General Dental Council | protecting patients, regulating the dental team

HEARING HEARD IN PUBLIC

NIKOLOV, Todor Nenkov

Registration No: 175280

PROFESSIONAL CONDUCT COMMITTEE

MARCH 2016 – APRIL 2018*

Most recent outcome: Suspended indefinitely

* See page 43 for the latest determination.

Todor Nenkov NIKOLOV, a dentist; DMD Plovdiv 1990, was summoned to appear before the Professional Conduct Committee on Tuesday 29 March 2016 for an inquiry into the following charge:

Charge (final version as agreed at the close of the GDC's case)

"That being a registered dentist:

1. At all material times you practised as a dentist at [address redacted] ("the practice").
2. You provided treatment to the patients listed in Schedule A.[1]

Patient A

3. You were consulted by Patient A between 2 June 2010 and 15 January 2014.

2 June 2010

4. You provided treatment to Patient A on 2 June 2010.
5. Your treatment and/or your record keeping in relation to that appointment was inadequate in that:
   (a) you did not take any or any adequate medical, dental or social history, or you made no or no adequate record of any medical, dental or social history taken;
   (b) you did not carry out any or any adequate intra-oral examination, or you made no or no adequate record of any intra-oral examination;
   (c) you did not carry out any or any adequate extra-oral examination, or you made no or no adequate record of any extra-oral examination;
   (d) you did not carry out any or any adequate charting of the teeth, or you made no or no adequate record of any charting of the teeth;
   (e) you did not carry out any or any adequate basic periodontal examination, or you made no or no adequate record of any basic periodontal examination;

[1] Schedule A is a private document and therefore cannot be disclosed to the public.

(f) you did not reach any adequate diagnosis or you made no adequate record of any diagnosis;

(g) you did not have any or any adequate discussion as to alternative treatment options to that proposed, or you made no or no adequate record of any discussion as to alternative treatment options;

(h) you did not make any or any adequate plan for the restoration placed at UR6 on 16 August 2010;

(i) you did not obtain informed consent to the proposed treatment of LL6 and UL6, or you made no or no adequate record of any informed consent to the proposed treatment of LL6 and UL6;

(j) you did not ensure any radiographs were taken when it was indicated to do so, or you did not retain or report adequately or at all on any radiographs.

9 August 2010

6. You provided treatment to Patient A on 9 August 2010.

7. Your treatment and/or your record keeping in relation to that appointment was inadequate in that:

(a) you did not obtain informed consent for the restorations provided at LL6 and UL6, or you made no or no adequate record of any informed consent;

(b) you did not place a lining in the cavity in LL6, or you made no or no adequate record of placing a lining in the cavity in LL6;

(c) you did not place a lining in the cavity in UL6, or you made no or no adequate record of placing a lining in the cavity in UL6.

16 August 2010

8. You provided treatment to Patient A on 16 August 2010;

9. Your treatment and/or your record keeping in relation to that appointment was inadequate in that:

(a) you made no or no adequate plan for treatment of UR6, or you made no or no adequate record of any plan for treatment of UR6;

(b) you made no or no adequate record of the detail of the treatment provided;

(c) you did not place a lining in the cavity in UR6, or you made no or no adequate record of placing a lining in the cavity;

(d) you did not have any or any adequate discussion as to alternative treatment options to that proposed, or you made no or no adequate record of any discussion as to alternative treatment options;

(e) You did not obtain informed consent for the restoration provided at UR6, or you made no or no adequate record of any informed consent.

23 March 2011

10. You provided treatment to Patient A on 23 March 2011.

11. Your treatment and/or your record keeping in relation to that appointment was inadequate in that:

    (a) you did not carry out any or any adequate examination and assessment, or you made no or no adequate record of any examination and assessment;

    (b) you did not take any or any adequate medical, dental or social history, or you made no or no adequate record of any medical, dental or social history taken;

    (c) you did not reach any or any adequate diagnosis, or you made no or no adequate record of any diagnosis;

    (d) you did not have any or any adequate discussion as to alternative treatment options to that proposed, or you made no or no adequate record of any discussion as to alternative treatment options;

    (e) you did not obtain informed consent for the proposed restorations at LL6 and UL6, or you made no or no adequate record of any informed consent.

31 March 2011

12. You provided treatment to Patient A on 31 March 2011.

13. Your record keeping in relation to that appointment was inadequate in that you made no or no adequate record of the technique, the material or the procedure used to place the composite restorations at UL6.

16 June 2011

14. You provided treatment to Patient A on 16 June 2011.

15. Your treatment and/or your record keeping in relation to that appointment was inadequate in that:

    (a) you did not carry out any or any adequate examination and assessment of UR6, or you made no or no adequate record of any examination and assessment;

    (b) you did not take any or any adequate medical, dental or social history, or you made no or no adequate record of any medical, dental or social history taken;

    (c) you did not ensure a periapical radiograph was taken when it was indicated to do so or you did not retain or report adequately or at all on any radiograph;

    (d) you did not reach any or any adequate diagnosis as to the extent of dental disease, or you made no or no adequate record of any such diagnosis;

    (e) you prescribed an antibiotic when it was not indicated to do so, or you made no or no adequate record of any indication;

    (f) you did not provide sufficient advice and information as to the risks and benefits of the antibiotic, or you made no or no adequate record of any such provision;

    (g) you did not have any or any adequate discussion as to alternative treatment options to that proposed, or you made no or no adequate record of any such discussion;

(h) you did not assess adequately or at all the vitality of LL6, or you made no or no adequate record of any such assessment.

17 June 2011

16. You provided treatment to Patient A on 17 June 2011.

17. Your treatment and/or your record keeping in relation to that appointment was inadequate in that:

(a) you did not carry out any or any adequate examination and assessment of UR6, or you made no or no adequate record of any examination and assessment;

(b) you did not take any or any adequate medical, dental or social history, or you made no or no adequate record of any medical, dental or social history taken;

(c) you did not ensure a periapical radiograph was taken when it was indicated to do so, or you did not retain or report adequately or at all on any radiograph;

(d) you did not reach any or any adequate diagnosis in relation to UR6, or you made no or no adequate record of any such diagnosis;

(e) you did not have any or any adequate discussion as to treatment options, or you made no or no adequate record of any such discussion;

(f) you did not make any or any adequate plan for treatment of UR6, or you made no or no adequate record of any plan for treatment of UR6;

(g) you did not provide sufficient information to Patient A regarding the planned treatment and the prognosis for UR6, or you made no or no adequate record of any such provision;

(h) you used cotton wool dressing without medication and/or sealant to protect UR6 from food impaction;

(i) you did not obtain informed consent for the treatment of UR6, or you made no or no adequate record of any informed consent.

1 November 2011

18. You provided treatment to Patient A on 1 November 2011.

19. Your treatment and/or your record keeping in relation to that appointment was inadequate in that:

(a) you did not ensure a periapical radiograph was taken when it was indicated to do so or you did not retain or report adequately or at all on any radiograph;

(b) you did not reach any or any adequate diagnosis in relation to UR6, or you made no or no adequate record of any such diagnosis;

(c) you did not place a dressing in the pulp chamber of UR6 to prevent food impaction;

(d) you made no or no adequate record of the indication for the prescription of an antibiotic;

(e) you did not provide advice in relation to the prescription of an antibiotic, or you made no or no adequate record of the advice provided.

8 November 2011

20. You provided treatment to Patient A on 8 November 2011.

21. Your treatment and/or your record keeping in relation to that appointment was inadequate in that:

(a) a periapical radiograph was taken which did not show a clear view of the root formation of UR6;

(b) you did not grade and record the quality of the radiograph;

(c) you made no or no adequate report of the radiograph;

(d) you made no or no adequate record of the justification for the radiograph;

(e) you did not have any or any adequate discussion as to treatment options for UR6, or you made no or no adequate record of any such discussion;

(f) you did not obtain informed consent for the proposed root canal treatment of UR6, or you made no or no adequate record of any informed consent.

16 November 2011

22. You provided treatment to Patient A on 16 November 2011.

23. Your treatment and/or your record keeping in relation to that appointment was inadequate in that:

(a) you did not carry out an adequate permanent root canal treatment at UR6;

(b) you made no or no adequate record of any justification for the restoration provided at UR6;

(c) you did not discuss with the patient adequately or at all the restoration of UR6, or you made no or no adequate record of any discussion;

(d) you did not discuss with the patient adequately or at all the treatment options for UR6, or you made no or no adequate record of any such discussion;

(e) you did not discuss with the patient adequately or at all the full risks and benefits of the restoration provided at UR6, or you made no or no adequate record of such discussion.

19 December 2011

24. You provided treatment to Patient A on 19 December 2011.

25. Your treatment and/or your record keeping in relation to that appointment was inadequate in that:

(a) you did not carry out any or any adequate examination and assessment of the presenting condition, or you made no or no adequate record of any examination and assessment;

(b) you did not take any or any adequate medical, dental or social history, or you made no or no adequate record of any medical, dental or social history taken;

(c) you did not reach any or any adequate diagnosis as to the extent of dental disease and/or the cause of the patient's pain, or you made no or no adequate record of any such diagnosis;

(d) you prescribed an antibiotic when it was not indicated to do so, or you made no or no adequate record of any indication;

(e) you did not provide advice in relation to the prescription of an antibiotic, or you made no or no adequate record of the advice provided;

(f) you made no provision for a review or follow-up appointment after prescribing an antibiotic.

3 July 2012

26. You provided treatment to Patient A on 3 July 2012;

27. Your treatment and/or your record keeping in relation to that appointment was inadequate in that:

(a) you did not carry out any or any adequate review of the mandibular pain complained of at the appointment on 19 December 2011, or you made no or no adequate record of any such review;

(b) you did not take any or any adequate medical, dental or social history, or you made no or no adequate record of any medical, dental or social history taken;

(c) you did not ensure bitewing radiographs were taken when it was indicated to do so, or you did not retain or report adequately or at all on any radiographs;

(d) [Withdrawn by the GDC]

4 October 2012

28. You provided treatment to Patient A on 4 October 2012.

29. Your treatment and/or your record keeping in relation to that appointment was inadequate in that:

(a) you did not remove caries from LL6;

(b) [Withdrawn by the GDC]

(c) you made no or no adequate record of any justification for not using local anaesthetic when treating LL6;

(d) you made no or no adequate record of your clinical decision-making in respect of LL6.

12 October 2012

30. You provided treatment to Patient A on 12 October 2012.

31. Your treatment and/or your record keeping in relation to that appointment was inadequate in that:

(a) [Withdrawn by the GDC]

(b) you placed an amalgam restoration at LL6 without prior removal of existing Ledermix paste;

(c) you did not assess adequately or at all the vitality of LL6, or you made no or no adequate record of any such assessment.

