General Dental Council

HEARING HEARD IN PUBLIC

LUCIOLA, Beatrice Jepkemoi

Registration No: 75787

PROFESSIONAL CONDUCT COMMITTEE

MAY 2021

Outcome: Erased with immediate suspension

LUCIOLA, Beatrice Jepkemoi, a dentist, MOrth Royal College of Surgeons of Edinburgh 2003, BDS University of Manchester 1999, was summoned to appear before the Professional Conduct Committee on 10 May 2021 for an inquiry into the following charge:

Charge (as amended on 12 May 2021)

1. "Between about 2013 and November 2017 you were providing orthodontic care and treatment as the principal and practice owner of Practice 1.
2. From 2017 or earlier you caused or allowed it to be advertised on Practice 1's website that you held membership of the following organisations when you did not:
   (a) British Dental Association;
   (b) British Orthodontic Society;
   (c) British Academy of Cosmetic Dentists;
   (d) British Lingual Orthodontic Society.
3. Your conduct as set out above at 2 was:
   (a) misleading;
   (b) dishonest in that you sought to create a false impression of your professional practice and/or status.
4. You routinely failed to ensure Practice 1 had sufficient administrative support.
5. You routinely treated patients at Practice 1 in the absence of a nurse or other appropriately trained dental team member.
6. A final demand for outstanding rent for Practice 1's premises was sent to you on 22 November 2017.
7. The lease to Practice 1's premises was forfeited on 1 December 2017.
8. You knew that the landlord had changed the locks to Practice 1's premises by 5 December 2017.
9. You caused or allowed Witness H, mother of Patient 11, to be asked to make payment in full for treatment:
   (a) by email sent on or after 29 November 2017 offering an appointment on 11 December 2017 and a 4% discount if paid upfront and providing details for Witness H to make a bank transfer of £4,147.20;

(b) by email dated 7 December 2017 in which you resent your earlier email dated on or about 29 November 2017.

10. You caused or allowed Patient 5 to be asked to make payment in full for treatment that had not commenced:

    (a) by email dated 4 December 2017 including an option of a 4 % discount if treatment was paid upfront;

    (b) by email dated 5 December 2017 confirming Patient 5 could take advantage of the 4% discount, offering an appointment on 9 December 2017 and stating you would return to the practice within the week, and providing details for Patient 5 to make a bank transfer of £4,449.60;

    (c) by email dated 7 December 2017 in which it was asked when payment could be expected in order to start treatment at the appointment confirmed for 9 December 2017.

11. On 7 December 2017 you received the following payments by bank transfer:

    (a) £4,147.20 on behalf of Patient 11;

    (b) £4,449.60 on behalf of Patient 5.

12. You thereafter cancelled the appointments booked for Patient 11 and/or Patient 5 and failed to provide a refund or provide or arrange further care and treatment.

13. Your conduct as set out above 9 and/or 10 and/or 12:

    (a) was misleading;

    (b) was dishonest in that you obtained and/or retained funds you knew you were not entitled to.

14. In about mid November 2017 you left Practice 1 for a trip to Kenya indicating your absence would be temporary.

15. You failed to make any, or any adequate, arrangements for the administration of Practice 1 in your temporary and/or long-term absence.

16. You caused or allowed patients to be informed that you would be returning to resume treatments:

    (a) by email dated 18 or 19 January 2018 in which you indicated you would inform patients when normal clinics were due to resume or words to that effect;

    (b) by email dated 1 March 2018 in which you indicated you were seeking to resolve issues and ensure a swift return to Practice 1 or words to that effect

17. You failed:

    (a) to return to resume treatments as indicated or at all;

    (b) to notify patients you would not be returning to resume their treatments as indicated or at all;

    (c) to make alternative arrangements for your patients to complete their treatments and/or obtain refunds

18. In February 2018 you informed the Quality Care Commission that Witness A was the

named contact for managing your regulated activities at Practice 1 without Witness A's permission to do so.

19. From December 2017 you failed to respond, adequately or at all, to communications from:

    (a) patients;

    (b) professional colleagues contacted by your patients;

    (c) organisations involved in assisting patients with complaints and potential claims for compensation.

20. From November 2017 you failed to maintain a valid registered address with the General Dental Council.

21. From March 2018 you failed to co-operate with the General Dental Council's fitness to practise investigation in that you did not provide when asked to do so on various dates between April 2018 and October 2019:

    (a) patient records;

    (b) proof of your indemnity;

    (c) consent to undergo a health assessment.

And that, by reason of the facts alleged, your fitness to practice is impaired by reason of your misconduct."

Ms Luciola was not present and was not represented. On 10 May 2021 the Chairman announced a statement on proof of service. On 12 May 2021 the Chairman announced a statement on the amendment to the charge under under Rule 57(3) and also announced the findings of fact to the Counsel for the GDC:

"This is a Professional Conduct Committee hearing of Ms Luciola's case. The hearing commenced on 10 May 2021 and is being conducted remotely via Microsoft Teams video-link in line with the current practice of the General Dental Council (GDC).

Ms Luciola is not present at this hearing and she is not represented in her absence. The Case Presenter for the GDC is Ms Lydia Barnfather, Counsel.

PRELIMINARY MATTER: Determination on application to proceed with the hearing in the absence of the registrant - 10 May 2021

At the outset, Ms Barnfather made an application under Rule 54 of the *GDC (Fitness to Practise) Rules Order of Council 2006* ('the Rules'), to proceed with the hearing notwithstanding Ms Luciola's absence. The Committee took into account Ms Barnfather's submissions in respect of the application and the supporting documentation provided. It accepted the advice of the Legal Adviser in relation to both service and proceeding in Ms Luciola's absence.

The Committee's decision on service

The Committee considered whether notice of the hearing had been served on Ms Luciola in accordance with Rules 13 and 65. It had regard to the Notice of Hearing dated 8 April 2021 ('the notice'), which was sent to Ms Luciola's registered address by International Tracked Post. The Committee was provided with the Royal Mail 'Track and Trace' receipt as proof of

postage. It noted that copies of the notice were also sent to Ms Luciola by email, both to her registered email address held by the GDC, and to her last known email address.

The Committee was satisfied that the notice sent to Ms Luciola complied with the 28-day notice period required by the Rules. It was further satisfied that the notice contained all the required particulars, including the date and time of the hearing, confirmation that it would be held remotely via video-link on Microsoft Teams, and that the Committee had the power to proceed with the hearing in her absence.

On the basis of all the information provided, the Committee was satisfied that notice of the hearing had been served on Ms Luciola in accordance with the Rules.

The Committee's decision on whether to proceed with the hearing in the absence of the registrant

The Committee next considered whether to exercise its discretion under Rule 54 of the Rules to proceed with the hearing in the absence of Ms Luciola. It approached this issue with the utmost care and caution. The Committee took into account the factors to be considered in reaching its decision, as set out in the case of *R v Jones [2003] 1 AC 1HL* and as explained in the joined cases of *General Medical Council v Adeogba* and *General Medical Council v Visvardis [2016] EWCA Civ 162*. The Committee remained mindful of the need to be fair to Ms Luciola and to the GDC, which included taking into account the public interest in the expeditious disposal of this case.

