Dental Professionals Hearings Service

PUBLIC HEARING
Professional Conduct Committee
Initial Hearing

28 – 29 July 2025

Name:	MORGAN, Simon
Registration number:	135053
Case number:	CAS: 205324

General Dental Council:	Eloise Power, Counsel Instructed by Jojo Navarro-Schrank, Capsticks Solicitors
Registrant:	Present Represented by Giles Colin, Counsel. Instructed by Chloe Hopkins, Keoghs Solicitors

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Fitness to practise:	Impaired by reason of misconduct
Outcome:	Erased with Immediate Suspension

Committee members:	Martin Isherwood (Chair, Dental Care Professional Member) Jeanett Martin (Lay Member) Philip Loughnane (Dentist Member)
Legal adviser:	Alex Coleman
Committee Secretary:	Jenny Hazell

The Charge against Simon Morgan is as follows:

"That being registered as a dental technician:

1. Between 10 June 2018 to 10 April 2020, you have worked outside the scope of your practice as a Dental Technician in that you independently performed clinical procedures related to providing removable dental devices to Patient 1 and Patient 2. Specifically:

   (a) On 20 June 2018 you recorded a jaw registration for Patient 1.
   (b) On 3 July 2018 you tried in a denture/s for Patient 1.
   (c) On 12 July 2018 you fitted a denture/s for Patient 1.
   (d) On 20 March 2020 you recorded a jaw registration for Patient 2.
   (e) On 7 April 2020 you tried in a denture for Patient 2.
   (f) On 10 April 2020 you fitted a denture for Patient 2.

2. Between 10 June 2018 and 12 July 2018 you provided treatment to Patient 1 at her home address without support from a second appropriately trained care professional.

3. Between 3 March 2020 and 10 April 2020 you provided treatment to Patient 2 at his home address without support from a second appropriately trained care professional.

4. At all material times, you failed to inform Patient 1 and Patient 2 that you were working outside the scope of your practice in performing clinical procedures related to providing removable dental devices.

5. You accepted financial payment in return for work undertaken outside the scope of your practice:

   (a) On 13 December 2018 from Patient 1;
   (b) At an unknown date or dates from Patient 2.

6. The conduct set out at Charges 1 - 5 above amounted to:

   (a) A failure to obtain Patient 1 and Patient 2's informed consent for the treatment, in that they were not informed that the treatment was being provided outside the scope of practice of a Dental Technician;
   (b) Misleading conduct, in that
   (i) you did not make clear that you were unable to undertake activities outside the scope of practice of a Dental Technician;
   (ii) you accepted payment in return for activities undertaken outside the scope of practice of a Dental Technician;

   (c) Dishonesty, in that
   (i) you knew that you were practising outside your scope of practice as a Dental Technician;
   (ii) you did not make clear that you were unable to undertake activities outside the scope of practice of a Dental Technician;
   (iii) you accepted payment in return for activities undertaken outside the scope of practice of a Dental Technician.

7. Between 10 June 2018 and 10 April 2020, you have provided dental treatment without holding adequate indemnity insurance in that:

   (a) Your indemnity insurance policies dated 21 June 2017 – 20 June 2018 and 14 December 2019 – 30 June 2021 did not cover the treatment which you provided to Patient 1 and Patient 2 was beyond the GDC's scope of practice for a Dental Technician and did not fall within the structure of your training as a Clinical Dental Technician.

(b) On the dates of your visits to Patient 1 on 3 July 2018 and 12 July 2018, you had no indemnity insurance in place.

8. At all material times, you failed to inform Patient 1 and Patient 2 that you did not have adequate indemnity insurance in place.

9. The conduct set out at Charges 7 - 8 above amounted to:

(a) A failure to obtain Patient 1 and Patient 2's informed consent for the treatment, in that they were not informed that you did not have adequate indemnity insurance in place;

(b) Misleading conduct, in that you accepted payment for dental treatment provided to Patient 1 and Patient 2 without having adequate indemnity insurance in place;

(c) Dishonesty, in that
(i) you knew that you did not have adequate indemnity insurance in place;
(ii) you did not inform Patient 1 and Patient 2 that you did not have adequate indemnity insurance in place;
(iii) you accepted payment for dental treatment provided to Patient 1 and Patient 2 without having adequate indemnity insurance in place.

