HEARING PART-HELD IN PRIVATE

Professional Conduct Committee
Initial Hearing

25 to 29 November 2024

Name:	SINGH, Abhishek
Registration number:	105433
Case number:	CAS-200892

General Dental Council:	Sam Thomas, counsel Instructed by Nicole Meehan, IHLPS
Registrant:	Present Not represented

Fitness to practise:	Impaired by reason of misconduct
Outcome:	Erased with Immediate Suspension
Duration:	N/A
Immediate order:	Immediate suspension order

Committee members:	Margaret Woolf (Lay) (Chair) Hemash Shah (Dentist) Joshua Kelly (Dental Care Professional)
Legal adviser:	Nicola Gordelier
Committee Secretary:	Gareth Llewellyn

At this hearing the Committee made a determination that includes some private information. That information shall be omitted from this public version of the determination and the document marked to show where private material has been removed.

Determination on preliminary matters – 25 November 2024

Mr Singh

1. This is a hearing before the Professional Conduct Committee (PCC). The hearing is being held remotely using Microsoft Teams in line with the Dental Professionals Hearings Service's current practice.

2. You are present and are not represented. Sam Thomas of counsel, instructed by Nicole Meehan of the General Dental Council's (GDC's) In-House Legal Presentation Service (IHLPS), appears for the GDC.

The charge

3. The charge that you face at this hearing is as follows:

That being a registered dentist:

1. *Between 4 April 2019 and 08 January 2021 you failed to provide Patient A with an adequate standard of care in that at one or more appointment, you treated Patient A without the support of an appropriately trained member of the dental team, who was required to be present at all times that you were treating Patient A in a dental setting.*

2. *You failed to adequately assess the risks to Patient A's safety, treating Patient A without adequate support, as set-out at 1 above, in that there was an increased risk of:*

    a. *Choking;*

    b. *Hypochlorite accidents during root canal treatment;*

    c. *Complications during extraction; or*

    d. *Inefficient response to medical emergencies such as cardiac arrest.*

3. *On 1 June 2019 you extracted the lower left wisdom tooth (LL8) without obtaining informed consent in that you failed to discuss with Patient A:*

    a. *The general risks of wisdom tooth extraction;*

    b. *The heightened risk of inferior alveolar nerve damage;*

    c. *The risk of osteonecrosis of the jaw; and*

    d. *The option of referral to a specialist.*

4. *You failed to co-operate with an investigation conducted by the General Dental Council ("Council") in that:*

a. *Between 05 November 2021 and 25 October 2023 you failed to provide the Council with proof of your indemnity for the period of 04 April 2018 and 22 September 2020;*

b. *You did not provide the Council with patient records for your treatment of Patient A between 5 November 2021 and 11 October 2023.*

5. *You failed to maintain with the Council a correct and up-to-date registered address.*

6. *On 30 June 2023, you emailed the GDC to state that you worked at the Practice part-time between 2013 – 2017 and that the Practice had an NHS inspection but closed down to the Covid pandemic.*

7. *Your actions at charge 6 were:*

a. *Misleading*

b. *Dishonest, as you treated Patient A between 2019 to 2021.*

8. *On 25 October 2023 you left a voicemail message for the GDC stating that the Practice was closed and that there was 'no access to any kind of records remaining, otherwise I would have sent them months ago'.*

9. *Your actions in relation to charge 8 was:*

a. *Misleading*

b. *Dishonest, in that you knew you were the owner of the Practice and could access Patient A's records.*

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

Hearing to be part-held in private

4. At the outset of the hearing Mr Thomas on behalf of the GDC invited the Committee to hold part of the hearing in private in accordance with Rule 53 of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules'). Mr Thomas made the application for the purposes of protecting your private and family life. You supported the application. Having accepted the advice of the Legal Adviser, the Committee determined to accede to the application in order to protect your private and family life.

Admissions

5. You tendered admissions to some of the heads of charge that you face. The heads of charge were, namely, heads of charge 1, 2 (a), 2 (c), 3 (d), 4 (b), 5, 6, 7 (a) and 8. The Committee, having accepted the advice of the Legal Adviser, determined and announced that the facts alleged at those heads of charge were proven on the basis of your admissions in accordance with Rule 17 (4) of the Rules.

6. During the course of the GDC's case on the facts, you tendered a further admission to another head of charge that you face, namely head of charge 4 (a). The Committee, having accepted the advice of the Legal Adviser, determined and announced that the facts alleged

at that further head of charge were proved on the basis of your admission.

Findings of fact – 28 November 2024

Background to the case

7. The allegations giving rise to this hearing relate to your care and treatment of a patient, who is referred to for the purposes of these proceedings as Patient A, as well as to your co-operation with a GDC investigation into your fitness to practise. Key appointments are referred to below.

8. Patient A is described as being a family friend of yours, with social connections and ties to your family. Patient A attended a number of appointments with you in relation to the pain with which she presented. Patient A initially attended for treatment with you on 4 April 2019 following a filling coming loose on her lower left back molar (LL8). You replaced the filling.

9. On 30 April 2019 you provided root canal therapy (RCT) treatment at the patient's lower left wisdom tooth (LL8) following her complaints of pain. After that treatment Patient A informed you that she was in increased pain and that she may have suffered nerve injury.