The Committee took into account the extensive efforts made by the GDC between 8 and 20 April 2021 to notify Ms Luciola of this hearing in addition to sending the notice of 8 April 2021. This included attempts to contact her on various telephone numbers and via various email addresses, which had been provided to the Council by a former business associate and patient.

The Committee noted that it was not until 7 May 2021, a few days before this scheduled hearing, that Ms Luciola contacted the GDC by email, from a new and unknown email address. It was not clear which of the GDC communications Ms Luciola was responding to, but she apologised for her lack of engagement in the process and the inconvenience caused. Ms Luciola informed the Council that she had suffered the bereavement of a close family member and indicated that she had only received notification *"of the most recent parcel from the GDC on 30th March 2021"*, which was four days before her close family member had passed away. Ms Luciola stated that she had requested that a letter be drafted on her behalf to the GDC stating that she would not be able to prepare nor attend any meetings. She stated that she had been surprised to be informed that her legal adviser *"forgot to write the letter"*. Ms Luciola stated that she intended to seek a new legal adviser.

The Committee noted the GDC's email in response to Ms Luciola that same day, strongly recommending that she attend this hearing. She was informed that provisions could be made for her to speak with the Legal Adviser for this hearing prior to it commencing, and although the Legal Adviser could not give her legal advice regarding the specifics of her case, she could be assisted with *"information on next steps and possible options"*.

In reaching its decision on whether to proceed with the hearing, the Committee noted that no clear explanation was provided by Ms Luciola in her email of 7 May 2021 for her persistent failure to respond to the GDC's communications about her case. The Committee noted that Ms Luciola had demonstrated a pattern of non-engagement over a number of years; her last contact with the GDC before 7 May 2021 had been in April 2019. The Committee also took

into account that Ms Luciola had not explicitly requested an adjournment of this hearing in her recent email. It noted that a Microsoft Teams link for this hearing was sent to Ms Luciola, but she has not participated, even for the purposes of requesting an adjournment. Whilst the Committee took into account the information provided by Ms Luciola regarding her bereavement, it received no indication from her as to when she might be in a position to attend a hearing of her case. In the absence of such information and given the history of Ms Luciola's non-engagement, the Committee considered that there was no guarantee that she would attend on a future occasion if this hearing were adjourned.

In all the circumstances, taking into account the issues of fairness, the interests of justice, and its duty to act expeditiously in the public interest, the Committee determined that the hearing should proceed in the absence of Ms Luciola.

Amendment of the charge by the Committee under Rule 57(3) of the GDC (Fitness to Practise) Rules 2006 ('the Rules') on 12 May 2021

The Committee noted that it has a power under Rule 57(3) of the Rules on its own initiative to make arrangements for the identity of a person (giving evidence) to be protected in such manner as the Practice Committee think appropriate.

To that end, the Committee noted that the original charge had mnemonic references to patients and witnesses. The Committee concluded that these could breach the confidentiality of the persons concerned as the mnemonics could be more easily cross-referenced than, for example, numbers and letters. Therefore, the Committee determined to simplify the references to patients and witnesses by the replacement of the mnemonics in the original charge with simple numbers and letters, as demonstrated in the identification key. The Committee was satisfied that the identification key would remain confidential as it reveals full names of all patients and witnesses. By this action, in the Committee's judgement, the charge properly protects the private and family life of all patients and witnesses. Furthermore, the Committee concluded that this was an administrative amendment, changed nothing in relation to the content of the case against Ms Luciola and, therefore, was a fair and proportionate action, as well as being logical.

FINDINGS OF FACT – 12 May 2021

Background and summary of the allegations against Ms Luciola

The Committee heard that between 2013 and 2017, Ms Luciola worked in a single-handed practice as a principal and specialist orthodontist at Practice 1. It is also understood that Ms Luciola worked part-time at another practice.

At the end of November 2017, Ms Luciola let it be known that she intended to be abroad in Kenya for a short period before returning to resume patient treatment in January 2018. Whilst it was said that she did return to the UK for a time, the GDC's case was that Ms Luciola never resumed treatments, nor did she make arrangements for her patients' ongoing care. The GDC maintained that the information available indicates that from 2018 Ms Luciola was living and practising in Kenya under her maiden name.

The charge against Ms Luciola is divided into five broad groups of allegations. She faced allegations relating to:

- dishonest claims on Practice 1's website with regard to professional membership;

- persistent management failings at Practice 1 and, in particular, failures to employ sufficient administrative support or nursing support;
- her conduct from about November 2017 in the lead up to the closure of Practice 1, which include allegations of dishonest enticement of payment from two patients;
- issues that arose following the closure of Practice 1 on 5 December 2017, including her alleged abandonment of her patients; and
- allegations in connection with the investigation conducted by the GDC into the matters including her alleged failure to co-operate.

Evidence

The evidence received by the Committee in this case was wholly documentary. A determination made at a Preliminary Meeting in respect of this case on 23 April 2021, provided that the witness statements of a number of the witnesses in this case could stand as their evidence in chief. Whilst this Committee was afforded the opportunity to call witnesses to ask any supplementary questions, it decided that it did not need to hear evidence from any of them. The Committee considered their witness statements to be clear and self-explanatory, and it was satisfied that questioning the witnesses would not assist any further in its fact-finding task.

The Committee received witness statements from 10 patients, with a number of associated exhibits. This included a witness statement dated 5 July 2018 from Patient 5, who is the subject of some of the allegations in the charge, and a witness statement dated 4 April 2018 from Patient 9, a former patient and business consultant to Ms Luciola. The Committee received a further two witness statements from the parents of patients who were minors at the time of their treatment with Ms Luciola. One of these parents was Witness H, who is also the subject of a number of allegations in the charge.

In addition, the Committee was provided with witness statements from a further eight witnesses, including associated exhibits. These included a witness statement dated 15 May 2019, from Witness A, a specialist orthodontist and friend of Ms Luciola who saw some of her patients following the closure of Practice 1. Also received were witness statements from two members of the GDC's in-house legal team, who exhibited copies of the documents and communications sent to Ms Luciola as part of the Council's investigation of this case.

The Committee's findings

The Committee considered all the evidence presented to it. It took account of the submissions made by Ms Barnfather on behalf of the GDC, both orally and in her written case summary. The Committee accepted the advice of the Legal Adviser. In accordance with that advice, it considered each head of charge separately, bearing in mind that the burden of proof rests with the GDC, and that the standard of proof is the civil standard, that is, whether the alleged facts are proved on the balance of probabilities.

