizarre statement with no evidence was produced to support it either in the bundle or by the expert.*

15. *The expert refused to accept that the undertaking BPE for orthodontic treatment might well have been the gold standard up until 2019 or thereabouts; any new requirement that becomes mandatory cannot become mandatory overnight without some sort of explanation to the profession – no evidence was furnished of such documentation by the GDC or the expert. The defence produced documentation from the British Society of Periodontology (BSP) following the work carried out by the BSP and the European periodontology groups in 2016, 2017 and 2018, following huge concerns raised regarding periodontal assessing and recording. The documentation produced by the BSP provided by the defence confirmed that the BSPs reasons for the huge change in periodontal recording and treating was to ensure that BPEs were used appropriately and not as diagnostic tools; also, to ensure that after the 2018 and 2019 BSP guidance, the periodontal assessment and treatment could be clearly defined. This was a total change in the approach to periodontal assessing, recording and treating. Any subsequent documentation after those dates would have to acknowledge and embrace that change but the GDC's expert's opinion was the new documents were the same as the previous ones prior to that period; however, he produced no evidence to confirm that position.*

16. *The clinical records for the patient from the GDP's practice, after the orthodontic treatment by the registrant were in the bundle and showed erratic BPE charting during the period 2016 to 2023. The records provided no evidence that the BPE's recorded were accurate and therefore were not meaningful. There was no evidence of any harm to Patient A as a result of the orthodontic treatment*

that the registrant had carried out. The GDC's expert admitted several times that there was no evidence that the patient had been harmed by the orthodontic treatment carried out by the registrant; the expert also confirmed that he agreed that the orthodontic treatment by the registrant had been successful as confirmed by the orthodontic specialist who examined the patient a year after the treatment had been completed in 2015, whose opinion was in the bundle.

17. *When challenged regarding the opinions that he was stating and the standards he was expressing the GDC's expert conceded that they were his standards; he could not and did not produce documentation to state that they were mandatory or in general usage by dentists, particularly orthodontists and in practices restricted to orthodontics. As previously stated, the GDC's document Standards for the Dental Teams states that a registrant must provide good quality care based on current evidence and authoritative guidance. Neither the GDC nor its expert have provided authoritative guidance or evidence that was current in 2013 to 2015 confirming that the items that the expert stated were mandatory were in fact mandatory. The patient did not come to harm, he was not placed at harm by the registrant's treatment, he was referred back to the general dental practitioner to have the periodontal treatment carried out; it was the general practitioner's duty to monitor the patient's periodontal health in the long term.*

18. *The GDC's contemporaneous document applicable in this case is Standards for the Dental Team; in addition to what was confirmed previously in this submission; Standard 7 states that patients expect to receive good quality care – there is no evidence, as admitted by the GDC's expert, the patient had not receive good quality appropriate care; the orthodontic specialists overseeing the registrant where he worked as an unpaid assistant in their practice confirmed that they had no concerns about the registrant. Or his performance.*

19. *Standard 3 concerns consent; I put it to you that the registrant complied fully with the requirements contained within standard 3.*

20. *Standard 4 contains the GDC's contemporaneous standards for record keeping required at the time. The GDC nor its expert have produced any evidence to suggest that the registrant has not complied fully with all the requirements of Standard 4 regarding record keeping. Standard 6.3.3 makes it quite clear that registrants should refer patients on if the treatment required is outside their scope of practice or competence; the registrant identified the requirement for restorative treatment, scaling and polishing and intensive oral hygiene instruction – he handed the patient on to have that treatment carried out by the GDP who was responsible for the patient's day to day care. What occurred in this case is what happened at the time over and over and continues in many areas today, dental practitioners carry out basic treatment handing the patients on to specialist practices or specialist practitioners to carry out treatment outwith their scope of practice. The referring dentist does not expect the dentist they are referring to carry out treatment that is within the referring dentist's scope of practice.*

21. *The GDC's expert is a general dental practitioner, not a specialist in orthodontics or periodontology; it appears from his evidence that he carries out both orthodontic treatment and general dentistry, including perio in his practice; he stated that the views that he was expressing were his own and what he did in his practice. His experience and his requirements are therefore quite different from the experience of a dentist to whom patients are referred. The GDC's expert is obviously responsible for the orthodontic treatment as well as the periodontal treatment of patients he treats; this is quite different from the shared care exhibited in this case by the specialist practitioners and the general dental practitioners.*