22 October 2012

32. You provided treatment to Patient A on 22 October 2012.

33. Your treatment and/or your record keeping in relation to that appointment was inadequate in that:

(a) you provided a non-standard temporary restoration at UR6;

(b) you did not reach any or any adequate diagnosis as to the extent of dental disease, or you made no or no adequate record of any such diagnosis;

(c) you did not commence root canal treatment at UR6 when it was indicated to do so;

(d) [Withdrawn by the GDC]

(e) [Withdrawn by the GDC]

(f) you made no or no adequate record of any justification for taking a radiograph.

24 October 2012

34. You provided treatment to Patient A on 24 October 2012.

35. Your treatment and/or your record keeping in relation to that appointment was inadequate in that:

(a) you did not have any or any adequate discussion as to treatment options, or you made no or no adequate record of any such discussion;

(b) you did not discuss with the patient adequately or at all the full risks and benefits of the restoration provided at UR6, or you made no or no adequate record of such discussion;

(c) you placed a restoration at UR6 without ensuring that the tooth did not require root treatment, or you made no or no adequate record of having done so;

(d) you made no or no adequate record of the technique, the material or the procedure used to place the restoration at UR6;

(e) you did not review adequately or at all radiographs taken at the appointment on 22 October 2012 when it was indicated to do so, or you made no or no adequate record of any such review;

(f) you did not obtain informed consent for the treatment of UR6, or you made no or no adequate record of any informed consent.

18 January 2013

36. You provided treatment to Patient A on 18 January 2013.

37. Your treatment and/or your record keeping in relation to that appointment was inadequate in that:

    (a) you did not carry out any or any adequate examination, or you made no or no adequate record of any examination;

    (b) you did not take any or any adequate medical, dental or social history, or you made no or no adequate record of any medical, dental or social history taken.

4 June 2013

38. You provided treatment to Patient A on 4 June 2013.

39. Your record keeping in relation to that appointment was inadequate, in that you recorded only 'PZ Toothache' and no other information.

7 June 2013

40. You provided treatment to Patient A on 7 June 2013.

41. Your treatment or your record keeping in relation to that appointment was inadequate in that:

    (a) you did not assess adequately or at all the vitality of LL6, or you made no or no adequate record of any such assessment;

    (b) you placed a composite restoration at LL6 without prior removal of caries;

    (c) you placed a composite restoration at LL6 without prior removal of existing Ledermix paste;

    (d) you made no or no adequate record of the technique, the material or the procedure used to place the restoration at LL6;

    (e) you made no or no adequate record of the appointment.

24 June 2013

42. you provided treatment to Patient A on 24 June 2013;

43. your record keeping in relation to that appointment was inadequate, in that you recorded only '*F3: private filling has came out*' (*sic*) and no other information.

27 June 2013

44. You provided treatment to Patient A on 27 June 2013.

45. Your treatment and/or your record keeping in relation to that appointment was inadequate in that:

    (a) a periapical radiograph of the lower left quadrant was taken which showed no root morphology or apical tissue;

    (b) You recorded only '*OZ RCT First visit*' and no other information.

3 July 2013

46. You provided treatment to Patient A on 3 July 2013.

47. Your treatment and/or your record keeping in relation to that appointment was inadequate in that:

    (a) you did not make any or any adequate plan for treatment of LL6, or you made no or no adequate record of any plan for treatment of LL6;

    (b) you did not assess adequately or at all the root canal lengths of LL6 prior to cleaning and shaping, or you made no or no adequate record of any such assessment;

    (c) no radiograph was taken to show root morphology.

48.

    (a) Withdrawn by the GDC]

    (b) [Withdrawn by the GDC]

8 July 2013

49. You provided treatment to Patient A on 8 July 2013.

50. Your record keeping in relation to that appointment was inadequate in that you recorded only '*OZ RCT First visit*' and no other information.

15 July 2013

51. You provided treatment to Patient A on 15 July 2013.

52. Your treatment and/or your record keeping in relation to that appointment was inadequate in that:

    (a) you did not adequately clean or shape the root canals in LL6 prior to filling;

    (b) you did not fill the root canals in LL6 to an acceptable standard;

    (c) you did not identify inadequate placement and density of the filled canals in LL6, or you made no or no adequate record of any such identification;

    (d) you did not grade and record the quality of the radiograph taken;

    (e) you made no or no adequate report of the radiograph taken.

53.

    (a) [Withdrawn by the GDC]

    (b) [Withdrawn by the GDC]

21 October 2013

54. You provided treatment to Patient A on 21 October 2013.

55. Your treatment and/or your record keeping in relation to that appointment was inadequate in that:

    (a) you did not grade the radiograph taken as unusable;

    (b) you made no or no adequate report of the radiograph taken*;*

(c) you did not retake a radiograph to show the whole of the root morphology and crowns of UR6 and UR7;

(d) you recorded only '*PZ Toothache*' and no other information.

29 October 2013

56. You provided treatment to Patient A on 29 October 2013.

57. Your record keeping in relation to that appointment was inadequate, in that your report of the radiograph taken at the appointment on 21 October 2013 stated that there were no visible problems, when it only showed part of the roots of UR6 and not the whole of the root, and showed blurred apices

5 November 2013

58. You provided treatment to Patient A on 5 November 2013.

59. Your treatment and/or your record keeping in relation to that appointment was inadequate in that:

(a) you did not reach any or any adequate diagnosis in relation to the complaint of pressure in the UR quadrant, or you made no or no adequate record of any diagnosis;

(b) you prescribed an antibiotic when it was not indicated to do so, or you made no or no adequate record of any indication;

(c) you made no provision for a review or follow-up appointment after prescribing an antibiotic;

(d) you did not commence root canal treatment at UR6 when it was indicated to do so.

19 December 2013

60. You provided treatment to Patient A on 19 December 2013.

61. Your treatment and/or your record keeping in relation to that appointment was inadequate in that:

(a) you did not carry out any or any adequate examination and assessment of the presenting condition, or you made no or no adequate record of any examination and assessment;

(b) you did not comment on the UR quadrant after prescribing antimicrobials at the visit on 5 November 2013.

15 January 2014

62. You provided treatment to Patient A on 15 January 2014.

63. Your record keeping in relation to that appointment was inadequate in that you recorded only '*Lost Filling*' and '*Composite Filling*' and no other information.

Patient B

64. You provided treatment to Patient B from 27 June 2013 until 5 September 2013.

27 June 2013

65. You first provided treatment to Patient B on 27 June 2013.

66. Your treatment and/or your record keeping in relation to that appointment was inadequate in that:

    (a) you did not take any or any adequate dental or social history, or you made no or no adequate record of any such history taken;

    (b) you did not carry out any or any adequate examination and assessment in respect of the space mesial UR3, or you made no or no adequate record of any such examination and assessment;

    (c) you did not have any or any adequate discussion as to the crown proposed at UR3, or you made no or no adequate record of any such discussion;

    (d) you did not have any or any adequate discussion as to alternative treatment options to the crown proposed, or you made no or no adequate record of any discussion as to alternative treatment options;

    (e) you did not make any or any adequate plan for treatment, or you made no or no adequate record of any plan for treatment;

    (f) you did not ensure a periapical radiograph was taken when it was indicated to do so, or you did not retain or report adequately or at all on any such radiograph;

    (g) you did not ensure any bitewing radiographs were taken when it was indicated to do so, or you did not retain or report adequately or at all on any such radiograph;

    (h) you did not obtain informed consent to the proposed treatment of UR3, or you made no or no adequate record of any informed consent to the proposed treatment of UR3.

3 July 2013

67. You provided treatment to Patient B on 3 July 2013.

68. Your record keeping in relation to that appointment was inadequate, in that you made no or no adequate record of the technique used to place the restoration at LR6.

22 August 2013

69. You provided treatment to Patient B on 22 August 2013.

70. Your record keeping in relation to that appointment was inadequate in that:

    (a) you did not record the justification for the provision of a crown at UR3;

    (b) you did not record sufficient detail of the preparation for a crown at UR3.

5 September 2013

71. You provided treatment to Patient B on 5 September 2013.

72. Your treatment and/or your record keeping in relation to that appointment was inadequate in that:

(a) you did not have any or any adequate discussion as to adjustment of the crown at UR3, or you made no or no adequate record of any such discussion;

(b) you made no or no adequate record of the reason for adjusting the crown at UR3;

(c) you made no or no adequate record of the detail of the complaint made by Patient B in relation to the crown at UR3;

(d) you fitted a crown at UR3 that was substandard;

(e) you made no or no adequate record of any justification for the periapical radiograph taken of UR3;

(f) you did not grade the radiograph adequately or at all;

(g) you did not report adequately or at all on the radiograph.

73. Your care of Patient B in relation to that appointment was inadequate in that:

(a) you did not respond adequately or at all to pain experienced by the patient during removal of the crown at UR3;

(b) you did not manage the pain experienced by the patient during removal of the crown at UR3;

(c) you did not offer any or any adequate assistance to remove debris from the mouth after removal of the crown;

(d) you did not provide any or any adequate post-treatment instruction after removal of the crown;

(e) you spoke to her in a manner which did not accord her with dignity and respect;

(f) your response to her subsequent written complaint was not timely.

AND that, by reason of the matter(s) alleged, your fitness to practise is impaired by reason of your misconduct."

Mr NIKOLOV was not present and was not represented. On 7 April 2016 the Chairman announced the findings of fact to the Counsel for the GDC, Mr McGhee. (Please note that Mr McGhee was absent at the time of reading out the determination and Mr Evans took his place):

"Mr McGhee: You appear for the General Dental Council (GDC) at this Professional Conduct Committee (PCC) hearing of the case of Todor Nenkov Nikolov. Mr Nikolov is neither present nor represented.

In Mr Nikolov's absence, the Committee first considered whether the notice of the hearing has been served on him in accordance with Rules 13 and 65 of the General Dental Council (Fitness to Practise) Rules 2006 (the Rules). The Committee has seen a copy of notice of hearing letter dated 29 February 2016 which was sent by Capsticks Solicitors (acting on behalf of the GDC) to Mr Nikolov's registered address by Special Delivery and first class post. The letter confirms the date, time and location of this hearing, in compliance with Rule 13. The Royal Track and Trace document confirms that the notice was delivered to Mr Nikolov's registered address on 1 March 2016.

The Committee also notes that a copy of the notice of hearing was sent to Mr Nikolov's other known address on 29 February 2016. That copy was returned to the offices of the solicitors acting for the GDC on 1 March 2016 with the information that the addressee had gone away. You also drew the Committee's attention to the extensive efforts made by the solicitors acting for the GDC to inform Mr Nikolov of these proceedings.