10. Patient A continued to experience pain, and reported the continuation of her pain to you.

11. On 1 May 2019 you provided RCT at the adjacent tooth, namely the LL7. On 6 May 2019 you re-cleaned the LL7 and applied a temporary filling in an effort to help Patient A's pain. You filed down the tooth on 16 May 2019. On 20 and 23 May 2019 you filed down Patient A's two RCT-treated teeth, namely LL7 and LL8, as part of your efforts to relieve Patient A's ongoing pain. On 27 May 2019 you again filed down Patient A's RCT-treated LL8.

12. On 29 May 2019 you saw Patient A and re-cleaned the temporary RCT at the patient's LL8 and applied a temporary filling at that tooth. Patient A asked you to refer her for a neurological assessment, having previously asked for a referral to another clinic or to a dental hospital. On 1 June 2019 you extracted the patient's LL8 in an effort to relieve the ongoing pain that Patient A continued to report to you. On 6 June 2019 Patient A was seen by a facial pain consultant at a local dental hospital, and on the following day was diagnosed with trigeminal neuralgia.

Summary of allegations

13. It is specifically alleged that, between 4 April 2019 and 8 January 2021 you failed to provide an adequate standard of care to Patient A, in that, at one or more appointments, you treated Patient A in the absence of an appropriately trained member of the dental team who was required to be present at all such times. It is further alleged that that you failed to adequately assess the risks to Patient A's safety, in that there were increased risks of choking, hypochlorite accidents during RCT, complications during extraction, and an inefficient response to medical emergencies such as cardiac arrest, associated with not having another appropriately trained member of the dental team working alongside you. The GDC also contends that you failed to obtain informed consent for the extraction of Patient A's lower left wisdom tooth (LL8) at an appointment that took place on 1 June 2019, in that you did not discuss a number of risks and other treatment options with Patient A.

14. The GDC also brings allegations against you in relation to your engagement with the GDC as part of its investigation of concerns about your fitness to practise.

15. It is alleged that you failed to co-operate with the GDC's investigation by failing to provide the GDC with proof of your indemnity insurance arrangements covering the period of 4 April 2018 to 22 September 2020, and failed to provide the GDC with Patient A's dental records. It is further alleged that you failed to keep your registered address up to date.

16. It is also contended that, on 30 June 2023, you contacted the GDC to state that you worked at the practice on a part-time basis between 2013 and 2017, and that the practice had had an NHS inspection but closed down due to the COVID-19 pandemic. The GDC alleges that this information was misleading, and was also dishonest, in that you had in fact treated Patient A between 2019 and 2021.

17. The GDC further alleges that on 25 October 2023 you again contacted the GDC and stated that the practice was closed, and that you had no access to any records. The GDC submits that this statement was again misleading, and was also dishonest, in that you knew that you were the owner of the practice and could access Patient A's records.

Evidence

18. The Committee has been provided with documentary material in relation to the heads of charge that you face, including the witness statements and documentary exhibits of Patient A; those of a caseworker in the GDC's Fitness to Practise (FtP) team with knowledge of the case; those of a paralegal in the GDC's In-House Legal Presentation Service (IHLPS), who also has knowledge of the case; and the report of an expert witness instructed by the GDC, namely Edward Bateman. In addition, the Committee was provided with the medical records of Patient A. The Committee also received some incomplete dental records relating to Patient A. These dental records were provided to the GDC by Patient A and Patient A's subsequent treating dentist. The only dental records that the Committee has been provided with in relation to the care and treatment that you provided to her consist of images of digital radiographs. The Committee also received documentary evidence from you in the form of photographs and email exchanges.

19. The Committee heard oral evidence from Patient A and Mr Bateman.

Committee's findings of fact

20. The Committee has taken into account all the evidence presented to it, both written and oral. It has considered the submissions made by Mr Thomas on behalf of the GDC and those made by you. The Committee received written submissions from you dated 26 and 27 November 2024, and also heard your supplementary oral submissions. For the avoidance of doubt, although you address the allegations set out in the heads of charge that you face in your written submissions, as well as in your previous written responses, the Committee noted that that information was not given as evidence, as it was not sworn or tested, and was instead given by way of submission.

21. The Committee has had regard to the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016, updated December 2020).

22. The Committee has accepted the advice of the Legal Adviser concerning the principles to which it should have regard. The Committee took into account the direction of the Legal Adviser that you are of good character. The Committee is mindful that the burden of proof lies with the GDC, and has considered the heads of charge against the civil standard of proof, that is to say, the balance of probabilities. The Committee has considered each head of charge separately, although some of its findings will be announced together.

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

1.	*Between 4 April 2019 and 08 January 2021 you failed to provide Patient A with an adequate standard of care in that at one or more appointment, you treated Patient A without the support of an appropriately trained member of the dental team, who was required to be present at all times that you were treating Patient A in a dental setting.* **Admitted and proved**
2.	*You failed to adequately assess the risks to Patient A's safety, treating Patient A without adequate support, as set-out at 1 above, in that there was an increased risk of:*
2. (a)	*Choking;* **Admitted and proved**
2. (b)	*Hypochlorite accidents during root canal treatment;* **Not proved**
	The Committee finds the facts alleged at head of charge 2 (b) not proved. The expert evidence of Mr Bateman is that accidents can occur when using hypochlorite, a disinfecting agent commonly used in RCT. The GDC's case is that the absence of adequate support from another appropriately trained member of the dental team increased the risk of a hypochlorite accident occurring, and that you therefore failed to adequately assess the risks to Patient A's safety. In your written submissions dated 27 November 2024 you stated that you do not use hypochlorite unless it is safe to do so, and that when using it you use it in conjunction with rubber dam. You stated that if that arrangement is not feasible you use saline solution only with mechanical debridement, a chelating agent, namely ethylenediaminetetraacetic acid (EDTA), and ultrasonics. You also stated that you saw Patient A as an emergency patient to relieve her pain. You stated that you commenced RCT purely to relieve that pain and to avoid the escalation of infection. You deny that risks arose from this manner of treatment. The Committee considers that the GDC has not demonstrated to the required standard that you did as a matter of fact use hypochlorite during RCT as alleged. As the Committee is not satisfied that the evidence is sufficient to demonstrate that hypochlorite was used, it follows that it cannot find that there was a risk of hypochlorite accidents associated with its use. Accordingly, the Committee finds the facts alleged at head of charge 2 (b) not proved.
2. (c)	*Complications during extraction; or* **Admitted and proved**
2. (d)	*Inefficient response to medical emergencies such as cardiac arrest.*