22. *In addition to the specific allegations made against the registrant by the GDC's expert, without supportive current evidence; in his report, the GDC Expert suggests sums of money that the Registrant*

allegedly paid to settle the claim made by the patient. The Dental Law Partnership carry out very thorough investigations and are very successful, through their diligence, in pursuing claims; there is no evidence in the GDC's bundle that there was any finding against the registrant regarding the quality of care he provided, only regarding the indemnity. The allegations in the GDC's expert's report about payments the registrant are not correct, there is no evidence in the bundle to support what is stated in his report. The evidence in the bundle confirms that the settlement made on the registrant's behalf was made for financial reasons because the registrant had no indemnity.

23. *To conclude I return to requirements as noted in Paragraph 57 (4) of the Fitness to Practise Rules which states that it is the requirement for the Council to prove any fact alleged in the Notice of the Hearing on the balance of probabilities. I believe that any reasonable individual would consider that expecting a registrant working in 2013 to 2015 to comply with documentation not available until 2016, 2018, 2022 or 2023 is clearly untenable, as is the evidence given by the expert at the hearing that the documents of with dates from 2016 onwards are the same as documents produced previously, that is also untenable. We have not been provided with a single document to confirm that statement.*

24. *I state therefore that the GDC has not provided 'evidence' or 'facts' to support the allegations 2, 3 and 4; furthermore, no evidence has been produced to suggest that the behaviour of the registrant could be regarded as misconduct or that his fitness to practise has been demonstrated to be impaired by the care and treatment that he provided for Patient A. I therefore believe that on the evidence there is no case to answer."*

25. Mr Khan on behalf of the GDC submitted that this is not a case where there is no evidence at all, nor is it where the evidence is of a tenuous character. This case depends largely on the credibility and reliability of the GDC expert witness, Dr Bateman. He submitted that this case is about maintaining proper standards which have always been in place when treating patients. Those standards include conducting diagnostic assessments, taking adequate clinical records, patients providing informed consent and maintaining adequate record keeping. It is alleged by the GDC that there has been a failure in this case by you to maintain these basic standards which are essential for patient safety.

26. Mr Khan submitted that this case has been in the process for some time and so far as Dr Bateman's expertise is concerned, has not been previously challenged by you. Mr Cameron on your behalf challenged Dr Bateman's expertise during his cross-examination evidence yesterday. If there were issues in relation to Mr Bateman's expertise and the defence felt that he was not in a position to provide expert evidence in this area, then this should have been raised prior to day one of the hearing. Mr Khan submitted that at the beginning of Dr Bateman's examination in chief, he took the Committee to his credentials, qualifications and experience and no challenge was made. Mr Khan submitted that if issue were to be taken about previous guidance which are not readily available, this should have been raised prior to the hearing. However, this was not done by the defence and Dr Bateman tried his best to deal with questions relating to what the previous guidance may have stated. However, Dr Bateman was certain that these diagnostic tests, which ought to have been done, are an absolute basic and minimum standard which have always been required.

27. Mr Khan submitted that the referral was made in January 2013 and you did not actually see the patient until 9 months later in October 2013. There is no evidence of a BPE examination, soft tissue examination or an assessment of oral hygiene being carried out. Nor were there clinical notes describing what was done in terms of the assessments. Further there is a lack

of evidence in the notes in relation to informed consent. Dr Bateman was clear in his evidence that this has always been the basic standard expected of a reasonably competent practitioner, even in 2013.

28. You accept that you did not have the equipment to carry out a BPE in your practice and you therefore returned the patient to a GDP to have the required periodontal and restorative treatment carried out and that this was in accordance with what regularly happened in 2013. Mr Khan submitted that this is a blanket exertion made by Mr Cameron and cannot be proved or disproved. Its not what others are doing in this case, the Committee is looking at your professional conduct.

29. Mr Khan submitted that the Committee should not stop the case and should continue so that it can carry out a fact-finding exercise. All these allegations are outstanding and should be allowed to proceed for determination on the facts.

