Dental Professionals Hearings Service

PUBLIC DETERMINATION

Professional Conduct Committee
Initial Hearing

9 – 10 April 2025

Name:	DOULGERIDIS, Theocharis
Registration number:	83084
Case number:	CAS-206344-Z2K3R8

General Dental Council:	Christopher Hamlet, Counsel Instructed by IHLPS
Registrant:	Present Represented by Ben Rich, Counsel Instructed by MDDUS

Fitness to practise:	Impaired by reason of misconduct
Outcome:	Conditions imposed (with a review)
Duration:	Six months
Immediate order:	Immediate conditions of practice order

Committee members:	Marnie Hayward	(Chair, Dental Care Professional member)
	Alison Mayell	(Dentist member)
	Anita Clay	(Lay member)
Legal adviser:	Justin Gau	
Committee Secretary:	Sara Page	

1. This is a Professional Conduct Committee (PCC) hearing. The members of the Committee, as well as the Legal Adviser and the Committee Secretary, conducted remotely via Microsoft Teams.

2. You were present at the hearing and represented by Mr Ben Rich, Counsel, instructed by the MDDUS.

3. Mr Christopher Hamlet, Counsel, appeared as Case Presenter on behalf of the GDC.

Charges

4. The charges being considered by the Committee, as detailed in the Notice of Hearing, dated 25 February 2025, are as follows:

> *'That being registered as a dentist Theocharis Doulgeridis's (83084) fitness to practise is impaired in that:*
>
> *1. You failed to provide an adequate standard of care to Patient A from 11 February 2020 to 31 March 2020 including by / in relation to;*
>
> *a) Your radiographic practice.*
> *b) Your antibiotic prescribing practices.*
> *c) By not discussing the full risks and benefits of the proposed treatment.*
>
> *2. You failed to maintain an adequate standard of record keeping in respect of Patient A's appointments from 11 February 2020 to 31 March 2020.*
>
> *3. You failed to obtain informed consent for the treatment provided to Patient A from 11 February 2020 to 31 March 2020.*
>
> *AND that by reason of the facts alleged, your fitness to practise is impaired by reason of misconduct.'*

Decision on finding of facts

Background

5. The GDC received a complaint from Patient A on 12 September 2022 relating to the extraction of LL8 provided by you on 18 February 2020. Patient A had reported that the treatment had resulted in the left-hand side of his face and gum becoming permanently numb. Patient A reported that the numbness resulting from the extraction has been stressful, as it is more difficult to chew in public and control food and drink without it running down his face.

6. Patient A stated that no warnings were given before the procedure that this outcome could be a possibility.

7. Patient A returned to the practice following the extraction and was told that the numbness would improve but it did not. You subsequently referred Patient A to the dental hospital where he was informed that the numbness in his lower left face is permanent and there is nothing more that can be done.

Evidence

8. Prior to the commencement of the hearing, the Committee was provided with the GDC's hearing bundle, referred to as Exhibit 1. This bundle included, but was not limited to, the following documents:

    - Witness statements and supporting documents of:
        - Witness 1 (Senior Lecturer and Consultant Oral Surgeon for the Manchester Foundation Trust);
        - Witness 2 (Senior Lecturer and Honorary Consultant for Manchester University Dental Hospital); and
        - Karen Geddes (Case Worker in Fitness to Practise at the GDC).
    - Patient A's Webform complaint;
    - Expert report of Dr Simon Quelch, dated 15 July 2024
    - Medical records of Patient A.

Admissions

9. At the outset of the hearing, Mr Rich, on your behalf, informed the Committee that you made full admissions to the charges.

10. Having carefully considered each of the charges, the Committee was unable to identify any discrepancies that would require further exploration of the admitted allegations and acknowledged supporting evidence for each of the admitted allegations.

11. Accordingly, the Committee accepted your admissions and found the charges proved in their entirety.

Decision on fitness to practise

12. Having announced its decision on the facts, the Committee then moved on to consider whether the facts found proved amount to misconduct and, if so, whether your practice is currently impaired.

13. In accordance with Rule 20 of the Fitness to Practise Rules 2006, the Committee heard submissions from Mr Hamlet and Mr Rich in relation to the matters of misconduct, impairment and sanction.