And that, in consequence of the matters set out above, your fitness to practise is impaired by reason of your misconduct."

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1. This is a hearing before the Professional Conduct Committee ('the Committee') which is being conducted remotely. You are present at this hearing and are represented by Mr Colin, Counsel. Ms Power, Counsel, appears on behalf of the General Dental Council (GDC).

Preliminary Matter – application for joinder

2. At the outset of the hearing, Ms Power made an application under Rule 25(2) of the 'General Dental Council (Fitness to Practise) Rules Order of Council 2006' ('the Rules') to join a number of charges highlighted in yellow in the document entitled 'Final Charge' dated 18 April 2024. The proposed additional charges are highlighted in bold below:

That being registered as a dental care professional (dental technician):

1. Between 10 June 2018 to 10 April 2020, you have worked outside the scope of your practice as a Dental Technician **in that you independently performed clinical procedures related to providing removable dental devices to Patient 1s and Patient 2. Specifically:**

(a) On 20 June 2018 you recorded a jaw registration for Patient 1.
(b) On 3 July 2018 you tried in a denture/s for Patient 1.
(c) On 12 July 2018 you fitted a denture/s for Patient 1.
(d) On 20 March 2020 you recorded a jaw registration for Patient 2.
(e) On 7 April 2020 you tried in a denture for Patient 2.
(f) On 10 April 2020 you fitted a denture for Patient 2.

2. Between 10 June 2018 and 12 July 2018 you provided treatment to Patient 1 at her home address without support from a second appropriately trained care professional.

3. **Between 3 March 2020 and 10 April 2020 you provided treatment to Patient 2 at his home address without support from a second appropriately trained care professional.**

4. At all material times, you failed to inform Patient 1 and Patient 2 that you were working outside the scope of your practice in performing clinical procedures related to providing removable dental devices.

5. **You accepted financial payment in return for work undertaken outside the scope of your practice:**

   (a) On 13 December 2018 from Patient 1;
   (b) At an unknown date or dates from Patient 2.

6. The conduct set out at Charges 1 - 5 above amounted to:

   (a) A failure to obtain Patient 1 and Patient 2's informed consent for the treatment, in that they were not informed that the treatment was being provided outside the scope of practice of a Dental Technician;

   (b) Misleading conduct, in that
   (i) you did not make clear that you were unable to undertake activities outside the scope of practice of a Dental Technician;
   (**ii) you accepted payment in return for activities undertaken outside the scope of practice of a Dental Technician**;

   (c) Dishonesty, in that:
   (i) you knew that you were practising outside your scope of practice as a Dental Technician;
   (ii) you did not make clear that you were unable to undertake activities outside the scope of practice of a Dental Technician;
   (iii) you accepted payment in return for activities undertaken outside the scope of practice of a Dental Technician.

7. Between 10 June 2018 and 10 April 2020, you have provided dental treatment without holding adequate indemnity insurance in that:

   (a) Your indemnity insurance policies dated 21 June 2017 – 20 June 2018 and 14 December 2019 – 30 June 2021 did not cover the treatment which you provided to Patient 1 and Patient 2 was beyond the GDC's scope of practice for a Dental Technician and did not fall within the structure of your training as a Clinical Dental Technician.

   (b) On the dates of your visits to Patient 1 on 3 July 2018 and 12 July 2018, you had no indemnity insurance in place.

8. At all material times, you failed to inform Patient 1 and Patient 2 that you did not have adequate indemnity insurance in place.

9. The conduct set out at Charges 7 - 8 above amounted to:
   (a) A failure to obtain Patient 1 and Patient 2's informed consent for the treatment, in that they were not informed that you did not have adequate indemnity insurance in place;

   (b) Misleading conduct, in that you accepted payment for dental treatment provided to Patient 1 and Patient 2 without having adequate indemnity insurance in place;

(c) Dishonesty, in that
(i) you knew that you did not have adequate indemnity insurance in place;
(ii) you did not inform Patient 1 and Patient 2 that you did not have adequate indemnity insurance in place;
(iii) you accepted payment for dental treatment provided to Patient 1 and Patient 2 without having adequate indemnity insurance in place.

