

**PUBLIC HEARING**  
**Professional Conduct Committee &**  
**Professional Performance Committee**  
**Initial Hearing**

**19 – 21 January & 27 – 30 January 2026; 5 & 16 March 2026;  
2 April 2026; 6 – 8 May & 29 May 2026; 4 – 5 June 2026**

**Name:** McLAUCHLAN, Colin Duncan

**Registration number:** 60088

**Case number:** CAS- 205742-X4Q5Z2

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**General Dental Council:** Tom Stevens, Counsel  
Instructed by Sarah Atkinson, Kingsley Napley

**Registrant:** Not Present  
Unrepresented

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**Fitness to practise:** Impaired by reason of misconduct

**Outcome:** Erased with Immediate Suspension

**Immediate order:** Immediate suspension order

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**Committee members:** Charlotte Carling (Chair, Dental Care Professional Member)  
Aditi Chowdhary-Gandhi (Lay Member)  
Anjali Patel (Dentist Member)

**Legal Adviser:** Trevor Jones (January 2026, 5 & 16 March 2026 and  
2 April 2026)  
Andrew Granville Stafford (6 – 8 May 2026)  
Graeme Dalglish (29 May 2026)  
Suzanne Palmer (4 – 5 June 2026)

**Committee Secretary:** Kate Anderson (21 January 2026, 5 & 16 March 2026)  
Jenny Hazell (19 – 20 & 27 – 30 January 2026, 2 April 2026,  
6 – 8 & 29 May 2026 and 4 – 5 June 2026)

1. This is a Professional Conduct Committee (PCC) hearing in respect of a case brought against Mr McLauchlan by the General Dental Council (GDC). The hearing is being conducted remotely by Microsoft Teams video-link.
2. Mr McLauchlan is neither present nor represented at the hearing. Mr Tom Stevens, Counsel, appears on behalf of the GDC.

### **Application to proceed with the hearing in the absence and preliminary matters - 27 January 2026**

3. At the outset, Mr Stevens made an application under Rule 54 of the GDC (Fitness to Practise) Rules Order of Council 2006 (the Rules'), for the hearing to proceed in the absence of Mr McLauchlan. He referred the Committee to the GDC's proceeding in absence/service bundle which contained a copy of the Notice of Hearing dated 8 December 2025, as well as the Royal Mail track and trace receipt which confirms delivery of the item on 10 December 2025.
4. Mr Stevens also referred to an email dated 17 January 2026 from Mr McLauchlan to Kingsley Napley Solicitors (acting on behalf of the GDC) in which he stated that he was not in a "fit state" to respond to the GDC. He submitted that Mr McLauchlan is aware of this hearing in light of his email dated 17 January 2026 but has provided no other supporting information in support of his circumstances which means that he is unable to respond to the GDC. Mr Stevens also referred to Mr McLauchlan's pattern of non-engagement over a sustained period of time with the GDC and submitted that there was a clear public interest in proceeding with the hearing. It was Mr Stevens' submission that were the hearing to be adjourned, this would lead to a delay in the resolution of the allegations. He advised that given the length of the case which involved a number of allegations with the evidence of a number of witnesses, it was unlikely that the case would be heard before February 2027, a delay of over a year.
5. The Committee took account of the submissions made by Mr Stevens, as well as the information contained in the GDC's proceeding in absence/service bundle. In addition the Committee had regard to the emails dated 16- 18 January 2026 between Kingsley Napley Solicitors and Mr McLauchlan regarding today's hearing. The Committee has accepted the advice of the Legal Adviser on the issues of service and proceeding in the absence of a registrant.

### **Decision on service**

6. The Committee first considered whether the Notice of Hearing (the Notice) had been served on Mr McLauchlan in accordance with Rules 13 and 65 and Section 50A(2) of the Dentists Act 1984 (as amended) (the 'Act'). It had regard to the Notice of Hearing dated 8 December 2025 (the 'Notice'), which was sent to Mr McLauchlan's registered address by Special Delivery. The Committee was satisfied that the address shown on the Notice is the same address as that shown in the bundle as being Mr McLauchlan's registered address with the GDC. The Royal Mail 'Track and Trace' receipt confirms that the Notice was delivered to Mr McLauchlan's registered address and was signed for on 10 December 2025.
7. The Committee was satisfied that the Notice sent Mr McLauchlan's registered address on 8 December 2025 complied with the 28-day notice period required by the Rules. The Committee was further satisfied that the Notice contained all the required particulars, including the date and time of the hearing, confirmation that the hearing would be held remotely by Microsoft Teams, and that the Committee had the power to proceed with the hearing in the absence of Mr McLauchlan. The Notice also specified the allegations against Mr McLauchlan.

8. The Notice was also sent via GDC secure file to Mr McLauchlan's registered email address on 8 December 2025. Mr McLauchlan sent a response from his registered email address to Kingsley Napley Solicitors on 17 January 2026.

9. On the basis of all the information provided, the Committee was satisfied that the Notice had been served on Mr McLauchlan in accordance with the Rules and the Act.

### **Decision on whether to proceed with the hearing in the absence of the registrant**

10. The Committee next considered whether to exercise its discretion under Rule 54 to proceed with the hearing in the absence of Mr McLauchlan. It 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, and as affirmed in the regulatory case of *General Medical Council v Adeogba* [2016] EWCA Civ 162. The Committee also had regard to paragraphs 33 onwards (under the heading *Proceeding in the absence of the registrant*) of the GDC's 'Fitness to Practise: Guidance for the practice committees' (effective from 6 January 2026) (the GDC's Guidance).

11. The Committee bore in mind the need to be fair to Mr McLauchlan as well as the GDC and the public interest in the expeditious disposal of this case.

12. The Committee was satisfied that all reasonable efforts had been made by the GDC to notify Mr McLauchlan of this hearing. Mr McLauchlan sent an email dated 17 January 2026 to Kingsley Napley Solicitors in which he stated that he was not in a "fit state" to respond to the GDC and set out his personal circumstances. However, he provided no information in support of these matters. Kingsley Napley Solicitors sent an email dated 18 January 2026 to Mr McLauchlan, which advised him that the GDC was proposing for the hearing to proceed in his absence. The email also explained that should Mr McLauchlan wish for the hearing to be adjourned so that he could attend at a later date, he was required to notify Kingsley Napley by that evening at the latest. He was also invited to provide Kingsley Napley with any further evidence he wished to reply on in support of any such application. Mr McLauchlan did not respond to that email.

13. In these circumstances, the Committee has concluded that Mr McLauchlan has voluntarily absented himself from these proceedings. He has not requested an adjournment of these proceedings and there is no information before it to suggest that adjourning this hearing would secure Mr McLauchlan's attendance at a future date.

14. The Committee is mindful that the allegations in this case relate to Mr McLauchlan's clinical failings concerning multiple patients. In the Committee's view the nature of the allegations are serious and potentially give rise to substantive potential risks to the public and public confidence which ought to be determined without undue delay. The Committee is aware that were it minded to adjourn the hearing it is unlikely that the case could be rescheduled before February 2027. The Committee also notes that the GDC proposes to call several witnesses in this case and has borne in mind the potential inconvenience to those witnesses should the hearing not proceed within the time allowed.

15. There is no good reason before the Committee as to why it should adjourn the hearing. Accordingly, the Committee has determined that it was fair and in the public interest to proceed with the hearing in the absence of Mr McLauchlan.

### **Application for joinder made by the GDC**

16. Mr Stevens made an application under Rule 25(2) to join further allegations against Mr McLaughlan, details of which were set out in the Notice of Hearing dated 8 December 2025. The further allegations to be considered under Rule 25(2) were as follows:

Patient C: Allegation 12 (stem only- date extended)

12. You failed to provide an adequate standard of care to Patient C from 6 August 2019 to 17 January 2023, in that:

Patient K: Allegation 36

36. Your conduct in charge 34.e. was:

- a. Misleading;
- b. Lacking integrity;
- c. Dishonest – in that you knew sockets should normally heal in less than 6 months

Patient R: Allegation 56

56. By reason of your conduct in charge 55 (g) (i) and/or charge 55 (g) (ii) you did not obtain Patient R's informed consent for the filling provided to their LL5

Patient Y: Allegation 78

78. By reason of your conduct in charge 77.e.iii you did not obtain Patient Y's informed consent for the crown at their UR2

17. These additional allegations had been raised in light of further concerns raised by Dr Pal (the GDC's expert instructed in this case). The evidence in support of these allegations (namely that of Dr Pal and the witness statement of Patient Y) had already been disclosed to Mr McLauchlan previously. It was Mr Stevens' submissions that these allegations were of a similar kind to that already pleaded in the earlier referrals and are thematically similar. Further, they are drawn from the same evidence.

18. The Committee considered the submissions made. It accepted the advice of the Legal Adviser. The Committee also had regard to paragraphs 62 and 63 of the GDC's Guidance in respect of an application for joinder. The Committee was satisfied that the additional allegations that form the subject of the GDC's application are of a similar kind to those already pleaded in the Notice of Hearing. They therefore fulfil the requirements of Rule 25(2)(c). Accordingly, having had regard to the circumstances of this case, the fairness of the proceedings as well as the expeditious disposal of this case, the Committee acceded to Mr Stevens' application under Rule 25 to join the additional allegations.

19. Accordingly, having had regard to all the circumstances, including the fairness of the proceedings and the GDC's overarching statutory objective, the Committee determined to allow the application under Rule 25(2) to join or add the additional charge in the terms quoted above.

### **Application to amend the charge**

20. Thereafter Mr Stevens made an application under Rule 18 to amend the charge, details of which were set out in a document entitled 'evidence schedule'.

21. The Committee had regard to the submissions made by Mr Stevens. It has accepted the advice of the Legal Adviser.

22. The first consideration for the Committee was whether the amendment under Rule 18 could be made "*without injustice*". The Committee also had regard to paragraphs 72 onwards of the GDC's Guidance under the heading "Amendment of the charge". It considers that most of the amendments relate to minor typographic errors, amending incorrect tooth notations and/or correcting the dates of appointments to reflect what is shown in the patients' clinical records. The Committee then

considered the request of the GDC for the withdrawal of four charges. The Committee permitted the withdrawal of these charges relating to patient care where the GDC had indicated they could no longer pursue and discharge the burden of proof. In the Committee's judgment, there was no further evidence that the GDC could be expected to obtain to support the charges in question. By way of example, the GDC applied for the removal of allegation 75(a)(iii) in the recording of a basic periodontal examination (BPE), as the dental hygienist had recorded the BPE prior to Mr McLaughlan seeing the patient on the same day. The Committee concluded that the amendments to the charge do not materially alter the scope of the GDC's case against Mr McLaughlan. It was therefore satisfied that the amendments could be made without injustice. It therefore acceded to the GDC's application as follows:

Charge 4 (c) - agrees to change the date to 10 February 2022

Charge 12(c) agrees to change date between 6 October 2023 and 17 January 2023.

Charge 16 (a) agrees to change the date range so that it reads "From 12 March 2021 to 2 April 2021."

Charge 16(c) - agrees to change the date to 8 September 2022 and to change the name of the Patient E in respect of 16 (c) (iii).

Charge 23(d) – agrees to change the date to 12 April 2023.

Charge 26(a) - agrees to change the tooth annotation to UR3. The tooth is reflected on the radiograph.

Charge 26(d) – agrees to change the date to 17 September 2020.

Charge 29 – agrees to change the date to 17 September 2020.

Charge 30(d) - agrees to change the date to 30 March 2023.

Charge 32(d) – (stem) – agrees to change the date to 22 March 2022

Charge 32d)(ii) – agrees to change the tooth annotation to UR6.

Charge 34(f) - agrees to correct the spelling of the word so that it now reads 'socket'.

Charge 34(f)(ii) - agrees to remove this charge relating to 15 March 2023.

Charge 38(a)(iii) - agrees to change the tooth annotation to UR8.

Charge 39 - agrees to change the tooth annotation to UR8.

Charge 41(d) - agrees to change the date to 12 September 2022.

Charges 43(f)(i) and (ii) - agrees to withdraw this charge.

Charge 44 - agrees to withdraw this charge.

Charge 58(b) – agrees to change the year to 2022.

Charge 58(f) – agrees to change date to read on 17 May 2023 and/or 28 September 2023.

Charge 65(k) (stem) and 65(k)(i) – agrees to change the date to 29 September 2023.

Charge 71(c)(ii) agrees to change the date to 25 April 2023.

Charge 75(a)(iii) - agrees to withdraw this charge.

Charge 77(c) - agrees to withdraw this charge.

Charge 84(g)(i) – agrees to amend to state “LR1, LR2, LL1 and LL3 all had a poor prognosis”.

Charge 86 – stem - agrees to include the year (2023).

Charges 89 and 90 - agrees to change the date to 29 August 2023.

Charge 98 – stem – agrees to the change to read from 20 August 2022 to 1 November 2023

### **Application to adduce hearsay evidence**

23. Mr Stevens made an application under Rule 57(1) for the witness statement of Patient 1 and Patient Y to be admitted as hearsay. This was in circumstances where Patient 1 and Patient Y were not willing and/or able to attend the hearing. Mr Stevens referred to the GDC’s written skeleton submissions dated 18 December 2025 as well as the appendices to the skeleton argument in relation to that matter. The skeleton arguments refers to the Guidance on Hearsay Evidence, including reference to the Civil Evidence Act 1995 (the 1995 Act) as well as the position of several legal authorities in respect of the treatment of hearsay evidence. This includes the cases of *El Karout v NMC* [2019] EWHC 28 (Admin) at [126] approving *Ogbonna v NMC* [2010] EWHC, as well as that of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin) at [45]; *v NMC* [2011] EWHC 1585 (Admin) at [108].

24. Mr Stevens addressed the rule 4 correspondence dated 13 November 2023 and requested the Committee to consider the initial comments made by Mr McLaughlan’s indemnity provider, MDDUS who were acting for him at that time, in relation to potential charges concerning Patient 1. Although the response was not provided directly by Mr McLaughlan, Mr Stevens submitted it constitutes a broadly adequate reply to the later formal charges raised, and an acceptance of the criticisms from patient 1. He suggested this strengthens the case insofar as the hearsay application being considered. Furthermore, Mr Stevens submitted that the patient did not have any ill intent in making the complaint.

25. Mr Stevens further submitted that the GDC have reviewed the evidential status of the treatment provided to Patient E and Patient L, as outlined in the evidential schedule. The initial letter of complaint from patient E was dated 28 September 2022, with a subsequent complaint letter sent 16 December 2022 in response to correspondence from Mr McLaughlan on 1 November 2022. Patient L sent a complaint letter on 24 August 2023, with both patients E and L addressing it to Mr McLaughlan’s practice. The GDC’s position is that those letters of complaint are considered to be relevant insofar as they relate to the consent charges. Mr Stevens informed the Committee that the patients’ complaint letters, as written by themselves, were not formal witness statements. He submitted that nonetheless they were contemporaneous documents detailing concerns about consent and the associated risks and benefits of the treatment provided. Consequently, he submitted that on balance this weighs in favour of their inclusion. Mr Stevens therefore made a hearsay application to include those letters of complaint because the maker of those complaints (Patients E and L) are not in attendance.

26. Mr Stevens invited the Committee to have regard to the law in considering the application. He set out a number of principles including Rule 57. The Committee has borne in mind that Hearsay evidence is admissible in these proceedings.

27. The Committee considered each submission and accepted the advice of the legal adviser. Each patient was considered individually by the Committee.

28. With respect to Patient 1, the Committee has acknowledged that Mr McLauchlan has neither contested the evidence nor refuted the allegations. Whilst Mr Stevens has been careful to say that the rule 4 correspondence sent on Mr McLaughlan's behalf was not in his own words, it was clear that those who were representing him at that time had indicated that Mr McLauchlan did not materially challenge Patient 1's complaint. The concerns that were being considered by the GDC at that time now largely, if not entirely, constitute the basis of the allegations in relation to Patient 1. The Committee considered the efforts made by the GDC to facilitate Patient 1's attendance at this hearing for the purpose of providing oral evidence to be proportionate and reasonable. However, these efforts were unsuccessful. The Committee was further satisfied that Patient 1 had presented valid reasons for her absence in a recent letter dated 11 December 2025, primarily stating that her health has not improved and that she wished not to revisit the trauma associated with the treatment. The Committee has concluded in line with the submissions made by the GDC that Patient 1's written evidence and exhibits are not the sole or decisive evidence in support of the charges pertaining to Patient 1. There are contemporaneous records and other notes within the Practice that the Committee will also be able to consider. The Committee is satisfied that the evidence of Patient 1 is relevant, fair and relates to the charges and therefore it agreed to admit this evidence.

29. In respect of Patient Y, the Committee has borne in mind that Mr McLauchlan had also not refuted his evidence. The Committee took into account the reasonable attempts from the GDC to secure his attendance and his subsequent reasons for non-attendance. The Committee has concluded in line with the submissions made that Patient Y's written evidence and materials are not the sole or decisive evidence in support of the charge(s). There are contemporaneous records and other notes within the Practice that the Committee will also be able to consider. The Committee is satisfied that the evidence of Patient Y is relevant, fair and relates to the charges and therefore it agreed to admit this evidence.

30. The Committee has duly considered the letters of complaint from Patient E and L, which were submitted contemporaneously and correspond to the charges. The Complaints from Patient E pertained to the matters outlined in allegations 16(a) and 16(b). The Complaints from Patient L correspond to the matters in allegations 38 and 39. Furthermore, there is nothing to suggest that there is any ill motive on the parts of Patients E and L. The Committee bore in mind that this was not the sole and decisive evidential basis of the case for both Patients E and L as the Committee has before it other documents of record, such as dental records in relation to the alleged events in question.

31. Accordingly, the Committee is satisfied that admitting the hearsay evidence is appropriate and fair. The Committee has also taken into account the public interest and believes that it would be fair and in the interest of justice to admit the material of Patient 1, Patient E, Patient L and Patient Y and has acceded to the GDC's application. The Committee reminded Mr Stevens, acting on behalf of the GDC, that the burden of proof in relation to all of the charges remains with the GDC.

### **Further application to adduce hearsay evidence – Patient T 2 April 2026**

32. Mr Stevens made a further application under Rule 57(1) for the witness statement of Patient T to be admitted as hearsay. He submitted that the GDC was proposing to call Patient T to give evidence on 27 January 2026 but Patient T had emailed the Hearing Support Officer to indicate that

she was not available to attend the hearing that day owing to work commitments. On receipt of that information the GDC's instructing solicitors then attempted to contact Patient T via email and by telephone call but no response had been received. Patient T had been put on notice to give evidence last week, when the PCC hearing commenced. However, due to unforeseen circumstances, there were two non-planned non-sitting days which necessitated changes in the timetabling of witnesses.

33. Mr Stevens submitted that the test that the Committee must consider is the relevance of Patient T's evidence and whether it is fair to admit it. He invited the Committee to consider that Patient T's signed witness statement dated 26 March 2025 is relevant to charges 62(c)(ii) to (iii), in particular to the matter of consent. He drew the Committee to the relevant paragraphs of Patient T's witness statement in support of that proposition.

34. Turning to the matter of fairness, it was Mr Stevens' submission that Patient T's evidence is not sole and decisive since the GDC places reliance on Patient T's contemporaneous dental records. There is nothing in these records to indicate that the risks and benefits and alternative treatment options were discussed with Patient T. Further, the GDC's position is that there is nothing to suggest any improper motive on the part of Patient T which would render her evidence unreliable. Mr Stevens further submitted that Mr McLauchlan has not sought to challenge the evidence of Patient T or provide a counter narrative to Patient T's account.

35. The Committee has considered the submissions made by Mr Stevens. It has accepted the advice of the legal adviser on the approach it should take. The Committee has borne in mind that Hearsay evidence is admissible in these proceedings.

36. The Committee has first considered the issue of relevance. It is satisfied that Patient T's evidence is relevant since it goes directly to the matters set out in charges 62(c)(ii) to (iii). Further, there is no information before it to suggest that there was any improper motive on the part of Patient T which would render her evidence unreliable.

37. Regarding the issue of fairness, the Committee has concluded that Patient T's witness statement is not the sole or decisive evidence in support of charges 62(c) (ii) to (iii) since the GDC places reliance on copies of Patient T's contemporaneous dental records. It has also borne in mind that Mr McLauchlan has not contested the evidence nor refuted the allegations, even though it was open to him to do so.

38. The Committee is aware that Patient T had been on notice to give evidence last week, when the hearing was due to start. However, due to unforeseen circumstances, there were two non-planned non-sitting days last week which resulted in changes having to be made to the timetabling of the GDC's witnesses. The Committee considered the efforts made by the GDC to facilitate Patient T's attendance at this hearing this week so as to give oral evidence to be proportionate and reasonable. It also considers the reasons cited for Patient T's non-attendance (work commitments) to be reasonable.

39. Taking all these factors into account and taking into account the public interest the Committee is satisfied that it would be fair and in the interest of justice to admit the hearsay evidence of Patient T. It has therefore acceded to the GDC's application.

## **Findings of fact – announced on 29 May 2026**

### **Case background**

40. Mr Stevens, on behalf of the General Dental Council (GDC), set out the background to Mr McLauchlan's case. Mr McLauchlan has not been present or represented throughout these proceedings.

41. The GDC first became aware of concerns about Mr McLauchlan following a complaint made by Patient 1 to the GDC on 28 November 2022 regarding the care she had received from Mr McLauchlan, particularly with his management of issues she was experiencing with her cheek on her right hand side, his referral practice and his handling of her written complaint.

42. The GDC received further complaints, initially in February 2023 and then in February 2024, from an anonymous source from the Practice where Mr McLauchlan worked. The issues identified were numerous and included incorrect diagnosis, not detecting caries and cavities and lack of basic periodontal examinations. The concerns were raised by dental colleagues, including a dental hygienist who had worked alongside Mr McLauchlan for a period of some 14 years. This in turn resulted in an internal investigation by the Practice. Following the conclusion of the Practice's internal investigation, it decided it was necessary to refer the matter to the GDC. The GDC instructed an expert, Dr Pal, who carried out his own assessment of the concerns raised, having regard to the relevant dental records. He provide a report dated 8 July 2025.

43. Mr Stevens submitted that there has been a repeated widespread failure to provide good dentistry. It relates to various alleged failings in assessments, pre-treatment investigation, radiographic practice, standard of care and consent process in relation to the care Mr McLauchlan provided to 39 patients between 2018 and 2023, who at the time was one of the Directors of the Practice.

44. In addition to the clinical matters, the GDC alleges concerns surrounding Mr McLauchlan's probity in connection with Patients B, H, K and N. Turning to Patient B, it is alleged that Mr McLauchlan left a dental bur in her mouth following treatment, but when Patient B complained about the matter, he denied that he had left anything in her mouth and told her that had she swallowed the dental bur left in her mouth it would not cause her harm. Regarding Patient H, the GDC's case is that Patient H received crown treatment from Mr McLauchlan but ultimately needed referral to a specialist dentist. The specialist dentist set out failings regarding the standard of treatment provided. Patient H subsequently complained to the Practice about the standard of care provided by Mr McLauchlan.

45. The GDC's case is that Mr McLauchlan did not provide an accurate report of the specialist dentist's opinion to Patient H. Turning to Patient K, the patient experienced complications in the form of a non-healing socket following extraction. The GDC's case is that by Mr McLauchlan allegedly informed Patient K that it normally takes 6 months for the gums to heal after extraction, in the knowledge that this was incorrect information. Finally, in respect of Patient N, this patient had been experiencing various issues with their UR1. This eventually resulted in Mr McLauchlan referring Patient N for specialist treatment. The GDC alleges that within the referral letter for specialist treatment, Mr McLauchlan stated that another dentist had previously provided Patient N with poor quality root canal treatment in the knowledge that he had previously provided this treatment.

## Evidence

46. The Committee received documentary and oral evidence on behalf of the GDC. This included a hearing bundle comprising some 1522 pages which included the signed witness statements and/or exhibits from the following:

- The Practice Manager dated 4 February 2025 and 20 March 2025 (as well as various other documents and the dental records of a number of the patients in this case)
- The Dental Hygienist dated 10 July 2025 and her email dated 2 May 2023 to the Practice Manager in which she raised concerns regarding Mr McLauchlan's treatment of his patients.
- Patient 1 dated 15 January 2025, as well as her letter of complaint to the Practice dated 30 November 2022

- Patient B dated 28 January 2025 as well as exhibits (dental bur image and emails with the Practice dated 16 October 2020)
- Patient N dated 17 March 2025 and exhibits (including photographs, and screenshots of Facebook conversations)
- Patient T dated 26 March 2025
- Patient V dated 19 March 2025
- Patient X dated 16 April 2025
- Patient Y dated 21 March 2025
- Patient FF dated 28 February 2025
- Paralegal from Kingsley Napley Solicitors dated 17 July 2025 which exhibited a copy of with Patient X's specialist dental records

47. The Committee acceded to a number of the GDC's preliminary application under Rule 57(1) to admit the signed witness statements of Patients 1, Y and T as well as Patients E and L's letters of complaint to Mr McLauchlan's practice. The reasons for the Committee's decision are set out in their previous determinations.

48. The Committee received oral evidence from the following witnesses called on behalf of the GDC:

- Patient B
- Patient N
- The Practice Manager
- Patient V
- Patient X
- The Practice Hygienist
- Patient FF

49. Each of these witnesses confirmed that the content of their signed witness statements were true and accurate.

50. The Committee also received a report dated 8 July 2025 from Dr Pal, a general dental practitioner. In that report Dr Pal set out that the accepted standard for record-keeping is given in the Faculty of General Dental Practice (FGDP)(UK) publication "Clinical Examination and Record Keeping" (CERK) published in 2009 and 2016. Dr Pal also set out that the accepted standard in relation to dental radiography which is set out in the FGDP publication "Selection Criteria in Dental Radiography" published in 2013. He cited that the accepted standard in relation to antibiotic prescribing is set out in the FGDP publication "Antimicrobial Prescribing 2012". Dr Pal set out in his evidence that Mr McLauchlan failed to conduct assessments and pre-treatment investigations, as particularised in the Heads of Charge, based largely on the absence of a record of such. Dr Pal also noted that in respect of a number of patients he has noted when radiographs were taken, as set out within the body of the dental records, there is an absence of a report on them. He referred to the requirement of a report drawing from the "Ionising Radiation (Medical Exposure) Regulations (IRMER)".

51. Dr Pal also provided his expert evidence in respect of the repeated concerns surrounding Mr McLauchlan's consent process, which flows from failures to inform patients of the risks associated with the treatment that was subsequently provided and provide them with alternative treatment options. His opinion was there is an absence of evidence within the records from which one can be satisfied that the risks and benefits and alternative options were discussed.

52. Dr Pal gave oral evidence in which he confirmed the opinions set out in his report. He also answered questions put to him by the Committee.

53. The Committee has borne in mind that Dr Pal has properly applied the correct standard, being that of a reasonably competent dental practitioner. It noted that his opinion was based on his analysis of what was contained in the relevant dental records for the patients under consideration in this case. Dr Pal accepted that in some of the cases, such as Patient EE, Mr McLauchlan has recorded certain examinations and appointments (but not in relation to a social history). However, Dr Pal was critical of those appointments where there is no record of the examinations and assessments having taken place. The Committee noted from Dr Pal's CV that he has considerable experience in general dental practice. It considered that Dr Pal gave a balance and fair opinion in respect of the charges against Mr McLauchlan.

54. The Committee has considered all the evidence presented to it, both documentary and oral, as well as the hearsay evidence. It has borne in mind that Mr McLauchlan has provided no formal response to the allegations against him, both in relation to the allegations set out in the Notice of Hearing dated 8 December 2025 and in relation to the additional allegations that form the subject matter of the Rule 25 application.

55. The Committee was provided with a letter dated 13 November 2023 from the Medical and Dental Union of Scotland (the MDDUS), then acting on behalf of Mr McLauchlan, to the GDC's Case Examiners. The letter set out Mr McLauchlan's responses to the allegations against him insofar as it related to Patient 1 (allegations 1 to 3). In broad terms Mr McLauchlan accepted a number of deficiencies in relation to his record keeping and the reporting of radiographs. The Committee did not accept these as formal admissions and the GDC accepted it had a duty to prove all of the allegations to the requisite standard.

56. The Committee has been advised that Mr McLauchlan is of good character in that he has no previous fitness to practise history.

57. The Committee has taken account of the submissions made by Mr Stevens and has accepted the advice of the Legal Adviser.

58. The Committee has borne in mind that the burden of proof rests with the GDC, and that the standard of proof is the civil standard, that is, whether the factual allegation is proved on the balance of probabilities. Mr McLauchlan need not prove anything.

59. Turning to those matters charged in the alternative, which relate to a failure to carry out various examinations and assessments, the Committee has drawn the reasonable inference, based on Dr Pal's report as well as its assessment of the whole of the relevant records, that the absence of any record of the assessments and pre-treatment investigations in the clinical notes indicates that it is more likely than not that these were not done as opposed to being a failure to record.

60. In respect of the allegations concerning lacking integrity, the Committee has kept in mind the principles set out in the case of *Wingate & Anor v Solicitors Regulation Authority* [2018] EWCA Civ 366.

61. Regarding the allegations of dishonesty, the Committee has applied the legal test for dishonesty, as set out in the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC. Further, the Committee has had regard to the GDC's "Fitness to Practise: Guidance for the practice committees" (January 2026) (the Guidance) in respect of the meaning of "lacking integrity" and "dishonesty".

62. The Committee has made the following findings:

<b>Patient 1</b>	
1	<i>You failed to provide an adequate standard of care to Patient 1 from 14 July 2021 to 29 November 2022, in that:</i>
1a	<i>You did not report on:</i>
1ai	<p><i>a radiograph taken on 14 July 2021</i> <b>Found proved</b></p> <p>Patient 1 attended for an emergency appointment on 14 July 2021, presenting with pain and swelling to the LR6. The clinical records indicate that a radiograph was taken on that date with the initials MC (McLauchlan Colin) against it but there is no reporting of the radiograph.</p> <p>Dr Pal referred to IR(MER)17 guidelines which stipulates, as a regulatory requirement, the need to undertake a clinical evaluation of all dental radiographs. Dr Pal set out that this would typically be seen in the narrative of clinical records as a radiographic report. Dr Pal noted that there was no record of a report of the radiograph taken and was critical of Mr McLauchlan's failure in this regard. The Committee is satisfied, having reviewed the patient records, that there is no report of the radiograph taken. It accepts Dr Pal's opinion that Mr McLauchlan was under a duty to report on the radiograph and that he did not do so.</p>
1aii	<p><i>a periapical radiograph taken on 29 September 2021</i> <b>Found proved</b></p> <p>The Committee noted that there is a record in the clinical note of "x-ray = Sm, Small x'Ray" and it has seen the radiograph that was taken. However, there is no evidence of a report of the radiographic in the clinical notes. The Committee accepts Dr Pal's opinion on this matter and find this allegation proved for the same reasons set out at charge 1ai above.</p>
1b	<i>During an appointment on 14 July 2021, you</i>
1bi	<p><i>did not diagnose and/or offer treatment for caries found at Patient 1's LR8;</i> <b>Found proved</b></p> <p>Dr Pal's evidence was that the radiograph taken at this appointment, the LR8 was visible with signs of caries and that 'this would have been evident clinically, and therefore failing to diagnose caries at LR8 was far below the standard expected since without diagnosis and treatment the condition would be likely to worsen'. The Committee noted that there was no record of a diagnosis or treatment for caries at Patient 1's LR8 in the clinical records. Therefore, on the balance of probabilities, the Committee determined that the diagnosis of the caries at the LR8 was not made and therefore it follows that he did not offer treatment for the caries. Accordingly, it finds this charge proved.</p>
1bii	<p><i>Did not check whether their LR6 and/or LR7 and/or LR8 were tender to percussion</i> <b>Found proved</b></p> <p>Dr Pal's evidence was that there was no record in the notes that Mr McLauchlan carried out further investigations such as conducting tender to percussion (TTP) on the teeth in question. He opined that Mr McLauchlan should have done so at this appointment since this would have assisted with identifying which tooth which was causing the problems. Therefore, Dr Pal concluded that Mr McLauchlan failed to provide an adequate standard of care. The Committee notes that there is no record</p>

	<p>in the notes of Mr McLauchlan having carried out this assessment and infers that in the absence of this, it was, on the balance of probabilities, not done. It therefore accepts Dr Pal's evidence on this.</p>
1biii	<p><i>Not adequately check Patient 1's medical history in advance of prescribing a penicillin antibiotic</i> <b>Found proved</b></p> <p>The Committee noted that the clinical records showed that Mr McLauchlan had made a note that he checked Patient 1's medical history and checked for allergies. It noted that the medical history section of the records has details of Patient 1's allergy to Penicillin, and that the patient had entered an allergy to penicillin on six occasions before the appointment. The latest records of this allergy were dated 15 August 2019, 19 February 2020 and 30 September in 2021, and therefore the Committee considered that the patient had clearly stated in her completing her medical history by an entry on the CliniPad that she was allergic to penicillin. Dr Pal's report opined that it was unlikely that Mr McLauchlan adequately checked the medical reports since the medical history had reported an allergy to Penicillin since 2016. The Committee accordingly finds this allegation proved.</p>
1biv	<p><i>Prescribed Patient 1 a penicillin antibiotic when Patient 1 was allergic of such.</i> <b>Found proved</b></p> <p>The Committee found this allegation proved for the same reasons set out in as 1biii. It also considered that had Mr McLauchlan adequately checked Patient 1's records, he would have realised that Patient 1 was allergic to penicillin and would not have prescribed amoxicillin caps 500 mg – an antibiotic containing penicillin. Accordingly, the Committee has concluded that Mr McLauchlan had failed to provide an adequate standard of care and found this charge proved.</p>
1c	<p><i>During an appointment on 17 March 2022, you did not:</i></p>
1ci	<p><i>Check whether Patient 1's LR7 was tender to percussion</i> <b>Found proved</b></p> <p>The Committee agreed with Dr Pal in that there was nothing in the records to suggest that Mr McLauchlan had checked to see whether Patient 1's LR7 was TTP. Had such a check been done, the Committee would have expected to see it recorded in the records. In the absence of any record to this effect the Committee has therefore found this charge proved.</p>
1cii	<p><i>Check whether Patient 1's LR7 was mobile</i> <b>Found not proved</b></p> <p>Dr Pal's evidence was that there is no note in the records dated 17 March 2022 of any details of the patient complaints, any clinical observations relating to the LR7 or of the soft tissues. He considered that he would have expected there to have been investigations relating to the LR7, such as TTP, mobility and an examination of the soft tissues.</p> <p>However, the Committee noted that Mr McLauchlan had checked the mobility two days earlier, namely on 15 March 2022 in which he refers to the LR3 having grade 3 mobility and that there was no option other than to extract the tooth. Given this entry, the Committee considers that there was no requirement for Mr McLauchlan to</p>

	re-check or record the mobility of LR7 two days later on 17 March 2022. Accordingly, it finds this charge not proved.
1ciii	<p><i>Conduct a soft tissue examination</i> <b>Found proved</b></p> <p>The Committee noted that there is nothing in the records to suggest that Mr McLauchlan had conducted a soft tissue examination, and they would have expected him to have recorded it. On the balance of probabilities, it concluded that an examination was not conducted. The Committee accepts Dr Pal's expert opinion that it is unlikely a soft tissue examination was carried out given the lack of records. This charge was accordingly found proved.</p>
1civ	<p><i>Discuss any alternative treatment options to extracting Patient 1's LR7</i> <b>Found proved</b></p> <p>Dr Pal's opinion was that there was no record of any alternative options to extraction. He accepted that the radiograph of LR7 taken on 29 September 2021 does show bone loss around the tooth and that it was possible that the LR7 exhibited mobility on 17 March 2022, even though there is no record of this.</p> <p>The Committee, having reviewed the patient's records, agrees with Dr Pal's evidence that the only option recorded in the notes is extracting the LR7. Accordingly, it finds this charge proved.</p>
1cv	<p><i>Discuss the risks and benefits of extracting Patient 1's LR7</i> <b>Found proved</b></p> <p>The Committee has had regard to its reasons set out at 1civ above. In addition, the Committee has taken into account Patient 1's witness statement. In various paragraphs of Patient 1's witness statement there is reference to Mr McLauchlan not having discussed with the patient the risks and benefits of the removal of their lower right (LR) teeth. Patient 1 was not specific in their witness statement about the removal of LR7 with regards to risks and benefits, whereas Patient 1 was in relation to the removal of the other LR teeth. However, the Committee notes that there is no record in the clinical notes of a discussion of the risks and benefits of extracting the Patient's LR7, other than the fact that it has to be extracted. Accordingly, it finds this charge proved.</p>
1d	<i>You did not adequately examine the mucosa on the right hand side of Patient 1's cheek during an appointment on</i>
1di	<p><i>14 July 2021</i> <b>Found proved</b></p> <p>Patient 1 presented at an emergency appointment with a history of pain and swelling on the right hand side. Dr Pal's evidence was that there was no record of Mr McLauchlan having carried out an adequate examination of the mucosa on the right hand side and he would have expected this to have taken place at this appointment given the patient's presenting symptoms.</p> <p>There is nothing in the clinical records to indicate that Mr McLauchlan had carried out an examination on the right hand side mucosa. The Committee would have expected, given Patient 1's presenting symptoms, for there to have been a record</p>

	and that in the absence of records supports the GDC's case that it was more likely than not that it was not undertaken. It therefore find the charge proved.
1dii	<p><i>29 September 2021</i> <b>Found proved</b></p> <p>In reaching its decision, the Committee has had regard to its reasons set out at charge 1d(i) above.</p>
1diii	<p><i>30 September 2021</i> <b>Found proved</b></p> <p>In reaching its decision, the Committee has had regard to its reasons set out at charge 1d(i) above.</p>
1div	<p><i>13 January 2022</i> <b>Found proved</b></p> <p>Patient 1 attended for another emergency appointment on 13 January 2022 as they had a sore right cheek. Dr Pal opined that at this appointment Mr McLauchlan noticed redness of the gums and advised a mouthwash, which suggested that the Registrant noted the appearance of the tissues to be a departure from normality. However, Dr Pal considered this observation to be an inadequate examination of the buccal mucosa of the right hand side. The Committee, having reviewed the patient's records for this appointment, agrees with Dr Pal's evidence. Accordingly, it finds this charge proved.</p>
1dv	<p><i>17 March 2022</i> <b>Found proved</b></p> <p>The Committee notes from Patient 1's dental records that there is no record of a soft tissue examination having been carried out. On the balance of probabilities, the Committee determined that this examination was not carried out. Accordingly, it finds this charge proved for the same reasons set out at charge 1d(i) above.</p>
1e	<p><i>You did not refer Patient 1 for specialist examination and/or treatment between 29 September 2021 and 15 July 2022</i> <b>Found proved</b></p> <p>Patient 1's evidence was that she had seen the hygienist on 22 April 2022 who had intervened and said that something needed to be done. Patient 1's evidence was that the hygienist raised the concerns with Mr McLauchlan and asked the patient to wait in the waiting room so that she could go and see Mr McLauchlan. On Patient 1's account, she saw Mr McLauchlan on 22 April 2022 where he told Patient 1 that he would refer her to an oral medicine specialist for treatment in the middle to not urgent range. Patient 1's evidence was that the referral did not happen and when she returned on 15 July 2022 for another appointment concerning the mucosa on the right hand side her cheek, Mr McLauchlan said again that he would refer her.</p> <p>Patient 1's account was supported by the dental hygienist's witness statement, her clinical notes and her oral evidence before the Committee, which it accepted. The Committee noted in particular that the dental hygienist was concerned about Patient</p>

	<p>1's condition to the extent that she personally escalated her concerns to Mr McLauchlan during the patient's visit to the practice on 22 April 2022.</p> <p>The Committee noted that there is no evidence in Patient 1's records that Mr McLauchlan sent a referral for specialist examination and/or treatment between 29 September 2021 and 15 July 2022. Dr Pal referred to the Scottish Referral Guidelines for Suspected Head and Neck Cancer which states that an urgent referral should be made for all unexplained red or mixed red and white patches of the oral mucosa persisting for more than 3 weeks. In Dr Pal's opinion it was likely that by 29 September 2021 this would have been the case and that the referral should have been at that point. Dr Pal's evidence was that despite Mr McLauchlan noting redness of tissues around the LR7 mucosa on 13 January 2022, there is no evidence of a referral being made. He was critical of Mr McLauchlan's delay in referring the patient between the dates in question.</p> <p>The Committee has accepted the evidence of Patient 1, the dental hygienist and that of Dr Pal. Having regard to the Scottish Referral Guidelines, the Committee considers that Mr McLauchlan should have referred the patient by 29 September 2021. Accordingly, the Committee finds this charge proved.</p>
<p>1f</p>	<p><i>You did not adequately respond to the concerns raised by Patient 1 about her treatment, in your letter to her dated 29 November 2022</i> <b>Found proved</b></p> <p>Patient 1 telephoned the Practice on 14 November 2022, and asked to be transferred to another dentist within the practice. She raised a number of concerns with the Practice Manager which are set out in the transfer request form dated 14 November 2022. There were a number of issues raised, included not resolving her initial clinical concerns through extractions, the delayed referral of the patient to oral maxillo facial department (OMF) after having told her that he would do so, the patient was concerned as she went to see the consultant, who asked her why her tooth was taken out and why she was given antibiotics and Mr McLauchlan having no interest in her mouth.</p> <p>Mr McLauchlan sent a letter dated 29 November 2022 to Patient 1 in which he sets out <i>"The teeth that were extracted all had a very poor prognosis, that is obvious with the radiographs that were taken. I totally understand the pain that you have experienced in your right hand side buccal mucosa and I am very sorry that you have gone through this."</i></p> <p>The Committee notes that Patient 1 sent a three page detailed letter of complaint the following day, 30 November 2022 in which they set out in chronological order as to what took place. In particular, Patient 1 describes Mr McLauchlan being condescending in tone, neglecting to enquire about problems or feelings leading up to check ups and examination.</p> <p>Dr Pal considered that Mr McLauchlan's response dated 29 November 2022 did not adequately respond to their specific concerns from 14 November 2022 or provide an adequate resolution. He opined that the letter should have addressed the delayed referral for the condition seen in her buccal mucosa, the patient's perception that a full exam had not been undertaken and a satisfactory resolution for the request to transfer her care.</p>

	<p>The Committee notes, through the representations made on behalf Mr McLauchlan of dated 13 November 2023 from the MDDUS that Mr McLauchlan accepted his shortcomings in respect of Patient 1's response. The Committee makes it clear that this acceptance is not the sole basis of its findings in this matter.</p> <p>The Committee is satisfied Mr McLauchlan's letter dated 29 November 2022 fails to respond to the numerous concerns raised by Patient 1. It accepts Dr Pal's opinion on this matter and accordingly finds this charge proved.</p>
2	<p><i>By reason of your conduct in charge 1.c.iv. and/or 1.c.v you did not obtain Patient 1's informed consent for the extraction of their LR7</i> <b>Found proved</b></p> <p>In Patient 1's witness statement they recollected orally consenting to the extraction as Mr McLauchlan told them that it needed to be done, but they could not 'recall signing any forms'.</p> <p>Dr Pal set out in his report that 'There is no record of any alternative options to extraction of LR7 such as investigation of the soreness of the cheek and failing to discuss such options meant that sufficient information for informed consent was not given on 17.03.22.'</p> <p>The Committee is satisfied that there are no notes in the medical records to suggest that Mr McLauchlan discussed the treatment options and the risks and benefits of the extraction of the LR7 and that this information should have been explained to Patient 1. In light of this, the Committee has concluded that charge 2 has been found proved.</p>
3	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient 1's appointments from 14 July 2021 to 15 July 2022, in that:</i> <b>Found not proved save for 3(c) and 3(e)</b></p> <p>The GDC puts charge 3 in its entirety in the alternative to charges 1(a), 1(b), 1(c) and 1(d).</p> <p>The alternative, as set out in charges 3, is that he carried out the alleged actions but he did not record them. The Committee has found charge 1(a), 1(b), 1(c) and 1(d) proved and therefore finds charge 3 not proved, save for charges 3(c) and 3(e)</p>
3a	<p><i>In your record of 14 July 2021 you did not:</i></p>
3ai	<p><i>Make any record of caries found at Patient 1's LR8</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at 3 above.</p>
3aii	<p><i>Record whether Patient 1's LR6 and/or LR7 and/or LR8 were tender to percussion</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at 3 above.</p>
3aiii	<p><i>Record offering Patient 1 any treatment for caries at their LR8</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at 3 above.</p>

3b	<i>You did not record the presence of a red lesion found at Patient 1's right buccal mucosa on:</i>
3bi	<i>14 July 2021</i> <b>Found not proved</b>  This is for the same reasons as set out at 3 above.
3bii	<i>29 September 2021</i> <b>Found not proved</b>  This is for the same reasons as set out at 3 above.
3biii	<i>30 September 2021</i> <b>Found not proved</b>  This is for the same reasons as set out at 3 above.
3biv	<i>13 January 2022</i> <b>Found not proved</b>  This is for the same reasons as set out at 3 above.
3bv	<i>17 March 2022</i> <b>Found not proved</b>  This is for the same reasons as set out at 3 above.
3c	<i>You did not record you had prescribed Patient 1 an alternative antibiotic to the one you originally prescribed on 14 July 2021;</i> <b>Found proved</b>  In reaching its decision, the Committee noted that there is no record in Patient 1's notes of an alternative antibiotic having been prescribed as an alternative to the penicillin (amoxicillin), which had been prescribed earlier that day.
3d	<i>You did not record sufficient details of Patient 1's presenting complaint on</i>
3di	<i>29 September 2021</i> <b>Found not proved</b>  This is for the same reasons as set out at 3 above.
3dii	<i>17 March 2022</i> <b>Found not proved</b>  This is for the same reasons as set out at 3 above.
3e	<i>In your record of 13 January 2022, you did not record what mouthwash you prescribed Patient 1</i> <b>Found proved</b>  As noted by Dr Pal, there is no record as to what mouthwash Mr McLauchlan prescribed for Patient 1.
3f	<i>In your record of 17 March 2022, you did not record the clinical findings that led to your decision to extract Patient 1's LR7.</i> <b>Found not proved</b>  This is for the same reasons as set out at 3 above.

