HEARING HEARD IN PUBLIC

RIGO, Ivan

Registration No: 174950

PROFESSIONAL CONDUCT COMMITTEE

SEPTEMBER 2017 – SEPTEMBER 2019

Most recent outcome: Suspended indefinitely **

** See page 12 for the latest determination

Ivan RIGO, a dentist, DMD Szeged 1990, was summoned to appear before the Professional Conduct Committee on 18 September 2017 for an inquiry into the following charge:

Charge

"That, being a registered dentist:

1. You failed to provide an adequate standard of care to Patient A, between 4 July 2013 and 12 July 2013 in respect of the bridgework which you carried out in that you did not register his occlusion.
2. You failed to obtain informed consent for the bridgework provided to Patient A between 4 July 2013 to 26 July 2013 in that you did not adequately inform him of:
    a. the risks and/or benefits of this treatment;
    b. the consequences of this treatment not being carried out; and/or
    c. alternative treatment options.
3. You failed to maintain an adequate standard of record keeping in respect of Patient A's treatment from 4 July 2013 to 26 July 2013 in that you did not;
    a. record registering his occlusion;
    b. adequately record discussions in respect of consent for the treatment provided.
4. From at least 11 August 2016 to 17 May 2017, you failed to co-operate with an investigation into the treatment of a patient conducted by the GDC in that you did not;
    a. respond to the correspondence sent to you by GDC;
    b. provide a full copy of Patient A's original records;
    c. provide details of your employer;
    d. provide details of your indemnity cover.

AND that by reason of the facts alleged, your fitness to practise is impaired by reason of your misconduct."

Mr Rigo was not present and was not represented. On 18 September 2017 the Chairman announced the findings of fact to the Counsel for the GDC:

"In reaching its decisions on the facts, the Committee considered all the evidence adduced in this case.

The Committee had regard to the submissions made by Mr Coke-Smyth on behalf of the GDC. It accepted the advice of the Legal Adviser. In accordance with that advice, it has considered each charge separately.

The Committee was aware that the burden of proof rests on the GDC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that the facts of a charge will only be proved if the Committee finds that it is more likely than not that the facts occurred as alleged. The Committee reminded itself that Mr Rigo was not required to prove or disprove anything.

The evidence before the Committee consisted of a written statement and associated exhibits from Patient A and oral evidence from Mr Bland, an expert witness instructed by the GDC. It also had number of further documents, including the expert report, a number of witness statements and their associated exhibits, and the relevant patient dental records.

The Committee made the following findings:

Ivan Rigo, that, being a registered dentist:	
1.	*You failed to provide an adequate standard of care to Patient A, between 4 July 2013 and 12 July 2013 in respect of the bridgework which you carried out in that you did not register his occlusion.* **Found Proved** The Committee heard from Mr Bland, in response to Committee questions, that a dental technician may be able to determine the bite based on the models provided if they were adequate. There were no models for the Committee to consider and nothing recorded in the records to indicate what was done by Mr Rigo and no record that he registered Patient A's occlusion. Further, Patient A has no recollection of this taking place. The Committee concluded that it was more likely than not that Mr Rigo did not register Patient A's occlusion. The Committee next considered whether this amounted to a failure to provide an adequate standard of care to Patient A. In his report Mr Bland stated: *An assessment of the occlusion was required. Clinically this is a simple matter of visually examining the way in which the teeth meet together and move across each other. A simple record of the occlusion can be recorded in the notes and/or on laboratory instruction tickets. The provision of anterior bridgework relies on a patient having a suitable posterior occlusion, such that the forces generated in mastication are borne primarily on the back teeth. I have not seen any study models or working models and so I am unable to determine whether the Patient presented with adequate posterior support or not.* Having accepted the evidence of Mr Bland the Committee concluded that by

