General Dental Council

HEARING HEARD IN PUBLIC

PINTO, Alexandre Jose Da Cruz Augusto

Registration No: 160825

PROFESSIONAL PERFORMANCE COMMITTEE

FEBRUARY-MARCH 2022

Outcome: Erased with immediate suspension

PINTO, Alexandre Jose Da Cruz Augusto, a dentist, LMD Lisbon 2000, was summoned to appear before the Professional Performance Committee on 28 February 2022 for an inquiry into the following charge:

Charge (as amended on 28 February 2022, 1 March 2022 & 9 March 2022)

"That being a registered dentist:

1. You failed to provide an adequate standard of care to Patient A between 8 June 2010 and 17 November 2011 in that you:
   (a) Failed to report on an OPG radiograph taken on 8 June 2010;
   (b) Failed to record adequately, or at all, that informed consent had been obtained in that you:
      i. Failed to record adequately, or at all, the treatment options provided to Patient A;
      ii. Failed to record adequately, or at all, the advice as to the risks and/or benefits of the treatment proposed prior to fitting appliances;
   (c) Inappropriately used Class II elastics.
2. You failed to provide an adequate standard of care to Patient B between 24 April 2009 and 17 November 2011 in that you:
   (a) Failed to record adequately, or at all, that informed consent had been obtained in that you:
      i. Failed to record adequately, or at all, the treatment options provided to Patient B;
      ii. Failed to record adequately, or at all, the advice as to the risks and/or benefits of the treatment proposed prior to fitting appliances;
   (b) Inappropriately used Class II elastics.
3. You failed to provide an adequate standard of care to Patient C between 03 June 2010 and 17 November 2011 in that you:
   (a) Failed to record adequately, or at all, that informed consent had been obtained in that you:
      i. Failed to record adequately, or at all, the treatment options provided to Patient C;
      ii. Failed to record adequately, or at all, the advice as to the risks and/or

benefits of the treatment proposed prior to fitting appliances;

(b) Inappropriately used Class II elastics.

4. You failed to provide an adequate standard of care to Patient D between 25 February 2010 and 21 November 2011 in that you:

   (a) Failed to record adequately, or at all, that informed consent had been obtained in that you:

      i. Failed to record adequately, or at all, the treatment options provided to Patient D;

      ii. Failed to record adequately, or at all, the advice as to the risks and/or benefits of the treatment proposed prior to fitting appliances;

   (b) Inappropriately used Class II elastics.

5. You failed to provide an adequate standard of care to Patient K between 7 July 2009 and 28 June 2012 in that you:

   (a) Failed to recognise and respond appropriately to Patient K's clinical needs as her orthodontic treatment progressed;

   (b) Failed to record adequately, or at all, that informed consent had been obtained in that you:

      i. Failed to record adequately, or at all, the treatment options provided to Patient K;

      ii. Failed to record adequately, or at all, the advice as to the risks and/or benefits of treatment proposed on prior to fixing appliances;

   (c) Failed to obtain informed consent for the treatment provided in that you:

      i. Failed to inform Patient K and/or her parent of all the treatment options available to Patient K; and/or

      ii. Failed to inform Patient K and/or his parent of the risks and/or benefits of the proposed orthodontic treatment.

   (d) Inappropriately used Class II elastics.

6. You failed to provide an adequate standard of care to Patient L between 23 July 2016 and 21 January 2017 in that you:

   (a) Failed to report an OPG radiograph taken on 23 July 2016;

   (b) Failed to record the taking of a lateral cephalometric radiograph;

   (c) Failed to report on the lateral cephalometric radiograph referred to in (b) above.

7. You failed to provide an adequate standard of care to Patient P between 13 August 2016 and 17 December 2016 in that you:

   (a) Failed to report on a lateral cephalometric radiograph taken on 5 November 2016;

   (b) Failed to record that an OPG had been taken;

   (c) Failed to report on the OPG referred to in (b) above.

8. You failed to provide an adequate standard of care to Patient Q between 24 September 2016 and 22 October 2016 in that:

   (a) Failed to report on an OPG radiograph taken on 24 September 2016;

   (b) Failed to report on the lateral cephalometric radiograph taken on 24 September 2016;

   (c) Undertook an exposure of a lateral cephalometric radiograph when it was not clinically necessary to do so.

9. You failed to provide an adequate standard of care to Patient U between 9 July 2016 and 26 November 2016 in that you:

   (a) Failed to report on an OPG radiograph taken on 9 July 2016;

   (b) Failed to record that a lateral cephalometric radiograph had been taken;

   (c) Failed to report on the lateral cephalometric radiograph referred to at (b) above;

   (d) Undertook the exposure of a lateral cephalometric radiograph when it was not clinically necessary to do so;

   (e) Failed to provide appropriate treatment to Patient U in that you:-

      i. Failed to note that the upper incisors were becoming unacceptably proclined; and

      ii. Failed to take appropriate action to change the treatment plan to include the extraction of premolar teeth to prevent increasing the overjet.

10. You failed to provide an adequate standard of care to Patient X between 9 July 2016 and 17 December 2016 in that you:

   (a) Failed to report on an OPG taken on 09 July 2016;

   (b) Failed to record that the OPG at (a) had been taken;

   (c) Failed to record that consent had been obtained;

   (d) Failed to record adequately, or at all, the treatment options provided to Patient X;

   (e) Failed to record adequately, or at all, the advice as to the risks and/or benefits of treatment proposed prior to fitting appliances.

11. You failed to provide an adequate standard of care to Patient Y between 9 July 2016 and 3 December 2016 in that you:

   (a) Failed to record that an OPG radiograph was taken;

   (b) Failed to report on an OPG radiograph referred to at (a) above;

   (c) Failed to report on lateral cephalometric radiograph taken on 10 September 2016;

   (d) WITHDRAWN

12. WITHDRAWN

13. You failed to provide an adequate standard of care to Patient DD between 23 July 2016 and 17 December 2016 in that you:

(a) Failed to report on OPG radiograph taken on 23 July 2016;

(b) Failed to record the taking of a lateral cephalometric radiograph;

(c) Failed to report on the lateral cephalometric radiograph referred to at (b) above.

14. You failed to provide an adequate standard of care to Patient FF between 6 August 2016 and 3 December 2016 in that you:

(a) Failed to record the taking of an OPG radiograph;

(b) Failed to report on the OPG radiograph referred to at (a) above;

15. You failed to provide an adequate standard of care to Patient GG between 6 August 2016 and 17 December 2016 in that you:

(a) Failed to record the taking of an OPG radiograph;

(b) Failed to report on the OPG radiograph referred to at (a) above.

16. You failed to provide an adequate standard of care to Patient JJ between 10 September 2016 and 17 December 2016 in that you:

(a) Failed to report on an OPG radiograph taken on 10 September 2016;

(b) Failed to report on a lateral cephalometric radiograph taken on 10 September 2016;

(c) Failed to provide appropriate treatment to Patient JJ in that you:-

i. Failed to consider reducing the increasing overjet;

ii. Failed to take appropriate action to change the treatment plan to include the extraction of two upper premolar teeth.

17. You failed to provide an adequate standard of care to Patient LL between 13 August 2016 and 10 December 2016 in that you:

(a) Failed to report on an the OPG radiograph;

(b) Failed to report on the lateral cephalometric radiograph.

18. You failed to provide an adequate standard of care to Patient MM between 10 September 2016 and 17 December 2016 in that you:

(a) Failed to report on OPG radiograph taken on 10 September 2016;

(b) Failed to report on lateral cephalometric radiograph taken on 10 September 2016.

19. You failed to provide an appropriate standard of care to Patient OO between 8 October 2016 and 26 November 2016 in that you:

(a) Failed to record the taking of an OPG radiograph on an unknown date;

(b) Failed to report on the OPG radiograph referred to at (a) above.

20. You failed to provide an adequate standard of care to Patient PP between 5 December 2013 and 20 February 2015 in that you:

(a) Failed to record any adequate treatment plan, in relation to Patient PP's impacted upper canines on 5 December 2013;

(b) Failed to report on an OPG radiograph taken on 9 December 2013;

(c) Failed to report on a lateral cephalometric radiograph taken on 9 December 2013;

(d) Undertook the exposure of a lateral cephalometric radiograph on 9 December 2013 when it was not clinically necessary to do so.

(e) Failed to seek a consultant orthodontic opinion regarding the upper impacted canines prior to commencing orthodontic treatment;

(f) Failed to record adequately, or at all, that informed consent had been obtained in that you:

i. Failed to record adequately, or at all, the advice as to the risks and/or benefits of treatment proposed on 09 December 2013

ii. Failed to record adequately, or at all, the treatment options provided to Patient PP (g).

You failed to obtain informed consent from Patient PP and/or his parent between 5 December 2013 and 20 February 2015 in that you:

i. Failed to inform Patient PP and/or his parent of all the treatment options available to Patient PP; and/or

ii. Failed to inform Patient PP and/or his parent of the risks and/or benefits of the proposed orthodontic treatment.

21. You failed to provide an adequate standard of care to Patient QQ between 17 February 2014 and 27 February 2015 in that you:

(a) WITHDRAWN;

(b) Failed to record adequately, or at all, the advice as to the risks and/or benefits of treatment proposed on 17 February 2014;

(c) Failed to record adequately, or at all, the treatment options provided to Patient QQ;

(d) Failed to record whether the spaces in the upper lateral incisor regions were to be closed

(e) Provided a poor standard of treatment in that you:-

i. Failed to note that the unerupted UR3 was impacted; and

ii. Failed to take appropriate action to treat the impacted UR3.

22. You failed to provide an adequate standard of care to Patient RR between 6 October 2014 and 18 March 2015 in that you:

(a) Failed to record adequately, or at all, that informed consent had been obtained in that you:

i. Failed to record adequately, or at all, the advice as to the risks and/or benefits of treatment proposed prior to fitting appliances;

ii. Failed to record adequately, or at all, the treatment options provided to Patient RR,

(b) Provided a course of treatment which was not clinically appropriate in Patient

RR's circumstances in that it did not involve extractions.

23. You failed to provide an adequate standard of care to Patient SS between 23 May 2013and 17 March 2015 in that you:

    (a) Failed to report on an OPG taken on 23 May 2013;

    (b) Failed to record adequately, or at all, that informed consent had been obtained in that you:-

        i. Failed to record adequately, or at all, the treatment options provided to Patient SS;

        ii. Failed to record adequately, or at all, the risks and benefits were provided to Patient SS;

    (c) Provided a course of treatment which was not clinically appropriate in Patient SS circumstances in that it did not include lower premolar extractions.

24. You failed to provide an adequate standard of care to patients VV between 13 March 2014 and 12 February 2015 in that you:

    (a) Failed to carry out a BPE on 13 March 2014;

    (b) Failed to report on an OPG taken on 17 March 2014;

    (c) Failed to report on lateral cephalometric radiograph taken on 17 March 2014;

    (d) AMENDED TO READ: Took a lateral cephalometric radiograph on 17 March 2014 when it was not clinically necessary to do so;

    (e) Failed to record adequately, or at all, that informed consent had been obtained in that you:

        i. Failed to record adequately, or at all, the treatment options provided to Patient VV;

        ii. Failed to record adequately or at all, the risks and benefits of treatment.