<b>Patient A</b>	
4	<i>You failed to provide an adequate standard of care to Patient A from 7 February 2022 to 17 February 2023, in that:</i>
4a	<i>During an appointment on 7 February 2022, you did not:</i>
4ai	<p><i>Check whether Patient A's UL6 was tender to percussion</i> <b>Found proved</b></p> <p>Patient A attended for an emergency appointment on 7 February 2022 with a throbbing sensation at UL6 and a report that the tooth had not settled since the last visit on 15 December 2021.</p> <p>There is no record in Patient A's notes to indicate that the TTP test was carried out at this appointment. Dr Pal's report stated that 'Given the symptoms, there was a failure to carry out diagnostic investigations such as TTP'. The Committee accepts Dr Pal's evidence on this point and accordingly finds this charge proved.</p>
4aii	<p><i>Take a periapical radiograph covering their UL6</i> <b>Found proved</b></p> <p>The Committee noted that there is no records in Patient A's notes to indicate that a periapical radiograph covering their UL6 was carried out. Dr Pal opined that further investigations should have been carried out such as the taking of a periapical radiograph. The Committee accepts Dr Pal's evidence and accordingly finds this charge proved.</p>
4b	<i>During an appointment on 10 February 2022 you did not:</i>
4bi	<p><i>Check whether Patient A's UL6 was tender to percussion</i> <b>Found proved</b></p> <p>The records indicate that Patient A returned as there was continuing pain to the UL6. The Committee found this charge proved for the same reasons set out at 4ai above.</p>
4bii	<p><i>Adequately report on a radiograph taken</i> <b>Found proved</b></p> <p>The clinical notes record that a radiograph had been taken on 10 February 2022. Dr Pal's evidence was that the radiograph shows the presence of an amalgam ledges at UL5 and UL7 as well as caries at the UL7 – none of which was reported. Dr Pal considered that the radiographic report was inadequate. The Committee agrees, having examined all the evidence, and accordingly finds this charge proved.</p>
4biii	<p><i>Diagnose caries found at Patient A's UL7</i> <b>Found proved</b></p> <p>The Committee has examined the patient's clinical records carefully. There is nothing in Patient A's clinical records regarding the diagnosis of caries at the UL7. Dr Pal's evidence is that caries can be seen at the UL7 distal but notes that Mr McLauchlan did not diagnosis this. There is also no reference to the diagnosis of the UL7 from the radiograph. Taking into account all the evidence, the Committee finds that Mr McLauchlan failed to diagnose the caries at Patient A's UL7.</p>
4c	<p><i>You did not offer to treat and/or manage caries found at Patient A's UL7 from 10 February 2022 to 17 February 2023</i> <b>Found proved</b></p>

	<p>The Committee notes that there is no reference in Patient A's clinical notes to any diagnosis of the caries of the UL7 during the time in question. The Committee notes that despite multiple visits by Patient A, there is no evidence of treatment or management of caries of Patient A's UL7. Dr Pal opined that there was a failure to diagnose and manage the UL7 between those dates. Having regard to all the evidence, the Committee accepts Dr Pal's opinion. It therefore finds this charge proved.</p>
4d	<i>During an appointment on 4 May 2022 you did not conduct:</i>
4di	<p><i>an extra oral examination</i> <b>Found proved</b></p> <p>The Committee has had regard to Patient A's dental records for this date. There is no reference in the clinical records of an extra oral examination having been carried out. Dr Pal opined that there was a failure to carry out the necessary clinical assessment set out in charge 4di. On the balance of probabilities, the Committee determined that this was not carried out. Accordingly, it finds this charge proved.</p>
4dii	<p><i>a soft tissue examination</i> <b>Found proved</b></p> <p>There is nothing in the clinical notes to indicate that this assessment was carried out. The Committee finds this charge proved for the same reasons set out in 4di above.</p>
4diii	<p><i>a Basic Periodontal Examination [BPE]</i> <b>Found proved</b></p> <p>There is nothing in the clinical notes to indicate that this examination was carried out. The Committee finds this charge proved for the same reasons set out at 4di above.</p>
4div	<p><i>an assessment of Patient A's oral hygiene</i> <b>Found proved</b></p> <p>There is nothing in the clinical notes to indicate that an oral hygiene assessment of Patient A was carried out. The Committee finds this charge proved for the same reasons set out in 4di above.</p>
4e	<i>During an appointment on 16 January 2023, you did not</i>
4ei	<p><i>Conduct an extra oral examination</i> <b>Found proved</b></p> <p>The Committee has had regard to Patient A's dental records for this routine examination appointment. There is no reference in the clinical records of an extra oral examination having been carried out. On the balance of probabilities, the Committee determined that this was not carried out. Dr Pal opined that there was a failure to carry out a full examination which would include extra-oral and soft tissue examinations, a periodontal assessment and an assessment of oral hygiene. The Committee finds this charge proved.</p>
4eii	<p><i>Conduct a soft tissue examination</i> <b>Found proved</b></p>

	<p>There is nothing in the clinical notes to indicate that the soft tissue examination was carried out. The Committee finds this charge proved for the same reasons set out in 4ei above.</p>
4eiii	<p><i>Conduct a BPE</i> <b>Found proved</b></p> <p>There is nothing in the clinical notes to indicate that the BPE examination was carried out. The Committee finds this charge proved for the same reasons set out in 4ei above.</p>
4eiv	<p><i>Conduct an assessment of Patient A's oral hygiene</i> <b>Found proved</b></p> <p>There is nothing in the clinical notes to indicate that an assessment of Patient A's oral hygiene was carried out. The Committee finds this charge proved for the same reasons set out in 4ei above.</p>
4ev	<p><i>Adequately report on bitewing radiographs taken</i> <b>Found proved</b></p> <p>Mr McLauchlan recorded in his clinical notes that two radiographs were taken on 16 January 2023 for 'caries detection and bone assessment'. There is note of LL7 distal caries, Dr Pal highlighted that Mr McLauchlan failed to record the bone loss and caries at UL8 mesially and therefore the radiographic report was inadequate. The Committee has seen the radiographs and in light of those, it accepts Dr Pal's expert opinion. Accordingly, the Committee finds this charge proved.</p>
4evi	<p><i>Diagnose caries found at Patient A's UL8</i> <b>Found proved</b></p> <p>The Committee, having examined the patient's records, noted that there is no reference from the clinical notes to a diagnosis of caries at Patient A's UL8. Accordingly, the Committee finds this charge proved.</p>
4f	<p><i>You did not offer to treat caries found at Patient A's UL8 from 16 January 2023 to 17 February 2023</i> <b>Found proved</b></p> <p>There is no reference to a diagnosis of caries at Patient A's UL8 as found in charge 4ev, and therefore it follows there was no treatment. Dr Pal opined that there was a failure to diagnose caries and subsequently treat these. The Committee accepts Dr Pal's evidence on this point. It therefore finds this charge proved.</p>
5	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient A's appointments from 7 February 2022 to 17 February 2023, in that:</i> <b>Found not proved</b></p> <p>The GDC puts its case that the record keeping failures (charge 5) are in the alternative of findings charge 4 not proved. The Committee has found charge 4 not proved. It therefore follows that the linked record keeping failures are found not proved because there would be no basis to record something which was not done. Accordingly, charge 5 is found not proved in its entirety.</p>

5a	<p><i>In your record of 7 February 2022, you did not record whether Patient A's UL6 was tender to percussion;</i></p> <p><b>Found not proved</b> This is for the same reasons as set out at 5.</p>
5b	<p><i>In your record of 10 February 2022, you did not make any record of caries found at Patient A's UL7 and/or the presence of ledges at their UL5 and UL7</i></p> <p><b>Found not proved</b> This is for the same reasons as set out at 5.</p>
5c	<p><i>In your record of 4 May 2022, you did not record:</i></p>
5ci	<p><i>an extra oral examination</i></p> <p><b>Found not proved</b> This is for the same reasons as set out at 5.</p>
5cii	<p><i>A soft tissue examination</i></p> <p><b>Found not proved</b> This is for the same reasons as set out at 5.</p>
5ciii	<p><i>a BPE</i></p> <p><b>Found not proved</b> This is for the same reasons as set out at 5.</p>
5civ	<p><i>An assessment of Patient A's oral hygiene</i></p> <p><b>Found not proved</b> This is for the same reasons as set out at 5.</p>
5d	<p><i>In your record of 16 January 2023 you did not record</i></p>
5di	<p><i>Caries found at Patient A's UL8</i></p> <p><b>Found not proved</b> This is for the same reasons as set out at 5.</p>
5dii	<p><i>an extra oral examination</i></p> <p><b>Found not proved</b> This is for the same reasons as set out at 5.</p>
5diii	<p><i>A soft tissue examination</i></p> <p><b>Found not proved</b> This is for the same reasons as set out at 5.</p>
5div	<p><i>a BPE</i></p> <p><b>Found not proved</b></p>

	This is for the same reasons as set out at 5.
5dv	<i>An assessment of Patient A's oral hygiene</i> <b>Found not proved</b>  This is for the same reasons as set out at 5.
<b>Patient B</b>	
6	<i>You failed to provide an adequate standard of care to Patient B from 8 October 2020 to 16 October 2020, in that:</i>
6a	<i>During an appointment on 8 October 2020, you did not</i>
6ai	<i>Conduct an extra oral examination</i> <b>Found proved</b> The Committee has considered carefully Patient B's dental records. There is no mention in the examination records of 8 October 2020 of an extra oral examination, soft tissue examinations, a periodontal assessment and an assessment of Patient B's oral hygiene.  The Committee notes that elsewhere in the notes, Mr McLauchlan has made a record of the examinations he has carried out on patients, but not on this occasion.  Dr Pal's opinion was that Mr McLauchlan should have carried out the necessary examinations as set out in this charge. He further commented that there was no radiographic report on the bitewing radiographs which were taken at this appointment. The Committee accepts Dr Pal's evidence. The Committee was satisfied that on the balance of probabilities, Mr McLauchlan did not carry out this examination. Accordingly, it finds this charge proved.
6aii	<i>Conduct a soft tissue examination</i> <b>Found proved</b> The Committee notes that there is no note in Patient B's dental records of a soft tissue examination being carried out. It finds this charge proved for the same reasons as set out in charge 6ai above.
6aiii	<i>Conduct a BPE</i> <b>Found proved</b> The Committee notes that there is no note in Patient B's dental records of a BPE examination being carried out in. It finds this charge proved for the same reasons as set out in charge 6ai above.
6aiv	<i>Conduct an assessment of Patient B's oral hygiene</i> <b>Found proved</b> The Committee notes that there is no evidence of this assessment of Patient B's oral hygiene being carried out in Patient B's dental records. It finds this charge proved for the same reasons as in charge 6ai above.
6av	<i>Report on bitewing radiographs taken</i> <b>Found proved</b>

	<p>The Committee has reviewed Patient B's dental records. It notes that there is a record of bitewing radiographs having been taken at this appointment but there is no report on it. Dr Pal's opinion was that there should have been a report on the bitewing radiographs taken. The Committee accepts Dr Pal's evidence on this matter and accordingly finds the charge proved.</p>
6b	<p><i>During an appointment on 15 October 2020, you:</i></p>
6bi	<p><i>left a dental bur in Patient B's mouth;</i> <b>Found proved</b></p> <p>The Committee is satisfied that Mr McLauchlan must have been drilling in Patient B's mouth because there is a record of him having carried out a filling on the LL7 at that appointment and the notes also record "<i>Drilling stopped</i>".</p> <p>The Committee had regard to Patient B's GDC witness statement in which she reports that on her return home after the dental visit and after the numbness of her mouth had worn away, she felt something "<i>tucked between the lower left jaw</i>" and her cheek. She describes investigating what was in her mouth with her tongue and that when she put her finger in her mouth, a dental bur came out.</p> <p>Patient B went on to explain that after discovering the dental bur, she sent an email to the Practice on 15 October 2020 at 16.07 (the same day that she had filling) containing an image of the bur with the following text "<i>after my filling with Colin today. Just as well I didn't swallow it.??</i>"</p> <p>Patient B sent a follow up email to the Practice on 16 October 2020 in which she referred to her first email regarding the bur left in her mouth. Patient B also referred in the email to Mr McLauchlan having called her at 16.18 in which he denied having left the bur in his mouth.</p> <p>Patient B gave oral evidence in which she confirmed the contents of her GDC witness statement. Patient B explained that she had been informed by Mr McLauchlan that if she had swallowed the bur she would excrete it. She described in her oral evidence feeling "<i>very shocked</i>" by Mr McLauchlan's comments.</p> <p>The Committee was satisfied that Patient B's evidence on this matter was credible. It considers that her discovery of a dental bur in her mouth would have been a memorable event. The Committee has also borne in mind that Patient B sent an email of complaint to the Practice on her return home from the appointment which lends weight to her evidence. There is no evidence before the Committee, such as entry in the clinical notes, to suggest that Mr McLauchlan had told Patient B that he had left the dental bur in her mouth. Indeed in response to questions by the Committee, Patient B said that Mr McLauchlan denied that he had left the dental bur in her mouth and said he did not use the equipment. Having regard to all the evidence, the Committee finds this charge proved.</p>
6bii	<p><i>Failed to inform Patient B that you had left a dental bur in her mouth.</i> <b>Found proved</b></p> <p>The Committee has had regard to its reasons set out at charge 6bi above.</p>

	<p>It has accepted Patient B's evidence that she realised for the first time that the dental bur had been left in her mouth on her return home from the appointment on 15 October 2020, after the numbness of her mouth had worn away.</p> <p>Dr Pal set out in his report that "The detaching of a bur from a dental handpiece during an operative procedure would be something the dentist would be aware of." He further opined that "If a dental bur detaches during a procedure, the dentists would be aware of such an event. The first duty would be to locate and retrieve the bur. The description of the patient is that the bur was found in the mouth. In my opinion it is almost certain the Registrant would have been able to find the bur intra-orally had he looked for the bur."</p> <p>The Committee accepts Dr Pal's evidence that if the dental bur had become detached during a procedure, Mr McLauchlan would have known this and should have informed Patient B of this. It therefore finds this charge proved.</p>
6c	<i>During a telephone call with Patient B, on or around 16 October 2020, you:</i>
6ci	<p><i>Denied that you had left a dental bur in her mouth during an appointment on 15 October 2020</i> <b>Found proved</b></p> <p>In reaching its decision, the Committee has had regard to Patient B's written and oral evidence in which she confirmed that she sent an email dated 16 October 2020 to the Practice. The Committee has had regard to that email in which Patient B states "<i>ref equipment left in my mouth, followed by a telephone call to Reception soon afterwards to check you had received it. The lady who answered said she hadn't seen the email but would ask Colin McLauchlan to ring her back. He did so at 16:18 Mr McLauchlan but said he hadn't read the email or seen the photograph when he telephone to discuss my major concern about negligent care. He did, however, deny having left anything in my mouth and that he didn't use the equipment I had described to him. Did he think I had access to such equipment?</i>" Patient B confirmed this position in her oral evidence.</p> <p>The Committee accepts Patient B's evidence that Mr McLauchlan initially denied leaving the bur in her mouth. It therefore found this charge proved.</p>
6cii	<p><i>claimed that had Patient B swallowed the dental bur left in mouth it would not cause her harm;</i> <b>Found proved</b></p> <p>The Committee has heard evidence from Patient B in support of this charge. In her email to the Practice manager on 17 October 2020, Patient B states that Mr McLauchlan had informed her, when discussing the dental bur, that if she swallowed the bur it "<i>would have passed straight through.</i>" In her oral evidence Patient B stood by what she had set out in that email. Patient B stated that she remembered what Mr McLauchlan said because of the language he used. The Committee notes that Patient B's contemporaneous emails to the Practice are consistent with her witness statement and her oral evidence. It finds Patient B's evidence to be credible in support of this charge and therefore found it proved.</p>
7	<p><i>Your conduct in charge 6bi and/or 6bii put Patient B's safety at risk</i> <b>Found proved</b></p>

	<p>Dr Pal set out that the risk of not retrieving the bur and allowing the patient to leave the surgery could be that the patient could have inhaled or swallowed the bur, which could have caused airway difficulties (if inhaled) or lodging of the bur in the gastro-intestinal passage (if swallowed). In Dr Pal's opinion, both situations could necessitate further treatment in hospital and pose a risk to patient safety.</p> <p>The Committee accepts Dr Pal's opinion and accordingly found this charge proved.</p>
8	<p><i>Your conduct in charge 6bii was in breach of your duty of candour</i> <b>Found proved</b></p> <p>Dr Pal considered that it was almost certain that Mr McLauchlan would have been aware that the bur had been left in the patient's mouth, bearing in mind the size of it. He opined that a reasonably competent general practitioner should have informed the patient about this.</p> <p>There is no evidence that Mr McLauchlan informed Patient B that the bur had been left in her mouth at the appointment on 15 October 2020. The Committee considers that it is more likely than not that Mr McLauchlan knew he had lost the bur in Patient B's mouth and that he should have informed her immediately what had happened. He did not do so. This was in breach of the GDC's Guidance "<i>Being open and honest with patients when something goes wrong</i>" (effective from 1 July 2016). The Committee is satisfied that Mr McLauchlan's conduct was in breach of his duty of candour.</p>
9	<p><i>Your conduct in charge 6ci was</i></p>
9a	<p><i>Misleading</i> <b>Found proved</b></p> <p>The Committee has concluded that it is more likely than not that Mr McLauchlan knew by the time when he had the telephone conversation with Patient B on 16 October 2020 that he had left the bur inside Patient B's mouth. It considers that Mr McLauchlan saying that he had not left the dental bur in Patient B's mouth was knowingly misleading. Further, given that the telephone call was made in the context of a complaint, the Committee has inferred that Mr McLauchlan was not wanting to accept responsibility for something that had gone wrong with Patient B's care.</p>
9b	<p><i>Lacking integrity</i> <b>Found proved</b></p> <p>The Committee has had regard to the case of <i>Wingate v Solicitors Regulation Authority [2018] EWCA Civ 366</i>. It has also had regard to paragraph 45 (under the heading 'Integrity') of Appendix 1 of the GDC's Guidance. It states: "...<i>professions have a privileged and trusted role in society and, as such, professions are expected to adhere to high professional and ethical standards.</i>"</p> <p>The Committee considers that Mr McLauchlan failed in his professional obligation to be open and truthful in his communications with Patient B. In light of its findings, the Committee is satisfied that Mr McLauchlan's conduct in denying to Patient B that he had left the dental bur in her mouth, in the knowledge that this was not the case, amounts to a lack of integrity.</p>
9c	<p><i>Dishonest, in that you knew you had left a dental bur in her mouth</i> <b>Found proved</b></p>

	<p>In applying the test set out in the case <i>Ivey v Genting Casinos (UK) Ltd t/a Crockfords</i> [2017] UKSC, has concluded that it is more likely than not that Mr McLauchlan, as an experienced dentist, having qualified in the 1980s, would have known that he had left the bur in Patient B's mouth. The Committee has further concluded that Mr McLauchlan's actions in saying to Patient B that he had not left the dental bur in her mouth when he knew that he had was objectively dishonest. It noted that the comment was made in the context of a patient complaint and where something had gone wrong (namely the leaving of the bur in the patient's mouth). Accordingly, it finds this charge proved.</p>
10	<i>Your conduct in charge 6cii was</i>
10a	<p><i>Misleading</i> <b>Found proved</b></p> <p>The Committee accepts Dr Pal's evidence regarding the risks to Patient B. The Committee determined that Mr McLauchlan would have known that had Patient B swallowed the dental bur, it would have caused her harm. The Committee considers despite knowing the risks, that Mr McLauchlan, sought to minimise the risk to Patient B by advising her that it would "<i>pass through</i>". Accordingly, it finds this charge proved.</p>
10b	<p><i>Lacking integrity</i> <b>Found proved</b></p> <p>This is found proved for the same reasons as set out at charge 9b above. In addition, the Committee considers that there is an expectation that Mr McLauchlan will be open and truthful to Patient B of the potential risks to her health if she had swallowed the bur. It considers that by denying and dismissing Patient B's valid concerns, in itself shows a lack of candour and lack of care. Accordingly, it finds this charge proved.</p>
10c	<p><i>Dishonest, in that you knew swallowing a dental bur had the potential to cause Patient B harm</i> <b>Found proved</b></p> <p>The Committee is satisfied, on the balance of probabilities, that Mr McLauchlan would have known that swallowing a dental bur had the potential to cause Patient B harm. It is further satisfied that in knowingly informing Patient B to the contrary, and effectively minimising her genuine concerns, his actions were dishonest. Accordingly, it finds this charge proved.</p>
11	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient B's appointments from 8 October 2020 to 16 October 2020, in that:</i> <b>Found not proved</b></p> <p>The GDC puts its case that the record keeping failures (charge 11) are in the alternative of findings charge 6 not proved. The Committee has already found proved the various failures set out in charge 6. Accordingly, charge 11(a)(i) to (iv) is found not proved in its entirety. Charge 11(b) relates to a separate matter not set out in charge 6. It has found that charge proved for the reasons set out below.</p>
11a	<i>In your record of 8 October 2020 you did not record:</i>
11ai	<i>An extra oral examination</i>

	<p><b>Found not proved</b></p> <p>This is for the reasons set out in charge 11.</p>
11aii	<p><i>A soft tissue examination</i></p> <p><b>Found not proved</b></p> <p>This is for the reasons set out in charge 11.</p>
11aiii	<p><i>A BPE</i></p> <p><b>Found not proved</b></p> <p>This is for the reasons set out in charge 11.</p>
11aiv	<p><i>An assessment of Patient B's oral hygiene</i></p> <p><b>Found not proved</b></p> <p>This is for the reasons set out in charge 11.</p>
11b	<p><i>You did not record any of your clinical observations that led to LL7 requiring a filling on 15 October 2020</i></p> <p><b>Found proved</b></p> <p>Dr Pal's evidence is that there was no record that led to the justification of the LL7 requiring a filling. He noted that there was a bitewing radiograph present which did not show any problems with the tooth. The Committee, having reviewed Patient B's dental records, accepts Dr Pal's evidence. Accordingly, it finds this charge proved.</p>
<b>Patient C</b>	
12	<p><i>You failed to provide an adequate standard of care to Patient C from 6 August 2019 to 17 January 2023, in that:</i></p>
12a	<p><i>During an appointment on 6 August 2019, you did not diagnose caries found at Patient C's UL8;</i></p> <p><b>Found Proved</b></p> <p>Patient C's dental records indicate that a bitewing radiograph was taken and recorded on 6 August 2019. Dr Pal's opinion was that the radiograph taken at that appointment showed the presence of caries at Patient C's UL8. He opined that there was no further notes or alternative evidence to suggest that Mr McLauchlan had diagnosed or managed the caries on that date. The Committee, having reviewed Patient C's dental records, agrees with Dr Pal's evidence that there is no further documentation regarding a diagnosis of caries at the UL8. It is satisfied that Mr McLauchlan had a duty to diagnose the caries found at the UL8 and that he failed to do so.</p>
12b	<p><i>You did not offer to treat and/or manage caries found at Patient C's UL8 from 6 August 2019 to 17 January 2023;</i></p> <p><b>Found Proved</b></p> <p>The patient records show that the hygienist had seen Patient C on 19 April 2021, 22 March 2022 and 7 March 2023 and had consistently recorded in the notes 'possible caries at UL7', which they requested Mr McLauchlan to check. Dr Pal's evidence was that there is no indication that Mr McLauchlan diagnosed or managed the caries</p>

	<p>at the UL8 during the period in question. The Committee agrees with Dr Pal's opinion. It notes there is no record of a treatment plan for the tooth in question or any follow up appointment for the management of the tooth. Accordingly, it finds this charge proved.</p>
12c	<p><i>You did not take any radiographs covering Patient C's upper posterior teeth between 6 August 2019 and 17 January 2023;</i> <b>Found proved</b></p> <p>Patient C's dental records show that the only radiographs taken by Mr McLauchlan during the period in question were periapical radiographs of the lower teeth on 11 October 2021 and 9 January 2023. An appointment with Patient C took place on 17 January 2023 but there is no record in Patient C's dental records to suggest radiographs of the patient's upper posterior teeth were taken. Dr Pal considered that radiographs of the upper posterior teeth should have been taken and he was critical of Mr McLauchlan's failure to do so. The Committee, having reviewed Patient C's dental records, accepts Dr Pal's evidence and therefore finds this charge proved.</p>
12d	<p><i>You did not follow up on the Hygienist requests to check for suspected caries from 23 April 2021 to 17 January 2023;</i> <b>Found proved</b></p> <p>The Committee has had regard to its findings in relation to charge 12b above. The hygienist has recorded in the clinical notes for the appointment for 19 April 2021 as follows "UL7 needs check has cons appt to note for colin". The hygienist has repeated the same request for the registrant to check the suspected caries at UL7 and/or UL8 on 22 March 2022. Dr Pal's evidence was that there is no indication that Mr McLauchlan checked these teeth for the presence or absence of caries. The Committee accepts Dr Pal's evidence and accordingly finds this charge proved.</p>
12e	<p><i>During an appointment on 18 March 2021, you did not conduct</i></p>
12ei	<p><i>an extra oral examination</i> <b>Found proved</b></p> <p>The Committee had regard to the patient's dental records which state that it was an "assessment appointment" but there was no additional documentation regarding an extra oral examination.</p> <p>Dr Pal's evidence was that even though the hygienist may have carried out and recorded some of these assessments at their visits, Mr McLauchlan still had a duty to independently carry out and record these assessments. There is no record of any of the examinations set out in charge 12e as having been carried out by Mr McLauchlan. In these circumstances, the Committee has drawn the inference that the examinations were not carried out. Accordingly, it finds this charge proved.</p>
12eii	<p><i>A soft tissue examination</i> <b>Found proved</b></p> <p>This is for the same reasons as set out at charge 12e(i) above.</p>
12eiii	<p><i>A BPE</i> <b>Found proved</b></p>

	This is for the same reasons as set out at charge 12e(i) above.
12eiv	<i>An assessment of Patient C's oral hygiene</i> <b>Found proved</b>  This is for the same reasons as set out at charge 12e(i) above.
12f	<i>During an appointment on 6 October 2021 you did not conduct</i>
12fi	<i>an extra oral examination</i> <b>Found proved</b>  The Committee notes from the patient's records that Mr McLauchlan undertook examinations on 6 October 2021 and 9 January 2023. However, there is no evidence of any of the assessments, only a record of carrying out observations of LR5. Dr Pal's opinion was that there were no records of an extra-oral examination, soft tissue examinations, periodontal assessment, an assessment of oral hygiene or an assessment of diet at these visits  The Committee has concluded that it was more likely than not that the assessments set out at charges 12f and 12g were not carried out. It therefore finds the charge proved.
12fii	<i>A soft tissue examination</i> <b>Found proved</b>  This is for the same reasons as set out at charge 12f(v) above.
12fiii	<i>A BPE</i> <b>Found proved</b>  This is for the same reasons as set out at charge 12f(v) above.
12fiv	<i>An assessment of Patient C's oral hygiene</i> <b>Found proved</b>  This is for the same reasons as set out at charge 12f(v) above.
12g	<i>During an appointment on 9 January 2023 you did not conduct</i>
12gi	<i>an extra oral examination</i>  <b>Found proved</b> It found this charge proved as at 12f(v) above.
12gii	<i>A soft tissue examination</i> <b>Found proved</b>  This is for the same reasons as set out at charge 12f(v) above.
12giii	<i>A BPE</i> <b>Found proved</b>  This is for the same reasons as set out at charge 12f(v) above.
12giv	<i>An assessment of Patient C's oral hygiene</i>

	<p><b>Found proved</b></p> <p>This is for the same reasons as set out at charge 12f (v) above.</p>
13	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient C's appointments from 18 March 2021 to 17 January 2023, in that:</i></p>
13a	<p><i>In your record of 18 March 2021, you did not record:</i></p> <p><b>Found not proved</b></p> <p>The GDC puts its case that the record keeping failures (charge 13) are in the alternative of finding charge 12 not proved. The Committee has already found charge 12 proved. Accordingly, charge 13 in its entirety is found not proved.</p>
13ai	<p><i>an extra oral examination</i></p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 13a above.</p>
13aai	<p><i>a soft tissue examination</i></p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 13a above.</p>
13aiii	<p><i>a BPE</i></p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 13a above.</p>
13aiv	<p><i>An assessment of Patient C's oral hygiene</i></p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 13a above.</p>
13b	<p><i>In your record of 6 October 2021, you did not record:</i></p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 13a above.</p>
13bi	<p><i>an extra oral examination</i></p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 13a above.</p>
13bii	<p><i>a soft tissue examination</i></p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 13a above.</p>
13biii	<p><i>a BPE</i></p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 13a above.</p>

13biv	<i>An assessment of Patient C's oral hygiene</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 13a above.
13c	<i>In your record of 9 January 2023, you did not record:</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 13a above.
13ci	<i>an extra oral examination</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 13a above.
13cii	<i>a soft tissue examination</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 13a above .
13ciii	<i>a BPE</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 13a above.
13civ	<i>An assessment of Patient C's oral hygiene</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 13a above.
<b>Patient D</b>	
14	<i>You failed to provide an adequate standard of care to Patient D from 2 March 2022 to 13 April 2023, in that:</i>
14a	<i>During an appointment on 2 March 2022, you did not conduct:</i>
14ai	<i>an extra oral examination</i> <b>Found proved</b>  Mr McLauchlan undertook examinations on 2 March 2022, 12 September 2022 and 13 April 2023. Dr Pal's opinion was that there was no record of extra-oral examination or an assessment of oral hygiene and that these examinations should have been carried out. His evidence was that oral hygiene was critical for the success of periodontal therapy and that Mr McLauchlan should have assessed it.  There is no record in the clinical notes of those examinations having taken place. Accordingly, the Committee finds the charge proved.
14aai	<i>an assessment of Patient D's oral hygiene</i> <b>Found proved</b>  This is for the same reasons as set out at charge 14ai above.
14b	<i>During an appointment on 12 September 2022, you did not conduct:</i>
14bi	<i>an extra oral examination</i>

	<p><b>Found proved</b></p> <p>This is for the same reasons as set out at charge 14ai above.</p>
14bii	<p><i>an assessment of Patient D's oral hygiene</i> <b>Found proved</b></p> <p>This is for the same reasons as set out at charge 14ai above.</p>
14c	<p><i>During an appointment on 13 April 2023, you did not conduct:</i></p>
14ci	<p><i>an extra oral examination</i> <b>Found proved</b></p> <p>This is for the same reasons as set out at charge 14ai above.</p>
14cii	<p><i>an assessment of Patient D's oral hygiene</i> <b>Found proved</b></p> <p>This is for the same reasons as set out at charge 14ai above.</p>
15	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient D's appointments from 2 March 2022 to 13 April 2023, in that:</i></p>
15a	<p><i>In your record of 2 March 2022, you did not record:</i></p>
15ai	<p><i>an extra oral examination</i> <b>Found not proved</b></p> <p>The GDC puts its case that the record keeping failures (charge 15) are in the alternative of finding charge 14 not proved. The Committee has found charge 14 proved. Accordingly, charge 15 in its entirety is found not proved.</p>
15aai	<p><i>an assessment of Patient D's oral hygiene in your record</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 15ai above.</p>
15b	<p><i>In your record of 12 September 2022, you did not record:</i></p>
15bi	<p><i>an extra oral examination</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 15ai above.</p>
15bii	<p><i>an assessment of Patient D's oral hygiene</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 15ai above.</p>
15c	<p><i>In your record of 13 April 2023, you did not record:</i></p>
15ci	<p><i>an extra oral examination</i> <b>Found not proved</b></p>

	This is for the same reasons as set out at charge 15ai above.
15cii	<i>an assessment of Patient D's oral hygiene</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 15ai above.
<b>Patient E</b>	
16	<i>You failed to provide an adequate standard of care to Patient E from 3 March 2021 to 9 September 2022, in that:</i>
16a	<i>From 12 March 2021 to 2 April 2021, you</i>
16ai	<i>provided Patient E with a bridge that was not clinically indicated;</i> <b>Found proved</b>  Dr Pal set out in his report that Patient E presented on 3 March 2021 with a distal cantilever bridge, replacing LR4 with LR3 as an abutment. Mr McLauchlan prepared the bridge on 17 March 2021 and fitted the bridge on 24 March 2021. The bridge subsequently failed and required re-cementation on 13 May 2021, 12 January 2022 and 4 August 2022. Dr Pal's opinion was that the design of the bridge had a "high likelihood of failure because it was retained on a post and there was reduced posterior support on the right side". Dr Pal further opined that "The design of a bridge was of a distal cantilever design which, in this situation, would place unfavourable forces on the LR3 post and make bridge failure more likely. The bridge in this situation was not clinically indicated." Dr Pal confirmed this position in his oral evidence.  The Committee accepts Dr Pal's evidence. It has also had regard to Patient E's contemporaneous letter of complaint dated 28 September 2022 in which he set out that the bridge " <i>has been fitted and refitted no less than four times and on the last occasion .... it fell out after just six hours</i> ". Accordingly, it finds this charge proved.
16aii	<i>did not discuss with Patient E the poor prognosis for the bridge provided and/or the poor prognosis for their LR3, in advance of providing this treatment;</i> <b>Found proved</b>  Dr Pal's opinion in his report was as follows "I would have expected a discussion of the poor prognosis of the bridge, other options and their costs between on 03.03.21 and 17.03.21. There is no indication in the records that Mr McLauchlan recognised that the design of the bridge had a poor chance of success, that there was any discussion with the patient about the prognosis of the bridge and the LR3, or the discussion of any options or costs. Options would have been a separate crown for LR3 together with and a denture or implant to replace the gap at LR4".  The Committee notes that there is a record in Patient E's notes that " <i>options have been discussed</i> ". However, the Committee considers that this entry is very brief and does not explicitly say that the bridge had a poor prognosis. This therefore suggests that there was no discussion with Patient E regarding the poor prognosis of the bridge. This is further supported by Patient E's letter of complaint dated 28 September 2022 which states " <i>Indeed, his very words to me at the time were "I would</i>

	<p><i>not recommend this treatment if I did not think it would work.” Patient E went on to explain that on the basis of that recommendation, he went ahead with the procedure.</i></p> <p>Patient E sent a second letter of complaint dated 16 December 2022. He set out that, as indicated in his previous letter of complaint, he went ahead with this procedure “<i>only on the clear recommendation from Dr McLauchlan that he was confident ‘replacing the failure bridge’ in this way was a suitable option, which in hindsight now was clearly misplaced.</i>” Patient E further set out that he refuted the assertion that he was told by Mr McLauchlan that “<i>this procedure was ‘unlikely to be successful’ quite the contrary. Indeed it was only after the second failed attempt to re-cement in securely in position was I informed of this, by which time the damage had already been done</i>”.</p> <p>The Committee has concluded, on the balance of probabilities, that Mr McLauchlan did not discuss with Patient E that the bridge was likely to fail.</p>
16aiii	<p><i>did not discuss alternative treatment options with Patient E in advance of providing a bridge;</i> <b>Found proved</b></p> <p>This is for the same reasons as set out in charge 16aii above.</p>
16b	<p><i>During an appointment on 13 May 2021, you:</i></p>
16bi	<p><i>did not discuss with Patient E the poor prognosis for their bridge in advance of recementing it;</i> <b>Found proved</b></p> <p>Patient E attended for an emergency appointment on 13 May 2021. Dr Pal’s opinion is that there is no record of a discussion regarding the poor prognosis of the bridge on 13 May 2021. The Committee, having reviewed the clinical records, agrees with Dr Pal’s opinion. It noted that Patient E presented for an emergency appointment with the bridge having fallen out a couple of months after its placement. In the absence of any record of the discussions outlined above, or a record of any alternative treatment options, the Committee is satisfied, on the balance of probabilities, that these discussions did not take place. It has therefore found this charge proved.</p>
16bii	<p><i>did not discuss alternative treatment options with Patient E in advance of recementing their bridge;</i> <b>Found proved</b></p> <p>This is for the same reasons as set out at charge 16bi above.</p>
16c	<p><i>Between 3 March 2021 and 8 September 2022, you did not conduct:</i></p>
16ci	<p><i>an extra oral examination;</i> <b>Found proved</b></p> <p>Dr Pal’s opinion was that there was no record of any of the assessments set out in charge 16c and that they should have taken place. There is no note in Patient E’s clinical records of the various assessments set out at charge 16c having been done. In the absence of any record, the Committee has drawn the inference that they were not done. Accordingly, it finds charge 16c proved.</p>