	Proved
	The Committee finds the facts alleged at head of charge 2 (d) proved. The expert evidence of Mr Bateman is that medical emergencies such as cardiac arrest, whilst rare, can occur during treatment. The GDC's case is that the absence of adequate support from another appropriately trained member of the dental team increased the risk of an inefficient response to such a medical emergency, and that you therefore failed to adequately assess the risks to Patient A's safety. In your written submissions dated 27 November 2024 you stated that a non-dental team member 'was at times present' in case of any medical emergencies, in that there was a treatment spa on the premises with basic life support (BLS)-trained personnel, and that in addition there was access to an adjacent medical practice. You also stated that you saw Patient A to attempt 'emergency care' in an effort to relieve the pain that she was experiencing. In your previous response to the allegations dated 15 October 2024 you stated that you 'felt guilty and responsible to help patients who contacted me between 2019/2021', and that you 'did not do active treatments but did meet/reassure any previous patients'. In your written submissions of 27 November 2024 you stated that you saw Patient A 'to ease her dental emergency as a genuine helping gesture but this doesn't equate to working regularly / doing clinical sessions'. The Committee notes that it is accepted that you did not treat Patient A when another appropriately trained member of the dental team, such as a dental nurse, was present. The Committee is mindful of the GDC's *Standards for the Dental Team* (September 2013), and in particular standards 6.2.2, 6.2.3 and 6.2.6, which state: *'6.2.2 You should work with another appropriately trained member of the dental team at all times when treating patients in a dental setting. The only circumstances in which this does not apply are when:* • *treating patients in an out of hours emergency* • *providing treatment as part of a public health programme, or* • *there are exceptional circumstances.* *'Exceptional circumstances' are unavoidable circumstances which are not routine and could not have been foreseen. Absences due to leave or training are not exceptional circumstances.* *6.2.3 If there are exceptional circumstances which mean you cannot work with an appropriately trained member of the dental team when treating a patient in a dental setting, you must assess the possible risk to the patient of continuing treatment.* *6.2.6 Medical emergencies can happen at any time. You must make sure that there is at least one other person available within the working environment to deal with medical emergencies when you are treating patients. In exceptional*

	circumstances the second person could be a receptionist or a person accompanying the patient.' The Committee considers that the circumstances in which you treated Patient A were not exceptional, and that the alternative recourses to assistance that you would have relied on as summarised above were not sufficient to deal with any medical emergencies that might have occurred. The Committee also does not consider that your treatment of Patient A was a one-off emergency, given that you treated her on a number of occasions over a protracted period of time. The Committee considers that your treatment of Patient A without another appropriately trained member of the dental team increased the risks to Patient A in relation to medical emergencies, and that your conduct amounted to a failure to properly assess those risks. The Committee therefore finds the facts alleged at head of charge 2 (d) proved.
3.	*On 1 June 2019 you extracted the lower left wisdom tooth (LL8) without obtaining informed consent in that you failed to discuss with Patient A:*
3. (a)	*The general risks of wisdom tooth extraction;* **Not proved**
3. (b)	*The heightened risk of inferior alveolar nerve damage;* **Proved**
3. (c)	*The risk of osteonecrosis of the jaw; and* **Not proved**
	The Committee finds the facts alleged at heads of charge 3 (b) proved, and the facts alleged at heads of charge 3 (a) and 3 (c) not proved. Patient A's evidence is that you informed Patient A that extraction of her LL8 was the only option to relieve her pain, and that, in relation to any further discussions that you had with her prior to the extraction, including postoperative advice, you provided her with advice about postoperative pain relief and diet. When questioned as part of her oral evidence to the Committee Patient A was not able to recall whether a discussion of the risk of osteonecrosis of the jaw took place on 1 June 2019, but that she does recall discussion of that specific matter on another occasion or occasions. Patient A stated that she did not think that the matters referred to at head of charge 3 (a), namely the general risks of wisdom tooth extraction, were discussed on 1 June 2019 or on any other occasion, but she was not able to be sure. Patient A however was adamant that you did not discuss the heightened risk of inferior alveolar nerve damage with her as alleged at head of charge 3 (b). The expert evidence of Mr Bateman in respect of the allegations set out at heads of charge 3 (a), 3 (b) and 3 (c) is that, in order for informed consent to have been obtained, there should have been a discussion of the general risks and benefits of the treatment that was proposed, including the possibility of pain, swelling, bleeding and damage to nearby teeth, and nerve damage. Further, Mr Bateman

opines that Patient A was at a particularly high risk of nerve damage, as demonstrated by radiographic examination of the canal around the apex of Patient A's LL8. In addition, Mr Bateman refers to Patient A's existing medical condition and suggests that that condition made her more susceptible to osteonecrosis.

