HEARING HEARD IN PUBLIC

ANDRADE, Andre Borges Da Silva

Registration No: 174649

PROFESSIONAL CONDUCT COMMITTEE

JANUARY – AUGUST 2023

Outcome: Conditions for 18 months with immediate Conditions (with a review)

ANDRADE, Andre Borges Da Silva, a dentist, LMD Lisbon 2000, was summoned to appear before the Professional Conduct Committee on 9 January 2023 for an inquiry into the following charge:

Charge (as amended 9 January 2023)

"That being a registered dentist;

1. Between 02 March 2017 and 02 June 2017, you failed to plan the treatment of Patient A either adequately or at all, in that you did not:
    a. explain the risks of the treatment to Patient A and/or her mother, including the risk of severe root resorption;
    b. explain all of the treatment options to Patient A and/or her mother, including the option of having no treatment;
    c. calculate the total time required for retention of the orthodontic appliance;
    d. obtain and assess the concerns of Patient A regarding her presenting condition and wishes for treatment;
    e. provide Patient A and/or her mother with a personal treatment plan with proposals for comprehensive tooth movements;
    f. advise Patient A and/or her mother of the option of referral for specialist opinion and treatment;
    g. advise Patient A and/or her mother of the full range of soft tissue factors in the causation of her malocclusion;
2. By reason of Charge 1, you failed to obtain informed consent from Patient A and/or her mother for the orthodontic treatment proposed;
3. Between 02 March 2017 and 02 June 2017, you failed to provide an adequate standard of care to Patient A, in that you:
    a. failed to assess and diagnose her presenting condition, including with regards to her:
        i. full malocclusion and its aetiological factors.

ii. existing and localised root resorption in the upper right lateral and central incisors;

iii. full range of soft tissue and facial factors;

iv. skeletal factors;

b. did not dis-impact and move the UR3 before beginning orthodontic treatment;

4. As amened - Between 12 June 2017 and 20 January 2020, you failed to manage the condition of Patient A, in that you failed to diagnose and treat her ongoing root resorption;

5. On 10 January 2020, you failed to provide an adequate standard of care to Patient A, in that you failed to assess her palatally impacted and displaced UR3;

6. You failed to maintain an adequate standard of radiographic practice, in that you did not:

a. take an orthopantomogram radiograph ("OPG") before proposing orthodontic treatment to Patient A and/or her mother on 02 March 2017;

b. justify, report, and/or quality assess the OPG that you took on 02 June 2017;

c. take further radiographs, including a cephalometric lateral skull radiograph, on 02 June 2017 to diagnose the impacted UR3;

d. take an OPG to review the progress of your treatment of Patient A on 17 November 2017;

e. take any radiograph to investigate root resorption between 12 June 2017 and 24 January 2020, as was clinically indicated;

7. You failed to maintain an adequate standard of record-keeping, in that you did not:

a. record your diagnosis of the full malocclusion of Patient A on

i. 16 June 2016;

ii. 02 June 2017;

b. record the findings of your soft tissue examinations on:

i. 02 March 2017;

ii. 24 August 2017;

c. adequately record the progress of your treatment of Patient A between 02 June 2017 and 24 January 2020;

d. record the root resorption of Patient A on 10 January 2020;

e. record the full narrative of your treatment plan anywhere in the clinical notes;

8. On 02 March 2017, you gave a booklet to Patient A and her mother in which you signed your name above the words “Orthodontist’s signature”;

9. Your conduct in respect of Charge 8 was misleading, in that you wrongly held yourself out as a specialist orthodontist to Patient A and her mother;

10. As amended - Between 02 June 2017 and 24 January 2020, you worked outside your competence as a general dental practitioner, in that you undertook specialist orthodontic treatment of Patient A without being qualified to do so.

AND that by reason of the matters alleged above, your fitness to practise is impaired by reason of misconduct.”

Mr Andrade was present and was represented. On 11 January 2023, the Chairman made a statement regarding the preliminary application:

11 January 2023 – Submission of No Case to Answer.

“Mr Geering on your behalf, made a submission under Rule 19(3) of the General Dental Council (GDC) (Fitness to Practise) Rules 2006 that there is no case to answer in respect of heads of charge 5 and 6(c).

Submissions

Mr Geering submitted that in respect of head of charge 5 that there is no evidence that there was a requirement on 10 January 2020 to undergo an assessment of Patient A’s UR3. Mr Geering submitted that a referral for this particular tooth had been made in October 2019. Therefore, by 10 January 2020 the patient had already been referred for secondary care. Mr Geering submitted that two radiographs had previously been taken on 19 December 2020 which identified the palatally impacted and displaced UR3. This diagnosis was communicated to you in a letter. Mr Geering submitted that therefore there was nothing for you to add to that assessment as all the relevant steps had been done. It was not necessary for you to take another radiograph on 10 January 2020 as two had already been taken at the Hospital. Mr Geering submitted that there is no case to answer as there is no evidence at all to support this allegation.