    (f) WITHDRAWN

    (g) Commenced orthodontic treatment when Patient VV had poor oral hygiene

    (h) Provided a poor standard of treatment by not realising and/or not adequately addressing that the lower second left and right premolar teeth were becoming lingually impacted.

25. You failed to provide an adequate standard of care to patient WW between 5 June 2014 and 13 April 2015, in that you:

    (a) Failed to report on a lateral cephalometric radiograph taken on 9 June 2014;

    (b) WITHDRAWN;

    (c) Failed to record adequately or at all that informed consent had been obtained in that you:

        i. Failed to record adequately, or at all, the advice as to the risks and/or benefits of treatment proposed prior to fitting appliances;

        ii. Failed to record adequately, or at all, the treatment options provided to

Patient WW.

(d) You failed to obtain informed consent from Patient WW and/or his parents between 5 June 2014 and 13 April 2015 in that you:

i. WITHDRAWN

ii. Failed to inform Patient WW and/or his parent of the risks and/or benefits of the proposed orthodontic treatment.

26. You failed to provide an adequate standard of care to patient XX between 10 June 2013 and 16 February 2015 in that you:

(a) Failed to carry out any or adequate periodontal assessment on 10 June 2013;

(b) Failed to report on an OPG taken on 25 June 2013;

(c) Failed to formulate any, or any adequate, treatment plan for Patient XX's ankylosed LL6;

(d) Undertook a course of orthodontic treatment which was not clinically appropriate in the circumstances of Patient XX's case;

(e) Failed to record adequately, or at all, that informed consent had been obtained in that you:

i. Failed to record adequately, or at all, the advice as to the risks and/or benefits of treatment proposed prior to fitting appliances;

ii. Failed to record adequately, or at all, the treatment options provided to Patient XX.

27. You failed to provide an adequate standard of care to patient YY between 12 May 2014 and 28 January 2015 in that you:

(a) Failed to report on an OPG taken on 29 May 2014;

(b) Failed to report on a lateral cephalometric radiograph taken on 29 May 2014;

(c) Took a lateral cephalometric radiograph on 29 May 2014 when it was not clinically necessary to do so;

(d) Failed to record adequately, or at all, that informed consent had been obtained in that you:

i. Failed to record adequately, or at all, the treatment options provided to Patient YY;

ii. Failed to record adequately, or at all, the advice as to the risks and/or benefits of treatment proposed prior to fitting appliances.

28. You failed to provide an adequate standard of care to patient ZZ between 13 May 2013 and the 28 January 2015 in that you:

(a) Failed to report on an OPG taken on 20 May 2013

(b) Failed to formulate any, or any adequate, treatment plan for Patient ZZ's:-

i. Supernumerary LR2;

ii. Missing lower second premolars.

(c) Failed to record adequately, or at all, that informed consent had been obtained in that you:-

i. Failed to record adequately, or at all, what treatment options were provided to Patient ZZ

ii. Failed to record adequately, or at all, the advice as to the risks and/or benefits of treatment proposed prior to fitting appliances;

(d) Provided a poor standard of treatment in that you failed to adequately treat Patient ZZ's presenting complex malocclusion.

29. You failed to provide an adequate standard of care to patient AAA between 18 February 2013 and 2 October 2014 in that you:

(a) Failed to report on OPG taken on 27 March 2013;

(b) Failed to record that consent had been obtained;

(c) Failed to record adequately, or at all, the treatment options provided to Patient AAA;

(d) Failed to record adequately, or at all, the advice as to the risks and/or benefits of treatment proposed prior to fitting appliances.

30. You failed to provide an adequate standard of care to patient CCC between 10 May 2013 and 15 October 2014 in that you:

(a) Failed to report on OPG taken on 17 May 2013;

(b) Provided a poor standard of treatment in that Patient CCC's buccal segment; interdigitation became worse during the course of her orthodontic treatment;

(c) Failed to record that consent had been obtained;

(d) Failed to record adequately, or at all, the treatment options provided to Patient CCC;

(e) Failed to record adequately, or at all, the advice as to the risks and/or benefits of treatment proposed prior to fitting appliances.

31. You failed to provide an adequate standard of care to patient DDD between 19 February 2013 and 13 October 2014 in that you:

(a) Failed to report on an OPG radiograph taken on 5 March 2013;

(b) Failed to record that consent had been obtained;

(c) Failed to record adequately, or at all, the treatment options provided to Patient DDD;

(d) Failed to record adequately, or at all, the advice as to the risks and/or benefits of treatment proposed prior to fitting appliances.

32. You failed to cooperate with the Council by not responding to the Council's correspondence from 04 April 2019 to 20 March 2020."

Mr Pinto was not present and was not represented. On 28 February 2022 the Chairman announced a statement on proof of service. On 4 March 2022 the Chairman announced the findings of fact to the Counsel for the GDC:

> "This is a hearing before a panel of the General Dental Council's (GDC) Professional Performance Committee (the "Committee") to consider the allegations against Mr Pinto set out in the notice of hearing dated 28 January 2022.
>
> Mr Pinto was neither present nor represented at the hearing, which was conducted remotely using Microsoft Teams.
>
> Ms Daly of Counsel submitted on behalf of the GDC that the notice of hearing had been served on Mr Pinto in accordance with the requirements of the General Dental Council (Fitness to Practise) practice 2006 (the "Rules") and that the hearing should proceed in his absence.
>
> *Service and absence 28 February 2022*
>
> The Committee accepted the advice of the Legal Adviser on the requirements of service and proceeding in the absence of the respondent.
>
> The Committee first considered whether the notice of hearing had been served on Mr Pinto in accordance with the requirements of the Rules.
>
> The notice of hearing was sent on 28 January 2022 to Mr Pinto at his registered address in the United Kingdom by Special Delivery. The Committee was satisfied that this document contained the required information under Rule 13 of the Rules, including the time, date and (remote) venue of this hearing.
>
> There had been no response or engagement from Mr Pinto regarding this hearing.
>
> By letter dated 03 April 2019, RadcliffesLeBraseur stated that they were no longer instructed by Dental Protection to represent Mr Pinto. By email on 27 April 2020, in reply to an enquiry from the GDC, Dental Protection stated: "*I am writing to confirm that Dental Protection has had no further instruction from Mr Pinto in respect of his GDC fitness to practise investigation. We are therefore no longer assisting him.*"
>
> The last record before the Committee of any communication from Mr Pinto is a chain of email correspondence between him and the GDC on 06 April 2018, in which he stated that he was in Mozambique and requested the cancellation of his GDC registration. He stated that: "*I am not planning on returning or working in the UK*".
>
> In an email Mr Pinto had sent on 10 March 2018 to NHS England regarding the entry of his name on the Performers List, he stated:
>
> > "Firstly my apologies for the late response.
> >
> > I have now left the UK. I don't have access to a secure printer in order to forward the documents you request. Therefor I would like to cancel my performer number since I don't plan to return.
> >
> > Thank you for your help in this matter."
>
> Accordingly, it was unclear to the Committee whether Mr Pinto is in fact still contactable at his registered address in the United Kingdom. In October 2018 and January 2019 the GDC wrote to the Portuguese Dental Regulator in an attempt to trace Mr Pinto. There is no record of any response from it to the GDC's requests.

On the material available to the Committee, Mr Pinto's registered address in the United Kingdom remains his last known address. The Committee was satisfied that this address was therefore valid for the purposes of serving the notice of hearing on him. As a registered dental professional it is his responsibility to ensure that his contact details are kept up-to-date with his regulatory body. Having regard to all the circumstances, the Committee was satisfied that the notice of hearing had been served on Mr Pinto in accordance with the requirements of Rule 65 of the Rules by virtue of it being posted to his registered address by Special Delivery.

The next consideration for the Committee was whether to proceed in the absence of Mr Pinto. This is a discretion which must be exercised with great care and caution. The Committee was satisfied that the GDC had made all reasonable efforts to send notice of this hearing to Mr Pinto. In addition to enquiring with the Portuguese authority for any current correspondence address, the GDC also emailed Mr Pinto on 28 January 2022 a secure link to download the notice of hearing, using the same email address which he had used to correspond with the GDC in April 2019.

There has been no response or engagement from Mr Pinto in respect of these proceedings since April 2018. He made no application for a postponement or adjournment of this hearing and there was nothing to suggest to the Committee that adjourning the hearing would make his attendance or engagement any more likely at a future date. The evidence before the Committee suggests that Mr Pinto has fully and deliberately disengaged from these proceedings and from the GDC as his regulator. He no longer appears to be practising dentistry in the United Kingdom and had previously stated to the GDC that he has no intention of doing so in the future.

Having regard to all the circumstances, including the convenience of the witnesses and the need for the expeditious disposal of proceedings, the Committee determined that Mr Pinto had voluntarily absented himself from this hearing and that it would be fair and in the public interest to proceed, notwithstanding his absence.

The factual inquiry

On 28 February 2022, Ms Daly applied for the following charges to be withdrawn: 11(d), 12, 21(a), 24(f) and 25(d)(i). She submitted that the evidence would no longer support those charges following a further review of the charges against the report of Mr G. Bellman, a specialist orthodontist instructed by the GDC for his expert opinion.

The Committee was satisfied that the charges could be withdrawn without injustice to either party and therefore acceded to the application.

On 1 March 2022 Ms Daly made an application to also withdraw charge 25(b) following a query from a Committee member that the records do appear to contain what could be characterised as a report on the radiograph in question, contrary to what was alleged by that charge. Ms Daly submitted that having reviewed the record with Mr Bellman the GDC accepted that there was such a record and therefore no longer pursued charge 25(b).

The Committee was satisfied that the charge could be withdrawn without injustice to either party and therefore acceded to the application.

The Committee heard oral evidence through Microsoft Teams from the following witnesses of fact:

Witness 1, the manager for Practice A;

Witness 2, the manager for Practice B;

Witness 3, the manager for Practice C;

Patient K;

Patient K's mother;

Patient PP;

Patient PP's mother;

Patient WW;

Patient WW's father.

The Committee also heard oral evidence from Mr Bellman.

The Committee accepted the evidence of the Legal Adviser.

