HEARING HEARD IN PUBLIC

DEAK, Gyorgy Andras

Registration No: 84412

PROFESSIONAL CONDUCT COMMITTEE

MARCH 2017 – MARCH 2019

Most recent outcome: Suspended indefinitely **

** See page 17 for the latest determination

Gyorgy Andras DEAK, a dentist, DMD Semmelweis University 1989 was summoned to appear before the Professional Conduct Committee on 27 February 2017 for an inquiry into the following charge:

Charge (as amended on 27 February 2017)

"That, being a registered dentist:

1. At all material times you were practising at Perfect Profiles, Tyburn Road, Wolverhampton, WV1 2PU.
2. Between 30 January 2014 and 26 March 2014 you treated Patient A (identified in Schedule A). As part of that course of treatment you placed implants at UL1, UR1, UL4, LL6 and LR6. In so doing you failed to:
   (a) evaluate the bone levels at UL4 and/or LL6 and/or LR6 adequately or at all;
   (b) identify the proximity of anatomical structures and/or the Inferior Alveolar Nerve (IAN) to the implant site at UL4 and/or LL6 and/or LR6.
3. By reason of your failure at 2(b) above you compromised the possible success of the restoration at UL4.
4. On 13 March 2014, in preparation for the placement of the implant at LR6, you damaged Patient A's IAN.
5. On 30 January 2014 and/or 13 March 2014 you took DPT radiographs in preparation for assessing and/or treating Patient A. In so doing you:
   (a) failed to adequately record, assess or otherwise interpret the radiographs;
   (b) had no clinical justification for taking the DPT radiograph on 13 March 2014.
6. Withdrawn by the GDC.
7. Your record keeping in relation to the planning of implants at UL4 and/or LL6 and/or LR6 for Patient A was inadequate in that you failed to record:
   (a) a clinical assessment adequately and/or at all;
   (b) evaluation of the levels of bone present at the implant site(s) adequately and or at all;

(c) anatomical structures adjacent to the implant site(s) adequately and/or at all.

And that by reason of the facts alleged above your fitness to practise as a dentist is impaired by reason of your misconduct."

Mr DEAK was not present and was not represented. On 1 March 2017 the Chairman announced the findings of fact to the Counsel for the GDC:

"**Service and proceeding in the absence of the Registrant**

Mr Deak is neither present nor represented at the Professional Conduct Committee (PCC) hearing of his case. In his absence, the Committee first considered whether the Notice of Hearing had been served on him in accordance with Rules 13 and 28 of the General Dental Council (GDC) (Fitness to Practise) Rules Order of Council 2006 (the Rules). In so doing, the Committee has had regard to the service bundle of documents as well as the submissions made by Mr Grey on behalf of the GDC. It has accepted the advice of the Legal Adviser.

The Committee has seen a copy of the Notice of Hearing letter dated 27 January 2017, giving Mr Deak notice of today's PCC hearing, which was sent by Capsticks Solicitors, acting on behalf of the GDC, to Mr Deak's registered address in Hungary by International Signed For Delivery. The letter sets out the date, time and location of today's hearing, as well as the particularised facts of the charge and the Royal Mail track and trace receipt states that delivery was attempted at Mr Deak's registered address on 2 February 2017. The Committee is satisfied that this letter sets out the information required in accordance with Rule 28 and that it was sent to Mr Deak's registered address more than 28 days in advance of today's hearing, also in accordance with Rule 28. The Committee is therefore satisfied that the requirements of service have been met in accordance with Rule 13 and 28.

Proceeding in absence

The Committee then went on to consider whether to hear this case in the absence of Mr Deak in accordance with Rule 54. Mr Grey submitted that it would be appropriate and in the public interest to proceed in the absence of Mr Deak, given that he is aware of the today's hearing, as well as the charges against him, but has chosen voluntarily not to attend.

The Committee's attention was drawn to the various emails from Capsticks Solicitors to Mr Deak concerning the listing of the PCC hearing; it was initially scheduled to take place from 16 January 2017 to 20 January 2017. However, by email dated 7 June 2016 Mr Deak stated that he was not available in January (2017) until mid-late February 2017. On 8 June 2016 the GDC's Hearings Team notified Mr Deak and Capsticks Solicitors by email that Mr Deak's case was being provisionally relisted to take place from 27 February to 3 March 2017. Thereafter, the Committee has seen copies of the emails from Capsticks Solicitors to Mr Deak regarding its attempts to obtain his disclosure of his case in response to the GDC's case, which had been served on him on 7 March 2016. Capsticks Solicitors had emailed Mr Deak on 3 and 9 January 2017, asking him to confirm whether or not he proposed to attend the hearing and/or be represented. The letter further stated that it had still not received disclosure of his case as soon as possible. No response has been received.

The Committee has considered the submissions made by Mr Grey. It has accepted the advice of the Legal Adviser. It has borne in mind the need for fairness to both parties, the nature of the allegations against Mr Deak as well as the public interest in the expeditious

disposal of this case. The Committee has seen a copy of Mr Deak's email dated 8 September 2016 to the GDC's Hearings Team in which he states that he has not been working in the UK since April 2014 and he is not willing to do so in the future. He states: "I am confused … better if I do keep being silent." It notes that Mr Deak has not engaged with the GDC since that email, despite attempts made by Capsticks Solicitors on a number of occasions to engage with him. The Committee has drawn the inference that Mr Deak has voluntarily absented himself from these proceedings. The Committee has received no compelling reasons as to why it should adjourn this PCC hearing and indeed there has been no such request from Mr Deak. There is nothing to suggest that Mr Deak would attend on a future occasion given his lack of engagement with the GDC, as well as his indication that he has not been working in the UK since April 2014. The Committee has also had regard to the public interest as well as Mr Deak's own interests, in the expeditious disposal of this case, given that the allegations involve matters relating to failings in respect of his treatment of a patient. The Committee has decided that it is fair to proceed in the absence of Mr Deak, in accordance with Rule 54.

