PUBLIC HEARING

Professional Conduct Committee
Initial Hearing

11 to 21 November 2024

Name:	BEVAN, Frances Louise
Registration number:	62549
Case number:	CAS-202393

General Dental Council:	Eloise Power, Counsel Instructed by Ervin Gjoleka, Capsticks
Registrant:	Not present Not represented at the hearing Legal Representative: Venessa Holt, Medical Defence Union

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Fitness to practise:	Impaired by reason of misconduct
Outcome:	Erased
Immediate order:	Immediate suspension order

Committee members:	Clive Powell	(Chair, Lay Member)
	Sharon Allen	(Dental Care Professional Member)
	Vatsal Amin	(Dentist Member)
Legal Adviser:	Charles Apthorp	
Committee Secretary:	Lola Bird	

BEVAN, Frances, a dentist, BDS University of Wales 1987 is summoned to appear before the Professional Conduct Committee on 11 November 2024 for an inquiry into the following charge:

The charge (as amended):

"That being a registered dentist:

Patient A

1. You failed to provide an adequate standard of care to Patient A (identified in Schedule A below)* from 11 February 2009 to 13 February 2019 including by;

   (a) not carrying out sufficient treatment planning, in that there was a failure to set in place a definitive plan for treating the LL5, LL6, LR6 and UR5 **(as amended)**

   (b) not adequately treating, including, at;

      i. UR5, in that between 14 June 2017 and 4 April 2019 there was a delay in providing definitive restoration or extraction of the grossly carious UR5 **(as amended)**

      ii. LL6, in that between 11 September 2009 and 23 November 2014 there was a delay in performing definitive restoration of LL6.

      iii. LL5, in that between 9 May 2016 and 19 July 2017 you repeatedly dressed LL5 without justification notwithstanding that it was suitable for a root canal treatment.

      iv. LR6, in that between 4 April 2014 and 13 February 2019 you repeatedly dressed LR6 without adequate justification notwithstanding that it was suitable for a root canal treatment.

      v. **Withdrawn.**

   (c) your radiographic practice in that:

      i. there was a failure to take and/ or record bitewing radiographs when indicated, which should have been at least annually,

      ii. there was a failure to take and/ or record periapical radiographs of any teeth of doubtful prognosis which should at least have included LL6, LL5 and LR6.

      iii. on 21 March 2014, 1 May 2018 and 13 February 2019 there was a failure to provide an adequate and accurate report upon radiographs.

2. You failed to maintain an adequate standard of record keeping in respect of Patient A's appointments from 11 February 2009 to 13 February 2019 in that:

   (a) on 3 January 2013, the expected examination detail, namely risk assessment, diagnosis and treatment plan is absent from the records;

   (b) between 11 February 2009 – 13 February 2019 only three examinations were recorded,

whereas at least one examination a year should have been recorded;

(c) between 11 February 2009 – 13 February 2019 there were no recorded caries risk assessments, whereas a minimum of one caries risk assessment per year should have been recorded;

(d) there was a failure to record BPE at least annually;

(e) **Withdrawn.**

(f) **Withdrawn.**

Patient C

3. You failed to provide an adequate standard of care to Patient C (identified in Schedule A below) from 18 February 2008 to 14 February 2019 including:

(a) by not adequately managing the patient's periodontal condition in that:

i. on around 28 February 2012 and 7 January 2013 you failed to adequately investigate the patient's BPE scores of 3;

ii. **Withdrawn;**

iii. **Withdrawn.**

(b) in relation to your radiographic practice in that;

i. there was a failure to take bitewing radiographs when indicated;

ii. on or around 28 February 2012 and 7 January 2013 there was a failure to take and/ or record periapical radiographs notwithstanding the patient's BPE scores of 3.

(c) your failure to prescribe additional fluoride such as high fluoride toothpaste notwithstanding the patient's high caries rate/risk.