And that, in consequence of the matters set out above, your fitness to practise is impaired by reason of your misconduct."

3. Rule 25 provides that:

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

4. Ms Power submitted that the additional charges are of a similar kind and arise out of the same factual evidence. They therefore fall within the provisions of Rule 25(2).

5. Mr Colin confirmed that he did not oppose the application.

Committee's decision on application for joinder

6. The Committee has considered the submissions made by both parties. It has accepted the advice of the Legal Adviser. The Committee is satisfied that the additional allegations that form the subject of the GDC's application are of a similar kind to those already pleaded. They therefore fulfil the requirements of Rule 25(2)(c). It noted that you had been placed on notice of this application by letter dated 18 April 2024 and that you had made full admissions to all of these charges.

7. Accordingly, the Committee acceded to the GDC's application under Rule 25 to join the additional charges as set out in bold quoted above.

Admissions

8. At the outset you admitted all of the charges (1 to 9) above. The Committee determined and announced that all the charges were found proved in light of your admissions, in accordance with Rule 17(4).

9. The Committee then went on to Stage Two.

Proceedings at stage two

10. The Committee has considered all the evidence presented to it. This includes the Stage 1 bundle which contains a copy of the clinical expert report of Mr Mulcahy dated 19 July 2024 as well as a copy of your witness statement dated 20 August 2024. In addition the Committee received further documentary information in relation to this second stage of the hearing. This includes correspondence between the GDC and you in respect of a previous referral dated 17 May 2019 to 27 April 2020; the PCC determination following the March – April 2021 hearing (the 'initial PCC'); a copy of your submissions (undated) prior to the PCC review hearing of October 2021 and a copy of the PCC review determination dated 8 October 2021. The bundle also contained a copy of your supplemental witness statement dated 25 July 2025 and two signed witness statements from two

dental colleagues with whom you have worked in your capacity as a process worker since June 2024.

11. The Committee has taken into account the submissions made by Ms Power on behalf of the GDC and those made by Mr Colin on your behalf. In its deliberations the Committee has had regard to the GDC's "Guidance for the Practice Committees, including Indicative Sanctions Guidance" (October 2016, updated December 2020). The Committee has accepted the advice of the Legal Adviser.

Fitness to practise history

12. The Committee's attention has been drawn to your fitness to practise. That history is summarised as follows.

13. In March-April 2021 you appeared before the initial PCC in relation to you having acted outside your scope of practise as a dental technician from 29 July 2016 to 2 August 2017 in respect of Patient A. You provided her with full dentures without the prescription of a dentist or a clinical dental technician and you inappropriately provided full dentures to Patient A. You also provided treatment to Patient A at her home address without the support from an appropriately trained care professional. For all or some of the period of time from 29 July 2016 to 20 June 2017 you provided dental services while you failed to hold adequate indemnity insurance. On or around 18 June 2019 you informed the GDC that you could not find your indemnity certificate. For a period of time up to and including at least 30 March 2020 you caused or allowed the following information to appear on your website: "Simon Morgan. RDT, SCDT, Royal College of Surgeons". During 2017 you created or allowed to be created an advert that included the wording; "Simon Morgan. RDT. SCDT, Royal College of Surgeons, London". You admitted most of the factual matters, save for the matters relating to your alleged misleading and dishonest conduct. The initial PCC found that your conduct in relation to these matters was misleading and dishonest (save for charges 6 and 7 relating to the information appearing on your website and on the advert).

14. That PCC determined that your fitness to practise was impaired by reason of your misconduct. It considered that the dishonesty in that case was serious. However, it did not consider it to be so serious that your conduct was "*fundamentally incompatible with continued registration*." It directed that your registration be suspended for a period of five months. The initial PCC also directed the suspension order be reviewed before its expiry. It indicated that it would be assisted to receive evidence of your further reflections into the dishonesty aspects of the case, as well as the importance of following the GDC's standards and guidance.