Finally, the Committee has seen documents which demonstrate that the notice of hearing was sent to Mr Nikolov's last known email address on 29 February 2016. The Committee has seen evidence that this email address was used to access other documents sent by the GDC on 24 and 25 March 2016

Taking all these matters into account, the Committee is satisfied that service has been properly effected in accordance with the Rules and that all reasonable efforts have been made by the GDC to notify Mr Nikolov of this hearing.

The Committee then went on to consider whether to proceed in the absence of Mr Nikolov in accordance with Rule 54. You invited the Committee to do so on the basis that the GDC has made all reasonable efforts to notify Mr Nikolov of these proceedings and that he has voluntarily absented himself. You drew the Committee's attention to Mr Nikolov's previous contact with the GDC in October 2014 in which he stated that he did not wish to make any representations. You also advised the Committee that there is evidence that Mr Nikolov's email address was used to access documents in relation to these proceedings on 24 and 25 March 2016. He was invited to acknowledge receipt of the correspondence but he has not done so.

The Committee has considered the submissions carefully. It has accepted the Legal Adviser's advice. It is aware that its discretion to proceed in the absence of Mr Nikolov must be exercised with the utmost care and caution. Having regard to the information before it, the Committee has concluded that Mr Nikolov has voluntarily absented himself from these proceedings. He has not responded to any of the correspondence from the GDC in respect of this hearing, despite being asked to do so. It considers that an adjournment would serve no purpose as it would be unlikely to secure Mr Nikolov's attendance, given that he has previously indicated that he does not wish to participate in the proceedings, has not responded to the numerous invitations to participate that have been sent to him and has not requested a postponement of the hearing. The Committee notes from Mr Nikolov's last communication with the GDC in October 2014 that he stated that he was suffering with a health problem at that time, but that he has not provided any further information in relation to that alleged condition. Issues concerning his health have not been referred to since that time, including at the time of providing information to the GDC about his indemnity insurance arrangements the following year.

The Committee also considers that there is a clear public interest in the expeditious disposal of these allegations before this PCC hearing. The Committee has also borne in mind the potential inconvenience to the GDC, and to those witnesses whom the GDC will call to give evidence, that would arise from a postponement of this hearing. Taking all these matters into account, the Committee has determined to proceed in the absence of Mr Nikolov.

The GDC's case

The allegations relate to the care and treatment that Mr Nikolov provided to two patients, (Patient A and Patient B) whilst practising at [address redacted] (the Practice).

Mr Nikolov provided treatment to Patient A on a number of occasions between 2 June 2010 and 15 January 2014. He provided treatment to Patient B on four occasions between 27 June 2013 and 5 September 2013. The allegations relate to a number of shortcomings in his treatment of Patients A and B, including a failure to adequately examine, diagnose and treatment plan, the taking of and reporting on radiographs; the quality of restorative and root canal treatment provided and his management of pain. It is also alleged that Mr Nikolov failed to obtain informed consent for the treatment that he provided. Mr Nikolov also faces a number of shortcomings relating to his record-keeping.

The evidence

In considering the allegations against Mr Nikolov, the Committee has had regard to all the evidence before it. This includes Patient B's oral evidence, her signed statements as well as copies of her dental records from the Practice. It notes that there were some inconsistencies in Patient B's recollection of events. Nevertheless, it considered that Patient B was a credible witness. The Committee noted Mr Nikolov's undated draft response to Patient B's complaint, which Patient B said she had not seen until the GDC started to investigate.

The Committee received copies of Patient A's dental records from the Practice as well as the witness statement of the Practice Manager.

The Committee heard oral evidence from Professor Stuart Morganstein, an expert witness, instructed by the GDC. Overall, it considered that Professor Morganstein gave a balanced opinion as to the shortcomings in Mr Nikolov's treatment of Patients A and B, and he was prepared to make appropriate concessions. The Committee has accepted Professor Morganstein's opinion in relation to most of the charges against Mr Nikolov. Where the Committee has reached a decision contrary to Professor Morganstein's opinion it has set out its reasons.

During the course of Professor Morganstein's evidence you made an application under Rule 57 for the Committee to receive two documents: Patient A's appointments history and a letter from Mr Nikolov in response to Patient A's complaint. You submitted that there would be no unfairness to Mr Nikolov in the Committee receiving these documents since neither of them are new, Mr Nikolov having received them at an earlier stage of the GDC's investigations. You also made the point that one of the documents had been written by Mr Nikolov. You confirmed that the GDC served both these two documents on him via email in advance of you making your application. The Committee has considered your submissions carefully. It has accepted the advice of the Legal Adviser. It is satisfied that there would be no injustice to Mr Nikolov in receiving these two documents for the reasons you rehearsed in you submissions. In considering what weight, if any, it should give to Mr Nikolov's written response to Patient A's complaint, the Committee has borne in mind that this statement was not made on oath and that Mr Nikolov has not been cross-examined on its content. It has therefore attached less weight to it.

At the close of the GDC's case you made an application under Rule 18 to amend the charge by withdrawing a number of the charges and also by making some textual changes to the charges, in line with the evidence. The amendments were as follows:

Withdrawing charges 27(d), 29(b), 31(a), 33(d), 33(e), 48(a), 48(b), 53(a) and 53(b).

Charge 35(f) – deleting the words 'proposed root canal' from the charge

Charges 41(b) and 41(c) – deleting the words 'an amalgam' and replacing it with the word 'composite'.

Charge 57 – deleting the date '15 July 2013' and replacing it with '21 October 2013'; deleting the words 'inadequate root canal treatment was shown' and inserting the following wording: 'it only showed part of the roots of UR6 and not the whole of the root, and showed blurred apices.'

59(a) – deleting the word 'pain' and replacing it with the word 'pressure'

In short, you submitted that there would be no prejudice to Mr Nikolov by these amendments. In respect of the textual changes to the charges listed above, you say that these do not introduce new criticisms or new evidence, but are simply amendments to reflect the evidence. You also advised the Committee that the GDC has notified Mr Nikolov of these proposed amendments in advance of you making your application.

The Committee has received legal advice on your application, which it has accepted. It is satisfied that the proposed amendments can be made without any injustice to Mr Nikolov. Having regard to the merits of your application, the Committee has acceded to your application. It has agreed to withdraw charges 27(d), 29(b), 31(a), 33(d), 33(e), 48(a), 48(b), 53(a) and 53(b). The Committee is satisfied that the case is still properly presented despite the withdrawal of those charges. It has also amended the wording of the other charges that form the basis of your application in the terms set out above.

The Committee has taken into account all of the evidence presented to it. It has also accepted the advice of the Legal Adviser. In accordance with that advice it has considered each head of charge separately. The Committee has been reminded that the burden of proof rests with the GDC, and has considered them against the civil standard of proof, namely on the balance of probabilities.

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

1.	Found proved
2.	Found proved The Committee has had regard to the dental records which confirm that Mr Nikolov provided treatment to Patients A and B.
3.	**Patient A** Found proved The schedule of appointments confirms that Mr Nikolov provided treatment to Patient A between 2 June 2010 and 15 January 2014
4.	Found proved The Committee has noted Patient A's clinical notes and the clinical chart for the items of treatment provided on 2 June 2010.
5.(a)	Found proved The Committee notes that on 2 June 2010 there is a reference in Patient A's records to hay fever and prescribed cream for bad skin (spots). Save for these references, there is no record contained in Patient A's notes of

	medical, dental or social history. The Committee accepts Professor Morganstein's opinion that the record is inadequate. It therefore finds this charge proved on the basis that there is no adequate record.
5.(b)	Found proved Mr Nikolov recorded in Patient A's records that amalgam restorations were required at LL6 and UL6. From these records the Committee infers that Mr Nikolov must have carried out an intra-oral examination at this appointment. Professor Morganstein's evidence is that the record is inadequate because Mr Nikolov failed to record any detail of what was examined and what was seen on examination. The Committee accepts Professor Morganstein's opinion on this matter. It therefore finds this charge proved on the basis that there is no adequate record.
5.(c)	Found proved There is no reference in Patient A's notes of an extra-oral examination for this appointment. It therefore finds this charge proved on the basis that there is no record.
5.(d)	Found not proved The Committee notes that there is reference in Patient A's notes to Mr Nikolov having carried out the charting of the teeth on 2 June 2010, including reference to the teeth that are missing and a note that LL6 and UL6 require restoration. However, in the absence of a subsequent or earlier dental chart the Committee is unable to assess the adequacy of the charting of the teeth carried out by Mr Nikolov on 2 June 2010. Accordingly, the Committee is not satisfied that this charge is proved.
5.(e)	Found proved Professor Morganstein's opinion was that a Basic Periodontal Examination (BPE) should be carried out when a new dentist sees a patient and should be repeated at intervals determined by the presence and severity of disease. There is no reference in Patient A's records to any BPE on 2 June 2010. The Committee is of the view that had such an examination taken place, the BPE scores would have been recorded in Patient A's notes. In the absence of any such notation in the records, the Committee finds that Mr Nikolov did not carry out a BPE.
5.(f)	Found not proved Professor Morganstein has not provided an opinion on this matter. There is reference in Patient A's clinical chart to a diagnosis of caries at LL6 and UL6 and there is also a treatment plan in the bundle dated 2 June 2010. The Committee is satisfied that a diagnosis was reached.
5.(g)	Found proved The Committee has received no evidence as to whether a discussion concerning alternative treatment options to that proposed had taken place.