Mr Bateman's view is that these general and specific risks should have been discussed with Patient A so that informed consent could be obtained. Mr Bateman opined that such discussions should have taken place at the point at which the decision was taken to proceed with treatment, and that he would have expected a repeat discussion when the tooth was extracted on 1 June 2019 following those prior discussions.

In your written submissions dated 27 November 2024 you stated that you had several discussions with Patient A prior to extracting her LL8, which included a discussion of the risks and benefits of osteonecrosis, RCT, extraction, implants, bone grafting and bridgework. You stated that, to your memory, you 'definitely' discussed all aspects of treatment and follow-up care, and that you did your best to communicate and check on the wellbeing of Patient A after treatment. You also stated that it is your routine practice to discuss post-extraction problems and the risk of nerve damage, but you accept in hindsight that a referral to a specialist because of Patient A's increased risk of osteonecrosis of the jaw was 'the optimal treatment choice'. You stated that you do take on difficult extractions so that patients do not suffer from delays.

The Committee accepts the expert evidence of Mr Bateman that, in order for informed consent to be obtained for the treatment that you provided, you were under a duty to discuss with Patient A the general risks of wisdom tooth extraction, the heightened risk of inferior alveolar nerve damage, and the risk of osteonecrosis of the jaw. The Committee then went on to determine whether, as a matter of fact, those conversations took place.

In relation to head of charge 3 (a), the Committee notes the evidence of Patient A that such a discussion of the general risks of wisdom tooth extraction did not take place, although she was not able to be sure, and also notes your account that such discussions did take place, and that they took place as a matter of your routine practice. The Committee considers that the GDC has not demonstrated to the standard required that you did not discuss the general risks of wisdom tooth extraction. The Committee noted that Patient A was not able to be precise about whether there was such a discussion, and that which she does recall discussing, namely matters relating to postoperative issues, suggests to the Committee that, as you maintain, a wide-ranging discussion about extraction is likely to have taken place. The Committee also accepts your account that it was your general practice to discuss such risks with patients. The Committee therefore finds the facts alleged at head of charge 3 (a) not proved.

In relation to head of charge 3 (b), the Committee notes the evidence of Patient A that she is certain that you did not discuss the heightened risk of inferior alveolar nerve damage with her. The Committee noted your account that you would ordinarily discuss the risks of nerve damage with patients, but it notes that you did not suggest that you had done so in this particular case. The Committee accepts as credible and reliable the evidence of Patient A on this point, and therefore finds the facts alleged at head of charge 3 (b) proved.

	In relation to head of charge 3 (c), the Committee considers that the GDC has not demonstrated to the required standard that you did not discuss the risk of osteonecrosis of the jaw prior to extracting Patient A's LL8. The Committee notes that Patient A's evidence agrees with your account, in that you and Patient A concur that discussion of this particular risk did take place. The Committee therefore finds the facts alleged at head of charge 3 (c) not proved.
3. (d)	*The option of referral to a specialist.* **Admitted and proved**
4.	*You failed to co-operate with an investigation conducted by the General Dental Council ("Council") in that:*
4. (a)	*Between 05 November 2021 and 25 October 2023 you failed to provide the Council with proof of your indemnity for the period of 04 April 2018 and 22 September 2020;* **Admitted and proved**
4. (b)	*You did not provide the Council with patient records for your treatment of Patient A between 5 November 2021 and 11 October 2023.* **Admitted and proved**
5.	*You failed to maintain with the Council a correct and up-to-date registered address.* **Admitted and proved**
6.	*On 30 June 2023, you emailed the GDC to state that you worked at the Practice part-time between 2013 – 2017 and that the Practice had an NHS inspection but closed down to the Covid pandemic.* **Admitted and proved**
7.	*Your actions at charge 6 were:*
7. (a)	*Misleading* **Admitted and proved**
7. (b)	*Dishonest, as you treated Patient A between 2019 to 2021.* **Proved**
	The Committee finds the facts alleged at head of charge 7 (b) proved. In approaching this head of charge, the Committee applied the test set out in *Ivey v Genting Casinos (UK) Ltd. t/a Crockfords* [2017] UKSC 67. The test is that the Committee must decide subjectively the actual state of an individual's knowledge or belief as to the facts, and must then apply the objective standards of ordinary

	and decent people to determine whether their conduct was dishonest by those standards. In your written submissions you stated that you did not intend to mislead, and you denied that you acted in a dishonest manner. You stated that you were the owner of, and worked part-time as the sole practitioner at, your practice from 2013 until its closure in December 2017. You stated that the practice was closed with the intention of it reopening as an NHS practice. You stated that you subsequently attempted to arrange an NHS inspection of the practice so that it could be reopened as a new dental practice, but that the COVID-19 pandemic and its associated lockdown restrictions prevented such a reopening. In your previous response to the allegations dated 15 October 2024 you stated that you 'felt guilty and responsible to help patients who contacted me between 2019/2021', and that you 'did not do active treatments but did meet/reassure any previous patients'. In your written submissions of 27 November 2024 you stated that you saw Patient A 'to ease her dental emergency as a genuine helping gesture but this doesn't equate to working regularly / doing clinical sessions'. IN PRIVATE [text omitted]. IN PUBLIC The GDC submits that your statement was dishonest, in that you treated, and knew that you had treated, Patient A at the practice premises between 2019 and 2021. In accordance with the legal test set out above, the Committee first considered the actual state of your knowledge or belief as to the facts when emailing the GDC on 30 June 2023. The Committee finds that your actual knowledge and belief at that time was that you knew that you had treated Patient A at the practice on a number of occasions between 2019 and 2021. The Committee considers that, by stating to the GDC that you had most recently worked at the practice in 2017, you misrepresented the situation concerning your treatment of Patient A. The Committee considers that you could not have been in any doubt that you had cared for and treated Patient A at your practice on a considerable number of occasions. Having determined your actual knowledge at the relevant time, the Committee went on to determine whether your conduct was dishonest by reference to the objective standards of ordinary and decent people. The Committee considers that your conduct was dishonest by reference to those objective standards. The Committee considers that ordinary and decent people would consider your statement to have been deliberately misleading, and intended to obfuscate the GDC's understanding of the circumstances of your practice, in particular relation to Patient A. For these reasons, the Committee finds the facts alleged at head of charge 7 (b) proved.