15. The PCC then reviewed that order on 8 October 2021. You were present at that hearing, unrepresented. The PCC had the benefit of hearing oral evidence from you at that hearing. That PCC attached weight to your oral and written evidence and "*took the view that your commitment to your professional development is genuine, as is your remorse for your past misconduct. The Committee considered that you have since realised that the outcome of the substantive hearing was based on your conduct and that you fully accept the seriousness of your actions and your dishonesty. You told the Committee that you have lived with this every day and that you wish that in 2019 you had accepted right from the beginning that you did not have insurance. You accepted that you were dishonest and that you dug yourself into a hole and could not see any way out of it. You told the Committee that you let the public down and that you have regretted it ever since*."

16. The PCC concluded that there was no evidence of any repetition of your dishonesty or your other misconduct and was satisfied that you had demonstrated sufficient insight. It determined that your fitness to practise was not currently impaired by reason of your misconduct and directed that the order of suspension on your registration be terminated with immediate effect.

Summary of submissions

17. Ms Power submitted that the facts found proved amount to misconduct. She referred to the gravamen of the charges found proved, including you working outside the scope of your practice as a dental technician for Patient 1 and Patient 2 on a number of occasions; providing treatment to Patient 1 and Patient 2 at their respective home addresses without support from a second appropriately trained care professional and accepting financial payment in return for work undertaken outside the scope of your practice and providing dental treatment without holding adequate indemnity insurance. Furthermore, you failed to obtain Patient 1 and Patient 2's informed consent for the treatment in that they were not informed that you did not have adequate indemnity insurance in place. The conduct was misleading and dishonest. Ms Power also highlighted a number of the GDC's Standards which you have breached. Further, Ms Power referred to Mr Mulcahy's report dated 19 July 2024 where he opined that in acting outside your Scope of Practice, and the risks to patient safety associated with that, the standard was far below that required.

18. Ms Power submitted that your fitness to practise is currently impaired by reason of your misconduct. Ms Power referred to the chronology of events relating to your previous fitness to practise history concerning similar matters.

19. Ms Power submitted that you repeated acting outside the scope of your practise in March-April 2020 in the second patient in this current case (Patient 2). This was at a time when you were aware that the GDC was investigating concerns about your fitness to practise. She referred the Committee to extracts of your witness statement dated 25 July 2025 in which you expressed your apologies to the patients involved in this investigation as well as your apologies to the Committee and the dental profession for what you have done. You stated that you "*will never act in this way again.*"

20. Ms Power submitted that in light of your previous fitness to practise history and the repetition of the wrongdoing in this case, the Committee cannot be assured that your remorse is genuine. She also highlighted the absence of any meaningful evidence of ongoing Continuing Professional Development (CPD). Ms Power invited the Committee to be cautious in concluding that your health matters (referred to in your witness statements) may have contributed to your behaviour. In short, Ms Power submitted that a finding of impairment on the grounds of misconduct is required, given the risk of repetition of the misconduct, including findings of dishonesty. She also submitted that a finding of current impairment is required in the wider public interest.

21. Ms Power submitted that the appropriate sanction in this case is that of erasure. She referred the Committee to relevant sections of the "Guidance for the Practice Committees, including Indicative Sanctions Guidance" which set out where erasure may be appropriate. She highlighted a number of points in support of that sanction, including that this case involves a serious departure from the standards of the dental team, where the conduct of practising outside the scope of your practise was repeated and where the dishonest conduct has been repeated. This was a case, she submitted, where you have demonstrated a persistent lack of insight into the seriousness of your actions and where your behaviour is fundamentally incompatible with being a dental professional.

22. Mr Colin, on your behalf, conceded that the findings against you amount to misconduct. He did not seek to argue that your health matters mitigates or excuses your behaviour. Mr Colin also conceded that your fitness to practise is currently impaired by reason of your misconduct. He submitted that you acknowledge the gravity of the findings against you.