16cii	<p><i>a BPE;</i> <b>Found proved</b></p> <p>This is for the same reasons as set out at charge 16ci above.</p>
16ciii	<p><i>an assessment of Patient D's oral hygiene;</i> <b>Found proved</b></p> <p>This is for the same reasons as set out at charge 16ci above.</p>
17	<p><i>By reason of your conduct in charge 16.a.ii. and/or 16.a.iii you did not obtain Patient E's informed consent for the bridge you provided.</i> <b>Found proved</b></p> <p>Dr Pal's evidence was that if it was found that Mr McLauchlan did not have the discussions outlined above, then informed consent was not obtained for the provision of the bridge on 24 March 2021. The Committee accepts Dr Pal's evidence. It has also had regard to Patient E's contemporaneous complaints dated 28 September 2022 and 16 December 2022 in which Patient E sets out that he went ahead with this procedure "<i>only on the clear recommendation from Dr McLauchlan that he was confident 'replacing the failure bridge' in this way was a suitable option.</i>"</p> <p>Taking all this evidence into account, the Committee has concluded that Mr McLauchlan did not advise the patient of the poor prognosis of the bridge at the outset or during the continuing failure of the bridge. He therefore did not obtain Patient E's informed consent.</p>
18	<p><i>By reason of your conduct in charge 16.b.i. and/or 16.b.ii. you did not obtain Patient E's informed consent for recementing their bridge.</i> <b>Found proved</b></p> <p>In addition to the reasons set out above at charge 18, the Committee has had regard to Dr Pal's evidence that there was no record of Mr McLauchlan informing the patient of the continuing poor prognosis of the bridge and other options. He considered that if it was found that this information was not provided, then informed consent was not obtained for re-cementing the bridge on 13 May 2021. The Committee accepts Dr Pal's evidence on this matter and accordingly finds the charge proved.</p>
19	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient E's appointments from 3 March 2021 to 9 September 2022, in that:</i></p>
19a	<p><i>you did not record:</i></p>
19ai	<p><i>any extra oral examinations;</i> <b>Found not proved</b></p> <p>The GDC puts its case that the record keeping failures (charge 19) are in the alternative of finding charge 16 not proved. The Committee has found charge 16 proved. Accordingly, charge 19 in its entirety is found not proved.</p>
19aia	<p><i>any BPEs;</i> <b>Found not proved</b></p>

	This is for the same reasons as set out at charge 19ai above.
19aiii	<i>any assessments of Patient D's oral hygiene;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 19ai above.
<b>Patient F</b>	
20	<i>You failed to provide an adequate standard of care to Patient F from 2 July 2018 to 13 December 2021, in that:</i>
20a	<i>During an appointment on 2 July 2018, you provided a poor standard of post crown treatment at Patient F's UR2;</i> <b>Found proved</b>  The clinical notes record that Mr McLauchlan fitted a crown at Patient F's UR2 on that date with a note that there was a five year guarantee. Dr Pal's opinion was that the post crown treatment was of a poor standard given that the post crown subsequently failed on 19 November 2018, 26 June 2019, 22 October 2019, 5 August 2020 and 21 August 2020. He explained that given that the UR2 had an adequate length of root and an adequate root filling on 30 April 2018, he considered that a post crown provided on 2 July 2018 by a reasonably competent dentist to an adequate standard would not fail within 5 months and then subsequently fail again another four times in the subsequent 21 months. Dr Pal further noted the comments of a subsequent treating dentist, referred to by Patient F in their letter of complaint dated 25 January 2022, words to the effect that the post fitted by Mr McLauchlan was not of an adequate size and this led to the failure of the crown.  The Committee has borne in mind that Patient F had several emergency appointments, where the crown had to be refitted, which suggested that the post crown was of a poor standard. The Committee accepts Dr Pal's evidence on this matter and accordingly finds the charge proved.
20b	<i>During an appointment on 30 April 2018, you did not conduct:</i>
20bi	<i>an extra oral examination;</i> <b>Found proved</b>  The Committee has reviewed Patient F's dental records for the dates in question and notes that there is no record of any examinations or assessment having been carried out. It has reached the same conclusion as Dr Pal. The Committee has determined, on the balance of probabilities, that the assessments set out in charges 20b(i) to (iv) were not carried out. Accordingly, it finds this charge proved.
20bii	<i>soft tissue examination;</i> <b>Found proved</b>  This is for the same reason as set out in charge 20bi above.
20biii	<i>a BPE;</i> <b>Found proved</b>  This is for the same reason as set out in charge 20bi above.
20biv	<i>an assessment of Patient F's oral hygiene;</i>

	<p><b>Found proved</b></p> <p>This is for the same reason as set out in charge 20bi above.</p>
20c	<p><i>During an appointment on 19 November 2018, you did not conduct:</i></p>
20ci	<p><i>an extra oral examination;</i> <b>Found proved</b></p> <p>The Committee has reviewed Patient F’s dental records for the dates in question and notes that there is no record of any examinations or assessment having been carried out. It has reached the same conclusion as Dr Pal. The Committee has determined, on the balance of probabilities, that the assessments set out in charges 20c (i) to (iii) were not carried out. Accordingly, it finds this charge proved.</p>
20cii	<p><i>soft tissue examination; a BPE;</i> <b>Found proved</b></p> <p>This is for the same reason as set out in charge 20ci above.</p>
20ciii	<p><i>an assessment of Patient F’s oral hygiene;</i> <b>Found proved</b></p> <p>This is for the same reason as set out in charge 20ci above.</p>
20d	<p><i>During an appointment on 26 June 2019, you did not conduct:</i></p>
20di	<p><i>an extra oral examination;</i> <b>Found proved</b></p> <p>The Committee has reviewed Patient F’s dental records for the dates in question and notes that there is no record of any examinations or assessment having been carried out. It has reached the same conclusion as Dr Pal. The Committee has determined, on the balance of probabilities, that the assessments set out in charges 20d (i) to (iv) were not carried out. Accordingly, it finds this charge proved.</p>
20dii	<p><i>soft tissue examination;</i> <b>Found proved</b></p> <p>This is for the same reason as set out in charge 20di above.</p>
20diii	<p><i>a BPE;</i> <b>Found proved</b></p> <p>This is for the same reason as set out in charge 20di above.</p>
20div	<p><i>an assessment of Patient F’s oral hygiene;</i> <b>Found proved</b></p> <p>This is for the same reason as set out in charge 20di above.</p>
20e	<p><i>During an appointment on 5 August 2020, you did not conduct:</i></p>
20ei	<p><i>an extra oral examination;</i> <b>Found proved</b></p>

	<p>The Committee has reviewed Patient F's dental records for the dates in question and notes that there is no record of any examinations or assessment having been carried out. It has reached the same conclusion as Dr Pal. The Committee has determined, on the balance of probabilities, that the assessments set out in charges 20e (i) to (iv) were not carried out. Accordingly, it finds this charge proved.</p>
20eii	<p><i>soft tissue examination;</i> <b>Found proved</b></p> <p>This is for the same reason as set out in charge 20ei above.</p>
20eiii	<p><i>a BPE;</i> <b>Found proved</b></p> <p>This is for the same reason as set out in charge 20ei above.</p>
20eiv	<p><i>an assessment of Patient F's oral hygiene;</i> <b>Found proved</b></p> <p>This is for the same reason as set out in charge 20ei above.</p>
20f	<p><i>During an appointment on 13 December 2021, you did not conduct:</i></p>
20fi	<p><i>an extra oral examination;</i> <b>Found proved</b></p> <p>The Committee has reviewed Patient F's dental records for the dates in question and notes that there is no record of any examinations or assessment having been carried out. It has reached the same conclusion as Dr Pal. The Committee has determined, on the balance of probabilities, that the assessments set out in charges 20f (i) to (iv) were not carried out. Accordingly, it finds this charge proved.</p>
20fii	<p><i>soft tissue examination;</i> <b>Found proved</b></p> <p>This is for the same reason as set out in charge 20fi above.</p>
20fiii	<p><i>a BPE;</i> <b>Found proved</b></p> <p>This is for the same reason as set out in charge 20fi above.</p>
20fiv	<p><i>an assessment of Patient F's oral hygiene;</i> <b>Found proved</b></p> <p>This is for the same reason as set out in charge 20fi above.</p>
21	<p><i>You did not offer Patient F a refund for the post crown treatment you provided at their UR2, following a complaint made by Patient F (on 25 January 2022) about the treatment they had received.</i> <b>Found proved</b></p>

	<p>The Committee has had regard to Patient F’s letter of complaint dated 25 January 2022 to the Practice in which he complains about the crown falling out, being refitted and falling out three times after that. Patient F asked for a copy of the practice’s insurance details so that he could seek financial remedy. Mr McLauchlan sent a letter dated 10 February 2022 to Patient F in which he made reference to Patient F having failed to attend various appointments and/ or appointments being cancelled at short notice. Mr McLauchlan went on to state: <i>“I do not believe your problems with UR2 are a consequence of poor or negligent treatment, and it was reasonable for me to advise you of the treatment costs associated with trying to retain the tooth. I hope you understand the rationale for refusing further treatment”</i>.</p> <p>The Committee has also had regard to the Practice Manager’s oral evidence in which she confirmed that Patient F had asked for a refund.</p> <p>Dr Pal’s evidence was that Mr McLauchlan should have offered a refund to Patient F for the post crown treatment provided given that it was of poor quality. He referred to the GDC’s standard 5.3.9 which sets out that a fair solution should be provided to the patient.</p> <p>Taking all the evidence into account, the Committee therefore finds this charge proved.</p>
22	<i>You failed to maintain an adequate standard of record keeping in respect of Patient F’s appointments from 30 April 2018 to 13 December 2021, in that:</i>
22a	<i>In your record 30 April 2018, you did not record:</i>
22ai	<p><i>an extra oral examination;</i> <b>Found not proved</b></p> <p>The GDC puts its case that the record keeping failures (charge 22) are in the alternative of finding charge 20 not proved. The Committee has found charge 20 proved. Accordingly, charge 22 in its entirety is found not proved.</p>
22aii	<p><i>soft tissue examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons set out at charge 22ai above.</p>
22aiii	<p><i>a BPE;</i> <b>Found not proved</b></p> <p>This is for the same reasons set out at charge 22ai above.</p>
22aiv	<p><i>an assessment of Patient F’s oral hygiene;</i> <b>Found not proved</b></p> <p>This is for the same reasons set out at charge 22ai above.</p>
22b	<i>In your record of 19 November 2018, you did not record:</i>
22bi	<p><i>an extra oral examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons set out at charge 22ai above.</p>

22bii	<i>soft tissue examination;</i> <b>Found not proved</b>  This is for the same reasons set out at charge 22ai above.
22biii	<i>a BPE;</i> <b>Found not proved</b>  This is for the same reasons set out at charge 22ai above.
22biv	<i>an assessment of Patient F's oral hygiene;</i> <b>Found not proved</b>  This is for the same reasons set out at charge 22ai above.
22c	<i>In your record of 26 June 2019, you did not record:</i>
22ci	<i>an extra oral examination;</i> <b>Found not proved</b>  This is for the same reasons set out at charge 22ai above.
22cii	<i>soft tissue examination;</i> <b>Found not proved</b>  This is for the same reasons set out at charge 22ai above.
22ciii	<i>a BPE;</i> <b>Found not proved</b>  This is for the same reasons set out at charge 22ai above.
22civ	<i>an assessment of Patient F's oral hygiene;</i> <b>Found not proved</b>  This is for the same reasons set out at charge 22ai above.
22d	<i>In your record of 5 August 2020, you did not record:</i>
22di	<i>an extra oral examination;</i> <b>Found not proved</b>  This is for the same reasons set out at charge 22ai above.
22dii	<i>soft tissue examination;</i> <b>Found not proved</b>  This is for the same reasons set out at charge 22ai above.
22diii	<i>a BPE;</i> <b>Found not proved</b>  This is for the same reasons set out at charge 22ai above.

22div	<p><i>an assessment of Patient F's oral hygiene;</i> <b>Found not proved</b></p> <p>This is for the same reasons set out at charge 22ai above.</p>
22e	<p><i>In your record of 13 December 2021, you did not record:</i> <b>Found not proved</b></p> <p>This is for the same reasons set out at charge 22ai above.</p>
22ei	<p><i>an extra oral examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons set out at charge 22ai above.</p>
22eii	<p><i>soft tissue examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons set out at charge 22ai above.</p>
22eiii	<p><i>a BPE;</i> <b>Found not proved</b></p> <p>This is for the same reasons set out at charge 22ai above.</p>
22eiv	<p><i>an assessment of Patient F's oral hygiene;</i> <b>Found not proved</b></p> <p>This is for the same reasons set out at charge 22ai above.</p>
<b>Patient G</b>	
23	<p><i>You failed to provide an adequate standard of care to Patient G from 2 September 2021 to 13 April 2023, in that:</i></p>
23a	<p><i>Between 2 September 2021 and 25 January 2023, you did not conduct any:</i></p>
23ai	<p><i>extra oral examinations;</i> <b>Found proved</b></p> <p>The Committee has had regard to Patient G's notes of the consultations during the time in question. It notes that clinical examinations have been charted during those dates. There is no record between those dates of an extra-oral examination, a periodontal assessment or an assessment of oral hygiene carried out by Mr McLauchlan. Dr Pal's report was critical of Mr McLauchlan's failure to carry out these assessments/examinations. The Committee agrees and finds this charge proved.</p>
23aii	<p><i>BPEs;</i> <b>Found proved</b></p> <p>This is for the same reasons as set out at charge 23ai above.</p>
23aiii	<p><i>assessments of Patient G's oral hygiene;</i> <b>Found proved</b></p> <p>This is for the same reasons as set out at charge 23ai above.</p>

23b	<p><i>During an appointment on 24 February 2023, you provided a poor standard of crown treatment at Patient G's UR4 and/or UR5;</i> <b>Found proved</b></p> <p>The clinical notes record that Mr McLauchlan fitted the crowns to UR4 and UR5 on 24 February 2023. The clinical notes also record that the patient had complained of severe discomfort from recently placed crowns. A subsequent treating dentist, in her clinical notes dated 5 April 2023, assessed from the photographs taken on that day show the buccal margins of the crowns to be short and the occlusion was high. Dr Pal's opinion was as follows: "Photographs taken on 05.04.23 show the buccal margins of the crowns to be short. It is likely that this would be the reason for the sensitivity to UR4 and the reason for the occlusion to be high. In my view, the crowns fitted at UR4 and UR5 were short of the margin and the fitting of these crowns was far below the standard expected. Fitting of the crowns carried a risk for pain from UR4, discomfort to UR4 and UR5 due to high occlusion and the increased risk of caries to both teeth."</p> <p>The Committee accepts Dr Pal's evidence and notes that there are no comments in Mr McLauchlan's clinical notes for this patient on the quality of the crowns when they were fitted. The Committee accordingly finds this charge proved.</p>
23c	<p><i>During an appointment on 24 March 2023, you did not make any arrangements to replace the crowns you provided at Patient G's UR4 and/or UR5;</i> <b>Found proved</b></p> <p>Patient G returned with pain from the UR4 on 24 March 2023. Dr Pal considered that Mr McLauchlan should have been aware of the defective margins of the crowns and arranged for their replacement. The Committee accepts Dr Pal's evidence. It finds this charge proved.</p>
23d	<p><i>During an appointment on 12 April 2023, you did not make any arrangements to replace the crowns you provided at Patient G's UR4 and/or UR5;</i> <b>Found proved</b></p> <p>Patient G returned on 12 April 2023, complaining that they were still struggling to bite on when eating. The clinical notes record that Mr McLauchlan adjusted the occlusion and applied Duraphat (a desensitising agent) and advised that the crowns would be replaced if they did not settle. Dr Pal's opinion was that Mr McLauchlan should have made arrangements for the crowns to be replaced at that appointment.</p> <p>On reviewing the records, the Committee notes that there is no record by Mr McLauchlan on 12 April 2023 of making any arrangements to replace the crowns.</p> <p>The Committee accepts Dr Pal's evidence and accordingly finds this charge proved.</p>
23e 23ei	<p><i>In advance of providing crowns at Patient G's UR4 and/or UR5, you did not discuss: the risks and/or benefits of the treatment;</i> <b>Found proved</b></p> <p>There is no record in the notes of the risks and benefits of treatment and/or treatment options. Dr Pal opined that he would have expected a discussion of the options, benefits and risks of providing crowns to these teeth. The Committee is satisfied, on</p>

	the balance of probabilities, that Mr McLauchlan did not discuss these. This charge was accordingly found proved.
23eii	<i>the alternative treatment options.</i> <b>Found proved</b>  This is for the same reasons as set out at 23ei above.
24	<i>By reason of you conduct in charge 23.e.i. and/or 23.e.ii. you did not obtain Patient G's informed consent for crowns provided at Patient G's UR4 and/or UR5.</i> <b>Found proved</b>  This is in light of the Committee's findings at charges 23ei and 23eii.
25	<i>You failed to maintain an adequate standard of record keeping in respect of Patient G's appointments from Between 2 September 2021 and 25 January 2023, in that:</i>
25a	<i>You did not record:</i>
25ai	<i>any extra oral examinations;</i> <b>Found not proved</b>  Charge 25a is charged in the alternative to the failures set out in charge 23. Given that it has found charged 23 proved, it follows that charge 25a is found not proved.
25aii	<i>any BPEs;</i> <b>Found not proved</b>  This is for the same reason as set out at charge 25ai.
25aiii	<i>any assessments of Patient G's oral hygiene.</i> <b>Found proved</b> This is for the same reason as set out at charge 25ai.
<b>Patient H</b>	
26	<i>You failed to provide an adequate standard of care to Patient J from 4 September 2018 to 17 September 2020 in that</i>
26a	<i>Between 4 September 2018 and 17 September 2020 you did not diagnose caries found at the crown margins on Patient H's UR3</i> <b>Found proved</b>  The Committee on reviewing the records noted that Mr McLauchlan has made no record of caries around the crown margins of UR3 between 4 September 2018 and 17 September 2020. Dr Pal's evidence was that the periapical radiograph of 30 November 2020 showed caries at UR3. His opinion was that caries at UR3 would be clinically detectable on 26 September 2018 when the crown at UR2 was provided. In Dr Pal's opinion, there was a failure by Mr McLauchlan to diagnose caries at the crown margins on UR3 between 4 September 2018 and 17 September 2020.  Dr Pal's evidence was that a subsequent general dental practitioner at the same practice records on the 16 March 2021 as follows 'caries beneath palatal crown margins 13,12 - 13 deep subging.' This indicated to the Committee that caries had

	<p>been undiagnosed for some considerable time. In light of this evidence and that of Dr Pal the Committee finds this charge proved.</p>
26b	<p><i>During an appointment on 26 September 2018 you provided a poor standard of crown treatment to Patient H's UR2 in that the crown had open margins</i> <b>Found proved</b></p> <p>Dr Pal's opinion was that a subsequent practitioner noted caries and an open crown margin of the post crown provided at UR2 by Mr McLauchlan on 26 September 2018. The first indication of this was on 16 March 2021. This was confirmed by another practitioner in a letter dated 7 July 2021. His opinion was that the margin between a crown and a tooth should be virtually imperceptible when examined with a probe. Dr Pal's evidence was that an open crown margin is a situation where there is a crown margin that allows a probe to pass through. It was Dr Pal's opinion that such a situation carried a high risk of plaque to stagnate at the crown margin and for the occurrence of caries. His opinion was that it was likely that this open margin was present from the time of fitting the crown.</p> <p>The Committee accepts Dr Pal's opinion on the UR2 in conjunction with reviewing the dental records of the subsequent practitioner's notes and the specialist whom the patient was referred to. Accordingly, it finds this charge proved.</p>
26c	<p><i>Between 26 September 2018 and 17 September 2020 you did not</i></p>
26ci	<p><i>Diagnose an open crown margin at Patient H's UR2</i> <b>Found proved</b></p> <p>Mr McLauchlan fitted the crown on 26 September 2018 and there is no record of the fact that there are open crown margins. There is no record in the notes of an open crown margin at Patient H's UR2 between the dates in question. The Committee accepts Dr Pal's evidence that Mr McLauchlan failed to identify the open crown margin at Patient H's UR2 on a number of occasions. Accordingly, it finds this charge proved.</p>
26cii	<p><i>Offer to treat and/or manage the open margins found at Patient H's UR2 crown</i> <b>Found proved</b></p> <p>The Committee, having found charge 26ci proved, was satisfied that it must follow that Mr McLauchlan did not treat or manage the open margins.</p>
26ciii	<p><i>Offer to treat and/or manage caries found at Patient H's UR2 and UR3</i> <b>Found proved</b></p> <p>The Committee notes from Patient H's records that Mr McLauchlan did not treat or manage caries found at Patient H's UR2 and UR3. In light of its findings at charge 26a, it follows that the Committee finds this charge proved.</p>
26d	<p><i>Between 4 September 2018 and 17 September 2020 you did not conduct</i></p>
26di	<p><i>An extra oral examination</i> <b>Found proved</b></p> <p>The Committee had regard to the patient's dental records. There is no record of any examinations or assessment having been carried out. The Committee accepts Dr Pal's opinion that these were not carried out. On the balance of probabilities, the</p>

	<p>Committee determined that an extra oral examination was not carried out. Accordingly, it finds this charge proved.</p>
26dii	<p><i>A BPE</i> <b>Found proved</b></p> <p>This is for the same reason as set in Charge 26di.</p>
26diii	<p><i>An assessment of Patient H's oral hygiene</i> <b>Found proved</b></p> <p>This is for the same reason as set in Charge 26di.</p>
27	<p><i>On 12 September 2022, in response to a complaint made by Patient H, you stated that the specialist practitioner who had seen Patient H following your treatment had stated that existing crowns provided by you "are generally satisfactory", without mentioning that this specialist practitioner went on to conclude that:</i></p>
27a	<p><i>The margins had "tarnished somewhat over time"</i> <b>Found proved</b></p> <p>The Committee has had regard to Patient H's letter of complaint dated 9 August 2022, in which they raised multiple concerns surrounding the treatment provided by Mr McLauchlan. The Committee has also had regard to Mr McLauchlan's response to Patient H's complaint dated 12 September 2022 in which he states "<i>I've reviewed the correspondence... I am reassured that, with reference to the crowns provided by me, the specialist has commented that the existing crowns are generally satisfactory</i>". However, there is no mention in Mr McLauchlan's letter regarding the specialist practitioner's conclusions that the '<i>existing crowns are generally satisfactory although the margins have tarnished somewhat over time</i>'.</p> <p>Dr Pal was critical that Mr McLauchlan appeared to have taken out a proportion of the specialist's opinion without including the overall context of the condition of the UR3 and UR2. The Committee, having reviewed both documents, agrees with Dr Pal's evidence. It therefore found this charge proved.</p>
27b	<p><i>That there was "gross caries" at Patient H's UR3 palatal</i> <b>Found proved</b></p> <p>The Committee had regard to the letter from the specialist practitioner in which they make reference to "<i>gross caries" at Patient H's UR3 palatal</i>". Dr Pal's opinion was that '<i>The Registrant appears to have taken one portion of the specialist's opinion and used this in the response without including the overall context of the condition of UR3 and UR2.</i>'</p> <p>The Committee noted that Mr McLauchlan's letter omitted this information in his reply to Patient H where he stated: '<i>I am reassured that, with reference to the crowns provided by me, the specialist has commented that the existing crowns are generally satisfactory</i>'. Accordingly, the Committee finds this charge proved.</p>
27c	<p><i>UR3 "appears to be unrestorable" and</i> <b>Found proved</b></p>

	<p>The Committee noted the reference in the specialist practitioner’s letter to the UR3 “<i>appears to be unrestorable</i>”. It further noted that Mr McLauchlan’s letter omitted this information in his reply to Patient H. The Committee finds this charge proved for the same reasons as set out at charge 27a above.</p>
27d	<p><i>the margin of UR2 “is poor”</i> <b>Found proved</b></p> <p>The Committee noted the reference in the specialist practitioner’s letter to the margin of UR2 “<i>is poor</i>”. The Committee further noted that Mr McLauchlan’s letter to Patient H omitted this information. The Committee finds this charge proved for the same reasons as set out at charge 27a above.</p>
28 28a	<p><i>Your conduct in respect of charge 27 was</i> <i>Misleading</i> <b>Found proved</b></p> <p>The Committee is satisfied, on the balance of probabilities, that Mr McLauchlan would have been aware of the content of the specialist practitioner’s letter given that he referred to extracts of that letter in his letter dated 12 September 2022 to Patient H’s complaint. The Committee considers that Mr McLauchlan knowingly chose to omit the specialist practitioner’s comments regarding the overall poor condition of the UR3 and UR2 so as to deflect attention away from his own failure to diagnose and address the problems of these two teeth. In the Committee’s judgement, it was a deliberate act of concealment which was misleading since it did not provide the full context of the condition of the UR3 and UR2 to Patient H. It therefore finds this charge proved.</p>
28b	<p><i>Lacking integrity</i> <b>Found proved</b></p> <p>The Committee has concluded that Mr McLauchlan was not open and truthful in expressing the specialist practitioner’s views in his letter dated 12 September 2022 to Patient H. His letter was in response to Patient H’s complaint where they had raised concerns about the standard of treatment and as a registered dentist, he was under an obligation to be open and truthful in his response. In the Committee’s view, Mr McLauchlan deliberately chose to misrepresent the opinion of a specialist practitioner rather than accept responsibility for his failure to diagnose and address the problems at UR2 and UR3. Such conduct undermines the higher ethical standards which society expects from regulated professionals. Accordingly, the Committee finds this charge proved.</p>
28d	<p><i>Dishonest – in that you knew you were not providing Patient H with a complete account of the specialist practitioner’s opinion on the standard of the crown treatment you had provided.</i> <b>Found proved</b></p> <p>The Committee is satisfied that Mr McLauchlan would have been aware of the content of the specialist practitioner’s letter for the reasons set out in charge 28 above. It is further satisfied that Mr McLauchlan knew that he was not providing Patient H with the complete account of the specialist practitioner’s opinion and had chosen to omit information relating to the overall context of the poor condition of the UR3 and the UR2. The Committee was satisfied that Mr McLauchlan’s conduct in knowingly not providing Patient H with a complete account of the specialist</p>

	practitioner's opinion of the standard of the crown treatment provided would be judged by the objective standards of ordinary decent people as dishonest. It was a deliberate act of concealment. Accordingly, the Committee finds this charge proved.
29	<i>You failed to maintain an adequate standard of record keeping in respect of Patient H's appointments between 4 September 2018 and 17 September 2020, in that:</i>
29a	<i>You did not record</i> <b>Found not proved</b>  The Committee notes that the GDC presented charge 29 in the alternative to charge 26 if found not proved. The Committee has found charge 26 proved. It follows that if he failed to carry out those assessments, there would be no record of what he has not done. Charge 29 is therefore found proved in its entirety.
29ai	<i>any extra oral examinations;</i> <b>Found not proved</b>  This is for the same reasons as set out at Charge 29a.
29aia	<i>BPEs</i> <b>Found not proved</b>  This is for the same reasons as set out at Charge 29a.
29aiaa	<i>Any assessments of Patient Hs oral hygiene</i> <b>Found not proved</b>  This is for the same reasons as set out at Charge 29a.
<b>Patient I</b>	
30	<i>You failed to provide an adequate standard of care to Patient I from 27 May 2022 to 20 December 2022, in that:</i>
30a	<i>During an appointment on 27 May 2022, you did not conduct:</i>
30ai	<i>an extra oral examination</i> <b>Found proved</b>  The clinical notes records that an exam took place on that date. However, there is no record of an extra oral examination, a soft tissue examination, a BPE or other assessments. Accordingly, it finds this charge proved.
30aia	<i>a soft tissue examination; a BPE</i> <b>Found proved</b>  This was for the same reasons as set out in Charge 30ai.
30aiaa	<i>an assessment of Patient I's oral hygiene;</i> <b>Found proved</b>  This was for the same reasons as set out in Charge 30ai.
30ab	<i>During an appointment on 14 December 2022, you did not conduct:</i>

30bi	<p><i>an extra oral examination</i> <b>Found proved</b></p> <p>The clinical notes records that an exam took place on that date. However, there is no record of an extra oral examination, a soft tissue examination, a BPE or other assessments. Accordingly, it finds this charge proved.</p>
30bii	<p><i>A soft tissue examination</i> <b>Found proved</b></p> <p>This was for the same reasons as set out in Charge 30bi.</p>
30biii	<p><i>a BPE;</i> <b>Found proved</b></p> <p>This was for the same reasons as set out in Charge 30bi.</p>
30biv	<p><i>an assessment of Patient I's oral hygiene;</i> <b>Found proved</b></p> <p>This was for the same reasons as set out in Charge 30bi.</p>
30c	<p><i>During an appointment on 27 May 2022, you did not:</i></p>
30ci	<p><i>report on bitewing radiographs taken</i> <b>Found proved</b></p> <p>The clinical notes record that a radiograph was taken on 27 May 2022 and the Committee also had sight of the radiograph for that same date. The notes records a clinical justification for the taking of the radiograph "<i>caries detection</i>". However, there is no further comment of the radiographs. The Committee therefore finds this charge proved.</p>
30cii	<p><i>diagnose caries found at Patient I's LR5;</i> <b>Found proved</b></p> <p>Dr Pal's interpretation of the radiograph was that it showed caries on LR5 which appeared not to have been identified until almost seven months later. The Committee notes the absence of any examination of the LR5 and there was no record of any treatment of the LR5. It therefore find this charge proved.</p>
30d	<p><i>During an appointment on 30 March 2023, you provided a poor standard of restoration treatment at Patient I's LR5, in that:</i></p>
30di	<p><i>the restoration was too high;</i> <b>Found proved</b></p> <p>The clinical notes recorded that Mr McLauchlan carried out an amalgam filling to the LR5 on 30 March 2023. There is a record in the notes dated 6 April 2023 from a subsequent treating dentist who comments on this particular tooth "<i>CO filling out. Slightly tender to bite. Food trap. OE high on distal.</i>" There are copies of the radiographs taken by that dentist on 6 April 2023 of the restoration done by Mr McLauchlan on 30 March 2023.</p>

	Dr Pal commented on these radiographs and considered that the restoration was poor given that it was too high, it had poor contours and open contact point. The Committee accepts Dr Pal's evidence and finds this charge proved.
30dii	<i>it had poor contours;</i> <b>Found proved</b>  This is for the same reasons set out at charge 30di above.
30diii	<i>it had an open contact point</i> <b>Found proved</b>  This is for the reasons set out at charge 30di above.
31	<i>You failed to maintain an adequate standard of record keeping in respect of Patient I's appointments from 27 May 2022 to 14 December 2022, in that:</i>
31a	<i>In your record of 27 May 2022, you did not record:</i>
31ai	<i>an extra oral examination;</i> <b>Found not proved</b>  The GDC presented charge 31 in the alternative to charge 30 being found not proved. The Committee has found charge 30 proved. The Committee has found charge 30 proved. Accordingly, charge 31 is found not proved in its entirety
31aai	<i>a soft tissue examination;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 31ai.
31aiii	<i>a BPE;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 31ai.
31aiv	<i>an assessment of Patient I's oral hygiene;</i> <b>Found not proved</b> This is for the same reasons as set out at charge 31ai.
31b	<i>In your record of 14 December, you did not record:</i>
31bi	<i>an extra oral examination</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 31ai.
31bii	<i>a soft tissue examination;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 31ai.

31biii	<p><i>a BPE;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 31ai.</p>
31biv	<p><i>an assessment of Patient I's oral hygiene</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 31ai.</p>
<b>Patient J</b>	
32	<p><i>You failed to provide an adequate standard of care to Patient J from 6 January 2022 to 19 July 2022, in that:</i></p>
32a	<p><i>During an appointment on 6 January 2022, you did not conduct:</i></p>
32ai	<p><i>an extra oral examination;</i> <b>Found proved</b></p> <p>The Committee had regard to the patient's dental records of 6 January 2022. There is no record of these examinations or assessments having been carried out and the Committee accepts Dr Pal's opinion that these were not carried out. On the balance of probabilities, the Committee determined that these was not carried out. Accordingly, it finds this charge proved.</p>
32aai	<p><i>a BPE;</i> <b>Found proved</b></p> <p>This is for the same reasons as set out at charge 32ai.</p>
32aiii	<p><i>an assessment of Patient J's oral hygiene;</i> <b>Found proved</b></p> <p>This is for the same reasons as set out at charge 32ai.</p>
32b	<p><i>You did not report on bitewing radiographs taken on 22 March 2022;</i> <b>Found proved</b></p> <p>The Committee noted from the dental records of 22 March 2022 that Mr McLauchlan had made a brief comment in the clinical notes stating, "UR6 shows shadow on x-ray". Dr Pal's opinion was that there was no adequate report on the bitewing radiographs taken on 22 March 2022. The Committee observed that this comment on one aspect of the radiograph did not constitute a sufficient radiographic report. The Committee therefore concluded that Mr McLauchlan did not report on the radiographs to an adequate standard, and this charge is found proved.</p>
32c	<p><i>During an appointment on 19 July 2022, you did not conduct:</i></p>
32ci	<p><i>an extra oral examination;</i> <b>Found proved</b></p> <p>The Committee had regard to the patient's dental records of 19 July 2022. There is no record of examinations or the assessments set out in charge 32ci to 32ciii having been carried out. The Committee accepts Dr Pal's opinion that these were not carried out. On the balance of probabilities, the Committee determined that these was not carried out. Accordingly, it finds this charge proved.</p>

32cii	<p><i>a BPE;</i> <b>Found proved</b></p> <p>This is for the same reasons set out at charge 32ci</p>
32ciii	<p><i>an assessment of Patient J's oral hygiene;</i> <b>Found proved</b></p> <p>This is for the same reasons set out at charge 32ci</p>
32d	<p><i>During an appointment on 22 March 2022, you did not diagnose:</i></p>
32di	<p><i>caries found on the mesial aspect of Patient J's LL7;</i> <b>Found proved</b></p> <p>The Committee noted that it has found at Charge 32b that the registrant did not provide an adequate report on the bitewing radiographs taken on 22 March 2022. Dr Pal's opinion was that these radiographs showed caries on the mesial aspect of LL7.</p> <p>There is no entry in the clinical records indicating that this caries was identified at the appointment. In the absence of any record of such a diagnosis, and accepting the expert's evidence, the Committee concluded that this charge is proved.</p>
32dii	<p><i>an overhanging amalgam restoration on the distal aspect of Patient J's UR6;</i> <b>Found proved</b></p> <p>The Committee noted from the dental records of 22 March 2022 there is no entry in the clinical notes indicating that an overhang on the distal aspect of Patient J's UR6 was identified or recorded at the appointment. The Committee accepts Dr Pal's evidence that the bitewing radiograph taken on 22 March 2022 showed an overhanging amalgam restoration on the distal aspect of UR6. In the absence of any record of such a finding, and accepting the expert's evidence, the Committee concluded that this charge is proved.</p>
33	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient I's appointments from 6 July 2022 to 19 July 2022, in that:</i></p>
33a	<p><i>In your record of 6 January 2022, you did not record:</i></p>
33ai	<p><i>an extra oral examination;</i> <b>Found not proved</b></p> <p>The GDC presented charge 33 in the alternative to the failures set out in charge 32. Since charge 32 was found proved, charge 33 is accordingly found not proved.</p>
33aii	<p><i>a BPE;</i> <b>Found not proved</b></p> <p>This is for the same reasons set out at Charge 33ai.</p>
33aiii	<p><i>an assessment of Patient J's oral hygiene;</i> <b>Found not proved</b></p> <p>This is for the same reasons set out at Charge 33ai.</p>

33b	<p><i>In your record of 19 July 2022, you did not record:</i> <b>Found not proved</b></p> <p>This is for the same reasons set out at Charge 33ai.</p>
33bi	<p><i>an extra oral examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons set out at Charge 33ai.</p>
33bii	<p><i>a BPE;</i> <b>Found not proved</b></p> <p>This is for the same reasons set out at Charge 33ai.</p>
33biii	<p><i>an assessment of Patient J's oral hygiene;</i> <b>Found not proved</b></p> <p>This is for the same reasons set out at Charge 33ai.</p>
<b>Patient K</b>	
34	<p><i>You failed to provide an adequate standard of care to Patient K from 11 April 2022 to 15 May 2023, in that:</i></p>
34a	<p><i>During an appointment on 11 April 2022, you did not conduct</i></p>
34ai	<p><i>An extra oral examination</i> <b>Found proved</b></p> <p>There is no record in Patient K's notes that <i>an extra oral examination</i> took place at this appointment. The Committee has drawn the inference that the absence of a record of the examination means it is more likely than not that he did not carry out the assessment.</p> <p>Dr Pal's opinion was that there was a duty to undertake these assessments. The Committee accepts Dr Pal's evidence and therefore found this charge proved.</p>
34aii	<p><i>A soft tissue examination</i> <b>Found proved</b></p> <p>There is no indication in Patient K's notes that a soft tissue assessment took place at this appointment. Accordingly, the Committee finds this charge proved for the same reasons set out at Charge 34ai above.</p>
34aiii	<p><i>A BPE</i> <b>Found proved</b></p> <p>There is no indication in Patient K's notes that a BPE took place. Dr Pal observed that the BPE was recorded only on 15 May 2023 and not during other examinations.</p> <p>Accordingly, the Committee finds this charge proved for the same reasons set out at Charge 34ai above.</p>
34aiv	<p><i>An assessment of Patient K's oral hygiene</i> <b>Found proved</b></p>

	<p>There is no record in Patient K's notes to indicate that an oral hygiene assessment took place at this appointment. Accordingly, the Committee finds this proved.</p>
34b	<p><i>During an appointment on 8 November 2022 you did not conduct</i></p>
34bi	<p><i>An extra oral examination</i> <b>Found proved</b></p> <p>There is no record in Patient K's notes to indicate that an extra oral examination took place on 8 November 2022. Accordingly, the Committee finds this proved.</p>
34bii	<p><i>A soft tissue examination</i> <b>Found proved</b></p> <p>There is no record in Patient K's notes to indicate that a soft tissue examination took place on the date in question. Accordingly, the Committee finds this proved.</p>
34biii	<p><i>A BPE</i> <b>Found proved</b></p> <p>There is no record in Patient K's notes to indicate that a BPE took place on the date in question. Accordingly, the Committee finds this proved.</p>
34biv	<p><i>An assessment of Patient K's oral hygiene</i> <b>Found proved</b></p> <p>There is no record in Patient K's notes to indicate that an assessment of Patient K's oral hygiene took place at this appointment. Accordingly, the Committee finds this proved.</p>
34c	<p><i>During an appointment on 8 November 2022 you did not:</i></p>
34ci	<p><i>Report on bitewing radiographs taken</i> <b>Found proved</b></p> <p>The Committee had regard to the clinical notes for 8 November 2022 including the radiographs that were taken at this appointment. The Committee noted the entry "bws taken all ok", confirming that bitewing radiographs were taken. However, the Committee considered that this wording lacked detail and was too limited to constitute a sufficient radiographic report. The Committee therefore concluded that Mr McLauchlan did not adequately report on the radiographs, and this part of the charge is found proved.</p>
34cii	<p><i>Identify bone loss around Patient K's LR5</i> <b>Found proved</b></p> <p>The Committee observed that the clinical records for the appointment of 8 November 2022 recorded "bws taken all ok", indicating that no abnormality was identified and did not note any other entry regarding the radiographs taken.</p> <p>The Committee accepts Dr Pal's opinion that 'The right bitewing radiograph shows significant bone loss around LR5, and the left bitewing radiograph shows bone 15-20% bone loss in the LL67 area.' The Committee concluded that the bone loss would have been visible on the radiographs at that appointment and should have</p>

	<p>been recognised and recorded. As Mr McLauchlan did not identify this bone loss, the Committee finds this charge proved.</p>
34ciii	<p><i>Identify bone loss in Patient K's LL67 area</i> <b>Found proved</b></p> <p>This is for the same reasons as set out at charge 34cii</p>
34d	<p><i>During an appointment on 15 May 2023 you did not conduct:</i></p>
34di	<p><i>An extra oral examination</i> <b>Found proved</b></p> <p>There is no record in Patient K's notes to indicate that an extra oral assessment took place at this appointment. In the Committee's judgement, on the balance of probabilities, it is more likely than not that Mr McLauchlan did not carry out this examination. The Committee agrees with Dr Pal's opinion on this matter. It finds the charge proved.</p>
34dii	<p><i>A soft tissue examination</i> <b>Found proved</b></p> <p>This is for the same reasons as set out at charge 34di above.</p>
34diii	<p><i>An assessment of Patient K's oral hygiene</i> <b>Found proved</b></p> <p>This is for the same reasons as set out at charge 34di above.</p>
34e	<p><i>During an appointment on 15 May 2023 you incorrectly advised Patient K that it normally takes 6 months for gums to heal after extraction</i> <b>Found proved</b></p> <p>The Committee has noted that Mr McLauchlan has recorded in Patient K's clinical notes the following "<i>Pt feeling some discomfort from LR6 xla area. Mc advs that it normally takes around 6 months for gum to heal from xla.</i>" Dr Pal's opinion is that that this was incorrect advice as a non-healing socket over 8 weeks should be referred to an Oral and Maxillo-facial surgeon unit to be investigated for any suspicious malignant lesions.</p> <p>Dr Pal referred to non-healing extraction sockets, a recent article in the British Dental Journal (British Dental Journal   Volume 237 no. 12   December 20, 2024) advised that: "<i>It would, therefore, be prudent for a GDP to promptly refer cases where there is a complete absence of any sign of healing after four weeks</i>". Dr Pal noted that whilst the article was written after the material time, this advice relied on a published article from 2006.</p> <p>Dr Pal considered that Mr McLauchlan, as a reasonably competent dentist, to have been aware of this. The Committee agrees with Dr Pal's evidence and accordingly finds the charge proved.</p>
34f	<p><i>You did not urgently refer Patient K to an oral maxilo facial surgery unit, because of a non-healing socket on:</i></p>
34fi	<p><i>8 November 2022</i></p>