Application by the GDC to withdraw charge 6

Mr Grey indicated that the GDC was not intending to call Patient A to give evidence and therefore no evidence would be offered in respect of the entirety of charge 6. He advised the Committee of the repeated efforts made by the GDC by telephone and email to secure the attendance of Patient A, but that these had proved unsuccessful. Patient A was no longer engaging with the GDC. Given these circumstances, the Committee acceded to the withdrawal of the entirety of charge 6.

The GDC's case

At the material times Mr Deak practised at Perfect Profiles (The Practice). Between 30 January 2014 and 26 March 2014 Mr Deak treated Patient A in relation to restorative dentistry. Mr Deak first saw Patient A on 30 January 2014 for an initial consultation. At this appointment it was agreed that implants would be provided to UR1 and UL1. At a later appointment it was agreed that additional implants at UL4, LL6 and LR6 would be provided. On 13 March 2014 Mr Deak placed implants at UR1, UL1, UL4, LR6 and LL6. On 19 March 2014 Patient A saw a different dentist for an emergency review due to numbness and a tingling sensation in the lower right side of her face. Patient A saw Mr Deak for the final time on 26 March 2014. On that occasion, Mr Deak removed the 13mm implant at LR6 and replaced it with a 10mm implant. In due course Patient A complained to the GDC.

In considering its findings on the facts, the Committee has taken into account all the evidence presented to it. This comprises the GDC's hearing bundle which contains copies of Patient A's records and a letter dated 15 September 2015 from Mr Deak to the GDC in which he set out his observations in response to the allegations. Mr Deak has not given evidence before the Committee and therefore it has not been possible to test his version of events by way of cross-examination. The Committee also received a report dated 11 February 2016 from Professor Brook, the GDC's expert. Professor Brook gave evidence before the Committee in which he confirmed the opinions set out in his report. The Committee considered that Professor Brook gave a balanced and fair opinion and has accepted his evidence.

The Committee has received advice from the Legal Adviser. In accordance with that advice, the Committee has borne in mind that the burden of proof is on the GDC and that Mr Deak

need not prove anything. It must decide the facts according to the civil standard of proof, namely on the balance of probabilities.

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

1.	Found proved The documents before the Committee establish that at the material times Mr Deak was practising at Perfect Profiles.
2. a) & 2.b)	Found proved Patient A's clinical records confirm that Mr Deak placed implants at UL1, UR1, UL4, LL6 and LR6 on 13 March 2014. Professor Brook told the Committee that proper planning for implant placement requires a dentist to evaluate the amount of bone into which the implants will be placed as well as the position of any key anatomical structures which might be adjacent to the implant sites. His evidence was that there was no record in the clinical notes of an evaluation of the bone levels present at the site of the implants for UL4, LR6 and LL6. He also found no record of the position of the Inferior Alveolar Nerve (IAN) relative to the planned implants in the lower molar sites or of the maxillary sinus relative to the proposed implant at UL4. Professor Brook accepted that failure to record such an assessment did not necessarily mean that it was not done. However, Professor Brook considered that the subsequent IAN damage that occurred following placement of a 13mm long implant at LR6 as well as the failure of the UL4 implant made it more likely than not that Mr Deak did not properly evaluate bone levels or the position of key anatomical structures at the planning stage. The Committee agrees with Professor Brook's evidence on this matter. It finds this charge proved on the basis of a failure at all to evaluate the bone levels at UL4, LL6 and LR6. There is no record in Patient A's clinical notes that Mr Deak identified the proximity of the IAN or the maxillary sinus. Professor Brook's evidence is that IANs are at risk of damage when placing implants at LR6 and LL6. He also explained that the dentist should determine the position of the IAN from the ridge crest to estimate the length of implant that could be placed, including a "safe zone" or distance to be left between the apex of the implant and the IAN canal. His oral evidence was that a safe zone of some 2mm would have been sufficient in this case. The fact that Mr Deak used a 13mm implant and left no safe zone in relation to LR6 is further evidence that he did not identify the proximity of the anatomical structures.
3.	Found proved In the light of its findings at 2, the Committee has found this charge proved.
4.	Found proved On 19 March 2014 (6 days after Mr Deak had placed the implants) Patient A returned to the Practice to see a different dentist for an emergency review, due to numbness and a tingling sensation on the lower right side of her face. According to Professor Brook, placing a 13mm implant at LR6 resulted in preventable long term damage to the IAN, as indicated by the symptoms complained of by Patient A. Mr Deak removed the 13mm implant at LR6 and replaced it with a 10mm implant on 26 March 2014. Mr Deak contends that he

	was not to blame for any nerve damage, and rather suggested that a haematoma forming at the site might have put pressure onto the nerve. He explained that he removed the implant as a "conservative treatment option". The Committee prefers Professor Brook's evidence on this matter. He opined that correct planning could have prevented IAN damage. The Committee is satisfied that in placing a 13mm implant in the site of LR6, not leaving a safe zone, Mr Deak damaged Patient A's IAN.
5. a)	Found not proved in relation to a failure to record for both dates. Found proved in relation to "assess or otherwise interpret" the pre-treatment radiograph taken on 13 March 2014. One DPT radiograph was taken on 30 January 2014 and two DPT radiographs were taken on 13 March 2014 – one pre-treatment and one post-treatment. Professor Brook was not critical of the post-treatment radiograph taken on 13 March 2014 and the Committee accepted his evidence on this matter. Professor Brook considered that the DPT radiograph taken on 30 January 2014 was appropriately justified and reported regarding the upper anterior implants only. However, he was critical that there is no report in relation to the UL4 site or the lower implants. Having regard to the fact that on 30 January 2014, Mr Deak had not decided to do the other implants, the Committee found that he had no obligation to make an interpretation and assessment in respect of these sites. In relation to 13 March 2014, there is a record of the pre-operative DPT being taken, but the Committee accepts Professor Brook's evidence that no assessment or interpretation of the radiograph is reported in the records.
5. b)	Found not proved Professor Brook was critical of Mr Deak's decision to take a pre-operative DPT on 13 March 2014, for which he considered there was no clinical justification. This was because extractions at UR1 and UL1 had only been carried out some 4 weeks previously and therefore insufficient time had elapsed for radiographic changes in bone contour to be visible on x-ray. The Committee agrees with Professor Brook's evidence on this matter. However, Professor Brook did not comment on a further entry recorded in the notes, namely "Dr Gd can measure the size of implants he would like to use." In the absence of Professor Brook's comments on the significance of this statement, the Committee is unable to determine whether this was an adequate clinical justification and therefore it is not satisfied that this charge is proved to the requisite standard.
6. a), b) & c)	WITHDRAWN
7. a). 7.b) & 7.c)	Found proved The Committee accepts Professor Brook's evidence that the record keeping is inadequate. It has scrutinised the records with care and can find no record of the matters set out at charges 7(a) 7(b) and 7(b).