	Professor Morganstein's evidence was that alternative options would have included using materials other than amalgam. The Committee accepts Professor Morganstein's evidence on this matter. It therefore finds this charge proved on the basis that there is no record.
5.(h)	Found proved There was a plan on that date which recorded treatment necessary at LL6 and UR6. However, there is no recorded plan for the restoration at UR6 in Patient A's notes. The Committee is therefore satisfied that it is more likely than not that no plan was made for UR6.
5.(i)	Found proved The Committee has found this proved solely on the basis that Mr Nikolov made no record of any informed consent to the proposed treatment of LL6 and UL6.
5.(j)	Found proved The Committee found that there was no evidence of radiographs having been taken on 2 June 2010. Professor Morganstein's evidence was that the registrant should have taken radiographs, especially bitewing radiographs, to check for aproximal caries and the level of the bone around the standing teeth. Accordingly, the Committee finds this charge proved.
6.	Found proved The Committee has seen a copy of Patient A's clinical record dated 9 August 2010 which refers to the amalgam fillings being placed at LL6 and UL6 by Mr Nikolov on this occasion.
7.(a)	Found proved There is no record of any informed consent for the restorations provided at LL6 and UL6. It therefore finds this charge proved on the basis that there is no record.
7.(b)	Found proved Professor Morganstein's evidence was that there is no record of the placement of a lining. There is no evidence in Patient A's dental records as to whether a lining was placed at LL6. It therefore finds this charge proved on the basis that there is no record
7.(c)	Found proved Professor Morganstein's evidence was that there is no record of the placement of a lining. There is no evidence in Patient A's dental records as to whether a lining was placed at UL6. It therefore finds this charge proved on the basis that there is no record.
8.	Found proved There is reference in Patient A's clinical notes to Mr Nikolov having provided

	treatment to Patient A on 16 August 2010.
9.(a)	Found not proved An amalgam filling was placed at UR6 on 16 August 2010. In Patient A's clinical chart there is an entry dated 16 August 2010 that states that UR6 was carious. The Committee does not accept the expert's evidence that although UR6 was filled, there was no indication as to the reason why.
9.(b)	Found proved On 16 August 2010 there is reference to an amalgam filling being placed. Professor Morganstein was critical of the lack of detail in the record of the treatment provided. His evidence was that there are no details of whether an old restoration was replaced or if this was a new restoration, the size and depth of the lesion treated and of the procedure recorded, such as was a lining placed and what material was used. The Committee accepts Professor Morganstein's evidence on this matter.
9.(c)	Found proved There is no evidence that Mr Nikolov placed a lining in the cavity and there is no record of a lining in the cavity at UR6.
9.(d)	Found proved The Committee has received no evidence as to whether a discussion concerning alternative treatment options to that proposed had occurred. There is no record in Patient A's notes as to whether Mr Nikolov had a discussion as to alternative treatment options on 16 August 2010. It therefore finds this charge proved on the basis that there is no record.
9.(e)	Found proved There is no record of any informed consent in any of Patient A's dental records. It therefore finds this charge proved on the basis that there is no record.
10.	Found proved There is reference in Patient A's clinical notes to Mr Nikolov having provided treatment to Patient A on 23 March 2011.
11.(a)	Found proved There is evidence in the notes that Mr Nikolov recorded an examination. However, Professor Morganstein's opinion was that this record was inadequate because there was no record of any details of what was examined and what was seen on examination. The Committee accepts Professor Morganstein's opinion. It therefore finds this charge proved on the basis that there is no adequate record.
11.(b)	Found proved The Committee notes that for 23 March 2011 Mr Nikolov had recorded in

	Patient A's notes that he had checked the medical questionnaire and no changes were noted. The Committee considers that this record is inadequate because although there is reference to checking the medical questionnaire, there is no detail as to the dental or social history. It therefore finds this charge proved on the basis that there is no adequate record.
11.(c)	Found proved Mr Nikolov noted Patient A's treatment needs but there is no record of the patient's presenting situation. Consequently, no diagnosis has been reached. In the absence of such information, the Committee considers that the record is inadequate.
11.(d)	Found proved The Committee has received no evidence as to whether a discussion concerning alternative treatment options to that proposed had occurred. There is no record in Patient A's notes as to whether Mr Nikolov had a discussion as to alternative treatment options on 23 March 2011. It therefore finds this charge proved on the basis that there is no record.
11.(e)	Found proved There is no record of any informed consent in Patient A's dental records. It therefore finds this charge proved on the basis that there is no record.
12.	Found proved There is reference in Patient A's clinical notes to Mr Nikolov having provided treatment to Patient A on 31 March 2011.
13.	Found proved The Committee notes that there is a record of the type of material used for the composite restorations at UL6. It accepts Professor Morganstein's evidence that this record was inadequate in that it did not include details of technique, type of composite and the procedure used.
14.	Found proved There is reference in Patient A's clinical notes to Mr Nikolov having provided treatment to Patient A on 16 June 2011.
15.(a)	Found proved The Committee found that periodontitis was diagnosed but no other details were recorded. The Committee accepted the view of Professor Morganstein that this record was inadequate. It therefore finds this charge proved on the basis that there is no adequate record.
15.(b)	Found proved There is no record in Patient A's dental records of any medical, dental or social history on this date.

15.(c)	Found proved There is no evidence that a periapical radiograph was taken on 16 June 2011. Professor Morganstein's evidence was that a periapical radiograph should have been taken to assist in identifying a provisional diagnosis. The Committee accepts Professor Morganstein's opinion on this matter. It has concluded that as there is neither a radiograph nor a record of it, on the balance of probabilities, no radiograph was taken.
15.(d)	Found proved Patient A's dental records states periodontitis at UR6, which was tender to pressure (TTP). However, there is no evidence as to the presenting condition, the examination undertaken or how the diagnosis was reached. The Committee agrees with Professor Morganstein's opinion that this was an inadequate record of the diagnosis reached.
15.(e)	Found proved Professor Morganstein's evidence was that there is no justification recorded for the prescribing of antibiotics without confirmation of the diagnosis. The Committee accepts Professor Morganstein's opinion on this matter. It therefore finds this charge proved on the basis that there is no record.
15.(f)	Found proved Professor Morganstein's opinion was that Mr Nikolov should have provided Patient A with sufficient advice and information as to the risks and benefits of taking prescribed antibiotics. There is no record of any advice as to the risks and benefits of taking the prescribed antibiotics. The Committee finds this charge proved on the basis that there is no record.
15.(g)	Found proved The Committee has received no evidence as to whether a discussion concerning alternative treatment options to that proposed had occurred. There is no record in Patient A's notes as to whether Mr Nikolov had a discussion as to alternative treatment options on 16 June 2011. It therefore finds this charge proved on the basis that there is no record.
15.(h)	Found not proved There is no evidence that there was a requirement for Mr Nikolov to assess the vitality of LL6 on 16 June 2011. Accordingly, the Committee finds this charge not proved.
16.	Found proved There is an entry in Patient A's clinical notes for the provision of treatment on 17 June 2011.
17.(a)	Found proved The record states: "Pat still in pain. Pulp chamber has been opened. Tooth stays with open access." Professor Morganstein was critical of the lack of

	detail in the records of the examination. The Committee has accepted Professor Morganstein's evidence. It therefore finds this charge proved on the basis that there is no adequate record.
17.(b)	Found proved There is no record in Patient A's dental records of any medical, dental or social history on 17 June 2011.
17.(c)	Found proved There is no evidence that a periapical radiograph was taken on 17 June 2011. Professor Morganstein's evidence was that a periapical radiograph would have assisted with the diagnosis. As there was neither a record nor a radiograph, the Committee find that on the balance of probabilities, no radiograph was taken.
17.(d)	Found proved The Committee notes that the nature of the presenting problem was not identified and a diagnosis was not recorded.
17.(e)	Found proved There is no record in Patient A's dental records as to whether Mr Nikolov had a discussion as to alternative treatment options on 17 June 2011. It therefore finds this charge proved on the basis that there is no record.
17.(f)	Found proved There is no record of a treatment plan for UR6. Professor Morganstein was critical of this omission. The Committee accepts Professor Morganistein's evidence on this matter. It therefore finds this charge proved on the basis that there is no adequate record.
17.(g)	Found proved The Committee has received no evidence as to whether a discussion of the planned treatment and the prognosis for UR6 had occurred on 17 June 2011. It therefore finds this charge proved on the basis that there is no adequate record.
17.(h)	Found not proved Professor Morganstein was critical of Mr Nikolov's use of cotton wool to protect UR6 from food packing. However, there is no evidence in Patient A's clinical records to show that Mr Nikolov used cotton wool dressing on this day on UR6.
17.(i)	Found proved There is no record in Patient A's dental records to indicate that Mr Nikolov obtained informed consent.
18.	Found proved

	There is an entry in Patient A's clinical notes and dental records for the provision of treatment on 1 November 2011.
19.(a)	Found proved The note for 1 November 2011 records that Patient A complained of pain at UR6. Professor Morganstein's evidence was that a periapical radiograph was indicated on 1 November 2011 due to the infection present at UR6. Mr Nikolov did not take a radiograph on that occasion and was intending to take one at the next visit, as referred to in his contemporaneous note which states "to take xray at NV" (next visit). Accordingly, the Committee finds proved that Mr Nikolov did not take a radiograph on this occasion.
19.(b)	Found proved The Committee found no evidence of a diagnosis of the patient's condition being made or recorded. The Committee has therefore found this charge proved.
19.(c)	Found not proved There is no evidence to indicate whether or not a dressing was placed in the pulp chamber of UR6 on 1 November 2011. Hence the Committee finds this charge not proved.
19.(d)	Found proved The Committee notes that Mr Nikolov recorded a 'large infection present', but the nature and extent of this infection was not described. Professor Morganstein was critical of Mr Nikolov's failure to record the indication for the prescription of an antibiotic. The Committee therefore finds this charge proved on the basis that there is no adequate record.
19.(e)	Found not proved Professor Morganstein's evidence was that Mr Nikolov should have confirmed in the record that the patient had no allergy to the medicine prescribed and that the patient was aware of the need to complete the course of treatment. The Committee notes that Mr Nikolov has recorded the dose, duration and frequency of antibiotics (amoxicillin). He has also recorded that he has checked the patient's medical history, as annotated in the notes 'MH checked – no allergies'. It considers that the details contained in this record were adequate.
20.	Found proved There is an entry in Patient A's clinical notes for the provision of treatment on 8 November 2011.
21.(a)	Found proved The Committee has seen the radiograph taken on 8 November 2011. Professor Morganstein states that the radiograph taken on this date shows a very large cavity at UR6 but does not show a clear view of the root

	formation. The Committee accepts Professor Morganstein's evidence on this matter.
21.(b)	Found proved The Committee has had regard to the Ionising Radiation Medical Exposure Regulations 2000 (IRMER) statutory regulations. IRMER requires the dentist to justify the taking of the radiograph, report on its finding and grade its quality. It also requires that a report is recorded for each radiograph. There is no evidence in Patient A's clinical records of Mr Nikolov recording the grade and quality of the radiograph, contrary to IRMER.
21.(c)	Found proved There is no evidence in Patient A's clinical records of Mr Nikolov recording a report of the radiograph, contrary to IRMER.
21.(d)	Found proved There is no evidence in Patient A's clinical records of Mr Nikolov recording the justification of the radiograph, contrary to IRMER.
21.(e)	Found proved There is no record in Patient A's dental records as to whether Mr Nikolov had a discussion as to treatment options on 8 November 2011. The Committee therefore finds this charge proved on the basis that there is no record.
21.(f)	Found proved There is no evidence in Patient A's dental records record on 8 November 2011 of informed consent being taken for the proposed root canal treatment at UR6.
22	Found proved There is an entry in Patient A's clinical notes for the provision of treatment on 16 November 2011.
23.(a)	Found proved UR6 was lined with Leadermix and flow composite and an amalgam restoration was placed on this. The Committee agrees with Professor Morganstein's evidence that the treatment provided was not an acceptable form of root treatment.
23.(b)	Found proved The Committee could find no record in Patient A's dental records of the justification for the restoration provided at UR6.
23.(c)	Found proved There is no evidence in Patient A's dental records as to whether Mr Nikolov had a discussion with Patient A as to the restoration of UR6 on 16