	not registering Patient A's occlusion Mr Rigo failed to provide an adequate standard of care to Patient A between 4 July 2013 and 12 July 2013.
2.	*You failed to obtain informed consent for the bridgework provided to Patient A between 4 July 2013 to 26 July 2013 in that you did not adequately inform him of:*
2. (a) 2. (b) 2. (c)	*the risks and/or benefits of this treatment;* *the consequences of this treatment not being carried out; and/or* *alternative treatment options.* **Found Proved in its entirety** The Committee noted that there was nothing recorded in Patient A's dental records to indicate that he had been informed of the risks or benefits of the proposed treatment, the consequences of the treatment not being carried out, or any alternatives to the proposed treatment. Patient A, in his evidence, confirmed that he was not informed of these matters and no discussion around this took place. Although the Committee noted that Patient A's witness statement was written nearly four years after the appointments, there were complaints made to the practice when the details of the appointments were fresher in Patient A's mind. The Committee had regard to the evidence of Mr Bland who outlined the risks and benefits that should have been discussed and the consequences of not carrying out the treatment. In considering whether not discussing these matters amounted to Mr Rigo's not having obtained informed consent, the Committee had regard to the guidance for patient consent, as published by the GDC. This states that*:* *1.3 Giving and getting consent is a process, not a one-off event. It should be part of an ongoing discussion between you and the patient.* Further that a dentist *must:* *1.4 Find out what your patients want to know, as well as telling them what you think they need to know. Examples of information which patients may want to know include:* *why you think a proposed treatment is necessary;* *the risks and benefits of the proposed treatment;* *what might happen if the treatment is not carried out; and* *other forms of treatment, their risks and benefits, and whether or not you consider the treatment is appropriate.* The Committee noted that Mr Rigo had recorded 'consent form signed' however no consent form was provided to the Committee. This does not amount to having obtained informed consent. Having regard to this guidance, the Committee concluded that Mr Rigo failed to obtain informed consent for the bridgework he provided between 4 July to 26 July 2013. Accordingly, this charge is found proved in its entirety.

3.	*You failed to maintain an adequate standard of record keeping in respect of Patient A's treatment from 4 July 2013 to 26 July 2013 in that you did not;*
3. (a) 3. (b)	*record registering his occlusion;* *adequately record discussions in respect of consent for the treatment provided.* **Found Not Proved in its entirety** Given the Committee's findings in respect of charge 1 and charge 2 Mr Rigo could not have recorded registering Patient A's occlusion nor could he record discussions in respect of consent for Patient A's treatment as he did not carry these out. Accordingly, this charge is found not proved in its entirety.
4.	*From at least 11 August 2016 to 17 May 2017, you failed to co-operate with an investigation into the treatment of a patient conducted by the GDC in that you did not;*
4. (a) 4. (b) 4. (c) 4. (d)	*respond to the correspondence sent to you by GDC;* *provide a full copy of Patient A's original records;* *provide details of your employer;* *provide details of your indemnity cover.* **Found Proved in its entirety** The Committee had sight of a witness statement provided by a GDC Case Worker. In this she outlined the attempts made to contact Mr Rigo and obtain the requisite information as part of the GDC investigation. Letters were sent to Mr Rigo on 11 August 2016, 1 September 2016 and 6 December 2016. The GDC attempted to contact him by post, email and telephone on multiple occasions. No response was received from Mr Rigo to any of these attempts to obtain information. The Committee noted that the GDC obtained Patient A's dental records from the practice and not from Mr Rigo. Further, despite multiple attempts to obtain details of Mr Rigo's employer and details of his indemnity cover his lack of cooperation resulted in this information not being received. The Committee considered that Mr Rigo's failure to provide the required information when requested amounts to a failure to cooperate with the GDC investigation. Accordingly, this charge is found proved in its entirety."

On 18 September 2017 the Chairman announced the determination as follows:

> "Having announced its finding on all the facts, the Committee heard submissions on the matters of misconduct, impairment and sanction.
>
> Mr Coke-Smyth informed the Committee that there was a previous fitness to practise matter considered by the Investigating Committee in September 2016 which was closed with advice. He submitted that this was neither a mitigating nor aggravating factor for the Committee, simply background information.