8.	*On 25 October 2023 you left a voicemail message for the GDC stating that the Practice was closed and that there was 'no access to any kind of records remaining, otherwise I would have sent them months ago'.* **Admitted and proved**
9.	*Your actions in relation to charge 8 was:*
9. (a)	*Misleading* **Proved**
9. (b)	*Dishonest, in that you knew you were the owner of the Practice and could access Patient A's records.* **Not proved**
	The Committee finds the facts alleged at head of charge 9 (a) proved, and the facts alleged at head of charge 9 (b) not proved. As set out above in respect of head of charge 7 (b), the Committee was mindful of the test set out in *Ivey v Genting Casinos (UK) Ltd. t/a Crockfords* [2017] UKSC 67. The test is that the Committee must decide subjectively the actual state of an individual's knowledge or belief as to the facts, and must then apply the objective standards of ordinary and decent people to determine whether their conduct was dishonest by those standards. In your written submissions of 26 November 2024 you denied that you acted in a dishonest manner, and that you did not intend to mislead. You stated that you were the owner of, and worked part-time as the sole practitioner at, your practice from 2013 until its closure in December 2017. You stated that patients' clinical records consisted of both paper-based records and digital radiographs. You stated that you boxed and stored the paper-based records in a separate storage garage, and that a water leak over a number of weeks caused damage to those stored and boxed records, with the damage being so serious that the contents were not salvageable and had to be disposed of. You stated that you attempted to arrange an NHS inspection of the practice so that it could be reopened as a new dental practice, but that the COVID-19 pandemic and its associated lockdown restrictions prevented such a reopening. In your previous response to the allegations dated 15 October 2024 you stated that you 'felt guilty and responsible to help patients who contacted me between 2019/2021', and that you 'did not do active treatments but did meet/reassure any previous patients'. In your written submissions of 27 November 2024 you stated that you did not have access to patient records which were stored in the garage, and that you had to ask family and friends to gain access to the garage. You also stated that in your voicemail message of 25 October 2023 you did not elaborate on the reasons for not being able to provide Patient A's records, that you accept that you should have done so, but you deny that you intended to mislead.

	You further stated in those written submissions of 27 November 2024 that you accept that you have a duty as a practice owner, including the owner of a closed practice, to keep patient records safe, and that the damage was beyond your control. You stated that you are not able to evidence your paper records for Patient A, and that there is no reason for you to lie about that matter. You stated that the digital records that you did have at the relevant time were shared with Patient A, and were later shared by her with the GDC. IN PRIVATE [text omitted]. IN PUBLIC The GDC submits that your statement was misleading, and was also dishonest, in that you were, and knew that you were, the owner of the practice, and that you could access and provide Patient A's records. The Committee accepts as plausible your account that paper-based records were destroyed as a result of water damage. Although you do not say so explicitly, the Committee infers from your representations of 27 November 2024 that this destruction included Patient A's records, as you state that the water damage affected 'all of the stored boxes' and that 'all of the contents had to be disposed [of] and were not salvageable'. The Committee was not entirely clear as to when the water damage happened, although it understands from the information that you have provided that it occurred subsequent to the closure of the practice, in December 2017. In relation to head of charge 9 (a), the Committee considers that actions in making the statement in question was misleading, in that you did not elaborate on why you could not access or provide any records, for instance because of the water damage that you state rendered the paper records unsalvageable. The Committee considers that your statement deprived the GDC of a proper understanding of the true situation pertaining to Patient A's records. Accordingly, the Committee finds that your actions in making this statement was misleading. The Committee therefore finds the facts alleged at head of charge 9 (a) proved. Having determined that your actions in making the statement were misleading, the Committee then turned to the question of whether it was also dishonest. The Committee reminded itself of the legal test set out above, namely that it must decide subjectively the actual state of an individual's knowledge or belief as to the facts, and must then apply the objective standards of ordinary and decent people to determine whether your conduct was dishonest by those standards. The Committee notes that the GDC's allegation of dishonesty is predicated on the contention that you could access Patient A's records. Therefore, before considering your actual state of knowledge and belief as to the facts, the Committee first considered whether you could indeed access Patient A's records. The Committee finds that the GDC has not demonstrated to the required standard that there were records in existence at that time that you were capable of accessing and providing. In oral submission Mr Thomas suggested that the position of the GDC is that it is more likely than not that there were no records made of your care of Patient A. The Committee notes that in your written

	submissions and earlier responses you have consistently stated that patient records, which as set out above the Committee infers included Patient A's records, had been destroyed as a result of water damage. As the Committee is not satisfied that you did have access to Patient A's records when you left the voicemail message, the issue of dishonesty falls away. It therefore finds the facts alleged at head of charge 9 (b) not proved.