	<p><b>Found proved</b></p> <p>The tooth was extracted on 7 June 2022. Patient K returned for an appointment on 8 November 2022. The clinical notes record that Patient K was “<i>struggling to eat after XLA (LR6)</i>”, which, in Dr Pal’s opinion, indicated that the socket was not healing. Dr Pal’s evidence was that he would expect Mr McLauchlan, as a reasonably competent general dental practitioner, to be aware that a non-healing socket over 8 weeks should be referred to an oral and maxillo-facial surgery unit to be investigated for any suspicious malignant lesions. He further opined that he would have expected Mr McLauchlan to have made an urgent referral when he saw Patient K at this appointment (five months after the extraction). The Committee noted that at this appointment Mr McLauchlan prescribed Difflam mouthwash, which also suggests that there was inflammation present.</p> <p>The Committee agrees with Dr Pal’s opinion. It considers that Mr McLauchlan, as an experienced dentist, would have known that by the time of the appointment on 8 November 2022 with the patient presenting with a non-healing socket, he should have referred Patient K to an oral maxillo-facial surgery unit. It therefore finds this charge proved.</p>
35	<p><i>Your conduct in charge 34fi and/or 34fii put Patient K’s safety at risk</i> <b>Found proved in relation to 34fi (charge 34fii was withdrawn by the GDC)</b></p> <p>Dr Pal opined that Mr McLauchlan should have referred the patient for an urgent referral for further investigation due to the non-healing socket because of the time lapse from the date of extraction (7 June 2022). The Committee accepts Dr Pal’s opinion. It considered that a five month delay put Patient K’s safety at risk and was well outside the recommended guidance on the referral of non-healing sockets. It noted that the subsequent biopsy report issued on 31 July 2023 showed that the lesion was found to be an invasive squamous cell carcinoma. This charge was accordingly found proved.</p>
36	<p><i>Your conduct in charge 34e was</i></p>
36a	<p><i>Misleading</i> <b>Found proved</b></p> <p>The Committee considers that it was more likely than not that Mr McLauchlan, as an experienced dentist, would have known that a socket would normally heal within 8 weeks and that if it has not healed within that time frame (ie within two months) he should refer the patient. The Committee notes that Patient K’s attendance on 15 May 2023 was the second time she had attended, complaining of pain in the LR6.</p> <p>The Committee is satisfied, on the balance of probabilities, that Mr McLauchlan knowingly misled Patient K by advising her that the socket was still healing when he knew that it should have healed by the time of the appointment, having extracted the LR6 on 7 June 2022.</p>
36b	<p><i>Lacking integrity</i> <b>Found proved</b></p> <p>The Committee has had regard to its findings in relation to 34e above. It considered that dental professionals have a responsibility to give correct advice to a patient. The Committee is satisfied, on the balance of probabilities, that Mr McLauchlan knew that the sockets were not healing and it was his professional obligation to truthfully inform</p>

	<p>the patient about the time frame for healing. It considered that Mr McLauchlan did not act in the higher professional and ethical standards that is expected of a registered dentist. Accordingly, it is satisfied that Mr McLauchlan's conduct was lacking integrity. It therefore finds this charge proved.</p>
36c	<p><i>Dishonest – in that you knew sockets should normally heal in less than 6 months</i> <b>Found proved</b></p> <p>The Committee is satisfied that on the balance of probabilities, Mr McLauchlan, as an experienced dentist, would have known that the sockets would normally heal within 8 weeks. In advising the patient that it was 'normal' to take 6 months for the gums to heal, in the knowledge that this advice was clearly untrue, the Committee has concluded that ordinary decent people would judge that to be dishonest. The Committee therefore finds this charge proved.</p>
37	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient K's appointments from 11 April 2022 to 15 May 2022, in that</i></p>
37a	<p><i>In your record of 11 April 2022 you did not record</i></p>
37ai	<p><i>An extra oral examination</i> <b>Found not proved</b></p> <p>The GDC's case is that the record keeping failures (charge 37) are put in the alternative of finding the failures set out in charge 34 not proved. The Committee has found charge 34 proved. Accordingly, charge 37 is found not proved in its entirety.</p>
37aii	<p><i>A soft tissue examination</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 37ai above.</p>
37aiii	<p><i>A BPE</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 37ai above.</p>
37aiv	<p><i>An assessment of Patient K's oral hygiene</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 37ai above.</p>
37b	<p><i>In your record of 8 November 2022 you did not record</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 37ai above.</p>
37bi	<p><i>An extra oral examination</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 37ai above.</p>
37bii	<p><i>A soft tissue examination</i> <b>Found not proved</b></p>

	This is for the same reasons as set out at charge 37ai above.
37biii	<i>A BPE</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 37ai above.
37biv	<i>An assessment of Patient K's oral hygiene</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 37ai above.
37c	<i>In your record of 15 May 2023 you did not record</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 37ai above.
37ci	<i>An extra oral examination</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 37ai above.
37cii	<i>A soft tissue examination</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 37ai above.
37ciii	<i>An assessment of Patient K's oral hygiene</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 37ai above.
<b>Patient L</b>	
38	<i>You failed to provide an adequate standard of care to Patient L on 4 August 2023, in that:</i>
38a	<i>You did not:</i>
38ai	<i>take a radiograph covering Patient L's UR8, before you attempted to extract this tooth;</i> <b>Found proved</b> The Committee notes that there is no record or a report of a radiograph being taken. The notes only record the extraction.  Dr Pal's evidence is that ' <i>Whilst a radiograph is not mandatory before every extraction, given the UR8 was noted by the Registrant as "pushing buccally" and "unable to see", I would have expected a radiograph to have been taken in this case</i> '. The Committee accepts Dr Pal's evidence that there was a duty on Mr McLauchlan to take a radiograph covering the UR8 before attempting to extract it. There is no evidence of a radiograph covering the UR8 and the Committee therefore finds this charge proved.
38aai	<i>discuss with Patient L the risks and benefits of extracting their UR8 in advance of attempting to do so</i> <b>Found proved</b>

	<p>The Committee considers that it is more likely than not that Mr McLauchlan did not discuss the risks and benefits of extracting the UR8 in advance of doing so, given that there is no record of a discussion in the patient's clinical notes.</p> <p>The Committee has also had regard to Patient L's letter of complaint dated 24 August 2023 in which they stated that Mr McLauchlan '<i>did not give any information on the procedure or what I should expect. And just started to numb my mouth.</i>' The Committee considers that Patient L's contemporaneous letter of complaint supports the allegation. Dr Pal's evidence is that there is no record of discussions of options, benefits and risks associated with the extraction of UR8. The Committee accepts Dr Pal's evidence. Taking all these factors into account the Committee finds this charge proved.</p>
38aiii	<p><i>discuss alternative treatment options with Patient L in advance of attempting to extract their UR8;</i> <b>Found proved</b></p> <p>This is for the same reasons as set out at charge 38aii above.</p>
39	<p><i>By reason of your conduct in 38.a.ii. and/or 38.a.iii. you did not obtain Patient L's informed consent for your attempted extraction of their UR8 on 4 August 2023.</i> <b>Found proved</b></p> <p>Dr Pal opined that an assessment and associated clinical findings should be discussed with the patient to obtain informed consent. No evidence appears to have been provided of any such discussions. The Committee notes that, in the dental records, Mr McLauchlan advises extraction and records "<i>pt happy with this</i>". The Committee, in its judgement, considers this insufficient information and does not adequately demonstrate that the patient was fully informed of the risks and benefits or alternative treatments prior to the extraction of UR8. Accordingly, the Committee finds this charge proved.</p>
40	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient L's appointment on 4 August 2023 in that:</i></p>
40a	<p><i>You did not record:</i></p>
40ai	<p><i>your discussion of the risks and benefits of extracting their UR8;</i> <b>Found not proved</b></p> <p>The GDC's case that the record keeping failures (charge 40a) are put in the alternative of finding charge 38 not proved. The Committee has found charge 38 proved. Accordingly, charge 40a is found not proved in its entirety.</p>
40aii	<p><i>your discussion of the alternative treatment options.</i> <b>Found not proved</b></p> <p>This is for the same reasons set out at Charge 40ai above.</p>
<b>Patient M</b>	
41	<p><i>You failed to provide an adequate standard of care to Patient M from 1 March 2022 to 13 April 2023, in that:</i></p>
41a	<p><i>During an appointment on 1 March 2022, you did not conduct:</i></p>
41ai	<p><i>an extra oral examination;</i> <b>Found proved</b></p>

	<p>The Committee had regard to the patient's dental records. There is no record of the examinations or assessments set out in charge 41a – 41b having been carried out. The Committee accepts Dr Pal's opinion that these were not carried out for the two appointments in question. On the balance of probabilities, the Committee determined that these was not carried out. Accordingly, it finds this charge proved.</p>
41aii	<p><i>a basic periodontal examination [BPE];</i> <b>Found proved</b></p> <p>This is for the same reasons as set out at charge 41ai above.</p>
41aiii	<p><i>an assessment of Patient M's oral hygiene;</i> <b>Found Proved</b></p> <p>This is for the same reasons as set out at charge 41ai above.</p>
41b	<p><i>During an appointment on 12 September 2022, you did not conduct:</i></p>
41bi	<p><i>an extra oral examination;</i> <b>Found Proved</b></p> <p>This is for the same reasons as set out at charge 41ai above.</p>
41bii	<p><i>a soft tissue examination;</i> <b>Found Proved</b></p> <p>This is for the same reasons as set out at charge 41ai above.</p>
41biii	<p><i>a BPE;</i> <b>Found Proved</b></p> <p>This is for the same reasons as set out at charge 41ai above.</p>
41biv	<p><i>an assessment of Patient M's oral hygiene;</i> <b>Found Proved</b></p> <p>This is for the same reasons as set out at charge 41ai above.</p>
41c	<p><i>You did not report on bitewing radiographs taken on 12 September 2022</i> <b>Found Proved</b></p> <p>Patient M attended for an examination appointment on 12 September 2022 at which bitewing radiographs were taken. The Committee had sight of the radiographs and observed that although they had been recorded as being taken in the clinical notes, there is no report present for the radiographs. The Committee therefore accepts Dr Pal's opinion that the reporting of the radiographs was not likely to have been carried out and finds the charge proved.</p>
41d	<p><i>During an appointment on 12 September 2022, you did not identify and/or arrange to treat:</i></p>
41di	<p><i>caries on the distal aspect of Patient M's LL6;</i> <b>Found Proved</b></p>

	<p>There is no reference to any caries being present on the distal aspect of Patient M's LL6 in the dental records of the appointment of 12 September 2022. Having viewed the radiographs, the Committee accepts Dr Pal's opinion that caries was present on the distal aspect of LL6 on that day and that there was a failure to identify and treat the caries.</p> <p>The Committee therefore concluded that there was a failure to identify the caries at LL6 which subsequently led to the failure to treat or arrange for treatment of the LL6 tooth at the time. Accordingly, the Committee finds the charge proved.</p>
41dii	<p><i>a restoration overhang on the mesial aspect of Patient M's LL7;</i> <b>Found Proved</b></p> <p>There is no reference to any overhang being present on the mesial aspect of Patient M's LL7 in the dental records of the appointment of 12 September 2022. Having viewed the radiographs, the Committee accepts Dr Pal's opinion that there was a restoration overhang present on the mesial aspect of LL7 and that there was a failure to treat the overhang. The Committee therefore concluded that there was a failure to identify the overhang which subsequently led to the failure to treat or arrange for treatment of the LL7 tooth at the time. Accordingly, the Committee finds the charge proved.</p>
41e	<p><i>During an appointment on 13 April 2023, you did not conduct:</i></p>
41ei	<p><i>an extra oral examination;</i> <b>Found proved</b></p> <p>The Committee noted that the clinical entry for this appointment recorded "OE NAD,". In the absence of any other information, the Committee considers this entry to be insufficient for it to conclude that an extra oral examination took place. Accordingly, the Committee finds the charge proved.</p>
41eii	<p><i>an assessment of Patient M's oral hygiene;</i> <b>Found proved</b></p> <p>Having regarded the clinical records, the Committee has found no entry to indicate that an assessment of Patient M's oral hygiene was carried out at this examination appointment. Given the absence of a recording of an assessment of oral hygiene the Committee find, on the balance of probabilities, that the assessment was not carried out and therefore finds this charge proved.</p>
42	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient M's appointments from 1 March 2022 to 13 April 2023, in that:</i> <b>Found not proved</b></p> <p>The GDC's case is that the record keeping failures (charge 42) are put in the alternative of finding the failures set out in charge 41 not proved. The Committee has found charge 41 proved and therefore charge 42 has been found not proved.</p>
42a	<p><i>In your appointment of 1 March 2022, you did not record:</i></p>
42ai	<p><i>an extra oral examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 42.</p>

42aii	<p><i>a BPE;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 42.</p>
42aiii	<p><i>an assessment of Patient M's oral hygiene;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 42.</p>
42b	<p><i>In your appointment of 12 September 2022, you did not record:</i></p>
42bi	<p><i>an extra oral examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 42.</p>
42bii	<p><i>a soft tissue examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 42.</p>
42biii	<p><i>a BPE;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 42.</p>
42biv	<p><i>an assessment of Patient M's oral hygiene;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 42.</p>
42c	<p><i>In your appointment of 13 April 2023, you did not record</i></p>
42ci	<p><i>an extra oral examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 42.</p>
42cii	<p><i>an assessment of Patient M's oral hygiene.</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 42.</p>
<b>Patient N</b>	
43	<p><i>You failed to provide an adequate standard of care to patient N from 16 May 2022 to 15 August 2023, in that:</i></p>
43a	<p><i>During an appointment on 16 May 2022 you did not:</i></p>
43ai	<p><i>Take a medical history update</i> <b>Found proved</b></p> <p>The clinical notes record that an examination took place on 16 May 2022. However, there is no note in Patient N's records of a medical history update for this appointment. Dr Pal's evidence was that examinations were carried out on 16 May 2022, 11 November 2022 and 27 July 2023. However, there was no indication that</p>

	<p>a medical history update was undertaken. The Committee accepts Dr Pal's evidence. It has concluded that in the absence of a note in the record it was more likely than not that the medical history update was not undertaken.</p>
43aii	<p><i>Conduct an extra oral examination</i> <b>Found proved</b></p> <p>There is no note in Patient N's records of an extra oral examination for this appointment. Accordingly, the Committee finds this charge proved for the same reasons as set out at Charge 43ai above.</p>
43aiii	<p><i>Conduct a soft tissue examination</i> <b>Found proved</b></p> <p>The Committee notes that there is no note in Patient N's records of a soft tissue examination for this appointment. Accordingly, the Committee finds this charge proved for the same reasons as set out at Charge 43ai above.</p>
43aiv	<p><i>Take a social history update</i> <b>Found proved</b></p> <p>There is no note in Patient N's records of a social history update for this appointment. Dr Pal's evidence was that there is reference to alcohol consumption in a previous appointment in November 2021. He opined that the patient's social history should have been checked. This is found proved for the same reasons as set out at Charge 43ai above.</p>
43b	<p><i>During an appointment on 11 November 2022 you did not:</i></p>
43bi	<p><i>Take a medical history update</i> <b>Found proved</b></p> <p>The Committee notes that save for a record of a covid screen in Patient N's records there is no note in Patient N's records of a medical history update for this appointment. This charge is found proved for the same reasons as set out at Charge 43ai above.</p>
43bii	<p><i>Conduct an extra oral examination</i> <b>Found proved</b></p> <p>There is no note in Patient N's records of an extra oral examination for this appointment. This charge is found proved for the same reasons as set out at Charge 43ai above.</p>
43biii	<p><i>Conduct a soft tissue examination</i> <b>Found proved</b></p> <p>There is no note in Patient N's records of a soft tissue examination for this appointment. This is found proved for the same reasons as set out at Charge 43ai above.</p>
43biv	<p><i>Conduct a BPE</i> <b>Found proved</b></p>

	There is no note in Patient N's records of BPE scores for this appointment. This charge is found proved for the same reasons as set out at Charge 43ai above.
43bv	<p><i>Take a social history update</i> <b>Found proved</b></p> <p>There is no note in Patient N's records of a social history update. This is found proved for the same reasons as set out at Charge 43ai above.</p>
43c	<i>During an appointment on 27 July 2023 you did not</i>
43ci	<p><i>Take a social history update</i> <b>Found proved</b></p> <p>There is a record of an appointment taking place on 27 July 2023. There is no note in Patient N's records of a social history update for this appointment. This charge is found proved for the same reasons as set out at Charge 43ai above.</p>
43cii	<p><i>Adequately report on bitewing radiographs taken</i> <b>Found proved</b></p> <p>Mr McLauchlan documented bitewing radiographs as having been taken on 27 July 2023. Dr Pal confirmed in his oral testimony that the correct date was 27 July 2023. The Committee noted that no radiographic report was provided with the evidence.</p> <p>The Committee concurs with Dr Pal's assessment and considers that the notation "n/a" was inadequate for diagnostic purposes. It determined that there was no radiographic reporting and finds this charge proved.</p>
43d	<i>From 27 July 2023 to 27 September 2023, you did not:</i>
43di	<p><i>Check whether Patient N's UR1 was tender to percussion</i> <b>Found proved</b></p> <p>The notes for the appointment for 27 July 2023 records "<i>upper lip swollen few weeks ago. Ok now.</i>" The notes for the subsequent appointments dated 8 August 2023 and 27 September refer to similar problems in the UR1.</p> <p>The entries in the clinical notes are supported by the photographs provided by Patient N which showed that his lip was swollen. There is no record in the appointment of Mr McLauchlan having checked to see whether Patient N's UR1 was tender to percussion during the dates from 27 July 2023 to 27 September 2023, even though it is clear from the records that the appointments between 27 July 2023 and 27 September 2023 continue to refer to the UR1 where Patient N complains of a swollen gum/feeling pressure and pain.</p> <p>Dr Pal's evidence is that there was no record of any clinical investigations of the UR1 between those dates, such as checking whether the tooth was tender to percussion.</p> <p>In light of this evidence, the Committee found this charge proved.</p>
43dii	<i>Take a periapical radiograph covering Patient N's UR1;</i>
43e	<i>You did not make a diagnosis for the swelling patient N presented with during an appointment on:</i>
43ei	<i>27 July 2023</i>

	<p><b>Found proved</b></p> <p>The Committee notes from Patient N's statement that a swelling was noticed in the upper lip since March 2020 and that he had reported this to Mr McLauchlan on four separate occasions. The clinical records record that Patient N first presented with a swelling of the upper lip on 27 July 2023. Dr Pal's evidence was that there was no record of Mr McLauchlan having made a diagnosis of the swelling and he was critical of Mr McLauchlan's failure to make a diagnosis. The Committee, having reviewed Patient N's records, accepts Dr Pal's evidence and finds this charge proved.</p>
43eii	<p><i>8 August 2023</i></p> <p><b>Found proved</b></p> <p>For this appointment, the Committee notes that there is an entry in Patient N's clinical notes as follows: "<i>swollen gum/feeling pressure</i>". However, there is no record of a diagnosis in the patient's records or any tests taken. Dr Pal was critical of Mr McLauchlan failure to provide a diagnosis of the swelling of the UR1. The Committee accepts Dr Pal's evidence and find this charge proved.</p>
<p><i>[charges 43f and 44 were removed by the GDC]</i></p>	
45	<p><i>Within a referral letter for specialist treatment and/or investigation of Patient N's UR1, dated 15 August 2023, you incorrectly stated that another dentist had previously provided Patient N with poor quality root canal treatment, or words to that effect</i></p> <p><b>Found proved</b></p> <p>The Committee has had regard to Patient N's clinical records which record that Mr McLauchlan carried out the root canal (RCT) filling to the UR1 on 15 September 2008. This information would have been apparent to Mr McLauchlan, when reviewing Patient N's notes. It has also had regard to the referral letter dated 15 August 2023 from Mr McLauchlan to the specialist which states "<i>Patient has had several episodes of apical swelling over upper right central incisor. Previous trauma to toothmore (sic) than 15 years ago. RCT carried out by previous GDP. GP short and poor lateral seal. Requires RCT or possible apicectomy</i>".</p> <p>Furthermore, the Committee has had regard to Patient N's witness statement in which he makes it clear that contrary to what is included within the referral letter, it was Mr McLauchlan who had previously provided the RCT.</p> <p>Accordingly, the Committee has found this charge proved.</p>
46	<p><i>Your conduct in charge 45 was</i></p>
46a	<p><i>Misleading</i></p> <p><b>Found proved</b></p> <p>The Committee is satisfied, on the balance of probabilities, that Mr McLauchlan knew when he wrote the referral letter dated 15 August 2023 that he had carried out RCT to Patient N's UR1 on 5 September 2008.</p> <p>Patient N was a long standing patient, who first attended on 9 June 2006. Patient N's evidence was that Mr McLauchlan had treated him since he was a child and had carried out the RCT in 2008. Furthermore, the clinical records make it clear that Mr McLauchlan carried out the RCT in 2008.</p>

	<p>In the Committee's judgement, given that the referral letter sets out in some detail the reasons for the referral and previous treatment, including that there was previous trauma to the tooth more than 15 years, as well as reference to the poor quality of the RCT having been carried out by another dentist. The Committee has drawn the inference that Mr McLauchlan would have reviewed Patient N's notes in order to come to the conclusion regarding the quality of the RCT, from which it was clear that he had carried out the RCT. He therefore wrote the referral letter in the knowledge that he had carried out the RCT.</p> <p>By stating in the referral letter that the RCT was carried out by another dentist, this gave the impression to the referring dentist that another dentist had carried out the RCT which was misleading. This also created an inaccurate clinical record. Accordingly, the Committee finds this charge proved.</p>
46b	<p><i>Lacking integrity</i> <b>Found proved</b></p> <p>The Committee considered that Mr McLauchlan had a duty to ensure that a referral letter to another clinician contains accurate information. A failure to provide accurate information undermines the trust between dental professionals as well as the relationship between the registrant and the patient. He sought to blame the poor RCT onto another dental practitioner. In these circumstances, the Committee is satisfied that Mr McLauchlan's conduct lacked integrity. The Committee therefore finds this charge proved.</p>
46c	<p><i>Dishonest in that you knew it was you that had previously provided the root canal treatment referred to</i> <b>Found proved</b></p> <p>The Committee is satisfied, on the balance of probabilities, that Mr McLauchlan knew that he had previously provided RCT to Patient N. The information was also set out in Patient N's notes, which Mr McLauchlan must have reviewed in order to write the referral letter. This was in the context of Patient N experiencing complications requiring referral. In the Committee's judgement, Mr McLauchlan knowingly placed the blame for the poor quality RCT on another unnamed dentist rather than be open and transparent in accepting that he had carried out RCT. The Committee, having applied the standards of ordinary decent people, is satisfied that Mr McLauchlan's actions were objectively dishonest. Accordingly, it finds this charge proved.</p>
47	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient N's appointments from 16 May 2022 to 8 August 2023 in that:</i></p>
47a	<p><i>In your record of 16 May 2022 you did not record:</i> <b>Found not proved</b></p> <p>The GDC's case is that the record keeping failures (charge 47) are put in the alternative of finding the failures set out in charge 43 not proved. The Committee has found charge 43 proved. Accordingly, charge 47 is found not proved, saved for charges 47fi and 47fii, which are found proved.</p>
47ai	<p><i>A medical history update</i> <b>Found not proved</b></p>

	This is for the same reasons as set out at charge 47a above.
47aii	<i>An extra oral examination</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 47a above.
47aiii	<i>A soft tissue examination</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 47a above.
47aiv	<i>A social history update</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 47a above.
47b	<i>In your record of 11 November 2022 you did not record</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 47a above.
47bi	<i>A medical history update</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 47a above.
47bii	<i>An extra oral examination</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 47a above.
47biii	<i>A soft tissue examination</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 47a above.
47biv	<i>A BPE</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 47a above.
47bv	<i>A social history update</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 47a above.
47c	<i>In your record of 27 July 2023 you did not record a social history update</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 47a above.

47d	<p><i>You did not record whether Patient N's UR1 was tender to percussion from 27 July 2023 to 27 September 2023</i></p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 47a above.</p>
47e	<p><i>You did not record a diagnosis for the swelling Patient N presented with during an appointment on</i></p>
47ei	<p>27 July 2023</p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 47a above.</p>
47eii	<p>8 August 2023</p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 47a above.</p>
47f	<p><i>You did not record your discussion of the treatment options for managing swelling found for their UR1 on</i></p>
47fi	<p>27 July 2023</p> <p><b>Found not proved</b></p> <p>The Committee notes from the patient records of 27 July 2023 that Patient N complains of '<i>upper lip swollen a few weeks ago, ok now</i>'. However, the Committee noted there are no records relating to a discussion of treatment options for managing the swelling. The Committee accepts Dr Pal's opinion that '<i>there is no record of any discussion of options, benefits and risks for management of the swelling</i>' and therefore finds this charge proved.</p>
47fii	<p>8 August 2023</p> <p><b>Found proved</b></p> <p>The Committee notes from Patient N's records of 8 August 2023 that Patient N complains of '<i>swollen gm/feeling pressure</i>' and '<i>needs ref to balbirnie</i>'. However the Committee noted there are no additional clinical notes recording a discussion of alternative treatment options for managing the swelling. The Committee accepts Dr Pal's opinion that '<i>there is no record of any discussion of options, benefits and risks for management of the swelling</i>' and therefore finds this charge proved.</p>
<b>Patient O</b>	
48	<p><i>You failed to provide an adequate standard of care to Patient O from 17 October 2022 to 18 October 2023, in that:</i></p>
48a	<p><i>During an appointment on 17 October 2022, you did not:</i></p>
48ai	<p><i>take a medical history update;</i></p> <p><b>Found proved</b></p> <p>The Committee had regard to the patient's dental records. There is no record of this assessment having been carried out. The Committee noted that a record of the medical history was done at a previous appointment, but not on 17 October 2022. The Committee accepts Dr Pal's opinion that this and the other examinations set out at charge 48a were not carried out. On the balance of probabilities, the Committee determined that they were not carried out. Accordingly, it finds this charge proved.</p>

48aii	<p><i>conduct an extra oral examination;</i> <b>Found proved</b></p> <p>This is for the same reasons as set out charge 48ai above.</p>
48aiii	<p><i>conduct a soft tissue examination;</i> <b>Found proved</b></p> <p>This is for the same reasons as set out charge 48ai above.</p>
48aiv	<p><i>conduct a BPE;</i> <b>Found proved</b></p> <p>This is for the same reasons as set out charge 48ai above.</p>
48av	<p><i>take a social history update;</i> <b>Found proved</b></p> <p>This is for the same reasons as set out charge 48ai above.</p>
48b	<p><i>During an appointment on 15 May 2023, you did not:</i></p>
48bi	<p><i>conduct an extra oral examination;</i> <b>Found proved</b></p> <p>The Committee had regard to the patient's dental records. There is no record of an extra oral or a soft tissue examination having been carried out on 15 May 2023. The Committee accepts Dr Pal's opinion that these examinations were not carried out. On the balance of probabilities, the Committee determined that they were not carried out. Accordingly, it finds this charge proved.</p>
48bii	<p><i>conduct a soft tissue examination;</i> <b>Found proved</b></p> <p>This is for the same reasons as set out charge 48bi above.</p>
48biii	<p><i>report on bitewing radiographs taken</i> <b>Found proved</b></p> <p>The Committee reviewed Mr McLauchlan's dental records for Patient O, noting that bitewing radiographs were taken on 15 May 2023. However, the records do not include any findings associated with these radiographs. Dr Pal opined that the bitewing radiographs taken on 15 May 2023 indicate the presence of bone loss. His evidence was that there is no indication from Mr McLauchlan's examination notes that any diagnosis of periodontal disease was made. The Committee accepts Dr Pal's evidence on this point and accordingly finds this charge proved.</p>
48biv	<p><i>diagnose bone loss;</i> <b>Found proved</b></p> <p>This is for the same reasons as set out at charge 48biii above.</p>
48c	<p><i>You did not diagnose periodontal disease from 17 October 2022 to 18 October 2023;</i> <b>Found proved</b></p>

	<p>The Committee reviewed the dental records and found there was no record of a diagnosis of periodontal disease by Mr McLauchlan for the 9 appointments in the period between 17 October 2022 and 18 October 2023. However, the Committee noted that a Basic Periodontal Examination (BPE) was conducted by the hygienist on 21 November 2022, which recorded a Code of 3, in both the upper right and upper left sextants, a diagnostic indicator for periodontal disease.</p> <p>Dr Pal's opinion was that a BPE was not undertaken by Mr McLauchlan at the examination appointment on 17 October 2022, although the hygienist undertook one on 21 November 2022 with a record of a Code 3. Dr Pal considered that this score was likely to have been similar on 17 October 2022. He further opined that the bitewing radiographs taken on 15 May 2023 indicated the presence of bone loss. Dr Pal further opined that there was no indication from Mr McLauchlan's notes that any diagnosis of periodontal disease was made.</p> <p>Having regard to all the evidence, the Committee accepts Dr Pal's opinion that periodontal disease was present on 17 October 2022 and was undiagnosed during the period in question. Accordingly, it finds this charge proved.</p>
48d	<p><i>You did not provide patient O with a treatment plan for filling their UL1 on 4 September 2023;</i> <b>Found proved</b></p> <p>Dr Pal noted that there was a written treatment plan dated the 17 October 2022 for a filling to UL6 but none has been provided for the filling at the UL1. The Committee, having reviewed the notes, noted the absence of a treatment plan for the filling at the UL1. The Committee has concluded, on the balance of probabilities, that a treatment plan for the UL1 was not provided to the patient. Accordingly, it finds this charge proved.</p>
49	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient O's appointments from 17 October 2022 to 18 October 2023, in that:</i> <b>Found not proved</b></p> <p>The GDC's case that the record keeping failures (charge 49) are put in the alternative of finding charge 48 not proved. The Committee has found charge 48 proved. It therefore follows that charge 49 is found not proved in its entirety.</p>
49a	<p><i>In your record of 17 October 2022, you did not record:</i></p>
49ai	<p><i>a medical history update;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 49.</p>
49aii	<p><i>an extra oral examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 49.</p>
49aiii	<p><i>a soft tissue examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 49.</p>

49aiv	<p><i>a BPE;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 49.</p>
49av	<p><i>a social history update;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 49.</p>
49b	<p><i>In your record of 15 May 2023, you did not record:</i></p>
49bi	<p><i>an extra oral examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 49.</p>
49bii	<p><i>a soft tissue examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 49.</p>
49c	<p><i>You did not record a diagnosis of periodontal disease from 17 October 2022 to 18 October 2023.</i></p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 49..</p>
<b>Patient P</b>	
50	<p><i>You failed to provide an adequate standard of care to Patient P from 13 September 2022 to 10 November 2023, in that:</i></p>
50a	<p><i>During an appointment on 13 September 2022, you did not:</i></p>
50ai	<p><i>Conduct an extra oral examination</i> <b>Found proved</b></p> <p>The Committee noted that the clinical entry for this appointment recorded “<i>oe nad,</i>”. In the absence of any other information, the Committee considers this entry to be insufficient for it to conclude that an extra oral examination took place. Accordingly, the Committee finds the charge proved.</p>
50aai	<p><i>conduct a BPE;</i> <b>Found proved</b></p> <p>The Committee had regard to the patient’s dental records. There is no record of these examinations or assessments having been carried out. The Committee accepts Dr Pal’s opinion that the BPE score was not carried out. On the balance of probabilities, the Committee determined that these assessments were not undertaken. Accordingly, it finds this charge proved.</p>
50b	<p><i>From 17 August 2022 to 30 August 2022, you did not:</i></p>
50bi	<p><i>adequately investigate the condition of Patient P’s UR3;</i></p>

	<p><b>Found proved</b></p> <p>The Committee has reviewed the dental records for the specified dates and noted that Patient P's UR3 came out on August 17th. It was recemented and bite-checked. Patient P returned for an emergency appointment on 30 August 2022 with the same issue, namely that UR3 had fallen out.</p> <p>Dr Pal opined that the UR3 crown fell out and required re-cementation on 17 August 22 and 30 August 2022. He further set out that there is no record of further investigations, such as the condition of the tooth or radiographs. The Committee noted that no investigations regarding the condition of Patient P's UR3 were recorded when the crown failed on these dates. The Committee accepts Dr Pal's evidence and finds this charge proved.</p>
50bii	<p><i>take a radiograph covering their UR3;</i> <b>Found proved</b></p> <p>The Committee notes that there is no record of a radiograph having been undertaken. It accepts the opinion of Dr Pal that no radiograph was undertaken to cover UR3 and accordingly finds the charge proved.</p>
50biii	<p><i>devise an adequate treatment plan for Patient P's UR3;</i> <b>Found proved</b></p> <p>The Committee notes that there is no treatment plan for Patient P's UR3. It accepts Dr Pal's opinion that there is a failure to undertake further investigations and draw up a treatment plan in relation to the UR3. Therefore, it finds the charge proved.</p>
50c	<p><i>You did not make a periodontal diagnosis between 17 August 2022 and 10 November 2023;</i> <b>Found proved</b></p> <p>The Committee reviewed the dental records for Patient P for the 11 appointments with Mr McLauchlan for the time period in question. It noted that Mr McLauchlan performed an examination on 13 September 2022; however, there is no record of a BPE score and subsequent periodontal diagnosis.</p> <p>The hygienist recorded a BPE score of 3-2-3 and 3-3-3 on 22 September 2022, noting '<i>chronic/perio and bone loss</i>'. Dr Pal's evidence was that the BPE score was not documented during the examination appointment on 13 September 2022 with Mr McLauchlan. He further comments that the hygienist's notes on 22 September 2022 indicated that Patient P had poor oral hygiene, a cement overhang at UR3, and extensive bleeding. Having regard to the dental records of Patient P, the Committee accepts Dr Pal's opinion that periodontal disease was not diagnosed for the period in question. Accordingly, it finds this charge proved.</p>
50d	<p><i>You did not report on bitewing radiographs taken on 25 May 2023;</i> <b>Found proved</b></p> <p>The Committee noted from Patient P's dental records that bitewing radiographs were taken on 25 May 2023. The records include an entry stating '<i>bws taken today n/a</i>', from which the Committee could draw no conclusion. However, no findings are documented on these radiographs. Dr Pal's opinion is that the entry indicates the findings were not available on that date, and there is no further report on the</p>

	<p>radiographs. The Committee accepts Dr Pal's evidence on this matter and accordingly finds this charge proved.</p>
50e	<p><i>You did not diagnose caries found at Patient P's LL4, between 2 June 2023 and 10 November 2023;</i> <b>Found proved</b></p> <p>The Committee, as stated in charge 50d, noted that there is no reporting on the radiographs on 25 May 2023 and accepts Dr Pal's opinion that the bitewings taken by Mr McLauchlan on 25 May 2023 show the presence of a distal caries lesion at LL4. There is no record that Mr McLauchlan noted this until it was brought to his attention on 10 November 2023 by the dental hygienist who noted '34dl foodtrap possible cavity'.</p> <p>The Committee agrees with Dr Pal's opinion that there was failure to diagnose the caries at LL4 over several appointments between 2 June 2023 and 10 November 2023. Accordingly, it finds this charge proved.</p>
51	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient P's appointments from 13 September 2022 to 10 November 2023, in that:</i> <b>Found not proved</b></p> <p>The GDC's case that the record keeping failures (charge 51) are put in the alternative of finding charge 50 not proved. The Committee has found charge 50 proved. Accordingly, charge 51 is found not proved in its entirety.</p>
51a	<p>In your record of, 13 September 2022, you did not record:</p>
51ai	<p><i>an extra oral examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at Charge 51.</p>
51aai	<p><i>a BPE;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at Charge 51.</p>
51b	<p><i>You did not record a periodontal diagnosis between 17 August 2022 and 10 November 2023;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at Charge 51.</p>
51c	<p><i>You did not record a diagnosis of caries at Patient P's LL4 between 2 June 2023 and 10 November 2023;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at Charge 51.</p>
51d	<p><i>From 17 August 2022 to 30 August 2022, You did not record:</i></p>
51di	<p><i>investigations into the condition of Patient P's UR3;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at Charge 51.</p>

51dii	<p><i>a adequate treatment plan for Patient P's UR3.</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at Charge 51.</p>
<b>Patient Q</b>	
52	<p><i>You failed to provide an adequate standard of care to Patient Q from 11 July 2023 to 25 July 2023, in that:</i></p>
52a	<p><i>During an appointment on 11 July 2023, you did not:</i></p>
52ai	<p><i>conduct an extra oral examination;</i> <b>Found proved</b></p> <p>The Committee has had regard to Patient Q's records which confirm an appointment took place on 11 July 2023. However there are no further records to indicate that an extra oral examination was conducted or a report on the radiograph provided by Mr McLauchlan. Dr Pal's evidence was he would have expected that an extra oral examination would have been carried out and was critical of Mr McLauchlan's failure to do so. The Committee accepts Dr Pal's evidence on this matter and accordingly finds the charge proved.</p>
52aii	<p><i>report on bitewing radiographs taken;</i> <b>Found proved</b></p> <p>The clinical records confirm that a bitewing radiograph was taken on 11 July 2023 and the reasons for taking it are recorded as "<i>caries detection and bone assessment.</i>" However, there is no report on the bitewing radiograph taken. Dr Pal's evidence was that there was a failure to report on the bitewing radiographs. The Committee agrees with Dr Pal's opinion and accordingly finds this charge proved.</p>
52b	<p><i>In advance of preparing Patient Q's LL6 for a crown on 25 July 2023, you did not;</i></p>
52bi	<p><i>take a periapical radiograph, covering Patient Q's LL6;</i> <b>Found proved</b></p> <p>Dr Pal's evidence was that there was no periapical radiograph of the LL6 as part of the planning for a crown to that tooth and he would have expected one to have been taken. The Committee has had regard to Patient Q's clinical notes and notes that there is no record of a periapical radiograph having been taken. The Committee accepts Dr Pal's evidence and accordingly finds this charge proved.</p>
52bii	<p><i>assess the remaining coronal tooth structure of Patient Q's LL6;</i> <b>Found proved</b></p> <p>Dr Pal set out in his report that "<i>there is no record of an assessment of the clinical condition of LL6 prior to providing the crown on this tooth. This would include an assessment of the remaining coronal tooth structure. In order to provide a predictable crown there needed to be sufficient coronal tooth tissue available.</i>"</p> <p>The Committee, having reviewed the patient records, can find no record of any such assessment and accordingly finds this charge proved.</p>
52biii	<p><i>discuss the risk of Patient Q's LL6 becoming non-vital and requiring root canal treatment;</i> <b>Found proved</b></p>

	<p>Dr Pal's evidence was that the patient should have been advised that there was a risk of LL6 becoming non-vital and requiring root canal treatment (RCT) and that there was no record of a discussion of the options, benefits and risks. The Committee accepts Dr Pal's evidence and accordingly finds this charge proved.</p>
52biv	<p><i>discuss the alternative treatment options for Patient Q's LL6.</i> <b>Found proved</b></p> <p>Dr Pal's evidence was that alternative treatment options for the LL6, including risks and benefits, should have been discussed. The Committee notes from the patient's records that there is a record "<i>advised lava crown</i>". However, there is no record of alternative treatment options in the notes, or a record of other treatment options. In these circumstances, the Committee finds this charge proved.</p>
53	<p><i>By reason of you conduct in charge 52.b.iii. and/or 52.b.iv. you did not obtain Patient Q's informed consent for the crown placed at their LL6.</i> <b>Found proved</b></p> <p>As found proved by the Committee in Charge 52, Patient Q's records show no evidence of a full discussion with the patient on the risks, options, potential alternative treatments in case the initial treatment did not work. Patient Q's records state '<i>patient consent given</i>' which, in the Committee's judgement, is not sufficient evidence of informed patient consent. The Committee therefore finds this charge proved.</p>
54	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient P's appointments from 11 July 2023 to 25 July 2023, in that:</i> <b>Found not proved</b></p> <p>The GDC puts its case that the record keeping failures (charge 54) are in the alternative of finding charge 52 not proved. The Committee has found charge 52 proved. Accordingly, charge 54 is found not proved in its entirety.</p>
54a	<p><i>In your record of 11 July 2023, you did not record an extra oral examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 54.</p>
54b	<p><i>In your record of 25 July 2023, you did not record:</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 54.</p>
54bi	<p><i>an assessment of the remaining coronal tooth structure of Patient Q's LL6 in advance of preparing this tooth for a crown on 25 July 2023;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 54.</p>
54bii	<p><i>a discussion of the risk of Patient Q's LL6 becoming non-vital and requiring root canal treatment.</i> <b>Found not proved</b></p>

	This is for the same reasons as set out at charge 54.
<b>Patient R</b>	
55	<i>You failed to provide an adequate standard of care to Patient R from 27 June 2022 to 5 October 2023, in that:</i>
55a	<i>During an appointment on 27 June 2022, you did not:</i>
55ai	<i>take a medical history update;</i> <b>Found proved</b>  Dr Pal's evidence is that there is no evidence that this, and the other assessments set out in charge 55a, were undertaken. The Committee, having reviewed Patient R's records, agrees with Dr Pal. Accordingly, it finds this charge proved.
55aii	<i>conduct an extra oral examination;</i> <b>Found proved</b>  This is for the same reasons as set out at charge 55ai above.
55aiii	<i>conduct a BPE;</i> <b>Found proved</b>  This is for the same reasons as set out at charge 55ai above.
55aiv	<i>conduct a soft tissue examination;</i> <b>Found proved</b>  This is for the same reasons as set out at charge 55ai above.
55av	<i>take a social history update;</i> <b>Found proved</b>  This is for the same reasons as set out at charge 55ai above.
55avi	<i>take a history of Patient R's reported pain;</i> <b>Found proved</b>  Mr McLauchlan has recorded in the notes that Patient R has an "aching gum", but no other history was provided. This was therefore found proved for the same reasons as set out at charge 55ai above.
55b	<i>During an appointment on 22 December 2022 you did not conduct:</i>
55bi	<i>an extra oral examination;</i> <b>Found proved</b>  The Committee notes that the patient attended for examination on 22 December 2022. Dr Pal's opinion was that there was no record of the assessments set out in charge 55b and he was critical of Mr McLauchlan's failure to carry them out. The Committee, having reviewed the records for this appointment, agrees with Dr Pal. Accordingly, it finds this charge proved.
55bii	<i>a BPE;</i> <b>Found proved</b>