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

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

1.	*You failed to provide an adequate standard of care to Patient A between 8 June 2010 and 17 November 2011 in that you:*
1.a	*Failed to report on an OPG radiograph taken on 8 June 2010;* Proved. Patient A's records contain an OPG (orthopantomogram) radiograph dated 8 June 2010 but do not contain any report on the radiograph. The Committee was therefore satisfied that the OPG radiograph had been taken but had not been reported on. The Committee accepted the evidence of Mr G. Bellman that Mr Pinto was under a statutory duty under the Ionising Radiation (Medical Exposure) Regulations 2000 ("IR(ME)R 2000") to report on the OPG radiograph. Accordingly, the Committee found this charge proved.
1.b	*Failed to record adequately, or at all, that informed consent had been obtained in that you:*
1.b.i	*Failed to record adequately, or at all, the treatment options provided to Patient A;* Proved.
1.b.ii	*Failed to record adequately, or at all, the advice as to the risks and/or benefits of the treatment proposed prior to fitting appliances;* Proved. The Committee accepted the evidence of Mr Bellman that the clinical records do not adequately record any discussion on the treatment options provided to the patient or any advice as to the risks and benefits of the proposed treatment prior to fitting appliances. The

	Committee noted the presence of a signed consent form in the clinical records, but this form post-dated the commencement of the treatment by some 3 months and was also generic and not specific to the patient. The consent form (retrospectively) recorded the common risks of the proposed treatment but did not also include the less common (but potentially serious) risks of pulp damage and allergies to the orthodontic materials. Having examined the clinical records and the chronology of the patient's treatment, the Committee was satisfied that Mr Pinto had failed to record adequately that informed consent had been obtained. Accordingly, the Committee found charges 1.b.i-ii proved.
1.c	*Inappropriately used Class II elastics.* Proved. The clinical records record the use by Mr Pinto of Class II elastics as part of the orthodontic treatment. Mr Bellman's opinion was that the use of Class II elastics in this case was inappropriate, as their use with the light flexible wires in the lower and upper arches could result in too much force being applied to the occlusion with "*the effect of upsetting the bite by elevating and dumping the lower molar teeth and extruding the upper canine teeth*". Mr Bellman explained that there is an alternative system called the Damon technique where elastics can be used at certain points of treatment, but that "*Dentists who practi[s]e the Damon technique are encouraged to use very light elastics in very short spans in flexible wires*". However, he was of the opinion that Mr Pinto did not use the Damon technique. In response to Committee questions, Mr Bellman was clear and unequivocal in his view that the use of Class II elastics in this case was inappropriate. The Committee accepted the opinion of Mr Bellman. Accordingly, the Committee found this charge proved.
2	*You failed to provide an adequate standard of care to Patient B between 24 April 2009 and 17 November 2011 in that you:*
2.a	*Failed to record adequately, or at all, that informed consent had been obtained in that you:*
2.a.i	*Failed to record adequately, or at all, the treatment options provided to Patient B;* Proved.
2.a.ii	*Failed to record adequately, or at all, the advice as to the risks and/or benefits of the treatment proposed prior to fitting appliances;* Proved.

	The Committee accepted the evidence of Mr Bellman that the clinical records do not adequately record any discussion on the treatment options provided to the patient or any advice as to the risks and benefits of the proposed treatment prior to fitting appliances. The Committee noted the presence of a signed consent form in the clinical records, but this form post-dated the commencement of the treatment by some 18 months and was also generic and not specific to the patient. The consent form (retrospectively) recorded the common risks of the proposed treatment but did not also include the less common (but potentially serious) risks of pulp damage and allergies to the orthodontic materials. Having examined the clinical records and the chronology of the patient's treatment, the Committee was satisfied that Mr Pinto had failed to record adequately that informed consent had been obtained. Accordingly, the Committee found charges 2.a.i-ii proved.
2.b	*Inappropriately used Class II elastics.* Proved. The Committee's reasons are the same as those set out under charge 1.c above.
3.	*You failed to provide an adequate standard of care to Patient C between 03 June 2010 and 17 November 2011 in that you:*
3.a	*Failed to record adequately, or at all, that informed consent had been obtained in thatyou:*
3.a.i	*Failed to record adequately, or at all, the treatment options provided to Patient C;* Proved.
3.a.ii	*Failed to record adequately, or at all, the advice as to the risks and/or benefits of the treatment proposed prior to fitting appliances;* Proved. The Committee accepted the evidence of Mr Bellman that the clinical records do not adequately record any discussion on the treatment options provided to the patient or any advice as to the risks and benefits of the proposed treatment prior to fitting appliances. The Committee noted the presence of a signed consent form in the clinical records, but this form post-dated the commencement of the treatment by some 4 months and was also generic and not specific to the patient. The consent form (retrospectively) recorded the common risks of the proposed treatment but did not also include the less common (but potentially serious) risks of pulp damage and allergies to the orthodontic materials. Having examined the clinical records and the chronology of the patient's treatment, the Committee was satisfied that Mr Pinto had

	failed to record adequately that informed consent had been obtained. Accordingly, the Committee found charges 3.a.i-ii proved.
3.b	*Inappropriately used Class II elastics.* Proved. The Committee's reasons are the same as those set out under charge 1.c above.
4.	*You failed to provide an adequate standard of care to Patient D between 25 February 2010 and 21 November 2011 in that you:*
4.a.	*Failed to record adequately, or at all, that informed consent had been obtained in thatyou:*
4.a.i	*Failed to record adequately, or at all, the treatment options provided to Patient D;* Proved.
4.a.ii	*Failed to record adequately, or at all, the advice as to the risks and/or benefits of the treatment proposed prior to fitting appliances;* Proved. The Committee accepted the evidence of Mr Bellman that the clinical records do not adequately record any discussion on the treatment options provided to the patient or any advice as to the risks and benefits of the proposed treatment prior to fitting appliances. The Committee noted the presence of a signed consent form in the clinical records, but this form post-dated the commencement of the treatment by some 8 months and was also generic and not specific to the patient. The consent form (retrospectively) recorded the common risks of the proposed treatment but did not also include the less common (but potentially serious) risks of pulp damage and allergies to the orthodontic materials. Having examined the clinical records and the chronology of the patient's treatment, the Committee was satisfied that Mr Pinto had failed to record adequately that informed consent had been obtained. Accordingly, the Committee found charges 4.a.i-ii proved.
4.b	*Inappropriately used Class II elastics.* Proved. The Committee's reasons are the same as those set out under charge 1.c above.
5.	*You failed to provide an adequate standard of care to Patient K between 7 July 2009 and 28 June 2012 in that you:*
5.a	*Failed to recognise and respond appropriately to Patient K's clinical needs as her orthodontic treatment progressed;*

	Proved. The Committee heard oral evidence from Patient K and her mother regarding the progression of Patient K's orthodontic treatment. The Committee accepted their evidence, in particular that Mr Pinto had not identified any problems with the treatment he was providing as that treatment progressed, notwithstanding the concerns that Patient K and her mother were reporting to him regarding the movement of her teeth and changes to shape of her face. Patient K and her mother ultimately sought a second opinion in January 2012. In his report dated 1 May 2020, Mr Bellman stated: The patient was seen by […] a consultant orthodontist at […] on 11 February 2013 for a second opinion. In her Treatment Plan she records "I have explained to [Patient K] and her mum that I am very concerned about the health and longevity of the lower incisors and demonstrated their proclination. I also demonstrated the position of the lower first molars and that they are now in crossbite with the uppers, in particular on the right side. Removing appliances at this stage would leave her with an awkward occlusion and lower incisors at risk of trauma." This appointment was 7 months after the registrant last saw the patient. She had been referred to the consultant by […] a specialist orthodontic practitioner, who saw the patient sometime earlier. According to the witness statement of Patient K this was in January 2012. From [the consultant orthodontist's] assessment of the presenting malocclusion it appears that treatment was going badly wrong with the lower incisors very proclined and molar crossbites. In my opinion the treatment of patient K would appear to be of a very poor standard by the Registrant... The Committee accepted the evidence of Mr Bellman. Mr Pinto should have identified that the orthodontic treatment he was providing was not going to plan and he should have adjusted the treatment plan accordingly. Accordingly, the Committee found this charge proved.
5.b	*Failed to record adequately, or at all, that informed consent had been obtained in that you:*
5.b.i	*Failed to record adequately, or at all, the treatment options provided to Patient K;* Proved.
5.b.ii	*Failed to record adequately, or at all, the advice as to the risks and/or benefits of treatment proposed on prior to fixing appliances;* Proved. There is no record of the treatment options provided to Patient K and no record of any advice given as to the risks and/or benefits of treatment proposed on prior to fixing appliances. There is no record either of any consent form (whether prior to or following the treatment).

	Accordingly, the Committee found charges 5.b.i-ii proved.
5.c	*Failed to obtain informed consent for the treatment provided in that you:*
5.c.i	*Failed to inform Patient K and/or her parent of all the treatment options available to Patient K; and/or* Proved
5.c.ii	*Failed to inform Patient K and/or his [sic] parent of the risks and/or benefits of the proposed orthodontic treatment.* Proved. The Committee accepted the evidence of Patient K and her mother. At paragraph 7 of her witness statement dated 22 June 2020, Patient K's mother stated: I have been asked whether we had any discussions with the Registrant regarding the risks and/or benefits of the treatment. I understood that the treatment was to straighten her teeth and correct her overbite. I was concerned about damage to [Patient K's] teeth when the braces were removed, but he explained that there would not be any damage. Apart from this discussion, the Registrant did not provide me with information in relation to any risks of the treatment. I also recall that photographs of [Patient K's] teeth were taken, however I am unable to recall when. I do not recall being given anything to read or take away at any of [Patient K's] appointments. I am unsure whether I was given anything to sign. I never had any discussions with the Registrant or any member of staff at the Practice regarding alternative treatments or options. Accordingly, the Committee found charges 5.c.i-ii proved.
5.d	*Inappropriately used Class II elastics.* Proved. The Committee's reasons are the same as those set out under charge 1.c above.
6.	*You failed to provide an adequate standard of care to Patient L between 23 July 2016 and 21 January 2017 in that you:*
6.a	*Failed to report an OPG radiograph taken on 23 July 2016;* Proved. Patient L's records contain an OPG radiograph dated 23 July 2016 but do not contain any report on the radiograph. The Committee was therefore satisfied that the OPG radiograph had been taken but had not been reported on. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty under IR(ME)R 2000 to report on the OPG radiograph. Accordingly, the Committee found this charge proved.

6.b	*Failed to record the taking of a lateral cephalometric radiograph;* Proved. Patient L's records contain the lateral cephalometric radiograph itself but there is no corresponding record of its being taken. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty to have recorded the taking of the radiograph. Accordingly, the Committee found this charge proved.
6.c	*Failed to report on the lateral cephalometric radiograph referred to in (b) above.* Proved. There is no record of the radiograph having been reported on. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty under IR(ME)R 2000 to have reported on the radiograph. Accordingly, the Committee found this charge proved.
7.	*You failed to provide an adequate standard of care to Patient P between 13 August 2016 and 17 December 2016 in that you:*
7.a	*Failed to report on a lateral cephalometric radiograph taken on 5 November 2016;* Proved. Patient P's records contain the lateral cephalometric radiograph on 5 November 2016 but there is no record of the radiograph being reported on. The Committee was therefore satisfied that the radiograph had been taken but had not been reported on. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty under IR(ME)R 2000 to report on the radiograph. Accordingly, the Committee found this charge proved.
7.b	*Failed to record that an OPG had been taken;* Proved. Patient P's records contain the OPG radiograph itself but there is no corresponding record of its being taken. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty to have recorded the taking of the radiograph. Accordingly, the Committee found this charge proved.
7.c	*Failed to report on the OPG referred to in (b) above.* Proved. There is no record of the radiograph being reported on. The Committee was satisfied that the radiograph had been taken but had not been

	reported on. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty under IR(ME)R 2000 to report on the OPG radiograph. Accordingly, the Committee found this charge proved.
8.	*You failed to provide an adequate standard of care to Patient Q between 24 September 2016 and 22 October 2016 in that:*
8.a	*Failed to report on an OPG radiograph taken on 24 September 2016;* Proved. Patient Q's records contain an OPG radiograph dated 24 September 2016 but do not contain any report on the radiograph. The Committee was therefore satisfied that the OPG radiograph had been taken but had not been reported on. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty under IR(ME)R 2000 to report on the OPG radiograph. Accordingly, the Committee found this charge proved.
8.b	*Failed to report on the lateral cephalometric radiograph taken on 24 September 2016;* Patient Q's records contain a lateral cephalometric radiograph dated 24 September 2016 but do not contain any report on the radiograph. The Committee was therefore satisfied that the radiograph had been taken but had not been reported on. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty under IR(ME)R 2000 to report on the radiograph. Accordingly, the Committee found this charge proved.
8.c	*Undertook an exposure of a lateral cephalometric radiograph when it was not clinically necessary to do so.* Proved. The Committee accepted the evidence of Mr Bellman that the patient had a normal overjet and that the taking of a lateral cephalometric radiograph was therefore not clinically necessary and that such a radiograph should not have been taken as a matter of routine. As the taking of the radiograph was not clinically necessary, Mr Pinto exposed the patient to radiation when this was not justified. Accordingly, the Committee found this charge proved.
9.	*You failed to provide an adequate standard of care to Patient U between 9 July 2016 and 26 November 2016 in that you:*
9.a	*Failed to report on an OPG radiograph taken on 9 July 2016;* Proved.