4. You failed to maintain an adequate standard of record keeping in respect of Patient C's appointments from 18 February 2008 to 14 February 2019 in that

i. on 28 February 2012 and 7 January 2013 the expected examination detail, namely diagnosis and treatment, is absent from the records; **(as amended)**

ii. between 1 February 2007 – 14 February 2019 there were no recorded caries risk assessments, whereas a minimum of one caries risk assessment per year should have been recorded;

iii. **Withdrawn.**

Patient D

5. You failed to provide an adequate standard of care to Patient D (identified in Schedule A below) from 3 September 2015 to 25 October 2018 including:

   (a) **Withdrawn.**

   (b) in relation to your radiographic practice in that:

      i. you failed to record bitewing radiographs when indicated, which should have been at least every two years; **(as amended)**

      ii. **Withdrawn.**

      iii. on 28 January 2016 and 5 April 2017 there was a failure to provide an adequate and accurate report upon radiographs.

Patient F

6. You failed to provide an adequate standard of care to Patient F (identified in Schedule A below) from 07 February 2008 to 24 January 2019 including by;

   (a) providing a poor standard of treatment, including, at;

      i. LL6, in that between 19 February 2007 and 7 September 2017 you repeatedly dressed LL6 in the course of 38 visits without any or any adequate justification and without finishing root canal treatment.

      ii. UR6, in that between 7 February 2008 and 24 January 2017 you repeatedly dressed UR6 without finishing root canal treatment.

7. You failed to maintain an adequate standard of record keeping in respect of Patient F's appointments from 07 February 2008 to 24 January 2019 in that:

      i. on 2 July 2013 expected examination detail, namely risk assessment, diagnosis and treatment, is absent from the records;

      ii. between 7 February 2008 and 24 January 2019 only three examinations were recorded, whereas at least one examination per year should have been recorded;

      iii. between 7 February 2008 and 24 January 2019 there were no recorded caries risk assessments, whereas a minimum of one caries risk assessment per year should have been recorded;

      iv. there was a failure to record BPE at recommended intervals, whereas this should have been recorded at least annually;

      v. there was a failure to take and/ or record bitewing radiographs when indicated (at least every two years);

      vi. on or around 20 March 2017 and 2 December 2013 there was a failure to provide

an adequate and accurate report upon radiographs;

vii. between 19 February 2007 and 24 January 2017 there was a failure to record any justification for delaying definitive treatment to the LL6 and UR6.

Patient G

8. You failed to provide an adequate standard of care to Patient G (identified in Schedule A below) from 17 January 2008 to 04 April 2019 including;

   (a) by providing a poor standard of treatment, including, at;

      i. UL6, in that between 17 January 2008 and 23 September 2014 there was a delay in providing definitive treatment to the UL6;

      ii. **Withdrawn.**

   (b) in your relation to your radiographic practice, in that bitewing radiographs were not taken at recommended intervals (every 12 – 18 months).

9. You failed to provide an adequate standard of record keeping in respect of Patient G's appointments from 17 January 2008 to 04 April 2019 in that:

   (a) between 17 January 2008 and 4 April 2019 there were no recorded caries risk assessments;

   (b) there was a failure to record the treatment plan or diagnosis in respect of UL5;

   (c) on 4 January 2016, 4 February 2016, 3 May 2016, 1 September 2016, 18 April 2017, 12 June 2017, 26 June 2017 and 5 July 2017 there was a failure to record options, diagnosis and treatment plan for the UR2

   (d) on 7 June 2007, 17 January 2008, 21 May 2008, 7 March 2012, 23 August 2012, 10 September 2013 and 20 December 2013 there was a failure to record options, diagnosis and treatment plan for the UL6.

10. You failed to maintain an adequate standard of record keeping in relation to radiographs, in that;

      i. radiographs taken on 2 August 2007, 30 August 2007 and 17 January 2008 are not reported upon;

      ii. the radiograph of 3 August 2017 is not recorded in the records.

Patient H

11. You failed to provide an adequate standard of care to Patient H (identified in Schedule A below) from 23 April 2013 to 12 July 2018 including by;

   (a) not adequately managing the patient's periodontal condition in that:

i. on 23 April 2013, 19 June 2014 and 7 June 2018 you failed to provide and/ or record adequate investigations following the patient's BPE scores of 3;

ii. **Withdrawn.**

(b) your radiographic practice in that

i. there was a failure to take bitewing radiographs when indicated, which should have been at least every two years

ii. there was a failure to take periapical radiographs to investigate periodontal disease between 23 April 2013 and 7 June 2018;

iii. on 6 June 2013 there was a failure to provide an adequate and accurate report upon radiographs.