14. The Committee heard and accepted the advice of the Legal Adviser, which included reference to relevant case law.

Evidence

15. The Committee also had regard to a further document, referred to as Exhibit 2, provided on your behalf. This bundle consisted of the following documents:

    - Your personal reflections;
    - Testimonials from colleagues and patients;
    - Patient feedback questionnaires;
    - Your Personal Development Plan (PDP) for 2025 – 2029;
    - Continuing Professional Development (CPD) certification;
    - Clinical audits.

16. The Committee was also provided with a further document by Mr Hamlet, referred to as Exhibit 3, as follows

    - An 'Investigating Committee decision' letter, dated 31 May 2016.

Submissions

17. Mr Hamlet submitted that the clinical failings in this case can be broken down into five specific areas, namely:

    - Radiographic practice;
    - Antibiotic prescribing;
    - Discussing full risks and benefits of treatment;
    - Record keeping; and
    - Obtaining informed consent.

18. Mr Hamlet stated that it was the GDC's case that your treatment of Patient A between 11 February and 31 March 2020, specifically your treatment and extraction of LL8, amounted to misconduct. In this regard, Mr Hamlet invited the Committee to consider the GDC document, *'Standards for the Dental Team (2014)'* and detailed a number of areas that he considered had been breached and as a result of these breaches, he submitted that the charges, found proved by way of your admissions, amounted to misconduct.

19. On the matter of impairment, Mr Hamlet submitted that your failings, being of a clinical nature, are capable of remediation and the Committee must therefore consider whether there is sufficient evidence to demonstrate that the concerns before the Committee have been sufficiently remediated so as to mitigate against any risk of repetition of similar conduct. Mr Hamlet reminded the Committee that it should be acknowledged that you have taken steps towards addressing the concerns, including undertaking relevant CPD, working with a mentor (since August 2024, who has been monitoring your progress), and producing a PDP which seeks to direct itself to the areas of concern and purports to have addressed those areas this year.

20. Having considered this evidence, Mr Hamlet submitted that it was the GDC's case that it would not be appropriate at this stage to find that there is no substantive risk of repetition and whilst appropriate credit must be given to you for the efforts you have made so far, the Committee may feel that it would be appropriate to seek further evidence over a longer period of time to confirm that you have fully remediated your previous failings and mitigated against the risk of repetition.

21. Mr Hamlet referred the Committee to Exhibit 3, namely the outcome letter from the Investigating Committee (IC), which issued a warning in 2016 for matters almost identical in nature to those being dealt with at this hearing. He stated that the IC inferred in 2016 that there was a low risk of repetition but that it has been repeated in 2020, and this raises the prospect of further repetition notwithstanding the efforts you have recently made to address your failings. Therefore, Mr Hamlet submitted that a finding of impairment was required on the ground of public protection.

22. In relation to public interest, Mr Hamlet submitted that the public would expect a finding of impairment in any event in response to what were serious allegations, to restore its confidence in the profession and in order to uphold proper professional standards.

23. Mr Hamlet then referred the Committee to consider the GDC document, *'Guidance for the Practice Committees including Indicative Sanctions Guidance (December 2020)',* referred to hereafter as 'the ISG', and invited the Committee to impose a conditions of practice order for a period of six to nine months, with a requirement for you to be placed under the supervision of a Workplace Supervisor (WPS). This, he submitted, would allow you to return to practise whilst under some monitoring to ensure these issues can be the subject of some oversight.

24. Mr Rich submitted that, on the basis of all the evidence, you have the ability to be – and are – a thorough, safe, and careful practitioner but that it is acknowledged by you that you allowed your standards to slip with Patient A. He accepted that it would be natural for the Committee to have some concerns regarding a similar event some 11 years prior to today's proceedings and that it is clear that you have accepted the fault and have not sought to minimalise the seriousness or impact. Mr Rich submitted that you clearly and deeply regret the incident and that you feel a deep sense of shame and embarrassment to be before your regulator again.

25. Mr Rich informed the Committee that your concerns for the effect on both the patient and the profession is manifest in your approach to this and in your reflection. In order to address your failings, you have structured your practice in such a way that you are reminded of all the things you ought to have done. He stated that this case shows many characteristics of an isolated incident and, despite a similar event having occurred in 2014, it does not show a pattern or general inability to practise safely. Mr Rich stated that between the warning being issued in 2016 and this incident in 2020, you have practised without issue, and you have not been under any kind of restriction during this period.