	Patient U's records contain an OPG radiograph dated 9 July 2016 but do not contain any report on the radiograph. The Committee was therefore satisfied that the OPG radiograph had been taken but had not been reported on. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty under IR(ME)R 2000 to report on the OPG radiograph. Accordingly, the Committee found this charge proved.
9.b	*Failed to record that a lateral cephalometric radiograph had been taken;* Proved. Patient U's records contain the lateral cephalometric radiograph itself but there is no corresponding record of its being taken. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty to have recorded the taking of the radiograph. Accordingly, the Committee found this charge proved.
9.c	*Failed to report on the lateral cephalometric radiograph referred to at (b) above;* Proved. There is no record of the radiograph being reported on. The Committee was satisfied that the radiograph had been taken but had not been reported on. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty under IR(ME)R 2000 to report on the radiograph. Accordingly, the Committee found this charge proved.
9.d	*Undertook the exposure of a lateral cephalometric radiograph when it was not clinically necessary to do so;* Proved. The Committee's reasons are the same as those under charge 8.c above.
9.e	*Failed to provide appropriate treatment to Patient U in that you:-*
9.e.i	*Failed to note that the upper incisors were becoming unacceptably proclined; and* Proved.
9.e.ii	*Failed to take appropriate action to change the treatment plan to include the extraction of premolar teeth to prevent increasing the overjet.* Proved. There is no record in the notes of the upper incisors becoming unacceptably proclined and there is no record to indicate any

	appropriate action to change the treatment plan to include the extraction of the premolar teeth. In his report, Mr Bellman stated: I have examined a set of post treatment study models taken on 27 May 2016 these show, crowding to still be present and the upper incisors proclined. In my opinion the registrant should have been monitoring the progress of treatment, realised that the upper incisors were proclining unacceptably and that the overjet was increasing and how to prevent the overjet increasing further, probably by the extraction of premolar teeth during treatment in order to prevent further proclination of the upper incisors and correction of the centre line. This is poor treatment by the registrant as during the treatment he should have been aware that the teeth were lining up at the expense of the upper incisors becoming unacceptably proclined and taken appropriate action to change the treatment to involve the extraction of premolar teeth to stop the overjet increasing… The Committee accepted Mr Bellman's opinion. Accordingly, the Committee found this charge proved.
10.	*You failed to provide an adequate standard of care to Patient X between 9 July 2016 and 17 December 2016 in that you:*
10.a	*Failed to report on an OPG taken on 09 July 2016;* Not proved. Mr Pinto reported on the LL5 in the clinical notes, which would only have been visible to him from the OPG radiograph taken on 9 July 2016. He had therefore clearly examined the radigoraph and reported on his findings, albeit indirectly and in bare terms.
10.b	*Failed to record that the OPG at (a) had been taken;* Not proved. It is noted in the clinical records for 9 July 2016 "proposed – panoral radiograph". Accordingly, the Committee found this charge not proved.
10.c	*Failed to record that consent had been obtained;* Proved. There is no note in the clinical records recording that informed consent had been obtained, neither is there any consent form contained within the clinical records. Accordingly, the Committee found this charge proved.
10.d	*Failed to record adequately, or at all, the treatment options provided to Patient X;* Proved. This information is absent from the clinical records.

	Accordingly, the Committee found this charge proved.
10.e	*Failed to record adequately, or at all, the advice as to the risks and/or benefits of treatment proposed prior to fitting appliances.* Proved. This information is absent from the clinical records. Accordingly, the Committee found this charge proved.
11.	*You failed to provide an adequate standard of care to Patient Y between 9 July 2016 and 3 December 2016 in that you:*
11.a	*Failed to record that an OPG radiograph was taken;* Proved. Patient Y's clinical records contain the OPG radiograph itself but there is no corresponding record of its being taken. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty to have recorded the taking of the radiograph. Accordingly, the Committee found this charge proved.
11.b	*Failed to report on an OPG radiograph referred to at (a) above;* Proved. There is no record of the radiograph being reported on. The Committee was satisfied that the radiograph had been taken but had not been reported on. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty under IR(ME)R 2000 to report on the radiograph. Accordingly, the Committee found this charge proved.
11.c	*Failed to report on lateral cephalometric radiograph taken on 10 September 2016;* Proved. The clinical records contain a lateral cephalometric radiograph dated 10 September 2016 but there is no record of the radiograph being reported on. The Committee was therefore satisfied that the radiograph had been taken but had not been reported on. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty under IR(ME)R 2000 to report on the radiograph. Accordingly, the Committee found this charge proved.
11.d	WITHDRAWN
12.	WITHDRAWN
12.a	WITHDRAWN
13.	*You failed to provide an adequate standard of care to Patient DD between 23 July 2016 and 17 December 2016 in that you:*

13.a	*Failed to report on OPG radiograph taken on 23 July 2016;* The clinical records contain an OPG radiograph dated 23 July 2016 but there is no record of the radiograph being reported on. The Committee was therefore satisfied that the radiograph had been taken but had not been reported on. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty under IR(ME)R 2000 to report on the radiograph. Accordingly, the Committee found this charge proved.
13.b	*Failed to record the taking of a lateral cephalometric radiograph;* Proved. Patient DD's clinical records contain the lateral cephalometric radiograph itself but there is no corresponding record of its being taken. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty to have recorded the taking of the radiograph. Accordingly, the Committee found this charge proved.
13.c	*Failed to report on the lateral cephalometric radiograph referred to at (b) above.* Proved. There is no record of the radiograph being reported on. The Committee was therefore satisfied that the radiograph had been taken but had not been reported on. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty under IR(ME)R 2000 to report on the radiograph. Accordingly, the Committee found this charge proved.
14.	*You failed to provide an adequate standard of care to Patient FF between 6 August 2016 and 3 December 2016 in that you:*
14.a	*Failed to record the taking of an OPG radiograph;* Proved. Patient FF's clinical records contain the OPG radiograph itself but there is no corresponding record of its being taken. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty to have recorded the taking of the radiograph. Accordingly, the Committee found this charge proved.
14.b	*Failed to report on the OPG radiograph referred to at (a) above;* Proved. There is no record of the radiograph being reported on. The Committee was therefore satisfied that the radiograph had been taken but had not been reported on. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty under IR(ME)R 2000

	to report on the radiograph. Accordingly, the Committee found this charge proved.
15.	*You failed to provide an adequate standard of care to Patient GG between 6 August 2016 and 17 December 2016 in that you:*
15.a	*Failed to record the taking of an OPG radiograph;* Proved. Patient GG's clinical records contain the OPG radiograph itself but there is no corresponding record of its being taken. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty to have recorded the taking of the radiograph. Accordingly, the Committee found this charge proved.
15.b	*Failed to report on the OPG radiograph referred to at (a) above.* Proved. There is no record of the radiograph being reported on. The Committee was therefore satisfied that the radiograph had been taken but had not been reported on. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty under IR(ME)R 2000 to report on the radiograph. Accordingly, the Committee found this charge proved.
16.	*You failed to provide an adequate standard of care to Patient JJ between 10 September 2016 and 17 December 2016 in that you:*
16.a	*Failed to report on an OPG radiograph taken on 10 September 2016;* Proved.
16.b	*Failed to report on a lateral cephalometric radiograph taken on 10 September 2016;* Proved. Patient JJ's clinical records contain the two radiographs referred to under charges 16.a and b but there is no record of either radiograph being reported on. The Committee was therefore satisfied that the radiographs had been taken but had not been reported on. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty under IR(ME)R 2000 to report on each radiograph. Accordingly, the Committee found charges 16.a-b. proved.
16.c	*Failed to provide appropriate treatment to Patient JJ in that you:-*
16.c.i	*Failed to consider reducing the increasing overjet;* Proved.
16.c.ii	*Failed to take appropriate action to change the treatment plan to*

	include the extraction of two upper premolar teeth. Proved. In his report, Mr Bellman stated: 5.16.5. I have examined a set of virtual study models taken on 6 August 2016, which are of poor quality and have several broken teeth. They are not occluded. I have also examined a set of photographs, a Lateral Cephalometric radiograph and an OPG radiograph. There is crowding present and LL5 is impacted and short of space to erupt. In his options for treatment he does not consider removal of upper premolars, and I am critical of this treatment. Although I am not critical of the original treatment plan, I am critical that the registrant did not alter this during treatment and arrange for the removal of two upper premolars as the overjet then could have been satisfactorily reduced. 5.16.6. I have examined a set of photographs taken by a colleague of the registrant on 31 May 2017, and these as I would have expected show an increase in the patient's overjet… The Committee accepted Mr Bellman's opinion. Accordingly, the Committee found charges 16c.i.-ii. proved.
17.	*You failed to provide an adequate standard of care to Patient LL between 13 August 2016 and 10 December 2016 in that you:*
17.a	*Failed to report on an the OPG radiograph;* Proved.
17.b	*Failed to report on the lateral cephalometric radiograph.* Proved. Patient LL's clinical records contain the two radiographs referred to under charges 17.a and b but there is no record of either radiograph being reported on. The Committee was therefore satisfied that the radiographs had been taken but had not been reported on. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty under IR(ME)R 2000 to report on each radiograph. Accordingly, the Committee found charges 17.a-b. proved
18.	*You failed to provide an adequate standard of care to Patient MM between 10 September 2016 and 17 December 2016 in that you:*
18.a.	*Failed to report on OPG radiograph taken on 10 September 2016;* Proved.
18.b	*Failed to report on lateral cephalometric radiograph taken on 10 September 2016.* Proved. Patient MM's clinical records contain the two radiographs referred to under charges 18.a and b but there is no record of either radiograph