The Committee's findings are as follows:

1.	*Between about 2013 and November 2017 you were providing orthodontic care and treatment as the principal and practice owner of Practice 1.* **Found proved.** The Committee was satisfied from the documentary evidence before it,

	which included copies of Ms Luciola's patient records and correspondence relating to the practice, that she was providing orthodontic care and treatment as principal and practice owner at Practice 1 over the period in question.
2.	*From 2017 or earlier you caused or allowed it to be advertised on Practice 1's website that you held membership of the following organisations when you did not:*
2. a)	*British Dental Association;* **Found proved.**
2. b)	*British Orthodontic Society;* **Found proved.**
2. c)	*British Academy of Cosmetic Dentists;* **Found proved.**
2. d)	*British Lingual Orthodontic Society.* **Found proved.** The Committee considered heads of charge 2(a) to 2(d) separately and reached the same finding in respect of each of the allegations. The Committee had regard to a copy of the screenshot of the website for Practice 1, which states "copyright 2017". The screenshot, taken in May 2018, shows that it was stated on the website that Ms Luciola was a member of the four associations in question. The Committee received evidence from the Society Administrator for the British Orthodontic Society and from the Membership Services Officer for the British Dental Association, which indicated that Ms Luciola had not been a member of those associations since 2013. Furthermore, there was evidence that Ms Luciola had never held membership with the British Academy of Cosmetic Dentists and British Lingual Orthodontic Society. Accordingly, the Committee found heads of charge 2(a) to 2(d) proved, as at the material time, 2017 to at least May 2018, Ms Luciola did not hold membership with any of the associations listed on Practice 1's website. In finding these allegations proved, the Committee was satisfied that Ms Luciola, as the principal and owner of Practice 1, was responsible for the accuracy of the information advertised on practice's website.
3.	*Your conduct as set out above at 2 was:*
3. a)	*misleading;* **Found proved.** The Committee found that, Ms Luciola causing or allowing to be advertised on Practice 1's website that she was a member of the associations at listed at heads of charge 2(a) to 2(d) above, was conduct that was misleading. It was satisfied that the information would, and in some cases did, lead people to believe that her claims were true, when they were not. In this regard, the

	Committee noted the evidence that some of the patients in this case had researched a number of orthodontists before deciding on a treating practitioner, and they had considered Ms Luciola to be the most qualified.
3. b)	*dishonest in that you sought to create a false impression of your professional practice and/or status.* **Found proved.** The proven facts are that Ms Luciola was not a member of the British Orthodontic Society, nor the British Dental Association at the relevant time. Further, she had never held membership with the British Academy of Cosmetic Dentists and British Lingual Orthodontic Society. The Committee considered the evidence before it and was satisfied that there was no indication of an alternative explanation indicating a mistake, carelessness or negligence by Ms Luciola in relation to the information featured on Practice 1's website. In all the circumstances, the Committee considered that it was more likely than not that she had wished to deliberately create a false impression of her professional practice and/or status. It was satisfied that ordinary decent people would consider that her conduct in this regard was dishonest.
4.	*You routinely failed to ensure Practice 1 had sufficient administrative support.* **Found proved.** The evidence received from a large number of the patients in this case was that there was an occasional receptionist at Practice 1, but no other administrative or clinical support staff. The indication from the evidence was that although treatment plans, text messages and emails sent on behalf of the practice referred to 'Treatment Co-ordinators' and other members of staff, the common perception was that these communications came from Ms Luciola herself. The Committee also noted the evidence of Patient 9, a former patient who subsequently provided business consultancy services to Ms Luciola at Practice 1. He stated in his witness statement that he did not see any personnel files during all his time at the practice. In making its finding in respect of this allegation, the Committee considered whether Ms Luciola had a duty to ensure that Practice 1 had sufficient administrative support. Whilst it took into account that no specific professional standards were advanced by the GDC in relation to this issue, it noted the evidence received from a number of the patients in this case regarding the problems they had experienced in accessing treatment with Ms Luciola. The patients complained of difficulties in getting hold of her in emergency situations, and of appointments being cancelled at short notice. They recalled their telephone calls to the practice going unanswered and their difficulties in receiving replies to emails sent to the practice. The Committee considered that these issues highlighted by the patients suggested that there was a risk of harm to them from not being able to easily communicate with Ms Luciola about their care and treatment. The Committee was satisfied that this risk implied that there was a duty upon her to ensure that she had enough administrative support to ensure her patients

	had access to her services, particularly for emergencies. Having taken into account the evidence from her patients about the persistent problems they encountered in gaining access to treatment when required, the Committee was satisfied that Ms Luciola did routinely fail to ensure that the practice had sufficient administrative support to function properly.
5.	*You routinely treated patients at Practice 1 in the absence of a nurse or other appropriately trained dental team member.* **Found proved.** The Committee was satisfied that Ms Luciola had a duty to ensure that she had clinical support when she treated patients at Practice 1. It had regard to Standard 6.2 of the GDC's '*Standards for the Dental Team (effective from September 2013)*, which states that registrants must *"Be appropriately supported when treating patients."* The Committee noted that the recollection of a large number of patients in this case was that Ms Luciola saw them alone with no other clinical staff present at their appointments. A number of the patients recalled seeing the picture of a dental nurse on the practice's website, but never saw that dental nurse at Practice 1. One parent of a patient in this case, Witness I, stated in her witness statement, dated 28 February 2019 that, *"In hindsight and having seen my daughter's recent appointment with her new orthodontist where they have a dental nurse present to help pass dental instruments and assist as necessary, I have noticed that the appointments are much quicker and work does not look as difficult as it did when Dr Luciola was working alone."* The Committee noted that it was also the evidence of Patient 9 that he never saw a dental nurse working at Practice 1 when he was working there. Taking all of the evidence into account, the Committee was satisfied that Ms Luciola routinely failed in her duty to be appropriately supported when treating patients at Practice 1.
6.	*A final demand for outstanding rent for Practice 1's premises was sent to you on 22 November 2017.* **Found proved.** The Committee had sight of a copy of the final demand for outstanding rent for Practice 1's premises, dated 22 November 2017. The copy of the final demand was provided to the GDC by the company that managed the lease for the practice.
7.	*The lease to Practice 1's premises was forfeited on 1 December 2017.* **Found proved.** The Committee had sight of a photograph provided to the GDC by the company that managed the lease for the practice of the notice that was put on the front door of Practice 1. The notice stated, *"We have forfeited the lease of this property 01.12.2017".* The Committee also had sight of a letter to Ms Luciola, dated 5 December 2017 confirming that the lease to Practice