Mr Coke-Smyth submitted that the facts found proved by the Committee amount to misconduct. He referred the Committee to the case of Roylance v GMC (no. 2) [2000] 1 AC 311 which defines misconduct as 'a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances'. He identified breaches of GDC standards and took the Committee through each finding in relation to these breaches.

Mr Coke-Smyth then addressed the Committee on the factors that it must consider in respect of current impairment, including Mr Rigo's level of insight and any remediation. He also addressed the Committee on the need to have regard to the protection of the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the GDC as a regulatory body. Mr Coke-Smyth referred the Committee to the test outlined by Dame Janet Smith in her Fifth Report from Shipman and confirmed in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin). He further referred to the case of Cohen v General Medical Council [2008] EWHC 581 (Admin) in respect of the factors the Committee must consider when looking at current impairment.

Mr Coke-Smyth submitted that Mr Rigo's fitness to practise is currently impaired by reason of misconduct.

Mr Coke-Smyth then addressed the Committee in regard to sanction and invited the Committee to consider whether this is a case where nothing short of a period of suspension, with a review, would be appropriate. He referred the Committee to the specific matters for consideration as set out in the *'Guidance for the Practice Committees including Indicative Sanction Guidance'* as published by the GDC in 2016.

The Committee considered all the evidence before it, together with the submissions made by Mr Coke-Smyth. It accepted the advice of the Legal Adviser, which included the factors relevant to the considerations of the Committee.

Decision on whether the facts found proved amount to misconduct:

When determining whether the facts found proved amount to misconduct the Committee had regard to the terms of the relevant professional standards in force at the time of the incidents.

The Committee, in reaching its decision, had regard to the public interest and accepted that there was no burden or standard of proof at this stage.

The Committee has concluded that Mr Rigo's conduct was in breach of the *Standards for Dental Professionals* (2005) and the *Standards for the Dental Team* (2013). In particular, the following sections:

(2005)

Standard 2.2

Recognise and promote patients' responsibility for making decisions about their bodies, their priorities and their care, making sure you do not take any steps without patients' consent (permission). Follow our guidance 'Principles of patient consent'.

Standard 2.4

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

communicating effectively with patients; explaining options (including risks and benefits); and giving full information on proposed treatment and possible costs.

(2013)

Standard 9.4

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

9.4.1 If you receive a letter from the GDC in connection with concerns about your fitness to practise, you must respond fully within the time specified in the letter.

The Committee appreciated that the above breaches do not automatically result in a finding of misconduct. However, it was of the view that the breaches in this case are serious and fundamental to the practice of dentistry. The Committee concluded that Mr Rigo's conduct was a significant departure from the standards expected of a registered dental professional.

The Committee accepted Mr Bland's opinion was that Mr Rigo's conduct fell far below the standard expected in the circumstances by failing to provide an adequate standard of care. It was clear that Patient A did not have a proper understanding of the treatment process given the lack of discussion having taken place. Patient A was unaware of the risks and benefits of the treatment, the consequences of not having the treatment nor the alternatives to the proposed treatment. Failing to obtain informed consent amounted to removing Patient A's right to make his own informed decision about his dental care, and the Committee concluded that this would be considered as unacceptable conduct by fellow professionals and falls far below the standards expected.

The Committee considered that in failing to co-operate with the GDC investigation Mr Rigo demonstrated a wilful disregard for the expectations of his regulator. The Committee concluded that Mr Rigo's conduct was a serious departure from the standards expected of a registered dental professional and would be considered deplorable by fellow professionals and members of the public.

The Committee therefore concluded that Mr Rigo's conduct, individually and cumulatively, fell seriously below the standards expected of a registered dental professional and amounted to misconduct.