24. We move to stage two.

Determination on misconduct, impairment and sanction – 29 November 2024

25. Following the handing down of the Committee's findings of fact on 28 November 2024, the hearing proceeded to stage two; that is to say, misconduct, impairment and sanction.

Proceedings at stage two

26. The Committee has considered all the evidence presented to it, both oral and documentary. It has taken into account the submissions made by Mr Thomas on behalf of the GDC and those made by you. In its deliberations the Committee has had regard to the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016, updated December 2020). The Committee has accepted the advice of the Legal Adviser concerning its powers and the principles to which it should have regard.

Documentary information at stage two

27. The Committee received further documentary information in relation to this second stage of the hearing. This includes the determinations of previous PCCs in relation to previous fitness to practise proceedings that were brought against you, and the determination of the Investigating Committee (IC) in relation to other concerns. These previous matters are referred to in more detail below. The Committee also received from you certificates of continuing professional development (CPD) that you have undertaken, and reviews and testimonials provided by patients, both online and by email.

Fitness to practise history

28. Mr Thomas addressed the Committee in relation to your fitness to practise (FtP) history in accordance with Rule 20 (1) (a) of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules'). That history is summarised as follows.

29. In March 2019 you appeared before the PCC in relation to concerns about the standard of care and treatment that you provided to a patient, your record-keeping of the appointments that you had with that patient, and your failure to respond adequately to the patient's complaint about your treatment. That Committee also found that you had acted in a misleading and dishonest manner, and in a manner that was lacking in integrity, in presenting notes that were not contemporaneous without indicating that they were not contemporaneous. That Committee determined that your fitness to practise was impaired by reason of the misconduct that arose from those factual findings, and that it would be appropriate to direct that you be made subject to a direction of conditional registration for a period of two years. That direction was reviewed by the PCC on 15 March 2021, with that reviewing Committee determining that your fitness to practise was no longer impaired. The extant conditions were revoked.

30. In addition, you were the subject of an unpublished warning made by the IC on 29 May 2014 following its consideration of allegations relating to your standard of care, record-keeping and probity.

Summary of submissions

31. Mr Thomas on behalf of the GDC submitted that the facts that the Committee has found proved amount to misconduct, and that your fitness to practise is currently impaired by reason of that misconduct. Mr Thomas submitted that a finding of impairment is further required in the wider public interest. Mr Thomas invited the Committee to direct that your name be erased from the register.

32. The Committee received further written submissions from you and also heard your supplementary oral submissions in response to the Committee's questions.

33. In your written submissions you stated that you have refocussed your practice on to general dental practice as an associate. You referred to improvements that have been made in your clinical practice, supported by a period of supervision and CPD.

34. In your supplementary oral submissions you stated that you engaged with the conditions that were imposed on your registration in connection with separate FtP proceedings. You stated that the process of remediation that commenced with those conditions has continued. You stated that you would now manage your care and treatment of Patient A in a markedly different way. You stated that, on reflection, the 'burden of social expectation' masked your identification of the appropriate care and treatment for Patient A.

35. You went on to express your apology for not engaging with the GDC as you should have, and that you have learnt from that. You stated that the personal matters referred to in the Committee's foregoing determination were a distraction. You reflected on the additional learning that you have undertaken, and you referred to a course on ethics which you attended in 2019. In relation to the Committee's findings of misleading and dishonest conduct, you stated that you were not trying to be difficult or to obfuscate, and that instead you did not at that time consider you seeing Patient A at your practice as routine practice at a place of work. You stated that you are now 'a changed person' and that you will not act dishonestly in the future. You asked the Committee for the opportunity to demonstrate your insight, and your improved clinical abilities and character, by continuing to practice. You stated that you would be 'proactive in following the [GDC's] standards and exceeding them'. You stated that, if there were to be a repeat of your disengagement from the GDC, you would ask for your name to be removed from the register.

Misconduct

36. The Committee first considered whether the facts that it has found proved at heads of charge 1, 2 (a), 2 (c), 2 (d), 3 (b), 4 (a), 4 (b), 5, 6, 7 (a), 7 (b), 8 and 9 (a) constitute misconduct. In considering this and all other matters, the Committee has exercised its own independent judgement.

37. In its deliberations the Committee has had regard to the following paragraphs of the GDC's *Standards for the Dental Team* (September 2013) in place at the time of the incidents giving rise to the facts that the Committee has found proved. These paragraphs state that as a dentist:

1.3 You must be honest and act with integrity.

1.4.2 You must provide patients with treatment that is in their best interests, providing appropriate oral health advice and following clinical guidelines relevant to their situation. You may need to balance their oral health needs with their desired outcomes. If their desired outcome is not achievable or is not in the best interests of their oral health, you must explain the risks, benefits and likely outcomes to help them to make a decision.

2.2.1 You must listen to patients and communicate effectively with them at a level they can understand. Before treatment starts you must:

- *explain the options (including those of delaying treatment or doing nothing) with the risks and benefits of each; and*
- *give full information on the treatment you propose and the possible costs.*

3.1 You must obtain valid consent before starting treatment, explaining all the relevant options and the possible costs.

3.3 You must make sure that the patient's consent remains valid at each stage of investigation or treatment.

6.2.2 You should work with another appropriately trained member of the dental team at all times when treating patients in a dental setting. The only circumstances in which this does not apply are when:

- *treating patients in an out of hours emergency*
- *providing treatment as part of a public health programme, or*
- *there are exceptional circumstances.*

'Exceptional circumstances' are unavoidable circumstances which are not routine and could not have been foreseen. Absences due to leave or training are not exceptional circumstances.