Committee's deliberations

30. The Committee has considered the submissions made by both Mr Cameron and Mr Khan. It has been referred to the law applicable to a no case to answer application. The Committee also had regard to Rule 19 which reads: *"When the presenter has completed presenting evidence, the respondent or the respondent's representative may open the case for the defence, which may include a submission that there is no case to answer."*

31. The Committee has accepted the Legal Adviser's advice as to the approach it should follow. It has borne in mind that the burden of proof is on the GDC and that the civil standard of proof applies, namely on the balance of probabilities.

32. The Committee would emphasise that it is not reaching any findings of fact at this stage of proceedings.

33. In its deliberations, the Committee has had regard to the oral and documentary evidence presented by the GDC. The documentary evidence includes the clinical records of the patient and an expert report signed and dated 18 March 2024 from Dr Bateman. The Committee also received oral evidence from Dr Bateman.

34. The Committee considered each charge in turn.

Charge 2

35. The Committee had regard to the stem of Charge 2 which read that *"you failed to provide Patient A with an adequate standard of care between 8 October 2013 and 15 September 2015 by not carrying out sufficient diagnostic assessments, in that you did not:"* It considered that if a failure is alleged, a duty would have to be established. It noted that there is nothing before the Committee to establish what the requirements were at the time. Dr Bateman has based his opinion on guidance which post-dates the time of the treatment that was carried

out by you. The Committee heard oral evidence from Dr Bateman, but he was unable to provide evidence of the specific requirement that was expected of you at the time.

36. Accordingly, the Committee considered that there is no case to answer because the GDC has provided insufficient evidence to support this charge.

Charge 3 and 4

37. The Committee considered each charge separately and reached the same finding. It considered that there is evidence upon which these charges could be found proved during the fact-finding stage.

38. The GDC standards applicable at the time were referenced by the expert witness in his report in respect of these charges. These standards specified requirements for obtaining informed consent and keeping adequate records. This evidence gives the Committee a basis for considering charges 3 and 4.

Evidence

39. The Committee considered all the evidence presented to it. This included oral evidence from the GDC expert, Dr Bateman and from yourself.

40. It also took account of the closing submissions made by Mr Khan on behalf of the GDC and those made by Mr Cameron on your behalf. The Committee accepted the advice of the Legal Adviser. It considered each head of charge separately, bearing in mind that the burden of proof rests with the GDC and that the standard of proof is the civil standard, that is, whether the alleged facts are proved on the balance of probabilities.

Committee's findings of fact (16 May 2024)

1.	You provided dental treatment for a period of time up to 1 October 2015 without: a. Appropriate indemnity insurance; and/or b. Run off cover. **ADMITTED AND FOUND PROVED**
2.	You failed to provide Patient A with an adequate standard of care between 8 October 2013 and 15 September 2015 by not carrying out sufficient diagnostic assessments, in that you did not: a. Carry out and/or record Basic Periodontal Examinations; and/or b. Carry out a soft tissue examination; and/or c. Carry out an assessment of oral hygiene status. **NO CASE TO ANSWER**
3.	You failed to obtain informed consent for all of the treatment provided to Patient A between 08 October 2013 to 15 September 2015, in that you did not: a. Carry out and/or record Basic Periodontal Examinations for Patient A; and/or b. Carry out soft tissue or oral hygiene assessments for Patient A; and/or c. Adequately discuss the risks and benefits of orthodontic treatment with Patient A; and/or d. Adequately discuss the expected timeframe and/or retention regime for treatment with Patient A. **FOUND NOT PROVED IN ITS ENTIRETY** Prior to the Committee making its findings in relation to charge 3, it first considered the duty upon you at the time. It had regard to the GDC Standards, particularly Standard 3.1 which reads: *"You must obtain valid consent before starting treatment, explaining all the relevant options and the possible costs".* The Committee was satisfied that there was a clear duty upon you to obtain informed consent. It went on to consider each particular of the charge before determining whether you have breached your duty. In relation to 3. (a) the Committee had regard to your oral evidence in which you were clear that you did not carry out a BPE as you did not have the necessary equipment to do so. It therefore finds that you did not carry out a BPE and naturally flows that there would not have been a record of one either. It therefore finds 3. (a) proved.