Decision on impairment:

The Committee proceeded to decide whether, as a result of this misconduct, Mr Rigo's fitness to practise is currently impaired.

The Committee recognised that the clinical failings in this case could be remedied. However, it had no information from Mr Rigo that he has taken any steps to remedy his conduct or that he had any recognition that his conduct was inappropriate. Further, there appears to be no appreciation by Mr Rigo of the seriousness of his conduct. The Committee considered that his failure to cooperate with the GDC demonstrated a lack of insight into the seriousness of his misconduct and there was no information before the Committee that he has any insight into the failings identified. The Committee concluded that the risk of repetition in this case was high in all the circumstances.

Dental professionals occupy a position of privilege and trust in society and must make sure that their conduct at all times justifies both their patients' and the public's trust in the

profession. In this regard the Committee considered the judgment of Mrs Justice Cox in the case of Grant.

The Committee found that the misconduct proved had the potential to place patients at unwarranted risk of harm. The Committee recognised that harm is not limited to physical harm but also includes emotional and mental harm. It also considered that there is an ongoing risk to patients as well as the public interest if Mr Rigo were permitted to return to practise without restriction. Moreover, Mr Rigo's conduct, including failing to cooperate with his regulator, brought the profession into disrepute. The Committee further found that Mr Rigo has demonstrated very poor professional judgement through his behaviour, thereby breaching fundamental tenets of the profession.

The Committee has borne in mind that its primary function is not only to protect patients but also to take account of the wider public interest, which includes maintaining confidence in the dental profession and the GDC as a regulator, and upholding proper standards and behaviour.

The Committee was of the view that the misconduct identified was sufficiently serious to warrant a finding of impairment on the grounds of public interest. Mr Rigo's failure to cooperate with his regulator undermines the purpose of regulation and the confidence that a member of the public should be able to have in a registered professional. Further, public confidence in the profession would be significantly undermined were the Committee not to make a finding of current impairment, which would effectively amount to a full acquittal.

Having regard to all of this the Committee has concluded that Mr Rigo's fitness to practise is currently impaired by reason of misconduct.

Decision on sanction

The Committee next considered what sanction, if any, to impose on Mr Rigo's registration. It recognised that the purpose of a sanction is not to be punitive, although it may have that effect, but rather to protect patients and the wider public interest.

The Committee applied the principle of proportionality, balancing the public interest with Mr Rigo's interests. It considered the range of sanctions available to it, starting with the least serious.

The mitigating factor identified by the Committee was the lack of evidence of serious patient harm. The aggravating factors included: the risk of harm to patients; there was a wilful disregard for the GDC process, standards and guidance; Mr Rigo's lack of insight; and that his failure to cooperate was was repeated and sustained over a period of time, it was the 11 August 2016 that a GDC caseworker wrote to Mr Rigo at his address on the Register and by email there has been no response whatsoever to this contact and multiple subsequent attempts to achieve engagement with him.

In the light of the findings against him the Committee has determined that it would be wholly inappropriate and irresponsible to conclude this case without taking any action or with a reprimand, as neither would restrict Mr Rigo's registration, address the lack of insight and ongoing risk of harm to patients and the wider public.

The Committee next considered whether a period of conditional registration would be appropriate in this case. The Committee was mindful that any conditions imposed must be proportionate, measurable and workable. The Committee considered that, in order for conditions to be workable, there would need to be insight, a measure of positive

engagement and co-operation from Mr Rigo, all of which are absent. In any event, the Committee determined that it would not be possible to formulate appropriate and practical conditions which would address the failure to cooperate found in this case. The Committee concluded that conditions would not be appropriate, workable or proportionate in this case.

The Committee then considered whether a suspension order would be proportionate and appropriate. The Committee is in no doubt that Mr Rigo's misconduct was wholly unacceptable and damaging to the reputation of the profession and to the public's confidence in the dental profession. The Committee had nothing before it to show that Mr Rigo has any insight into the seriousness of his actions or the potential consequences, neither has Mr Rigo provided any assurance to this Committee that his misconduct would not be repeated.