12. You failed to maintain an adequate standard of record keeping in respect of Patient H's appointments from 23 April 2013 to 12 July 2018 in that:

i. on 23 April 2013 expected examination detail, namely risk assessment, diagnosis and treatment, is absent from the records;

ii. there was a failure to record 6 point pocket charts on 23 April 2013, 19 June 2014 and 7 June 2018 notwithstanding the BPE scores of 3.

Patient J

13. You failed to provide an adequate standard of care to Patient J (identified in Schedule A below) from 06 September 2016 to 17 July 2019 including by;

(a) providing a poor standard of treatment, including at UR1, in that between 23 October 2017 and 14 January 2019 you repeatedly dressed UR1 rather than providing timely definitive treatment by way of root canal treatment.

(b) not adequately managing the patient's risk of caries in that you failed to prescribe additional fluoride such as high fluoride toothpaste notwithstanding the patient's high caries rate/risk.

(c) by your radiographic management in that bitewing radiographs were not taken and/ or recorded when indicated.

14. You failed to maintain an adequate standard of record keeping in relation to radiographs in respect of Patient J's appointments of 6 September 2016 to 17 July 2019 in that:

i. on 23 November 2017 there was a failure to provide an adequate and accurate report upon radiographs;

ii. there was a failure to record any justification for repeatedly dressing UR1;

iii. there was a failure to record whether additional fluoride was advised or provided.

Patient K

15. You failed to provide an adequate standard of care to Patient K (identified in Schedule A below) from 04 December 2017 to 22 May 2019 including by;

    (a) **Withdrawn;**

        i. **Withdrawn.**

    (b) not adequately managing the patient's risk of caries in that you failed to perform and/ or record any caries risk assessments between 4 December 2017 and 22 May 2019.

16. You failed to provide an adequate standard of record keeping in respect of Patient K's appointments from 04 December 2017 to 22 May 2019 in that:

    i. between 4 December 2017 and 22 May 2019 there were no recorded caries risk assessments;

    ii. **Withdrawn;**

    iii. only one examination was recorded between 4 December 2017 and 22 May 2019;

    iv. no BPE scores were recorded prior to 22 May 2019

Patient L

17. You failed to provide an adequate standard of care to Patient L (identified in Schedule A below) from 29 January 2008 to 05 June 2019 including;

    (a) by providing a poor standard of treatment, including, at;

        i. UR6, in that between 12 March 2012 and 12 February 2018 you repeatedly dressed UR6 rather than providing timely definitive treatment.

    (b) by not providing the patient with full information regarding their treatment;

    (c) in relation to radiographic management in that:

        i. between 29 January 2008 and 5 June 2019 there was a failure to take and/ or record bitewing radiographs when indicated, which should have been at least every two years;

        ii. on 1 December 2015 there was a failure to provide an adequate and accurate report upon radiographs.

18. You failed to maintain an adequate standard of record keeping in respect of Patient L's appointments from 29 January 2008 to 05 June 2019 in that:

    i. on 22 March 2011 and 10 November 2011 expected examination detail, namely risk assessment, diagnosis and treatment, is absent from the records;

    ii. between 10 November 2011 and 6 March 2019 only one examination is recorded;

iii. between 29 January 2008 – 5 June 2019 there were no recorded caries risk assessments,

iv. there is no justification recorded for the delay in providing definitive treatment to the UR6 on multiple occasions.

Patient O

19. You failed to provide an adequate standard of care to Patient O (identified in Schedule A below) from 22 November 2010 to 10 April 2019 including;

(a) by providing a poor standard of treatment, including, at;

i. **Withdrawn.**

ii. UL7, in that there was a failure to provide restoration to the UL7 between 3 April 2017 and 10 April 2019.

(b) in relation to your radiographic practice in that there was:

i. **Withdrawn;**

ii. failure to report upon radiographs of 20 March 2017.