In respect of head of charge 6(c*),* Mr Geering submitted that you have accepted that further radiographic images should have been taken but you deny that this cephalometeric lateral skull radiograph was necessary. He submitted that however, when Patient A was referred for secondary care and treated by Witness 2 (a Locum Speciality Doctor in Oral & Maxillofacial Surgery), she made an initial diagnosis regarding Patient A’s UR3 without a cephalometric radiograph. Mr Geering submitted that it is of note that no such radiograph has ever been taken in this case. Mr Geering submitted that there is sufficient evidence that the tooth was diagnosed

without the benefit of that technique, and that there are other radiographic techniques available. Mr Geering submitted that this particular allegation is specific to the diagnosis of UR3, and it is clear that you could do so without a cephalometeric lateral skull radiograph. Mr Geering submitted that therefore the wording "*including a cephalometric lateral skull radiograph*" should be removed.

Mr Sykes in respect of head of charge 5 requested that the Committee consider two things, was there an obligation to assess the UR3 on 10 January 2020 and also was it assessed. He submitted that such an obligation did exist, and a letter dated 19 December 2019 by Witness 2 asked you to review the patient as soon as possible. Mr Sykes submitted that the patient records confirmed that the UR3 was not assessed. He submitted that there was an obligation on you to assess Patient A on that date. The dental records make no mention of UR3 and therefore there was a failure on your part to assess Patient A's UR3. Mr Sykes submitted that the Committee have yet to hear an explanation from you as to why you did not do this. He submitted that it would be premature to withdraw this head of charge until the Committee has heard evidence from you and your expert witness.

In respect of head of charge 6(c), Mr Sykes submitted that this Committee had heard expert evidence from Mr Powell, who has been clear and unequivocal that this cephalometric lateral skull radiograph was necessary. Mr Powell has stated that it was dangerous not to take one. Mr Sykes submitted that the radiographs beyond 24 January 2020 are not available, and the Committee has no knowledge of subsequent radiographs. He submitted that a cephalometric lateral skull radiograph was necessary to locate the exact position of the UR3 in Patient A's mouth. He invited the Committee to reject the application in respect of this head of charge.

Committee's deliberations

The Committee has considered the submissions made by both Counsel. The Committee has accepted the Legal Adviser's advice as to the approach it should follow. It has borne in mind that the burden of proof is on the GDC and that the civil standard of proof applies, namely on the balance of probabilities.

The Committee would emphasise that it is not reaching any findings of fact at this stage of proceedings. In its deliberations, the Committee has had regard to the oral and documentary evidence presented by the GDC.

The Committee notes that the head of charge 5 relates to a specific date. The Committee noted the entry on 21 January 2020 stating that letters received from treating practitioners mention further discussion was made to explore all options with Witness 1, mother of Patient A. The letter of 19 December 2019 from the Hospital to you confirms it was now considered that the treatment of this patient was now in the hands of specialists with regards to UR3. They also confirmed that two radiographs had been taken. The letter did not specifically request you to review Patient A's UR3 again. The Committee is satisfied there is no evidence to demonstrate that you had a

duty to assess Patient A's palatally impacted and displaced UR3 on 10 January 2020.

The Committee is therefore satisfied that the GDC has failed to provide sufficient evidence to support this charge. The Committee therefore allows the application in respect of head of charge 5.

In respect of head of charge 6(c), the Committee notes the application is to remove the words" "*including a cephalometric lateral skull radiograph*". The Committee notes that you have admitted that you should have taken further radiographs. Mr Powell, a specialist orthodontist, stated in his oral evidence that a cephalometric lateral skull radiograph was required to precisely locate the UR3. Therefore, the Committee considers that there is further evidence that needs to be considered in respect of the full wording of this head of charge before making a finding.

The Committee therefore rejects the application in respect of head of charge 6(c)."

On 13 January 2023, the hearing adjourned part-heard and resumed on 9 February 2023.

On 9 February 2023, the Chairman made a statement regarding the preliminary application. On 10 February 2023 the Chairman announced the findings of fact:

"Mr Andrade

This is the Professional Conduct Committee's inquiry into the facts which form the basis of the allegation against you. You attended the hearing, and you are represented by Mr Christopher Geering, Counsel. Mr Christopher Sykes of Counsel presented the General Dental Council's (GDC) case. All parties attended in person from 8-12 January 2023. However due to a lack of time, the matter was adjourned and reconvened remotely via Microsoft Teams video-link in line with the GDC's current guidance on 9 and 10 February 2023.

The Committee has taken into account all the evidence presented to it. It has accepted the advice of the Legal Adviser. In accordance with that advice, it has considered each head of charge separately.

Preliminary applications - 9 January 2023

Mr Geering on 9 January 2023 made an application for the defence expert to attend remotely, due to a medical matter that has resulted in him being unable to attend in person. No objection was made by the GDC.

The Committee accepted advice from the Legal Adviser. The Committee is satisfied that allowing the defence expert to attend this hearing remotely will not cause prejudice to either party. It notes no objection from the GDC and that many GDC PCC substantive hearings with witnesses giving evidence remotely, are held successfully.

Mr Sykes made an application under Rule 18 to amend heads of charge 4 and 10.

In respect of head of charge 4, he applied to change the date from 2 June 2017 to 12 June 2017. He submitted that the orthodontic treatment had not begun on 2 June 2017, in that the braces had not yet been installed. No objection was made by Mr Geering on your behalf.