The Committee then considered whether the issues identified are fundamentally incompatible with Mr Rigo remaining on the Register.

The Committee had regard to the fact that the clinical matters in this case related to a single patient. Although serious, it did consider that the misconduct was such that it could be remediated were Mr Rigo to engage. The Committee considered that a period of suspension would give Mr Rigo the opportunity to engage with the GDC and demonstrate that he takes the process seriously and has taken steps to remedy the deficiencies identified. Although it gave it serious consideration, the Committee concluded that, in all the circumstances, erasure would be disproportionate.

Taking into account all of the above, the Committee has determined that the appropriate and proportionate sanction in this case is that of suspension for a period of 12 months. The Committee considered it necessary in the circumstances of this case to require a review prior to the expiry of the order.

The Committee considered that this was proportionate to address the gravity of the matters identified in this case and to mark the importance of maintaining the standards expected of a registered dentist and send a message to the profession that this type of conduct is not acceptable.

The Committee was aware that the effect of this order is that Mr Rigo will be prevented from working as a registered dentist in the UK. This could result in financial hardship, the Committee received no information from Mr Rigo about this. However, in applying the principle of proportionality, the Committee determined that Mr Rigo's interests in this regard were outweighed by that of the wider public interest.

Before the end of the period of suspension the order will be reviewed. At the review hearing the Committee may revoke the order, or it may confirm the order allowing it to lapse on expiry, or it may replace the order with another order. Any future Committee reviewing this order is likely to be assisted by evidence of further training that focuses on the deficiencies highlighted in this decision, a written reflective piece from Mr Rigo on the importance of informed consent, what he has learned from this process, the impact of his misconduct on the public and the profession and evidence of any other remediation that he may have undertaken.

As a result of the Committee's decision in this case, the interim order currently imposed on Mr Rigo's registration is hereby revoked.

Immediate Order:

Having directed that Mr Rigo's name be suspended from the register for a period of 12 months, the Committee had to consider whether to impose an immediate order to cover the appeal period, or until any appeal against the outcome is heard.

The Committee has considered the submissions made by Mr Coke-Smyth that an immediate order of suspension should be made to protect the public and uphold public confidence in the profession. He applied for this order to cover any possible appeal period and submitted that this would be compatible with the Committee's findings.

The Committee accepted the advice of the Legal Adviser.

The Committee was satisfied that an immediate order of suspension was entirely appropriate to protect the public and maintain public confidence in the profession and in the GDC as the regulator. The Committee considered that, in all the circumstances, public confidence in the profession and in the GDC as its regulator would be undermined if an immediate order of suspension were not imposed, particularly in light of the finding that Mr Rigo's lack of insight and engagement increases the risk of repetition of the misconduct identified. The Committee considered that the risks identified in its findings warrant the imposition of an immediate order to protect the public and maintain public confidence in the profession.

If, at the end of the appeal period of 28 days, Mr Rigo has not lodged an appeal, this immediate order will lapse and will be replaced by the substantive direction of suspension for 12 months. If Mr Rigo does lodge an appeal, this immediate order will continue in effect until that appeal is determined.

Unless Mr Rigo exercises his right of appeal, his name will be substantively suspended for 12 months from the register 28 days from the date on which this determination is deemed to have been served upon him.

That concludes this determination."

At a review hearing on 3 October 2018 the Chairman announced the determination as follows:

"Neither party is present at this resumed hearing of the Professional Conduct Committee (PCC). The GDC has invited the Committee to conduct the hearing on the papers in the absence of both parties.

Purpose of hearing

The purpose of today's hearing is to review a substantive direction of suspension first imposed on Mr Rigo's registration by the PCC on 18 September 2017. The hearing is being held in accordance with section 27C (1) of the Dentists Act 1984 (as amended) ('the Act'). The suspension is due to expire on 19 October 2018.