	being reported on. The Committee was therefore satisfied that the radiographs had been taken but had not been reported on. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty under IR(ME)R 2000 to report on each radiograph. Accordingly, the Committee found charges 18.a-b. proved.
19.	*You failed to provide an appropriate standard of care to Patient OO between 8 October 2016 and 26 November 2016 in that you:*
19.a	*Failed to record the taking of an OPG radiograph on an unknown date;* Proved. Patient OO's clinical records contain an undated OPG radiograph but there is no corresponding record of its being taken. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a duty to make such a record. Accordingly, the Committee found this charge proved.
19.b	*Failed to report on the OPG radiograph referred to at (a) above.* Proved. There is no record of the radiograph being reported on. The Committee was therefore satisfied that the radiograph had been taken but had not been reported on. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty under IR(ME)R 2000 to report on the radiograph. Accordingly, the Committee found this charge proved.
20.	*You failed to provide an adequate standard of care to Patient PP between 5 December 2013 and 20 February 2015 in that you:*
20.a	*Failed to record any adequate treatment plan, in relation to Patient PP's impacted upper canines on 5 December 2013;* Proved. Although the registrant noted that the impacted canines were present, there is no record of any treatment plan to address Patient PP's impacted upper canines. Accordingly, the Committee found this charge proved.
20.b	*Failed to report on an OPG radiograph taken on 9 December 2013;* Proved.
20.c	*Failed to report on a lateral cephalometric radiograph taken on 9 December 2013;* Proved. Patient PP's clinical records contain the two radiographs referred to under charges 20.b and c but there is no record of either radiograph

	being reported on. The Committee was therefore satisfied that the radiographs had been taken but had not been reported on. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty under IR(ME)R 2000 to report on each radiograph. Accordingly, the Committee found charges 20.b.-c. proved.
20.d	*Undertook the exposure of a lateral cephalometric radiograph on 9 December 2013 when it was not clinically necessary to do so.* Proved. The Committee's reasons are the same as those under charge 8.c above.
20.e	*Failed to seek a consultant orthodontic opinion regarding the upper impacted canines prior to commencing orthodontic treatment;* Proved. The Committee accepted the evidence of Mr Bellman that it would have been clear to Mr Pinto that the upper canines were clearly impacted and that he should have sought a consultant orthodontic opinion regarding the need for specialist surgical intervention to those teeth prior to commencing orthodontic treatment. Accordingly, the Committee found this charge proved.
20.f	*Failed to record adequately, or at all, that informed consent had been obtained in that you:*
20.f.i	*Failed to record adequately, or at all, the advice as to the risks and/or benefits of treatment proposed on 09 December 2013;* Proved.
20.f.ii	*Failed to record adequately, or at all, the treatment options provided to Patient PP.* Proved. Patient PP's clinical records do not contain any adequate record of advice as to the risks and/or benefits of treatment proposed on 09 December 2013 and the treatment options provided to him. Accordingly, the Committee found charges 20.f.i.-ii. proved.
20.g.	*You failed to obtain informed consent from Patient PP and/or his parent between 5 December 2013 and 20 February 2015 in that you:*
20.g.i	*Failed to inform Patient PP and/or his parent of all the treatment options available to Patient PP; and/or* Proved.
20.g.ii	*Failed to inform Patient PP and/or his parent of the risks and/or benefits of the proposed orthodontic treatment.*

	Proved. The Committee accepted the evidence of Patient PP and his mother. In his witness statement dated 1 February 2019, Patient PP stated: 6. I have been asked by the Council, whether the Registrant advised me of the risks and benefits of the treatment. I recall the Registrant explaining that as the retainer would move my teeth apart, this would cause discomfort. He also said I wouldn't need an operation to bring the canines down, however this was not the case, the treatment did not work as my canines did not drop through naturally. The Registrant also explained that it would be easier to put the brace on following having the retainer. The Committee accepted the evidence of Mr Bellman that this would not have been an adequate discussion on the treatment options and the risks and benefits of the proposed orthodontic treatment. Accordingly, the Committee found charges 20.g.i.-ii. proved.
21.	*You failed to provide an adequate standard of care to Patient QQ between 17 February 2014 and 27 February 2015 in that you:*
21.a	WITHDRAWN
21.b	*Failed to record adequately, or at all, the advice as to the risks and/or benefits of treatment proposed on 17 February 2014;* Proved.
21.c	*Failed to record adequately, or at all, the treatment options provided to Patient QQ;* Proved. Patient QQ's clinical records do not contain any adequate record of advice as to the risks and/or benefits of treatment proposed on 17 February 2014 and the treatment options provided to him. Accordingly, the Committee found charges 21.b.-c. proved.
21.d	*Failed to record whether the spaces in the upper lateral incisor regions were to be closed* Proved. The clinical records only went so far as to record an intention to treat the upper lateral incisor regions and did not state whether the spaces in those regions were to be closed. Accordingly, the Committee found this charge proved.
21.e	*Provided a poor standard of treatment in that you:-*
21.e.i	*Failed to note that the unerupted UR3 was impacted; and* Proved.
21.e.ii	*Failed to take appropriate action to treat the impacted UR3.* Proved.

	The notes made by Mr Pinto only went so far as to identify that the UR3 was impacted and not that it was unerupted. There is nothing in the clinical notes to indicate that Mr Pinto took appropriate action to treat the impacted UR3. Accordingly, the Committee found charges 21.e.i.-ii. proved.
22.	*You failed to provide an adequate standard of care to Patient RR between 6 October 2014 and 18 March 2015 in that you:*
22.a	*Failed to record adequately, or at all, that informed consent had been obtained in that you:*
22.a.i	*Failed to record adequately, or at all, the advice as to the risks and/or benefits of treatment proposed prior to fitting appliances;* Proved.
22.a.ii	*Failed to record adequately, or at all, the treatment options provided to Patient RR,* Proved. Patient RR's clinical records do not contain any adequate record of advice as to the risks and/or benefits of treatment proposed prior to fitting appliances and the treatment options provided to him. Accordingly, the Committee found charges 22.a.i.-ii. proved.
22.b	*Provided a course of treatment which was not clinically appropriate in Patient RR's circumstances in that it did not involve extractions.* Proved. The Committee accepted the evidence of Mr Bellman that extractions would have been appropriate in this case. Accordingly, the Committee found this charge proved.
23.	*You failed to provide an adequate standard of care to Patient SS between 23 May 2013and 17 March 2015 in that you:*
23.a	*Failed to report on an OPG taken on 23 May 2013;* Proved. Patient SS's clinical records contain an OPG radiograph dated 23 May 2013 but do not contain any report on the radiograph. The Committee was therefore satisfied that the OPG radiograph had been taken but had not been reported on. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty under IR(ME)R 2000 to report on the OPG radiograph. Accordingly, the Committee found this charge proved.
23.b	*Failed to record adequately, or at all, that informed consent had been obtained in that you:-*

23.b.i	*Failed to record adequately, or at all, the treatment options provided to Patient SS;* Proved.
23.b.ii	*Failed to record adequately, or at all, the risks and benefits were provided to Patient SS [sic];* Proved. Patient SS's clinical records do not contain any adequate record of the treatment options provided to him and any advice as to the risks and/or benefits of treatment proposed. Accordingly, the Committee found charges 23.b.i.-ii. proved.
23.c	*Provided a course of treatment which was not clinically appropriate in Patient SS circumstances in that it did not include lower premolar extractions.* Proved. The Committee accepted the evidence of Mr Bellman that extractions would have been appropriate in this case. Accordingly, the Committee found this charge proved.
24.	*You failed to provide an adequate standard of care to patients [sic] VV between 13 March 2014 and 12 February 2015 in that you:*
24.a	*Failed to carry out a BPE on 13 March 2014;* Proved. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a duty to carry out a BPE at this appointment owing to the patient's poor oral hygiene. Accordingly, the Committee found this charge proved.
24.b	*Failed to report on an OPG taken on 17 March 2014;* Proved.
24.c	*Failed to report on lateral cephalometric radiograph taken on 17 March 2014;* Proved. Patient VV's clinical records contain the two radiographs referred to under charges 24.b and c but there is no record of either radiograph being reported on. The Committee was therefore satisfied that the radiographs had been taken but had not been reported on. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty under IR(ME)R 2000 to report on each radiograph. Accordingly, the Committee found charges 24.b.-c. proved.

24.d	*Took a lateral cephalometric radiograph on 17 March 2014 when it was not clinically necessary to do so;* Proved. The Committee's reasons are the same as those under charge 8.c above. In addition, the Committee noted that a lateral cephalometric radiograph was not in any event justified at this stage as Patient VV's oral hygiene needed to improve before the orthodontic treatment could commence.
24.e	*Failed to record adequately, or at all, that informed consent had been obtained in that you*
24.e.i	*Failed to record adequately, or at all, the treatment options provided to Patient VV;* Proved.
24.e.ii	*Failed to record adequately or at all, the risks and benefits of treatment.* Proved. Patient VV's clinical records do not contain any adequate record of advice as to the risks and/or benefits of treatment proposed and the treatment options provided. Accordingly, the Committee found charges 24.e.i.-ii. proved.
24.f.	WITHDRAWN
24.g	*Commenced orthodontic treatment when Patient VV had poor oral hygiene;* Proved. The clinical records for Patient VV indicate that the patient presented with poor oral hygiene. The Committee accepted Mr Bellman's evidence that Mr Pinto should have addressed this prior to commencing the orthodontic treatment. Accordingly, the Committee found this charge proved.
24.h	*Provided a poor standard of treatment by not realising and/or not adequately addressing that the lower second left and right premolar teeth were becoming lingually impacted.* Proved. The Committee accepted Mr Bellman's evidence that Mr Pinto should have realised this prior to the orthodontic treatment commencing. Alternatively, at an early stage of the treatment, Mr Pinto should have noted that if the lower premolars were not to be extracted they would become more impacted, as per the expert opinion. There is nothing in the clinical records to indicate that Mr Pinto had adequately done so or that he proposed or took any action accordingly. Accordingly, the Committee found this charge proved.