	This is for the same reasons as set out at charge 55bi above.
55c	<p><i>During an appointment on 3 October 2023 you did not take a history in relation to Patient R's lost filling at their LL5;</i> <b>Found proved</b></p> <p>Dr Pal's evidence was that Mr McLauchlan failed to record an assessment or history of the LL5 at this appointment. This was on the basis that the subsequent dentist deemed the cavity was unsuitable for an amalgam filling at the appointment on 6 October 2023. The Committee accepts Dr Pal's evidence and in light of the patient's records, it found this charge proved for the same reasons as set out at charge 55aii.</p>
55d	<p><i>You did not report on bitewing radiographs taken on 27 June 2022;</i> <b>Found proved</b></p> <p>The Committee noted that there is a record in the clinical notes of the appointment of 27 June 2022 of "<i>BW, Bite Wing X-Rays FDC (no charge - Inc.), caries detection</i>", and had regard to these radiographs. However, there is no evidence of a radiographic report in the clinical notes. The Committee accepts Dr Pal's opinion that there was no radiographic report and find this charge proved.</p>
55e	<p><i>You did not diagnose and/or plan treatment for caries found at Patient R's LL6 and/or LL5 on 27 June 2022;</i> <b>Found proved in part</b></p> <p>The Committee, having taken into consideration Dr Pal's opinion that caries was not diagnosed on 27 June 2022, found that there was an entry in the clinical notes of 'LL56 caries present' as part of the record entered for the examination appointment that day. It therefore finds that caries was diagnosed at the appointment and finds this part of the charge not proved.</p> <p>However, the Committee accepts Dr Pal's view that the treatment planning was inadequate, as there is no evidence in the records of any discussion, treatment plan, or documentation for the work carried out on the LL6 or LL5 at either the examination appointment on 27 June 2022 or the treatment visit on 11 July 2022. The Committee therefore finds this element of the charge proved.</p>
55f	<i>You did not conduct an adequate assessment of the suitability of Patient R's LL5 for a restoration on:</i>
55fi	<p><i>3 October 2023;</i> <b>Found proved</b></p> <p>Having reviewed the clinical records, the Committee accepts that there is no documented assessment of the condition of the LL5, and therefore no evidence that its suitability for restoration was properly evaluated. The Committee also accepts Dr Pal's opinion, supported by clinical records of a subsequent treating dentist, that the decision to place an amalgam restoration was not appropriate in the circumstances. Considering this, the Committee finds the charge proved.</p>
55fii	<p><i>5 October 2023;</i> <b>Found proved</b></p> <p>The Committee is satisfied that Mr McLauchlan failed to conduct an adequate assessment of the suitability of Patient R's LL5 for restoration on 5 October 2023</p>

	<p>after the patient returned following a repeated failure of the restoration. The clinical records do not demonstrate findings or documentation evidencing any assessment of the condition of the tooth. The Committee accepts Dr Pal's view, supported by the clinical records of a subsequent treating dentist, that the decision to place an amalgam restoration was not appropriate in the circumstances. On this basis, the Committee is satisfied that an adequate assessment was not undertaken and finds this charge proved.</p>
55g	<p><i>You did not offer Patient R the option of having their LL5 extracted on:</i></p>
55gi	<p>3 October 2023; <b>Found proved</b></p> <p>The Committee is satisfied that Mr McLauchlan did not offer Patient R the option of extraction of the LL5 on 3 October 2023, given that he later considered an extraction to be appropriate. The clinical records contain no evidence that any alternative treatment options, including extraction, were discussed or offered at this appointment. The Committee accepts Dr Pal's opinion that such options should have been presented and in the absence of any recorded discussion of alternatives, the Committee finds this charge proved.</p>
55gii	<p>5 October 2023; <b>Found proved</b></p> <p>The Committee finds that Mr McLauchlan did not offer Patient R the option of extraction of the LL5 on 5 October 2023, given that he later considered an extraction to be appropriate. The clinical records do not show that any alternative treatment options, including extraction, were discussed or offered at this appointment. The Committee accepts Dr Pal's opinion that such options should have been presented. In the absence of any recorded discussion of alternatives, the Committee finds this charge proved.</p>
55h	<p><i>You provided an amalgam restoration at Patient R's LL5 on 5 October 2023 that was not clinically justified</i> <b>Found proved</b></p> <p>The Committee noted that Patient R attended for an appointment on 5 October 2023 following the filling provided by Mr McLauchlan on 3 October 2023 having fallen out. Mr McLauchlan then proceeded to place an amalgam filling on the LL5 on 5 October 2023 but it subsequently fell out. Patient R returned again on 6 October 2023 and saw another clinician. They observed "<i>filling just placed yesterday lost</i>" and "<i>unsuitable for af placement</i>".</p> <p>The Committee observed that Mr McLauchlan later considered extraction to be the best option for the tooth.</p> <p>The Committee accepts Dr Pal's opinion that the tooth was unsuitable for an amalgam on 5 October 2023. This was given Dr Pal's findings that the radiographs dated 27 June 2022 showed the LL5 to have a large carious lesion as well as the subsequent dentist's assessment of the tooth. Considering the clinical records, the subsequent clinician's findings and Dr Pal's evaluation of the radiograph, the Committee is satisfied that the restoration was not clinically justified and finds this charge proved.</p>



56	<p><i>By reason of your conduct in charge 55 (g) (i) and/or charge 55 (g) (ii) you did not obtain Patient R's informed consent for the filling provided to their LL5</i> <b>Found proved</b></p> <p>The Committee has considered the facts proved at charge 55 g(i) and charge 55 g(ii) in that the alternative option of extraction was not given. The Committee also observed a lack of evidence in the clinical notes of any discussion of risks, benefits or alternative options given to Patient R at both appointments. The Committee accepts Dr Pal's opinion that there was '<i>no record of any discussions about options, benefits, and risks to placing a filling at LL5</i>' and that a '<i>Failure to do so would mean informed consent for the filling at LL5 was not gained</i>'.</p> <p>The Committee concluded that these omissions meant the patient may have made a different decision had they been provided with all relevant information at these appointments. Taking all these factors into account, the Committee is satisfied that Mr McLauchlan did not obtain Patient R's informed consent for the restoration provided to their LR5. It therefore finds this charge proved.</p>
57	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient R's appointments from 27 June 2022 to 5 October 2023, in that:</i> <b>Found not proved</b></p> <p>The GDC's case that the record keeping failures (charge 57) are put in the alternative of finding charge 55 not proved. The Committee has found charge 55 proved. Accordingly, charge 57 is found not proved in its entirety.</p>
57a	<p><i>In your record of 27 June 2022, you did not record:</i></p>
57ai	<p><i>a medical history update;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 57.</p>
57aii	<p><i>an extra oral examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 57.</p>
57aiii	<p><i>a BPE; a soft tissue examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 57.</p>
57aiv	<p><i>a social history update;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 57.</p>
57av	<p><i>a history of Patient R's reported pain;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 57.</p>
57b	<p><i>In your record of 22 December 2022, you did not record:</i></p>
57bi	<p><i>an extra oral examination;</i></p>

	<p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 57.</p>
57bii	<p><i>a BPE;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 57.</p>
57c	<p><i>In your record of 3 October 2023, you did not record a history in relation to Patient R's lost filling at their LL5;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 57.</p>
57d	<p><i>You did not record an adequate assessment of the suitability of Patient R's LL5 for a restoration on:</i></p>
57di	<p><i>3 October 2023;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 57.</p>
57dii	<p><i>5 October 2023;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 57.</p>
57e	<p><i>You did not record discussing the option of having Patient R's LL5 extracted on:</i></p>
57ei	<p><i>3 October 2023;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 57.</p>
57eii	<p><i>5 October 2023</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 57.</p>
<b>Patient S</b>	
58	<p><i>You failed to provide an adequate standard of care to Patient S from 10 May 2022 to 22 November 2023, in that:</i></p>
58a	<p><i>During an appointment on 10 May 2022 you did not:</i></p>
58ai	<p><i>conduct an extra oral examination;</i> <b>Found proved</b></p> <p>The Committee had regard to the patient's dental records. There is no record of the examinations or assessments set out in charges 58a, 58b, 58c and 58d as having been carried out. The Committee accepts Dr Pal's opinion that these were not carried out. On the balance of probabilities, the Committee determined that these were not undertaken. Accordingly, it finds this charge proved.</p>
58aai	<p><i>conduct a BPE;</i> <b>Found Proved</b></p>

	This is for the same reasons as set out at charge 58ai above.
58aiii	<p><i>conduct a soft tissue examination;</i> <b>Found Proved</b></p> <p>This is for the same reasons as set out at charge 58ai above.</p>
58b	<p><i>During an appointment on 1 November 2022, you did not conduct an extra oral examination;</i> <b>Found Proved</b></p> <p>This is for the same reasons as set out at charge 58ai above.</p>
58c	<i>During an appointment on 16 May 2023 you did not:</i>
58ci	<p><i>conduct an extra oral examination;</i> <b>Found Proved</b></p> <p>This is for the same reasons as set out at charge 58ai above.</p>
58cii	<p><i>take a social history;</i> <b>Found Proved</b></p> <p>This is for the same reasons as set out at charge 58ai above.</p>
58d	<p><i>During an appointment on 7 November 2023 you did not take a social history;</i> <b>Found Proved</b></p> <p><i>For the same reasons as in 58ai.</i></p>
58e	<p><i>You did not undertake an adequate assessment of Patient S's UL1 crown and remaining tooth structure, between 18 May 2022 and 11 September 2023;</i> <b>Found Proved</b></p> <p>The Committee viewed Patient S's notes from 18 May 2022 to the 11 September 2023 and observed that he attended on seven separate occasions for the re-cementing of UL1 as follows: 18 May 2022, 19 May 2022, 11 January 2023, 11 July 2023, 12 July 2023, 7 September 2023 and 11 September 2023. The notes for 11 January 2023 recorded '<i>crown out recement</i>'. There are no additional dental records detailing any further assessments.</p> <p>Dr Pal's evidence was that there was no assessment of the UL1 crown or the remaining tooth between 18 May 2022 and 11 September 2023, despite the crown requiring re-cementation on a number of occasions during this time. The Committee accepts Dr Pal's evidence accordingly finds the charge proved.</p>
58f	<p><i>You did not undertake an adequate assessment of Patient S's UR1 crown and remaining tooth structure, on 17 May 2023 and/or 28 September 2023;</i> <b>Found Proved</b></p> <p>The Committee noted from Patient S's clinical notes that he had attended emergency appointments on three occasions: 15 June 2022, 19 December 2022, and 17 May 2023, for the UR1 crown that had come out. There are no additional notes or assessments regarding the UR1 other than the re-cementing of the crown and the cleaning off of the old cement.</p>

	<p>Dr Pal's evidence was there was no assessment of the UR1 crown or the remaining tooth during the appointments on 17 May 2023 and 28 September 2023, when the crown again came out. The Committee, having reviewed Patient S's notes, accepts Dr Pal's evidence and finds the charge proved.</p>
58g 58gi	<p><i>Between 15 June 2022 and 22 November 2023, you did not:</i> <i>provide an adequate treatment plan for Patient S's UL1 and/or UR1;</i> <b>Found Proved</b></p> <p>There are no treatment plans in the records for Patient S's UL1 and UR1. The Committee noted that the records indicate that on 11 September 2023, when the UL1 crown came out, Patient S was "<i>keen to discuss options</i>". Brief treatment options are documented, whereas previously, notes were recorded as crown-out, cleaned, and recemented.</p> <p>Dr Pal opined that given the number of times crowns at UR1 and UL1 required re-cementing between 10 May 2022 and 11 September 2023 (when extraction and a denture was advised) one would have expected a treatment plan formulated for these teeth in the event of further de-bonding by 15 June 2022. In Dr Pal's opinion no plan for the UL1 and/or UR1 is recorded. The Committee agrees with Dr Pal's evidence. Accordingly, the Committee finds this charge found proved.</p>
58gii	<p><i>discuss the risk and benefits of recementing Patient S's crown at their UL1;</i> <b>Found Proved</b></p> <p>The Committee noted that Patient S attended for the recementing of the UL1 crown on 5 separate appointments between 15 June 2022 and 22 November 2023. There is no record in the clinical notes of any discussion of the risks and benefits associated with recementing Patient S's UL1 crown at these appointments.</p> <p>The Committee accepts Dr Pal's opinion that "<i>it was necessary to discuss the options, benefits and risks for re-cementing the failed crowns</i>" and therefore finds this charge proved.</p>
58giii	<p><i>discuss the alternative treatment options to recementing Patient S's crown at their UL1;</i> <b>Found proved in part</b></p> <p>The Committee noted that at the 5 appointments between 15 June 2022 and 11 September 2023 where Patient S's UL1 crown was recemented, there is no record in the clinical notes of any discussion of alternative treatment options prior to Mr McLauchlan recementing the crown at each visit. However, on 11 September 2023 the clinical records show that Mr McLauchlan recorded a discussion of the alternative options as follows: "<i>pt keen to discuss options - xla/immed p/- or ref implant (has had previous quote for an implant LR5).....denture discussed/described</i>".</p> <p>The Committee accepted Dr Pal's opinion that "<i>Once it became apparent by 15.06.22 that the crowns at UR1 and UL1 were failing it was necessary to discuss the options, benefits and risks for re-cementing the failed crowns. There were no such discussions until 11.09.23 for UL1...</i>".</p> <p>Given these findings, the Committee is satisfied that for the period from 15 June 2022 to 11 September 2023 is proved.</p>

	<p>However, it is not satisfied that the allegation is proved for the period between 11 September 2023 and 22 November 2023.</p> <p>It therefore finds this allegation part proved.</p>
58giv	<p><i>discuss the risk and benefits of recementing Patient S's crown at their UR1;</i> <b>Found Proved</b></p> <p>This is for the same reasons as set out at Charge 58gi above.</p>
58gv	<p><i>discuss the alternative treatment options to recementing Patient S's crown at their UR1;</i> <b>Found Proved</b></p> <p>The Committee noted that Patient S attended for the recementing of the UR1 crown on 15 June 2022. There is no record in the clinical notes of any discussion of the risks and benefits associated with recementing Patient S's UR1 crown at this appointment.</p> <p>The Committee accepted Dr Pal's opinion that "<i>it was necessary to discuss the options, benefits and risks for re-cementing the failed crowns</i>" and therefore finds this charge proved.</p>
58h	<p><i>You did not report on bitewing radiographs taken on 1 November 2022;</i> <b>Found Proved</b></p> <p>The Committee reviewed Patient S's dental records and noted that bitewing radiographs were taken on 1 November 2022. However, the records do not include any findings associated with these radiographs, although justification for the taking of the radiograph is recorded for "<i>caries detection and bone assessment</i>". Dr Pal opined that for the bitewing radiograph taken on 1 November 2022 there is no radiographic report. The Committee accepts Dr Pal's evidence and therefore finds this charge proved.</p>
58i	<p><i>You did not diagnose caries found at Patient S's UR6, between 1 November 2022 and 29 November 2023;</i> <b>Found Proved</b></p> <p>The Committee notes the UR6 is not documented as having caries between 1 November 2022 and 29 November 2023. Dr Pal opined that the bitewing radiographs taken on 1 November 2022 showed caries at UR6. The Committee accepts Dr Pal's evidence on this point and accordingly finds this charge proved.</p>
58j	<p><i>You did not take a periapical radiograph covering Patient S's UL1 and/or UR1, between 10 May 2022 and 19 December 2022;</i> <b>Found Proved</b></p> <p>The Committee found that no periapical radiographs were taken for Patient's UL1 and UR1 between 10 May 2022 and 19 December 2022. Dr Pal noted that no periapical radiographs of UL1 and UR1 were obtained during this period, despite the crowns repeatedly failing and the planned replacement of UR1 on 19 December 2022. The Committee has accepted Dr Pal's evidence on this point and accordingly finds this charge proved.</p>

59	<p><i>By reason of you conduct in charge 58.g.ii. and/or 58.g.iii. you did not obtain Patient S's informed consent for the treatment provided to their UL1.</i></p> <p><b>Found Proved</b></p> <p>The Committee noted that Charge 58gii, concerning the failure to discuss the risks and benefits of recementing Patient S's UL1 crown, was proved in its entirety. The Committee found Charge 58giii, relating to the failure to discuss alternative treatment options to be proved for the period from 15 June 2022 to 11 September 2023, but not proved thereafter, when a discussion of alternative treatment options was documented.</p> <p>Taken together, these findings demonstrate that, for a substantial period during which treatment was provided to UL1, Mr McLauchlan did not provide Patient S with the information required to obtain valid informed consent. On that basis, the Committee determined that this charge is proved.</p>
60	<p><i>By reason of you conduct in charge 58.g.iv. and/or 58.g.v. you did not obtain Patient S's informed consent for the treatment provided to their UR1.</i></p> <p><b>Found Proved</b></p> <p>The Committee noted that Charge 58giv and Charge 58gv were found proved. In the absence of any recorded discussion of the risks, benefits, or alternative treatment options for UR1, the Committee is satisfied that Mr McLauchlan did not provide Patient S with the information required to obtain valid informed consent for the treatment carried out on UR1. The Committee therefore finds this charge is proved.</p>
61	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient S's appointments from 10 May 2022 to 22 November 2023, in that:</i></p>
61a	<p><i>In your record of 10 May 2022, you did not record:</i></p> <p><b>Found not proved</b></p> <p>The GDC's case that the record keeping failures (charge 61) are put in the alternative of finding charge 58 not proved. The Committee has found charge 58 proved. Accordingly, charge 61 is found not proved in its entirety.</p>
61ai	<p><i>an extra oral examination;</i></p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 61a.</p>
61aii	<p><i>a BPE;</i></p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 61a.</p>
61aiii	<p><i>a soft tissue examination;</i></p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 61a.</p>
61b	<p><i>In your record of 1 November 2023, you did not record an extra oral examination;</i></p> <p><b>Found not proved</b></p>

	This is for the same reasons as set out at charge 61a.
61c	<i>In your record of 16 May 2023, you did not record:</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 61a.
61ci	<i>an extra oral examination;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 61a.
61cii	<i>a social history;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 61a.
61d	<i>In your record of 7 November 2023, you did record a social history;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 61a.
61e	<i>You did record an assessment of Patient S's UL1 crown and remaining tooth structure between 18 May 2022 and 11 September 2023;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 61a.
61f	<i>You did not record an assessment of Patient S's UR1 crown and remaining tooth structure from 15 June 2022 to 28 September 2023</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 61a.
61g	<i>Between 15 June 2022 and 22 November 2023, you did not record:</i>
61gi	<i>an adequate treatment plan for Patient S's UL1 and/or UR1;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 61a.
61gii	<i>a discussion of the risk and benefits of recementing Patient S's crown at their UR1;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 61a.
61giii	<i>a discussion of the alternative treatment options to recementing Patient S's crown at their UR1;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 61a.
61h	<i>You did not record a discussion of the risk and benefits of recementing Patient S's crown at their UL1 between 15 June 2022 and 10 September 2023;</i>

	<p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 61a.</p>
61i	<p><i>You did not record a discussion of the alternative treatment options to recementing Patient S's crown at their UL1 between 15 June 2022 and 10 September 2023.</i></p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 61a.</p>
<b>Patient T</b>	
62	<p><i>You failed to provide an adequate standard of care to Patient T from 14 October 2022 to 27 September 2023, in that:</i></p>
62a	<p><i>During an appointment on 14 October 2022, you did not:</i></p>
62ai	<p><i>conduct an extra oral examination;</i></p> <p><b>Found proved</b></p> <p>The Committee had regard to the patient's dental records for the dates set out in the stem of charge 62. There is no record of these examinations or assessments having been carried out. The Committee accepted Dr Pal's expert opinion that these were not carried out. On the balance of probabilities, the Committee determined that these were not undertaken. Accordingly, it finds this charge proved.</p>
62aii	<p><i>take a social history;</i></p> <p><b>Found Proved</b></p> <p>This is for the same reasons as set out in Charge 62ai.</p>
62aiii	<p><i>conduct a BPE;</i></p> <p><b>Found Proved</b></p> <p>This is for the same reasons as set out in Charge 62ai.</p>
62b	<p><i>During an appointment on 26 May 2023, you did not:</i></p>
62bi	<p><i>conduct an extra oral examination;</i></p> <p><b>Found Proved</b></p> <p>This is for the same reasons as set out in Charge 62ai.</p>
62bii	<p><i>conduct a soft tissue examination;</i></p> <p><b>Found Proved</b></p> <p>This is for the same reasons as set out in Charge 62ai.</p>
62biii	<p><i>report on bitewing radiographs taken;</i></p> <p><b>Found proved</b></p> <p>The Committee notes for this appointment on 26 May 2023 that there is a record for the justification of the bitewings being taken but no report on them. Dr Pal observed that there was no report on them. The Committee agrees. Accordingly, it finds this charge proved.</p>
62c	<p><i>During an appointment on 27 September 2023, you did not:</i></p>

62ci	<p><i>take a periapical radiograph covering patient T's UL5, to assess its suitability for restoration;</i> <b>Found proved</b></p> <p>The Committee had regard to the clinical records and noted that a radiograph was not undertaken. Dr Pal's evidence was that when the UL5 filling required restoration on 27 September 2023, a periapical radiograph should have been taken of this tooth to assess restorability. The previous bitewing did not capture this tooth adequately. The Committee accepts Dr Pal's opinion and finds the charge proved.</p>
62cii	<p><i>discuss the risk and benefits of restoring Patient T's UL5;</i> <b>Found proved</b></p> <p>Dr Pal's evidence was that the UL5 had a broken filling on 27 September 2023 and a glass ionomer restoration was placed but the filling came out the following day.</p> <p>Dr Pal set out in his report that when the patient presented on 20 October 2023 with the filling having fallen out, Mr McLauchlan advised that there was very little tooth remaining and if there were any problems the tooth should be extracted. In Dr Pal's opinion, there was no record of options, benefits and risks of providing the filling at Patient T's UL5.</p> <p>The Committee considered the clinical records and Patient T's witness statement. It noted that there is nothing in Patient T's clinical records which indicates that the risks and benefits of restoring UL5 or alternative treatment options were discussed. In Patient T's witness statement, they stated, "<i>I have been asked whether the Registrant ever discussed the risks and benefits of treatment with me. I do not think he did.</i>"</p> <p>Therefore, based on the balance of probabilities, the Committee finds that it is more likely than not that these discussions did not take place and accordingly finds this charge proved.</p>
62ciii	<p><i>discuss the alternative treatment options for Patient T's UL5.</i> <b>Found proved</b></p> <p>This is for the same reasons as set out at Charge 62cii above.</p>
63	<p><i>By reason of your conduct in charge 62.c.i and/or 62.c.iii. you did not obtain Patient T's informed consent for the restoration at their UL5.</i> <b>Found proved</b></p> <p>The Committee considered both the clinical records and Patient T's witness statement. There are no documented records indicating that consent was gained for restoring UL5 . Patient T set out in their witness statement as follows: "<i>I have been asked whether I recall ever signing any consent forms. I cannot remember signing anything. I have been asked whether I ever recall giving oral consent to treatment. I do not think so. I would just go in, and the Registrant would say what needed to be done and then it was done.</i>"</p> <p>Dr Pal's evidence is that there is no record of options, benefits and risks of providing the filling at UL5. He set out as follows; "The patient's statement reports risks and benefits not being discussed for her treatments. If options, benefits and risks of</p>

	<p>providing the filling at UL5 were not discussed then informed consent for this treatment was not obtained. “</p> <p>The Committee has accepted the evidence of Patient T and that of Dr Pal. It is satisfied, based on the balance of probabilities, that it is more likely than not that these discussions did not take place and therefore informed consent was not obtained. The Committee finds this charge proved.</p>
64	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient T's appointments from 14 October 2022 to 27 September 2023, in that:</i> <b>Found not proved</b></p> <p>The GDC's case is that the record keeping failures (charge 64) are put in the alternative of finding the failures set out in charge 62 not proved. The Committee has found charge 62 proved. Accordingly, charge 64 is found not proved in its entirety.</p>
64a	<i>In your record of 14 October 2022, you did not record:</i>
64ai	<p><i>an extra oral examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at Charge 64.</p>
64aii	<p><i>a social history;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at Charge 64.</p>
64aiii	<p><i>a BPE;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at Charge 64.</p>
64b	<i>In your record of 26 May 2023, you did not record:</i>
64bi	<p><i>an extra oral examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at Charge 64.</p>
64bii	<p><i>a soft tissue examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at Charge 64.</p>
64c	<i>In your record of 27 September 2023, you did not record:</i>
64ci	<p><i>a discussion of the risk and benefits of restoring Patient T's UL5;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at Charge 64.</p>
64cii	<p><i>a discussion of the alternative treatment options for restoring their UL5 on 27 September 2023.</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at Charge 64.</p>

<b>Patient U</b>	
65	<i>You failed to provide an adequate standard of care to Patient U from 27 September 2022 to 7 August 2023, in that:</i>
65a	<i>During an appointment on 27 September 2022, you did not:</i>
65ai	<i>conduct an extra oral examination;</i> <b>Found proved</b>  The Committee had regard to the patient's dental records from 27 September 2022 to 7 August 2023. There is no record of these examinations or assessments having been carried out. The Committee accepted Dr Pal's opinion that these were not carried out. On the balance of probabilities, the Committee determined that these were not undertaken. Accordingly, it finds this charge proved.
65aii	<i>take a social history;</i> <b>Found Proved</b>  This is for the same reasons as set out in Charge 65ai.
65aiii	<i>conduct a BPE;</i> <b>Found Proved</b>  This is for the same reasons as set out in Charge 65ai.
65aiv	<i>adequately assess Patient U's UR8;</i> <b>Found Proved</b>  This is for the same reasons as set out in Charge 65ai.
65b	<i>You did not take a periapical radiograph covering Patient U's UL3, in advance of undertaking root canal treatment on 21 October 2022;</i> <b>Found Proved</b>  The Committee noted from the dental records that a periapical radiograph was not taken prior to the commencement of undertaking RCT on 21 October 2022. The Committee accepted Dr Pal's opinion that a periapical radiograph should have been taken to assess the UL3 before commencing RCT. The Committee accepts Dr Pal's evidence and accordingly finds this charge proved.
65c	<i>You took an inadequate post operative radiograph on 21 October 2022 in that it missed the apex of Patient U's UL3;</i> <b>Found Proved</b>  The Committee noted that the patient's records confirm that an adequate radiograph was not obtained as the post-operative radiograph taken of UL3 on 21 October 2022 shows that the apex was not visible. The Committee accepted Dr Pal's opinion that the post-operative radiograph was inadequate in that it failed to capture the apex of Patient U's UL3 and finds this charge proved.
65d	<i>You did not report on the radiograph taken on 21 October 2022;</i> <b>Found proved</b>  The Committee noted that there was no record of any report or interpretation of the radiograph taken on 21 October 2022. Dr Pal confirmed that no reporting had been

	<p>undertaken. Given the absence of any documented assessment, the Committee is satisfied that Mr McLauchlan did not report on the radiograph. Accordingly, it finds this charge proved.</p>
65e	<p><i>You did not take a periapical radiograph to assess Patient U's UL3 on 7 August 2023;</i> <b>Found proved</b></p> <p>The Committee noted from the clinical records that Patient U returned with pain from UL3 on 7 August 2023. There is no record of a radiograph of the UL3 being taken or any reference to one in the clinical records. Dr Pal's opinion was that a radiograph should have been taken to investigate the cause of the patient's symptoms. The Committee has accepted Dr Pal's opinion that a radiograph was indicated and not taken and therefore finds this charge proved.</p>
65f	<p><i>During an appointment on 28 October 2022, you did not:</i></p>
65fi	<p><i>adequately assess the suitability of Patient U's LR5 for a restoration;</i> <b>Found proved</b></p> <p>The Committee noted that the clinical records for 28 October 2022 show that the restoration procedure of LR5 was recorded but there is no evidence of an assessment of the suitability of Patient U's LR5 for the restoration. Dr Pal's opinion was that there was a failure to assess the LR5 adequately prior to its restoration at this appointment. The Committee agrees with Dr Pal and therefore finds this charge proved.</p>
65fii	<p><i>discuss the risk and benefits of restoring Patient U's LR5;</i> <b>Found proved</b></p> <p>The Committee observed that the clinical records contain no documentation of any discussion of the risks or benefits of restoring Patient U's LR5. While an entry indicates that consent was given, no detail is provided regarding the basis upon which consent was gained. Dr Pal confirmed that a discussion of risks and benefits should have taken place and were not carried out. In the absence of any evidence that such a discussion occurred, the Committee has concluded, on the balance of probabilities, that no discussions took place. The Committee therefore finds this charge proved.</p>
65fiii	<p><i>discuss alternative treatment options for restoring Patient U's LR5;</i> <b>Found proved</b></p> <p>The Committee observed that the clinical records contain no record of any discussion of alternative treatment options for restoring Patient U's LR5. Dr Pal's opinion was that the option of RCT or extraction should have been discussed and documented. Given the absence of any record of this discussion, the Committee is satisfied, on the balance of probabilities, that no discussions took place. The Committee therefore finds this charge proved.</p>
65fiv	<p><i>remove all caries from Patient U's LR5 before placing a filling on it;</i> <b>Found proved</b></p> <p>The Committee has accepted Dr Pal's expert opinion that a radiograph taken at a subsequent appointment on 18 November 2022 showed the presence of caries at Patient U's LR5. Having reviewed the records and given that the radiograph was taken less than a month after the placement of the restoration, the Committee</p>

	determined that it was more likely than not that all caries was not removed before the filling was placed on 28 October 2022 and finds this charge is proved.
65g	<i>During an appointment on 20 April 2023, you did not:</i>
65gi	<i>conduct an extra oral examination;</i> <b>Found proved</b>  The Committee had regard to the patient's dental records of 20 April 2023. There is no record of the examinations or assessments set out in charge 65g as having been carried out at that appointment. Dr Pal's opinion was that these were not carried out. On the balance of probabilities, the Committee determined that these were not undertaken. Accordingly, it finds this charge proved.
65gii	<i>conduct a BPE;</i> <b>Found proved</b>  This is for the same reasons set out at charge 65gi above.
65giii	<i>diagnose caries found at:</i>
65giii1	<i>the mesial surface of Patient U's LL3;</i> <b>Found proved</b>  The Committee noted that the clinical records for the appointment of 20 April 2023 contain no record of any diagnosis of caries at the mesial surface of Patient U's LL3. Dr Pal opined that caries would have been present, and would have been visible at this earlier date, given that caries was diagnosed at an emergency appointment on 1 June 2023. The Committee accepted Dr Pal's opinion that caries was likely to be present at this appointment and should have been diagnosed at this examination appointment and therefore finds this charge proved.
65giii2	<i>the buccal surface of Patient U's UL4</i> <b>Found proved</b>  The Committee noted that the clinical records for the appointment of 20 April 2023 contain no record of any diagnosis of caries at the mesial surface of Patient U's UL4. Dr Pal opined that caries would have been present, and would have been visible at this earlier date, given that caries was diagnosed at an emergency appointment on 1 June 2023. The Committee accepted Dr Pal's opinion that caries was likely to be present and should have been diagnosed at this examination appointment and therefore finds this charge proved.
65h	<i>You did not diagnose caries found at Patient U's LL1 on:</i>
65hi	<i>20 April 2023;</i> <b>Found proved</b>  The Committee noted that the clinical records for 20 April 2023 contain no entry indicating that caries at Patient U's LL1 was identified or diagnosed. Dr Pal's opinion was that caries would have been present at this appointment given that the LL1 was this was later treated with a composite filling on 26 July 2023. The Committee accepted Dr Pal's evidence that caries was likely to have been present and should have been diagnosed at this examination appointment and therefore finds this charge proved.

65hii	<p><i>1 June 2023;</i> <b>Found proved</b></p> <p>The Committee noted that the clinical records for an emergency visit on 1 June 2023 contain no entry indicating that caries at Patient U's LL1 was identified or diagnosed. Dr Pal's opinion was that caries would have been present at this appointment given that it was this was later treated with a composite filling on 26 July 2023. The Committee accepted Dr Pal's evidence that caries was likely to be present and should have been diagnosed at this appointment and therefore finds this charge proved.</p>
65hiii	<p><i>2 June 2023</i> <b>Found proved</b></p> <p>The Committee noted that the clinical records for an emergency visit on 2 June 2023 contain no entry indicating that caries at Patient U's LL1 was identified or diagnosed. Dr Pal's opinion was that caries would have been present at this appointment given that it was this was later treated with a composite filling on 26 July 2023. The Committee accepted Dr Pal's evidence that caries was likely to be present and should have been diagnosed at this appointment and therefore finds this charge proved.</p>
65hiv	<p><i>16 June 2023</i> <b>Found proved</b></p> <p>Dr Pal's opinion was that caries would have been present at this appointment given that it was this was later treated with a composite filling on 26 July 2023. The Committee noted that the clinical records for an emergency visit on 16 June 2023 contain no entry indicating that caries at Patient U's LL1 was identified or diagnosed. The Committee accepted Dr Pal's evidence that caries was likely to be present and should have been diagnosed at this appointment and therefore finds this charge proved.</p>
65i	<p><i>During an appointment on 24 July 2023, you did not:</i></p>
65ii	<p><i>assess whether Patient U's LL1 was tender to percussion;</i> <b>Found proved</b></p> <p>The Committee noted that the clinical records for the appointment on 24 July 2023 contain no entry indicating that Mr McLauchlan assessed whether Patient U's LL1 was tender to percussion, although Mr McLauchlan had made a record of "<i>possible swelling?</i>".</p> <p>The Committee accepted Dr Pal's opinion that this assessment should have been undertaken and documented given that a possible swelling had been recorded in the notes. In the absence of any record that this assessment occurred, the Committee is satisfied that the assessment was not carried out and finds this charge is proved.</p>
65iii	<p><i>take a radiograph covering Patient U's LL1;</i> <b>Found proved</b></p> <p>The Committee observed that the clinical records for 24 July 2023 contain no radiograph of Patient U's LL1. The Committee accepted Dr Pal's evidence that a radiograph should have been taken at this appointment to assess Patient U's LL1.</p>

	Given the absence of any radiographic record the Committee determined that no radiograph was taken and finds this charge proved.
65j	<i>You provided a poor standard of restoration treatment at Patient U's LL1 (in that it was insufficiently retentive) on:</i>
65ji	<p>26 July 2023; <b>Found proved</b></p> <p>The Committee noted from the clinical records that the restoration placed at Patient U's LL1 on 26 July 2023 subsequently failed, with the patient returning on 17 August 2023 because the filling had fallen out. The clinical records confirm the loss of the restoration and subsequently, a further restoration was placed. Dr Pal considered that the restoration placed on 26 July 2023 was poorly executed given its failure shortly after it had taken place. The Committee accepts Dr Pal's evidence and is satisfied that the restoration provided on this date was of a poor standard. Accordingly, the Committee finds this charge proved.</p>
65jii	<p>17 August 2023; <b>Found proved</b></p> <p>The Committee noted from the clinical records that the restoration placed on 17 August 2023 failed the following day, 18 August 2023. Dr Pal's opinion was that this restoration was poorly executed given its failure. The Committee has accepted Dr Pal's evidence and is satisfied that the restoration provided on this date was of a poor standard. Accordingly, the Committee finds this charge proved.</p>
65jiii	<p>18 August 2023; <b>Found proved</b></p> <p>The Committee noted from the clinical records that the restoration placed on 18 August 2023 failed as the patient returned on 25 August 2023 and another restoration on LL1 was placed. The Committee accepted Dr Pal's opinion that this restoration was poorly executed given its failure. Accordingly, the Committee finds this charge proved.</p>
65k	<i>During an appointment on 29 September 2023, you did not:</i>
65ki	<p><i>report on a radiograph taken on 29 September 2023;</i> <b>Found proved</b></p> <p>The Committee noted that there was no record of any report or interpretation of the radiograph taken on 29 September 2023. Dr Pal confirmed that no reporting had been undertaken. Given the absence of any documented report on the radiograph, the Committee finds this charge proved.</p>
65kii	<p><i>diagnose and/or plan to treat periapical radiolucency found at Patient U's LL1;</i> <b>Found proved</b></p> <p>Dr Pal's evidence was that the radiograph taken on 29 September 2023 showed the presence of periapical radiolucency at LL1 which was not diagnosed. The Committee, having regard to the dental records and radiograph taken on 29 September 2023, notes there is no diagnosis recorded for the LL1 nor any plans for any treatment of the LL1. It therefore finds this charge proved.</p>

65l	<p><i>You did not diagnose and/or plan to treat caries found at Patient U's LR2 on 4 October 2023;</i> <b>Found proved</b></p> <p>The Committee noted that a post-operative radiograph was taken on 4 October 2023; however, the clinical records contain no report of diagnosis or plan to treat caries at Patient U's LR2. Dr Pal's opinion that there was failure to diagnose and treat the caries present at LR2 from a post operative radiograph taken on 4 October 2023. The Committee accepted Dr Pal's opinion. It therefore finds this charge proved.</p>
65m 65mi	<p><i>You prescribed antibiotics without first attempting local drainage on;</i> <i>17 October 2022;</i> <b>Found proved</b></p> <p>The Committee noted that the clinical records for 17 October 2022 contain no evidence that local drainage was offered or attempted prior to prescribing antibiotics. Dr Pal's evidence was that this approach did not follow accepted clinical guidance, namely "Antimicrobial Prescribing in Dentistry", which requires local measures in this situation to be attempted before systemic antibiotics are prescribed. In the absence of any recording of local drainage, the Committee is satisfied that Mr McLauchlan prescribed antibiotics without first attempting local drainage and finds this charge is proved.</p>
65mii	<p><i>7 August 2023;</i> <b>Found proved</b></p> <p>The clinical records for 7 August 2023 contain no evidence that local drainage was offered or attempted prior to prescribing antibiotics. Dr Pal again maintained that this approach did not follow accepted clinical guidance, which requires local measures in this situation to be attempted before systemic antibiotics are prescribed. In the absence of any recording of local drainage, the Committee is satisfied that that Mr McLauchlan prescribed antibiotics without first attempting local drainage and finds this charge is proved.</p>
65miii	<p><i>21 September 2023.</i> <b>Found proved</b></p> <p>The Committee noted that the clinical records for 21 September 2023 contain no evidence that local drainage was offered or attempted prior to prescribing antibiotics. Dr Pal set out in his report that this approach did not follow accepted clinical guidance, which requires local measures in this situation to be attempted before systemic antibiotics are prescribed. In the absence of any recording of local drainage, the Committee is satisfied that Mr McLauchlan prescribed antibiotics without first attempting local drainage and finds this charge is proved.</p>
66	<p><i>By reason of you conduct in charge 65.f.ii. and/or 65.f.iii. you did not obtain Patient U's informed consent for the restoration at their LR5.</i> <b>Found proved</b></p> <p>The Committee had regard to its findings in charges 65.f.ii and 65.f.iii, namely that Mr McLauchlan did not discuss the risks, benefits, or alternative treatment options relating to the proposed restoration of Patient U's LR5. The Committee accepted Dr Pal's evidence that such discussions were required to obtain valid informed consent. In the absence of any record of consent, and given the findings in charges 65.f.ii and</p>

	65.f.iii, the Committee is satisfied that informed consent for the restoration was not obtained and finds this charge proved.
67	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient U's appointments from 27 September 2022 to 7 August 2023, in that:</i> <b>Found not proved</b></p> <p>The GDC's case that the record keeping failures (charge 67) are put in the alternative of finding charge 65 not proved. The Committee has found charge 65 proved. It therefore follows that charge 67 is found not proved in its entirety.</p>
67a	<i>In your record of 27 September 2022, you did not record:</i>
67ai	<p><i>an extra oral examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 67 above.</p>
67aia	<p><i>a social history; a BPE;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 67 above.</p>
67aiaa	<p><i>an assessment of Patient U's UR8;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 67 above.</p>
67b	<i>In your record of 20 April 2023, you did not record:</i>
67bi	<p><i>an extra oral examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 67 above.</p>
67bia	<p><i>a BPE;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 67 above.</p>
67c	<i>In your record of 28 October 2022, you did not record:</i>
67ci	<p><i>a discussion of the risk and benefits of restoring Patient U's LR5;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 67 above.</p>
67cib	<p><i>a discussion of alternative treatment options for restoring Patient U's LR5;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 67 above.</p>
67d	<p><i>You did not record whether Patient U's LL1 was tender to percussion on 24 July 2023;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 67 above.</p>