23. In terms of sanction, Mr Colin invited the Committee to conclude this case with an order suspending your registration for the maximum period of 12 months, with a review hearing to take place before the expiry of the order. It would be open to the Committee to direct that you undertake relevant CPD and E learning. Mr Colin submitted that there is no evidence of harmful deep-seated personality or professional attitudinal problems (which might make erasure the appropriate order). In support of that contention, Mr Colin referred to the two witness statements, both dated 25 July 2025, from professional colleagues, who attest to your skills and competencies as a dental

technician. He also referred to paragraphs 16 and 17 of your witness statement dated 20 August 2024 which set out that you were trying to help Patient 1 and Patient 2, albeit you accepted that you should not have provided the treatment.

24. In short, Mr Colin invited the Committee to have regard to your apologies to Patient 1 and Patient 2, which were genuine, as well as your acknowledgement that your behaviour was unacceptable. He urged the Committee to consider suspending your registration and submitted that the sanction of erasure would be excessive and disproportionate.

25. The Committee has considered the submissions made by both parties. It has accepted the advice of the Legal Adviser.

Misconduct

26. The Committee first considered whether the facts found proved at charges 1 to 9 constitute misconduct. In doing so, the Committee has exercised its own independent judgement.

27. In its deliberations the Committee has had regard to the GDC's Standards for the Dental Team (September 2013) in place at the time of the incidents giving rise to the facts that the Committee has found proved. It has determined that you have breached the following sections in particular:

> *Principle 1 - Put patients' interests first*
>
> *Standards*
> *1.3 You must be honest and act with integrity*
>
> *1.8 You must have appropriate arrangements in place for patients to seek compensation if they suffer harm.*
>
> *1.8.1 You must have appropriate insurance or indemnity in place to make sure your patients can claim any compensation to which they may be entitled (See our website for further guidance on what types of insurance or indemnity the GDC considers to be appropriate).*
>
> *1.8.2 You should ensure that you keep to the terms and conditions of your insurance or indemnity and contact the provider as soon as possible when a claim is made. A delay in contacting the provider could disadvantage patients and may affect the level of help you receive from the provider.*
>
> *6.3 You must delegate and refer appropriately and effectively*
>
> *6.3.3 You should refer patients on if the treatment required is outside your scope of practice or competence. You should be clear about the procedure for doing this.*

28. In addition to the GDC's Standards, the Committee also determined that you failed to adhere to the GDC's guidance on indemnity (2016) and scope of practice (2013). Further, the Committee had regard to your failure to obtain Patient 1 and Patient 2's informed consent for the treatment in that they were not informed that the treatment you were providing fell outside the scope of practice of a dental technician. Nevertheless, you accepted financial payment in return for work undertaken outside the scope of your practice. Your conduct was found to be misleading and dishonest. The Committee considers that you should have been aware of the boundaries as to what you could and could not do as a registered dental technician. It did not accept your explanation that you were wanting to help the patients and you were acting in their best interests by providing treatment. Your actions placed Patient 1and Patient 2 at risk of harm.

29. The Committee takes a serious view of your actions in this case - it was repeated behaviour and took place in circumstances within months of you giving assurances to the previous PCC that you would not act in this way again by providing treatment outside the scope of your practise.

30. The Committee has also had regard Mr Mulcahy's report dated 19 July 2024 where he opined that in acting outside your scope of practice, the standard of care fell far below that required. Mr Mulcahy also referred to the fact that all dental registrants are legally required to have appropriate indemnity insurance. His evidence was that one of the possible consequences of a dental care professional working their scope of practise and/or the specific terms of their cover is that it may render any indemnity policy invalid. You have accepted that between 10 June 2018 and 10 April 2020 you provided dental treatment without holding adequate indemnity insurance. Mr Mulcahy's opinion considered that your failure in this regard fell far below that expected. Finally, Mr Mulcahy opined that a failure to obtain consent would represent a standard far below that expected. The Committee accepts Mr Mulcahy's evidence.

31. The Committee considers that the findings against you, which include findings of dishonesty, as well as your breaches of the GDC's standards, are serious and amount to misconduct.