We move to Stage Two."

On 1 March 2017 the Chairman announced the determination as follows:

"Mr Grey: 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 Deak 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 the evidence before it, as well as the submissions you have made on behalf of the GDC. You submitted that the findings against Mr Deak, which relate to the care and treatment he provided to Patient A, are serious and amount to misconduct.

The Committee has exercised its own professional judgement on this matter. 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 Deak treated Patient A over a period of two months between 30 January 2014 and 26 March 2014. As part of the treatment Mr Deak placed implants at UL1, UR1, UL4, LL6 and LR6. The Committee has found proved the following:

- A failure to evaluate the bone levels at UL4 and/or LL6 or at all,
- A failure to identify the proximity of anatomical structures and/or the Inferior Alveolar Nerve (IAN) to the implant site at UL4 and/or LL6 and/or LR6,
- Compromising the possible success of the restoration at UL4,
- In preparation for the placement of the implant at LR6, he damaged Patient A's IAN.
- A failure to assess or otherwise interpret the radiographs taken on 13 March 2014
- Inadequate record keeping in relation to the planning of implants at UL4 and/or LL6 and/or LR6 for Patient A in that he failed to record the following: a clinical assessment adequately and/or at all; evaluation of the levels of bone present at the implant site(s) adequately and or at all and anatomical structures adjacent to the implant site(s) adequately and/or at all.

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

4.1 Make and keep contemporaneous, complete and accurate patient records.

7.1 Provide good quality care based on current evidence and authoritative guidance.

7.2 Work within your knowledge, skills, professional competence and abilities.

Professor Brook (the GDC's expert witness) was of the opinion that the shortcomings identified in Mr Deak's care of Patient A amounted to a falling far below the standards

expected of a registered dentist. The Committee accepted his opinion. There were several failings in Mr Deak's treatment of Patient A, including a failure to evaluate the bone levels and the proximity of anatomical structures to the implant sites; causing damage to Patient A's Inferior Alveolar Nerve in preparation for the placement of the implant at LR6; failures in his radiographic practice and failures in his record keeping. The Committee considered that although this was a single patient complaint, Mr Deak's failings were serious, with life changing consequences to the patient. The record keeping failings were equally serious because a failure to make adequate records would mean that a subsequent treating dentist who intervened, as occurred in this case on one occasion, would have no knowledge of the bone levels or position of the anatomical structures relative to the implants. The Committee found that the record keeping failings fell far below the standards expected of a registered dental professional.

The Committee concluded that the facts found proved against Mr Deak amount to misconduct.

Impairment

The Committee next considered whether Mr Deak's fitness to practise is currently impaired by reason of that misconduct.

You submitted that Mr Deak's fitness to practise is currently impaired. You referred to the failings identified in this case as well as the absence of evidence to demonstrate remediation or insight. You therefore submitted that a risk of repetition of the failings remains. 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 considered the submissions made. It has received no submissions or evidence from Mr Deak, noting that he has chosen not to engage in these proceedings. It has exercised its own independent judgement.

The Committee first considered whether the misconduct is capable of being remedied, whether it has in fact been remedied, and whether it is likely to be repeated. The Committee is satisfied that Mr Deak's clinical deficiencies are remediable. However, it has received no evidence of Mr Deak's attempts to remedy his failings. It has also seen no evidence of insight into his clinical deficiencies. Indeed, it is apparent from his letter to the GDC dated 15 September 2015 that he does not accept the criticisms raised against him or show any remorse for the significant adverse outcomes experienced by the patient. In the Committee's view, given the absence of any insight or remediation, there is a risk of Mr Deak 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, so as to maintain public confidence in the profession. Mr Deak has breached the GDC's standards. He failed to provide an appropriate standard of care to Patient A. For these reasons, 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 determined that Mr Deak's fitness to practise is currently impaired by reason of his misconduct.

Sanction

The Committee considered what sanction, if any, to impose on Mr Deak's registration. In reaching its decision, it has taken into account the GDC's 'Guidance for the Practice Committees including Indicative Sanctions Guidance' (October 2016). 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 Deak's own interests.

You submitted that the appropriate and proportionate sanction is the suspension of Mr Deak's registration for a period of 12 months.

The Committee has taken into account the mitigating and aggravating features of this case. In mitigation, it has borne in mind that Mr Deak has no previous fitness to practise history. The aggravating factors include the serious nature of the findings against Mr Deak 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 Deak'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 Deak'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 Deak'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 one patient, are remediable and this is a case where Mr Deak's deficiencies could be addressed by conditions on his registration. However, the Committee has borne in mind the absence of any evidence of remediation, as well as Mr Deak's lack of engagement with the GDC from September 2016 onwards. The Committee has concerns about Mr Deak'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 be sufficient for the protection of the public or be in the public interest.

Accordingly, the Committee determined that Mr Deak's registration be suspended. It considered 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. The Committee determined that the suspension will be for a period of twelve months. In reaching this decision, the Committee considered that Mr Deak would need time to develop insight into his failings and to embark on a path of remediation. Accordingly, the Committee was satisfied that a period of twelve months, with a review, is appropriate and proportionate in this case.

The Committee considered the sanction of erasure but decided that it would be disproportionate, given that this case involved one patient against an otherwise unblemished record.

The Committee also directed that the order be reviewed prior to the end of the 12 month suspension. A review Committee will consider what action it should take in relation to Mr Deak'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 and his insight into the seriousness of the findings made. Mr Deak will be informed of the date and time of that resumed hearing.