	1's premises had been forfeited.
8.	*You knew that the landlord had changed the locks to Practice 1's premises by 5 December 2017.* **Found proved.** The Committee had before it a copy of an email dated 5 December 2017 from Ms Luciola to the company that managed the lease for the Practice 1. She stated in that email that *"I understand from our conversation also, that you have changed the locks at the premises…".*
9.	*You caused or allowed Witness H, mother of Patient 11, to be asked to make payment in full for treatment:*
9. a)	*by email sent on or after 29 November 2017 offering an appointment on 11 December 2017 and a 4% discount if paid upfront and providing details for Witness H to make a bank transfer of £4,147.20;* **Found proved.** The Committee did not have before it a copy of the original email sent to Witness H. However, it had sight of a copy of an email exhibited by Witness H with her witness statement, which had been sent to her by Ms Luciola on 7 December 2017. In that email, Ms Luciola stated, *"As I have not heard back from you I thought I would resend the email below".* The Committee noted that the email below was the offer of an appointment on 11 December 2017 and the option to take advantage of a 4% discount. The Committee was satisfied from the wording of Ms Luciola's email on 7 December 2017, that the offer of the appointment and the discount had been sent to Witness H on a previous date prior to 7 December 2017 and was, as Ms Luciola stated, being resent. The Committee was therefore satisfied this head of charge, which refers to an *"email sent on or after 29 November 2017"* is proved.
9. b)	*by email dated 7 December 2017 in which you resent your earlier email dated on or about 29 November 2017.* **Found proved.** For the same reasons set out at head of charge 9(a) above.
10.	*You caused or allowed Patient 5 to be asked to make payment in full for treatment that had not commenced:*
10. a)	*by email dated 4 December 2017 including an option of a 4 % discount if treatment was paid upfront;* **Found proved.** The Committee had sight of a copy of the email exchange between Patient 5 and the 'Treatment Co-ordinator' at Practice 1 on 4 December 2017, as exhibited by the patient with her witness statement. In the email to Patient 5, the 'Treatment Co-ordinator' stated "*We would be grateful if you would let us know by return which option you would be interested in"* and it was indicated that a treatment plan and options were attached to that email. In her reply on

	that same day, Patient 5 stated "*I have chosen Option 1 at £4635 and would like to take advantage of the 4% discount if paying the lump sum upfront so please confirm this will be £4449.60".*
10. b)	*by email dated 5 December 2017 confirming Patient 5 could take advantage of the 4% discount, offering an appointment on 9 December 2017 and stating you would return to the practice within the week, and providing details for Patient 5 to make a bank transfer of £4,449.60;* **Found proved.** The Committee had sight of a copy of an undated email, as exhibited by Patient 5 with her witness statement. This was an email from Practice 1 to Patient 5 confirming her own confirmation of Option 1 which, with the 4% discount, was £4,449.60. The same email also gave Patient 5 her appointment for 9 December 2017. Therefore, the Committee was satisfied that this head of charge is proved.
10. c)	*by email dated 7 December 2017 in which it was asked when payment could be expected in order to start treatment at the appointment confirmed for 9 December 2017.* **Found proved.** The Committee had sight of a copy of the email dated 7 December 2017, as exhibited by Patient 5 with her witness statement. The email was from Practice 1 to Patient 5 asking when they could expect to receive payment and that the writer of the email needed to confirm receipt *"as soon as possible"* in order to start treatment on Patient 5's confirmed appointment date. Therefore, the Committee was satisfied that this head of charge is proved.
11.	*On 7 December 2017 you received the following payments by bank transfer:*
11. a)	*£4,147.20 on behalf of Patient 11;* **Found proved.** The Committee accepted the evidence of Witness H, mother of Patient 11, who confirmed in her witness statement that she made the payment to Ms Luciola by bank transfer as requested on 7 December 2017. Witness H also provided a copy of an email dated 7 December 2017 from the practice confirming the payment of £4,147.20.
11. b)	*£4,449.60 on behalf of Patient 5.* **Found proved.** The Committee accepted the evidence of Patient 5, who stated in her witness statement that *"On 7 December I received an email, again from the 'Treatment Coordinator' chasing for payment…I paid the £4,449.60 by bank transfer that same day".* The Committee also noted the email receipt sent to Patient 5 on 7 December 2017 by the practice confirming the payment.
12.	*You thereafter cancelled the appointments booked for Patient 11 and/or Patient 5 and failed to provide a refund or provide or arrange further care*

	and treatment. **Found proved.** The Committee had regard to the evidence of both Witness H and Patient 5 as set out in their witness statements. They both stated that, following the payments they made, their appointments with Ms Luciola were cancelled. Witness H stated that she was informed that Ms Luciola needed to visit her family in Kenya as a close family member was seriously ill. Patient 5 also stated that she was told that a close family member of Ms Luciola had been taken to hospital and therefore Ms Luciola *"needed to travel".* The Committee noted the details provided by both Witness H and Patient 5 of their subsequent unsuccessful attempts to contact Ms Luciola and to obtain refunds. They both confirmed that no further treatment was received from Ms Luciola and that no future care was arranged. The evidence was that Patient 11 eventually sought treatment elsewhere, whilst Patient 5 who anticipated doing the same, noted in her witness statement that "*this will prove very expensive for me as I have not received any refund from the Registrant".*
13.	*Your conduct as set out above 9 and/or 10 and/or 12:*
13. a)	*was misleading;* **Found proved in relation to heads of charge 9, 10 and 12.** In the Committee's view, Ms Luciola's conduct caused Witness H and Patient 5 to believe that they would be attending respective appointments for treatment at Practice 1 on 9 and 11 December 2017. However, neither of the appointments could have occurred as Ms Luciola had ceased to have access to the practice premises on 5 December 2017 and there was nothing to suggest that she would have been able to provide treatment from the practice on the dates proposed to Witness H and Patient 5. Consequently, Ms Luciola cancelled the appointments, further misleading Witness H and Patient 5 into thinking that the appointments would be rearranged. The evidence was that the appointments were never rearranged. Indeed, Ms Luciola failed to arrange any further care and treatment for the patients concerned. The Committee was satisfied that Ms Luciola's conduct was misleading in all respects. By acting as she did, Ms Luciola gave Witness H and Patient 5 the wrong impression as to the true circumstances regarding Practice 1 and the impact on her being able to provide treatment.
13. b)	*was dishonest in that you obtained and/or retained funds you knew you were not entitled to.* **Found proved in relation to heads of charge 9, 10 and 12.** Ms Luciola obtained funds from Witness H and Patient 5, having offered them both a discount as an enticement to make payment for treatment upfront. Whilst the Committee considered that it was not dishonest in itself to obtain payment for treatment upfront, the circumstances in this case were that Ms Luciola received the money from Witness H and Patient 5 at a time when she did not have access to Practice 1 to provide the services she had offered them. The lease to the practice had already been forfeited and Ms

	Luciola knew that the locks to the premises had been changed. Whilst the Committee took into account the indication that Ms Luciola's intention was to rearrange the patients' appointments on her return from Kenya, where she was said to have gone to visit her family, that intention was not borne out. The evidence was that the patients in question were not seen by Ms Luciola again, and she did not make any arrangements for their future care, nor did she refund their money. The Committee considered the evidence before it and was satisfied that there was no indication of an alternative explanation indicating a mistake, carelessness or negligence on the part of Ms Luciola in relation to the facts found proved at heads of charge 9, 10 and 12. It was satisfied, taking into account all the information regarding the material time, that it was more likely than not, that Ms Luciola deliberately obtained and retained funds that she knew she was not entitled to. In all the circumstances, the Committee was satisfied that ordinary decent people would consider that Ms Luciola's conduct was dishonest.
14.	*In about mid November 2017 you left Practice 1 for a trip to Kenya indicating your absence would be temporary.* **Found proved.** The Committee received a number of accounts from patients indicating that they had been told that Ms Luciola needed to travel to Kenya around this time, but that she would be returning to Practice 1. This was also the evidence of Patient 9 and Witness A. Witness A stated in her witness statement that *"the Registrant contacted me towards the end of November 2017 or beginning of December 2017, to say that she was in Kenya…The Registrant asked if I could cover any emergencies on her behalf while she was away in Kenya."* Witness A further stated that *"On 17 January 2018 I received a call from the Registrant, from Kenya…and that she would be returning to the United Kingdom soon".* The Committee was satisfied on the evidence that this head of charge is proved.
15.	*You failed to make any, or any adequate, arrangements for the administration of Practice 1 in your temporary and/or long-term absence.* **Found proved.** The Committee considered that there was an obvious duty on Ms Luciola to make arrangements for the administration of Practice 1 in her absence. In considering whether this obligation was met by Ms Luciola, the Committee had regard to the evidence of the steps taken by her to make such arrangements. The Committee noted the evidence of Witness A, who confirmed in her witness statement that she had agreed to cover any patient emergencies in Ms Luciola's absence. Witness A stated, however, that she had not been aware of Ms Luciola's intention to email all of her patients sign-posting them to her practice. Witness A stated that she was forwarded a copy of the email, dated 19 January 2018, and subsequently raised concerns with Ms Luciola by email on 26 January 2018, after having seen a number of her patients.