Patient T

20. You failed to provide an adequate standard of care to Patient T (identified in Schedule A below) from 14 January 2008 to 20 February 2019 including;

(a) by providing a poor standard of treatment, including, at;

i. UR8, in that between 28 December 2011 and 18 January 2018 there was a failure to provide an adequate restoration. **(as amended)**

ii. LL5, in that between 19 May 2015 and 15 February 2018 there was a failure to provide an adequate restoration.

iii. UR6, in that between 11 October 2012 and 5 November 2018 there was a failure to provide an adequate restoration.

iv. UL7, in that between 16 November 2017 and 11 October 2018 there was a failure to provide an adequate restoration.

(b) by not diagnosing the need for further treatment, including, at;

i. UR5, in that around July 2018 you failed to recognise the need for root canal treatment at UR5 in or around July 2018.

(c) in relation to your radiographic practice in that

i. there was a failure to take and/ or record bitewing radiographs when indicated,

which would have been at least every two years;

ii. on 30 December 2008, 5 June 2018 and 19 July 2018 there was a failure to report upon radiographs.

21. You failed to maintain an adequate standard of record keeping in respect of Patient T's appointments from 14 January 2008 to 20 February 2019 in that;

i. there was a failure to explain the repeated failures to the restorations of UR8, LL5, UR6 and UL7,

ii. there was a failure to record treatment planning in relation to restoration options for UR8, LL5, UR6 and UL7.

Patient V

22. You failed to provide an adequate standard of care to Patient V (identified in Schedule A below) from 22 February 2008 to 24 January 2019 including;

(a) by providing a poor standard of treatment, including, at;

i. UL5, in that between 8 December 2008 and 11 February 2013 there was a failure to provide definitive treatment to the UL5,

ii. UR7, in that between 22 February 2008 and 29 March 2009 there was a failure to provide definitive treatment to the UR7,

iii. UL3, in that between 25 March 2010 and 8 June 2011 there was a failure to provide definitive treatment to the UL3,

(b) On or around 4 July 2018, there was a failure to diagnose caries at the UR7.

(c) your radiographic practice in that

i. between 22 February 2008 and 24 January 2019 there was a failure to take and/ or record bitewing radiographs when indicated, which should have been at least every two years;

ii. on 4 July 2018 there was a failure to report upon two radiographs.

23. You failed to maintain an adequate standard of record keeping in respect of Patient V's appointments from 22 February 2008 to 24 January 2019 in that

i. between 22 February 2008 to 24 January 2019 there was no recorded caries risk assessment;

ii. there was no adequate recorded justification for the delay in treatment to the UL5, UR7 and UL3.

Patient W

24. You failed to provide an adequate standard of care to Patient W (identified in Schedule A below) from 06 December 2012 to 16 May 2019 including by; **(as amended)**

    (a) by providing a poor standard of treatment, including, at;

        i. UL2, in that between 26 September 2013 and 24 July 2018 you repeatedly dressed the UL2 without providing timely definitive treatment.

        ii. LR6, in that between 6 April 2017 and 16 May 2019 you repeatedly dressed the LR6 without providing definitive treatment.

    (b) your radiographic practice in that

        i. there was a failure to take and/ or record bitewing radiographs when indicated, which should have been at least every two years;

        ii. on or around 26 September 2013 there was a failure to take periapical radiographs notwithstanding the patient's BPE score of 3;

        iii. on 4 December 2012, 4 September 2014 and 16 November 2018 there was a failure to provide an adequate and accurate report upon radiographs.

    (c) periodontal management in that on or around 26 September 2013 you failed to

        i. adequately investigate the patient's BPE score of 3 by way of periapical radiographs and

        ii. provide any or any adequate treatment for the patient's periodontal condition, which should at least have included root surface debridement (RSD).

25. You have failed to maintain an adequate standard of record keeping in respect of Patient W's appointments from 7 March 2007 to 09 May 2015 in that

        i. on 6 November 2012 and 26 September 2013 expected examination detail, namely risk assessment, diagnosis and treatment, is absent from the records;

        ii. between 6 November 2012 and 9 May 2015 there were no recorded caries risk assessments;

        iii. there was no or no adequate justification recorded for the delay in providing definitive treatment to the UL2 and LR6.