26. Mr Rich invited the Committee to consider all matters individually and reminded it that these matters cannot be 'added up' to justify a finding of misconduct. He stated that a warning was sufficient on the previous occasion in 2016 and there was no need for a hearing and that, if this were the only incident of these failings, a similar approach may have been taken today. However, Mr Rich acknowledged that on this occasion, the Committee must go somewhat further than last time.

27. If a finding of misconduct is found, Mr Rich asked the Committee to consider your significant reflection and remediation, the insight you have provided, and the evidence you have put forward regarding the quality of your current practice in its consideration of current impairment. He informed the Committee that you have embedded a number of changes into your practice to eliminate the faults to which you have made full admissions. He reminded the Committee that you have effectively put yourself under conditions of practice in essence for the previous nine months and whilst this has ensured public safety, it also addresses the public interest. Mr Rich submitted that as a result, a fair-minded member of the public would not consider it undermined confidence in the profession or the GDC as its regulator if a finding of impairment were not made.

28. Mr Rich submitted that, if the Committee was not with him in not finding current impairment, that the imposition of a conditions of practice order would be appropriate and proportionate. Referring to the GDC's proposed conditions, he stated that the conditions would be workable and, if any residual risk to public safety remains, they would suitably address ongoing concerns. However, Mr Rich submitted that should the Committee find that there is no residual risk to public safety, but that a finding of impairment is required in the public interest only, this could confidently be addressed by the issuing of a reprimand.

Committee's decision and reasons on misconduct

29. In coming to its decision on misconduct, the Committee bore in mind that in the case of Roylance v GMC (No. 2) [2000] 1 AC 311, misconduct is defined as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

30. In considering whether any or all of the facts found proved amount to misconduct, the Committee had regard to the following principles from 'Standards for the Dental Team (September 2013)', ('the Standards') in particular:

Standard 1.1
You must listen to your patients.

1.1.1 You must discuss treatment options with patients and listen carefully to what they say. Give them the opportunity to have a discussion and to ask questions.

Standard 2.1
You must communicate effectively with patients – listen to them, give them time to consider information and take their individual views and communication needs into account.

Standard 2.2
You must recognise and promote patients' rights to and responsibilities for making decisions about their health priorities and care.

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.*

Standard 2.3
You must give patients the information they need, in a way they can understand, so that they can make informed decisions.

2.3.4 You should satisfy yourself that patients have understood the information you have given them, for example by asking questions and summarising the main points of your discussion.
2.3.5 You should make sure that patients have enough information and enough time to ask questions and make a decision.

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

Standard 3.2
You must make sure that patients (or their representatives) understand the decisions they are being asked to make.

Standard 4.1
You must make and keep contemporaneous, complete and accurate patient records.

Standard 7.1
You must provide good quality care based on current evidence and authoritative guidance.

31. In relation to your radiographic practice, the Committee considered the expert report of Dr Quelch. He opined that, based on the evidence that you failed to take a radiograph prior to the extraction of the LL8, this failure has led to such significant patient harm and had huge consequences for Patient A. Dr Quelch stated that lower wisdom teeth can be in close association with the nerves running in the mandible and a thorough assessment of the tooth and the relationship of the inferior alveolar dental nerve should have been completed on either an intra oral periapical or OPG radiograph. In light of the fact that this was not done, Dr Quelch opined that this fell far below the standards of a reasonable and competent dentist. Having carefully considered Dr Quelch's report against the evidence provided, the Committee agreed with the expert and concluded that your radiographic practice fell far below the standards expected and amounted to misconduct.

32. In relation to your antibiotic practice, the Committee bore in mind that the first course of action was not the prescription of antibiotics but rather to have drained the site. In any event, your prescription of antibiotics was incorrect. The Committee also noted Dr Quelch's opinion that the same antibiotic was prescribed ten days later (albeit the correct dosage), and it is generally not recommended to give the same antibiotic in a short period of time. Moreover, the Committee took into account that you had received the 2016 warning as a result of similar issues with the prescription of antibiotics and therefore you should have been more aware of ensuring that the correct checks were undertaken and the correct guidance referred to. Having carefully considered the expert report, the Committee did not agree with Dr Quelch's opinion that your antibiotic practice fell below the standards and noted that he may not have been advised of the 2016 warning and the similarities in the issues that arose when compiling his report. Therefore, the Committee concluded that your antibiotic prescribing practices fell far below the standards expected and did amount to misconduct.