	Witness A provided with her witness statement a copy of her email exchange with Ms Luciola regarding the matter. The Committee noted that Ms Luciola stated in her email response dated 31 January 2018, *"Yes, as I alluded to I definitely required a very short-term stop gap arrangement…I will be travelling back ASAP…".* Witness A further detailed in her witness statement her surprise at having been named by Ms Luciola on a CQC Statutory Notification as being responsible for managing Ms Luciola's activities in her absence. Witness A stated that Ms Luciola had not made her aware of this, and highlighted that it was not what had been agreed. Witness A stated that she emailed Ms Luciola on 20 February 2018 to tell her that she had informed the CQC that she had not assumed responsibility for her patients, but that she received back what *"looked like an automatic response"* from Ms Luciola's email account. Witness A stated that was the last email correspondence that she had with Ms Luciola. The Committee also took into account the evidence of Patient 9 who stated in his witness statement that he had retained access to Practice 1's email account. He indicated that the account had received multiple emails from patients in Ms Luciola's absence, and that he had also received emails directly from patients who knew that he had worked with Ms Luciola. He also referred to a number of instances of patients trying to contact him via Facebook to find out when Ms Luciola would be returning from Kenya. The Committee noted that Patient 9's evidence was supported by a number of the accounts given by the patients in this case regarding the lack of any arrangement for the continuity of their treatment and care. Taking all the evidence into account, the Committee considered that Ms Luciola had taken some steps to make a short term arrangement for the emergency care for her patients by Witness A. It found, however, that she failed in her duty to make any other arrangements for the administration of Practice 1, which included the lack of any longer-term plans for all of her patients, when it became apparent that her stay in Kenya would become extended.
16.	*You caused or allowed patients to be informed that you would be returning to resume treatments:*
16. a)	*by email dated 18 or 19 January 2018 in which you indicated you would inform patients when normal clinics were due to resume or words to that effect;* **Found proved.** The Committee had sight of a copy of the email dated 19 January 2018, which was sent to Ms Luciola's patients from Practice 1. The email indicated that Ms Luciola had suffered a family bereavement and stated *"We will keep you informed as soon as normal clinics are due to resume.* Reference was made in the email to Witness A being "*our Special Orthodontist cover"* and her contact telephone number was provided.

16. b)	*by email dated 1 March 2018 in which you indicated you were seeking to resolve issues and ensure a swift return to Practice 1 or words to that effect* **Found proved.** The Committee had sight of a copy of the email dated 1 March 2018, which was sent to patients of Practice 1 by Ms Luciola. The email stated that "*Over the past several weeks we have been experiencing multiple difficulties in seeking to resume our service to full capacity*". The Committee noted that Ms Luciola also stated that she had experienced *"several personal difficulties, including my own health".* Ms Luciola further stated that "*My team are now in talks with the landlord and appropriate legal representatives to resolve all issues and ensure I can return swiftly to the practice."* Having considered the details of the email of 1 March 2018, the Committee was satisfied that this head of charge is made out.
17.	*You failed:*
17. a)	*to return to resume treatments as indicated or at all;* **Found proved.**
17. b)	*to notify patients you would not be returning to resume their treatments as indicated or at all;* **Found proved.**
17. c)	*to make alternative arrangements for your patients to complete their treatments and/or obtain refunds* **Found proved.** The Committee considered heads of charge 17(a) to 17(c) separately and made the same finding in respect of each head of charge. The Committee was satisfied that Ms Luciola had a duty to return to resume the treatments of her patients, or alternatively to notify them that she would not be returning and to make other arrangements for the continuity of their care. The overwhelming evidence from the patient witness statements provided to the Committee is that Ms Luciola did not return to Practice 1 to resume their treatment. One of the patients affected, Patient 3, provided with her witness statement a screenshot of a YouTube video published on 17 September 2018 which indicated that Ms Luciola was practising as a dentist in Kenya around that time. The Committee noted that many of the patients detailed in their witness statements their unsuccessful attempts in trying to contact Ms Luciola after she left Practice 1 to go to Kenya, and that they ultimately sought treatment elsewhere. It also took into account Witness A's evidence and the evidence of Patient 9 about the lack of arrangements by Ms Luciola for the continuity of patient care. Witness A stated in her witness statement that by 1 February 2018 some of Ms Luciola's patients *"were asking me what they should do in relation to the unfinished treatment with the Registrant."* The Committee further noted that a number of the patients stated that they were, at the time of writing their witness statements, still trying to obtain

	refunds for money they had paid to Ms Luciola for treatment. In all the circumstances, the Committee found the alleged failings at 17(a) to 17(c) proved.
18.	*In February 2018 you informed the Quality Care Commission that Witness A was the named contact for managing your regulated activities at Practice 1 without Witness A's permission to do so.* **Found proved.** The Committee had sight of a copy of the CQC Statutory Notification completed by Ms Luciola and naming Witness A as the person who would be managing her activities from 5 February 2018. The Committee accepted the evidence of Witness A that she did not agreed to this and that Ms Luciola informed the CQC of the arrangement without her permission to do so.
19.	*From December 2017 you failed to respond, adequately or at all, to communications from:*
19. a)	*patients;* **Found proved.** The Committee received considerable evidence from the patients concerned, which it accepted. They detailed their efforts in trying to contact Ms Luciola about their treatment, without success. The Committee noted the evidence that some of the patients had set up a Facebook group in light of the situation they faced. Patient 9 recalled in his witness statement how many patients had contacted him about Ms Luciola's whereabouts, including via Facebook. Further, Witness A recalled her contact with a number of Ms Luciola's patients asking her about their unfinished treatment provided by Ms Luciola. Whilst the Committee took into account that some emails were sent by and/or on behalf of Ms Luciola to her patients after December 2017, it did not consider those emails, which were essentially 'holding responses', to be adequate.
19. b)	*professional colleagues contacted by your patients;* **Found proved.** The Committee noted the evidence of Patient 9 and Witness A in this regard. They also outlined in their witness statements their attempts to contact Ms Luciola during her continued absence from Practice 1. Whilst the Committee noted that Ms Luciola did respond on occasions, it was not satisfied that her responses were adequate, as they did not address the issues raised on behalf of her patients. The Committee noted that after some time, Ms Luciola stopped responding altogether. The Committee further noted the evidence of Witness B, a Consultant in Orthodontics who also saw some of Ms Luciola's patients after December 2017. In her witness statement, dated 27 September 2019, Witness B stated that since December 2017, which is when she understood that Ms Luciola's patients became unable to contact her, Ms Luciola had left her two