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

Decision on immediate order

Mr Grey:

Having directed that Mr Deak's registration be suspended, the Committee went on to consider whether to make an order for the immediate suspension of Mr Deak's registration. In so doing, it has had regard to the submissions made by you on behalf of the General Dental Council (GDC) as well as the advice of the Legal Adviser.

In accordance with Section 30 of the Dentists Act 1984 (as amended) the Committee has determined that it is necessary for the protection of the public and is otherwise in the public interest that Mr Deak's registration be suspended forthwith. In reaching its decision, the Committee has concluded, for the reasons set out it its previous determination on stage 2, that Mr Deak currently poses a risk to the public and that immediate action is necessary for the protection of the public and to maintain public confidence in the profession. It is satisfied that it would be inconsistent to allow Mr Deak to practise during the 28-day appeal period, should he return to the United Kingdom, or, if an appeal is lodged, until it has been disposed of.

The effect of this direction is that Mr Deak's registration will be suspended immediately. Unless Mr Deak exercises his right of appeal, the substantive order of suspension will come into effect 28 days from the date on which notice of this decision is deemed to have been served on him. Should Mr Deak exercise his right of appeal, this immediate order for suspension will remain in place until the resolution of any appeal.

That concludes the hearing of Mr Deak's case."

On 19 March 2018 at a review hearing the Chairman announced the determination as follows:

"Mr Deak,

This is a resumed hearing pursuant to s 27C of the Dentists Act 1984. On 1 March 2017 the Professional Conduct Committee (PCC) found your fitness to practise to be impaired by reason of your misconduct, summarising the misconduct as follows:

> …Mr Deak treated Patient A over a period of two months between 30 January 2014 and 26 March 2014. As part of the treatment Mr Deak placed implants at UL1, UR1, UL4, LL6 and LR6. The Committee has found proved the following:
>
> - A failure to evaluate the bone levels at UL4 and/or LL6 or at all,
> - A failure to identify the proximity of anatomical structures and/or the Inferior Alveolar Nerve (IAN) to the implant site at UL4 and/or LL6 and/or LR6,
> - Compromising the possible success of the restoration at UL4,
> - In preparation for the placement of the implant at LR6, he damaged Patient A's IAN.
> - A failure to assess or otherwise interpret the radiographs taken on 13 March 2014

- Inadequate record keeping in relation to the planning of implants at UL4 and/or LL6 and/or LR6 for Patient A in that he failed to record the following: a clinical assessment adequately and/or at all; evaluation of the levels of bone present at the implant site(s) adequately and or at all and anatomical structures adjacent to the implant site(s) adequately and/or at all.

…There were several failings in Mr Deak's treatment of Patient A, including a failure to evaluate the bone levels and the proximity of anatomical structures to the implant sites; causing damage to Patient A's Inferior Alveolar Nerve in preparation for the placement of the implant at LR6; failures in his radiographic practice and failures in his record keeping. The Committee considered that although this was a single patient complaint, Mr Deak's failings were serious, with life changing consequences to the patient. The record keeping failings were equally serious because a failure to make adequate records would mean that a subsequent treating dentist who intervened, as occurred in this case on one occasion, would have no knowledge of the bone levels or position of the anatomical structures relative to the implants…

In finding your fitness to practise to be impaired, the initial PCC stated:

…The Committee is satisfied that Mr Deak's clinical deficiencies are remediable. However, it has received no evidence of Mr Deak's attempts to remedy his failings. It has also seen no evidence of insight into his clinical deficiencies. Indeed, it is apparent from his letter to the GDC dated 15 September 2015 that he does not accept the criticisms raised against him or show any remorse for the significant adverse outcomes experienced by the patient. In the Committee's view, given the absence of any insight or remediation, there is a risk of Mr Deak 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, so as to maintain public confidence in the profession. Mr Deak has breached the GDC's standards. He failed to provide an appropriate standard of care to Patient A. For these reasons, 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…

The initial PCC directed that your registration be suspended for a period of 12 months with a review:

…the Committee determined that Mr Deak's registration be suspended. It considered 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. The Committee determined that the suspension will be for a period of twelve months. In reaching this decision, the Committee considered that Mr Deak would need time to develop insight into his failings and to embark on a path of remediation. Accordingly, the Committee was satisfied that a period of twelve months, with a review, is appropriate and proportionate in this case.

…A review Committee will consider what action it should take in relation to Mr Deak'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 and his insight into the seriousness of the findings made. Mr Deak will be informed of the date and time of that resumed hearing.

It is the role of the PCC today to undertake that review. In so doing, the Committee heard your submissions, and those made on behalf of the General Dental Council (GDC) by Mr Middleton. Mr Middleton submitted that there is a paucity of reflective and remedial evidence before the Committee, that your fitness to practise continues to be impaired and that the suspension of your registration should be extended for a further period of 6-12 months.

Your submissions were essentially that your fitness to practise is not currently impaired.

By email to the GDC sent 16 February 2018, in response to the notification of hearing, you stated:

> …As I have informed the Commitee since April 2014 I am not practising in the UK and I am not willing to do so in the future neither.
>
> If/after my GDC registration is fully recovered I will request my voluntary removal from the register...

You sent a further email to the GDC on 2 March 2018, in which you confirmed that you would be attending this hearing via videolink and stated:

> …about the comments by the Commitee at the last PCC hearing I am happy to inform you that I have competed the raised action was considered, namely
>
> - returning home in April 2014 I became an oral surgeon resident in Hungary and successfully passed my Oral Surgeon Specialist exam in April 2016
> - to proove my goodwillness to the GDC I have registered myself in the Oral Surgeon Specialist list (see enclosed)
> - since January 2016 I am an external researcher in the Maxillo Facial and Oral Surgery Clinic of the Semmelweis Medical University, just granted University fund last week for our 2018 research project.
> - I am/became a well respected oral surgeon specialist giving practical postgraduation trainings, lectures in universities and international conferences
>
> [sic]

You put before the Committee no other documentary evidence or written reflection in support of your remediation. In your submissions today, you denied that you were responsible for the record keeping matters which had been found proved against you. You also referred to the fact that you had completed specialist training in Hungary in oral surgery as evidence of your remediation. You stated that there was further documentary evidence you could put before the Committee in respect of your attendance/delivery of lectures but that you would need 24 hours to provide those documents, as you need time to scan them: you did not have time to do so today, as you are due to catch a flight, but would have time tomorrow.