Service

The Committee first considered whether service has been properly effected in accordance with the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules').

In its written representations to the Committee the GDC has submitted that Mr Rigo has been properly notified of today's hearing in accordance with Rule 28 of the Rules. The Committee noted that a notice of hearing was sent to Mr Rigo's registered address on 22 August 2018 using the Royal Mail's International Recorded Delivery postal service. That

notice set out the date, time and venue of the hearing, as well as confirming the nature of the hearing and the powers available to the Committee. The Royal Mail's Track and Trace service records that an attempt was made to deliver the notice on 29 August 2018, but that its delivery partner had stated that it had not been possible to identify the delivery address. A copy of the notice was also sent by email on 22 August 2018.

The Committee accepted the advice provided by the Legal Adviser. Having regard to the GDC's submissions and the evidence placed before it the Committee was satisfied that service has been properly effected in accordance with the Rules.

Proceeding in absence

The Committee then went on to consider whether to exercise its discretion to proceed in the absence of Mr Rigo in accordance with Rule 54 of the Rules. It was mindful that the discretion to proceed in the absence of a registrant must be exercised with the utmost care and caution. The Committee notes that the GDC has invited the Committee to proceed in the absence of Mr Rigo.

The Committee accepted the advice of the Legal Adviser. It determined that it would be appropriate and fair to proceed with the hearing in Mr Rigo's absence. The Committee considers that there is a clear public interest in ensuring that the suspension order is reviewed before its expiry, and that the GDC has made all reasonable efforts to inform Mr Rigo of today's hearing. The Committee considers that an adjournment would serve no useful purpose, as it would be unlikely to secure his attendance in circumstances where Mr Rigo has not engaged with the Council since the substantive PCC hearing in September 2017, and indeed was not present at that hearing. The Committee therefore determined to proceed in the absence of Mr Rigo.

Existing order

In September 2017 the PCC held a hearing to consider allegations about Mr Rigo's conduct. As stated above Mr Rigo was not present at the hearing, and was not represented in his absence. The allegations which Mr Rigo faced, and which the Committee subsequently found proved, related to the standard of care and treatment that he provided to a patient, referred to for the purposes of its proceedings as Patient A, in the period of 4 July 2013 to 12 July 2013. The Committee found that the bridgework that Mr Rigo undertook was inadequate, that he failed to obtain the patient's informed consent, and that he failed to maintain an adequate standard of record-keeping. The Committee also found that Mr Rigo failed to co-operate with the GDC's investigation of the same matters.

On 18 September 2017 the Committee determined that the facts that it had found proved amounted to misconduct and that Mr Rigo's fitness to practise was impaired as a result. The Committee determined that his name should be suspended from the register for a period of 12 months, with a review hearing to take place prior to the expiry of the suspension.

Committee's determination

The Committee has carefully considered all the information presented to it, including the written documentation and submissions provided by the GDC. In its deliberations the Committee has had regard to the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016). The Committee has accepted the advice of the Legal Adviser.

Impairment

The Committee has determined that Mr Rigo's fitness to practise remains impaired. It notes that Mr Rigo has provided no information whatsoever about any steps that he may have taken to remedy the misconduct that was previously found, or to develop and demonstrate insight into his actions. The Committee further notes that there is no other information available from any other sources to suggest that he has reflected upon and remedied any of the issues which led to the previous Committee's findings of facts, misconduct and impairment. There has been no material change in circumstances and Mr Rigo has not engaged. The Committee has therefore concluded that the same risks to public safety and to public trust and confidence in the profession persist, and that accordingly Mr Rigo's fitness to practise remains impaired.

Sanction

The Committee considers that it would not be appropriate to terminate the suspension given the continued risks that arise from Mr Rigo's continued impairment.