	voicemails and had one conversation with her. That conversation, Witness B stated, was in February 2018, and on her account, it was a conversation that appeared to cause Witness B some concerns, including in relation to Ms Luciola's health. Witness B stated that Ms Luciola left the second of the two voicemails in April 2018, in which she stated that she would provide Witness B with an update on her circumstances. Witness B stated that the voicemail was from a Kenyan telephone number, and that she subsequently sent a text message to the number, but received no response. Witness B stated that she had not heard from Ms Luciola since that time. The Committee was satisfied on all the evidence that from December 2017, Ms Luciola had failed to respond adequately to communications from the professional colleagues in question, all of whom had been in contact with her patients.
19. c)	*organisations involved in assisting patients with complaints and potential claims for compensation.* **Found proved.** The Committee noted that in addition to having their treatments abandoned or interrupted due to Ms Luciola absence from Practice 1, Patient 3, Patient 6, Patient 10, Patient 12 and Witness H were subsequently informed that they have no means of seeking compensation for lost or additional costs incurred from Ms Luciola's insurers because she was not co-operating with her insurers. In addition, Patient 10 and Patient 3 took legal advice, but were told a civil claim against Ms Luciola was not possible as she had not co-operated with her indemnity organisation. The Committee also had regard to the evidence set out in various witness statements (for example Witness I, Patient 4, Patient 3 and Patient 5) indicating that there were a number of unresolved complaints against Ms Luciola, and highlighting her failure to respond to them. Accordingly, the Committee was satisfied that this head of charge is proved.
20.	*From November 2017 you failed to maintain a valid registered address with the General Dental Council.* **Found proved.** In finding this head of charge proved, the Committee had regard to the communications sent to Ms Luciola by the GDC requesting that she update her registered address. Whilst she did provide an updated contact address to the GDC on 30 May 2018, which was an address in c/o another person, she did not formally update her registered address with the GDC. Ms Luciola stated that she had been unable to use the eGDC portal to amend her registered address as her emails had been hacked. The Committee noted that dental professionals have an obligation to ensure that their registration information is up to date, which includes a valid registered address. The purpose of this principle is to enable the GDC to perform its function as a regulator with its primary function of protecting the public.

21.	*From March 2018 you failed to co-operate with the General Dental Council's fitness to practise investigation in that you did not provide when asked to do so on various dates between April 2018 and October 2019:*
21. a)	*patient records;* **Found proved.** In finding this head of charge proved, the Committee had regard to the communications sent to Ms Luciola by the GDC requesting her patient records. It noted that on 18 May 2018, Ms Luciola's solicitors indicated that the records were in storage. They stated that she was in Kenya and provided information regarding her personal circumstances, including medical information. Further requests for the records were made by the GDC on 23 May 2018, 31 May 2018, 12 June 2018 and 11 September 2018. The evidence provided by those working on Ms Luciola's case for the GDC indicates that no patient records have been received by the Council to date. The Committee was satisfied on the evidence that there was a failure on Ms Luciola's part to adhere to Standard 9.4 of the GDC's *'Standards for the Dental Team (effective from September 2013)*, which states that registrants must *"Co-operate with any relevant formal or informal inquiry and give full and truthful information".*
21. b)	*proof of your indemnity;* **Found proved.** The Committee noted that requests were also made by the GDC in communications to Ms Luciola for proof of her indemnity. The evidence indicates that despite a number of attempts by the Council to obtain this information, including reminders on 31 May 2018, 12 June 2018 and 11 September 2018, no information regarding Ms Luciola's indemnity has been supplied. The Committee was satisfied on the evidence that there was a failure on Ms Luciola's part to adhere to Standard 9.4 of the GDC's *'Standards for the Dental Team (effective from September 2013)*, which states that registrants must *"Co-operate with any relevant formal or informal inquiry and give full and truthful information".*
21. c)	*consent to undergo a health assessment.* **Found proved.** The Committee noted that, as a result of references in correspondence to potential issues relating to Ms Luciola's health, the GDC invited her to consent to undergo a health assessment. The evidence indicates that this request was repeated by the Council on a number of occasions, including in the reminder communications sent to Ms Luciola on 31 May 2018, 12 June 2018 and 11 September 2018. The Committee noted that in September 2018, Ms Luciola's solicitors responded to the GDC's requests for information, including her consent for a health assessment, by stating that they had been unable to take instructions

	from her. The evidence indicates that on 27 September 2019, Ms Luciola's solicitors formally ceased to represent her. The evidence received from the GDC indicates that Ms Luciola has not provided her consent for a health assessment to date. The Committee was satisfied on the evidence that there was a failure on Ms Luciola's part to adhere to Standard 9.4 of the GDC's *'Standards for the Dental Team (effective from September 2013)*, which states that registrants must *"Co-operate with any relevant formal or informal inquiry and give full and truthful information".*

We move to Stage Two."

On 13 May 2021 the Chairman announced the determination as follows:

"This is a Professional Conduct Committee hearing of Ms Luciola's case. The hearing commenced on 10 May 2021 and is being conducted remotely via Microsoft Teams video-link in line with the current practice of the General Dental Council (GDC).

Ms Luciola is not present at this hearing and she is not represented in her absence. The Case Presenter for the GDC is Ms Lydia Barnfather, Counsel.

The Committee's task at this second stage of the hearing has been to consider whether the facts found proved against Ms Luciola amount to misconduct and, if so, whether her fitness to practise is currently impaired by reason of that misconduct. The Committee noted that if it found current impairment, it would need to go on to consider the issue of sanction.

The Committee considered all the evidence presented to it, both at the fact-finding stage and at this stage. The evidence received by the Committee at this stage was a bundle of documents provided by the GDC relating to Ms Luciola's fitness to practise history.

The Committee took account of the submissions made by Ms Barnfather in relation to misconduct, impairment and sanction. It accepted the advice of the Legal Adviser. The Committee reminded itself that misconduct and current impairment were matters for its own independent judgement. There is no burden or standard of proof at this stage of the proceedings.

Summary of the facts found proved

Between 2013 and 2017, Ms Luciola worked in a single-handed practice as a principal and specialist orthodontist at Practice 1. It is also understood that Ms Luciola worked part-time at another practice.

At the end of November 2017, Ms Luciola let it be known that she intended to be abroad in Kenya for a short period before returning to resume patient treatment in January 2018. Whilst she did return to the UK for a time, Ms Luciola never resumed treatments, nor did she make arrangements for her patients' ongoing care. The lease for Practice 1 was forfeited on 1 December 2017. The information available indicates that from 2018 Ms Luciola was living and practising in Kenya under her maiden name.