Decision

The Committee accepted the advice of the Legal Adviser. The Committee had regard to the *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016).

A decision to grant voluntary erasure is not one which this Committee can make: it is a decision for the Registrar. The role of the Committee is to determine whether your fitness to practise continues to be impaired. There was a persuasive burden on you to demonstrate today that you acknowledge the clinical failings found proved against you and that you have adequately addressed them.

The Committee was encouraged by the fact that you attended the hearing via videolink, as you had failed to attend or otherwise engage in the initial hearing. Apart from that, there is no evidence of any progress in respect of your remediation. You were given clear guidance by the initial PCC on the steps you could take to demonstrate on review that you acknowledge your clinical failings and that you have adequately addressed them. You have failed to follow

any of those steps, or to otherwise provide any evidence of reflection, remorse or remediation.

You have not demonstrated any insight to the Committee, nor have you shown that the areas of clinical concern have been addressed. Indeed, you deny responsibility for the serious record keeping failings found proved against you. The initial PCC merely found that there was no evidence of insight: today, the Committee, if anything, has evidence of a lack of insight.

You refer to your entry on the GDC specialist list as evidence of your "goodwill" in respect of these proceedings, but that entry pre-dates the time of your hearing before the initial PCC and is not relevant. You have had ample notice of today's hearing to gather and put before the Committee adequate documentary evidence of your remedial steps, but you have not done so. There was a wide range of clinical failings which had "life changing" consequences for the patient and yet you show no specific clinically relevant evidence of addressing those failings. You also express no remorse for the harm your patient suffered.

In the continued absence of any evidence of insight, reflection and remediation, there remains a real risk of repetition. Further, wider public confidence in the profession would also be seriously undermined if a finding of continued impairment were not made, given the lack of any insight and remedial evidence into the seriousness of your clinical failings and the level of harm caused to the patient.

A sanction on your registration remains necessary for the protection of the public and is also necessary to maintain public confidence in the profession and this regulatory process. The Committee considered that conditions of practice could theoretically be formulated to be measurable, workable and proportionate to the clinical failings in this case, as those failings are capable of remedy through reflection, audit and targeted Continuing Professional Development (CPD) activity. However, you have demonstrated today no insight and no willingness to remedy through conditional registration your serious and widespread clinical failings.
Accordingly, the suspension of your registration remains necessary and proportionate at this stage of your remediation. The Committee therefore directs that the period of suspension be extended for a further period of 6 months, beginning with the date on which it would otherwise expire. A period of 6 months is proportionate, as it will allow you sufficient time to reflect and to gather evidence of remediation.

The extended period of suspension shall be reviewed prior to its expiry. Any reviewing Committee may be assisted by evidence of improved clinical practice, audit (in particular, in relation to those areas where there were failings), testimonials from patients and professional peers, and reflective writing on how your actions had impacted on the patient and the reputation of the profession.

That concludes the hearing today."

On 13 September 2018 at a review hearing the Chairman announced the determination as follows:

"Service

Ms Headley appears on behalf of the General Dental Council (GDC) at this Professional Conduct Committee (PCC) review hearing of Mr Deak's case. Mr Deak is neither present nor represented at today's hearing. In his absence the Committee first considered whether the

GDC had complied with service of the Notice of Hearing in accordance with Rules 28 and 65 of the GDC (Fitness to Practise) Rules Order of Council 2006 (the Rules). In so doing, it took into account the submissions made by Ms Headley on behalf of the GDC. It accepted the advice of the Legal Adviser.

The Committee has received a copy of the Notification of Hearing, dated 14 August 2018, which was sent to Mr Deak's registered address, by way of special delivery and by secure email. The Committee is satisfied that the letter contains 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 PCC hearing in Mr Deak's absence. Further, the letter was sent more than 28 days in advance of today's hearing. The Committee was provided with an emailed copy of the Notification of Hearing sent to Mr Deak's email address. Taking all this information into account, the Committee is satisfied that notification of this hearing had been served on Mr Deak in compliance with the rules.

Proceeding in the absence of Mr Deak

The Committee then considered whether to exercise its discretion under Rule 54 to proceed in Mr Deak's absence. In so doing, it has borne in mind the submissions made by Ms Headley on behalf of the GDC. It has accepted the advice of the Legal Adviser.

The Committee is aware that its discretion to proceed in the absence of Mr Deak must be exercised with the utmost care and caution. It also had regard to the need for fairness to both parties, as well as the public interest in the expeditious disposal of the hearing.

The Committee is satisfied that Mr Deak has been sent notification of today's hearing. It had regard to an email dated 10 September 2018 in which Mr Deak acknowledges the letter sent on 14 August 2018. The Committee noted that Mr Deak has not requested an adjournment of this hearing and in the Committee's view, there is nothing before it to suggest that if it adjourned today Mr Deak might attend a future hearing. Further, the Committee considers that that there is a clear public interest in reviewing the order today. Having weighed the interests of Mr Deak with those of the GDC, the Committee has determined to proceed with today's review hearing in Mr Deak's absence.

Background

This is a resumed hearing pursuant to Section 27C of the Dentists Act 1984. On 1 March 2017 the Professional Conduct Committee (PCC) that found Mr Deak's fitness to practise to be impaired by reason of misconduct, summarising the misconduct as follows:

…Mr Deak treated Patient A over a period of two months between 30 January 2014 and 26 March 2014. As part of the treatment Mr Deak placed implants at UL1, UR1, UL4, LL6 and LR6. The Committee has found proved the following:

- A failure to evaluate the bone levels at UL4 and/or LL6 or at all,
- A failure to identify the proximity of anatomical structures and/or the Inferior Alveolar Nerve (IAN) to the implant site at UL4 and/or LL6 and/or LR6,
- Compromising the possible success of the restoration at UL4,
- In preparation for the placement of the implant at LR6, he damaged Patient A's IAN.
- A failure to assess or otherwise interpret the radiographs taken on 13 March 2014
- Inadequate record keeping in relation to the planning of implants at UL4 and/or LL6 and/or LR6 for Patient A in that he failed to record the following: a clinical assessment adequately and/or at all; evaluation of the levels of bone present at the implant site(s)

adequately and or at all and anatomical structures adjacent to the implant site(s) adequately and/or at all.