6.2.3 If there are exceptional circumstances which mean you cannot work with an appropriately trained member of the dental team when treating a patient in a dental setting, you must assess the possible risk to the patient of continuing treatment.

6.2.6 Medical emergencies can happen at any time. You must make sure that there is at least one other person available within the working environment to deal with medical emergencies when you are treating patients. In exceptional circumstances the second person could be a receptionist or a person accompanying the patient.

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

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

9.4.1 If you receive a letter from the GDC in connection with concerns about your fitness to practise, you must respond fully within the time specified in the letter. You should also seek advice from your indemnity provider or professional association.

38. The Committee's factual findings relate to your care and treatment of Patient A, and to your co-operation with the GDC. The Committee found that, between 4 April 2019 and 8 January 2021, you failed to provide an adequate standard of care to Patient A, in that, at one or more appointments, you treated Patient A in the absence of an appropriately trained member of the dental team who was required to be present at all such times. The Committee went on to find that you failed to adequately assess the risks to Patient A's safety, in that there were

increased risks of choking, complications during extraction, and an inefficient response to medical emergencies such as cardiac arrest, associated with not having another appropriately trained colleague with you. The Committee also found that you failed to obtain informed consent for your extraction of Patient A's lower left wisdom tooth (LL8) at an appointment that took place on 1 June 2019, in that you did not discuss the heightened risk of inferior alveolar nerve damage and the option of a referral to a specialist with Patient A.

39. The Committee has also found that you failed to co-operate with the GDC's investigation by failing to provide the GDC with proof of your indemnity insurance arrangements covering the period of 4 April 2018 to 22 September 2020, and failing to provide the GDC with Patient A's dental records. The Committee also found that you failed to keep your registered address up to date. The Committee also found that, on 30 June 2023, you contacted the GDC to state that you worked at the practice on a part-time basis between 2013 and 2017, and that the practice had had an NHS inspection but closed down due to the COVID-19 pandemic. The Committee determined that your actions in this regard were misleading, and were also dishonest, in that you had in fact treated Patient A between 2019 and 2021. Finally the Committee determined that on 25 October 2023 you again contacted the GDC and stated that the practice was closed, and that you had no access to any records. The Committee found that this statement was misleading.

40. In light of the findings of fact that it has made, the Committee has determined that those proven facts amount to misconduct.

41. The Committee considers that its factual findings about your clinical conduct placed Patient A at significant and unwarranted risk of harm. By not working with another appropriately trained member of the dental team, and by not obtaining Patient A's informed consent for the treatment that you provided, you failed to put patient safety first. In the Committee's judgement these clinical shortcomings are serious, and represent a falling far short of the standards reasonably to be expected of a registered dental professional. The Committee therefore finds that your clinical failings amounted to misconduct.

42. The Committee also considers that its other findings, relating as they do to your failure to co-operate with the GDC, including misleading and dishonest actions, also amount to misconduct. The Committee considers that the need to act with honesty and to co-operate appropriately with the GDC is a fundamental tenet of the profession. The Committee considers that your acts and omissions inhibited the GDC's ability to discharge properly its overarching regulatory responsibility to regulate the profession in an effective manner. Your compromising of these proper functions was liable to undermine the public's trust and confidence in the profession and in the regulatory process.

43. The Committee has therefore determined that the facts that it has found proved at heads of charge 1, 2 (a), 2 (c), 2 (d), 3 (b), 4 (a), 4 (b), 5, 6, 7 (a), 7 (b), 8 and 9 (a) amount to misconduct.

Impairment

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

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

46. The Committee considers that your misconduct arising from your clinical failings is in theory capable of being remedied, relating as it does to discrete and identifiable aspects of your practice. The Committee has had regard to the CPD that you have undertaken. In the Committee's judgement this learning does not demonstrate that you have adequately addressed the specific shortcomings that this Committee has identified. Whilst the Committee has had regard to the testimonials and reviews submitted about patients, these do not appear to demonstrate that you have improved your practice to the required extent in the specific areas of concern. The Committee is also mindful that these clinical shortcomings arose at a time when you were subject to conditions imposed as a result of separate FtP proceedings. In the Committee's judgement this suggests that it might be more difficult for you to remedy your clinical shortcomings, as the Committee would expect a registrant in such circumstances to be all the more likely to be practising to the required standard.

47. Whilst the Committee has taken careful account of your submissions and other information, the Committee considers that the information with which it has been provided suggests that you lack insight into your clinical failings. Your reflections focus on your own personal circumstances at the time, as well as the personal consequences for you of these and other regulatory proceedings. You have provided little in the way of detailed and considered reflections on the impact of the failings in your care and treatment of Patient A on her. In light of the shortcomings that the Committee has identified in respect of your insight and remediation, the Committee finds that you are liable to repeat your clinical failings, and that you therefore continue to pose a risk to the public. The Committee therefore finds that your misconduct in relation to its clinical findings mean that your fitness to practise is currently impaired.