	In relation to 3. (b) the Committee had regard to your evidence in that you did carry out a soft tissue and oral hygiene assessment. It had sight of an orthodontic assessment which included reference to soft tissue and intra oral examination. The Committee also had regard to Mr Bateman's evidence that whilst the assessment carried out was an orthodontic assessment, he does concede that it is possible that you carried out a soft tissue assessment. Further, in relation to the oral hygiene assessment, the Committee noted that you wrote a referral letter dated 15 October 2013 in which you made reference to the patient's oral health. You stated in your evidence that you must have made some form of assessment in order to recommend the treatment to the patient. Taking the above into account, the Committee considers that there is some evidence that you did do some form of soft tissue and oral hygiene assessments. It therefore finds 3. (b) not proved. In relation to 3.(c) the Committee heard your evidence that you did discuss the risks and benefits of orthodontic treatment with the patient and that you had used a particular consent form. Looking through the document before it, the Committee could see that you had recorded a note to say that you discussed the options with the patient and it also had sight of a letter dated 12 November 2013 which detailed that you had sent a consent form to the patient to be signed. The Committee however did not have sight of this consent form as the documents were all paper records which have been misplaced since the events took place approximately a decade ago. Taking the above into account, the Committee considers that there is some evidence that you did discuss the risks and benefits of the treatment with the patient. It therefore finds 3. (c) not proved. In relation to 3. (d), the Committee was not provided with the original consent form due to it being lost, as already noted in the above particular. However, it had sight of a consent form that was created towards the end of the treatment for debonding. On this form, which has been signed by the patient, there is a reference to retention. In terms of the timeframe and the patient being aware of the expected timeframe, there is a repeated reference in the notes to "TCA" (to come again) and a designated time for the patient to return to the practice. The Committee inferred from these repeated references that there was some discussion around timeframes. There is also a quotation for private orthodontic treatment dated 12 November 2013 and signed by the patient on 15 January 2014. This includes the number of visits and cost for each visit. Taking the above into account, the Committee considers that there is some evidence that you did discuss the expected timeframe and retention regime for treatment with patient A. It therefore finds 3.(d) not proved. The Committee found in 3.(a) that you did not carry out or record that a BPE was carried out. Having made this positive finding, the Committee went on to consider whether it amounted to a failure to obtain informed consent for all of the treatment provided to Patient A between 08 October 2013 to 15 September 2015. Looking at standard 3.1, the Committee was not satisfied that failing to

	carry/record out a BPE in itself would be a failure to obtain informed consent. In addition, the Committee noted that whilst you did not personally carry out the BPE you did refer the patient back to their general dental practitioner so that an assessment could be carried out in relation to their oral health. Having considered the Charge in detail and looking at the particulars individually the Committee finds the entirety of Charge 3 not proved.
4.	You failed to maintain an adequate standard of record keeping between 08 October 2013 to 15 September 2015 in respect of Patient A's appointments, in that you did not: a. Record a soft tissue examination; and/or b. Record hygiene status; and/or c. Record a discussion of the risks and benefits of the orthodontic treatment proposed; and/or d. Record the expected timeframe and/or retention regime for treatment. **FOUND NOT PROVED IN ITS ENTIRETY** Prior to the Committee making its findings in relation to charge 4, it first considered the duty upon you at the time. It had regard to the GDC Standards, particularly Standard 4.1 which reads: *"You must make and keep contemporaneous, complete and accurate patient records."* The Committee was satisfied that there was a clear duty upon you to maintain an adequate standard of record keeping. It went on to consider each particular of the charge before determining whether you have breached your duty. In relation to 4. (a) the Committee had regard to its findings in 3.(b) in that there was evidence a soft tissue examination had been carried out, albeit specific to orthodontics. It had sight of the orthodontic assessment form which details that an assessment was carried out. The Committee was therefore satisfied that there is a record of a soft tissue examination even though it is specific to orthodontics. It therefore finds 4. (a) not proved. In relation to 4. (b) the Committee had sight of the clinical records and noted that there is a record that the patient complains of bleeding and a further entry stating that patient feels gums much better. The Committee also noted that you made reference to oral hygiene advice being given but not what the status was. The Committee acknowledged these references but considered they were not records of the patient's hygiene status. It therefore finds 4. (b) proved. In relation to 4. (c) the Committee determined that given its findings in 3. (c) that there was a discussion and record of the risks and benefits, it finds this charge not proved.