Current Impairment

32. The Committee next considered whether your fitness to practise is currently impaired by reason of the misconduct that it has found. In doing so, the Committee again exercised its own independent judgement.

33. Throughout its deliberations, the Committee has borne in mind that its overarching objective is to protect the public, which includes the protection of patients and the wider public, the maintenance of public confidence in the profession and in the regulatory process, and the declaring and upholding of proper standards of conduct and behaviour.

34. The Committee accepted the guidance on the matters relevant when considering current impairment provided by Mrs Justice Cox in *The Council for Healthcare Regulatory Excellence* (CHRE) v (1) NMC and (2) *Paula Grant* [2011] EWHC 927 (Admin) and the four limbs set out by the Judge. These were as follows:

> *"Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
> *a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
> *b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
> *c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
> *d. has in the past acted dishonestly and/or is liable to act dishonestly in the future."*

35. The Committee considered that undertaking work outside your scope of practice, is serious and highly likely to damage public confidence in the profession. The public is entitled to expect, when they consult a dental professional, that you are acting only within the scope of your practice.

36. The Committee considers that your misconduct arising from the clinical matters in this case, namely that you worked outside the scope of your practice and without indemnity, is in theory capable of being remedied. The Committee has considered your witness statement dated 20 August 2024 in which accepted that you were working outside your scope of practice as a dental technician by performing clinical procedures relating to providing removable dental devices to Patient 1 and Patient 2 without support from a second appropriately trained care professional. You accepted that you

should not have provided the procedures but you say that you were acting in their best interests. You also set out some of the health treatment that you were undergoing at the relevant times, albeit you accept that this did not excuse your actions.

37. You set out your current employment arrangements and state that since the allegations by the GDC have been raised, you have considered the GDC's Scope of Practice to improve your understanding and awareness as to why your actions were wrong.

38. Notwithstanding your statement that you have learnt from this experience and you "will maintain the highest level of professionalism moving forward", the Committee considers that you demonstrated a persistent lack of insight into your shortcomings and your professional obligations. This was not a situation where you were acting under duress in respect of either or both patients but rather you offered to treat Patient 1 and Patient 2 in the knowledge that you should not have done so. Further, the Committee has had regard to the fact that the misconduct in this case, both in relation to you acting outside the scope of your practise, and your dishonesty arising that, has been repeated. It was not reassured by your statement that you have reflected on the implications of working outside of your scope of practice and that you understand the risks associated.

39. You further stated that in your statement dated 25 July 2025 that you had recently completed CPD and kept up to date with relevant reading. However, the Committee has received no evidence of that CPD and noted the most recent certificates of CPD cover on-line courses which were completed over two days in May 2021.

40. In light of the shortcomings that the Committee has identified in respect of your insight and remediation, the Committee finds that you are liable to repeat your clinical failings and dishonesty, and that you therefore continue to pose a risk to the public.

41. The Committee considers that a finding of impairment is also required to maintain public confidence in the profession and to declare and uphold proper professional standards of conduct and behaviour. Your actions were liable to have brought the reputation of the profession into considerable disrepute. In the Committee's judgement the public's trust and confidence in the profession, and in the regulatory process, would be significantly undermined if a finding of impairment was not made given the nature of your misconduct, and particularly your misleading and dishonest conduct.

42. Having regard to all the factors in this case, the Committee is satisfied that all four limbs as set out in the case of *Grant* are met in this case. Accordingly, the Committee finds that your fitness to practise is currently impaired by reason of your misconduct.

Sanction

43. The Committee then determined what sanction, if any, is appropriate in light of the findings of facts, misconduct and impairment that it has made. The Committee recognises that the purpose of a sanction is not to be punitive, although it may have such an effect, but is instead imposed to protect patients and safeguard the wider public interests mentioned above.

44. In reaching its decision the Committee has again taken into account the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016, updated December 2020). The Committee has applied the principle of proportionality, balancing the public interest with your own interests. The Committee has once more exercised its own independent judgment.

45. The Committee has paid careful regard to the mitigating and aggravating factors present in this case.

46. In respect of the mitigating factors that are present, the Committee notes that you offered an apology for your actions and you made full admissions.