	November 2011. It therefore finds this charge proved on the basis that there is no record.
23.(d)	Found proved There is no evidence in Patient A's dental records as to whether Mr Nikolov had a discussion as to treatment options for UR6 on 16 November 2011. It therefore finds this charge proved on the basis that there is no record.
23.(e)	Found proved There is no evidence in Patient A's dental records as to whether Mr Nikolov had a discussion as to the full risks and benefits of the restoration provided at UR6 on 16 November 2011. It therefore finds this charge proved on the basis that there is no record.
24.	Found proved There is an entry in Patient A's clinical notes for the provision of treatment on 19 December 2011.
25.(a)	Found proved There is no record of any details of the examination and assessment of Patient A's presenting condition. Professor Morganstein was critical of Mr Nikolov as the record does not contain any details of the patient's complaint. He considered that Mr Nikolov only recorded a very superficial examination in which he stated that the bite was 'ok'. The Committee accepts Professor Morganstein's views on this matter.
25.(b)	Found proved There is evidence in Patient A's notes that the medical history had been checked and a record made 'no allergy'. The Committee considers that this does not constitute an adequate record as there is no record of Patient A's dental or social history being checked on 19 December 2011. Accordingly, the Committee finds the charge proved.
25.(c)	Found proved The records detail that Patient A was complaining of some pain in the right and left mandible. There is no record of a detailed examination and no diagnosis is recorded.
25.(d)	Found proved Professor Morganstein's evidence was that it is not acceptable to prescribe antibiotics as a precaution without recording a justification. The Committee accepts Professor Morganstein's opinion on this matter. It therefore finds this charge proved on the basis that there is no record of any indication of the use of antibiotics.
25.(e)	Found not proved Professor Morganstein was critical of Mr Nikolov's failure to confirm in the

	record that the patient had no allergy to the medicine prescribed and that the patient was aware of the need to complete the course of treatment. However, it is apparent from the records that Mr Nikolov has checked the patient's medical history and that there are no allergies, with advice to the patient "tca" (to come again) if any further problems. The Committee notes that Mr Nikolov has recorded the dose, frequency and duration of the antibiotic he has prescribed. The Committee considers that the entries recorded by Mr Nikolov are adequate.
25.(f)	Found proved There is no record of any provision of a review or follow-up appointment by Mr Niolov for Patient A following the prescribing of the antibiotics.
26.	Found proved The clinical chart and the dental records confirm that Mr Nikolov provided treatment to Patient A on 3 July 2012.
27.(a)	Found not proved Professor Morganstein's evidence was that there was no mention in the record of Mr Nikolov having reviewed the symptoms that Patient A complained of on 19 December 2011. The Committee notes Mr Nikolov's undated letter in which he states: "She never complained any further about any problems regarding her jaw. I don't feel this was anything to do with any dental procedures done by myself." The Committee notes that this was a single episode of care seven months earlier, with no history of previous jaw complaints and no complaints in the intervening period. The Committee accepts Mr Nikolov's explanation of his reasons for not reviewing the symptoms Patient A experienced seven months earlier.
27.(b)	Found proved There is evidence in Patient A's notes that the medical history had been checked in that it states 'MH - no changes'. However, there is no record of Patient A's dental or social history being recorded on 3 July 2012. Accordingly, the Committee finds the charge proved.
27.(c)	Found proved There is no evidence that bitewing radiographs were taken on 3 July 2012. Professor Morganstein's evidence was that he would have expected bitewing radiographs to have been taken at this appointment. The Committee accepts Professor Morganstein's opinion on this matter. It has concluded that as there are neither bitewing radiographs nor a record of them, on the balance of probabilities, no radiographs were taken.
28.	Found proved The clinical notes confirm that Mr Nikolov provided treatment to Patient A on 4 October 2012.

29.(a)	Found not proved This was an emergency appointment that was made due to the LL6 having a broken tooth/filling, which Mr Nikolov recorded in the notes. A dressing was placed and 'if everything is ok by NV (next visit) to do permanent filling'. There is no record of the patient complaining of pain at LL6. Professor Morganstein's opinion was that Mr Nikolov should have removed the caries at LL6 at that appointment. The Committee was not persuaded by Professor Morganstein's opinion on this matter. Mr Nikolov had dealt with the broken tooth/filling at LL6 and another appointment had been made for the definitive treatment of LL6. This was an emergency appointment and the Committee considers that it was reasonable for Mr Nikolov to postpone removing any caries at LL6 until the following appointment.
29.(c)	Found not proved Professor Morganstein was critical of Mr Nikolov's note that local anaesthesia was not required. However, the Committee notes that Mr Nikolov was merely providing a dressing at LL6, with a view to providing definitive treatment at a subsequent appointment. The Committee accepts that Mr Nikolov's record that local anaesthetic was not required was adequate.
29.(d)	Found proved There was no record of any clinical decision-making in respect of definitive treatment of LL6.
30.	Found proved The dental records confirm that Mr Nikolov provided treatment to Patient A on 12 October 2012.
31.(b)	Found not proved The records indicate that an amalgam restoration was placed at LL6. They state that decay was removed and the cavity was prepared. The Committee considers that it is more likely than not that the Ledermix paste would have been removed during this process. It therefore finds this charge not proved.
31.(c)	Found proved The note in Patient A's clinical records for 12 October 2012 indicate that no local anaesthetic was required. This could indicate that the LL6 may have been non-vital. Vitality tests should have been carried out and recorded. There is no record of any vitality testing of LL6 on this date.
32.	Found proved The dental records confirm that Mr Nikolov provided treatment to Patient A on 22 October 2012.
33.(a)	Found proved The records state that this was an emergency appointment with the patient

	complaining of pain at UR6. They further state: 'filling loose, have removed amalgam filling. No LA required. have applied Ledermix – cotton – max fill temp dressing.' Professor Morganstein was critical of Mr Nikolov's use of Ledermix as a temporary dressing material, which he considered was not appropriate. The Committee accepts Professor Morganstein's opinion on this matter. It finds this charge proved.
33.(b)	Found proved There is no record of a diagnosis as to the extent of dental disease.
33.(c)	Found proved Professor Morganstein's evidence was that Mr Nikolov should have recognised that the UR6 was probably non-vital and instigated root canal treatment instead of just dressing the tooth prior to re-filling it. In Mr Nikolov's undated letter he explained that after giving the patient options she wanted to leave things alone for now as she did not like needles or root canal treatment. However, there is nothing in the records to this effect. The Committee accepts Professor Morganstein's evidence that root canal treatment should have been commenced on this day.
33.(f)	Found proved The Committee has seen the radiograph taken by Mr Nikolov on 22 October 2012. There is no record of its justification in Patient A's dental records, contrary to IRMER guidelines.
34.	Found proved The dental records confirm that Mr Nikolov provided treatment to Patient A on 24 October 2012.
35.(a)	Found proved The Committee has received no evidence as to whether any or any adequate discussion as to the treatment options took place on 24 October 2012. It therefore finds this charge proved on the basis that there is no adequate record of any such discussion.
35.(b)	Found proved The Committee has received no evidence as to whether any or any adequate discussion as to the full risks and benefits of the restoration provided at UR6 on 24 October 2012. It therefore finds this charge proved on the basis that there is no record of any such discussion.
35.(c)	Found proved Professor Morganstein's evidence was that before restoring UR6 Mr Nikolov should have ensured that the tooth did not require root treatment. There is no evidence in Patient A's clinical notes that Mr Nikolov did this.
35.(d)	Found proved

	The Committee notes that Patient A's dental records confirm that a composite filling at UR6 was placed on 24 October 2012. However, there are no other details in the notes of the technique, the material or the procedure used to place the restoration at UR6. Professor Morganstein's evidence was that it is usual to record the use of an acid etch, adhesive and the type of composite used. He was critical of the lack of details in the records. The Committee accepts his evidence on this matter.
35.(e)	Found proved The Committee notes from Patient A's dental records that on 22 October 2012, Mr Nikolov recorded that he would "review the xrays at the next visit", but there is no record of such a review.
35.(f)	Found proved Patient A's dental records show that verbal consent was taken on 24 October 2012. However, the records do not make clear that Patient A was fully acquainted with the relevant benefits and risks associated with the various treatment options for UR6. Therefore, the Committee finds that there is no adequate record of informed consent.
36.	Found proved The dental records confirm that Mr Nikolov provided treatment to Patient A on 18 January 2013.
37.(a)	Found proved Patient A's dental notes confirm that an examination was carried out. Professor Morganstein conceded that there was a record of the examination but he considered that it contained insufficient detail. In particular, he considered that the record should have contained details of the radiographs and the intra-oral and extra-oral examination. The Committee agrees.
37.(b)	Found proved There is some record of the dental history being checked, with a recording of no changes, but there is no record of the dental or social history.
38.	Found proved There is an entry in Patient A's appointment history on 4 June 2013 which states 'toothache'. On 7 June 2013 there is reference to the temporary dressing removed. The Committee has drawn the inference that Mr Nikolov provided treatment to Patient A on 4 June 2013, given that he removed the temporary dressing on 7 June 2013.
39.	Found proved There is no other information in the record for 4 June 2013 save for the entry in Patient A's appointment history which states 'toothache'. The Committee accepts Professor Morganstein's view that this information is inadequate.