Patient Z

26. You failed to provide an adequate standard of care to Patient Z (identified in Schedule A below) from 10 November 2015 to 20 June 2019 including;

    (a) by not adequately treating the patient's periodontal condition in that

i. on 10 November 2015 you failed to record BPE scores notwithstanding the periodontally involved LR5;

ii. **Withdrawn,**

iii. **Withdrawn,**

iv. **Withdrawn.**

(b) your radiographic practice in that

i. there was a failure to take and/ or record bitewing radiographs when indicated;

ii. there was a failure to adequately report on the radiographs of 10 November 2015 in that the extent of bone loss is not recorded;

iii. on or around 9 January 2018 there was a failure to take and/ or record periapical radiographs notwithstanding the patient's BPE score of 4;

iv. **Withdrawn.**

27. You failed to maintain an adequate standard of record keeping in respect of patient Z's appointments from 10 November 2015 to 20 June 2019 in that the records lack an adequate recorded diagnosis, a clear explanation of treatment options and a clear explanation of risks.

Patient AA

28. You failed to provide an adequate standard of care to Patient AA (identified in Schedule A below) from 21 February 2008 to 11 September 2018 including:

(a) your radiographic practice, in that

i. there was a failure to take and/ or record bitewing radiographs when indicated, which should have been at least every two years;

ii. on or around 1 November 2017 there was a failure to take and/ or record periapical radiographs notwithstanding the patient's BPE score of 3;

Patient DD

29. You failed to provide an adequate standard of care to Patient DD (identified in Schedule A below) from 25 January 2008 to 04 July 2019 including by;

(a) by not adequately managing the patient's periodontal condition, in that:

i. On or around 14 September 2010 and 14 August 2014 you failed to adequately investigate the patient's BPE scores of 3 and 4 by way of periapical radiographs;

ii. On or around 14 September 2010 and 14 August 2014 you failed to provide any or any adequate treatment for the patient's periodontal disease. Adequate treatment should have included root surface debridement (RSD) rather than simple scaling.

30. You failed to maintain an adequate standard of record keeping in relation to Patient DD's appointments from 25 January 2008 to 04 July 2019, in that:

    i. On 15 January 2019 you noted "no areas of concern" in relation to the patient's face, neck, forehead, scalp, ears, nose, cheek and chin. You failed to record the presence of a lump on the patient's neck and you failed to record any discussions with the patient in respect of the plan for the lump.

    ii. On 4 July 2019 you failed to record any discussions with the patient in respect of the plan for the lump on the patient's neck.

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

* Schedule A is a private document that cannot be disclosed.

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1. This is a Professional Conduct Committee hearing in respect of a case brought against Ms Bevan by the General Dental Council (GDC). The charge against Ms Bevan concerns the standard of care she provided to a number of patients.

2. The hearing commenced on 11 November 2024 and is being held remotely by Microsoft Teams video-link.

3. Ms Bevan is not present or represented at the hearing, however she is assisted in this case by her legal representatives at the Medical Defence Union (MDU). The Case Presenter for the GDC is Ms Eloise Power, Counsel.

Application to proceed with the hearing in the absence of the registrant – 11 November 2024

4. At the outset, Ms Power made an application pursuant to Rule 54 of the *GDC (Fitness to Practise) Rules Order of Council 2006* ('the Rules') to proceed with the hearing notwithstanding Ms Bevan's absence.

5. The Committee took account of Ms Power's submissions in respect of the application along with the supporting documentation provided. It was Ms Power's submission that notice had been duly served in this case. She submitted that Ms Bevan had made a conscious and reasoned decision not to attend or be represented at these proceedings. Ms Power drew the Committee's attention to correspondence from Ms Bevan's solicitors in relation to this hearing. Ms Power further referred to Ms Bevan's own explanation regarding her non-attendance, as set out in her witness statement dated 21 October 2024. The Committee heard the detail of that explanation in private session.

6. In reaching its decisions on the issue of service and whether to proceed in the absence of Ms Bevan, the Committee accepted the advice of the Legal Adviser.