33. In relation to your failure to discuss the risks and benefits of treatment, the Committee noted that Dr Quelch identified that Patient A's records contain no evidence that the risks of the extraction were discussed, and this omission was confirmed within Patient A's complaint. Dr Quelch stated, *'A dental professional has a duty to fully assess a proposed procedure to predict the risks, so the patient can be fully informed on what could happen'.* Having established that you did not discuss the risks and benefits with Patient A regarding the extraction of LL8, the Committee was satisfied that this fell far below the standards expected, Therefore, the Committee concluded that your failure to discuss the risks and benefits with Patient A amounted to misconduct.

34. In relation to your record keeping, the Committee had careful regard to Patient A's clinical notes. The Committee considered that the entries regarding the relevant appointments were minimal, and you accepted in your oral evidence that you had not elaborated on the template entries, resulting in minimal detail being recorded for Patient A's appointments. The Committee considered Dr Quelch's opinion that your limited detail in the records fell far below the standard expected. However, the Committee bore in mind that this is a single incident of poor record keeping since at least 2016 and one of two incidents of poor record keeping in your career and therefore the Committee disagreed with the expert's evidence. Accordingly, the Committee found that this did not amount to misconduct.

35. In relation to your practice of obtaining informed consent, the Committee referred to Dr Quelch's expert report, in which he stated, 'A dentist is expected to obtain valid consent for a procedure including discussing the risks and benefits including all relevant options with a patient.' The Committee was satisfied that it is a fundamental tenet of the dental profession to obtain consent before undertaking treatment and that it is a basic element of dental practice for a patient to provide informed consent. The Committee took into account that on this occasion, one of the risks that should have been discussed with Patient A came to fruition having not informed Patient A that damage to the nerve resulting from the extraction may result in permanent loss of sensation in the face and gum. Therefore, the Committee was satisfied that your failure to obtain informed consent fell far below the standards expected and amounted to misconduct.

36. The Committee was therefore satisfied that, having considered the facts found proved individually and collectively, your conduct had breached a number of the Standards and was sufficiently serious to amount to falling far short of what can be expected of reasonable and competent dentist.

37. Accordingly, the Committee determined that these breaches amounted to misconduct.

Committee's decision and reasons on impairment

38. The Committee considered whether your misconduct is remediable, whether it had been remedied, and the risk of repetition. The Committee also had regard to the wider public interest, which includes the need to uphold and declare proper standards of conduct and behaviour to maintain public confidence in the profession and this regulatory process.

39. The Committee acknowledged that this case involves elements of clinical practice that are capable of remediation and that this is not a case involving behavioural concerns. Therefore, it considered whether those elements of your clinical practice have been remedied.

40. The Committee commended you for the attempts you have made to address the failings that resulted in Patient A's complaint, noted that you have undertaken a number of hours of relevant and focused CPD, and you have self-appointed a mentor to discuss your practice and undertake audits of your work. It also bore in mind that you have addressed some practical elements of your individual practice including lengthening appointment times to allow you further time to discuss treatment with patients and provide more detailed clinical notes in patient records. Whilst the Committee accepted that these improvements would no doubt have lessened the risk previously posed, there remained some concerns about the risk of repetition due to your currently limited insight and understanding of the incident.

41. It was clear from your reflective statement that this incident and these proceedings have had a considerable impact on you, and you have stated that you are embarrassed and ashamed of your conduct. In your reflective statement, you very obliquely address the effect on Patient A (*'…I am reflecting on a specific incident than not only brought discomfort on my patient…')* but focus more directly on the impact this incident has had on you *('…I cannot accept that there is no hope for me as my will to excel was and is my main drive.')* Therefore, the Committee considered that your current insight is unsatisfactory, and this increases the risk of repetition of similar conduct in the future.

42. Moreover, the Committee bore in mind that a very similar incident occurred previously, for which the IC recorded in its notification of the warning in 2016 that you had also undertaken targeted remediation at that time. In light of the previous incident and the ongoing harm to Patient A, it could not be assured that the remediation and limited insight demonstrated was sufficient to address the concerns regarding future risk. The Committee concluded that despite the clinical remediation undertaken, the limited insight and failure to understand how this incident occurred increased the risk of repetition in the future. In addition, there is limited evidence to demonstrate that your remedial efforts have been sufficiently embedded in your practice at this time.