…There were several failings in Mr Deak's treatment of Patient A, including a failure to evaluate the bone levels and the proximity of anatomical structures to the implant sites; causing damage to Patient A's Inferior Alveolar Nerve in preparation for the placement of the implant at LR6; failures in his radiographic practice and failures in his record keeping. The Committee considered that although this was a single patient complaint, Mr Deak's failings were serious, with life changing consequences to the patient. The record keeping failings were equally serious because a failure to make adequate records would mean that a subsequent treating dentist who intervened, as occurred in this case on one occasion, would have no knowledge of the bone levels or position of the anatomical structures relative to the implants…

In finding Mr Deak's fitness to practise to be impaired, the initial PCC stated:

…The Committee is satisfied that Mr Deak's clinical deficiencies are remediable. However, it has received no evidence of Mr Deak's attempts to remedy his failings. It has also seen no evidence of insight into his clinical deficiencies. Indeed, it is apparent from his letter to the GDC dated 15 September 2015 that he does not accept the criticisms raised against him or show any remorse for the significant adverse outcomes experienced by the patient. In the Committee's view, given the absence of any insight or remediation, there is a risk of Mr Deak 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, so as to maintain public confidence in the profession. Mr Deak has breached the GDC's standards. He failed to provide an appropriate standard of care to Patient A. For these reasons, 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…

The initial PCC directed that Mr Deak's registration be suspended for a period of 12 months with a review:

…the Committee determined that Mr Deak's registration be suspended. It considered 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. The Committee determined that the suspension will be for a period of twelve months. In reaching this decision, the Committee considered that Mr Deak would need time to develop insight into his failings and to embark on a path of remediation. Accordingly, the Committee was satisfied that a period of twelve months, with a review, is appropriate and proportionate in this case.

…A review Committee will consider what action it should take in relation to Mr Deak'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 and his insight into the seriousness of the findings made. Mr Deak will be informed of the date and time of that resumed hearing.

A PCC review was held on 19 March 2018 and it found Mr Deak's fitness to practise remained impaired stating:

The Committee was encouraged by the fact that you attended the hearing via videolink, as you had failed to attend or otherwise engage in the initial hearing. Apart from that, there is no evidence of any progress in respect of your remediation. You were given clear guidance by the initial PCC on the steps you could take to demonstrate on review that you acknowledge your clinical failings and that you have adequately addressed them. You have failed to follow any of those steps, or to otherwise provide any evidence of reflection, remorse or remediation.

You have not demonstrated any insight to the Committee, nor have you shown that the areas of clinical concern have been addressed. Indeed, you deny responsibility for the serious record keeping failings found proved against you. The initial PCC merely found that there was no evidence of insight: today, the Committee, if anything, has evidence of a lack of insight.

You refer to your entry on the GDC specialist list as evidence of your "goodwill" in respect of these proceedings, but that entry pre-dates the time of your hearing before the initial PCC and is not relevant. You have had ample notice of today's hearing to gather and put before the Committee adequate documentary evidence of your remedial steps, but you have not done so. There was a wide range of clinical failings which had "life changing" consequences for the patient and yet you show no specific clinically relevant evidence of addressing those failings. You also express no remorse for the harm your patient suffered.

In the continued absence of any evidence of insight, reflection and remediation, there remains a real risk of repetition. Further, wider public confidence in the profession would also be seriously undermined if a finding of continued impairment were not made, given the lack of any insight and remedial evidence into the seriousness of your clinical failings and the level of harm caused to the patient.

The PCC review directed that Mr Deak's registration be suspended for a period of 6 months with a review:

A sanction on your registration remains necessary for the protection of the public and is also necessary to maintain public confidence in the profession and this regulatory process. The Committee considered that conditions of practice could theoretically be formulated to be measurable, workable and proportionate to the clinical failings in this case, as those failings are capable of remedy through reflection, audit and targeted Continuing Professional Development (CPD) activity. However, you have demonstrated today no insight and no willingness to remedy through conditional registration your serious and widespread clinical failings.

Accordingly, the suspension of your registration remains necessary and proportionate at this stage of your remediation. The Committee therefore directs that the period of suspension be extended for a further period of 6 months, beginning with the date on which it would otherwise expire. A period of 6 months is proportionate, as it will allow you sufficient time to reflect and to gather evidence of remediation.

Submissions

It is the role of the PCC today to undertake a review of the suspension order. The Committee heard submissions from Ms Headley on behalf of the General Dental Council (GDC). Ms Headley submitted that Mr Deak's fitness to practise remains impaired. She referred to Mr Deak's limited engagement with the GDC. She referred the Committee to the CPD certificates Mr Deak provided. Ms Headley submitted there is otherwise no evidence of remediation or insight, or follow the recommendations made by previous Committees. Ms Headley referred to the case of Abrahaem v GMC [2008] EWHC 183 (Admin) where it was held that at review hearings there is a persuasive burden on the Registrant to satisfy the regulator that his or her fitness to practise is no longer impaired. Mr Deak has failed to discharge that burden. Ms Headley invited the Committee to direct that Mr Deak's registration be suspended for a further period of 6 months.

Decision

The Committee accepted the advice of the Legal Adviser. The Committee had regard to the *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016).

This Committee has comprehensively reviewed the current order. In so doing, it has had regard to the GDC bundle, as well as the GDC's submissions and further documents sent by Mr Deak.

The Committee had regard to the CPD certificates and the email Mr Deak provided. However, the Committee is of the view that the certificates do not address the areas of clinical concerns identified by the initial PCC. The Committee noted that Mr Deak was given clear guidance by the initial PCC and the reviewing PCC Committee on the steps he could

take to acknowledge and demonstrate insight, and remediation into his clinical failings. However, Mr Deak has failed to provide evidence of having taken these steps, or demonstrated reflection, remorse or remediation.