	In relation to 4. (d) the Committee determined that given its findings in 3. (d) that there was a discussion and record of the expected timeframe and/or retention regime for treatment, it finds this charge not proved. The Committee found in 4.(b) that there was no record made about the patient's hygiene status. Having made this positive finding, the Committee went on to consider whether it amounted to a failure to maintain an adequate standard of record keeping between 08 October 2013 to 15 September 2015. Looking at standard 4.1, the Committee was not satisfied that failing to record the hygiene status in itself would be a failure to maintain adequate record keeping. Having considered the Charge in detail and looking at the particulars individually the Committee finds the entirety of Charge 4 not proved.

Decision on fitness to practise

41. Mr Khan submitted that your failure identified in this case is serious, amounting to a falling short of what would be proper in the circumstances. He drew the Committee's attention to the relevant standard from the Standards for the Dental Team (September 2013) namely 1.8 which in his submission, has been breached. He submitted that the failure to have adequate indemnity in place is serious and amounts to misconduct.

42. Mr Khan moved on to the matter of current impairment and referred the Committee to the principles it must have regard to when considering current impairment. He submitted that you put patients at unwarranted risk of harm by not having adequate indemnity insurance in place at the time. Whilst it is accepted by the GDC that you have shown insight, have clearly reflected and taken steps to remedy such behaviour, the Committee may conclude that it is unlikely to be repeated again. However, the public interest would require a finding of impairment to uphold proper standards of conduct by registrants and maintain confidence in the profession.

43. Prior to making submissions on sanction, Mr Khan referred to your previous fitness to practise history. He informed the Committee that you received a reprimand from a PCC in 2014 in relation to a three registrant NHS Claiming case. Claims were being made to the NHS for treatment which were not merited on the basis of the work that was done. The claims were regarded as inappropriate but were not considered to be dishonest. Mr Khan submitted that it is recognised by the GDC that this matter occurred some time ago and that the findings in the previous case are dissimilar to the findings in this case.

44. Mr Khan submitted that the GDC invites the Committee to make an order of suspension for 3 months with a review. He submitted that it is necessary to mark the conduct in respect of indemnity. However, if the Committee finds that there still is an ongoing risk that it should consider a longer period of suspension. Mr Khan concluded that if the Committee decide to

suspend your registration in the public interest, the GDC would not apply for an immediate order.

45. Mr Cameron on your behalf submitted that the matters in this case occurred approximately 9-11 years ago. On 15 November 2018 you received a letter from Patient A's solicitors. At this time, you were unaware that a claim would not be undertaken by your indemnifiers and up until that point you were sure that you had indemnity in place. In January 2019 you had employed appropriate specialist solicitors to deal with a claim made by the patient and cooperated fully to ensure that the patient was not disadvantaged. You were then reported to the GDC two years after the settlement, and you accepted full responsibility.

46. Mr Cameron submitted that throughout the process you have accepted what has happened and dealt with matters openly and honestly. There was no reasonable explanation that you were required to pay run off cover once you stopped paying the insurance payments or that claims would not be honored after that time. Furthermore, you confirmed that when you needed additional insurance in 2015, you had notified your insurers that you were going to retire, you were offered a policy for a year or a 90 day policy however you were not advised that you should have had run off cover.

47. Mr Cameron submitted that a registrant not having indemnity is serious. However, mistakes can happen and the Committee should consider how you faced up to the consequences and that you accept that it is your responsibility to have indemnity insurance in place. Mr Cameron submitted that the claim made by the patient and the GDC investigation has impacted your life. [PRIVATE.] He referred to the positive testimonials which confirm that you are a champion of patient safety. Further, you have undertaken CPD and you have attended conferences where you talked about patient safety.

48. Mr Cameron submitted that there has been no repetition of your failing and that you have been a professional that has accepted what has happened and handled it appropriately and professionally. A period of suspension would only lengthen this episode.