43. Therefore, the Committee determined that a finding of impairment is necessary on the ground of public protection.

44. The Committee bore in mind the overarching objective to maintain public confidence in the profession and upholding standards. It concluded, having considered all the information before it, that public confidence would be undermined if a finding of impairment were not made in this case.

45. Therefore, the Committee also determined that your practice is currently impaired on the ground of public interest.

Committee's decision and reasons on sanction

46. In coming to its decision on sanction, the Committee considered what action, if any, to take in relation to your registration. It took into account the GDC's document *'Guidance for the Practice Committees, including Indicative Sanctions Guidance 2016* (ISG)' (revised December 2020). The Committee reminded itself that any sanction imposed must be proportionate and appropriate and, although not intended to be punitive, may have that effect.

47. The Committee took into account the following aggravating features were present in this case:

- Actual harm or risk of harm to a patient or another;
- Previous warning given in 2016; and
- Limited insight into the impact on Patient A.

48. The Committee also took into account the following mitigating features:

- Evidence of good conduct following the incident in question, including remedial steps;
- Some evidence of remorse shown;
- Evidence of steps taken to avoid a repetition;
- No financial gain on your part;
- Time elapsed since the incident; and
- Positive testimonials form colleagues and patients.

49. The Committee had regard to its previous findings on misconduct and impairment in coming to its decision and considered each sanction in ascending order of severity.

50. The Committee first considered whether to impose no order or to issue a reprimand but concluded that this would be inappropriate in view of the risk of repetition of similar conduct that has been identified in this case. The Committee did not consider it would sufficiently protect the public, nor would it be in the public interest, to allow you to return to practice without some form of restriction in place.

51. The Committee then considered whether placing conditions on your registration would be a sufficient and appropriate response. Any conditions that may be formulated must be workable, measurable, enforceable and address the risks that have been identified.

52. The Committee took account of the ISG, which states conditions may be suitable where most of the following factors are present:

- There are discrete aspects of your clinical practice that are problematic;
- Those deficiencies are not so significant that patients will be put at risk directly or indirectly as a result of continued – albeit restricted – registration;
- You have shown evidence of insight and willingness to respond positively to conditions, including working under your self-imposed 'conditions' since August 2024; and
- It is possible to formulate conditions that will protect the public during the period they are in force.

53. Having carefully considered the misconduct in this case, the Committee was satisfied that the discreet areas of your practice, namely your radiographic practice, your antibiotic prescribing practice, your discussion of risks and benefits of treatment and obtaining informed consent were such that conditions for practice could be specifically formulated to protect the public and address the wider public interest whilst allowing you to return to practice.

54. The Committee bore in mind that in an attempt to remediate your failings, you have arranged a mentor with whom your have been working closely to discuss your practice and undertake audits of your work. In addition, you have chosen to undertake a number of CPD courses in 2024 that are relevant to the shortcomings resulting from the incident in 2020. Therefore, the Committee was satisfied that you have demonstrated you are willing to respond positively to conditional registration and work with others to ensure compliance with them.

55. In its consideration of whether a more restrictive sanction was required, the Committee concluded that a suspension or erasure would be wholly disproportionate and would not be a reasonable response in the circumstances of your case.

56. Accordingly, the Committee determined that an order of conditional registration would be appropriate and proportionate to address the areas of concern and sufficiently protect the public and the wider public interest.

57. Having had regard to the matters it has identified, the Committee concluded that conditions would mark the importance of maintaining public confidence in the profession, and will send the public and the profession a clear message about the standards of practice required of a dentist.

58. Balancing all of these factors, the Committee determined the following conditions are appropriate and proportionate in this case:

1) He must notify the GDC within seven days of any post he accepts for which GDC registration is required.

2) If employed, he must provide contact details of his employer within seven days from the date these conditions take effect and allow the GDC to exchange information with his employer or any contracting body for which he provides dental services.

3) He must inform the GDC within seven days of any formal disciplinary proceedings taken against him from the date these conditions take effect.

4) He must inform the GDC within seven days of any complaints made against him from the date these conditions take effect.

5) He must inform the GDC if he applies for dental employment outside the UK within seven days of making any application.