25.	*You failed to provide an adequate standard of care to patient WW between 5 June 2014 and 13 April 2015, in that you:*
25.a	*Failed to report on a lateral cephalometric radiograph taken on 9 June 2014;* Proved. Patient SS's clinical records contain a lateral cephalometric radiograph dated 09 June 2014 but do not contain any report on the radiograph. The Committee was therefore satisfied that the radiograph had been taken but had not been reported on. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty under IR(ME)R 2000 to report on the radiograph. Accordingly, the Committee found this charge proved.
25.b	WITHDRAWN
25.c	*Failed to record adequately or at all that informed consent had been obtained in that you:*
25.c.i	*Failed to record adequately, or at all, the advice as to the risks and/or benefits of treatment proposed prior to fitting appliances;* Proved.
25.c.ii	*Failed to record adequately, or at all, the treatment options provided to Patient WW.* Proved. Patient WW's clinical records do not contain any adequate record of advice as to the risks and/or benefits of treatment proposed prior to fitting appliances and the treatment options provided. Accordingly, the Committee found charges 25.c.i.-ii. proved.
25.d	*You failed to obtain informed consent from Patient WW and/or his parents between 5 June 2014 and 13 April 2015 in that you:*
25.d.i	WITHDRAWN
25.d.ii	*Failed to inform Patient WW and/or his parent of the risks and/or benefits of the proposed orthodontic treatment.* Proved. The Committee accepted the evidence of Patient WW and his father. Patient WW's evidence was that the only risk discussed with him by Mr Pinto was that he would experience pain similar to that of a toothache. The Committee accepted Mr Bellman's evidence that this would not have been an adequate discussion on the risks of the proposed treatment and that consequently informed consent would not have been obtained

	Accordingly, the Committee found his charge proved.
26.	*You failed to provide an adequate standard of care to patient XX between 10 June 2013 and 16 February 2015 in that you:*
26.a	*Failed to carry out any or adequate periodontal assessment on 10 June 2013;* Proved. The clinical records do not contain a BPE or any comment on Patient XX's oral hygiene at this appointment. The Committee accepted the evidence of Mr Bellman that Patient XX's oral health should have been assessed and recorded at this appointment, as it had been a year since the patient was last seen and it was necessary to identify whether the patient had any active periodontal disease prior to commencing orthodontic treatment. Accordingly, the Committee found this charge proved.
26.b	*Failed to report on an OPG taken on 25 June 2013;* Proved. Patient XX's clinical records contain an OPG radiograph dated 25 June 2013 but do not contain any report on the radiograph. The Committee was therefore satisfied that the OPG radiograph had been taken but had not been reported on. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty under IR(ME)R 2000 to report on the OPG radiograph. Accordingly, the Committee found this charge proved.
26.c	*Failed to formulate any, or any adequate, treatment plan for Patient XX's ankylosed LL6;* Proved. The clinical records for Patient XX identified that the LL6 was not fully erupted but did not go so far as to record that it was ankylosed (fused to bone). There is no record of the formulation of any treatment plan in respect of this. Accordingly, the Committee found this charge proved.
26.d	*Undertook a course of orthodontic treatment which was not clinically appropriate in the circumstances of Patient XX's case;* Proved. The Committee accepted the evidence of Mr Bellman that Mr Pinto needed to address Patient XX's poor oral health first and his ankylosed LL6 before it would be clinically appropriate to have commenced with the course of orthodontic treatment.

	Accordingly, the Committee found this charge proved.
26.e	*Failed to record adequately, or at all, that informed consent had been obtained in that you:*
26.e.i	*Failed to record adequately, or at all, the advice as to the risks and/or benefits of treatment proposed prior to fitting appliances;* Proved.
26.e.ii	*Failed to record adequately, or at all, the treatment options provided to Patient XX.* Proved. Patient XX's clinical records do not contain any adequate record of advice as to the risks and/or benefits of treatment proposed prior to fitting appliances and the treatment options provided. Accordingly, the Committee found charges 26.e.i.-ii. proved.
27.	*You failed to provide an adequate standard of care to patient YY between 12 May 2014 and 28 January 2015 in that you:*
27.a	*Failed to report on an OPG taken on 29 May 2014;* Proved. Patient YY's clinical records contain an OPG radiograph dated 29 May 2014 but do not contain any report on the radiograph. The Committee was therefore satisfied that the OPG radiograph had been taken but had not been reported on. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty under IR(ME)R 2000 to report on the OPG radiograph. Accordingly, the Committee found this charge proved.
27.b	*Failed to report on a lateral cephalometric radiograph taken on 29 May 2014;* Proved. Patient YY's clinical records contain a lateral cephalometric radiograph dated 29 May 2014 but do not contain any report on the radiograph. The Committee was therefore satisfied that the radiograph had been taken but had not been reported on. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty under IR(ME)R 2000 to report on the radiograph. Accordingly, the Committee found this charge proved.
27.c	*Took a lateral cephalometric radiograph on 29 May 2014 when it was not clinically necessary to do so;* Proved.

	The Committee's reasons are the same as those under charge 8.c above.
27.d	*Failed to record adequately, or at all, that informed consent had been obtained in that you:*
27.d.i	*Failed to record adequately, or at all, the treatment options provided to Patient YY;* Proved.
27.d.ii	*Failed to record adequately, or at all, the advice as to the risks and/or benefits of treatment proposed prior to fitting appliances.* Proved. Patient YY's clinical records do not contain any adequate record of advice as to the risks and/or benefits of treatment proposed prior to fitting appliances and the treatment options provided. Accordingly, the Committee found charges 27.d.i.-ii. proved.
28.	*You failed to provide an adequate standard of care to patient ZZ between 13 May 2013 and the 28 January 2015 in that you:*
28.a	*Failed to report on an OPG taken on 20 May 2013;* Proved. Patient ZZ's records contain an OPG radiograph dated 20 My 2013 but do not contain any report on the radiograph. The Committee was therefore satisfied that the OPG radiograph had been taken but had not been reported on. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty under IR(ME)R 2000 to report on the OPG radiograph. Accordingly, the Committee found this charge proved.
28.b	*Failed to formulate any, or any adequate, treatment plan for Patient ZZ's:-*
28.b.i	*Supernumerary LR2;* Proved.
28.b.ii	*Missing lower second premolars.* Proved. There is no record in the clinical notes of a treatment plan for these areas of Patient ZZ's jaw. Accordingly, the Committee found charges 28.b.i.-ii. proved.
28.c	*Failed to record adequately, or at all, that informed consent had been obtained in that you:-*
28.c.i.	*Failed to record adequately, or at all, what treatment options were*

	provided to Patient ZZ; Proved.
28.c.ii	*Failed to record adequately, or at all, the advice as to the risks and/or benefits of treatment proposed prior to fitting appliances;* Proved. Patient ZZ's clinical records do not contain any adequate record of advice as to the risks and/or benefits of treatment proposed prior to fitting appliances and the treatment options provided. Accordingly, the Committee found charges 28.c.i.-ii. proved.
28.d	*Provided a poor standard of treatment in that you failed to adequately treat Patient ZZ's presenting complex malocclusion.* Proved. The Committee accepted the evidence of Mr Bellman that this complex problem had not been adequately treated. Accordingly, the Committee found charge 28.d proved.
29.	*You failed to provide an adequate standard of care to patient AAA between 18 February 2013 and 2 October 2014 in that you:*
29.a	*Failed to report on OPG taken on 27 March 2013;* Proved. Patient AAA's records contain an OPG radiograph dated 27 March 2013 but do not contain any report on the radiograph. The Committee was therefore satisfied that the OPG radiograph had been taken but had not been reported on. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty under IR(ME)R 2000 to report on the OPG radiograph. Accordingly, the Committee found this charge proved.
29.b	*Failed to record that consent had been obtained;* Proved. There is no consent form present or record in Patient AAA's clinical records of obtaining consent. Accordingly, the Committee found this charge proved.
29.c	*Failed to record adequately, or at all, the treatment options provided to Patient AAA;* Proved. There is no adequate record in Patient AAA's clinical records of the treatment options.

	Accordingly, the Committee found this charge proved.
29.d	*Failed to record adequately, or at all, the advice as to the risks and/or benefits of treatment proposed prior to fitting appliances.* Proved. There is no adequate record in Patient AAA's clinical records of advice as to the risks and/or benefits of treatment proposed prior to fitting appliances. Accordingly, the Committee found this charge proved.
30.	*You failed to provide an adequate standard of care to patient CCC between 10 May 2013 and 15 October 2014 in that you:*
30.a	*Failed to report on OPG taken on 17 May 2013;* Proved. Patient CCC's clinical records contain an OPG radiograph dated 17 May 2013 but do not contain any report on the radiograph. The Committee was therefore satisfied that the OPG radiograph had been taken but had not been reported on. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty under IR(ME)R 2000 to report on the OPG radiograph. Accordingly, the Committee found this charge proved.
30.b	*Provided a poor standard of treatment in that Patient CCC's buccal segment interdigitation became worse during the course of her orthodontic treatment;* Proved. The Committee accepted the evidence of Mr Bellman, as stated in his report: On 24 May 2013, it is recorded that upper and lower fixed appliances were placed. There followed several adjustment visits with the registrant and on 28 May 2014, the fixed appliances were removed and retainers subsequently fitted. The registrant saw the patient for the last time on 15 October 2014 for a retainer review. I have examined both pre-treatment and post-treatment study models. The pretreatment study models show a class I malocclusion, with minimal crowding the posttreatment study models dated June 2014, show that the incisor alignment has improved, but the buccal segment interdigitation is worse than at the start of treatment. However, the buccal segments tend to improve over time. In my opinion the improvement in alignment is minimal, and the buccal segments are worse and I am therefore critical of the registrant's treatment, but as these will tend to improve over time… Accordingly, the Committee found this charge proved.
30.c	*Failed to record that consent had been obtained;*

	Proved. There is no consent form present or record in Patient CCC's clinical records of obtaining consent. Accordingly, the Committee found this charge proved.
30.d	*Failed to record adequately, or at all, the treatment options provided to Patient CCC;* Proved. There is no adequate record in Patient CCC's clinical records of the treatment options. Accordingly, the Committee found this charge proved.
30.e	*Failed to record adequately, or at all, the advice as to the risks and/or benefits of treatment proposed prior to fitting appliances.* Proved. There is no adequate record in Patient CCC's clinical records of advice as to the risks and/or benefits of treatment proposed prior to fitting appliances. Accordingly, the Committee found this charge proved.
31.	*You failed to provide an adequate standard of care to patient DDD between 19 February 2013 and 13 October 2014 in that you:*
31.a	*Failed to report on an OPG radiograph taken on 5 March 2013;* Proved. Patient DDD's records contain an OPG radiograph dated 5 March 2013 but do not contain any report on the radiograph. The Committee was therefore satisfied that the OPG radiograph had been taken but had not been reported on. The Committee accepted the evidence of Mr Bellman that Mr Pinto was under a statutory duty under IR(ME)R 2000 to report on the OPG radiograph. Accordingly, the Committee found this charge proved.
31.b	*Failed to record that consent had been obtained;* Proved. There is no consent form present or record in Patient DDD's clinical records of obtaining consent. Accordingly, the Committee found this charge proved.
31.c	*Failed to record adequately, or at all, the treatment options provided to Patient DDD;* Proved. There is no adequate record in Patient DDD's clinical records of the

	treatment options. Accordingly, the Committee found this charge proved.
31.d	*Failed to record adequately, or at all, the advice as to the risks and/or benefits of treatment proposed prior to fitting appliances.* Proved. There is no adequate record in Patient DDD's clinical records of advice as to the risks and/or benefits of treatment proposed prior to fitting appliances. Accordingly, the Committee found this charge proved.
32.	*You failed to cooperate with the Council by not responding to the Council's correspondence from 04 April 2019 to 20 March 2020.* Not proved. The Committee considered all of the evidence in this regard. Between the relevant dates the Council tried to communicate with Mr Pinto at the address he supplied on many occasions without success. Mr Pinto has not at any stage informed the Council that he has an alternative address for the purpose of his registration or for communication purposes. The service bundle seen by the Committee indicates that in March 2018 Mr Pinto informed NHS England that he had left the country, had no intention of returning and wished to be removed from the NHS Performers List. On 6 April 2018 Mr Pinto informed the Council by the same email address that he was now in Mozambique and asked to cancel his GDC registration. The Council has tried many times since, without success, to communicate with Mr Pinto at the same email address which was clearly accessible from whatever location he was in, in April 2018. Some of the correspondence sent by the Council to Mr Pinto at his registered address has been returned to sender with the envelope marked "addressee gone away". Secure file share links emailed to Mr Pinto to download correspondence from the GDC regarding these fitness to practise proceedings have not been accessed and downloaded by Mr Pinto. The Committee is satisfied that the Council has done everything possible to properly communicate with Mr Pinto. When examined in round, the Committee was satisfied that there had been a failure by Mr Pinto to cooperate with the GDC as part of these fitness to practise proceedings. However, the wording of this charge confines the alleged failure to cooperate to "*not responding to the Council's correspondence from 04 April 2019 to 20 March 2020".* The correspondence in question related to notices of hearing for, as the Committee understands it, the review hearings before the Interim

	Orders Committee in respect of an interim order to which Mr Pinto is currently subject. The notices of hearing did not require Mr Pinto to respond. Rather, they stated: "*If there is any reason why this hearing should not proceed on the papers, please contact me by [specified date] so that arrangements for an oral hearing can be considered*". Accordingly, Mr Pinto was only under a duty to respond to the correspondence if he did not agree to the Council's preference that the review hearing be conducted on the papers: the Council had deliberately phrased its correspondence so that Mr Pinto's lack of a response could be treated as his non-objection to the review hearing being conducted on the papers. In addition, there was correspondence from the Council to Mr Pinto regarding an application to the High Court for an extension of the interim order. However, that correspondence only required him to respond if he wished to consent to the interim order being extended, which was a matter for him to decide. The letter was not phrased in a way which otherwise placed him under any obligation or expectation to respond. In those circumstances, having regard to specific wording of this charge, the Committee could not find that Mr Pinto had failed in a duty to respond to the correspondence in question and could not therefore find that in that regard he had failed in his duty to cooperate with the GDC. Accordingly, the Committee found this charge not proved.