67e	<p><i>You did not record an adequate justification for the prescription of antibiotic on: 17 October 2022; 7 August 2023; 21 September 2023.</i></p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 67 above.</p>
<b>Patient V</b>	
68	<p><i>You failed to provide an adequate standard of care to Patient V from 2 August 2022 to 14 August 2023, in that:</i></p>
68a	<p><i>During an appointment on 2 August 2022, you did not:</i></p>
68ai	<p><i>conduct an extra oral examination;</i></p> <p><b>Found proved</b></p> <p>The Committee had regard to the patient's dental records. There is no record of the examinations or assessments set out in charge 68a as having been carried out on 2 August 2022. The Committee accepted Dr Pal's expert opinion that these were not carried out. On the balance of probabilities, the Committee determined that these were not undertaken. Accordingly, it finds this charge proved.</p>
68aai	<p><i>take a social history;</i></p> <p><b>Found Proved</b></p> <p>This is for the same reasons as set out in Charge 68ai.</p>
68aiii	<p><i>conduct a BPE;</i></p> <p><b>Found Proved</b></p> <p>This is for the same reasons as set out in Charge 68ai.</p>
68aiv	<p><i>adequately report on bitewing radiographs taken</i></p> <p><b>Found proved</b></p> <p>The Committee noted that the bitewing radiographs were taken on 2 August 2022, where Mr McLauchlan has recorded '<i>caries detection = LL5DO/LL7DO and bone assessment</i>'. Dr Pal's evidence was that bitewing radiographs were taken and caries was diagnosed at the LL5 and the LL7. He further opined that caries could also be seen as a radiolucent area at UL5, which was not reported on. The Committee accepts the opinion of Dr Pal and finds this charge proved.</p>
68av	<p><i>diagnose and or manage caries found at Patient V's UL5</i></p> <p><b>Found proved</b></p> <p>Dr Pal asserts that '<i>Failing to diagnose and manage caries at UL5 on 02.08.22 was far below the standard expected.</i>' As caries was not diagnosed, it was subsequently not treated and or/ managed. The Committee accepts Dr Pal's evidence and finds this charge proved.</p>
68b	<p><i>In advance of proving a filling at Patient V's LL7 on 4 August 2022, you did not:</i></p>
68bi	<p><i>assess whether Patient V's LL7 was tender to percussion;</i></p> <p><b>Found proved</b></p>

	<p>According to the records, Mr McLauchlan has completed a LL7 DO amalgam filling. However, there is no documentation indicating that a TTP test was performed. Dr Pal's evidence was that <i>'The LL7 had a crown provided previously and the caries found on 02.08.22 was under the distal crown margin. Given the location of the caries, there was a reasonable risk that the tooth may have been non-vital and had a periapical infection which may have required RCT. A reasonably competent dentist would have carried out TTP testing and taken a periapical radiograph. These tests were not done'</i></p> <p>The Committee accepts the opinion of Dr Pal and finds the charge proved.</p>
68bii	<p><i>take a periapical radiograph covering Patient V's LL7;</i> <b>Found proved</b></p> <p>There is no record of a periapical radiograph having been undertaken covering LL7. Dr Pal's opinion regarding the periapical radiograph is as stated at charge 68bi.</p> <p>The Committee finds this charge proved.</p>
68biii	<p><i>discuss the risks of restoring Patient V's LL7;</i> <b>Found proved</b></p> <p>The records showed no documentation of the risks and benefits being given to Patient V regarding the restoration of the LL7. The Committee had regard to Patient V's witness statement in which they state: <i>'The Registrant would say mostly what the benefits of treatment would be and why he would recommend a particular treatment. I believe we discussed a crown, composite or amalgam filling in relation to the benefits of one over another depending on the tooth to be filled.'</i></p> <p>In the Committee's judgement, notwithstanding Patient V's evidence that a discussion took place, there was no mention in Patient V's statement of the risks involved in restoring the LL7. Accordingly, it finds this charge proved.</p>
68c	<p>During an appointment on 9 February 2023, you did not:</p>
68ci	<p><i>conduct an extra oral examination;</i> <b>Found proved</b></p> <p>The Committee had regard to Patient V's dental records. There is no record of the examinations or assessments set out in charge 68ci as having been carried out. The Committee accepted Dr Pal's expert opinion that these were not carried out. On the balance of probabilities, the Committee determined that these were not undertaken. Accordingly, it finds this charge proved.</p>
68cii	<p><i>conduct a BPE;</i> <b>Found Proved</b></p> <p>This is for the same reasons as set out in Charge 68ci.</p>
68d	<p><i>During an appointment on 14 August 2023, you did not conduct a BPE</i> <b>Found Proved</b></p> <p>Mr McLauchlan states in the records that <i>"BPE/soft tissue charting done"</i>. There is no record of a BPE chart within Patient V's records on 14 August 2023, despite it being reported as completed. Therefore, the Committee finds this charge proved.</p>

69	<p><i>By reason of you conduct in charge 68.b.ii. and/or 68.b.iii. you did not obtain Patient V's informed consent for the restoration at their LL7.</i></p> <p><b>Found Proved</b></p> <p>There is nothing in the records to indicate there was any discussion of options, benefits and risks in respect of the restoration at their LL7. Patient V set out in their witness statement on the matter of consent as follows: ' I do not remember ever signing any consent forms, but that is not to say I did not do it. I have been asked whether I ever gave oral consent to treatment. If the Registrant suggested treatment to me, I would have just said that is fine.'</p> <p>Dr Pal's evidence was that if there was no discussion of options, benefits and risks of restoring the LL7 then informed consent was not obtained.</p> <p>In light of its findings as set out at charge 68.b.ii. and 68.b.iii above, the Committee finds this charge proved.</p>
70	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient V's appointments from 2 August 2022 to 14 August 2023, in that:</i></p> <p><b>Found not proved</b></p> <p>The GDC's case that the record keeping failures (charge 70) are put in the alternative of finding charge 68 not proved. The Committee has found charge 68 proved. Accordingly, charge 70 is found not proved in its entirety.</p>
70a	<p><i>In your record of 2 August 2022, you did not record:</i></p>
70ai	<p>an extra oral examination;</p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 70.</p>
70aii	<p>a social history;</p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 70.</p>
70aiii	<p>a BPE;</p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 70.</p>
70b	<p><i>In your record of 4 August 2022 you did not record:</i></p>
70bi	<p>whether Patient V's LL7 was tender to percussion;</p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 70.</p>
70bii	<p>discussing the risks of restoring Patient V's LL7;</p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 70.</p>
70biii	<p>discussing alternative treatment options for restoring Patient V's LL7;</p>

	<b>Found not proved</b>
	This is for the same reasons as set out at charge 70
70c	<i>In your record of 9 February 2023, you did not record:</i>
70ci	<i>an extra oral examination;</i> <b>Found not proved</b>
	This is for the same reasons as set out at charge 70
70cii	<i>a BPE;</i> <b>Found not proved</b>
70d	<i>In your record of 14 August 2023, you did not record a BPE.</i> <b>Found not proved</b>
	This is for the same reasons as set out at charge 70
<b>Patient W</b>	
71	<i>You failed to provide an adequate standard of care to Patient W from 13 July 2022 to 1 November 2023, in that:</i>
71a	<i>During an appointment on 13 July 2022, you did not conduct:</i>
71ai	<i>an extra oral examination;</i> <b>Found proved</b>
	The Committee had regard to the patient's dental records. There is no record of these examinations or assessments having been carried out. The Committee accepted Dr Pal's opinion that these were not carried out. On the balance of probabilities, the Committee determined that these were not undertaken. Accordingly, it finds this charge proved.
71aii	<i>a BPE</i> <b>Found Proved</b>
	This is for the same reasons as in charge 71ai.
71b	<i>During an appointment on 19 January 2023, you did not:</i>
71bi	<i>conduct an extra oral examination;</i> <b>Found Proved</b>
	This is for the same reasons as in charge 71ai.
71bii	<i>take a social history;</i> <b>Found Proved</b>
	This is for the same reasons as in charge 71ai.
71biii	<i>conduct a BPE;</i> <b>Found Proved</b>
	This is for the same reasons as in charge 71ai.
71c	<i>You did not take a periapical radiograph in advance of providing a crown at Patient W's LL7 on:</i>
71ci	<i>21 April 2023;</i> <b>Found Proved</b>

	<p>The Committee noted that the clinical records for 21 April 2023 contain no evidence that a periapical radiograph was taken at this visit after failure of the re-cementation of the crown at Patient W's LL7. The Committee accepted Dr Pal's opinion that although a radiograph of the tooth taken on 26 August 2022 was available, another was clinically indicated at this appointment and should have been taken to assess the tooth underlying the crown. In the absence of any record that such a radiograph was obtained, the Committee is satisfied that it was not taken and finds this charge proved.</p>
71cii	<p><i>25 April 2023;</i> <b>Found Proved</b></p> <p>The Committee noted that the clinical records for 25 April 2023 also contains no evidence that a periapical radiograph was taken at the crown preparation visit. The Committee accepted Dr Pal's opinion that a radiograph was clinically indicated at this appointment and should have been taken to assess the underlying tooth.</p> <p>In the absence of any record that such a radiograph was obtained, the Committee is satisfied that it was not taken and finds this charge proved.</p>
71d	<p><i>During an appointment on 9 May 2023 you:</i></p>
71di	<p><i>failed to adequately assess the suitability of Patient W's LL7 for a crown;</i> <b>Found Proved</b></p> <p>The Committee noted that the clinical records of the crown fitting appointment on 9 May 2023 contain no evidence of any assessment of the suitability of Patient W's LL7 for crown placement. Dr Pal's evidence was that " <i>it is my opinion that it is more likely than not that the Registrant failed to undertake a proper assessment of the LL7 and its suitability for a crown</i>".</p> <p>In the absence of any record that such an assessment occurred, the Committee is satisfied that the tooth's suitability for a crown was not adequately assessed. It has accepted Dr Pal's evidence and finds this charge proved.</p>
71dii	<p><i>provided a poor standard of crown treatment to Patient W's LL7;</i> <b>Found Proved</b></p> <p>The Committee observed that the clinical records indicate that the crown provided at Patient W's LL7 subsequently failed on 23 October 2023, 24 October 2023 and 1 November 2023. The Committee considered Dr Pal's opinion that the treatment was poorly executed and that repeated failures of the crown support this conclusion.</p> <p>On the balance of probabilities, the Committee finds that the crown treatment provided on this date was of a poor standard and finds this charge proved.</p>
71diii	<p><i>did not discuss the risks and benefits of placing a crown at Patient W's LL7 in advance of doing so;</i> <b>Found proved</b></p> <p>The Committee noted that the clinical records do not contain any documentation of any discussion of the risks or benefits associated with placing a crown at Patient W's LL7. Dr Pal's opinion was that such a discussion was required to obtain valid informed consent. In the absence of any record that these matters were addressed,</p>

	<p>the Committee is satisfied that the risks and benefits were not discussed and finds this charge is proved.</p>
71div	<p><i>did not discuss the alternative treatment options for Patient W's LL7 in advance of providing a crown on 9 May 2023;</i> <b>Found proved</b></p> <p>The Committee observed that the clinical records contain no evidence of any discussion of alternative treatment options prior to providing the crown at Patient W's LL7. Dr Pal's opinion was that alternative options should have been discussed and documented. In the absence of any such record, the Committee determined that alternative treatment options were not presented to the patient and finds this charge is proved.</p>
71e	<p><i>During an appointment on 12 September 2023, you did not take a social history;</i> <b>Found proved</b></p> <p>The Committee had regard to the patient's dental records. There is no record of a social history being taken. The Committee accepted Dr Pal's opinion that these were not carried out. On the balance of probabilities, the Committee determined that these were not undertaken. Accordingly, it finds this charge proved.</p>
71f	<p><i>You did not discuss the risks and benefits of recementing Patient W's LL7 crown in advance of doing so on:</i></p>
71fi	<p><i>23 October 2023</i> <b>Found proved</b></p> <p>The Committee noted that the clinical records for 23 October 2023 contain no documentation of any discussion of the risks or benefits associated with recementing Patient W's LL7 crown. The Committee accepted Dr Pal's opinion that a discussion regarding the risks and benefits of re-cementation was required at this appointment. In the absence of any record that these matters were addressed, the Committee is satisfied that it is likely that risks and benefits were not discussed and finds this charge proved.</p>
71fii	<p><i>24 October 2023;</i> <b>Found proved</b></p> <p>The Committee noted that the clinical records for 24 October 2023 contain no documentation of any discussion of the risks or benefits associated with re-cementing Patient W's LL7 crown. The Committee accepted Dr Pal's opinion that a discussion regarding the risks and benefits of re-cementation was required at this appointment. In the absence of any record that these matters were addressed, the Committee is satisfied that it is likely that risks and benefits were not discussed and finds this charge proved.</p>
71fiii	<p><i>1 November 2023;</i> <b>Found proved</b></p> <p>The Committee noted that the clinical records for 1 November 2023 do not contain documentation of any discussion of the risks or benefits associated with recementing Patient W's LL7 crown. The Committee accepted Dr Pal's opinion that a discussion regarding the risks and benefits of re-cementation was required at this appointment. In the absence of any record that these matters were addressed, the Committee is</p>

	satisfied that it is likely that risks and benefits were not discussed and finds this charge proved.
71g	<i>You did not discuss alternative treatment options for recementing Patient W's LL7 crown in advance of doing so on:</i>
71gi	<p>23 October 2023; <b>Found proved</b></p> <p>The Committee noted that the clinical records for 23 October 2023 do not contain documentation of any discussion of the alternative treatment options to recementing Patient W's LL7 crown. The Committee accepted Dr Pal's opinion that such a discussion about options was required at this appointment. In the absence of any record that these matters were addressed, the Committee is satisfied that it is likely that alternative treatment options were not discussed and finds this charge proved.</p>
71gii	<p>24 October 2023; <b>Found proved</b></p> <p>The Committee noted that the clinical records for 24 October 2023 do not contain documentation of any discussion of the alternative treatment options to recementing Patient W's LL7 crown. The Committee accepted Dr Pal's opinion that such a discussion about options was required at this appointment. In the absence of any record that these matters were addressed, the Committee is satisfied that it is likely that alternative treatment options were not discussed and finds this charge proved.</p>
71giii	<p>1 November 2023; <b>Found proved</b></p> <p>The Committee noted that the clinical records for 1 November 2023 contain no documentation of any discussion of the alternative treatment options to recementing Patient W's LL7 crown. The Committee accepted Dr Pal's opinion that such a discussion about options was required at this appointment. In the absence of any record that these matters were addressed, the Committee is satisfied that it is likely that alternative treatment options were not discussed and finds this charge proved.</p>
72	<p><i>By reason of your conduct in charge 71.d.iii. and/or 71.d.iv. you did not obtain Patient W's informed consent for crown placed at their LL7.</i> <b>Found proved</b></p> <p>The Committee had regard to its findings in charges 71.d.iii and 71.d.iv, namely that Mr McLauchlan did not discuss the risks, benefits, or alternative treatment options associated with placing a crown at Patient W's LL7. It accepted Dr Pal's opinion that without these discussions, the patient could not have been provided with sufficient information to give informed consent. Considering these findings, the Committee is satisfied that informed consent for the crown placement was not obtained and finds this charge proved.</p>
73	<p><i>By reason of you conduct in charge 71.f.i.-iii. and/or 71.g.i.-iii. you did not obtain Patient W's informed consent for recementing the crown placed at their LL7.</i> <b>Found proved</b></p> <p>The Committee had regard to its findings in charges 71.f.i-iii and 71.g.i-iii, which established that Mr McLauchlan did not discuss the risks, benefits, or alternative treatment options associated with re-cementing a crown at Patient W's LL7. It</p>

	accepted Dr Pal's opinion that without these discussions, the patient could not have been provided with sufficient information to give informed consent. Considering these findings, the Committee is satisfied that informed consent for each re-cementation was not obtained and finds this charge proved.
74	<i>You failed to maintain an adequate standard of record keeping in respect of Patient W's appointments from 13 July 2022 to 1 November 2023, in that:</i> <b>Found not proved</b>  The GDC's case is that the record keeping failures (charge 74) are put in the alternative of finding the failures set out in charge 71 not proved. The Committee has found charge 71 proved. Accordingly, charge 74 is found not proved in its entirety. .
74a	<i>In your record of 13 July 2022, you did not record:</i>
74ai	<i>an extra oral examination;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 74.
74aii	<i>a BPE;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 74.
74b	<i>In your record of 19 January 2023, you did not record:</i>
74bi	<i>an extra oral examination;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 74.
74bii	<i>a social history;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 74.
74biii	<i>a BPE</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 74.
74c	<i>in your record of 9 May 2023, you did not record:</i>
74ci	<i>discussing the risks and benefits of placing a crown at Patient V's LL7;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 74.
74cii	<i>discussing the alternative treatment options for Patient W's LL7;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 74.
74d	<i>In your record of 12 September 2023, you did not record a social history;</i> <b>Found not proved</b>

	This is for the same reasons as set out at charge 74.
74e	<i>You did not record discussing the risks and benefits of recementing Patient W's LL7 crown in advance of doing so on:</i>
74ei	23 October 2023; <b>Found not proved</b>
	This is for the same reasons as set out at charge 74.
74eii	24 October 2023; <b>Found not proved</b>
	This is for the same reasons as set out at charge 74.
74eiii	1 November 2023; <b>Found not proved</b>
	This is for the same reasons as set out at charge 74.
74f	<i>You did not record discussing alternative treatment options for recementing Patient W's LL7 crown in advance of doing so on:</i>
74fi	23 October 2023; <b>Found not proved</b>
	This is for the same reasons as set out at charge 74.
74fii	24 October 2023; <b>Found not proved</b>
	This is for the same reasons as set out at charge 74.
74fiii	1 November 2023. <b>Found not proved</b>
	This is for the same reasons as set out at charge 74.
<b>Patient X</b>	
75	<i>You failed to provide an adequate standard of care to Patient X from 28 November 2022 to 5 September 2023, in that:</i>
75a	<i>During an appointment on 28 November 2022, you did not:</i>
75ai	<i>conduct an extra oral examination;</i> <b>Found proved</b>
	The Committee had regard to Patient X's dental records. There is no record of these assessments and examinations being carried out. The Committee accepted Dr Pal's expert opinion that these were not carried out. On the balance of probabilities, the Committee determined that these were not undertaken. Accordingly, it finds this charge proved.
75aai	<i>conduct a soft tissue examination;</i> <b>Found Proved</b>

	This is for the same reasons as set out in Charge 75ai.
75aiii	(charge 75aiii was removed)
75aiv	<p><i>report on bitewing radiographs taken;</i> <b>Found Proved</b></p> <p>The Committee assessed the dental record and noted that bitewing radiographs were taken on 28 November 2023, and the records stated, '<i>caries detection and bone assessment</i>'. However, there is no accompanying radiographic report. Dr Pal opined that bitewing radiographs were taken on 28 November 2023 but no radiographic report was present. The Committee accepts Dr Pal's evidence and therefore finds the charge proved.</p>
75av	<p><i>diagnose and/or arrange to treat caries found at the distal surface of Patient X's LR6;</i> <b>Found Proved</b></p> <p>Upon reviewing the notes, the Committee noted in point 75aiv that there was a failure to report on the bitewing radiographs, as well as the omission of a record of caries on the distal surface of LR6 beneath the crown margin. In the Committee's view, this resulted in a missed diagnosis and lack of subsequent treatment for LR6.</p> <p>Dr Pal's evidence was that caries at LR6 distal surface under the crown margin was present and not diagnosed. His opinion was that there was a failure to manage caries at LR6 and that management would have been to replace the crown or extraction. In Dr Pal's opinion there was a failure to advise the patient of the presence of caries at LR6 and to offer options, benefits and risks of treatment to LR6.</p> <p>The Committee has accepted Dr Pal's evidence on this point and accordingly finds this charge proved.</p>
75avi	<p><i>inform Patient X caries was present at their LR6 on 28 November 2022;</i> <b>Found proved</b></p> <p>This is for the same reasons as set out in Charge 75av.</p>
75b	<p><i>You did not assess tooth-ware between 28 November 2022 and 5 September 2023.</i> <b>Found Proved</b></p> <p>The Committee assessed the records and found no documentation of tooth wear between 28 November 2022 and 5 September 2023. Dr Pal states that there is no record that Mr McLauchlan assessed tooth wear at any time between the referred dates. Accordingly, the Committee finds the charge proved.</p>
76	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient X's appointments from 28 November 2022 to 5 September 2023, in that:</i> <b>Found not proved</b></p> <p>The GDC's case is that the record keeping failures (charge 76) are put in the alternative of finding the failures set out in charge 75 not proved. The Committee has found charge 75 proved. Accordingly, charge 76 is found not proved, save for charge 76c, which is found proved.</p>
76a	<i>In your record of 28 November 2022, you did not record:</i>

76ai	<p><i>an extra oral examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at Charge 76.</p>
76aii	<p><i>a soft tissue examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at Charge 76.</p>
76aiii	<p><i>a BPE;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at Charge 76.</p>
76aiv	<p><i>a discussion about caries found at their LR6;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at Charge 76.</p>
76b	<p><i>You did not record an assessment of toothware between 28 November 2022 and 5 September 2023;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at Charge 76.</p>
76c	<p><i>You did not record your reason for restoring their UR2 on 15 June 2023.</i> <b>Found proved</b></p> <p>The Committee having reviewed the records on the 15 June 2023 note that the documentation is recorded as '<i>UR2M, Anterior composite</i>'. However, there is no additional record for the reasons for restoring the UR2.</p> <p>Dr Pal's opinion was that there was a failure to record the reason for UR2 to require a composite filling. The Committee agrees with Dr Pal's evidence on this matter and accordingly finds this charge proved.</p>
<b>Patient Y</b>	
77	<p><i>You failed to provide an adequate standard of care to Patient Y from 22 June 2022 to 15 March 2023, in that:</i></p>
77a	<p><i>During an appointment on 22 June 2022, you did not:</i></p>
77ai	<p><i>conduct an extra oral examination;</i> <b>Found proved</b></p> <p>The Committee had regard to the patient's dental records. There is no record of these assessments and examinations being carried out on 22 June 2022. The Committee accepted Dr Pal's opinion that these were not carried out. On the balance of probabilities, the Committee determined that these were not undertaken. Accordingly, it finds this charge proved.</p>
77aii	<p><i>conduct a soft tissue examination;</i> <b>Found Proved</b></p>

	This is for the same reasons as set out in Charge 77ai.
77aiii	<p><i>conduct a BPE;</i> <b>Found Proved</b></p> <p>This is for the same reasons as set out in Charge 77ai.</p>
77b	<p><i>During an appointment on 13 January 2023 and/or 26 January 2023, you did not conduct a BPE;</i> <b>Found Proved</b></p> <p>This is for the same reasons as set out in Charge 77ai but in relation to the appointments set out in charge 77b.</p>
77c	(charge 77c was removed)
77d	<p><i>You did not diagnose and/or manage Patient Y's chronic periodontitis between 22 June 2022 and 18 September 2023;</i> <b>Found Proved</b></p> <p>Dr Pal's evidence is that the hygienist recorded BPEs of Code 3 in all sextants on 1 August 2022 and 2 March 2023 which indicated chronic periodontitis. He further set out that Mr McLauchlan only recorded a BPE on 18 September 2023. In Dr Pal's opinion, Mr McLauchlan should have undertaken BPEs on 22 June 2022 and on 13 January 2023 or 26 January 2023. Dr Pal noted that radiographs available show the presence of bone loss and taken with the BPE records, suggest the presence of chronic periodontitis. He opined that there was no indication that Mr McLauchlan diagnosed chronic periodontitis.</p> <p>The Committee, having reviewed the records, notes there is no record of a diagnosis of chronic periodontitis and accordingly finds that Mr McLauchlan did not manage the diagnosis, even though it was documented by the Hygienist. The Committee therefore finds this charge proved.</p>
77e	<i>During an appointment on 15 March 2023, you:</i>
77ei	<p><i>did not take a periapical radiograph covering Patient Y's UR2 in advance of providing crown treatment;</i> <b>Found proved</b></p> <p>The Committee on reviewing the records notes that a periapical radiograph covering Patient's Y's UR2 had not been taken in advance of providing crown treatment on 15 March 2023.</p> <p>Dr Pal's opinion is that no periapical radiograph was taken prior to the provision of the crown and that one should have been taken. The Committee has accepted Dr Pal's evidence and accordingly finds this charge proved.</p>
77eii	<p><i>did not adequately assess the suitability of Patient Y's UR2 for a crown in advance of providing crown treatment;</i> <b>Found proved</b></p> <p>On reviewing the clinical records, the Committee notes that there is no documentation that Patient Y's UR2 was assessed for suitability for a crown.</p>

	<p>Dr Pal stated that the crown required re-cementing on 2 May 2023, 13 June 2023, 18 September 2023, 17 October 2023 and finally on 23 October 2023 when it was decided to extract the tooth and provide a denture. Dr Pal's evidence was that given the number of the times the crown required re-cementing it is more likely than not that the UR2 was inadequately assessed for the suitability of a crown.</p> <p>The Committee has accepted Dr Pal's opinion on this matter and finds the charge proved.</p>
77eiii	<p><i>did not discuss the risk and benefits of placing a crown at Patient Y's UR2 in advance of providing this treatment;</i> <b>Found proved</b></p> <p>The Committee considered both the clinical records and Patient Y's witness statement. It noted from the clinical records that there are no documented records indicating that risk and benefits were discussed prior to placing a crown at UR2. Patient Y confirmed in his witness statement as follows " <i>I have been asked whether the Registrant ever discussed risks and benefits of treatments with me. He did not do this.</i>"</p> <p>In light of Patient Y's evidence, as well as the evidence of Dr Pal, the Committee has concluded, on the balance probabilities, that a discussion on risks and benefits of placing the crown at the UR2 did not take place. The Committee therefore finds this charge proved.</p>
77eiv	<p><i>provided a poor standard of crown treatment at Patient Y's UR2 on 15 March 2023;</i> <b>Found proved</b></p> <p>Dr Pal's opinion is that it is more likely than not that the UR2 was inadequately assessed for crown treatment and that the crown provided was substandard. The Committee notes that the crown is documented as coming out multiple times. This was also confirmed by Patient Y in their witness statement in which they stated: <i>'I was in the Practice and the Registrant, and I decided that I would get a crown. After a couple of appointments, the crown was fitted and it fell out about 2 days later. I went back to the Practice, and the Registrant fitted it again, bearing in mind I live about 40 minutes away. Around the fourth time the crown was fitted I went back home and it fell out again. This all happened in the space of about two weeks.'</i></p> <p>The Committee has accepted Dr Pal's evidence and accordingly finds this charge proved.</p>
78	<p><i>By reason of your conduct in charge 77.e.iii you did not obtain Patient Y's informed consent for the crown at their UR2.</i> <b>Found proved</b></p> <p>In reaching its decision, the Committee has had regard to Patient Y's clinical records as well as her witness statement in which she states "<i>I have been asked whether I recall signing any consent forms. I do not really recall. Between May 2022 and November 2023, however, I never signed anything.</i>"</p> <p>The Committee accordingly finds this charge proved.</p>

79	<i>You failed to maintain an adequate standard of record keeping in respect of Patient Y's appointments from 22 June 2022 to 15 March 2023, in that:</i>
79a	<i>In your record of 22 June 2022, you did not record:</i> <b>Found not proved</b>  The GDC's case is that the record keeping failures (charge 79) are put in the alternative of finding the failures set out in charge 77 not proved. The Committee has found charge 77 proved. Accordingly, charge 79 is found not proved in its entirety.
79ai	<i>an extra oral examination;</i> <b>Found not proved</b>  This is for the same reasons set out at charge 79a above.
79aii	<i>a soft tissue examination;</i> <b>Found not proved</b>  This is for the same reasons set out at charge 79a above.
79aiii	<i>a BPE;</i> <b>Found not proved</b>  This is for the same reasons set out at charge 79a above.
79b	<i>In your record of 13 January 2023 and/or 26 January 2023 you did not record a BPE;</i> <b>Found not proved</b>  This is for the same reasons set out at charge 79a above.
79c	<i>You did not record a diagnosis of chronic periodontitis between 22 June 2022 and 18 September 2023;</i> <b>Found not proved</b>  This is for the same reasons set out at charge 79a above.
79d	<i>You did not record an adequate assessment of the suitability of UR2 for a crown in advance of providing crown treatment on 15 March 2023.</i> <b>Found not proved</b>  This is for the same reasons set out at charge 79a above.
<b>Patient Z</b>	
80	<i>You failed to provide an adequate standard of care to Patient Z from 30 August 2022 to 1 February 2023, in that:</i>
80a	<i>During an appointment on 30 August 2022, you did not:</i>
80ai	<i>conduct an extra oral examination;</i> <b>Found proved</b>  The Committee had regard to the patient's dental records. There is no record of these assessments and examinations being carried out on 30 August 2022 and 1 February 2023. The Committee accepted Dr Pal's expert opinion that these were not carried out at these two appointments. On the balance of probabilities, the

	Committee determined that these were not undertaken. Accordingly, it finds this charge proved.
80aai	<i>conduct a BPE</i> <b>Found Proved</b>  This is for the same reasons as set out in Charge 80ai
80b	<i>During an appointment on 1 February 2023, you did not:</i>
80bi	<i>conduct an extra oral examination</i> <b>Found Proved</b>  This is for the same reasons as set out in Charge 80ai
80bii	<i>conduct a BPE;</i> <b>Found Proved</b>  This is for the same reasons as set out in Charge 80ai
81	<i>You failed to maintain an adequate standard of record keeping in respect of Patient Z's appointments from 30 August 2022 to 1 February 2023, in that:</i> <b>Found not proved</b>  The GDC's case is that the record keeping failures (charge 81) are put in the alternative of finding the failures set out in charge 80 not proved. The Committee has found charge 80 proved. Accordingly, charge 81 is found not proved in its entirety.
81a	<i>In your record of 30 August 2022, you did not record:</i>
81ai	<i>an extra oral examination;</i> <b>Found not proved</b>  This is for the same reasons as set out at Charge 81.
81aai	<i>a BPE;</i> <b>Found not proved</b>  This is for the same reasons as set out at Charge 81.
81b	<i>In your record of 1 February you did not record:</i> <b>Found not proved</b>  This is for the same reasons as set out at Charge 81.
81bi	<i>an extra oral examination;</i> <b>Found not proved</b>  This is for the same reasons as set out at Charge 81.
81bii	<i>a BPE.</i> <b>Found not proved</b>  This is for the same reasons as set out at Charge 81.
<b>Patient AA</b>	

82	<i>You failed to provide an adequate standard of care to Patient AA on 11 May 2022, in that:</i>
82a	<i>You did not take a medical history update.</i> <b>Found proved</b>  The Committee had regard to the patient's dental records. There is no record of a medical history update being taken on 11 May 2022. The Committee accepted Dr Pal's expert opinion that this was not carried out. On the balance of probabilities, the Committee determined that this was not undertaken. Accordingly, it finds this charge proved.
83	<i>You failed to maintain an adequate standard of record keeping in respect of Patient AA's appointment on 11 May 2022, in that:</i>
83a	<i>You did not record</i>
83ai	<i>a medical history update;</i> <b>Found not proved</b>  The GDC has put charge 83(ai) in the alternative to charge 82. The Committee has found charge 82 proved and therefore finds charge 83 (ai) not proved.
83aii	<i>a dental history;</i> <b>Found proved</b>  The Committee notes that Patient AA had attended as an emergency appointment on 11 May 2022. Mr McLauchlan had recorded the patient complaining of (C/O) 'toothache sensitivity upper right 5 next to extraction site-advised sensitive toothpaste'. The Committee considered that this documentation was insufficient to identify the cause of the pain. Additionally, there is a limited dental history recorded, making it unclear what is causing the pain.  Dr Pal states that although no diagnosis of the toothache was recorded, it can be assumed this was due to gum recession adjacent to the extraction site. The committee accepts Dr Pal's opinion and finds this charge proved.
83aiii	<i>clinical observations leading to a diagnosis and the care provided</i> <b>Found proved</b>  The Committee notes there are no clinical records of observations of UR5, only what is stated in 83aii. Therefore, the committee finds this charge proved.
<b>Patient BB</b>	
84	<i>You failed to provide an adequate standard of care to Patient BB from 19 May 2022 to 24 November 2023, in that:</i>
84a	<i>During an appointment on 19 May 2022, you did not:</i>
84ai	<i>conduct an extra oral examination;</i> <b>Found proved</b>  The Committee had regard to the patient's dental records and observed there is no record that Mr McLauchlan carried out an extra-oral examination during the appointment on 19 May 2022.

	<p>Dr Pal's evidence was that this examination, alongside a soft tissue examination and BPEs were indicated. It was Dr Pal's opinion that these examinations were neither undertaken nor recorded. The Committee accepts Dr Pal's evidence. It is satisfied, on the balance of probabilities, that an extra-oral examination was not conducted and finds this charge proved.</p>
84aii	<p><i>conduct a soft tissue examination;</i> <b>Found proved</b></p> <p>This is for the same reasons as set out at charge 84ai above.</p>
84aiii	<p><i>conduct a BPE;</i> <b>Found proved</b></p> <p>This is for the same reasons as set out at charge 84ai above</p>
84b	<p><i>During an appointment on 12 May 2023, you did not:</i></p>
84bi	<p><i>conduct an extra oral examination;</i> <b>Found proved</b></p> <p>The Committee had regard to the patient's dental records and observed there is no record that Mr McLauchlan carried out an extra-oral examination during the appointment on 12 May 2023.</p> <p>Dr Pal's evidence was that this examination, alongside a soft tissue were indicated. It was Dr Pal's opinion that these examinations were neither undertaken nor recorded. The Committee accepts Dr Pal's evidence. It is satisfied, on the balance of probabilities, that an extra-oral examination and/or a soft tissue examination were not conducted and finds this charge proved.</p>
84bii	<p><i>conduct a soft tissue examination;</i> <b>Found proved</b></p> <p>This is for the same reasons as set out at charge 84bi above.</p>
84c	<p><i>During an appointment on 18 May 2023 you:</i></p>
84ci	<p><i>placed a filling at Patient BB's LL3 and/or LR1 and/or/ LR2 without first removing all of the caries present;</i> <b>Found proved</b></p> <p>The Committee noted from the dental records of the appointment on 18 May 2023 that Mr McLauchlan placed restorations at Patient BB's LL3, LR1 and LR2.</p> <p>Dr Pal's opinion was that the radiographic evidence of caries only five months later indicated that caries was likely to have been left when the restorations were provided. The Committee has accepted Dr Pal's evidence. It is satisfied that the restorations were more likely than not to have been placed without complete removal of caries and therefore finds this charge proved.</p>
84d	<p><i>You failed to diagnose and/or treat caries found at Patient BB's LL2 on:</i></p>
84di	<p><i>12 May 2023;</i> <b>Found proved</b></p> <p>The Committee noted from the dental records of the appointment on 12 May 2023 that there is no record of a finding of dental caries at LL2.</p>

	<p>Dr Pal's opinion was that there was caries present at LL2 on the radiograph of 11 October 2023 and that this should have been detected clinically on 12 May 2023. He opined that Mr McLauchlan missed the opportunity to diagnose and treat the caries. The Committee accepts Dr Pal's opinion and finds this charge proved.</p>
84dii	<p><i>18 May 2023;</i> <b>Found proved</b></p> <p>The Committee noted from the dental records of the appointment on 18 May 2023 that there is also no record of a finding of dental caries at LL2. The Committee accepted Dr Pal's opinion that there is caries present at LL2 on the radiograph of 11 October 2023 and that this should have been detected clinically on 18 May 2023. As the further opportunity to diagnose and treat the caries was missed, the Committee is satisfied that Mr McLauchlan failed to do so and finds this charge is proved.</p>
84e	<p><i>You did not conduct sufficient investigations of Patient BB's pain on:</i></p>
84ei	<p><i>16 October 2023;</i> <b>Found proved</b></p> <p>The Committee had regard to the dental records for an emergency appointment on 16 October 2023 where the records show that Patient BB reported toothache after antibiotics had been prescribed by another dentist on 11 October 2023. It noted that Mr McLauchlan recorded the presence of caries in the LR2, LR1, LL2 and LL3 on that day but there is no record of any investigation into the cause of Patient BB's pain. The Committee accepted Dr Pal's opinion that no diagnostic tests such as TTP were undertaken to identify the source of the pain and that these were indicated. Considering these findings, the Committee is satisfied that insufficient investigations of Patient BB's pain were carried out and therefore finds this charge proved.</p>
84eii	<p><i>23 October 2023;</i> <b>Found proved</b></p> <p>The Committee had regard to the dental records for a subsequent treatment appointment on 23 October 2023 for a procedure at UR4. However, the Committee noted there is no record of any investigations into the cause of Patient BB's pain that had presented at the previous appointment of 16 October 2023.</p> <p>The Committee accepted Dr Pal's opinion that no diagnostic tests such as TTP were undertaken to identify the source of the pain at this appointment and that these were indicated. In light of Dr Pal's evidence as well as the patient's dental records, the Committee is satisfied that insufficient investigations of Patient BB's pain were carried out and therefore finds this charge proved.</p>
84f	<p><i>During an appointment on 16 October 2023, you:</i></p>
84fi	<p><i>did not identify the cause of Patient BB's pain;</i> <b>Found proved</b></p> <p>The Committee noted that the dental records of 16 October 2023 show no recording of the cause of Patient BB's pain or a record of a diagnosis. The Committee accepted Dr Pal's opinion that no diagnosis was made. Considering these findings, and the findings at Charge 84ei, namely that the pain was not adequately investigated at that appointment, the Committee is satisfied that this charge is proved.</p>

84fii	<p><i>prescribed amoxicillin without identifying the cause of Patient BB's pain and without attempting measures to drain the infection first;</i> <b>Found proved</b></p> <p>The clinical records for this appointment show that amoxicillin was prescribed by Mr McLauchlan. The records do not show any justification of the use of antibiotics or give any reference to drainage of the infection. The Committee accepted Dr Pal's opinion that antibiotics were prescribed without identifying the cause of the pain and without attempting measures to drain the infection. The Committee is therefore satisfied that amoxicillin was prescribed by Mr McLauchlan without a clear cause of Patient BB's pain being established and therefore finds this charge proved.</p>
84g 84gi	<p><i>During an appointment on 23 October 2023, you:</i> <i>incorrectly advised Patient BB that their LR1, LR2, LL2 and LL3 all had a poor prognosis;</i> <b>Found proved</b></p> <p>The Committee noted that the dental records for the appointment on 23 October 2023 recorded caries at LR2, LR1, LL2 and LL3. The record further stated that these teeth had a poor prognosis and should be "<i>left as is until t/ment necessary.</i>"</p> <p>Dr Pal, having considered the radiograph taken on 11 October 2023, opined that LR1 and LL2 had a reasonable prospect of being restored and that LR2 also might be restorable depending on the clinical situation. Having accepted the expert opinion, the Committee has concluded that Mr McLauchlan incorrectly advised the patient that these teeth had a poor prognosis. Therefore the Committee finds this charge is proved.</p>
84gii	<p><i>did not offer treatment options for the management of LR2 and/or LR1 and/or LL2 and/or LL3</i> <b>Found proved</b></p> <p>The Committee had regard to the dental notes of the appointment of 23 October 2023 and notes that there is no record of any treatment options given to Patient BB for the management of LR2, LR1, LL2 and LL3. The clinical notes recorded caries at these teeth and advised a poor prognosis with a plan to "<i>left as is until t/ment necessary</i>"</p> <p>The Committee agrees with Dr Pal's opinion that options were not offered for the management of LR2, LR1, LL2 and LL3. The Committee is therefore satisfied that Mr McLauchlan failed to offer appropriate treatment options for these teeth and finds this charge proved.</p>
84h	<p><i>During an appointment on 24 November 2023, you did not conduct a BPE</i> <b>Found proved</b></p> <p>Dr Pal's evidence was that there was a failure to record a BPE for this appointment. The Committee notes that there is a record that Mr McLauchlan has done a BPE but there is no record of the scores. In light of the absence of a score, the Committee finds this charge proved.</p>
85	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient BB's appointments from 19 May 2022 to 24 November 2023, in that:</i> <b>Found not proved</b></p>

	<p>The GDC's case that the record keeping failures (charge 85) are put in the alternative of finding charge 84 not proved. The Committee has found charge 84 proved. Accordingly, saved for charge 85b, the remaining parts of charge 85 are found not proved.</p>
85a	<p><i>In your record of 19 May 2022, you did not record:</i></p>
85ai	<p><i>an extra oral examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 85.</p>
85aai	<p><i>a soft tissue examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 85.</p>
85aiii	<p><i>a BPE;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 85.</p>
85b	<p><i>In your record of 14 July 2022, you did not record your clinical justification for filling Patient BB's UL5, UL7 and UR6;</i> <b>Found proved</b></p> <p>Dr Pal's evidence was that "there was a failure to record..... Clinical justification for fillings at UL5, UL7 and UR6 on 14.07.22. "</p> <p>The Committee, having reviewed Patient BB's records, agrees with Dr Pal. Accordingly, it finds this charge proved.</p>
85c	<p><i>In your record of 12 May 2023, you did not record:</i></p>
85ci	<p><i>an extra oral examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 85.</p>
85cii	<p><i>a soft tissue examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 85.</p>
85d	<p><i>In your record of 23 October 2023 you did not record discussing treatment options for the management of their LR2 and/or LR1 and/or LL2 and/or LL3;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 85.</p>
85e	<p><i>In your record of 16 October 2023 and/or 23 October 2023, you did not record the cause of Patient BB's pain;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 85.</p>

85f	<p><i>In your record of 24 November 2023, you did not record a BPE.</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 85.</p>
<b>Patient CC</b>	
86	<p><i>You failed to provide an adequate standard of care to Patient CC on 13 November 2023, in that:</i></p>
86a	<p><i>You did not:</i></p>
86ai	<p><i>conduct an extra oral examination;</i> <b>Found proved</b></p> <p>The Committee notes from Patient CC's dental records that there is no record of the assessments/examinations/ providing advice/instruction on 13 November 2023 as set out in charge 86a being carried out. The Committee accepted Dr Pal's opinion that these were not carried out. Accordingly, it finds this charge proved.</p>
86aii	<p><i>conduct a soft tissue examination;</i> <b>Found Proved</b></p> <p>This is for the same reasons as at Charge 86ai.</p>
86aiii	<p><i>conduct a BPE;</i> <b>Found Proved</b></p> <p>This is for the same reasons as at Charge 86ai.</p>
86aiv	<p><i>provide oral health instruction;</i> <b>Found Proved</b></p> <p>This is for the same reasons as at Charge 86ai.</p>
86av	<p><i>provide dietary advice.</i> <b>Found Proved</b></p> <p>This is for the same reasons as at Charge 86ai.</p>
87	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient CC's appointment on 13 November, in that:</i> <b>Found not proved</b></p> <p>The GDC's case is that the record keeping failures (charge 87) are put in the alternative of finding the failures set out in charge 86 not proved. The Committee has found charge 86 proved. Accordingly, charge 87 is found not proved in its entirety.</p>
87a	<p><i>You did not record:</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 87 above.</p>
87ai	<p><i>an extra oral examination;</i> <b>Found not proved</b></p>

	This is for the same reasons as set out at charge 87 above.
87aii	<i>a soft tissue examination;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 87 above.
87aiii	<i>a BPE;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 87 above.
87aiv	<i>providing oral health instruction;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 87 above.
87av	<i>providing dietary advice;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 87 above.
<b>Patient DD</b>	
88	<i>You failed to provide an adequate standard of care to Patient DD on 9 August 2023, in that:</i>
88a	<i>You failed to detect mesial caries found at Patient DD's UR2 on 9 August 2023</i> <b>Found proved</b>  The Committee, having reviewed Patient DD's records for 9 August 2023, noted that there is no reference to caries on the UR2.  On 25 October 2023, Patient DD attended an appointment with the hygienist, where the following was recorded: " <i>needs fill ur 2 m and ur6m , ref dent, pt made aware</i> ".  Dr Pal's opinion is that on 25 October 2023 the hygienist found mesial caries at UR2 which Mr McLauchlan provided a filling to on 3 November 2023. In Dr Pal's opinion, it was likely that caries at UR2 was detectable clinically on 9 August 2023. The Committee has accepted Dr Pal's evidence on this point and accordingly finds this charge proved.
<b>Patient EE</b>	
89	<i>You failed to provide an adequate standard of care to Patient EE on 29 August 2023 in that you did not take a social history.</i> <b>Found proved</b>  Dr Pal noted from Patient EE's clinical records that a full mouth examination was undertaken on 29 August 2023, that the medical history was updated, and an extra-oral and soft tissue examinations were undertaken. Dr Pal further noted that no social history is recorded and considered that one should have been taken. The Committee agrees with Dr Pal's opinion, It is satisfied, on the balance of probabilities, that a social history was not undertaken. The Committee therefore finds the charge is proved.