40.	Found proved There is reference in Patient A's dental records to Mr Nikolov providing treatment to Patient A on 7 June 2013.
41.(a)	Found proved The records state that an amalgam was placed at LL6, with a note that "no AL(sic) req", meaning no local anaesthetic was required. Professor Morganstein's evidence was that Mr Nikolov had not recognised that the tooth was probably non vital due to no necessity for local anaesthetic during treatment at LL6. There is no record of any assessment of the vitality of LL6. Accordingly, the Committee finds this charge proved.
41.(b)	Found proved Although there is no recorded evidence of caries being present at LL6 as at 7 June 2013, it is apparent from the record of another dentist, that by the time of the appointment dated 20 June 2013, there was "very big decay" noted in that same tooth by the other dentist, with irreversible pulpitis being recorded. Professor Morganstein's evidence was that the decay noted on 20 June 2013 must have been apparent as at 7 June 2013 when Mr Nikolov restored LL6. The Committee accepts Professor Morganstein's evidence on this matter.
41.(c)	Found not proved There is evidence that Ledermix paste was used at LL6 on 4 October 2012. However, the Committee considers that it is more likely than not that the Ledermix paste would have been removed during the preparation of this tooth on 7 June 2013. It therefore finds this charge not proved.
41.(d)	Found proved There is no record of the technique, material or the procedure used to place the restoration at LL6. The Committee therefore finds this charge proved.
41.(e)	Found proved There are no clinical notes to record this appointment.
42.	Found proved There is an entry in Patient A's appointment history for an appointment for 24 June 2013.
43.	Found proved The only recorded information is "F3: private filling has came out" (sic).
44.	Found proved There is an entry in Patient A's appointment history for 27 June 2013.
45.(a)	Found proved The Committee has seen the radiograph dated 27 June 2013 which shows

	no detail of root morphology or apical tissue.
45. (b)	Found proved There are no other records for 27 June 2013 save for 'OZ RCT First Visit'.
46.	Found proved There is an entry in Patient A's appointment history for 3 July 2013.
47.(a)	Found proved In Patient A's dental records for 3 July 2013 there is reference to Root Canal Treatment being continued at LL6. However, there is no record of any plan for its treatment.
47.(b)	Found proved There is no record in Patient A's dental records of the recording of the root canal lengths of LL6.
47.(c)	Found proved There is no evidence of a radiograph being taken at this appointment.
49.	Found not proved There is an entry in Patient A's appointment history for 8 July 2013. The Committee considers that it is unlikely that Mr Nikolov provided treatment on this occasion since the only entry in the appointment history records 'OZ RCT First visit'. This is completely at odds with the record that he had treated Patient A previously, including treatment for the root canal on 27 June 2013 and 3 July 2013. The Committee therefore finds this charge not proved.
50.	Found not proved This in the light of the Committee's finding at 49 above.
51.	Found proved There is an entry in Patient A's appointment history for 15 July 2013 which demonstrates that Mr Nikolov provided treatment on that day.
52.(a)	Found proved There is no record in the notes of the cleaning or the shaping of the root canals. The Committee has seen the radiograph taken on 15 July 2013 which shows that the cleaning and shaping of the root canals was inadequate.
52.(b)	Found proved It is evident from the radiograph taken on 15 July 2013 that the root canals had not been filled to an acceptable standard.
52.(c)	Found proved

	The radiograph taken on 15 July 2013 shows that the root canals were inadequately filled and there is nothing noted in the clinical records to identify this.
52.(d)	Found proved There is no evidence in the clinical records to indicate that the radiograph was graded, contrary to IRMER.
52.(e)	Found proved There is no record, contrary to IRMER.
54.	Found proved The Committee noted the appointment history and the radiograph taken on 21 October 2013.
55.(a)	Found proved A radiograph was taken of the UR quadrant. Professor Morganstein's view was that the film had no clinical value and should have been retaken to show the whole of the root morphology and the crowns of UR6 and UR7. The Committee accepts his evidence on this matter.
55.(b)	Found proved There is no evidence in the clinical records that the radiograph has been graded or reported on, contrary to IRMER.
55.(c)	Found proved Professor Morganstein said that the original radiograph had no clinical value and should have been retaken to show the whole root morphology and the crowns of UR6 and UR7. There is no evidence of a second radiograph in the clinical records to indicate that the radiograph was retaken.
55.(d)	Found proved
56.	Found proved The Committee notes the appointment history and the dental notes taken on 29 October 2013.
57.	Found proved The Committee notes that this was a review appointment at which the radiograph of 21 October 2013 would be reviewed. Mr Nikolov's clinical notes indicate that the radiograph shows no visible problems. However, this radiograph is inadequate in that it shows only part of the roots of UR6 and has blurred apices.
58.	Found proved The Committee notes the appointment history and the dental records taken on 5 November 2013.

59.(a)	Found proved The Committee found no record of any diagnosis of Patient A's complaint of pressure on the gums of the UR quadrant.
59.(b)	Found proved Mr Nikolov prescribed Metronidazole 200mg to be taken 3 times a day for 5 days. Professor Morganstein's view was that antibiotics were not clinically indicated and observed that there was no record of any indication. The Committee has accepted Professor Morganstein's evidence on this point.
59.(c)	Found proved The patient's notes record the following: 'advised patient tca if any further problems'. Professor Morganstein's opinion was that the patient should have been reviewed following the issuing of a prescription. The Committee accepted his evidence on this matter.
59.(d)	Found proved Mr Nikolov had identified UR6 as requiring root canal treatment on 8 November 2011. Despite Patient A's continuing problems with UR6, no root canal treatment was undertaken.
60.	Found proved The Committee notes Patient A's appointment history and the dental notes taken on 19 December 2013.
61.(a)	Found proved Patient A attended for an examination appointment. Professor Morganstein opinion was that there was no reference made to UR6 nor any examination or assessment of it. This tooth had been treated with antibiotics on 5 November 2013. The Committee accepts the view of Professor Morganstein that there should have been a record of an assessment of UR6.
61.(b)	Found proved This is for the same reasons as set out at 61(a) above.
62.	Found proved The appointment history and the clinical chart confirm that Mr Nikolov provided treatment to Patient A on 15 January 2014.
63.	Found proved There is no other information recorded for this appointment except 'Lost Filling' and 'Composite Filling'.
	Patient B
64.	Found proved The Committee notes Patient B's dental records, which confirm that Mr

	Nikolov provided treatment between 27 June 2013 and 5 September 2013
65.	Found proved The Committee notes Patient B's dental records, as well as Patient B's evidence that her first appointment with Mr Nikolov took place on 27 June 2013.
66.(a)	Found proved Patient B's evidence was that there was no discussion with Mr Nikolov of her dental or social history. The Committee has accepted her evidence on this matter. It notes that there are no records of a dental or social history having been taken, which supports Patient B's account.
66.(b)	Found proved The Committee notes that there are no records of any examination and assessment in respect of the space mesial to UR3. Professor Morganstein's evidence is that there is no record of the actual size of the gap that the patient was concerned about. The Committee finds that Mr Nikolov did not make a record of any such examination and assessment.
66.(c)	Found proved Mr Nikolov recorded the following in Patient B's notes: 'patient concerned about small space left by UR2, explained this space is very small poss option is to have a crown UR3 and make slightly larger. Patient to think about it.' Patient B's evidence was that Mr Nikolov offered to provide her with a crown at UR3 to look the same as the other side and that he would fix it for her. She was clear in her evidence that there was no discussion as to the size of the crown. Mr Nikolov in his notes said that he explained that the crown would be larger. Although Patient B's evidence on this point was slightly confused, the Committee is satisfied that the discussion was inadequate.
66.(d)	Found proved The Committee accepted Patient B's evidence that she had no recollection of Mr Nikolov having discussed alternative options with her. She refuted Mr Nikolov's position, as set out in his undated letter, that treatment options were put to her and that she agreed to have a crown. The Committee also notes that there is no record of any discussion as to alternative treatment options in the notes. It therefore finds the entirety of the charge proved.
66.(e)	Found proved The Committee has seen no evidence of any plan for treatment.
66.(f)	Found proved There is no evidence of a periapical radiograph having been taken or recorded on 27 June 2013. Professor Morganstein's evidence was that a periapical radiograph was clinically indicated on this occasion in view of the

	treatment proposed, which was the crowning of UL3.
66.(g)	Found proved Patient B had no recollection of radiographs having been taken on either side of her mouth. There is no evidence of bitewing radiographs having been taken or recorded on 27 June 2013. In Professor Morganstein's report, he said that he would have expected bitewing radiographs to have been taken at this appointment. The Committee has found that Mr Nikolov did not ensure that bitewing radiographs were taken.
66.(h)	Found proved Given the Committee's finding at 66(d) – namely there was no adequate discussion of alternative treatment options there could not be informed consent for the proposed treatment of UR3. Furthermore, there is no record of informed consent being taken.
67.	Found proved The Committee notes Patient B's dental records, which confirm that Mr Nikolov carried out treatment on Patient B on 3 July 2013.
68.	Found not proved The patient's record states that a composite was placed at LR6 using 'flow comp shade A1'. The Committee accepts the view of Professor Morganstein, in his report, that he was not critical of the omission in the record of the technique used in this instance. Accordingly, the Committee finds this charge not proved.
69.	Found proved The Committee notes that there was a clinical chart and the treatment plan for the appointment of 22 August 2013.
70.(a)	Found proved The Committee has noted the absence of any record as to justification for the provision of the crown at UR3.
70.(b)	Found proved There was no record of the preparation of a crown at UR3.
71.	Found proved The Committee notes there are clinical notes and a clinical chart for the items of treatment provided on 5 September 2013.
72.(a)	Found not proved Patient B's evidence was that she had no recollection as to whether Mr Nikolov adjusted the crown at UR3 at the appointment on 5 September 2013. In the absence of any evidence that the crown at UR3 was adjusted at this appointment, either from Patient B, or in the clinical records, the

	Committee is not satisfied that this charge is found proved.
72.(b)	Found not proved This is for the same reasons as set out at 72(a).
72.(c)	Found proved Patient B's evidence was that she was dissatisfied about the size and shade of the crown at UR3 and she complained to Mr Nikolov about it. In his undated letter Mr Nikolov substantiated the fact that Patient B had returned 30 minutes later on the same day as when was the crown at UR3 was fitted and complained about it to him. The Committee accepts Patient B's evidence on this matter. It notes that there is no record of the complaint made by Patient B in the patient's clinical notes.
72.(d)	Found not proved Patient B complained of the size and shade of the crown at UR3. Professor Morganstein's opinion was that if the patient's account of the appearance of the crown was correct, he would be critical of it. However, the Committee was provided with no objective evidence as to the standard of the crown at UR3. It therefore finds this charge not proved.
72.(e)	Found proved There is no record of any justification of the periapical radiograph taken of UR3, contrary to IRMER.
72.(f)	Found proved There is no grading of the radiograph, contrary to IRMER.
72.(g)	Found proved There is no report of the radiograph, contrary to IRMER.
73.(a)	Found proved Patient B's evidence was that she recollected that the crown was removed without local anaesthesia and that she was in pain and crying during this procedure. Her evidence was that Mr Nikolov continued to remove the crown at UR3 despite her obvious signs of pain and distress. Mr Nikolov accepted that he had removed the crown at UR3, at Patient B's request, and that she was upset at this time. The Committee considered that Patient B's evidence on this matter was credible and has therefore found this charge proved.
73.(b)	Found proved This is for the same reasons as set out at 73(a) above.
73.(c)	Found proved Patient B recollected that when the crown at UR3 was removed there were still bits of the crown and cement remaining in her mouth. Patient B further recollected that Mr Nikolov did not offer her any mouthwash or a tissue to

	help remove the debris from her mouth, but that she was given a tissue by the dental nurse. It has accepted Patient B's evidence on this matter.
73.(d)	Found proved The Committee accepts Patient B's evidence that Mr Nikolov did not provide any post treatment instruction following the removal of the crown at UR3.
73.(e)	Found proved Patient B recollected that Mr Nikolov did not say anything to her following the removal of the crown at UR3, save for a 'sarcastic comment', words to the effect of: 'Are you happy now? I hope that you are happy with the gap? The Committee accepts Patient B's evidence on this matter.
73.(f)	Found proved The Committee notes that Mr Nikolov never directly responded to Patient B's complaint, apart from an undated letter, which she says she never received. The Patient Advice and Support Service (PASS) wrote an initial letter of complaint on 30 September 2013 on behalf of Patient B. This letter was acknowledged by the Practice on 15 October 2013. This was outside the Practice's own policy of three days for acknowledgement. On 11 November 2013 the Practice again wrote to PASS, indicating they were still investigating the matter and would endeavour to respond within 21 working days. On 20 December 2013 PASS sent an email to the GDC, stating that they had tried to contact the Practice as 21 days had passed and had been unsuccessful. Taking all these matters into account, the Committee finds this charge proved.