The Committee accepted advice from the Legal Adviser. The Committee considered that the proposed amendment clarifies the head of charge. The Committee is satisfied that this amendment will not cause prejudice to either party and accepts the amendment to head of charge 4.

In respect of head of charge 10, Mr Sykes applied to delete the words "*the scope of*". He submitted this wording should be removed because it could wrongly suggest that General Dental Practitioners who conduct orthodontic treatment are working outside the scope of practice. He submitted that this is not the case. No objection was made by Mr Geering on your behalf.

The Committee were referred to the GDC's scope of practice document, by both parties, and concluded that a GDP can carry out orthodontic treatment including fixed appliances if they are trained, competent and indemnified. As a result, the Committee considered that the amendment would avoid confusion and would not result in injustice to either party.

Background

The allegations you face at this hearing relate to the receipt of two complaints concerning the standard of treatment you provided to a child patient between 2017 and 2020. The first complaint was received by the GDC from the subsequent treating dentist, a consultant in maxillofacial surgery (Witness 2) on 28 February 2020 and the second complaint from the patient's mother (Witness 1) on 18 April 2020.

Witness 2 raised a concern that the patient had suffered life changing effects, including root resorption, due to orthodontic treatment carried out by you. Witness 2 also raised a concern that you had shown no insight and that you were holding yourself out as a specialist orthodontist. Concerns were also raised that you did not take adequate radiographs.

It is alleged that you failed to provide an adequate standard of care to the patient from 02 March 2017 to 24 January 2020, in relation to:

- not carrying out a full assessment of the patient's presenting condition
- failing to plan the treatment of Patient A either adequately or at all;
- failing to obtain informed consent from Patient A and/or her mother for the orthodontic treatment proposed
- failing to diagnose and treat her ongoing root resorption;
- failing to assess her palatally impacted and displaced UR3
- failing to maintain an adequate standard of radiographic practice

- failing to maintain an adequate standard of record-keeping
- giving a booklet to Patient A and her mother in which you signed your name above the words “Orthodontist’s signature, which was misleading;
- working outside your competence between 02 June 2017 and 24 January 2020 as a general dental practitioner, in that you undertook specialist orthodontic treatment of Patient A without being qualified to do so.

Evidence

The Committee has been provided with documentary material in relation to the allegations that you face, including the dental records of Patient A; the witness statement and documentary exhibits of Patient A’s mother, who is referred to for the purposes of these proceedings as Witness 1; and the report of the GDC’s expert witness dated 16 January 2021, namely Dr Stephen Powell.

The Committee heard oral evidence from Witness 1 and from Dr Powell.

The Committee received the witness statement of Witness 2, a Consultant Maxillofacial Surgeon, dated 21 January 2021.

The Committee heard oral evidence from you and received your signed witness statement dated 14 January 2022. It received a report from your expert witness dated 3 January 2022, namely Professor Derrick Willmot, and heard oral evidence from him. The Committee also received a joint expert report dated 16 March 2022.

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

1.	*Between 02 March 2017 and 02 June 2017, you failed to plan the treatment of Patient A either adequately or at all, in that you did not:*
1.(a)	*explain the risks of the treatment to Patient A and/or her mother, including the risk of severe root resorption;* ***Admitted and found proved***
1.(b)	*explain all of the treatment options to Patient A and/or her mother, including the option of having no treatment;* ***Admitted and found proved.***
1.(c)	*calculate the total time required for retention of the orthodontic appliance;* **Proved.** You stated in oral evidence that you usually confirmed the period of retention at the end of treatment and you told patients that retainers were needed for as long as they wanted their teeth to remain straight. The Committee were taken to the Treatment plan on FP17 DCO. On it there were 3 options; Up to 12 months, long term and permanent. You selected “long term”. You said in oral evidence that this would be 3 years to 30

	years or lifelong retention, although it is not clear that this was discussed with the patient or their parent. Dr Powell's view was that the correction of anterior open bite invariably required lifelong retention as the risk of relapse was high. He was of the view that this information was an important element of the consent process and the patient and their parent needed to be aware as lifelong retention was an onerous commitment. Professor Willmot disagreed. He stated that permanent retention was more likely to be required than not, however, it was not a certainty. His view was that a reasonable body of practitioners would finalise the retention period when the treatment was completed and the impact of soft tissue positioning was known. The Committee preferred the evidence of Dr Powell. Your explanation of "*3 years to 30 to lifelong*" did not give the Committee confidence that this matter had been carefully considered in a case where the likelihood of relapse was high. In addition, the Committee noted that the FP17 DCO treatment plan required a decision on the period of retention to be made before treatment commenced and not after as suggested by Professor Willmot. For these reasons it therefore finds this head of charge proved.
1.(d)	*obtain and assess the concerns of Patient A regarding her presenting condition and wishes for treatment;* **Not proved.** You stated that there was a discussion about Patient A's concerns, including the position of her teeth, open bite and thumb sucking habits. However, after 5 years you admit that you cannot remember the exact words that Patient A said to you. You admitted that this discussion should have been recorded. You agreed that the wishes and concerns of Patient A were not recorded in the medical records. The Committee notes that the only evidence in respect of this head of charge comes from Witness 1 and you. You have stated that it is your usual practice to have such discussions with your patients. The Committee notes that Witness 1 had difficulty in recollecting exactly what was said during the consultation due to the passage of time but agrees that this conversation probably did take place. The Committee is satisfied that on the balance of probabilities that a discussion would have taken place between you and Witness 1 regarding the reasons for the referral. The Committee considers that the GDC has failed to provide evidence to prove this head of charge.