90	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient EE's appointment on 28 August 2023, in that you did not record taking a social history.</i></p> <p><b>Found not proved</b></p> <p>The GDC's case is that the record keeping failure (charge 90) is put in the alternative of finding the failure set out in charge 89 not proved. The Committee has found charge 89 proved. Accordingly, charge 90 is found not proved.</p>
<b>Patient FF</b>	
91	<p><i>You failed to provide an adequate standard of care to Patient FF from 3 August 2022 to 4 October 2023, in that:</i></p>
91a	<p><i>During an appointment on 3 August 2022, you did not:</i></p>
91ai	<p><i>conduct an extra oral examination;</i></p> <p><b>Found proved</b></p> <p>The Committee had regard to the patient's dental records. There is no record of these assessments and examinations being carried out. The Committee accepted Dr Pal's expert opinion that these were not carried out. On the balance of probabilities, the Committee determined that these were not undertaken. Accordingly, it finds this charge proved.</p>
91aii	<p><i>take a social history;</i></p> <p><b>Found Proved</b></p> <p>This is for the same reasons as set out in Charge 91ai above.</p>
91aiii	<p><i>adequately report on bitewing radiographs taken;</i></p> <p><b>Found proved</b></p> <p>On reviewing Patient FF's dental records, the Committee noted that Mr McLauchlan's radiographic report states '<i>caries detection = UR3D/LL7L</i>'. However, there is no record of a caries diagnosis of UL5, based on this evidence, the radiographs were inadequately reported on.</p> <p>Dr Pal's evidence was that bitewing radiographs were taken on 03 August 2022 which show caries at UL5 (distal surface). The caries at the UL5 was not reported on, although caries at UR3 was reported. Given that there is no record of a diagnosis of caries of UL5, the Committee is satisfied that the bitewings were inadequately reported on. Accordingly, it finds this charge proved.</p>
91aiv	<p><i>diagnose and/or treat caries found at Patient FF's UL5;</i></p> <p><b>Found proved</b></p> <p>As stated at charge 91aiii above, as the caries on UL5 was not diagnosed and therefore not documented, the Committee has concluded that treatment to the UL5 was not undertaken. Dr Pal's opinion was that there was a failure on 3 August 2022 to diagnose and treat caries at UL5. The Committee agrees with Dr Pal's opinion and accordingly finds this charge proved.</p>
91b	<p><i>During an appointment on 17 August 2022, you provided a poor standard of restoration at Patient FF's UR3, in that it had a poor seal;</i></p> <p><b>Found proved</b></p>

	<p>The Committee noted that Mr McLauchlan completed a filling on UR3 and documented "<i>caries removed distal.</i>" Dr Pal considered that the composite restoration provided at UR3, which can also be seen in the radiograph, had a poor seal. The Committee, having reviewed the radiograph, has accepted Dr Pal's evidence on this point. Accordingly the Committee finds this charge proved.</p>
91c	<p><i>During an appointment on 6 February 2023, you did not:</i></p>
91ci	<p><i>take a social history;</i></p> <p><b>Found proved</b></p> <p>The Committee had regard to the patient's dental records. There is no record of these assessments and examinations being carried out at the appointments on 6 February 2023 and 28 September 2023. The Committee accepted Dr Pal's opinion that these were not carried out at these two appointments. Accordingly, it finds this charge proved.</p>
91cii	<p><i>conduct a BPE;</i></p> <p><b>Found Proved</b></p> <p>This is for the same reason as set out at Charge 91ci above.</p>
91d	<p><i>During an appointment on 28 September 2023, you did not take a social history;</i></p> <p><b>Found Proved</b></p> <p>This is for the same reason as set out at Charge 91ci above.</p>
91e	<p><i>During an appointment on 4 October 2023, you:</i></p>
91ei	<p><i>filled Patient FF's UR6 without first removing all of the caries present;</i></p> <p><b>Found Proved</b></p> <p>The Committee reviewed Patient FF's dental record and noted that two fillings were performed on 4 October 2023. The procedures documented were as follows: "<i>UR6 Distal Occlusal (DO), using molar amalgam with caries removed, and UR4 DO, using premolar amalgam with caries removed</i>".</p> <p>On 9 October 2023, the patient returned to see another dentist because one of the fillings had fallen out. The patient stated in her report that she would be leaving for Australia in one month.</p> <p>Dr Pal noted that a periapical radiograph revealed deep distal caries at UR6 with a periapical radiolucency, as well as caries present around the filling at UR4. The quality of the fillings provided on 4 October 2023, was deemed poor and significantly below the expected standard, as the caries at these teeth were left untreated, carrying the risk of further pain and infection.</p> <p>The Committee concluded that the caries was not fully removed before the UR4 and UR6 fillings were applied, agreeing with Dr Pal's assessment of the situation. Therefore, the Committee finds this charge to be proven.</p>
91eii	<p><i>filled Patient FF's UR4 without first removing all of the caries present;</i></p> <p><b>Found Proved</b></p> <p>This is for the same reasons as set out at charge 91ei above.</p>

91eiii	<p><i>did not: check whether Patient FF's UR6 was tender to percussion;</i> <b>Found Proved</b></p> <p>The Committee noted that there is no record that Mr McLauchlan checked the UR6 for TTP. Dr Pal reported that on 4 October 2023, there was a failure to adequately assess the UR6 by TTP testing and/or a radiograph. In his opinion, given the extent of caries, it would have been obvious to a reasonably competent practitioner, when undertaking this filling, that the prognosis of the UR6 would be poor and that there was a risk of the patient suffering pain and infection if further treatment, such as extraction, was not undertaken. In Dr Pal's opinion, this amounted to a failure to adequately assess the UR6. The Committee has accepted Dr Pal's evidence on this point and accordingly finds this charge proved.</p>
91eiv	<p><i>take a periapical radiograph covering Patient FF's UR6.</i> <b>Found Proved</b></p> <p>The Committee notes there is no record of a periapical radiograph having been taken of the UR6. Dr Pal's evidence is that Mr McLauglan failed to adequately assess the UR6. The Committee accepts Dr Pal's evidence and in the absence of a radiograph to assess Patient FF's UR6, it finds the charge proved.</p>
92	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient FF's appointments from 3 August 2022 to 4 October 2023, in that:</i> <b>Found not proved</b></p> <p>The GDC's case is that the record keeping failures (charge 92) are put in the alternative of finding the failures set out in charge 91 not proved. The Committee has found charge 92 proved. Accordingly, charge 92 is found not proved in its entirety.</p>
92a	In your record of 3 August 2022, you did not record:
92ai	<p><i>an extra oral examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 92 above.</p>
92aai	<p><i>a social history;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 92 above.</p>
92aiii	<p><i>a diagnosis of caries found at Patient FF's UL5;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 92 above.</p>
92b	<p><i>In your record of 6 February 2023, you did not record:</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 92 above.</p>
92bi	<p><i>a social history;</i> <b>Found not proved</b></p>

	This is for the same reasons as set out at charge 92 above.
92bii	<i>a BPE;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 92 above.
92c	<i>In your record of 28 September 2023, you did not record a social history;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 92 above.
92d	<i>You did not record whether Patient FF's UR6 was tender to percussion on 4 October 2023</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 92 above.
<b>Patient GG</b>	
93	<i>You failed to provide an adequate standard of care to Patient GG from 8 June 2022 to 9 June 2023, in that:</i>
93a	<i>During an appointment on 8 June 2022, you did not:</i>
93ai	<i>conduct an extra oral examination;</i> <b>Found proved</b>  The Committee had regard to the patient's dental records. There is no record of these assessments and examinations being carried out on 8 June 2022. The Committee accepted Dr Pal's opinion that these were not carried out. On the balance of probabilities, the Committee determined that these were not undertaken. Accordingly, it finds this charge proved.
93aii	<i>conduct a soft tissue examination;</i> <b>Found Proved</b>  This is for the same reasons as set out at charge 93ai above.
93aiii	<i>conduct an assessment of Patient GG's oral health;</i> <b>Found Proved</b>  This is for the same reasons as set out at charge 93ai above.
93aiv	<i>diagnose and/or treat caries found at Patient GG's UR1 and/or UL1;</i> <b>Found Proved</b>  Upon reviewing the records, the Committee noted that an examination was conducted on 6 June 2022. The only clinical note recorded during this examination was ' <i>co nil</i> '. Additionally, the Committee observed that the hygienist treated Patient FF on 20 June 2022, and made a note of ' <i>ref dent, root caries upper centrals, fill out 46</i> '.  Dr Pal opined that the hygienist assessed Patient GG on 20 June 2022, and appeared to have identified caries on the labial surfaces of the upper right central

	<p>incisor (UR1) and upper left central incisor (UL1). This occurred 12 days after the patient had last attended an examination with the registrant on 8 June 2022. The registrant failed to recognise and plan treatment for the caries on UR1 and UL1 during the examination. Therefore, the Committee accepts Dr Pal's evidence that caries on the Patient GG's UR1 and UL1 were diagnosed and subsequently untreated. Accordingly, the Committee finds this charge proved.</p>
93b	<p><i>During an appointment on 20 December 2022, you did not conduct an extra oral examination</i> <b>Found Proved</b></p> <p>The Committee on the balance of probabilities concludes that Mr McLauchlan did not conduct an extra oral examination on 20 December 2022 as the dental notes showed no record of this having been undertaken. Dr Pal's opinion was that there was a failure to carry out an extra oral examination. The Committee accepts Dr Pal's opinion and accordingly finds this charge proved.</p>
93c	<p><i>You did not report on bitewing radiographs taken on:</i></p>
93ci	<p><i>20 September 2022;</i> <b>Found Proved</b></p> <p>The Committee viewed Patient GG's notes and observed that the records showed no radiographic report on the bitewing radiographs that were taken.</p> <p>Dr Pal's evidence was that there were no reports on any of the radiographs taken at this appointment, or on 9 June 2023. The Committee accepts Dr Pal's evidence and accordingly finds this charge proved.</p>
93cii	<p><i>9 June 2023;</i> <b>Found Proved</b></p> <p>This is for the same reasons as set out at charge 93ci above.</p>
93d	<p><i>You did not diagnose and/or treat caries found at Patient GG's UR7 on:</i></p>
93di	<p><i>20 December 2022;</i> <b>Found Proved</b></p> <p>The Committee reviewed the records and noted that Mr McLauchlan recorded Patient GG's '<i>c/o URQ sensitive, ULQ feel a slight gap</i>'. However, there is no mention of a caries diagnosis and therefore no subsequent treatment of UR7.</p> <p>Dr Pal's opinion is that caries at UR7 would have been identifiable clinically on 20 December 2022 when the patient presented with sensitivity. He further opined that the subsequent right bitewing radiograph taken on 9 June 2023 shows deep caries on the UR7 into the pulp. The Committee has accepted Dr Pal's evidence on this point and accordingly finds this charge proved.</p>
93dii	<p><i>9 June 2023</i> <b>Found proved</b></p> <p>The Committee reviewed the records and noted that there is no record of caries in relation to the UR7. Dr Pal's opinion was that caries should have been diagnosed on that day. The Committee agrees and accordingly finds this charge proved.</p>

93e	<p><i>During an appointment on 9 June 2023, you did not take an adequate BPE.</i> <b>Found proved</b></p> <p>The Committee noted that Mr McLauchlin made a record of a BPE having been carried out. However, the Committee viewed the records and noted that a BPE score was not recorded. Dr Pal states that the notes say that a BPE was carried out on 9 June 2023, but there are no records of a BPE score on any of the examination dates. The Committee accepts Dr Pal's evidence and accordingly it finds this charge proved.</p>
94	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient GG's appointments from 8 June 2022 to 9 June 2023, in that:</i> <b>Found not proved</b></p> <p>The GDC's case is that the record keeping failures (charge 94) are put in the alternative of finding the failures set out in charge 93 not proved. The Committee has found charge 93 proved. Accordingly, charge 94 is found not proved in its entirety.</p>
94a	<p><i>In your record of 8 June 2022, you did not record:</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at Charge 94.</p>
94ai	<p><i>an extra oral examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at Charge 94.</p>
94aai	<p><i>a soft tissue examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 94.</p>
94aiii	<p><i>an assessment of Patient GG's oral health;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 94.</p>
94aiv	<p><i>a diagnosis of caries found at Patient GG's UR1 and/or UL1;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 94.</p>
94b	<p><i>In your record of 20 October 2022, you did not record an extra oral examination;</i> <b>Found not proved</b></p> <p><i>This is for the same reasons as set out at charge 94.</i></p>
94c	<p><i>In your record of 9 June 2023, you did not record an adequate BPE.</i> <b>Found not proved</b></p> <p><i>This is for the same reasons as set out at charge 94.</i></p>
94d	<p><i>You did not record a diagnosis of caries found at Patient GG's UR7 on:</i></p>

94di	<p><i>20 December 2022;</i> <b>Found not proved</b></p> <p><i>This is for the same reasons as set out at charge 94.</i></p>
94dii	<p><i>9 June 2023.</i> <b>Found not proved</b></p> <p><i>This is for the same reasons as set out at charge 94.</i></p>
<b>Patient HH</b>	
95	<p><i>You failed to provide an adequate standard of care to Patient HH from, 24 August 2022 to 1 November 2023, in that:</i></p>
95a	<p><i>During an appointment on 24 August 2022, you did not conduct:</i></p>
95ai	<p><i>an assessment of Patient HH's oral health;</i> <b>Found proved</b></p> <p>The Committee had regard to the patient's dental records. There is no record of these assessments and examinations being carried out from 24 August 2022 to 1 November 2023.</p> <p>The Committee accepted Dr Pal's opinion that these were not carried out. On the balance of probabilities, the Committee determined that these were not undertaken. Accordingly, it finds this charge proved.</p>
95aai	<p><i>a BPE;</i> <b>Found Proved</b></p> <p>This is for the same reasons set out in Charge 95ai</p>
95b	<p><i>During an appointment on 6 February 2023, you did not conduct:</i></p>
95bi	<p><i>an extra oral examination;</i> <b>Found Proved</b></p> <p>This is for the same reasons set out in Charge 95ai</p>
95bii	<p><i>a soft tissue examination;</i> <b>Found Proved</b></p> <p>This is for the same reasons set out in Charge 95ai</p>
95biii	<p><i>an assessment of Patient HH's oral health;</i> <b>Found Proved</b></p> <p>This is for the same reasons set out in Charge 95ai</p>
95biv	<p><i>a BPE;</i> <b>Found Proved</b></p> <p>This is for the same reasons set out in Charge 95ai</p>
95c	<p><i>You did not report on a periapical radiograph taken of Patient HH's LR45 on 29 May 2023;</i> <b>Found Proved</b></p>

	<p>The Committee noted from the dental records that Patient HH attended for an appointment on 29 May 2023 during which a periapical radiograph was taken.</p> <p>The Committee had sight of the radiograph and observed that although it had been recorded as being taken in the clinical notes, there is no report present for the radiographs. The Committee therefore accepts Dr Pal's opinion that the reporting of the radiograph was not carried out and finds the charge proved.</p>
95d	<i>During an appointment on 7 August 2023, you did not conduct:</i>
95di	<p><i>an extra oral examination;</i> <b>Found Proved</b></p> <p>This is for the same reasons set out in Charge 95ai</p>
95dii	<p><i>a soft tissue examination;</i> <b>Found Proved</b></p> <p>This is for the same reasons set out in Charge 95ai.</p>
95diii	<p><i>an assessment of Patient HH's oral health;</i> <b>Found Proved</b></p> <p>This is for the same reasons set out in Charge 95ai</p>
95div	<p><i>a BPE;</i> <b>Found not proved</b></p> <p>The Committee notes that there is no documentation from Mr McLauchlan indicating that he has carried out a BPE score. However, the Committee observed that a BPE score has been recorded, and therefore disagrees with the expert on this matter. Accordingly, it finds this charge not proved.</p>
95e	<p><i>You did not take a periapical radiograph on 21 September 2023, covering Patient HH's LL3, in advance of planning a new post crown;</i> <b>Found proved</b></p> <p>The Committee reviewed the records on 21 September 2023 and observed that a periapical radiograph was not taken in advance of planning a new crown at Patient HH's LL3.</p> <p>Dr Pal's evidence was that the Registrant failed to consider/provide a a periapical radiograph of LL3 prior to planning a new post crown considering the crown had fractured. The Committee has accepted the expert's evidence on this point and accordingly finds this charge proved.</p>
95f	<i>During an appointment on 16 August 2023, you did not:</i>
95fi	<p><i>check whether Patient GG's LR5 and/or LR4 was tender to percussion;</i> <b>Found proved</b></p> <p>On reviewing the notes, the Committee observes there is no record of either LR5 or LR4 being tested for TTP. Dr Pal opined that Mr McLauchlan saw the patient on 16 August 2023 for extraction of LR5 and LR4. He explained that there were no records of any special tests such as tenderness on percussion for LR4 and LR5.</p>

	<p>The Committee accepts Dr Pal's evidence and accordingly finds this charge proved.</p>
95fii	<p><i>discuss the risks and benefits of extracting Patient GG's LR5 and/or LR4 in advance of doing such;</i> <b>Found proved</b></p> <p>The Committee noted that the records show that extraction of LR5 and LR4 took place, but risks and benefits are not documented as having been discussed. Dr Pal's opinion is that there are no records of discussions regarding options, risks and benefits for these teeth and possible ways to replace these teeth if lost.</p> <p>The Committee therefore finds this charge proved.</p>
95fiii	<p><i>discuss the alternative treatment options to extracting Patient GG's LR5 and/or LR4 in advance of doing such;</i> <b>Found proved</b></p> <p>As for the reasons stated in Charge 95fii, no further documentation is recorded in the notes regarding alternative treatment options. Accordingly, the Committee finds this charge proved.</p>
95g	<p><i>On 1 November 2023, in advance of preparing a post crown at Patient HH's LL3, you did not:</i></p>
95gi	<p><i>check whether Patient HH's LL3 was tender to percussion;</i> <b>Found proved</b></p> <p>Mr McLauchlan saw the patient on 1 November 2023 regarding a new post crown on LL3. Dr Pal opined that there was no documentation for special tests such as checking for tenderness upon percussion on LL3. The Committee notes that there is no record indicating any testing of LL3 for TTP. It has accepted Dr Pal's evidence and accordingly, the Committee finds this charge proved.</p>
95gii	<p><i>take a radiograph covering Patient HH's LL3:</i> <b>Found proved</b></p> <p>The Committee notes that there is no radiograph in the clinical records, so has drawn the conclusion that one was not taken. Dr Pal's evidence was that there are no records of a radiographic assessment of LL3. It has accepted Dr Pal's evidence and accordingly finds this charge proved.</p>
95giii	<p><i>discuss the risks and benefits of providing a crown post at Patient HH's LR3; LL3</i> <b>Found proved</b></p> <p>The Committee noted that this charge (95giii) refers to LR3 rather than LL3. However, the stem of this charge at 95g makes it clear that all the sub-charges at 95g are relating to Patient HH's LL3. The Committee proceeded on the basis that the above reference to LR3 was a typographical error, and this charge in fact relates to LL3.</p> <p>The Committee notes that there are no risks and benefits discussed for the crown post at LL3, save for the record stating '<i>crown prep</i>'. Dr Pal states that there are no records of discussions regarding risks, benefits and alternative treatment options for LL3. The Committee accepts Dr Pal's evidence and finds this charge proved.</p>

95giv	<p><i>discuss the alternative treatment options for Patient HH's LL3;</i> <b>Found proved</b></p> <p>The Committee notes that no treatment options were recorded in the clinical records. Dr Pal's evidence is that there is no record of any discussions regarding risk, benefits and alternative treatment options for Patient HH's LL3. The Committee accepts Dr Pal's evidence and therefore finds this charge proved.</p>
96	<p><i>By reason of you conduct in charge 95.f.ii. and/or 95.f.iii. you did not obtain Patient HH's informed consent for the extraction of their LR5 and/or LR4.</i> <b>Found proved</b></p> <p>The Committee noted that the following was recorded in Patient HH's records: '<i>pt consent given</i>'. The Committee determined this entry was insufficient as there is no record of risks, benefits, alternative treatment options. Dr Pal opines there are no records of discussions regarding options, risks and benefits for these teeth and possible ways to replace these teeth if lost.</p> <p>The Committee considers that these discussions would have been necessary prior to extracting the Patient's LR5 and/or LR4 and that the absence of them meant that Mr McLaughlan did not obtain the Patient's informed consent. Accordingly it finds this charge proved.</p>
97	<p><i>By reason of you conduct in charge 95.g.iii. and/or 95.g.iv. you did not obtain Patient HH's informed consent for the crown post placed at their LL3.</i> <b>Found proved</b></p> <p>The Committee notes there is no record of consent obtained from Patient HH for the crown post at their LL3. Dr Pal's evidence is that there are no records of discussions regarding risks, benefits and alternative treatment options for LL3. The Committee agrees and finds the charge proved.</p>
98	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient HH's appointments from 24 August 2022 to 7 August 2023, in that</i></p>
98a	<p><i>In your record of 24 August 2022, you did not record:</i></p>
98ai	<p><i>an assessment of Patient HH's oral health;</i> <b>Found proved</b></p> <p>The Committee notes that there is no record of an assessment of Patient's HH's oral health for 24 August 2022. Dr Pal's evidence is that there are no records of BPE and an assessment of oral hygiene in any of the examination relating to the appointment on 24 August 2022. On the balance of probabilities, the Committee determined that there was no record of an assessment of Patient HH's oral health. Accordingly, it finds this charge proved.</p>
98aii	<p><i>a BPE;</i> <b>Found proved</b></p> <p>This is for the same reasons set out at Charge 98ai above.</p>
98b	<p><i>In your record of 6 February 2023, you did not record:</i></p>
98bi	<p><i>an extra oral examination;</i> <b>Found not proved</b></p>

	<p>The GDC's case is that the record keeping failures (charge 98b) are put in the alternative of finding the failures set out in charge 95b not proved. The Committee has found charge 95b proved. Accordingly, charge 98b is found not proved in its entirety.</p>
98bii	<p><i>a soft tissue examination;</i> <b>Found proved</b></p> <p>This is for the same reasons set out at Charge 98bi above.</p>
98biii	<p><i>an assessment of Patient HH's oral health;</i> <b>Found proved</b></p> <p>This is for the same reasons set out at Charge 98bi above.</p>
98biv	<p><i>a BPE</i> <b>Found proved</b></p> <p>This is for the same reasons set out at Charge 98bi above.</p>
98c	<p><i>In your record of 7 August 2023, you did not record:</i></p>
98ci	<p><i>an extra oral examination;</i> <b>Found proved</b></p> <p>This is for the same reasons set out at Charge 98bi above.</p>
98cii	<p><i>a soft tissue examination;</i> <b>Found proved</b></p> <p>This is for the same reasons set out at Charge 98bi above.</p>
98ciii	<p><i>an assessment of Patient HH's oral health;</i> <b>Found proved</b></p> <p>This is for the same reasons set out at Charge 98bi above.</p>
98civ	<p><i>a BPE.</i> <b>Found Proved</b></p> <p>This is for the same reasons set out at Charge 98bi above.</p>
<b>Patient II</b>	
99	<p><i>You failed to provide an adequate standard of care to Patient II from 14 June 2023 to 21 November 2023, in that:</i></p>
99a	<p><i>During an appointment on 14 June 2023, you did not:</i></p>
99ai	<p><i>conduct an extra oral examination;</i> <b>Found proved</b></p> <p>The Committee had regard to Patient II's dental records. There is no record of the assessments and/or examinations set out in charges 99 ai to aiii as being carried out at the appointment on 14 June 2023. The Committee accepts Dr Pal's expert opinion that these were not carried out. On the balance of probabilities, the Committee determined that these were not undertaken. Accordingly, it finds this charge proved.</p>

99aii	<p><i>conduct an assessment of Patient II's oral health;</i> <b>Found Proved</b></p> <p>This is for the same reasons as set out in charge 99ai above.</p>
99aiii	<p><i>report on bitewing radiographs taken;</i> <b>Found proved</b></p> <p>The Committee noted from the dental records that Patient II attended for an examination appointment on 14 June 2023 during which bitewing radiographs were taken. Dr Pal's opinion was that there was no report of the radiographs.</p> <p>The Committee had sight of the radiographs and observed that although they had been recorded as being taken in the clinical notes, there is no report present for the radiographs. It accepts Dr Pal's evidence and accordingly finds this charge proved.</p>
99b	<p><i>During an appointment on 21 November 2023, in advance of refilling the Patient II's UR4, you did not:</i></p>
99bi	<p><i>adequately assess why the filling placed at Patient II's UR4 on 14 June 2023 fell out;</i> <b>Found proved</b></p> <p>The Committee noted that the clinical records for the appointment on 21 November 2023 have no record of any assessment of UR4 to determine why the filling placed on 14 June 2023 had fallen out.</p> <p>Dr Pal's opinion was that there was no evidence of an assessment of UR4 to indicate the reason why the filling fell out. In Dr Pal's opinion, Mr McLauchlan failed to assess the reason why the filling at UR4 had fallen out. The Committee accepts Dr Pal's evidence. On the balance of probabilities, the Committee is satisfied that no adequate assessment was undertaken and finds this charge proved.</p>
99bii	<p><i>discuss the risk and benefits of refilling Patient II's UR4;</i> <b>Found proved</b></p> <p>The Committee noted from the clinical records for the appointment on 21 November 2023 that there is no record of any discussion with Patient II regarding the risks or benefits of re-filling Patient II's UR4. Dr Pal's opinion was that there are no records of discussions of the risks and benefits for re-filling Patient II's UR4. On the balance of probabilities, the Committee is satisfied that Mr McLauchlan did not discuss the risks and benefits of re-filling Patient II's UR4 as there is no evidence that any discussions were undertaken and therefore finds this charge proved.</p>
99biii	<p><i>discuss the alternative treatment options for Patient II's UR4.</i> <b>Found proved</b></p> <p>The Committee noted from the clinical records for the appointment on 21 November 2023 that there is no record of any discussion with Patient II regarding the alternative treatments for Patient II's UR4.</p> <p>Dr Pal's opinion is that there are no records of discussions regarding alternative treatment options for Patient II's UR4. On the balance of probabilities, the Committee is satisfied that Mr McLauchlan did not discuss the risks and benefits of re-filling Patient II's UR4 as there is no evidence that any discussions were undertaken and therefore finds this charge proved.</p>

100	<p><i>By reason of you conduct in charge 99.b.ii. and/or 99.b.iii. you did not obtain Patient II's informed consent for the restoration placed at their UR4.</i></p> <p><b>Found proved</b></p> <p>The Committee noted that although the clinical record for 21 November 2023 includes a brief entry stating that consent was given, there is no record of any discussion of the risks, benefits or alternative treatment options regarding UR4. Dr Pal's evidence was that Mr McLauchlan failed to assess the reason for failure of the filling at Patient II's UR4 and discuss the findings with the patient. His evidence was that such findings and discussions should have been discussed with the patient in order to obtain informed consent. The Committee accepts Dr Pal's evidence. It has therefore concluded that in light of its findings at charges 99bii and/ or 99biii, Patient II could not have been provided with sufficient information to give informed consent and therefore find this charge proved.</p>
101	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient II's appointments from, in that:</i></p> <p><b>Found not proved</b></p> <p>The GDC's case is that the record keeping failures (charge 101) are put in the alternative of finding the failures set out in charge 99 not proved. The Committee has found charge 99 proved. Accordingly, charge 101 is found not proved in its entirety.</p>
101a	<p><i>In your record of 14 June 2023, you did not record:</i></p>
101ai	<p><i>an extra oral examination;</i></p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 101.</p>
101aii	<p><i>an assessment of Patient II's oral health;</i></p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 101.</p>
101b	<p><i>In your record of 21 November 2023, you did not record:</i></p>
101bi	<p><i>discussing the risk and benefits of refilling Patient II's U;</i></p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 101.</p>
101bii	<p><i>discussing the alternative treatment options for Patient II's UR4</i></p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 101.</p>
<b>Patient JJ</b>	
102	<p><i>You failed to provide an adequate standard of care to Patient JJ from 13 July 2022 to 22 August 2023, in that:</i></p>
102a	<p><i>During an appointment on 13 July 2022, you did not:</i></p>
102ai	<p><i>Conduct an extra oral examination;</i></p> <p><b>Found proved</b></p>

	<p>Dr Pal's opinion is that there was no record of extra-oral examinations, BPE and an assessment of oral hygiene on 13 July 2022 and 11 January 2023. He opined that even though the hygienist may have carried out and recorded some of the periodontal assessments at their visit, Mr McLauchlan still had a duty to independently carry out the assessments. The Committee accepted Dr Pal's opinion.</p> <p>The Committee had regard to Patient JJ's dental records. There is no record of these assessments and examinations being carried out for the appointment on 13 July 2022 that these were not carried out. The Committee is satisfied that it is more likely than not that an extra-oral examination was not undertaken. Accordingly, it finds this charge proved.</p>
102aii	<p><i>Conduct a BPE;</i> <b>Found Proved</b></p> <p>This is for the same reasons as set out in charge 102ai, but in relation to a BPE.</p>
102aiii	<p><i>Conduct an assessment of Patient JJ's oral health;</i> <b>Found Proved</b></p> <p>This is for the same reasons as set out at charge 102ai, but in relation to an oral health assessment.</p>
102aiv	<p><i>check whether Patient JJ's UL5 was tender to percussion in advance of filling this tooth;</i> <b>Found Proved</b></p> <p>This is for the same reasons as set out at charge 102ai but in relation to a failure to check whether the tooth at UL5 was tender to percussion.</p>
102av	<p><i>discuss the risks and benefits of filling Patient JJ's UL5;</i> <b>Found Proved</b></p> <p>The Committee observed that there is no record or documentation in Patient JJ's clinical records of any discussion of the risks or benefits of filling Patient JJ's UL5 at the appointment on 13 July 2022. Dr Pal's opinion was that there was a failure to carry out any discussion of the risks and benefits of filling Patient JJ's UL5. In the absence of any evidence that such a discussion occurred, it is likely that no discussions took place. The Committee accepts Dr Pal's opinion and finds this charge proved.</p>
102avi	<p><i>discuss the alternative treatment options for Patient JJ's UL5</i> <b>Found Proved</b></p> <p>The Committee noted that there is no record in Patient JJ's clinical notes of any discussion of the alternative treatment options for Patient JJ's UL5. Dr Pal's opinion was that there was failure to carry out a discussion about options at this appointment. The Committee accepted Dr Pal's opinion. In the absence of any record that these matters were addressed, the Committee is satisfied that it is likely that alternative treatment options were not discussed and finds this charge proved.</p>
102b	<p><i>During an appointment on 11 January 2023, you did not:</i></p>
102bi	<p><i>conduct an extra oral examination;</i> <b>Found Proved</b></p>

	<p>The Committee noted that the clinical records for the appointment on 11 January 2023 contain no record of an extra-oral examination being carried out. The Committee accepted Dr Pal's opinion that this examination was not undertaken. On the balance of probabilities, the Committee determined that an extra-oral examination was not performed and therefore finds this charge proved.</p>
102bii	<p><i>conduct a BPE;</i> <b>Found proved</b></p> <p>This is for the same reasons as set out at Charge 102bi above but in relation to a BPE.</p>
102biii	<p><i>conduct an assessment of Patient JJ's oral health;</i> <b>Found proved</b></p> <p>This is for the same reasons as set out at Charge 102bi above but in relation to an assessment of the patient's oral health.</p>
102biv	<p><i>report on a left bitewing radiographs taken;</i> <b>Found proved</b></p> <p>The Committee noted that a left bitewing radiograph was taken at the appointment on 11 January 2023, but there is no record of any report on it. The Committee accepted Dr Pal's opinion that although the radiograph was known to have been taken, no assessment or report was recorded. Accordingly, the Committee is satisfied that no report was made on the radiograph and finds the charge proved.</p>
102c	<p><i>You did not take a radiograph, covering Patient JJ's UL2:</i></p>
102ci	<p><i>in advance of planning a new post crown for that tooth on 26 July 2023;</i> <b>Found proved</b></p> <p>The Committee observed from the dental records of the appointment of 26 July 2023 that there is no record of a radiograph covering UL2 being taken in advance of planning a new post crown for that tooth. The Committee accepted Dr Pal's opinion that no radiograph was considered or taken prior to planning a new post crown for the UL2. Dr Pal considered that a radiograph should have been taken. Having regard to Dr Pal's evidence and the absence of a radiograph, the Committee finds this charge proved.</p>
102cii	<p><i>on 3 August 2023</i> <b>Found proved</b></p> <p>The Committee noted that there is no record of a radiograph covering UL2 being taken in advance planning and preparing a new post crown for that tooth. Dr Pal's opinion was that a radiograph covering the patient's UL2 should have been taken prior to planning a new post crown but noted that no radiograph was taken. The Committee has accepted Dr Pal's evidence and finds this charge is proved.</p>
102d	<p><i>During an appointment on 3 August 2023, you did not:</i></p>
102di	<p><i>check whether Patient JJ's UL2 was tender to percussion in advance of preparing Patient JJ's UL2 for a post crown;</i> <b>Found proved</b></p>

	<p>The Committee noted that there is no entry in Patient JJ's clinical records for the appointment on 3 August 2023 to indicate that Mr McLauchlan assessed whether or not Patient JJ's UL2 was tender to percussion.</p> <p>The Committee accepted Dr Pal's opinion that this assessment should have been undertaken and documented. In the absence of any record that this assessment occurred, the Committee is satisfied that the assessment was not likely to have been carried out and finds this charge is proved.</p>
102dii	<p><i>discuss the risks and benefits of providing a post crown at Patient JJ's UL2;</i> <b>Found proved</b></p> <p>The Committee observed that there is no record in the clinical records of any discussion of the risks or benefits of the provision of a post crown at Patient JJ's UL2 at the appointment on 3 August 2023. Dr Pal's opinion confirmed that there was a failure to carry out a discussion. In the absence of any record that such a discussion occurred, it is more likely than not that a discussion regarding risks and benefits of providing a post crown at Patient JJ's UL2 did not take place. Accordingly, the Committee finds this charge proved.</p>
102diii	<p><i>discuss the alternative treatment options for Patient JJ's UL2;</i> <b>Found proved</b></p> <p>The Committee noted that the clinical records do not contain documentation of any discussion of the alternative treatment options for Patient JJ's UL2.</p> <p>Dr Pal's opinion was that Mr McLauchlan failed to carry out a discussion about options at this appointment. The Committee accepted Dr Pal's evidence on this matter. In the absence of any record that a discussion had occurred, the Committee is satisfied that it is more likely than not that alternative treatment options were not discussed and finds this charge proved.</p>
102e	<p><i>You provided a poor standard of post crown treatment at Patient JJ's UL2 on:</i></p>
102ei	<p><i>18 August 2023;</i> <b>Found proved</b></p> <p>The dental records for the appointment on 18 August 2023 confirm that the crown was fitted at UL2, state that patient JJ reported that the crown felt '<i>thick at back</i>' and that Mr McLauchlan noted that no adjustments were required. The dental records show that Patient JJ returned on 22 August 2023, complaining that the crown felt thick at the back. Mr McLauchlan smoothed the crown.</p> <p>Dr Pal's opinion was that the patient's concerns indicated deficiencies in the crown. Therefore, on the balance of probabilities, the Committee is satisfied that the standard of post-crown treatment provided at the fitting appointment on 18 August 2023 was more likely than not to have been of a poor standard and therefore finds this charge proved.</p>
102eii	<p><i>22 August 2023.</i> <b>Found proved</b></p> <p>The Committee noted from the dental records that Patient JJ saw the hygienist on 1 September 2023. The hygienist recorded that Patient JJ said '<i>ul2 crown is rough</i></p>

	<p><i>palatally</i>'. The hygienist also recorded that the crown was causing a food trap in the cervical area of the crown.</p> <p>Dr Pal's opinion was that these findings demonstrated poor quality of care by Mr McLauchlan with respect to the UL2 crown and fell far below the standard expected for post-crown treatment. The Committee accepts Dr Pal's evidence and accordingly finds this charge is proved.</p>
103	<p><i>By reason of your conduct in charge 102.a.v.and/or 102.a.vi. you did not obtain Patient JJ's informed consent for the filling placed at their UL5.</i></p> <p><b>Found proved</b></p> <p>Given the Committee's findings at charges 102a.v and 102a.v.i, the Committee considered whether informed consent had been obtained for the filling placed at UL5. The clinical records contain no record of any discussion with Patient JJ regarding the risks and benefits of the procedure, or any alternative treatment options.</p> <p>The Committee accepts Dr Pal's opinion that these discussions should have taken place and that the absence of such information indicates that informed consent was not obtained. On the balance of probabilities, the Committee finds this charge is proved.</p>
104	<p><i>By reason of you conduct in charge 102.d.ii. and/or 102.d.iii. you did not obtain Patient JJ's informed consent for the crown post placed at their UL2.</i></p> <p><b>Found proved</b></p> <p>Given the Committee's findings at charges 102d.ii/and 102d.iii., the Committee considered whether informed consent had been obtained for the post crown placed at UL2. The clinical records contain no record of any discussion with Patient JJ regarding the risks and benefits of the proposed post crown, or any alternative treatment options.</p> <p>The Committee accepts Dr Pal's opinion that these discussions should have taken place and that the absence of such information indicates that informed consent was not obtained. On the balance of probabilities, the Committee finds this charge proved.</p>
105	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient JJ's appointments from 13 July 2022 to 3 August 2023, in that:</i></p> <p><b>Found not proved</b></p> <p>The GDC has put charge 105 in the alternative to finding charge 102 not proved. The Committee has found charge 106 proved and therefore finds charge 109 not proved in its entirety.</p>
105a	<p><i>In your record of 13 July 2022, you did not record:</i></p>
105ai	<p><i>an extra oral examination;</i></p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 105 above.</p>
105aii	<p><i>a BPE;</i></p> <p><b>Found not proved</b></p>

	This is for the same reasons as set out at charge 105 above.
105aiii	<i>an assessment of Patient JJ's oral health;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 105 above.
105b	<i>In your record of 11 January 2022, you did not record:</i>
105bi	<i>an extra oral examination;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 105 above.
105bii	<i>a BPE;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 105 above.
105biii	<i>an assessment of Patient JJ's oral health;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 105 above.
105c	<i>In your record of 13 July 2022 you did not record:</i>
105ci	<i>discussing the risks and benefits of filling Patient JJ's UL5;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 105 above.
105cii	<i>discussing the alternative treatment options for Patient JJ's UL5;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 105 above.
105d	<i>In your record of 3 August 2023 you did not record:</i>
105di	<i>discussing the risks and benefits of providing a post crown at Patient JJ's UL2;</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 105 above.
105dii	<i>discussing the alternative treatment options for Patient JJ's UL2.</i> <b>Found not proved</b>  This is for the same reasons as set out at charge 105 above.
<b>Patient KK</b>	
106	<i>You failed to provide an adequate standard of care to Patient KK from 20 May 2022 to 4 July 2023, in that:</i>
106a	<i>During an appointment on 20 May 2022, you did not conduct:</i>
106ai	<i>an extra oral examination;</i> <b>Found proved</b>