Decision on misconduct

49. The Committee considered the background to Charge 1. It notes that Patient A had made a negligence claim against you. The firm of solicitors who were acting on behalf of Patient A were informed by your solicitors that you only had claims made indemnity cover at all material times until you ceased providing dental services. This however did not include run off cover. This information prompted Patient A's solicitors to lodge a complaint against you to the GDC on 5 July 2021. The GDC received the complaint and commenced an investigation into the alleged lack of indemnity cover.

50. The Committee notes that you had claims made cover which involves a limited level of cover and is often for a specified period, usually the duration of the policy. Beyond that the cover ends which means that if an incident took place during the policy period the policy holder will only be covered if the claim is made within that policy period, if made after the duration the

policy holder would not be covered. Therefore, you would have been required to hold run off cover.

51. You admitted this charge, albeit stated that you unknowingly did not have appropriate indemnity insurance in place. The Committee acknowledged your evidence that you unknowingly did not have appropriate indemnity insurance in place and when you found out, you took the necessary steps to rectify the issue and ensure that the patient was not disadvantaged at the time of the claims. However, the Committee bore in mind that a Registrant practicing dentistry is required to have appropriate indemnity insurance in place. This is a fundamental tenet of the profession which is outlined in the Dentists' Act 1984:

"26A.Indemnity arrangements

(1)A registered dentist who is practising as a dental practitioner must have in force in relation to him an indemnity arrangement which provides appropriate cover for practising as such."

52. The Committee considered the possible risks to patients treated by you in that their ability to proceed with any potential claim regarding your clinical practice would be impacted by your failure to hold appropriate indemnity insurance. It was of the view that you had the responsibility to ensure that you were appropriately indemnified and that your failing concerned fundamental aspects of dentistry and directly impacted upon the overarching issue of patient safety.

53. The Committee, in reaching its decision, had regard to the public interest and reminded itself that misconduct was a matter for its judgment.

54. When determining whether the facts found proved amount to misconduct the Committee had regard to the terms of the relevant professional standards in force at the time of the incidents. It concluded that your conduct was in breach of the following *Standards for the Dental Team* (2013):

1.8 Have appropriate arrangements in place for patients to seek compensation if they suffer harm.

1.8.1 You must have appropriate insurance or indemnity in place to make sure your patients can claim any compensation to which they may be entitled.

55. The Committee appreciated that the above breaches do not automatically result in a finding of misconduct. However, it was of the view that the breaches in this case are serious and fundamental and the Committee concluded that your conduct was a significant departure from the standards expected of a registered dental professional.
56. It was satisfied that the failing was for a prolonged period and was serious. It went to the very heart of a dentist's duty to ensure patient safety and to put patients' interests first. The Committee therefore concluded that your conduct fell far below the standards expected of a registered dental professional and amounted to misconduct.

Current Impairment

57. The Committee then went on to consider whether your fitness to practise is currently impaired by reason of your misconduct. In doing so, the Committee has again exercised its independent judgement.

58. The Committee has had regard to its findings in relation to your failure to have appropriate indemnity insurance. In considering the likelihood of repetition in relation to your misconduct, it considered the level of your insight into your actions and any remediation you have undertaken. The Committee has had regard to the evidence of the steps you have taken to address the misconduct in this case.

59. The Committee considered whether you have demonstrated insight into your failings. You have engaged fully with the regulatory process, made an admission at the start of these proceedings and accepted it was your responsibility to have appropriate indemnity insurance in place. It further noted your regret and remorse in apologising to Patient A and to the Committee in the course of your oral evidence. Within your written statement, the Committee noted: *"I am bitterly disappointed that I failed to purchase run off cover, I apology unreservedly for my error to the GDC and particularly to Patient A, although I do believe that the actions that I took, at my own expense, immediately upon finding out about the problem meant that any concerns that the patient had that he might be disadvantaged by my error were addressed and removed expeditiously."*

60. Further, during your oral evidence, the Committee considered that you were open and frank. It was persuaded that you would react differently should this situation arise again as indicated in your oral evidence. The Committee also took into account your evidence of CPD provided.