6) He must notify the GDC promptly of any professional appointment he accepts and provide the contact details of his employer or any organisation for which he is contracted to provide dental services, and the Commissioning Body on whose Dental Performers List he is included or Local Health Board if in Wales, Scotland or Northern Ireland.

7) He must allow the GDC to exchange information with his employer or any organisation for which he is contracted to provide dental services, and workplace supervisor referred to in these conditions.

*8) At any time he is employed, or providing dental services, which require him to be registered with the GDC; he must place himself and remain under the **supervision*** of a workplace supervisor nominated by him , and agreed by the GDC.*

9) He must allow his workplace supervisor to provide reports to the GDC every 3 months and at least 14 days prior to any review hearing. The workplace supervisor should provide information and/or feedback commenting on:

a) Antibiotic Prescribing;
b) Pre-operative radiographs in relation to extractions
c) Communication to patients of full risks and/or benefits of proposed treatment
d) Seeking Informed Consent for treatments

10) He must inform within seven days the following parties that his registration is subject to the conditions listed at 1) to 9):

a) Any locum agency or out-of-hours service he is registered with or applies to be registered with (at the time of application);
b) Any prospective employer (at the time of application);
c) Any organisation or person employing or contracting with him to undertake dental work; and
d) His workplace supervisor.

11) He must permit the GDC to disclose the conditions 1) to 10) to any person requesting information about his registration.

** **Supervised:** the workplace supervisor must supervise the registrant's day-to-day work in a way prescribed in the relevant condition or undertaking. The workplace supervisor does not need to work at the same practice as the registrant, but they must be available to provide advice or assistance if the registrant needs it. Where the workplace supervisor is unavailable through illness or planned absence, the registrant must not work, unless an approved alternative workplace supervisor is in place. The workplace supervisor must review the registrant's work at least once a fortnight in one-to-one meetings and case-based discussions. These meetings must focus on all areas of concern identified by the conditions or undertakings. These meetings should usually be in person. If this is not possible, at least one of every two fortnightly meetings must be in person.*

59. The period of this order is for six months to allow you sufficient time to demonstrate sufficient insight into your misconduct and that you have embedded the remediative steps into your practice so as to negate the risk of repetition. The Committee directs that this order be reviewed before its expiry, and you will be informed of the date and time in writing. The reviewing Committee will consider what action it should take in relation to your registration following an assessment of the concerns affecting your fitness to practise.

60. The reviewing Committee may be assisted to receive a detailed reflective statement demonstrating your insight into and understanding of:

- *The impact of your misconduct on Patient A;*
- *The potential impact on patients and on public confidence; and*
- *The impact of your misconduct on the dental profession.*

61. The Committee now invites submissions as to whether the conditions should take immediate effect to cover the 28-day appeal period.

Decision on immediate order

62. The conditions of practice order does not come into effect until the end of the appeal period or, if an appeal is lodged, until it has been disposed of. The appeal period expires 28 days after the date on which the notification of the determination is served on you.

Submissions

63. In this regard, Mr Hamlet made an application for an immediate conditions of practice order, in the same terms as the substantive conditions, to be imposed on your registration. He submitted that, as the Committee has identified an ongoing and present risk of repetition, an immediate order is necessary on the ground of public protection and is otherwise in the public interest.

64. Mr Rich submitted that the imposition of an immediate order should be necessary for the protection of the public. He submitted that there are some features of this case that demonstrate where an immediate order is not necessary and referred to case law to support his submissions. Mr Rich submitted that you have worked for a considerable period without issue and that you have subjected yourself to self-imposed conditions under the supervision of a mentor and therefore an immediate order is not necessary in the circumstances of this case.

65. The Committee heard and accepted the advice of the Legal Adviser, referring the Committee to the criteria for the imposition of an immediate order.

Committee's decision and reasons on immediate order

66. Having already identified a risk of harm and a risk of repetition should you be permitted to practise without restriction, the Committee was satisfied that an immediate order is necessary for the protection of the public. The Committee was satisfied that an immediate order is also required on the ground of public interest to maintain public confidence in the profession. To do otherwise would be incompatible with the Committee's substantive findings.

67. The conditions for the immediate order will be the same as those detailed in the substantive order. This immediate order will remain in place until any appeal is disposed of or, if no appeal is lodged, the substantive conditions will replace the immediate order 28 days after you are sent the decision of the Committee in writing.

68. This will be confirmed to you in writing in accordance with the Act.

69. That concludes this determination.