The Committee found proved a number of serious allegations against Ms Luciola relating to the following:

- her dishonest claims on Practice 1's website with regard to professional membership of a number of associations;
- her persistent management failings at Practice 1 and, in particular, failures to employ sufficient administrative support or nursing support;
- her conduct from about November 2017 in the lead up to the closure of Practice 1, which included findings of dishonest enticement of payment from two patients;
- her abandonment of her patients following the closure of Practice 1 on 5 December 2017;
- her failure to co-operate with the investigation conducted by the GDC into her fitness to practice, which included her failure when requested to provide patient records, proof of her indemnity and consent to undergo a health assessment.

Summary of the submissions made by the GDC

Ms Barnfather drew the Committee's attention to the information regarding Ms Luciola's fitness to practise history. Ms Barnfather informed the Committee that Ms Luciola had previously been issued with formal advice from the GDC's Investigating Committee following a complaint about sub-standard treatment and record keeping between July 2014 and January 2015.

Ms Barnfather went on to make submissions in relation to this current case. In addressing the issue of misconduct, she referred the Committee to the relevant legal authorities, which highlight that a finding of misconduct requires a serious falling short of what is expected in the circumstances. Ms Barnfather outlined the standards that she considered to be relevant in this case, as contained within the GDC's publication *'Standards for the Dental Team (effective from September 2013)'* ('the GDC Standards'). Ms Barnfather submitted that Ms Luciola's failings, as identified in this case, were amongst the most serious of failings, were wide-ranging, included multiple breaches of fundamental tenets of the profession, and were directly connected to her performance as a dentist. She stated that the failings included the deceit of patients, breach of trust and an ongoing failure by Ms Luciola to co-operate with her regulator. It was Ms Barnfather's submission that whether taken separately or cumulatively, the facts found proved in this case amount to misconduct.

Ms Barnfather further submitted that Ms Luciola's fitness to practice is currently impaired by reason of misconduct. Ms Barnfather submitted that there was nothing at all prepared by, or on behalf of Ms Luciola, to even suggest that she recognises the need for remediation. Ms Barnfather stated that in the circumstances, the only conclusion that could be made is that there is a risk of repetition and therefore a risk to patient safety. She also asked the Committee to take into account the wider public interest considerations in this case, and submitted that public confidence in the dental profession would be seriously undermined if a finding of impairment were not made.

In relation to sanction, Ms Barnfather asked the Committee to have regard to the *'Guidance for the Practice Committees including Indicative Sanctions Guidance (effective from October 2016; last revised in December 2020)* ('the Guidance'). She invited the Committee to consider whether there were any mitigating factors in this case, although it was her submission that there were none. She highlighted a number of aggravating features which she considered to be present and invited the Committee to take them into account. Ms Barnfather's submission on behalf of the GDC was that Ms Luciola was unsuitable for

continued membership of the dental profession and therefore the only appropriate and proportionate sanction in this case was one of erasure.

The Committee's decision on misconduct

The Committee considered whether the facts found proved against Ms Luciola amount to misconduct. It took into account that a finding of misconduct in the regulatory context requires a serious falling short of the professional standards expected of a registered dental professional. The Committee had regard to the GDC Standards. It considered the following professional standards to be engaged in this case:

1.3 Be honest and act with integrity.

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

1.3.3 You must make sure that any advertising, promotional material or other information that you produce is accurate and not misleading, and complies with the GDC's guidance on ethical advertising.

1.7.1 You must always put your patients' interests before any financial, personal or other gain.

1.8 You must have appropriate arrangements in place for patients to seek compensation if they have suffered harm.

4.4.1 Although patients do not own their dental records, they have the right to access them under Data Protection legislation. If patients ask for access to their records, you must arrange for this promptly, in accordance with the law.

5.3 Give patients who complain a prompt and constructive response.

6.1 Work effectively with your colleagues and contribute to good teamwork.

6.2 Be appropriately supported when treating patients.

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

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

It was the view of the Committee that the dishonesty found proved in this case, in and of itself, represented serious departures from a number of the above standards. Ms Luciola's conduct in deliberately misrepresenting her professional memberships on Practice 1's website, and her conduct in inducing and obtaining large sums of money upfront from patients for life-changing treatment that she knew she had no prospect of fulfilling, were clear breaches of fundamental tenets of the profession. The Committee was in no doubt that Ms Luciola's dishonesty was at the high end of the scale.

In addition, the Committee found a number of other serious failings, covering a wide spectrum of Ms Luciola's professional conduct, which continued over a protracted period of time and involved a large number of patients. She persistently failed to ensure that Practice 1 had sufficient administrative support, which meant that patients had difficulty getting hold of her, including in emergency situations, and their appointments were routinely cancelled at

short notice. Further, when she did treat patients at Practice 1, she routinely treated patients without any nursing support in contravention of Standard 6.2.

When Practice 1 closed in December 2017, on account of Ms Luciola's failure to pay the outstanding rent for the premises, she abandoned all of her patients without any adequate arrangements for the continuity of their care and treatment. The Committee considered that Ms Luciola had an obvious duty to make such arrangements and to keep her patients properly informed, regardless of whether she considered that her absence from the practice would be temporary. Instead, she left many of her patients, including children, at risk of harm from unfinished treatment and lack of access to emergency care. The continuity of their care was further compromised by the fact that they could not gain access to their patient records held by Ms Luciola. The Committee considered that the evidence it received from the patients involved in this case demonstrated their frustration and desperation at the situation in which they were left. In the Committee's view this made them more vulnerable. It further took into account that many of the patients have been unable to seek any compensation on account of her lack of co-operation with her insurers. The Committee considered it clear from the evidence it received from Ms Luciola's professional colleagues, who subsequently treated and sought to offer assistance to the patients, that they were appalled by her conduct.

The Committee further found proved that Ms Luciola failed to co-operate with the investigation of her regulatory body into the matters in this case. She has persistently failed over a prolonged period of time to respond to requests for information by the GDC. Therefore, displaying, in the Committee's view, a complete disregard for the function of the Council and its statutory functions, which include the protection of the public.

The Committee was satisfied, having considered all of the matters outlined, that the facts found proved in this case, both individually and cumulatively, amount to misconduct.

The Committee's decision on impairment

The Committee next considered whether Ms Luciola's fitness to practise is currently impaired by reason of her misconduct. It had regard to the over-arching objective of the GDC, which is: the protection, promotion and maintenance of the health, safety and well-being of the public; the promotion and maintenance of public confidence in the dental profession; and the promotion and maintenance of proper professional standards and conduct for the members of the dental profession.

The Committee considered Ms Luciola's misconduct to be at the higher end in terms of the seriousness of her behaviour, which included high level dishonesty. The Committee was of the view that misconduct of the kind found in this case is not easily remediable, given that it involves significant concerns of an attitudinal nature. It noted, however, that there was no evidence before it to suggest that Ms Luciola had taken any steps to address the issues that have been raised.