61. The Committee considers that you have demonstrated insight as to the seriousness of your misconduct and its impact on both the reputation of the profession and public confidence. It was provided with testimonials from professional colleagues who are aware of the charge and attest to your character and skills as a dental practitioner.

62. In the Committee's judgement, the risk of repetition is low. It is satisfied that you have learned from past events. The Committee does not find current impairment in relation to any ongoing risk of harm to the public in relation to your misconduct.

63. However, the Committee was in no doubt that a finding of current impairment is required in the wider public interest. You placed patients at potential risk of financial harm as they would not be able to claim compensation for any potential negligent treatment. Furthermore, as an experienced dentist, you are in a privileged position by virtue of your professional status. Patients, employers, colleagues and the public should be able to rely on a registrant's professionalism. You were under a professional duty to adhere to the GDC's standards.

64. Having regard to the wider public interest in this case, the Committee decided that public confidence in the dental profession would be undermined if a finding of impairment were not made in the circumstances. Further, a finding of impairment is necessary to declare and

uphold proper standards of conduct and behaviour within the profession. The Committee has therefore determined that your fitness to practise is currently impaired by reason of your misconduct.

Sanction

65. The Committee next considered what sanction, if any, to impose on your registration. It recognises that the purpose of a sanction is not to be punitive, although it may have that effect, but to protect patients and the wider public interest. The Committee has taken into account the GDC's "Guidance for the Practice Committees, including Indicative Sanctions Guidance" (updated December 2020). It has applied the principle of proportionality, balancing the public interest with your own interests. [PRIVATE.]

66. In considering the appropriate sanction, the Committee had regard to the mitigating and aggravating factors in this case.

67. In mitigation, it considered the following:
    - You made an admission at the outset. Your acceptance of your wrongdoing has been consistent throughout the GDC investigation and the PCC hearing.
    - The evidence of your good conduct following the incidents in question, particularly your remedial action which you started early.
    - The significant level of remorse, remediation and insight shown and your apology.
    - Further, since the incident occurred approximately 9 years ago, there has been no repeat of your misconduct.

68. In terms of aggravating factors, the Committee identified the following:

- Your previous adverse history with the GDC prior to this incident. The Committee heard from Mr Khan that findings were made against you by a PCC in 2014 and you were given a reprimand. However, it notes that this matter occurred approximately 9 years ago and the facts of that case are not similar to the findings in this case. You otherwise have an unblemished record throughout your career of practicing as a dentist for over two decades. The Committee could see from the testimonial evidence before it that you are a highly regarded clinician.
- Risk of financial harm to patients.

69. The Committee considered whether to issue you with a reprimand. It had regard to the relevant paragraphs of the Guidance at 6.7 to 6.9. It took into account that a number of the factors relevant to issuing a reprimand are present in this case, including that there is no evidence that you currently pose a danger to the public. In all the circumstances of this case, the Committee was satisfied that a reprimand was the appropriate and proportionate disposal in order to mark these matters. The Committee did not consider that an order for conditional

registration or suspension was either necessary or proportionate in all the circumstances of the case.

70. The Committee was satisfied that you are highly unlikely to repeat your misconduct. You have shown insight and remorse and you are aware of the importance of your role as a dentist and the impact your actions have on the public and are fully aware of the GDC standards. The Committee considered that there was no danger to the public in allowing you to practice without restrictions. The Committee had regard to the positive testimonial evidence provided from colleagues that attest to your skills and nature as a dentist. The Committee considered that the public would expect an otherwise competent dentist to be allowed to return to safe practice following adequate reflection.

71. In reaching this conclusion, the Committee does not in any way seek to minimise the importance of the duty of registered dental professionals to have appropriate indemnity insurance in place. Your failure was serious as you recognise by your admission and the Committee gave careful consideration to the GDC's submission that your registration should be suspended. However, in the particular circumstances of this case, the Committee was persuaded by your sufficient level of remediation and insight and that you took steps to ensure that Patient A was fully compensated. The Committee applied the principle of proportionality by weighing the interests of the public with those of yours.

72. The Committee therefore determined and now directs that a reprimand be recorded against your name in the GDC Register.

73. That concludes this case.