The Committee next considered whether it could formulate conditions which would be workable and which would address the risks that persist. The Committee concluded that it could not formulate any conditions which would be practicable or workable, given that Mr Rigo has not engaged with these proceedings for a considerable period of time and indeed appears to have disengaged from the regulatory process. The Committee also considers that conditions would not adequately address the risks.

The Committee then went on to consider whether it would be appropriate to extend the current period of suspension. It has determined that suspension remains the proportionate and appropriate sanction in the circumstances. There remains a risk of harm to the public and to public trust and confidence in the profession arising from Mr Rigo's continued impairment. A further period of suspension is required to continue to protect the public, to declare and uphold proper standards of conduct and behaviour and to maintain trust and confidence in the profession.

In view of the risks to patients and to the wider public interest, as well as the absence of any evidence of remediation, the Committee hereby directs that Mr Rigo's registration be suspended for a further period of 12 months. This period of time is proportionate to the ongoing risks that have been identified. Such a period of time will also allow Mr Rigo to demonstrate insight into and remediation of the matters that have precipitated these proceedings, should he be minded to do so.

In accordance with section 27C (1) of the Act this extended period of suspended registration will take effect from the date on which the existing period of suspension would otherwise expire, namely on 19 October 2018. The Committee has further determined that the suspension should again be reviewed prior to its expiry.

Recommendations

Although it is mindful that the task of reviewing this extended suspension is entirely one for the next PCC, the Committee considered that the reviewing Committee may find it helpful to have sight of the following:

- Evidence of further training focusing on the identified deficiencies
- Reflective piece on the importance of informed consent

- Reflective statement on what Mr Rigo has learned from this process, and the impact of his misconduct on the public and the profession
- Evidence of any other remediation.

Right of appeal

Mr Rigo will have 28 days from the date on which notice of this decision is deemed to have been served on him to appeal against this decision. Should he decide to appeal, the extant suspension will remain in force until the resolution of any such appeal. Should he decide not to appeal, the current suspension will be extended for a period of 12 months from the date on which it would otherwise expire, that is to say 19 October 2018.

That concludes this case for today."

At a review hearing on 30 September 2019 the Chairman announced the determination as follows:

"Mr Rigo 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). The Committee 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 Rigo 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 19 August 2019, and a Royal Mail 'Track and Trace' receipt confirming that delivery was attempted to Mr Rigo's registered address by Special Delivery. A copy of the letter was also sent to him by email on the same date.

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 Rigo's absence. On the basis of the information provided, the Committee was satisfied that notice of the hearing had been served on Mr Rigo in accordance with the Rules.

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

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 Rigo. 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 Rigo and the GDC, and it had regard to the public interest in the expeditious review of the suspension order in place on Mr Rigo's registration. The Committee took into account that the current order is due to expire on 19 October 2019.

The Committee noted from the Notification of Hearing letter of 19 August 2019 that Mr Rigo was asked to confirm by 02 September 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 Rigo. 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 Rigo had voluntarily absented himself from today's proceedings. It decided that an adjournment was unlikely to secure his attendance on a future date. The Committee also noted that Mr Rigo did not attend and was not represented

at the initial PCC hearing of his case in September 2017 and the review hearing in October 2018.

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 Rigo and/or any representative on his behalf.

Background matters

This is the second review of a suspension order that was first imposed on Mr Rigo's registration for a period of 12 months by the Professional Conduct Committee (PCC) in September 2017. Mr Rigo did not attend that hearing and he was not represented. At that hearing the allegations which Mr Rigo faced, and which the Committee subsequently found proved, related to the standard of care and treatment that he provided to a patient, referred to for the purposes of its proceedings as Patient A, in the period between 4 July 2013 to 12 July 2013. The Committee found that the bridgework that Mr Rigo undertook was inadequate, that he failed to obtain the patient's informed consent, and that he failed to maintain an adequate standard of record-keeping. The Committee also found that Mr Rigo failed to co-operate with the GDC's investigation of the same matters.