	It therefore finds this head of charge not proved.
1.(e)	*provide Patient A and/or her mother with a personal treatment plan with proposals for comprehensive tooth movements;* **Not proved.** You stated that FP17 DCO was the treatment plan that you gave to Patient A. You also stated that the treatment plan was provided as a summary and to reinforce the verbal advice you gave during the consultation. However, you admitted that your entries were generic and lacked detail. The Committee has considered the expert evidence of Dr Powell and Professor Willmot on these issues and notes their disagreement. The Committee is satisfied that what was contained in the FP17 DCO, which is clearly a treatment plan, was adequate information for the patient and her mother. The Committee considers that between 2 March and 12 June 2017 that information on comprehensive tooth movement would not have been helpful to Patient A and her mother. The Committee is satisfied that the GDC has failed to provide sufficient evidence to demonstrate that you had a duty to provide on the FP17 DCO form proposals for comprehensive tooth movements. It therefore finds this head of charge not proved.
1.(f)	*advise Patient A and/or her mother of the option of referral for specialist opinion and treatment;* ***Admitted and found proved.***
1.(g)	*advise Patient A and/or her mother of the full range of soft tissue factors in the causation of her malocclusion;* ***Admitted and found proved.***
2.	*By reason of Charge 1, you failed to obtain informed consent from Patient A and/or her mother for the orthodontic treatment proposed;* ***Admitted and found proved.***
3.	*Between 02 March 2017 and 02 June 2017, you failed to provide an adequate standard of care to Patient A, in that you:*
3.(a)	*failed to assess and diagnose her presenting condition, including with regards to her:*
3.(a)(i)	*full malocclusion and its aetiological factors;* **Admitted on the basis that the mandibular assessment was wrong.**

	Proved in its entirety. You stated that you had initially assessed Patient A in August 2016 and again in March 2017. You accept that the skeletal and sagittal classification you made at that time, class 1, might not be accurate. You stated that the maxillary/mandibular plane angle was incorrectly recorded as normal, class 1 incisor relationship was incorrectly recorded, and the anterior open bite asymmetry was not recorded. The Committee noted that the expert witnesses' views differed in relation to the assessment and diagnosis of the presenting condition. Dr Powell stated that Patient A presented with an asymmetric anterior open bite which was incorrectly assessed by you. He stated that some of the factors were not recorded at the outset of the treatment when considering malocclusion. Professor Willmot stated that the form had a few minor irregularities but contained the necessary information. He admitted in cross examination that the incisor classification was wrong and should have been classified as class 2. The Committee accepted the evidence of Dr Powell and that you had failed to assess and diagnoses Patient A's presenting condition including her full malocclusion and its aetiological factors. The Committee is satisfied that the Orthotrac document was incomplete, contrary to the evidence that you gave in paragraph 64 of your witness statement. Therefore, the Committee is satisfied that you had failed to assess and diagnose Patient A's full malocclusion and its aetiological factors. It therefore finds this head of charge proved.
3.(a)(ii)	*existing and localised root resorption in the upper right lateral and central incisors;* ***Admitted and found proved.***
3.(a)(iii)	*full range of soft tissue and facial factors;* **Admitted on the basis that the lip competence was not recorded.** **Proved in its entirety.** You admitted in oral evidence that an anterior open bite, always involves incompetent lips and a tongue thrust. You stated that this did not need to be specifically recorded by you. The Committee noted the evidence of Dr Powell on this issue which was that there was no soft tissue analysis recorded.

	Professor Willmot stated that whilst you had recorded some soft tissue factors you had not recorded lip competency. He also noted that you had diagnosed Patient A's profile as normal. Both experts had stated that the profile was retrusive, although in Professor Willmot's case in oral evidence he stated "*not wildly so*". The Committee prefers the evidence of Dr Powell on this matter. It considers that there is no evidence that you had assessed and diagnosed the full range of Patient A's soft tissue and facial factors. The Committee considers that on the balance of probabilities that you failed to assess and diagnose Patient A's presenting condition with regards to her full range of soft tissue and facial factors. It therefore finds this head of charge proved.
3.(a)(iv)	*skeletal factors;* ***Admitted and found proved.***
3.(b)	*did not dis-impact and move the UR3 before beginning orthodontic treatment;* ***Admitted and found proved.***
4.	*As amended - Between 12 June 2017 and 20 January 2020, you failed to manage the condition of Patient A, in that you failed to diagnose and treat her ongoing root resorption;* ***Admitted and found proved.***
5.	*On 10 January 2020, you failed to provide an adequate standard of care to Patient A, in that you failed to assess her palatally impacted and displaced UR3;* **WITHDRAWN**
6.	*You failed to maintain an adequate standard of radiographic practice, in that you did not:*
6.(a)	*take an orthopantomogram radiograph ("OPG") before proposing orthodontic treatment to Patient A and/or her mother on 02 March 2017;* **Proved.** In your evidence you explained that on 2 March the OPG machine was faulty and that you needed to delay the radiograph until the next appointment. Your records for that date show that upper and lower fixed appliances and upper and lower retainers were proposed at that time but that the treatment plan would be formulated after the OPG was taken and