Ms Luciola has not engaged in any meaningful way with this hearing's process. The Committee considered this to be consistent with the evidence of her pattern of engagement in the past, which has consisted of sporadic contact with the GDC over a number of years. Consequently, there has been no evidence from her as to her insight into her breaches of fundamental tenets of the dental profession, including her serious dishonesty, the harm she caused to her patients' health, as well as the financial and emotional harm, or her attitude towards her regulatory body. In the circumstances, the Committee considered the risk of

repetition to be very high. Indeed, the Committee noted Ms Luciola's sporadic engagement with the GDC continues to be an issue and has continued up to and including this week.

In the absence of any evidence of Ms Luciola's insight into the seriousness of her misconduct or any evidence of remediation, the Committee considered that the public would be at risk of harm if current impairment were not found. It therefore decided that such a finding is necessary for the protection of the public.

The Committee went on to consider the wider public interest. Ms Luciola's misconduct occurred over a significant period of time, involved dishonest conduct, as well as serious failings that affected a large number of her patients. The Committee considered that public confidence in the dental profession and the GDC as a regulator would be seriously undermined if a finding of impairment were not made in the circumstances of this case. It also considered that a finding of impairment was required to uphold and maintain proper professional standards.

Accordingly, the Committee determined that Ms Luciola's fitness to practise is currently impaired by reason of her misconduct on the grounds of public protection and in the wider public interest.

The Committee's decision on sanction

The Committee considered what sanction, if any, to impose on Ms Luciola's registration. It noted that the purpose of a sanction is not to be punitive, although it may have that effect, but to protect patients and the wider public interest. In reaching its decision, the Committee had regard to the Guidance. It applied the principle of proportionality, balancing the public interest with Ms Luciola's own interests.

In deciding on the appropriate sanction, the Committee first considered the issue of mitigating and aggravating factors. It decided that there was no evidence of any mitigating factors in this case. It did, however, identify a considerable number of aggravating factors, which are as follows:

- actual harm or risk of harm to a patient or another;
- dishonesty
- premeditated misconduct;
- financial gain by Ms Luciola;
- breach of trust;
- the involvement of a vulnerable patient or other vulnerable individual;
- misconduct sustained or repeated over a period of time;
- blatant or wilful disregard of the role of the GDC and the systems regulating the profession; and
- lack of insight.

Taking all of these factors into account, the Committee considered the available sanctions, starting with the least restrictive. The Committee noted that it was open to it to conclude this case without taking any action in relation to Ms Luciola's registration. However, it concluded that taking no action would be wholly inappropriate, given the gravity of its findings and the

absence of any evidence of insight or remediation, which means that there is an ongoing risk to the public and the wider public interest.

The Committee considered whether to issue Ms Luciola with a reprimand. However, it similarly concluded that a reprimand would be insufficient to protect the public and the wider public interest, and disproportionate in all the circumstances. A reprimand is the lowest sanction which can be applied and is usually considered be appropriate where the misconduct is at the lower end of the spectrum. This is not such a case.

Whilst the Committee considered whether to impose conditions on Ms Luciola's registration, it decided that this is not a case where conditional registration is relevant. Ms Luciola has not engaged with the process and therefore there is no indication that she would even comply with conditions. In any event, the Committee considered that it could not formulate any workable or enforceable conditions to address the concerns in this case, which include dishonesty.

The Committee next considered whether to suspend Ms Luciola's registration for a specified period. In doing so, it took into account its duty to impose the least restrictive sanction necessary in all the circumstances. It had regard to the Guidance at paragraph 6.28, which sets out the factors to be considered when deciding whether the sanction of suspension would be appropriate. The Committee noted that the majority of those factors are present in this case, including that Ms Luciola has not shown insight and that there remains a risk of repetition. However, it also noted from paragraph 6.28 that a suspension could be considered appropriate in circumstances where *"there is no evidence of harmful deep-seated personality or professional attitudinal problems"*. In the Committee's view, this is a case where the actions of the registrant have demonstrated personality and professional attitudinal problems. The findings made against Ms Luciola are of the most serious kind, involving serious dishonesty and actual harm to patients. Further, there has been no evidence to indicate that she has even acknowledged her wrongdoing and its impact on her patients and the reputation of the dental profession.

Given the Committee's concerns about Ms Luciola's attitude and the ongoing risk it has identified to the public and the wider public interest considerations, the Committee went on to consider whether a higher sanction would be more appropriate and proportionate. It had regard to paragraph 6.34 of the Guidance which deals with erasure. That paragraph states that, "*Erasure will be appropriate when the behaviour is fundamentally incompatible with being a dental professional: any of the following factors, or a combination of them, may point to such a conclusion:*

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

The Committee noted that all but one of the factors from paragraph 6.34 apply, which in its view gives indication of the seriousness of the matters highlighted in Ms Luciola's case. Taking this into account, together with its concerns about Ms Luciola's attitude, the Committee concluded that the only appropriate and proportionate sanction to protect the public is erasure. It further considered that public confidence in the dental profession and the GDC would be seriously undermined if a lesser sanction were to be imposed. The Committee was satisfied that a reasonable and informed member of the public would expect an outcome of erasure in this case. The Committee considered that the public interest would not be satisfied by a period of suspension, even the maximum period of 12 months, as this would potentially allow Ms Luciola an opportunity to return to the profession after that time.

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

Unless Ms Luciola exercises her right of appeal, her name will be erased from the Register, 28 days from the date when notice of this Committee's direction is deemed to have been served upon her.

The Committee now invites submissions from Ms Barnfather, as to whether an immediate order of suspension should be imposed on Ms Luciola's registration to cover the appeal period, pending its substantive determination taking effect.

In reaching its decision on whether to impose an immediate order of suspension on Ms Luciola's registration, the Committee took account of Ms Barnfather's submission that such an order should be imposed and noted her references to the relevant paragraphs in the Guidance. The Committee accepted the advice of the Legal Adviser.

The Committee noted its powers to impose an immediate order under Sections 27B(10) and 30(1) of the *Dentists Act 1984 (as amended)* ('the Act').

The Committee determined that it is necessary for the protection of the public and is otherwise in the public interest to impose an immediate order of suspension on Ms Luciola's registration. It has found serious dishonesty in this case, as well as a number of other serious and wide-ranging failings relating to Ms Luciola's practice. Further, the Committee received no evidence of any insight or remediation. Consequently, it has identified a risk of harm to the public. An immediate order is therefore necessary for the protection of the public.

The Committee also considered that the imposition of an immediate order is in the wider public interest. It has determined that Ms Luciola is not fit to remain on the Dentists Register. The Committee considered that public confidence in the dental profession and this regulatory process would be seriously undermined in the absence of an order suspending Ms Luciola's registration immediately. It considered that it would be inconsistent not to impose an order in all the circumstances.

The effect of the foregoing determination and this order is that Ms Luciola's registration will be suspended from the date on which notice is deemed to have been served upon her. Unless she exercises her right of appeal, the substantive direction for erasure, as already announced, will take effect 28 days from the date of deemed service.

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

The interim order currently in place on Ms Luciola's registration is hereby revoked under Section 27B(9) of the Act.

That concludes this determination."