We move to Stage Two."

On 9 March 2022 the Chairman announced the determination as follows:

"Having announced its findings of fact, the role of the Committee at this stage of the proceedings is to determine whether Mr Pinto's fitness to practise as a dentist is currently impaired by reason of misconduct and/or deficient professional performance and, if so, what action (if any) to take in respect of his registration.

The Committee had regard to the Stage 2 bundle provided by the General Dental Council (GDC), consisting mainly of a witness statement dated 11 February 2022 from Ms Islam, a paralegal within the GDC's in-house legal presentation service. The documents exhibited to that witness statement indicate that Mr Pinto, in response to various concerns raised with the NHS by his peers from 2012 onwards regarding the standard of his clinical work, left one practice to commence work at another, or suddenly stated he had returned to Portugal for urgent family reasons.

The Committee heard the submissions made on behalf of the GDC by Ms Daly.

Ms Daly submitted that Mr Pinto's fitness to practise is currently impaired by reason of deficient professional performance. Ms Daly submitted that, in the alternative, it was open to the Committee to find impairment by reason of misconduct, but that the GDC's case was pursued on the basis of deficient professional performance.

Ms Daly submitted that, whether impairment is found by reason of misconduct or deficient professional performance, the appropriate outcome in this case is that of erasure, owing to Mr Pinto's lack of engagement in these proceedings and the absence of any evidence from him of remediation.

The Committee accepted the advice of the Legal Adviser.

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

Decision

Mr Pinto graduated as a dentist in Portugal and first registered with the GDC on 30 August 2008. He was enrolled on the NHS performers list from 26 November 2009 until 8 December 2017. His failings relate to his provision of orthodontic treatment to 30 patients at the following three dental practices.

- Practice A from 1 February 2008 to 30 September 2013. At that practice he provided orthodontic treatment to Patients A, B, C, D and K.
- Practice B from 4 January 2013 to 31 March 2015. At that practice he provided orthodontic treatment to Patients L, P, Q, U, X, Y, BB, DD, FF, GG, JJ, LL, MM and OO.
- Practice C from 9 July 2016 to 17 December 2016. At that practice he provided orthodontic treatment to Patients PP, QQ, RR, SS, VV, WW, XX, YY, ZZ, AAA, CCC and DDD.

Mr Pinto's failings can be categorised as falling into the following categories: (i) radiography, (ii) obtaining and/or recording informed consent, and (iii) inadequate treatment planning and providing a poor standard of treatment.

The Committee first considered the seriousness of Mr Pinto's failings. In particular, the Committee considered whether Mr Pinto's failings fell far below the standards reasonably expected of him (the standards of a reasonably competent dental practitioner providing orthodontic treatment), or whether they fell only below those standards. In reaching its decisions, the Committee had regard to all the evidence it heard as part of the factual inquiry, including the evidence given by Mr Bellman, a specialist orthodontist instructed by the GDC for his expert opinion. In deciding whether something fell far below (as opposed to only below) the required standards, the Committee had particular regard to whether harm (or the risk of harm) resulted from the failing in question.

Radiography

The Committee found proved failures to report on orthopantomogram ("OPG") radiographs taken in respect of the following patients, contrary to the requirements of the Ionising Radiation (Medical Exposure) Regulations 2000 ("IR(ME)R 2000"): Patient A on 8 June 2010, Patient L on 23 July 2016, Patient P (undated), Patient Q on 24 September 2016, Patient U on 9 July 2016, Patent X on 9 July 2016, Patient Y (undated), Patient DD on 23 July 2016, Patient FF (undated), Patient GG (undated), Patient JJ on 10 September 2016, Patient LL (undated), Patient MM on 10 September 2016, Patient OO (undated), Patient PP on 9 December 2013, Patient SS on 23 May 2013, Patient VV on 17 March 2014, Patient XX on 25 June 2013, patient YY on 29 May 2014, Patient ZZ on 20 May 2013, Patient AAA on 27 March 2013, Patient CCC on 17 May 2013 and Patient DDD on 5 March 2013,

In addition, Mr Pinto had failed even to record the taking of the OPG radiographs in question in respect of Patient P, Patient X on 9 July 2016, Patient Y, Patient DD on 23 July 2016, Patient FF, Patient GG and Patient OO.

The Committee found proved failures to report on lateral cephalometric radiographs taken in respect of the following patients, contrary to the requirements of IR(ME)R 2000: Patient L on 23 July 2016, Patient P on 5 November 2016, Patient Q on 24 September 2016, Patient U (undated), Patient Y on 1 September 2016, Patient DD (undated), Patient JJ on 10 September 2016, Patient LL (undated), Patient MM on 10 September 2016, Patient PP on 9 December 2013, Patient VV on 17 March 2014, Patient WW on 9 June 2014 and Patient YY on 29 May 2014.

In addition, Mr Pinto had failed even to record the taking of the lateral cephalometric radiographs in question in respect of Patient L on 23 July 2016, Patient U (undated) and Patient DD (undated).

Mr Pinto had also exposed the lateral cephalometric radiographs in question in respect of the following patients when it was not clinically necessary to do so: Patient Q on 24 September 2016, Patient U (undated), Patient PP on 9 December 2013, Patient VV on 17 March 2014 and Patient YY on 29 May 2014.

In the Committee's judgment, Mr Pinto's failures to have reported on the OPG and lateral cephalometric radiographs (and, in some instances, even to have recorded the fact that he had taken the radiographs) was conduct which fell below (as opposed to far below) the standard reasonably expected of him. These were clear breaches of basic statutory and record keeping requirements in respect of radiography. However, the breaches did not in themselves put Mr Pinto's patients at a real risk of harm and were not otherwise in context so serious as to amount to conduct which fell far below the standards reasonably expected of Mr Pinto.

The Committee viewed Mr Pinto's taking of the lateral cephalometric radiographs when it was not clinically necessary to do so to be conduct which fell far below the standards reasonably expected of him, as this was conduct which unnecessarily exposed his patients to radiation which could result in serious harm.

Obtaining and/or recording informed consent.

Mr Pinto failed to record that he had obtained informed consent in respect of the following Patients: A, B, C, D, K, PP, RR, SS, VV, WW, XX, YY and ZZ, as he had failed to record adequately or at all matters necessary for the obtaining of informed consent, such as discussion with the patient (or their parent) of the treatment options and the risks and benefits of the proposed treatment. In some cases a signed consent form was present in the notes, but these forms had been signed several months after the commencement of the treatment in question and would in any event have been too generic to document adequately the obtaining of informed consent.

In respect of Patients X, AAA, CCC and DDD, Mr Pinto had failed to record that consent had been obtained at all, in that there was no record even of a consent form (whether signed prior to or following the commencement of the treatment in question).

The Committee found as fact that informed consent had not been obtained in respect of the treatment provided to Patients K, PP and WW, having heard oral evidence from each of these three patients and their parents. In respect of Patients K and PP, Mr Pinto had failed to discuss the treatment options and the risks and benefits of the proposed treatment. In

respect of Patient WW, Mr Pinto had failed to discuss the risks and benefits of the proposed treatment only.

As to the remaining 14 patients, it was unclear whether or not informed consent had been obtained, as the patients (and/or, where relevant, their parent(s)) had not given evidence to the Committee about what was discussed during their consultations with Mr Pinto. Mr Pinto also had not given evidence to the Committee or otherwise provided any statement or explanation in response to the allegations against him.

In the Committee's judgment, Mr Pinto's failings in respect of obtaining informed consent fell far below the standards reasonably expected of him. In respect of the three patients for which it was established that informed consent had not been obtained, this was clearly in breach of a fundamental principle of clinical practice, as expressed under Principle 3 ("Obtain Valid Consent") of the GDC's *Standards for Dental Professionals* (September 2013), including:

> Standard 3.1: You must obtain valid consent before starting treatment, explaining all the relevant options and the possible costs.
>
> 3.1.1 You must make sure you have valid consent before starting any treatment or investigation. This applies whether you are the first member of your team to see the patient or whether you are involved after other team members have already seen them. Do not assume that someone else has obtained the patient's consent.
>
> 3.1.2 You should document the discussions you have with patients in the process of gaining consent. Although a signature on a form is important in verifying that a patient has given consent, it is the discussions that take place with the patient that determine whether the consent is valid.

The seriousness of Mr Pinto's failure to have obtained informed consent is compounded by the complex and lengthy nature of the orthodontic treatment which was to be provided. In respect of the remaining 14 patients, where there had been a failure to have recorded the obtaining of informed consent (or consent at all), this was equally serious in the Committee's judgement as the proven failures to have in fact obtained informed consent. Although these were failures in record keeping, the adequate recording of the process of obtaining consent is integral to the consent process and to the patient's continuity of care. In the absence of any adequate records, as is the case here with the 14 patients, neither this Committee nor any subsequent treating practitioner is able to determine whether and to what extent the patient had consented to the complex and lengthy orthodontic treatment in question.

Inadequate treatment planning and providing a poor standard of treatment

Mr Pinto inappropriately used Class II elastics in respect of Patients A, B, C and K. Mr Bellman was clear in his evidence that there were no circumstances under which the use of such elastics would have been appropriate in these cases. In the Committee's judgement, Mr Pinto's use of the elastics fell far below the standards reasonably expected of him owing to the risk of patient harm which could be caused as a result of the elastics causing too much force to be applied to the occlusion with the effect of pulling the teeth in different directions. As with many of his clinical failings, Mr Pinto's use of Class II elastics in the treatment of these patients appears to have been the result of his lack of adequate training and competence in carrying out orthodontic treatment.

There were also other specific failings in respect of the following patients.