The PCC concluded that the findings against Mr Rigo amounted to misconduct and considered that Mr Rigo breached a fundamental tenet of the profession. That Committee had no information from Mr Rigo to demonstrate what, if any, steps he may have taken to remedy his misconduct. It could not be satisfied that there is no risk of repetition. It concluded that Mr Rigo's fitness to practise remained impaired by reason of misconduct. The Committee considered that the reviewing Committee may find it helpful to have sight of the following:

> *"Any future Committee reviewing this order is likely to be assisted by evidence of further training that focuses on the deficiencies highlighted in this decision, a written reflective piece from Mr Rigo on the importance of informed consent, what he has learned from this process, the impact of his misconduct on the public and the profession and evidence of any other remediation that he may have undertaken."*

The PCC reviewed the order on 03 October 2018. Mr Rigo did not attend the hearing and was not legally represented. The Committee determined that his fitness to practise remained impaired by reason of misconduct. The Committee determined that the period of suspension should be extended by a further 12 months.

The Committee considered that the reviewing Committee may find it helpful to have sight of the following:

- *Evidence of further training focusing on the identified deficiencies*
- *Reflective piece on the importance of informed consent*
- *Reflective statement on what Mr Rigo has learned from this process, and the impact of his misconduct on the public and the profession*
- *Evidence of any other remediation*

Today's review

In comprehensively reviewing Mr Rigo'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 Rigo.

Mr Middleton told the Committee that there is no evidence that Mr Rigo has practised in contravention of his current suspension order. He also stated that to date, there is no evidence that Mr Rigo has remedied any of the failings identified by the previous Committees. In relation to the matters before the Committee today, he stated that in the circumstances, the GDC invited the Committee to find that Mr Rigo's fitness to practise remains impaired. Mr Middleton further invited the Committee, if it found current impairment, to indefinitely suspend Mr Rigo's registration under Section 27C (4) of the Dentist's Act 1984 "as amended".

The Committee first considered whether Mr Rigo's fitness to practise is still impaired. There is no evidence before this Committee that Mr Rigo has addressed his past impairment or provided any information as recommended to him by the PCC at the initial hearing and the subsequent reviewing Committee. In addition, he has not demonstrated any evidence of insight. In these circumstances, the Committee considers that there remains a risk that Mr Rigo could repeat the misconduct identified and thus he remains a risk to the public. It also notes that Mr Rigo has not engaged with the GDC in relation to these proceedings over a protracted period of time, despite repeated attempts by the GDC to secure his involvement. Accordingly, the Committee has determined that Mr Rigo's fitness to practise is currently impaired.

The Committee next considered what direction, if any, to make. It has had regard to the GDC's "Guidance for the Practice Committees including Indicative Sanctions Guidance" (Effective October 2016, revised May 2019).

The Committee has borne in mind the principle of proportionality, balancing the public interest against Mr Rigo's own interests. The public interest includes the protection of the public, the maintenance of public confidence in the profession, and declaring and upholding proper 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 terminate it with immediate effect. Given Mr Rigo's lack of engagement with the GDC and the absence of any remediation or insight, 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 Rigo. To date, he has not engaged with the GDC or provided any 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 Rigo's lack of engagement with the GDC over a sustained period of time and the absence of any information as to his professional intentions. Mr Rigo has chosen not to attend any of the hearings of his case or to provide any evidence of his remediation. In these circumstances, the Committee has concluded that a further time limited period of suspension is unlikely to achieve his engagement or delivery of material requested to assist any future Committee. In

these circumstances an indefinite period of suspension is the appropriate and proportionate outcome. It therefore directs that Mr Rigo's registration be suspended indefinitely.

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

The Committee would also highlight to Mr Rigo that should he wish to engage with the GDC, he can apply for a review of this order in accordance with Section 27C (4) of The Dentist's Act 1984 "as amended".

That concludes the case for today."