47. In terms of aggravating factors, the Committee has reminded itself that your conduct placed Patient 1 and Patient 2 at risk of harm; dishonesty, which involved financial gain, as well as your lack of insight. The Committee has also had regard to your wilful disregard of the GDC's scope of practice guidance, as well as your previous fitness to practise history in relation to similar matters.

48. The Committee has considered the range of sanctions available to it, starting with the least restrictive. In the light of its findings, the Committee considers that taking no action, or issuing a reprimand, would not be sufficient in the particular circumstances of this case. In the Committee's judgement public trust and confidence in the profession and in the regulatory process would be significantly undermined if no action were taken, or if a reprimand were issued. The Committee also considers that taking no action or issuing a reprimand would not adequately protect the public, and would not be sufficient to declare and uphold proper professional standards of conduct and behaviour.

49. The Committee also considers that a direction of conditional registration would not be sufficient to meet the public protection and public interest considerations engaged in this case. The Committee considers that conditions could not be formulated to deal with the risks that it has identified. The Committee also considers that, even if conditions could be formulated, a direction of conditional registration would not be sufficient to declare and uphold proper professional standards of conduct and behaviour because of the serious nature of your misconduct involving repeated dishonesty after a previous PCC had suspended your registration for a period of five months.

50. The Committee then went on to consider whether a direction of suspended registration would represent an appropriate and proportionate outcome. After careful consideration the Committee has determined that suspension would not be sufficient to protect the public or meet the public interest considerations that it has identified above. Your misconduct, which includes a finding of dishonesty, represents a serious departure from professional standards and is highly damaging to your fitness to practise. Your misconduct, in the Committee's judgement, is particularly serious because it was repeated over a sustained period of time, despite your assurances to previous PCCs that you had learnt your lesson. You have demonstrated a persistent lack of insight into your conduct, and the consequences that it has for patient safety. You pose an ongoing risk of significant harm to the public.

51. The Committee considers that its findings, including dishonesty, connote a fundamental disregard and disdain for the regulatory process. This is such to suggest a deep-seated professional attitudinal problem. The Committee considers that a direction of suspended registration would not be likely to serve any useful purpose as, in light of previous findings, especially of dishonesty, the Committee does not consider that a period of suspension will bring about the necessary rectification of your conduct and behaviour. The Committee considers that a period of suspended registration would not be sufficient to protect the public or the wider public interest.

52. The Committee has therefore determined that the only appropriate and proportionate sanction to impose in the particular circumstances of this case is that of erasure. The Committee hereby directs that your name be erased from the register.

53. The Committee now invites submissions as to whether to impose an immediate order.

Decision and reasons on immediate order

54. Mr Morgan, The interim order of suspension currently on your registration is hereby revoked.

55. Ms Power made an application for an immediate order of suspension to be imposed on your registration under Section 36(U) of the Dentists Act 1984. She submitted that an order is necessary on the grounds of public protection and is otherwise in the public interest in light of the Committee's

findings at the impairment and sanction stage. Ms Power referred to some of the Committee's conclusions as set out in paragraph 50 of the Committee's determination in support of her application.

56. Mr Colin made no submissions on the GDC's application.

57. The Committee has considered the submissions made. It has accepted the advice of the Legal Adviser. The Committee has taken into account the principle of proportionality.

58. The Committee has reached serious findings against you and has already identified that there remains an ongoing risk of significant harm in this case. Consequently, the Committee has determined that an immediate order is necessary on the grounds of public protection and is otherwise in the public interest. It has taken into account that in the absence of an immediate order, you could return to unrestricted clinical practice during the 28-day appeal period, or for potentially longer, in the event of an appeal. An immediate order is therefore necessary for the protection of the public and is otherwise in the public interest. To do otherwise would be incompatible with the Committee's earlier findings.

59. The effect of this immediate order is that your registration is now suspended. Unless you exercise your right of appeal, the substantive direction of erasure will replace the immediate suspension upon the expiry of the 28-day appeal period. Should you exercise your right of appeal, this immediate order shall remain in force pending the resolution of the appeal.

60. That concludes this determination.