In the continued absence of evidence of insight, reflection and remediation, there remains a real risk of repetition. Further, wider public confidence in the profession would also be seriously undermined if a finding of continued impairment were not made, given the lack of insight and remedial evidence into the seriousness of Mr Deak's clinical failings and the level of harm caused to the patient. Accordingly, the Committee has determined that Mr Deak's fitness to practise remains impaired.

The Committee next considered what direction to give, bearing in mind its powers in accordance with Section 27C of the Dentists Act 1984.

The Committee has borne in mind the principle of proportionality, balancing the public interest against Mr Deak's own interests. The public interest includes the protection of the public, the maintenance of public confidence in the profession, and declaring and upholding standards of conduct and performance within the profession.

The Committee first considered whether it would be appropriate to allow the current order to lapse at its expiry or to revoke it with immediate effect. Given the absence of remediation from Mr Deak, the Committee has concluded that it would not be appropriate to revoke the current order or to allow it to lapse given the clear risk of repetition.

The Committee next considered whether a period of conditional registration would be appropriate in this case. The Committee considered that conditions of practice could theoretically be formulated to be measurable, workable and proportionate to the clinical failings in this case, as those failings are capable of remedy through reflection, audit and targeted Continuing Professional Development (CPD) activity. However, Mr Deak has not demonstrated any insight or a willingness to remedy the serious and widespread clinical failings despite being given the opportunity to do so. Furthermore, Mr Deak is not currently working in the UK and therefore conditions would be unworkable. In these circumstances, the Committee has concluded that replacing the suspension order with a conditions of practice order would not be workable or appropriate.

In all the circumstances, the Committee has decided to extend the period of the current suspension order by 6 months. In reaching its decision, the Committee took into account the limited lack of engagement by Mr Deak and the absence of evidence of insight or remediation. In deciding on the period of 6 months, the Committee decided that 6 months is an appropriate and proportionate length of time, as it would afford Mr Deak sufficient opportunity to reflect on all the matters that have been raised and to provide evidence of remediation. In the meantime, the public and the wider public interest will be sufficiently protected by the continued suspension of his registration.

The extended period of suspension shall be reviewed prior to its expiry. Any reviewing Committee may be assisted by evidence of improved clinical practice, audit (in particular, in relation to those areas where there were failings), testimonials from patients and professional peers, and reflective writing on how Mr Deak's actions had impacted on the patient and the reputation of the profession.

That concludes the hearing today."

At a review hearing on 7 March 2019 the Chairman announced the determination as follows:

"Mr Deak is neither present nor represented at this resumed hearing of the Professional Conduct Committee (PCC). Mr Middleton is the Case Presenter for the General Dental Council (GDC).

At the outset, Mr Middleton made an application under Rule 54 of the GDC (Fitness to Practise) Rules 2006 Order of Council (the Rules), to proceed with the hearing notwithstanding Mr Deak's absence. The Committee took account of Mr Middleton's submissions in respect of the application and had regard to the supporting documentation provided. It accepted the advice of the Legal Adviser.

Decision on service of the Notification of Hearing

The Committee considered whether notice of the hearing had been served on Mr Deak in accordance with Rules 28 and 65 of the Rules. It received a bundle of documents containing a copy of the Notification of Hearing letter, dated 06 February 2019, and a Royal Mail 'Track and Trace' receipt confirming that the letter was sent to Mr Deak's registered address by Special Delivery. A copy of the letter was also sent to him by email.

The Committee was satisfied that the letter contained proper notification of today's review hearing, including its time, date and venue, as well as notification that the Committee had the power to proceed with the hearing in Mr Deak's absence. On the basis of the information provided, the Committee was satisfied that notice of the hearing had been served on Mr Deak in accordance with the Rules.

Decision on proceeding with the hearing in the absence of Mr Deak

The Committee next considered whether to exercise its discretion under Rule 54 of the Rules to proceed with the hearing in the absence of Mr Deak. It approached this issue with the utmost care and caution. The Committee took into account the factors to be considered in reaching its decision as set out in the case of *R v Jones [2003] 1 AC 1HL*. It remained mindful of the need to be fair to both Mr Deak and the GDC, and it had regard to the public interest in the expeditious review of the suspension order in place on Mr Deak's registration. The Committee took into account that the current order is due to expire on 02 April 2019.

The Committee noted from the Notification of Hearing letter of 06 February 2019 that Mr Deak was asked to confirm by 15 February 2019 whether he would be attending today's hearing and/or whether he would be represented. The information before the Committee indicates that there has been no response from Mr Deak. He has not provided a reason for his non-attendance, either in person or remotely, nor has he requested an adjournment. The Committee therefore concluded that Mr Deak had voluntarily absented himself from today's proceedings. It decided that an adjournment was unlikely to secure his attendance on a future date.

In all the circumstances, the Committee determined that it was fair and in the public interest to proceed with the hearing in the absence of Mr Deak and/or any representative on his behalf.

Background to Mr Deak's case

Mr Deak's case was first considered by the PCC at a hearing in March 2017. That Committee considered and found proved allegations in relation to:

"Mr Deak treated Patient A over a period of two months between 30 January 2014 and 26 March 2014. As part of the treatment Mr Deak placed implants at UL1, UR1, UL4, LL6 and LR6. The Committee has found proved the following:

- *A failure to evaluate the bone levels at UL4 and/or LL6 or at all,*
- *A failure to identify the proximity of anatomical structures and/or the Inferior Alveolar Nerve (IAN) to the implant site at UL4 and/or LL6 and/or LR6,*
- *Compromising the possible success of the restoration at UL4,*
- *In preparation for the placement of the implant at LR6, he damaged Patient A's IAN.*
- *A failure to assess or otherwise interpret the radiographs taken on 13 March 2014*
- *Inadequate record keeping in relation to the planning of implants at UL4 and/or LL6 and/or LR6 for Patient A in that he failed to record the following: a clinical assessment adequately and/or at all; evaluation of the levels of bone present at the implant site(s) adequately and or at all and anatomical structures adjacent to the implant site(s) adequately and/or at all."*

The Committee that sat in March 2017 considered that the breaches of the GDC's standards, as highlighted by its findings, were serious and were capable of undermining public confidence in the profession. That Committee found that the facts found proved against Mr Deak amounted to misconduct and it determined that his fitness to practise was impaired by reason of that misconduct.