	reported. Nevertheless, the Orthoworld Informed Consent Booklet was signed by you and Patient A's parent on that day, in confirmation that the treatment plan had been explained and accepted. The Committee accepted the evidence of Dr Powell that no orthodontic treatment should have been proposed before an OPG radiograph had been taken. Professor Willmot in cross examination agreed that it was not ideal. The Committee finds that in this case, it is unacceptable for a dentist to make proposals for orthodontic treatment without having taken and seen an OPG radiograph. You should have stated that you were not in a position to make proposals for orthodontic treatment until you had seen a OPG radiograph. In the absence of such a radiograph you failed to maintain an adequate standard of radiographic practice. It therefore finds this head of charge proved.
6.(b)	*justify, report, and/or quality assess the OPG that you took on 02 June 2017;* ***Admitted and found proved.***
6.(c)	*take further radiographs, including a cephalometric lateral skull radiograph, on 02 June 2017 to diagnose the impacted UR3;* ***Admitted in respect of a failure to take further radiographs and found proved. – Found proved.*** ***Not proved - in respect of a cephalometric lateral skull radiograph, on 02 June 2017 to diagnose the impacted UR3*** The Committee noted that both experts agreed that further radiographs were needed to diagnose the position of the impacted UR3. The point of contention between the two experts was whether it required a cephalometric lateral skull radiograph. Dr Powell stated that this particular radiograph would give more detail and would assist a maxillofacial surgeon and was therefore necessary for a proper diagnosis of the exact position of UR3. However, in oral evidence he acknowledged that there are other ways of determining the position of unerupted canines such as intra oral views. The Committee noted that an intra oral view was used by the maxillofacial team at Northampton Hospital. Professor Willmot maintained that a body of reasonable practitioners would not expose a cephalometric lateral skull radiograph but would take a standard upper occlusal radiograph to locate the position of an unerupted canine.

	The Committee reminded itself that this head of charge relates to the diagnosis of the impacted UR3. It accepted the evidence of Professor Wilmott that there were alternatives to a cephalometric lateral skull radiograph that a GDP could use. It therefore finds this head of charge not proved.
6.(d)	*take an OPG to review the progress of your treatment of Patient A on 17 November 2017;* ***Admitted and found proved.***
6.(e)	*take any radiograph to investigate root resorption between 12 June 2017 and 24 January 2020, as was clinically indicated;* ***Admitted and found proved.***
7.	*You failed to maintain an adequate standard of record-keeping, in that you did not:*
7.(a)	*record your diagnosis of the full malocclusion of Patient A on*
7.(a)(i)	*16 June 2016;* ***Admitted and found proved.***
7.(a)(ii)	*2 June 2017;* ***Admitted and found proved.***
7.(b)	*record the findings of your soft tissue examinations on:*
7.(b)(i)	*2 March 2017;* ***Admitted and found proved.***
7.(b)(ii)	*24 August 2017;* ***Admitted and found proved.***
7.(c)	*adequately record the progress of your treatment of Patient A between 02 June 2017 and 24 January 2020;* **Proved.** You state that you had adequately recorded the course of Patient A's treatment, and the progress from the appointment before. You said that you were recording if progress was happening but not specific distances. You stated that if you were to write everything that happened it would be overwhelming with too much information. Professor Willmot in his evidence stated that the progress recorded in Patient A's notes was adequate. Dr Powell stated than an experienced orthodontist can "*eyeball*" how a

	patient's teeth were doing. He stated that you are not an experienced orthodontist and that metric measurements were required, and that over 2.5 years you did not measure the movement of her teeth. The Committee accepted the evidence of Dr Powell. It considers that during this lengthy treatment, you were reliant on your records. Professor Willmot stated that it is common practice for descriptive terms such as "*good*" to be used by dental professionals. However, the Committee noted this is a very complex case with teeth moving over different planes. The Committee considers that on balance, given the difficulty and length of time, that some form of metric measurement and recording would be appropriate and would have assisted you and any other treating dentist. It therefore finds this head of charge proved.
7.(d)	*record the root resorption of Patient A on 10 January 2020;* ***Admitted and found proved.***
7.(e)	*record the full narrative of your treatment plan anywhere in the clinical notes;* ***Admitted and found proved.***
8.	*On 02 March 2017, you gave a booklet to Patient A and her mother in which you signed your name above the words "Orthodontist's signature";* ***Admitted and found proved.***
9.	*Your conduct in respect of Charge 8 was misleading, in that you wrongly held yourself out as a specialist orthodontist to Patient A and her mother;* ***Admitted and found proved.***
10.	*As amended - Between 02 June 2017 and 24 January 2020, you worked outside your competence as a general dental practitioner, in that you undertook specialist orthodontic treatment of Patient A without being qualified to do so.* ***Admitted and found proved.***

We move to Stage Two."