In respect of Patient U, Mr Pinto failed to note that the upper incisors were becoming

unacceptably proclined and failed to take appropriate action to change the treatment plan to include the extraction of premolar teeth to prevent increasing the overjet. Mr Pinto's failings in this regard stemmed from his failure to have planned the treatment adequately, to have provided appropriate treatment and, in any event, to have recognised during the course of treatment that things were getting worse and to have responded to that. In the Committee's judgement, this fell far below the standards reasonably expected of Mr Pinto. These were basic failings which resulted in patient harm and the elongation of treatment.

In respect of Patient JJ, Mr Pinto failed to provide appropriate treatment in that he failed to consider reducing the increasing overjet and failed to take appropriate action to change the treatment plan to include the extraction of two upper premolar teeth. Mr Pinto's failings in this regard stemmed from his failure to have planned the treatment adequately, to have provided appropriate treatment and, in any event, to have recognised during the course of treatment that things were getting worse and to have responded to that. In the Committee's judgement, this fell far below the standards reasonably expected of Mr Pinto. These were basic failings which resulted in patient harm and the elongation of treatment.

In respect of Patient PP, Mr Pinto failed to record any adequate treatment plan in relation to the impacted upper canines and failed to seek a consultant orthodontic opinion regarding the impacted upper canines prior to commencing orthodontic treatment. Adequate treatment planning is an essential element of orthodontic work. In the Committee's judgement, this fell far below the standards reasonably expected of Mr Pinto. These were basic failings which resulted in patient harm and the elongation of treatment.

In respect of Patient QQ, Mr Pinto failed to record whether the spaces in the upper lateral incisor regions were to be closed, which had the potential to affect Patient QQ's continuity of care. He also provided a poor standard of treatment in that he failed to note that the unerupted UR3 was impacted and failed to take appropriate action to treat this. In the Committee's judgement, this fell far below the standards reasonably expected of Mr Pinto. These were basic failings which resulted in patient harm and the elongation of treatment.

In respect of Patient RR, Mr Pinto Provided a course of treatment which was not clinically appropriate in the circumstances in that it did not include extractions. In the Committee's judgement, this fell far below the standards reasonably expected of Mr Pinto. These were basic failings which resulted in patient harm and the elongation of treatment.

In respect of Patient SS, Mr Pinto Provided a course of treatment which was not clinically appropriate in the circumstances in that it did not include lower premolar extractions. In the Committee's judgement, this fell far below the standards reasonably expected of Mr Pinto. These were basic failings which resulted in patient harm and the elongation of treatment.

In respect of Patient VV, Mr Pinto had commenced orthodontic treatment when the patient had poor oral hygiene and Mr Pinto also had not adequately addressed that the lower second left and right premolar teeth were becoming lingually impacted. In the Committee's judgement, this fell far below the standards reasonably expected of Mr Pinto. These were basic failings which resulted in patient harm and the elongation of treatment.

Mr Pinto had also failed to carry out a Basic Periodontal Examination for Patient VV on 13 March 2014. However, the Committee did not regard this in itself as falling far below the standards reasonably expected of him, as the failure to carry out the BPE did not in itself result in patient harm.

In respect of Patient XX, Mr Pinto had failed to formulate any treatment plan for the patient's

ankylosed (fused to bone) LL6 and undertook a course of orthodontic treatment which was not clinically appropriate in the circumstances. It would have been clearly visible to Mr Pinto from the radiograph he had taken that Patient XX's LL6 was ankylosed. There is no record that Mr Pinto had identified this, or that he had formulated any treatment plan to address it. Mr Pinto commenced orthodontic treatment without having first addressed the patient's poor oral hygiene and without having formulated any treatment plan to address the ankylosed LL6. In the Committee's judgement, this fell far below the standards reasonably expected of Mr Pinto. These were basic failings which resulted in patient harm and the elongation of treatment.

Mr Pinto had also failed to carry out any adequate periodontal assessment for Patient XX on 10 June 2013. However, the Committee did not regard this in itself as falling far below the standards reasonably expected of him, as the failure to carry out the assessment did not in itself result in patient harm.

In respect of Patient ZZ, Mr Pinto had failed to formulate any adequate treatment plan for the patient's supernumerary LR2 and missing lower second premolars and failed to adequately treat the patient's presenting complex malocclusion. In the Committee's judgment, this fell far below the standards reasonably expected of Mr Pinto. Adequate treatment planning is an essential element of orthodontic work. Mr Pinto should also have recognised the complexity of the patient's presenting condition and sought a specialist opinion. These were basic failings which resulted in patient harm and the elongation of treatment.

In respect of Patient CCC, her buccal segment interdigitation became worse during the course of her orthodontic treatment. In the Committee's judgment, this fell far below the standards reasonably expected of Mr Pinto. These were basic failings which resulted in patient harm and the elongation of treatment.

Deficient professional performance and misconduct

The Committee considered whether the facts found proved amounted to deficient professional performance or, in the alternative, misconduct.

The Committee was satisfied that the 30 patients in respect of which it had made findings of fact represented a fair sample of Mr Pinto's work. His failings occurred over a period of several years involving numerous patients in three different successive practice environments. These were substantial failings which, on a number of occasions, caused significant harm to the patients in question. Far from trying to resolve the concerns which had repeatedly been raised with the NHS by his peers regarding his clinical work, he appears instead to have moved from practice to practice before ultimately leaving the United Kingdom.

In the Committee's judgement, Mr Pinto's failings largely involved his acting beyond his skill and training when providing orthodontic treatment. In some cases he appears to have provided complex orthodontic treatment which was far beyond his expertise. Some of his serious clinical failings could be characterised as misconduct. However, when examined in the round, the Committee determined that the failings in this case more properly amounted to deficient professional performance.

The Committee considered whether Mr Pinto's fitness to practise as a dentist is currently impaired by reason of his deficient professional performance. Mr Pinto has not engaged at all in these proceedings. The last record before the Committee of any communication from him is a chain of email correspondence between him and the GDC on 06 April 2018, in

which he stated that he was in Mozambique and requested the cancellation of his GDC registration. He stated that: "*I am not planning on returning or working in the UK*".

There is no evidence whatsoever before the Committee of any insight or remediation into the significant and widespread clinical failings which the Committee has found proved. The Committee does not know Mr Pinto's current circumstances, including whether he is still practising and, if so, where in the world he is practising and in what aspects of dentistry. The Committee has no evidence of any reflection or remedial steps undertaken by Mr Pinto in response to the matters which the Committee has found proved. Mr Pinto has demonstrated substantial clinical failings in respect of the provision of orthodontic treatment. Those failings occurred over a period of years in relation to numerous patients. Whilst the failings may be capable of being remedied through reflection, insight, mentorship, supervision, and comprehensive retraining, there is no evidence of any remediation. In the absence of such evidence there remains a very high risk of repetition, in the Committee's judgement, should Mr Pinto be allowed to resume practice in the United Kingdom without any restriction on his registration.

In addition, the Committee determined that wider public confidence in the profession also requires a finding of impairment. This is not only because of the real risk of repetition of significant clinical failings but because of the actual harm which had been caused to a number of the patients referred to in these proceedings. This included physical harm and emotional suffering during their orthodontic treatment, which was the direct result of Mr Pinto's clinical failings. Mr Pinto has not demonstrated to this Committee any insight. He has demonstrated no remedial steps and instead appears to have left the country, having previously moved from practice to practice. In these circumstances, the Committee determined that public confidence in the profession and in the GDC as regulator would be seriously undermined if no finding of impairment were to be made.

Accordingly, the Committee determined that Mr Pinto's fitness to practise as a dentist is currently impaired by reason of his deficient professional performance.

Sanction

The purpose of a sanction is not to be punitive, although it may have that effect, but to protect the public and the wider public interest. In deciding on which sanction, if any, to impose on Mr Pinto's registration, the Committee had regard to the mitigating and aggravating factors present in this case.

The aggravating factors present in this case include significant harm caused to patients and also the risk of significant harm; a number of the patients in this case were particularly vulnerable in that they were children; Mr Pinto demonstrates very little, if any, insight and he has completely disengaged from these proceedings and from the GDC.

In mitigation, the Committee acknowledged that Mr Pinto had no prior fitness to practise history. The Committee noted that a considerable period of time has lapsed since the events in question. However, the Committee did not regard this to be a mitigating factor as there was no evidence from Mr Pinto as to what he had done in the intervening period. Rather, he had disengaged from the GDC and left the United Kingdom.

The Committee considered sanction in ascending order of severity.

To conclude this case with no further action or a reprimand would be inappropriate in the Committee's judgement. This is because of the seriousness of Mr Pinto's clinical failings, his lack of engagement and remediation, and the high risk that he would repeat his clinical

failings if allowed to resume unrestricted practice in the United Kingdom. Taking no further action or issuing a reprimand would therefore be wholly insufficient to protect the public and to maintain wider public confidence in the profession and this regulatory process.

The Committee next considered whether to direct that Mr Pinto's registration be made subject to his compliance with conditions for a period of up to 36 months, with or without a review. In the Committee's judgement, no conditions of practice could be formulated which would be workable, measurable and proportionate. There have been significant clinical failings over a period of many years involving 30 patients. Those failings do not appear to be related to one particular dental practice, as the failings were repeated at different practices in respect of different patients. Mr Pinto's failings would require substantial remediation. There is no engagement from him and therefore no evidence of any remedial steps. Mr Pinto has deliberately and completely disengaged from these proceedings and the Committee could therefore find nothing to suggest that he would comply with any conditions on his registration.

The Committee next considered whether to direct that Mr Pinto's registration be suspended for a period of up to 12 months, with or without a review. In the Committee's judgement, a period of suspension would not be sufficient to protect the public or to maintain wider public confidence in the profession and this regulatory process. This is because Mr Pinto has caused significant harm to patients, including children, and has acted beyond his training and competency. He has fully disengaged from the GDC and has demonstrated a disregard for the role of his regulator and for this regulatory process. There is nothing whatsoever to indicate to the Committee that Mr Pinto is likely to engage in these proceedings in the future.

In the Committee's judgement, erasure is necessary and proportionate. Mr Pinto has deliberately disengaged from the proceedings and the evidence is that he has no intention of engaging in the future. He has shown little if any insight and presented no evidence of remediation. His failings are serious and have caused significant harm to patients, including children. The Committee has found that there is a high risk of repetition and, in light of this, erasure is the only proportionate sanction in this case.

Accordingly, the Committee directs that the name of Alexandre Jose Da Cruz Augusto Pinto be erased from the register.

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

Ms Daly applied for an immediate order of suspension on the grounds that it is necessary for the protection of the public and is otherwise in the public interest.

The Committee accepted the advice of the Legal Adviser.

The Committee is satisfied that it is necessary for the protection of the public and is otherwise in the public interest to order that Mr Pinto's registration be suspended forthwith under section 30(1) of the Dentists Act 1984. It would be inconsistent with the decision the Committee has made not to make an immediate order. There continues to be a high risk of harm to the public should Mr Pinto be allowed to practise without any restriction on his registration. The public with full knowledge of the case would expect an immediate order of suspension to be made.

The effect of this order is that Mr Pinto's registration is immediately suspended upon notification of this decision being served on him. Unless he exercises his right of appeal, his name will be erased from the Register 28 days later. Should he exercise his right of appeal, this immediate order shall remain in force pending the disposal of the appeal.

The interim order of suspension on his registration is hereby revoked.

That concludes the hearing."