We move to stage two."

On 8 April 2016 the Chairman announced the determination as follows:

"Mr Evans: The Committee has considered the submissions you have made under Rule 20 of the General Dental Council (GDC) (Fitness to Practise) Rules 2006 (the Rules) following the Committee's announcement of the facts found proved. The Committee has accepted the advice of the Legal Adviser.

Previous fitness to practise history

You informed the Committee that Mr Nikolov has no previous fitness to practise history.

Misconduct

The Committee has considered whether the facts found proved amount to misconduct. In so doing, it has had regard to all of the evidence before it, as well as the submissions you have made on behalf of the GDC. It has been mindful of the GDC's 'Standards for Dental Professionals'.

You submitted that the findings against Mr Nikolov, which relate to the care and treatment he provided to Patients A and B, are serious and amount to misconduct.

In considering whether there is misconduct in this case, the Committee has exercised its own professional judgement. It is aware that a finding of misconduct in this regulatory context requires a serious falling short of the standards to be expected of a registered dentist.

Mr Nikolov treated Patient A over three and a half years, during which time it was noted that:

- Clinical records were incomplete
- Consent to treatment and treatment plans were not recorded
- Restorations were placed in cavities without adequate removal of caries
- UR6, which had a non-vital pulp, was not root treated in an acceptable manner
- Antibiotics were given as a treatment for pain and infection at UR6 on several occasions, for which no justification was recorded
- Radiographs were not taken, or when taken, did not comply with IRMER regulations.

Mr Nikolov treated Patient B for three appointments over a two and a half month period, during which time it was noted that:

- Clinical records were incomplete
- One appointment was not recorded at all
- Informed consent to treatment was not obtained/recorded
- Treatment plans were not recorded
- A periapical radiograph of UR3 was not taken when it was indicated to do so
- Mr Nikolov did not respond adequately or at all to the pain experienced by the patient during the removal of the crown at UR3.
- During the removal of the crown at UR3 Mr Nikolov spoke to the patient in a manner which did not accord her dignity and respect
- Mr Nikolov did not respond to Patient B's complaint.

The Committee has had regard to the professional standards applicable over the period in question, including the following paragraphs from 'Standards for Dental Professionals (May 2005)':

1.1 Put patients' interests before your own or those of any colleague, organisation or business.

1.3 Work within your knowledge, professional competence and physical abilities. Refer patients for a second opinion and for further advice when it is necessary, or if the patient asks. Refer patients for further treatment when it is necessary to do so.

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

1.5 Give patients who make a complaint about the care or treatment they have received a helpful response at the appropriate time. Respect the patient's right to complain. Make sure that there is an effective complaints procedure where you work and follow it at all times. Co-operate with any formal inquiry into the treatment of a patient.

2.1 Treat patients politely and with respect, in recognition of their dignity and rights as individuals.

2.4 Listen to patients and give them the information they need, in a way they can use, so that they can make decisions.

The Committee has also had regard to the following principles from *'*Standards for the Dental Team' (September 2013):

1 Put patients' interests first

2 Communicate effectively with patients

3 Obtain valid consent

Professor Morganstein (the GDC's expert witness) was critical of Mr Nikolov's failures in this case. He considered that many of the shortcomings identified in Mr Nikolov's care of Patients A and B amounted to a falling far below the standards expected of a registered dentist. The Committee agrees. There were multiple failings in Mr Nikolov's clinical practice, covering a wide range of basic areas of dentistry, including treatment planning, record keeping, radiographic practice and obtaining informed consent. These failings persisted over a protracted period of time, during which Mr Nikolov consistently failed to provide an adequate standard of care to Patients A and B. In addition to the clinical failings, the Committee takes a serious view of Mr Nikolov's failure to manage the pain and distress experienced by Patient B during the removal of the crown at UR3 and his unprofessional manner towards her on that occasion. Patient B recollected that Mr Nikolov spoke to her in a sarcastic manner following the removal of the crown. Mr Nikolov never directly responded to Patient B's complaint; his failure to do so contravenes the GDC's guidance that dentists should provide patients with a prompt and constructive response.

Having considered Mr Nikolov's acts and omissions, the Committee has concluded that they were serious. It is therefore satisfied that the facts found proved in this case amount to misconduct.

Impairment

The Committee next considered whether Mr Nikolov's fitness to practise is currently impaired as a result of that misconduct.

You submitted that Mr Nikolov's fitness to practise is currently impaired. You referred to the multiple deficiencies and failings identified in this case as well as the absence of evidence to demonstrate remediation or insight. You therefore submit that the risk of repetition of the failings identified in this case remain. You also invited the Committee to reach a finding of current impairment in the wider public interest, which includes upholding the reputation of the profession and the declaring and upholding of proper standards of conduct and competence.

The Committee has carefully considered the submissions made. It has received no submissions or evidence from Mr Nikolov, noting that he has chosen not to engage in these proceedings. It has exercised its own independent judgement.

The Committee first considered whether the deficiencies in Mr Nikolov's practice are capable of being remedied, whether they have in fact been remedied, and whether they are likely to be repeated. The Committee is satisfied that Mr Nikolov's clinical deficiencies are potentially remediable. However, it has received no evidence of Mr Nikolov's attempts to remediate the deficiencies in his practice nor of his insight into the shortcomings of his treatment of Patients A and B. In these circumstances the Committee cannot be satisfied that Mr Nikolov no longer poses a risk to patients. In the Committee's view, there is a risk of Mr Nikolov repeating his behaviour and therefore a finding of current impairment is necessary for the protection of patients.

The Committee has also borne in mind the wider public interest, including the need to declare and uphold proper standards of conduct and behaviour, in order to maintain public confidence in the profession. The Committee has found proved that Mr Nikolov has breached the GDC's standards. He failed to provide an appropriate standard of care to Patients A and B, resulting in demonstrable harm to them. In these circumstances, the Committee considers that public confidence in the profession would be undermined if a finding of impairment were not made, especially where evidence of remediation is non-existent.

Having regard to all of these matters, the Committee has determined that Mr Nikolov's fitness to practise is currently impaired by reason of his misconduct.

Sanction

The Committee has considered what sanction, if any, to impose on Mr Nikolov's registration. 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 has taken into account the 'Guidance for the Practice Committees including Indicative Sanctions Guidance (effective from October 2015)'. It has considered the range of sanctions available to it, starting with the least serious. The Committee has applied the principle of proportionality, balancing the public interest with Mr Nikolov's own interests.

You submitted that suspending Mr Nikolov's registration for a period of nine months would be the appropriate and proportionate sanction in this case.

The Committee has taken into account the mitigating and aggravating features of this case. In mitigation, it has borne in mind that Mr Nikolov has no previous fitness to practise history. The aggravating factors include that Mr Nikolov caused harm to Patients A and B and the absence of any evidence of remediation, remorse or insight.

The Committee has determined that it would be inappropriate to conclude this case without taking any action in respect of Mr Nikolov's registration. It reached the same conclusion in respect of a reprimand. These courses of action would not adequately reflect the serious nature of Mr Nikolov's misconduct and the ongoing risk to patient safety. Nor would they satisfy the public interest in this case.

The Committee next considered the imposition of conditions on Mr Nikolov's registration, bearing in mind that any conditions must be proportionate, measurable and workable. The Committee has had regard to the fact that the clinical failings in this case, which concern two patients, are potentially remediable. On the face of it, this is a case where Mr Nikolov's deficiencies could be addressed by conditions on his registration. However, the Committee has borne in mind the absence of any evidence of corrective steps he has taken, as well as his lack of engagement with the GDC in these proceedings. The Committee has concerns about Mr Nikolov's willingness to respond positively to conditional registration, which it considers is an essential basis upon which conditions can be imposed. In all the circumstances, the Committee is not satisfied that conditions will adequately protect the public and the public interest.

Accordingly, the Committee directs that Mr Nikolov's registration be suspended. It considers that this sanction is necessary for the protection of the public and that public confidence in the profession would be insufficiently protected by a lesser sanction. It considers that the findings against Mr Nikolov are serious and that the sanction of suspension is proportionate to the findings against him. The Committee considered the sanction of erasure but decided that it would be disproportionate, given the nature of the misconduct in this case and that Mr Nikolov has no previous fitness to practise history.

The Committee directs that Mr Nikolov's registration be suspended for a period of twelve months. In reaching its decision, the Committee considers that Mr Nikolov will need time to develop insight into his failings and for him to embark on a path of remediation Accordingly, the Committee is satisfied that a period of twelve months is appropriate and proportionate.

A Committee will review Mr Nikolov's case at a resumed hearing to be held shortly before the end of the period of suspension. That Committee will consider what action it should take in relation to Mr Nikolov's registration. It may be assisted by evidence of sustained and targeted CPD specifically designed to address the deficiencies in his practice identified in this case, in particularly in relation to examination, diagnosis, treatment planning, radiographic practice, communication with patients and record keeping. Mr Nikolov will be informed of the date and time of that resumed hearing.

The Committee now invites submissions from you as to whether Mr Nikolov's registration should be suspended immediately."

"Decision on immediate order

Mr Evans: Having directed that Mr Nikolov's registration be suspended, the Committee has considered whether to impose an order for immediate suspension in accordance with Section 30(1) of the Dentists Act 1984. In so doing, it has had regard to the GDC's 'Guidance for the Practice Committees including Indicative Sanctions Guidance' (October 2015).

You, on behalf of the General Dental Council (GDC), have submitted that an order for immediate suspension is necessary in light of the nature of the Committee's findings at stage two. During the course of your submissions you referred to the relevant considerations a Committee should take into account in determining whether to impose an order for immediate suspension, as set out in the relevant paragraphs of the GDC's 'Guidance for the Practice Committees including Indicative Sanctions Guidance' (October 2015).