On 01 August 2023 the Chairman announced the finding of facts as follows:

"The hearing resumed on the morning of 31 July 2023. The Committee's findings of fact were handed down on 10 February 2023 which had been sent to parties on that same day for the purposes of facilitating their preparation for this second stage of the hearing.

Proceedings at stage two

The Committee has considered all the evidence presented to it. It has also taken into account the submissions made by Mr Christopher Sykes on behalf of the GDC and those made by Mr Christopher Geering on your behalf.

In its deliberations the Committee has had regard to the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016, updated December 2020). The Committee has accepted the advice of the Legal Adviser.

Evidence

The Committee has been provided with documentary material relevant to its consideration at this second stage of the hearing, namely certificates and logs of continuing professional development (CPD), reflections on learning, and testimonials.

The Committee has also had regard to the documentary evidence presented to it at the previous, factual stage of the hearing.

The Committee heard no oral evidence at this stage of the hearing.

Submissions

Mr Sykes submitted that the facts that the Committee has found proved amount to misconduct. He further submitted that in particular Head of charge10 must amount to misconduct. You should never have undertaken the treatment of Patient A. Your decision to do so had a severely negative impact on her long-term dental health. Embarking on this treatment which was beyond your competence was serious professional misconduct, as both experts agreed. Mr Sykes submitted that with regards to Heads of charge 1-9, the Council invite the Committee to prefer the evidence of Dr Powell for the purposes of assessing misconduct. The findings of Dr Powell were that most if not all of the Heads of charge did concern misconduct falling far below the standard expected of the reasonable practitioner.

Mr Sykes submitted that your fitness to practise is currently impaired, and that a finding of impairment is required for the protection of the public and also in the public interest. The failures were wide-ranging, and included; inadequate treatment planning; a failure to obtain informed consent; inadequate diagnosis; inadequate preparation for complex treatment; a failure to monitor, record, and diagnose the evolving condition of Patient A; failures in radiography; failures in record-keeping, and not recording the treatment of Patient A over time; and finally failures to communicate with Patient A regarding his expertise, or lack thereof. Mr Sykes submitted that these failures were aggravated by the fact that they collectively occurred between 02 June 2017 and 24 January 2020. This is an extended period over which you were acting outside of your competence.

Mr Sykes invited the Committee to impose a sanction of suspension for 6-9 months, with a review hearing to take place prior to the end of that period of suspended registration.

Mr Geering invited the Committee to consider each Head of charge found proved individually. You have accepted that your actions in multiple respects amount to serious professional misconduct. Mr Geering directed the Committee to Heads of charge 1(c), 1(g), 6(a), 7(a), 7(b), and 7(c) and submitted that these would not be considered deplorable nor meet the threshold of a finding of misconduct. He submitted that, even if the Committee were to find misconduct, your fitness to practise is not currently impaired. Mr Geering submitted that you have admitted a large number of Heads of charge, and you have demonstrated remorse and insight into your failings. Mr Geering submitted that you have undertaken a large volume of remediation and have produced to the Committee over 100 Continuing Professional Development (CPD) certificates. You have reflected fully on your failings, particularly on misleading Patient A, gaining informed consent, radiography and record keeping. You have apologised to Patient A and the GDC and have engaged fully with these proceedings.

Mr Geering submitted that were the Committee to find that your fitness to practise is currently impaired, no higher sanction than that of conditional registration is warranted requiring indirect supervision, together with audits of your caseload.

Misconduct

The Committee first considered whether some or all the facts that it has found proved constitute misconduct. In considering this matter, the Committee has exercised its own independent judgement.

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

Standard 1.3.2*: You must make sure you do not bring the profession into disrepute.*

Standard 2.3*: Give patients the information they need, in a way they can understand, so that they can make informed decisions.*

Standard 3.1*: Obtain valid consent before starting treatment, explaining all the relevant options.*

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

Standard 4.1*: Make and keep contemporaneous, complete, and accurate patient records.*

Standard 6.4*: Only accept a referral or delegation if you are trained and competent to carry out the treatment and you believe that what you are being asked to do is appropriate for the patient.*

The allegations giving rise to this case concern the standard of care and treatment that you provided to Patient A between 2016 – 2020. The Committee found that the treatment required was outwith your competence. You accepted and undertook a complex case which should have been referred to a specialist orthodontist team in secondary care. The Committee's specific findings relate to wide-ranging failings; inadequate treatment planning; a failure to obtain informed consent; inadequate diagnosis; inadequate preparation for complex treatment; a failure to monitor, record, and diagnose the evolving condition of Patient A; failures in radiography; failures in record-keeping, and not recording the treatment of Patient A over time; and finally failures to communicate with Patient A regarding your expertise or lack thereof.

The Committee notes that the GDC's expert witness, namely Dr Powell opined that the majority of the proven facts fell far below the standards.