In its determination on impairment, that Committee stated that Mr Deak's misconduct was remediable. However, it had received no evidence of Mr Deak's attempts to remedy his failings. It had also seen no evidence of insight into his clinical deficiencies. Indeed, it was apparent from his letter to the GDC dated 15 September 2015 that he did not accept the criticisms raised against him or show any remorse for the significant adverse outcomes experienced by the patient. In the Committee's view, given the absence of any insight or remediation, there was a risk of Mr Deak repeating his behaviour and therefore a finding of current impairment was necessary for the protection of patients.

Accordingly, the Committee decided that Mr Deak's fitness to practise was impaired. That Committee determined to suspend Mr Deak's registration for a period of 12 months and imposed an immediate order of suspension. It directed a review of his case prior to the end of the 12 month period.

The PCC reviewed the order on 19 March 2018. Mr Deak attended the hearing via video link and represented himself. The Committee determined that Mr Deak's fitness to practise remained impaired by reason of his misconduct. The Committee considered there was no evidence of any progress in respect of Mr Deak's remediation or insight. In the continued absence of any evidence of insight, reflection and remediation, there remained a real risk of repetition. The Committee directed that the period of suspension be extended for a further period of 6 months to allow him sufficient time to reflect and to gather evidence of remediation.

The second review of the order took place on 13 September 2018. The hearing proceeded in Mr Deak's absence. At this review hearing the Committee was presented with CPD certificates and an email from Mr Deak. However, it formed the view that the certificates did not address the areas of clinical concerns identified by the initial PCC. The Committee noted that Mr Deak was given clear guidance by the initial PCC and the reviewing PCC Committee on the steps he could take to acknowledge and demonstrate insight, and remediation into his

clinical failings. However, Mr Deak failed to provide evidence of having taken these steps, or to demonstrate reflection, remorse or remediation and determined that Mr Deak's fitness to practise remained impaired.

Today's review

In comprehensively reviewing Mr Deak's case today, the Committee considered all the evidence before it. It took account of the submissions made by Mr Middleton on behalf of the GDC and accepted the advice of the Legal Adviser. No material or written submissions were received from, or on behalf of, Mr Deak.

Mr Middleton told the Committee that there is no evidence that Mr Deak has practised in contravention of his current suspension order. He stated, however, that to date, there is no evidence that Mr Deak has remedied any of the failings identified by the previous and reviewing Committees. Mr Middleton submitted that Mr Deak has not fully engaged with the GDC.

In relation to the matters before the Committee today. He stated that in the circumstances, the GDC had no option but to invite the Committee to find that Mr Deak's fitness to practise remains impaired. Mr Middleton further invited the Committee, if it found current impairment, that an order of indefinite suspension be directed.

Decision on impairment

In reaching its decision on whether Mr Deak's fitness to practise remains impaired, the Committee exercised its own judgement. It had regard to the over-arching objective of the GDC, which is: the protection, promotion and maintenance of the health, safety and well-being of the public; the promotion and maintenance of public confidence in the dental profession; and the promotion and maintenance of proper professional standards and conduct for the members of the dental profession.

Mr Deak's misconduct, as found by the initial PCC, was serious and capable of undermining public confidence in the dental profession. This Committee accepted the submissions of Mr Middleton and the advice of the Legal Adviser.

The information before this reviewing Committee today indicates that Mr Deak has failed to engage in any way with the GDC since the last review. Consequently, it has received no evidence to indicate that he has made any efforts to fulfil the recommendations made by the Committee in March 2017.

In this Committee's view, Mr Deak's ongoing failure to engage effectively with the GDC demonstrates that he had not developed any insight into the concerns identified at the hearing in March 2017. Taking into account this lack of insight and the absence of any evidence of remediation to show that Mr Deak has addressed the findings of the previous Committees, this Committee concluded that the serious concerns remain.

Having taken all the information before it into account, the Committee continues to be concerned about the serious risk of repetition. In all the circumstances, the Committee decided that a finding of current impairment is necessary for the protection of the public. The Committee also decided that public confidence in the dental profession would be undermined if such a finding were not made in the circumstances of this case.

Accordingly, the Committee has determined that Mr Deak's fitness to practise remains impaired by reason of his misconduct.

Decision on Sanction

The Committee considered what action, if any, to take in respect of Mr Deak's registration. It had regard to its powers under Section 27C(1) of the *Dentists Act 1984 (as amended)*, which sets out the options available to it. The Committee took into account that the purpose of any sanction is not to be punitive, although it may have that effect, but to protect patients and the wider public interest.

The Committee first considered whether it would be appropriate to allow the current order to lapse at its expiry or to terminate it with immediate effect. Given Mr Deak's lack of engagement with the GDC, non-acceptance of his misconduct and the absence of any remediation, the Committee has concluded that it would not be appropriate to terminate the current order or to allow it to lapse.

The Committee next considered whether a period of conditional registration would be appropriate in this case. The Committee is aware that in order for conditions to be appropriate and workable there would need to be some measure of positive engagement from Mr Deak. To date, he has not engaged with the GDC at all since the last review or provided evidence of remediation, despite being given the opportunity to do so. In these circumstances, the Committee has concluded that replacing the suspension order with a conditions of practice order would not be workable or appropriate.

The Committee then went on to consider whether to direct that the current period of suspension be extended for a further period. It has borne in mind Mr Deak's limited engagement with the GDC over a sustained period of time. Mr Deak has chosen not to attend this hearing, nor has he provided any evidence of his remediation or demonstrated any insight. In these circumstances, the Committee has concluded that a further period of suspension of 12 months would serve no useful purpose and that an indefinite period of suspension is the appropriate and proportionate outcome. It therefore directs that Mr Deak's registration be suspended indefinitely.

The effect of the foregoing direction is that, unless Mr Deak exercises his right of appeal, his registration will be suspended indefinitely from the date on which this direction takes effect.

The Committee would also highlight to Mr Deak that should he wish to engage with the GDC, he can apply for a review of the indefinite suspension order after two years have elapsed since the direction for indefinite suspension takes effect.

That concludes the case for today."