In accordance with Section 30 of the Dentists Act 1984 the Committee has determined that it is necessary for the protection of the public and is in the public interest to order that Mr Nikolov's registration be suspended forthwith. In reaching its decision, the Committee is satisfied that Mr Nikolov poses a risk to patients for the reasons set out in its determination at stage two. It is satisfied that it would be inconsistent to allow Mr Nikolov to continue to practise during the intervening appeal period.

The effect of this direction is that Mr Nikolov's registration will be suspended immediately. Should Mr Nikolov exercise his right of appeal, this immediate order for suspension will remain in place until the resolution of any appeal.

The interim order of suspension on Mr Nikolov's registration is hereby revoked.

That concludes the case."

At a review hearing on 21 April 2017 the Chairman announced the determination as follows:

"Mr Keating

This is the resumed Professional Conduct Committee (PCC) hearing of Mr Nikolov's case.

Service of Notice of Hearing

Mr Nikolov was not in attendance nor was he represented at this review hearing today.

The Committee saw a copy of the Notification of Resumed Hearing dated 10 March 2017 that was sent to Mr Nikolov's registered address via Special Delivery, First Class Post and email.

It saw a printout from the Royal Mail Track and Trace website service which stated that delivery was attempted but the item was returned to sender.

The Committee was satisfied that notification of the hearing had been effected in accordance with Rules 28 and 65.

Proceeding in the absence of Mr Nikolov

The Committee then considered whether to exercise its discretion to proceed in the absence of Mr Nikolov. It bore in mind that its discretion to proceed had to be exercised with the utmost care and caution. It balanced the interests of Mr Nikolov against the public interest in the expeditious disposal of this matter. It is aware that the current order will expire on 10 May 2017.

The Committee has noted that although Mr Nikolov has not responded to the notice of hearing, he has downloaded the GDC email which contains the notice of hearing on 10 March 2017.

The Committee noted that Mr Nikolov had made no request for an adjournment. It was satisfied that he had been furnished with all of the relevant information to allow him to participate in the hearing. It was satisfied that he was afforded the opportunity to be present and had chosen voluntarily to absent himself. It determined that there was a pressing public interest in proceeding, bearing in mind the imminent expiry of the order.

The Committee therefore determined that it was fair and reasonable to proceed with the hearing notwithstanding Mr Nikolov's absence.

Background

On 8 April 2016 the PCC found that Mr Nikolov's care of Patients A and B amounted to a falling far below the standards expected of a registered dentist. There were multiple failings in Mr Nikolov's clinical practice, covering a wide range of basic areas of dentistry, including treatment planning, record keeping, radiographic practice and obtaining informed consent. These failings persisted over a protracted period of time, during which Mr Nikolov consistently failed to provide an adequate standard of care to Patients A and B.

The PCC determined that the facts found proved against Mr Nikolov amounted to misconduct. That Committee found that his fitness to practise was currently impaired and suspended his registration for a period of 12 months.

Decision on review

Today this Committee has undertaken a review. It took account of the submissions put forward by the GDC and all of the material before it. It accepted the advice of the Legal Adviser.

Impairment

The Committee considered whether Mr Nikolov's fitness to practise remains currently impaired by reason of his misconduct.

As was stated at the initial hearing, that Committee took a serious view of Mr Nikolov's multiple clinical failings which exposed both patients to risk of harm.

The Committee notes that the GDC wrote to Mr Nikolov on 18 April, 10 August, and 9 December 2016, as well as on 23 February 2017 reminding him of the evidence that the initial Committee suggested he put together prior to this review in order to assist this Committee in reaching its decision. Mr Nikolov did not respond to any of these letters.

At this review, the onus is on Mr Nikolov to demonstrate that he has addressed the concerns identified.

Mr Nikolov has submitted no evidence of insight into the seriousness of his misconduct or of remediation. The Committee has seen no evidence of continuing professional development, no reflective documentation, nor any evidence relating to courses or other activity in relation to ethics or professionalism.

The Committee therefore takes the view that there remains a risk of repetition of Mr Nikolov's misconduct.

The Committee has further concluded that a finding of current impairment remains necessary in order to declare and uphold proper professional standards and to maintain public confidence in the profession. The Committee has therefore determined that Mr Nikolov's fitness to practise remains impaired.

Sanction

The Committee sought to determine what action to take in relation to Mr Nikolov's registration. It bore in mind that the purpose of a sanction is not to be punitive, but rather to protect patients and the wider public interest.

It first considered whether to revoke the order of suspension and take no further action. In the light of the seriousness of the findings made against Mr Nikolov, the Committee decided that it would be inappropriate to revoke the order and conclude the case with no action. This would not provide the public with any protection from the risk of harm.

The Committee considered whether to revoke the order of suspension and replace it with one of conditional registration. It noted Mr Nikolov's total lack of engagement with the GDC in relation to this matter. He has produced none of the evidence suggested by the initial Committee and has demonstrated no insight. The Committee determined that conditional registration would therefore not be appropriate. It considered that no conditions could be formulated which would be sufficiently workable, practicable and measurable and which would address the identified failings in this case. In particular, no conditions could assist Mr Nikolov's development of full insight and reflection upon his conduct in any meaningful way.

The Committee has determined that an extension of the order of suspension for the maximum period of 12 months is necessary for the protection of patients and will serve to safeguard public confidence in the profession and uphold standards. This period of time will also provide Mr Nikolov with the opportunity to demonstrate insight and remediation and to undertake appropriate CPD activities.

The order is imposed for 12 months from the date at which the current order would otherwise expire and will be reviewed shortly before the end of that period.

A Committee will review Mr Nikolov's case at a resumed hearing to be held shortly before the end of the period of suspension. That Committee will consider what action it should take in relation to Mr Nikolov's registration. It may be assisted by evidence of sustained and targeted CPD specifically designed to address the deficiencies in his practice identified in this case, in particularly in relation to examination, diagnosis, treatment planning, radiographic practice, communication with patients and record keeping. Mr Nikolov will be informed of the date and time of that resumed hearing.

This Committee did not have the power to impose an indefinite order of suspension, although the next reviewing Committee will have such a power.

That concludes the case for today."

At a review hearing on 26 April 2018 the Chairman announced the determination as follows:

"This is the resumed Professional Conduct Committee (PCC) hearing of the case of Todor Nenkov Nikolov.

Decision on service of notice of hearing

Neither party was present at today's hearing following a request by the General Dental Council (GDC) for this matter to be heard on the papers. The Committee first considered whether notice of this hearing had been served on Mr Nikolov in accordance with Rules 28

and 65 of the *General Dental Council (Fitness to Practise) Rules Order of Council* 2006 (the rules).

The Committee has received a bundle of documents which contains a copy of the notification of today's review hearing, dated 28 March 2018, that was sent to Mr Nikolov's registered address by special delivery and by email. The Committee was satisfied that the letter contained proper notification of today's hearing, including its time, date and location, as well as notification that the Committee has the power to proceed with the hearing in Mr Nikolov's absence.

The Committee also had sight of the extract from the Royal Mail Track and Trace service, regarding the notice of hearing. This shows that the item was delivered and signed for on 3 April 2018.

Accordingly, the Committee concluded that the notice of this hearing was served on Mr Nikolov in accordance with the rules.

Decision on proceeding with the hearing on the papers

Mr Nikolov has not responded to the notification, nor has he engaged with the GDC in respect of this matter.

The Committee had sight of written submissions from the GDC, dated 18 April 2018, requesting that the Committee consider this review on the papers and confirming that a continuation of the substantive order of suspension is sought.

The Committee was satisfied that it was appropriate to proceed in the absence of both parties. It considered that no purpose would be achieved by adjourning the hearing to give the registrant a further opportunity of attending. It took into account the need to review this substantive order. It was therefore satisfied that it was appropriate to review the order on the basis of the papers before it.

Background

On 8 April 2016 the PCC found that Mr Nikolov's care of Patients A and B fell far below the standards expected of a registered dentist. There were multiple failings in Mr Nikolov's clinical practice, covering a wide range of basic areas of dentistry, including treatment planning, record keeping, radiographic practice and obtaining informed consent. These failings persisted over a protracted period of time, during which Mr Nikolov consistently failed to provide an adequate standard of care to Patients A and B.

The PCC determined that the facts found proved against Mr Nikolov amounted to misconduct, that his fitness to practise was currently impaired and suspended his registration for a period of 12 months.

The matter was reviewed on 21 April 2017. Mr Nikolov did not attend the hearing, nor did he provide evidence of insight or remediation. The PCC determined that his fitness to practise remained impaired and imposed an order of suspension upon his registration for a further 12 months.

Decision on review

Today this Committee has undertaken a second review. It took account of the submissions put forward by the GDC and all of the material before it. It accepted the advice of the Legal

Adviser. The Committee noted that Mr Nokolov has not engaged, nor has he produced evidence of insight or remediation for its consideration.

Impairment

The Committee considered whether Mr Nikolov's fitness to practise remains currently impaired by reason of his misconduct.

At this review, the onus is on Mr Nikolov to demonstrate that he has addressed the concerns identified. The Committee notes that he has not responded to the GDC's correspondence requesting evidence and information relevant to this review.

Once again Mr Nikolov has submitted no evidence of insight into the seriousness of his misconduct or of remediation. The Committee has seen no evidence of continuing professional development, no reflective documentation, nor any evidence relating to courses or other activity in relation to ethics or professionalism.

The Committee therefore takes the view that there remains a risk of repetition of Mr Nikolov's misconduct.

The Committee has further concluded that a finding of current impairment remains necessary in order to declare and uphold proper professional standards and to maintain public confidence in the profession. The Committee has therefore determined that Mr Nikolov's fitness to practise remains impaired.

Sanction

The Committee sought to determine what action to take in relation to Mr Nikolov's registration. It bore in mind that the purpose of a sanction is not to be punitive, but rather to protect patients and the wider public interest.

It first considered whether to revoke the order of suspension and take no further action. In the light of the seriousness of the findings made against Mr Nikolov, the Committee decided that it would be inappropriate to revoke the order and conclude the case with no action as such an outcome would not provide the public with any protection from the risk of harm.

The Committee considered whether to revoke the order of suspension and replace it with one of conditional registration. It noted Mr Nikolov's continuing lack of engagement with the GDC in relation to this matter. He has produced none of the evidence suggested by the Committee and has demonstrated no insight. The Committee determined that conditional registration would therefore not be appropriate. It considered that no conditions could be formulated which would be sufficiently workable, practicable and measurable and which would address the identified failings in this case.

The Committee has determined that an order of suspension remains necessary in this case for the protection of patients and will serve to safeguard public confidence in the profession and uphold standards. In the light of Mr Nikolov's continued lack of engagement, the Committee has determined that the order of suspension be imposed for an indefinite period.

Mr Nikolov may apply for a review of this order after two years have elapsed.

That concludes the case for today."