	<p>The Committee reviewed Patient KK's records and noted that Mr McLauchlan recorded an exam, an emergency appointment and patient complaints. However, there are no record of the examinations/assessments set out in charge 106a.</p> <p>Dr Pal opines that there are no records of extra-oral examinations and an assessment of oral hygiene on 20 May 2022 and 7 December 2022 and no records of BPE on 20 May 2022.</p> <p>The Committee, having reviewed Patient KK's records, accepts Dr Pal's evidence on this matter and finds this charge proved</p>
106aii	<p><i>a BPE;</i> <b>Found proved</b></p> <p>This is for the same reasons as set out at charge 106ai above.</p>
106aiii	<p><i>an assessment of Patient KK's oral health;</i> <b>Found proved</b></p> <p>This is for the same reasons as set out at charge 106ai above.</p>
106b	<p><i>On 2 September 2022, in advance of filling Patient KK's LR6, you did not:</i></p>
106bi	<p><i>discuss the risks and benefits of providing this treatment;</i> <b>Found proved</b></p> <p>The Committee reviewed Patient KK's dental records and noted that Mr McLauchlan saw Patient KK on 2 September 2022 when the filling at the LR6 was redone. There are no record of discussions regarding the risks and benefits of providing treatment and alternative treatment options. Dr Pal's opinion was that there are no records of discussions regarding prognosis, risks, benefits and alternative treatment options for LR6. The Committee accepts Dr Pal's evidence and finds this charge proved.</p>
106bii	<p><i>discuss the alternative treatment options for Patient KK's LR6;</i> <b>Found proved</b></p> <p>As stated in charge 106i above, there are no records of alternative treatment options either.</p>
106c	<p><i>During an appointment on 7 December 2022, you did not:</i></p>
106ci	<p><i>conduct an extra oral examination;</i> <b>Found proved</b></p> <p>The Committee notes there is no record in Patient KK's notes of an extra oral exam. In the Committee's judgement, on the balance of probabilities, this examination was not carried out. The Committee finds this charge proved.</p>
106cii	<p><i>Conduct an assessment of Patient KK's oral health;</i> <b>Found proved</b></p> <p>On reviewing the notes, the Committee noted there was no record of the assessment of KK's oral health. It was satisfied, on the balance of probabilities it was not carried out. The Committee finds this charge proved.</p>

106d	<i>You did not report on:</i>
106di	<i>bitewing radiographs taken on 7 December 2022;</i> <b>Found proved</b>  The Committee noted that a small X-ray was recorded in the dental records but there is no report on it. Dr Pal considered that Mr McLauchlan’s failure to report on the radiographs taken demonstrated poor radiographic practice. The Committee accepts Dr Pal’s evidence and finds this charge proved.
106dii	<i>two periapical radiographs taken on 4 July 2023;</i> <b>Found proved</b>  Dr Pal’s evidence was that two periapical radiographs were taken on 4 July 2023 but there was no report on them. The Committee, having reviewed the patient records, accepts Dr Pal’s evidence and finds this charge proved.
106e	<i>You provided a poor standard of care by using ‘Unicem’ under an existing bridge retainer on Patient KK’s UR5, to patch up a loose bridge, on:</i>
106ei	<i>4 January 2023;</i> <b>Found proved</b>  Mr McLauchlan recorded the following in the clinical records: <i>“the bridge has moved more now, seen it moving when using teepees. used unicem under UL5 today to support bridge, dont want to try remove the bridge incase damaging the roots”</i> .  Dr Pal’s evidence was that on two occasions (4 January 2023 and 22 March 2023), Mr McLauchlan tried to patch up the loose bridge using Unicem under the existing bridge retainer on UR5. In Dr Pal’s opinion, this demonstrated poor treatment planning and poor clinical care. The Committee accepts Dr Pal’s evidence on this point and accordingly finds this charge proved
106eii	<i>22 March 2023;</i> <b>Found proved</b>  This is for the same reasons as set out at charge 106ei above.
106f	<i>On 4 January 2023 and/or 22 March 2023 you did not:</i>
106fi	<i>advise Patient KK that the bridge was failing;</i> <b>Found proved</b>  On reviewing the records, the Committee noted there are no further clinical records for 4 January 2023 other than that set out in Charge 106ei.  The clinical notes for 22 March 2023 state <i>“pt going away on holiday, would like a quick fix. UR5/4/3 bridge loose again. placed unicem under UR5 to help support it”</i> .  Dr Pal considered that Mr McLauchlan should have advised the patient that the bridge was failing and discussed treatment options. The Committee accepts Dr Pal’s evidence on this point and accordingly finds this charge proved.
106fii	<i>discussed the options for treatment;</i> <b>Found proved</b>

	<p>The Committee notes that there are no additional clinical records beyond what is documented in and stated in charges 106ei and 106fi above. The Committee accepts Dr Pal's opinion, as set out at charge 106fi above, and accordingly finds this charge proved.</p>
106g 106gi	<p><i>During an appointment on 14 June 2023, you did not conduct: an extra oral examination;</i> <b>Found proved</b></p> <p>The Committee reviewed Patient KK's records and noted that a soft tissue examination was conducted, but there was no record of an extra oral examination.</p> <p>Dr Pal noted that there are no records of extra-oral examinations or an assessment of oral hygiene for this appointment. On the balance of probabilities, the Committee concluded that these assessments were not carried out. Accordingly, it finds this charge proved.</p>
106gii	<p><i>an assessment of Patient KK's oral health;</i> <b>Found proved</b></p> <p>The Committee notes that there is no record of Patient KK's oral health. It agrees with Dr Pal's opinion that an assessment of the patient's oral health was not carried out. The Committee, therefore, finds the charge proved.</p>
106h 106hi	<p><i>Your radiographic practice was poor, in that: the left bitewing radiograph you took on 7 December 2022 was poorly positioned;</i> <b>Found proved</b></p> <p>The Committee took note of the bitewing radiograph taken on 7 December 2022. Dr Pal's evidence was that the left bitewing radiograph is poorly positioned, and it was not possible to fully view the upper left posterior bone level.</p> <p>The Committee, having reviewed the bitewing radiograph, accepts Dr Pal's evidence on this point and accordingly finds this charge proved.</p>
106hii	<p><i>one of the periapical radiographs you took on 4 July 2023 is poorly positioned with limited and/or no diagnostic yield;</i> <b>Found proved</b></p> <p>The Committee took note of the radiographs on 4 July 2023. Dr Pal's opinion is that one of the periapical radiographs is also poorly positioned and has limited or no diagnostic yield.</p> <p>The Committee, having reviewed the periapical radiograph, accepts Dr Pal's evidence on this point and accordingly finds this charge proved.</p>
106i 106i.i	<p><i>On 4 July 2023, in advance of providing Patient KK with a new bridge at their UR345, you did not: check whether the proposed bridge retainers were tender to percussion;</i> <b>Found proved</b></p> <p>Dr Pal opines that there are no records of periodontal assessments and any special tests, such as tenderness on percussion around the bridge retainers. The Committee</p>

	<p>reviewed the records and noted that there is no record of TTP having been undertaken. Therefore, it finds this charge proved.</p>
106i.ii	<p><i>warn Patient KK that their UL5 would be a poor bridge retainer resulting in the bridge having a guarded prognosis;</i> <b>Found proved</b></p> <p>The Committee notes there is no record of a discussion regarding the UL5 being a poor bridge retainer.</p> <p>Dr Pal's opinion is that the UR5 was a retained root stump and would be a poor bridge retainer. He noted that there is no record which indicates that Patient KK has been warned of this or of the guarded prognosis for a new bridge.</p> <p>The Committee accepts Dr Pal's evidence on this point and accordingly finds this charge proved.</p>
106i.iii	<p><i>discuss the risks, benefits of the bridge treatment proposed;</i> <b>Found proved</b></p> <p>Dr Pal's opinion is that there are no records of discussions regarding risks, benefits and alternative treatment options for the bridge at Patient KK's UR345.</p> <p>The Committee notes that there is no record of a discussion and, on the balance of probabilities, has concluded that this did not take place. The Committee finds the charge proved</p>
106i.iv	<p><i>discuss the alternative treatment options for the bridge proposed.</i> <b>Found proved</b></p> <p>This is for the same reasons as set out at charge 106i.iii above.</p>
107	<p><i>By reason of your conduct in charge 106.b.i. and/or 106.b.ii. you did not obtain Patient KK's informed consent for the filling at their LR6.</i> <b>Found proved</b></p> <p>Dr Pal's evidence was that there are no records of discussions regarding the prognosis, risks, benefits and alternative treatment options for LL6. He considered that there was a failure to carry out these assessments and discuss the findings with Patient KK and hence a failure to obtain informed consent.</p> <p>The Committee notes that there is no documentation in Patient KK's records regarding prognosis, risks and benefits and alternative treatment options for the LL6, which, on the balance of probabilities, indicates that Mr Mclauchlan did not obtain Patient KK's informed consent.</p> <p>In light of its findings in relation to charges 106.b.i. and 106.b.ii, the Committee therefore finds this charge proved.</p>
108	<p><i>By reason of your conduct in charge 106.i.ii. and/or 106.i.iii. and/or 106.i.iv. you did not obtain Patient KK's informed consent for the bridge at their UR345.</i> <b>Found proved</b></p>

	<p>Dr Pal's evidence was that Mr McLauchlan saw Patient KK on 20 May 2022, 4 January 2023 and 22 March 2023 regarding problems with the bridge on URQ. His opinion was that there are no records about discussions regarding the guarded prognosis of a new bridge. Further, Dr Pal noted that there were no records of discussions regarding risks, benefits and alternative treatment options for the bridge at Patient KK's UR345.</p> <p>The Committee accepts Dr Pal's evidence that Mr McLauchlan did not therefore obtain Patient KK's informed consent and accordingly finds this charge proved.</p>
109	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient KK's appointments from 20 May 2022 to 4 July 2023, in that:</i> <b>Found not proved</b></p> <p>The GDC's case is that the record keeping failures (charge 109) are put in the alternative of finding the failures set out in charge 106 not proved. The Committee has found charge 106 proved. Accordingly, charge 109 is found not proved in its entirety.</p>
109a	<i>In your record of 20 May 2022, you did not record:</i>
109ai	<p><i>an extra oral examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 109.</p>
109aai	<p><i>a BPE;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 109.</p>
109aiii	<p><i>an assessment of Patient KK's oral health;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 109.</p>
109b	<i>In your record of 7 December 2022, you did not record:</i>
109bi	<p><i>an extra oral examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 109.</p>
109bii	<p><i>an assessment of Patient KK's oral health;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 109.</p>
109c	<i>In your record of 14 June 2023, you did not record:</i>
109ci	<p><i>an extra oral examination;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 109.</p>
109cii	<i>an assessment of Patient KK's oral health;</i>

	<p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 109.</p>
109d	<p><i>In your record of 4 January 2023 and/or 22 March 2023 you did not record:</i></p>
109di	<p><i>advising Patient KK that the bridge was failing;</i></p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 109.</p>
109dii	<p><i>discussing the options for treatment;</i></p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 109.</p>
109e	<p><i>In your record of 4 July 2023, you did not record:</i></p>
109ei	<p><i>warning Patient KK that their UL5 would be a poor bridge retainer resulting in the bridge having a guarded prognosis;</i></p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 109.</p>
109eii	<p><i>discussing the risks, benefits of the bridge treatment proposed;</i></p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 109.</p>
109eiii	<p><i>discussing the alternative treatment options for the bridge proposed.</i></p> <p><b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 109.</p>
<b>Patient LL</b>	
110	<p><i>You failed to provide an adequate standard of care to Patient LL from 11 January 2023 to 27 October 2023, in that:</i></p>
110a	<p><i>During an appointment on 11 January 2023, you did not conduct:</i></p>
110ai	<p><i>an extra oral examination;</i></p> <p><b>Found proved</b></p> <p>The Committee noted from Patient LL's dental records that Mr McLauchlan undertook examinations on 11 January 2023 and 4 September 2023. However, there are no records of the assessments and/or examinations as set out in charges 110a and 110b as having been carried out on these two dates.</p> <p>Dr Pal's evidence was that these were not carried out and should have been. The Committee accepts Dr Pal's evidence. On the balance of probabilities, the Committee determined that these were not undertaken. Accordingly, it finds this charge proved.</p>
110aai	<p><i>a BPE;</i></p> <p><b>Found Proved</b></p>

	This is for the same reasons as set out in charge 110ai, but in relation to a BPE.
110aiii	<i>an assessment of Patient LL's oral health;</i> <b>Found Proved</b>  This is for the same reasons as set out in charge 110ai, but in relation to an assessment of Patient LL's oral health.
110b	<i>During an appointment on 4 September 2023, you did not conduct:</i>
110bi	<i>a BPE;</i> <b>Found Proved</b>  This is for the same reasons as set out in charge 110ai but in relation to a BPE.
110bii	<i>an assessment of Patient LL's oral health;</i> <b>Found Proved</b>  This is for the same reasons as set out in charge 110ai but in relation to the patient's oral health.
110c	<i>You did not take a radiograph covering Patient LL's:</i>
110ci	<i>UR6 on 27 October 2023;</i> <b>Found Proved</b>  The records for this appointment state " <i>UR6 tooth specific note: Pt still feeling strong sensitivity from 16, triggered most by hot temperatures, states the duraphat placed two days ago did not settle the pain.</i> "  Dr Pal's evidence was that Patient LL returned on 27 October 2023, complaining of strong sensitivity to hot UR6. In Dr Pal's view, this was suggestive of irreversible pulpitis or pulp necrosis which should have been investigated further. Dr Pal opined that Mr McLauchlan failed to undertake any radiographic assessment of Patient LL's UR6.  The Committee noted there is no record of a dental radiograph of the UR6 in Patient LL's records having been undertaken.  The Committee, having assessed Patient LL's records, accepts Dr Pal's evidence on this matter and accordingly finds this charge proved.
110cii	<i>LL6 on 4 September 2023;</i> <b>Found proved</b>  Patient LL attended an appointment on 4 September 2023, presenting with a fractured lingual wall of the tooth LL6. Dr Pal's opinion was that Mr McLauchlan failed to undertake any radiographic assessment of LL6 which demonstrated poor radiographic practice. The Committee, having reviewed Patient LL's records, notes that no radiograph has been undertaken. The Committee accepts Dr Pal's opinion and finds this charge proved.
110d	<i>On 27 October 2023 you:</i>
110di	<i>did not diagnose irreversible pulpitis or pulp necrosis at Patient LL's UR6;</i> <b>Found proved</b>

	<p>Dr Pal noted that there no records of a diagnosis and treatment plan for that tooth. The Committee accepts Dr Pal’s opinion and finds this charge proved.</p>
110dii	<p><i>did not check whether Patient LL’s UR6 was tender to percussion;</i> <b>Found proved</b></p> <p>Dr Pal’s opinion is that there are no records of any special tests such as tenderness on percussion on UR6, and no records of a diagnosis and treatment plan for UR6. The Committee, having reviewed Patient LL’s dental records, agrees with Dr Pal’s opinion and hence finds this charge proved.</p>
110diii	<p><i>did not discuss appropriate treatment options for Patient LL’s UL6;</i> <b>Found proved</b></p> <p>The Committee notes that the records show that an LL6 Mesial occlusal distal lingual (MODL) amalgam filling was recorded, with no further documentation. Dr Pal states there are no records of discussions regarding prognosis, risks, benefits and alternative treatment options for LL6. The Committee accepts Dr Pal’s evidence on this matter and finds this charge proved.</p>
110e	<p><i>On 11 September 2023, in advance of filling Patient LL’s LL6, you did not discuss:</i></p>
110ei	<p><i>the prognosis for this tooth;</i> <b>Found proved</b></p> <p>As set out in Charge 110diii above, the Committee notes that there is no additional documentation regarding a discussion on the prognosis of Patient LL’s LL6. Accordingly, it finds this charge proved.</p>
110eii	<p><i>the risk and benefits of filling this tooth,</i> <b>Found proved</b></p> <p>As for the reasons set out in Charge 110diii, the Committee notes there is no additional documentation regarding a discussion on the risks and benefits of filling Patient LL’s LL6. Accordingly, it finds this charge proved</p>
110eiii	<p><i>the alternative treatment options for this tooth</i> <b>Found proved</b></p> <p>As for the reasons set out in Charge 110diii, there is no additional documentation regarding alternative treatment options for Patient’s LL6.</p>
111	<p><i>By reason of you conduct in charge 110.e.i. and/or 110.e.ii. and/or 110.e.iii you did not obtain Patient LL’s informed consent for the filling at their LL6.</i> <b>Found proved</b></p> <p>The Committee noted that Mr McLauchlan has recorded in Patient LL’s notes for the appointment on 11 September 2023: “<i>pt consent given</i>”. The Committee determined this entry was insufficient as there is no record of risks, benefits, or alternative treatment options. Dr Pal opined that there are no records of discussions regarding prognosis, risks, benefits and alternative treatment options for LL6. The Committee accepts Dr Pal’s evidence and in light of its findings at charges 110ei, 110eii and 110eiii, finds this charge proved.</p>

112	<p><i>You failed to maintain an adequate standard of record keeping in respect of Patient LL's appointments from 11 January 2023 to 27 October 2023, in that:</i> <b>Found not proved</b></p> <p>The GDC's case is that the record keeping failures (charge 112) are put in the alternative of finding the failures set out in charge 110 not proved. The Committee has found charge 110 proved. Accordingly, charge 112 is found not proved in its entirety.</p>
112a	<p><i>In your record of 11 January 2023, you did not record:</i></p>
112ai	<p><i>an extra oral examination</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 112.</p>
112aai	<p><i>a BPE</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 112.</p>
112aiii	<p><i>an assessment of Patient LL's oral health</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 112.</p>
112b	<p><i>In your record of 4 September 2023, you did not record a BPE; an assessment of Patient LL's oral health;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 112.</p>
112c	<p>In your record of 27 October 2023, you did not record:</p>
112ci	<p><i>a diagnosis of irreversible pulpitis or pulp necrosis at Patient LL's UR6;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 112.</p>
112cii	<p><i>discussing treatment options for Patient LL's UL6;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 112.</p>
112d	<p><i>In your record of 11 September 2023, you did not record discussing:</i></p>
112di	<p><i>the prognosis for Patient LL LL6;</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 112.</p>
112dii	<p><i>the risk and benefits of filling LL6,</i> <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 112.</p>

112diii	<p><i>the alternative treatment options for Patient LL's LL6.</i>  <b>Found not proved</b></p> <p>This is for the same reasons as set out at charge 112.</p>
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63. The hearing moves to Stage 2.

**Stage Two – 4 - 5 June 2026**

64. Mr McLauchlan is not present or represented at this second stage of the proceedings. He was neither present nor represented at stage one (the factual inquiry) of the hearing and the Committee decided to proceed in his absence.

65. The Committee has been informed that the GDC's Listings Team sent an email to Mr McLauchlan on 21 May 2026, advising him that the Committee would be returning in camera on the afternoon of Friday 29 May 2026 to finalise the Stage 1 determination. That same email also advised Mr McLauchlan that stage 2 of the hearing was scheduled to take place on Thursday 4 and Friday 5 June 2026, starting at 9.30 am on Thursday 4 June 2026.

66. Mr McLauchlan was not present when the Committee handed down its decision on the facts on the afternoon of 29 May 2026. The Committee Secretary advised that a copy of the determination of the Committee's determination on the facts was emailed to him that afternoon. Further, Mr McLauchlan was sent a Teams invite to attend this resumed hearing remotely but no response was received.

67. The Committee has borne in mind the Legal Adviser's advice that the GDC is not required to send a new Notice of Hearing to Mr McLauchlan in circumstances when the hearing is resuming. However, Rule 58(3) required the GDC to notify a Registrant of the date of the resumed hearing. The Committee is satisfied that Rule 58(3) has been met and that it is appropriate to continue with stage 2 of the proceedings in the absence of Mr McLauchlan.

68. At this second stage of the hearing the Committee has considered whether the facts found proved against Mr McLauchlan amount to misconduct and/or deficient professional performance, and if so, whether his fitness to practise is currently impaired. The Committee took into account that if it found current impairment, it would need to consider what sanction, if any, to impose on Mr McLauchlan's registration.

69. In reaching its decision, the Committee considered all the evidence presented to it at the fact-finding stage. It received no further evidence at this second stage. It has taken into account Mr Stevens' written submissions dated 4 June 2026 on behalf of the GDC as well as his oral submissions. Mr Stevens addressed the Committee on the matters set out in Rule 20(1).

70. The Committee has accepted the advice of the Legal Adviser concerning its powers and the principles to which it should have regard to at this stage of the proceedings. The Committee kept in mind the GDC's "Fitness to Practise: Guidance for the practice committees" (January 2026) (the GDC's Guidance).

**Fitness to practise history**

71. Mr Stevens confirmed that Mr McLauchlan has no fitness to practise history.

## Summary of submissions

72. With reference to the relevant legal authorities, Mr Stevens submitted that in light of the Committee's factual findings, which relate to a failure to provide an adequate standard of care to a number of patients over the course of many years of practise years are sufficiently serious to amount to misconduct. He also invited the Committee to consider that each of its dishonesty findings in relation to four patients (which fall under the category of probity/behavioural failings) fall within the threshold for a finding of misconduct.

73. Mr Stevens set out the broad areas of clinical concern in this case, which include Mr Mc Lauchlan's multiple failures in his radiographic practice, his failures to diagnose and/or treat caries and bone loss; his failures in his prescription practise, his failure to obtain informed consent for treatment, providing a poor standard of treatment, failures in his referral practise and failures in aftercare. He referred to Dr Pal's unchallenged evidence (GDC expert) that he considered that each of the individual failings fell far below the accepted standards. In summary, Mr Stevens submitted that the failings are serious, relating to repeated failures to provide basic and fundamental aspects of good dentistry. Mr Stevens submitted that Mr McLauchlan has breached Standards 3.1 and 7.1 of the GDC's "Standards for the Dental Team".

74. Regarding the probity/behavioural concerns, Mr Stevens submitted that each of the findings of dishonesty regarding four separate patients meet the threshold for a finding of misconduct. The GDC's position is that such conduct, particularly when directly linked to Mr McLauchlan's professional practice, brings the profession into disrepute and is fundamentally incompatible with the standards demanded of registered individuals. Mr Stevens invited the Committee to have regard to Standards 1.3, 1.7, 1.7.1 and 9.1 of the GDC's "Standards for the Dental Team" which he submitted Mr Lauchlan has breached.

75. Mr Stevens submitted that the GDC's primary case in relation to the clinical failures is that Mr McLauchlan did not carry out the matters set out in the charges, which go to the issue of misconduct. These charges were put in the alternative as record keeping failures. Given that the Committee has found proved that Mr McLauchlan failed to carry out certain matters the GDC's position is that if the Committee were to conclude that the findings amount to misconduct, it was not necessary for it to consider whether the findings amounted to deficient professional performance. Furthermore, the GDC did not positively submit that the few discrete record keeping failures found proved in this case (relating to Patients 1, X, AA and HH) amount to misconduct. This was in view of Dr Pal's evidence that such failings were below, as opposed to far below, the standards expected of a reasonably competent dentist.

76. Turning to current impairment, Mr Stevens set out the legal principles which the Committee should take into account in considering whether Mr McLauchlan's fitness to practise is currently impaired. The GDC submits that whilst the clinical failings are capable of remedy, there is no evidence that they have been, from which this Committee could conclude that there is a low risk of repetition. In this regard, the GDC submits that Mr McLauchlan has not engaged in these proceedings and there is no evidence of corrective steps taken. It was Mr Stevens' submission that there is a real risk that the clinical failings highlighted in this case will be repeated were Mr McLauchlan allowed to practise unrestricted. The GDC submits that a finding of impairment is necessary on public protection grounds. in this case.

77. Mr Stevens further submitted that given the serious nature of the repeated clinical failures identified in this case, in which Mr McLauchlan has repeatedly breached a number of the fundamental tenets of the profession and on several occasions placed patients at unwarranted risk of harm, a finding of impairment is required on wider public interest grounds to uphold confidence in the profession and ensure proper standards are maintained.

78. Mr Stevens set out the GDC's position on impairment in relation to the probity/behavioural failings. In short, it was Mr Stevens' submission that the Committee should conclude that Mr McLauchlan's fitness to practise is impaired on the grounds of public protection and the public interest grounds. Mr Stevens highlighted Mr McLauchlan's lack of engagement in these proceedings and the absence of any evidence of remorse or insight into his past dishonest conduct. This was in circumstances where there were repeated acts of dishonesty.

79. On the matter of sanction, Mr Stevens submitted that the only sufficient sanction in this case is to direct that Mr McLauchlan's name be erased from the register. In support of that submission, Mr Stevens highlighted a number of features of this case, including that it involves actual harm or risk of harm to patients; the misconduct was sustained over a period of time; there were attempts to cover up wrongdoing and there is a lack of insight.

80. Mr Stevens further highlighted the serious nature of the repeated acts of dishonesty in this case, directly related to Mr McLauchlan's professional practice. He submitted that a number of the instances involved carefully calculated acts of deception, motivated by a desire to protect himself from potential criticism. In short, the GDC's submission is that having regard to the multiple and serious clinical failings, as well as the multiple findings of dishonesty, the appropriate sanction is that of erasure.

### **Misconduct**

81. The Committee first considered whether the facts found proved, which concern 39 separate patients, constitute misconduct. In so doing, it has considered the expert evidence of Dr Pal. It has also exercised its own independent judgement.

### **Clinical failings**

82. The Committee has considered each of the clinical failings identified in this case and sets out its assessment of them as follows:

*Failures in radiographic practice (inadequate reporting / not taking when required)* – found proved in relation to 20 patients. Dr Pal's opinion was that each of the clinical failures highlighted in this case (save for the record keeping failures) represents a standard of care that fell far below the standards expected of a reasonably competent dentist. Dr Pal cited relevant regulations such as IRMER that were not adhered to on a number of occasions. The Committee agrees with Dr Pal's opinion. It is satisfied that each failure in radiographic practice is sufficiently serious to amount to misconduct.

*Failures in pre-treatment assessment / examination (including not conducting BPEs / soft tissue examinations / extra oral examinations / oral hygiene assessments / medical and social histories)* - found proved in relation to 36 patients. The Committee has accepted Dr Pal's evidence that these clinical failings fell far below the standards expected of a reasonably competent dentist. The Committee considers that these assessments were basic and necessary as part of providing good quality care. Providing such a level of care is something upon which public trust in the profession is based. It is satisfied that each of these failures is sufficiently serious to amount to misconduct.

*Failures to diagnose and/or treat (predominantly caries but also bone loss / periodontal disease / chronic periodontitis / irreversible pulpitis or pulp necrosis / overhanging amalgam fillings)* - found proved in relation to 22 patients. The Committee considers that diagnosing and/or treating caries and periodontal disease is a basic requirement of a dentist. The Committee has accepted Dr Pal's evidence that each of these failures fell far below the

standards expected of a reasonably competent dentist. It concluded that each of them is sufficiently serious to amount to misconduct.

*Failures in prescription practise* – found proved in relation to three patients. The Committee noted that one of the failures involved a prescription for penicillin where there was a record in the clinical notes that the patient (Patient 1) was allergic to penicillin. This could have had severe consequences for the patient. The Committee has accepted Dr Pal's evidence that each of the failures regarding prescribing fell far below the standards expected of a reasonably competent dentist. It has concluded that each of them is sufficiently serious to amount to misconduct.

*Failures to obtain informed consent for treatment (including crowns, bridges, restorations and extraction)* – found proved in relation to 17 patients. Obtaining valid consent is an essential component of the patient-dentist relationship and is something which members of the public are entitled to expect from their treating dentist. It notes that the failure relates to various types of treatment, some of which were irreversible. The Committee has accepted Dr Pal's evidence that these clinical failings fell far below the standards expected of a reasonably competent dentist. It has concluded that each of them is sufficiently serious to amount to misconduct.

*Providing a poor standard of treatment / treatment not clinically indicated (including crowns / bridges / restorations)* - found proved in relation to 15 patients. The Committee considers that each of the findings was serious and caused a risk of harm to the patient. This included leaving a dental bur in situ, which posed a significant risk to patient safety. Dr Pal opined that each of these clinical failings fell far below the standards expected of a reasonably competent dentist. The Committee agrees. It has concluded that each finding is sufficiently serious to amount to misconduct.

*Failures in referral practise (with associated risks to patient safety)* - found proved in relation to two patients. The Committee considers that the delay in referring Patients 1 and K of themselves are particularly serious given that there was a delay in them having access to specialist care which was required urgently. The Committee noted that Patient 1 was in some discomfort which could have been treated much earlier had a referral been made promptly. Dr Pal opined that Mr McLauchlan's failures in his referral practise each fell far below the standards expected of a reasonably competent dentist. The Committee agrees. It has concluded that each finding is sufficiently serious to amount to misconduct.

*Failures in aftercare* - found proved in relation to two patients. The Committee considers that providing appropriate aftercare to a patient is just as important as the treatment provided. Mr McLauchlan failed to provide appropriate aftercare which potentially placed the patients at harm and inconvenience. Dr Pal's opinion was that each of these clinical failures represents a standard of care that fell far below the standards expected of a reasonably competent dentist. The Committee agrees. It has concluded that each finding is sufficiently serious to amount to misconduct.

83. Dr Pal cited relevant FGDP guidance and Regulations such as IRMER that were not adhered to on a number of occasions. The Committee takes a serious view of each of Mr McLauchlan's clinical failings as set out above. They involve repeated failures to provide an adequate standard of care in respect of basic aspects of dentistry. The Committee is satisfied that Mr McLauchlan has repeatedly breached the following GDC's *Standards for the Dental Team*:

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

- *Standard 7.1: Provide good quality care based on current evidence and authoritative guidance.*

### **Probity/behavioural failings**

84. The Committee then went on to consider each finding separately in relation to Patients B, H, K and N. It considered the dishonest behaviour to Patient B fell far short of what is expected of a registered dentist. Mr McLauchlan left a dental bur in Patient B's mouth and denied that he had left it when asked about it by the patient. He then sought to minimise the incident by downplaying the risk of the dental bur being left in the patient's mouth. Turning to Patient H, the Committee considered that Mr McLauchlan's conduct was a conscious act of selective presentation of a specialist practitioner's view of his crown treatment in response to a letter of complaint from the patient. The motivation in this case and that of Patient K appears to be Mr McLauchlan's desire to protect himself and his reputation and put those needs above that of the patient. Regarding Patient N (attributing poor RCT to another practitioner in referral letter) the Committee considered that Mr McLauchlan was deliberately trying to deflect attention away from any potential criticism he might have received. This was in circumstances where he had been treating the patient for a long period of time and where there was no clinical justification for Mr McLauchlan to have made the comment in the referral letter.

85. A fundamental requirement under the GDC's standards is that registrants are honest. The Committee takes a serious view of each of the dishonesty findings. They each took place in the context of Mr McLauchlan's professional practice and in some instances, involve carefully calculated acts of deception, designed to deflect attention away from his clinical care. It considers that Mr McLauchlan has breached the following GDC's Standards for the Dental Team which states:

- *Standard 1.3: You must be honest and act with integrity*
- *Standard 1.3.1: You must justify the trust that patients, the public and your colleagues place in you by always acting honestly and fairly in your dealings with them. This applies to any business or education activities in which you are involved as well as to your professional dealings.*
- *Standard 1.3.2: You must make sure you do not bring the profession into disrepute.*
- *Standard 1.7: You must put patients' interests before your own or those of any colleague, business or organisation*
- *Standard 1.7.1 You must always put your patients' interests before any financial, personal or other gain*
- *Standard 9.1 You must ensure that your conduct, both at work and in your personal life, justifies patients' trust in you and the public's trust in the dental profession*

86. The Committee is satisfied that each of the clinical findings and each of the probity/behavioural matters is sufficiently serious to amount to misconduct. Accordingly, the Committee has concluded that the facts found proved are sufficiently serious to amount to misconduct.

Decision on misconduct in relation to the record keeping findings and deficient professional performance

87. The Committee has borne in the GDC's submissions and the advice of the Legal Adviser that if the Committee were to conclude that the facts found proved amount to misconduct, it did not need

to go on to consider the matter of deficient professional performance in respect of the clinical allegations. Given that it has found that the facts found proved amount to misconduct, the Committee did not go on to consider whether the facts found proved amount to deficient professional performance.

88. In respect of the record keeping failures, the Committee noted Dr Pal's opinion that these fell below but not far below the required standards. The Committee did not consider that each individual record keeping failure was a sufficiently serious departure from the standards to amount to misconduct. It was mindful of the case of *Schodlok v GMC* and the advice it received from the Legal Adviser that it was not usually appropriate to look at non-serious findings cumulatively. The Committee noted that there were only four proven incidents of poor record keeping. This was not enough to regard this cumulatively as misconduct. Moreover, there were not enough incidents to represent a "fair sample" of Mr McLauchlan's record keeping practice. The Committee therefore concluded that the test for deficient professional performance was also not met in respect of the record keeping.

### **Current impairment - misconduct**

89. The Committee next considered whether Mr McLauchlan's fitness to practise is currently impaired by reason of his misconduct. In doing so, the Committee has exercised its own independent judgement.

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

91. The Committee considers that the clinical failings in this case, albeit wide ranging in nature and covering 39 patients, are capable of remedy. The Committee has had regard to the steps taken at a local level by the directors at Mr McLauchlan's practice to address the clinical concerns raised by colleagues, as set out in the witness statement of the Practice Manager. It notes that a meeting was held at the practice on 25 July 2022, where concerns were raised about Mr McLauchlan's standard of care. The notes set out that the directors emphasised the importance of comprehensive notes, X-rays, and photographs. They suggested that Mr McLauchlan book a course to refresh his root canal treatment (RCT) skills, as Mr McLauchlan admitted to feeling less confident in this area. It is unclear what the follow up was after this meeting but in any event the Committee noted that the clinical concerns continued and resulted in Mr McLauchlan being referred to the GDC.

92. The Committee has borne in mind that Mr McLauchlan has not engaged in these proceedings and therefore there is no evidence of remorse, insight into his past failings or evidence of corrective steps taken since. In light of this, and given the repeated nature of the numerous and basic clinical concerns involved in this case the Committee is satisfied that here is a real risk that the clinical failings highlighted in this case will be repeated in future were Mr McLauchlan allowed to practise unrestricted. Accordingly, the Committee is satisfied that a finding of impairment on the grounds of misconduct is necessary for the protection of the public. It is further satisfied that given the serious nature of the repeated clinical failures, where Mr McLauchlan has repeatedly breached a number of fundamental tenets of the profession and has, in some cases, placed patients at unwarranted risk of harm, a finding of impairment is required on public interest grounds to uphold confidence in the profession.

93. Turning to the probity concerns, the Committee has borne in mind the absence of any evidence of remorse, Mr McLauchlan's insight into his past dishonest conduct and why he acted in the way that he did. Furthermore, the Committee has borne in mind that this case involves repeated acts of dishonesty which can be described of deliberate acts of deception, which point toward

entrenched attitudinal failings as opposed to a momentary lapse of professional judgement. The Committee considers that Mr McLauchlan's dishonest conduct is liable to be repeated and might put the public at unwarranted risk of harm and therefore a finding of current impairment is necessary on the grounds of public protection.

94. The Committee considers that a finding of impairment on the grounds of misconduct is also required to maintain public confidence in the profession and to declare and uphold proper professional standards of conduct and behaviour in light of the findings of dishonesty. Mr McLauchlan's actions were liable to have brought the reputation of the profession into considerable disrepute. In the Committee's judgement the public's trust and confidence in the profession, and in the regulatory process, would be significantly undermined if a finding of impairment was not made given the nature of Mr McLauchlan's dishonest conduct.

95. Accordingly, both in relation to the clinical matters and the probity matters, the Committee finds that Mr McLauchlan's fitness to practise is currently impaired by reason of his misconduct.

### Sanction

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

97. In reaching its decision the Committee has kept in mind the GDC's "Fitness to Practise: Guidance for the practice committees (6 January 2026)". The Committee has applied the principle of proportionality, balancing the public interest with Mr McLauchlan's own interests.

98. The Committee has considered the mitigating and aggravating factors present in this case. In respect of the mitigating factors that are present, the Committee notes that Mr McLauchlan has no previous fitness to practise history.

99. In terms of aggravating factors, the Committee has had regard to the following:

- Actual harm or risk of harm to patients
- Premeditated misconduct
- Abuse of trust/abuse of professional position
- Misconduct sustained or repeated over a period of time
- Attempts to cover up wrongdoing
- A finding of dishonest conduct
- Lack of any evidence of insight

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

101. The Committee also considers that a direction of conditional registration would not be sufficient to meet the public protection and public interest considerations engaged in this case. The Committee considers that conditions could not be formulated to deal with the multiple concerns in relation to his

clinical practice as well as the risks that arise from Mr McLauchlan's repeated dishonest conduct. The Committee also considers that, even if conditions could be formulated, a direction of conditional registration would not be sufficient to declare and uphold proper professional standards of conduct and behaviour because of the serious nature of Mr McLauchlan's misconduct.

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

103. Mr McLauchlan's misconduct, both in relation to the clinical matters, and the probity matters, represents a serious departure from professional standards and is highly damaging to his fitness to practise. In the Committee's judgement, Mr McLauchlan's dishonest conduct was particularly serious, in that it involved four separate incidents in the context of his professional practice. Mr McLauchlan has provided no explanation for his conduct or any reflections on these matters. Notwithstanding that there is some information before the Committee to suggest that Mr McLauchlan is no longer practising as a dentist since February 2024, it has borne in mind that it could be open to him to return to practise at a later date, should he choose to do so. The Committee considers that Mr McLauchlan poses an ongoing risk of significant harm to the public.

104. The Committee considers that Mr McLauchlan's repeated clinical failures, despite being given the opportunity by his practice to improve, speak of an attitudinal problem. This is further compounded by his repeated dishonesty, as well as a lack of reflection and insight. Mr McLauchlan has showed a complete disregard for his professional obligations towards his patients and on multiple occasions he failed to provide a basic standard of care. It does not consider that a period of suspension will bring about the necessary rectification of Mr McLauchlan's conduct and behaviour. The Committee considers that a period of suspended registration would not be sufficient to protect the public or the wider public interest.

105. The Committee has therefore determined that the only appropriate sanction to impose in the particular circumstances of this case is that of erasure. It is satisfied that imposing a sanction of erasure is consistent with the GDC's Guidance. The Committee is further satisfied that the following features at present in this case which points towards erasure:

- The findings include serious departures from the relevant professional standards.
- Where serious harm to patients... has occurred...
- Where a continuing risk of serious harm to patients, colleagues, or other persons is identified.
- Where the findings include serious dishonesty, particularly where persistent or covered up.
- Where there is a persistent lack of insight into the seriousness of actions or their consequences.
- A lesser sanction would be insufficient to meet the public interest.

106. The Committee hereby directs that Mr McLauchlan's name be erased from the register. The Committee is satisfied that anything less than erasure would fundamentally undermine public confidence in the profession and fail to declare and uphold professional standards.

107. The Committee now invites submissions on an immediate order.

### Decision and reasons on immediate order – 5 June 2026

108. Mr Stevens: You have made an application under section 30(1) of the Dentists Act 1984 for an immediate suspension order to be imposed on Mr McLauchlan's registration. You submitted that Mr McLauchlan represents an ongoing risk of repetition identified by the Committee such that an immediate order is necessary on the grounds of the protection of the public and is otherwise in the public interest. You further submitted that the test for the making of an immediate order is made out and is consistent with the Committee's reasons for directing erasure.

109. The Committee has accepted the advice of the Legal Adviser. In so doing, it has carried out a balancing exercise, taking into account Mr McLauchlan's own interests, balanced against the protection of the public and the wider public interest.

110. The Committee is aware that Mr McLauchlan can appeal against any sanction which will restrict his registration. It is further aware that during the appeal period (28 days) Mr McLauchlan's registration continues unrestricted, unless an immediate order is imposed.

111. In the circumstances, the Committee determined that the imposition of an immediate order of suspension on Mr McLauchlan's registration is necessary for the protection of the public and is otherwise in the public interest. In its substantive determination, the Committee has identified a risk of repetition, given the lack of any evidence of meaningful insight or remorse, and no evidence of any remediation from Mr McLauchlan. In the circumstances, the Committee considered that it would be inconsistent not to impose an immediate order for the protection of the public.

112. The Committee was also satisfied that an immediate order is required in the wider public interest in view of the gravity of the matters found proved. This includes multiple clinical failings as well as four separate findings of dishonesty which took place in the context of Mr McLauchlan's professional practice. It considered that immediate action is necessary in this case to maintain public confidence in the dental profession and the regulatory process, and to uphold proper professional standards of conduct and behaviour.

113. The effect of the foregoing substantive determination and this order is that Mr McLauchlan's registration will be suspended to cover the appeal period. Unless he exercises his right of appeal, the substantive direction for erasure will take effect 28 days from the date of deemed service.

114. Should Mr McLauchlan exercise his right of appeal, this immediate order will remain in place until the resolution of the appeal.

115. That concludes this determination.