48. The Committee also considers that the misconduct that it has found in relation to your co-operation with the GDC, including your misleading and dishonest conduct, means that your fitness to practise is impaired. Your conduct represents a persistent and repeated failure to co-operate with GDC over a period of almost two years. The Committee is mindful that such conduct is likely to be more difficult to remediate than the clinical failings referred to above, as it might be suggestive of an attitudinal or behavioural failing. The Committee finds that you have not remedied that misconduct. You have had a considerable period of time in which to develop and demonstrate your insight and remediation. The Committee has however been provided with little in the way of information to suggest that you have developed any significant insight into your conduct, or that you have taken steps to address and rectify your actions. Indeed, that which the Committee has received from you by way of your reflections relates more to the consequences that the GDC's proceedings, both historic and current, have had on you, with little mention of any understanding of how your conduct might affect the public's perception of the profession.

49. The Committee has received only limited information from you as to how you might act differently in the future, and attaches little weight to your assertion that you would not act in such a manner in the future. The Committee therefore considers that your misconduct is liable to be repeated. Its findings relate to a sustained and repeated failure to co-operate with the GDC, including an act of dishonesty, in relation to formal regulatory dealings and in connection with a patient. The Committee considers that a repeat of such conduct, which in its judgement cannot be said to be highly unlikely, might put the public at unwarranted risk of harm. Accordingly, the Committee finds that your fitness to practise is currently impaired in relation to its findings about your co-operation with the GDC.

50. The Committee considers that a finding of impairment is also, and undoubtedly, required to maintain public confidence in the profession and to declare and uphold proper professional standards of conduct and behaviour. Your actions were liable to have brought the reputation

of the profession into considerable disrepute. In the Committee's judgement the public's trust and confidence in the profession, and in the regulatory process, would be significantly undermined if a finding of impairment was not made given the nature of your misconduct, and particularly your misleading and dishonest conduct.

51. Accordingly, the Committee finds that your fitness to practise is currently impaired by reason of your misconduct.

Sanction

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

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

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

55. In respect of the mitigating factors that are present, the Committee notes the information that you have provided about your personal circumstances as referred to in its foregoing determination; that you made an apology to Patient A for her experience with you, and you also made an apology for your lack of co-operation with the GDC; that some time has elapsed since the clinical aspects of this case; and that your conduct did not bring about any, or any significant, financial gain.

56. In terms of aggravating factors, the Committee has reminded itself that your conduct placed Patient A at the risk of harm; that its findings include a finding of dishonest conduct, that you lack insight into your misconduct; that your failure to co-operate with the GDC represents a blatant and wilful disregard of the GDC which was sustained over a protracted period of time; and that you are the subject of previous adverse regulatory findings, including in relation to similar matters, namely dishonest conduct.

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

58. The Committee also considers that a direction of conditional registration would not be sufficient to meet the public protection and public interest considerations engaged in this case. The Committee considers that conditions could not be formulated to deal with the risks that it has identified, and in particular those that arise from your dishonest conduct. The Committee is also mindful that you are the subject of a previous PCC finding of dishonesty, resulting in the imposition of conditions which predate the matter in respect of which this Committee has made a finding of dishonesty. The Committee also considers that, even if

conditions could be formulated, a direction of conditional registration would not be sufficient to declare and uphold proper professional standards of conduct and behaviour because of the serious nature of your misconduct.

59. The Committee then went on to consider whether a direction of suspended registration would represent an appropriate and proportionate outcome. After careful consideration the Committee has determined that suspension would not be sufficient to protect the public or meet the public interest considerations that it has identified above.

60. Your misconduct represents a serious departure from professional standards and is highly damaging to your fitness to practise. Your dishonest conduct is in the Committee's judgement particularly serious, in that it related to your dealings with the GDC, whose statutory remit is to protect the public. You have demonstrated a persistent lack of insight into your conduct, and the consequences that it had for Patient A and the wider public. You pose an ongoing risk of significant harm to the public.

61. The Committee considers that its findings, and in particular its identification of persistent and repeated obfuscation, including dishonesty, connote a fundamental disregard and disdain for the regulatory process. This is such to suggest a deep-seated professional attitudinal problem. The Committee considers that, particularly because of the previous findings made against you, you ought to have been in no doubt whatsoever as to the importance of being honest and open, and of the importance of engaging with the GDC. The Committee considers that a direction of suspended registration would not be likely to serve any useful purpose as, in light of previous findings, especially of dishonesty, the Committee does not consider that a period of suspension will bring about the necessary rectification of your conduct and behaviour. The Committee considers that a period of suspended registration would not be sufficient to protect the public or the wider public interest.

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

Existing interim order

63. In accordance with Rule 21 (3) of the Rules and section 27B (9) of the Dentists Act 1984 (as amended) the interim order of suspension in place on your registration is hereby revoked.

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64. Mr Thomas on behalf of the GDC submitted that an immediate order of suspension is necessary to protect the public and is otherwise in the public interest. You made no submissions as to whether or not an immediate order should be imposed.

65. The Committee accepted the advice of the Legal Adviser concerning its powers and the principles to which it should have regard. The Committee has again had regard to the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016, updated December 2020).

66. In all the circumstances, the Committee considers that an immediate order of suspension is necessary to protect the public and is otherwise in the public interest. The Committee has determined that, given the risks to the public and the public interest that it has identified, it would not be appropriate to permit you to practise before the substantive direction of erasure takes effect. The Committee considers that an immediate order for suspension is consistent with the findings that it has set out in its foregoing determination.

67. The effect of the foregoing determination and this immediate order is that your registration will be suspended from the date on which notice of this decision is deemed to have been served upon you. Unless you exercise your right of appeal, the substantive direction of suspension will be recorded in the register 28 days from the date of deemed service. Should you decide to exercise your right of appeal, this immediate order of suspension will remain in place until the resolution of any appeal.

68. That concludes this case.