The Committee first considered whether the facts that it has found proved amount to misconduct. The Committee notes the expert view of Dr Powell that most if not all of the Heads of charge did concern misconduct falling far below the standard expected of the reasonable practitioner. The Committee finds that certain acts and omissions represent conduct which falls far short of the standards reasonably to be expected of a general dental practitioner. In particular the Committee finds that Heads of charge 1 (a), 1(b), 1(f), 2, 3(a)(i)-(iv), 3(b), 4, 6(a), 6(b), 6(c), 6(d), 6(e), 8, 9, and 10 would be considered deplorable by fellow practitioners as they each relate to serious misconduct, which resulted in harm to Patient A who suffered as Witness 2 stated "*life changing root resorption due to orthodontic treatment*".

The Committee therefore finds that the facts that it has found proved at Heads of charge 1 (a), 1(b), 1(f), 2, 3(a)(i)-(iv), 3(b), 4, 6(a), 6(b), 6(c), 6(d), 6(e), 8, 9, and 10 amount to misconduct.

The Committee also finds that the record-keeping facts that it has found proved at Heads of charge 7(a)(i), 7(a)(ii), 7(b) (i), 7(b)(ii), 7(c), 7(d), and 7(e) did not amount to serious misconduct. The Committee noted that although these Heads of charge were found proved, it did not consider these to be serious misconduct.

The Committee therefore finds that there is misconduct in this case.

Impairment

The Committee then went on to consider whether your fitness to practise is currently impaired by reason of the misconduct that it has found. In doing so, the Committee has again exercised its independent judgment. Throughout its deliberations, the Committee has borne in mind that its primary duty is to address the public interest, which includes the protection of patients, the maintenance of public confidence in the profession and in the regulatory process, and the declaring and upholding of proper standards of conduct and behaviour.

The Committee has determined that your fitness to practise is currently impaired. The Committee considers that as your acts and omissions relate to specific, basic

and fundamental aspects of dentistry they lend themselves to remediation. However, you have not demonstrated sufficient remediation of these matters.

The Committee finds that you have demonstrated a good level of insight and remorse. You made admissions to a number of the Heads of charge, and you have made attempts to remediate. However, audits which are referred to in testimonials from colleagues have not been presented to the Committee. You have had time to present these since the findings of facts were handed down in February 2023. The Committee has not been presented with evidence to demonstrate that your recent learning has been embedded in your practice.

The Committee finds that the steps that you have taken to remedy your clinical failings are lacking. The Committee notes that your recent CPD concerns areas such as radiography but is not targeted towards orthodontic treatment. The Committee is concerned that a limited amount of CPD has been undertaken in respect of orthodontics since you were provided with an advance copy of the Committee's findings of fact, despite those findings clearly identifying the Committee's specific concerns. There is no evidence that you have undertaken formal training in orthodontics, and the Committee is not confident that your knowledge base in this field of dentistry has significantly increased. Nevertheless you continue to practice primarily in orthodontics. The Committee considers that the process of remedying the deficiencies that it has identified is not complete, and that you continue to pose a risk to patients. Accordingly, the Committee finds that your fitness to practise is currently impaired.

The Committee also finds that a finding of impairment is required in order to declare and uphold proper standards of conduct and behaviour and to maintain trust and confidence in the profession and in the regulatory process. In the Committee's judgment public trust and confidence in the profession, and in the regulator, would be seriously undermined if a finding of impairment were not made in the particular circumstances of this case.

Sanction

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

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

The Committee has considered the mitigating and aggravating factors present in this case.

In relation to mitigating factors, the Committee is mindful that you made admissions to the facts that the Committee found proved, and that there have been no further reported concerns of these or other matters. The Committee has taken into account your remediation. The Committee is also mindful that a considerable amount of time has elapsed since the time of the incidents giving rise to these proceedings, and that you have shown insight into your misconduct. There is evidence of previous good character and conduct.

In relation to aggravating factors, the Committee notes that your acts and omissions entailed actual harm to a patient. Your clinical failings were basic and repeated over a long period of time.

The Committee has considered the range of sanctions available to it, starting with the least restrictive. In the light of the findings made against you, the Committee has determined that it would not be appropriate to conclude this case with no action or with a reprimand. Such outcomes would leave the public and the public interest at considerable risk of harm on account of your unremediated misconduct. Taking no action, or issuing a reprimand, would be insufficient to protect the public, would undermine public confidence and trust in the profession and in the regulatory process, and would not be sufficient to declare and uphold proper standards of conduct and behaviour.

The Committee next considered whether a period of conditional registration would be appropriate. As noted above the Committee considers that your misconduct is remediable and that in that regard conditions might be suitable.

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

- Registrant has shown evidence of insight and willingness to respond positively to conditions;
- it is possible to formulate conditions that will protect the public during the period they are in force;

The Committee noted that any conditions must be:

- necessary in order to protect patients, the public or the interests of the profession;
- clear;
- relevant to the identified shortcomings;
- proportionate to the identified impairment;
- workable (conditions must not be such that in reality they amount to suspension);
- capable of being monitored for compliance by the executive and/or at a review hearing;

- addressed only to the Registrant and not to a third party.

The Committee determined that it would be possible to formulate appropriate and proportionate conditions which would address the failings highlighted in this case. The Committee finds that you have demonstrated a level of insight and remorse. You have engaged in these proceedings. The Committee notes that the issues of concern relate to your clinical practice.

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.

The Committee did consider a more severe sanction, however it considered that a period of conditional registration would provide protection to the public whilst enabling you to improve your clinical competence. A period of suspension, whilst protecting the public, would deny you the opportunity to remediate your failings under structured supervision.

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

1. He must notify the GDC promptly of any post he accepts for which GDC registration is required and the Commissioning Body on whose Dental Performers List he is included.
2. If employed, he must provide contact details of his employer(s) and allow the GDC to exchange information with his employer(s) or any contracting body for which he provides dental services.
3. He must provide the contact details of any practices of which he is an owner or part owner and allow the GDC to exchange information with the practice manager.
4. He must inform the GDC of any formal disciplinary proceedings taken against him, within 7 days from the date of this determination.
5. He must inform the GDC if he applies for dental employment outside the UK within 7 days from the date of application.
6. He must inform the GDC within 7 days of any complaints made against him, from the date of this determination.
7. He must work with a Development Advisor (or a nominated deputy) approved by the GDC, to formulate a Personal Development Plan, specifically designed to address the deficiencies in the following areas of his practice:
    - Radiographic practice in orthodontic treatment.
    - Assessment and diagnosis of presenting orthodontic conditions.

- Malocclusion and its aetiological factors.
- Risks in orthodontic treatment.
- Soft tissue and facial factors.
- Skeletal factors.
- Risks of impacted teeth on orthodontic treatment.
- Selection of cases suitable for his level of competence.

8. He must forward a copy of his Personal Development Plan to the GDC within 3 months of the date on which these conditions become effective.
9. He must meet with the Development Advisor (or a nominated deputy), on a regular basis to discuss his progress towards achieving the aims set out in his Personal Development Plan. The frequency of his meetings is to be set by the Development Advisor (or a nominated deputy).
10. He must allow the GDC to exchange information about the standard of his professional performance and his progress towards achieving the aims set out in his Personal Development Plan with the Development Advisor (or a nominated deputy), and any other person involved in his retraining and supervision.
11. He must provide the GDC with three-monthly audits to demonstrate compliance with current laws, relations, standards and policies in force, in relation to:
    a) Informed consent
    b) Orthodontic record keeping
    c) Radiography monitoring of orthodontics cases
12. At any time he is providing dental services, which require him to be registered with the GDC, he must agree to the appointment of a reporter nominated by the Development Advisor and approved by the GDC. The reporter shall be a GDC registrant.
13. He must allow the reporter to provide reports to the GDC at intervals of not more than three months and the GDC will make these reports available to any Development Advisor or workplace supervisor referred to in these conditions.
14. 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 close supervision* of a workplace supervisor with a post graduate qualification in orthodontics, nominated by the Development Advisor, and agreed by the GDC.
15. He must allow his workplace supervisor to provide reports to the GDC at intervals of not more than 3 months and the GDC will make these reports

available to any Development Advisor or Reporter referred to in these conditions.

16. 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].*
17. He must allow the GDC to exchange information with his employer or any organisation for which he is contracted to provide dental services, and any reporter, workplace supervisor or Development Advisor referred to in these conditions.
18. He must inform within 1 week the following parties that his registration is subject to the conditions, listed at (1) to (17), above:
    a) Any organisation or person employing or contracting with him to undertake dental work,
    b) Any locum agency or out-of-hours service he is registered with or applies to be registered with (at the time of application),
    c) Any prospective employer (at the time of application),
    d) The Commissioning Body in whose Dental Performers List he is included, or seeking inclusion (at the time of application),
    e) All staff at his place of work.
19. He must permit the GDC to disclose the above conditions, (1) to (18), to any person requesting information about his registration status.

* *The registrant's day to day work must be supervised by a person who is registered with the GDC in their category of the register or above and who must be on site and available at all times. As a minimum, the registrant's work must be reviewed at least twice a week by the supervisor via one to one meetings and case-based discussion. These bi-weekly meetings must be focussed on all areas of concern identified by the conditions.*

The period of this order is for 18 months, which will afford you the opportunity to further develop your insight and provide evidence of remedial action in the areas of concern. 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.

The Committee now invites submissions as to whether an immediate order should be imposed to cover the 28-day appeal period."

Decision on immediate order

“Having announced its decision on impairment and sanction, the Committee invited submissions on the imposition of an immediate order. The substantive conditions of practice order does not come into effect until the end of the appeal period or, if an appeal is lodged, until it the appeal has been disposed of. The appeal period expires 28 days after the date on which the notification of the determination is served on you.

In this regard, Mr Sykes made an application for an immediate order to be imposed on your registration on the grounds of public protection and in the wider public interest.

Mr Geering did not make any submissions.

The Committee heard and accepted the advice of the Legal Adviser.

The Committee was satisfied that an immediate order is necessary for the protection of the public and is otherwise in the public interest. To do otherwise would be incompatible with the Committee’s earlier findings.

Therefore, the Committee concluded that it would be appropriate and proportionate to impose an immediate order of conditional registration to cover the appeal period. The conditions for the immediate order will be the same as those detailed in the substantive order. 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.

That concludes this determination.”