Decision on service – 11 November 2024

7. The Committee considered whether notice of the hearing had been served on Ms Bevan in accordance with Rules 13 and 65. It had sight of the Notice of Hearing dated 1 October 2024 ('the notice'), which was sent to Ms Bevan's registered address by Special Delivery.

8. The notice was 'returned to sender' on 21 October 2024. However, the Committee took into account that there is no requirement within the Rules for the GDC to prove delivery of the notice, only that it was sent. It was satisfied from the proof of posting information provided by the Council that the requirement of sending notice had been met.

9. The Committee also took into account that a copy of the notice was sent by email on 1 October 2024 to Ms Bevan's legal representatives at the MDU, and that they corresponded with the GDC regarding this hearing. This included an email dated 4 November 2024, in which they confirmed receipt of the notice.

10. The Committee was satisfied that the notice sent to Ms Bevan and to her legal representatives complied with the 28-day notice period required by the Rules. It was also satisfied that the notice contained all the necessary particulars, including the date and time of the hearing, confirmation that it would be conducted remotely by Microsoft Teams video-link, and that the Committee had the power to proceed with the hearing in Ms Bevan's absence.

11. On the basis of all the information before it, the Committee was satisfied that notice of this hearing had been served on Ms Bevan in accordance with the Rules.

Decision on whether to proceed with the hearing in the absence of the registrant – 11 November 2024

12. The Committee next considered whether to exercise its discretion under Rule 54 to proceed with the hearing in the absence of Ms Bevan. It approached this issue with the utmost care and caution. The Committee took into account the factors to be considered in reaching its decision, as set out in the relevant case law, including the case of *General Medical Council v Adeogba* [2016] EWCA Civ 162.

13. The Committee remained mindful that fairness to Ms Bevan was an important consideration, however, it also bore in mind the need to be fair to the GDC, and the public interest in the expeditious disposal of this case.

14. The Committee was satisfied that Ms Bevan is aware of this PCC hearing. It had before it correspondence from her legal representatives regarding these proceedings. In a letter to Capsticks, the solicitors acting on behalf of the GDC, Ms Vanessa Holt, solicitor at the MDU stated that *"I can confirm that Ms Bevan will not be attending the hearing and will not be represented. Her witness statement is to stand as her written representations…".*

15. The Committee took into account that Ms Bevan has the benefit of legal representation. It considered the confirmation on her behalf that she would not be in attendance or represented at this hearing to be clear and unequivocal. Ms Bevan's solicitor did not request an adjournment. Furthermore, the Committee was satisfied on the basis of the information contained in Ms Bevan's witness statement, that deferring the hearing was unlikely to secure her attendance on a future date. The indication is that Ms Bevan has voluntarily absented herself and that she wishes the hearing to proceed in her absence. The Committee noted that she has provided a comprehensive witness statement in response to the allegations.

16. It was the conclusion of the Committee that an adjournment would serve no meaningful purpose. It took into account that the GDC was ready to present its case, and that a number of witnesses had been scheduled to attend these proceedings, should they be required. In all the circumstances, the Committee determined that it was fair and in the public interest to proceed with the hearing in the absence of Ms Bevan.

Further preliminary applications made by the GDC – 11 November 2024

17. Ms Power made three further preliminary applications. She applied to:

- withdraw a number of allegations from the charge, some wholly and some in part;
- amend two allegations within the charge, pursuant to Rule 18 of the Rules;
- join additional allegations to the charge, pursuant to Rule 25 of the Rules.

18. The Committee heard Ms Power's submissions in respect of three applications before deciding on them separately.

19. Ms Power applied to withdraw the following heads of charge in their entirety: 1(b)(v), 2(e), 2(f), 3(a)(ii), 3(a)(iii), 4(iii), 5(a), 5(b)(ii), 8(a)(ii), 11(a)(ii), 15(a)(i), 16(ii), 19(a)(i), 19(b)(i), 26(a)(ii), 26(a)(iii) and 26(a)(iv). She also applied for some of the wording from heads of charge 4(i) and 5(b)(i) to be withdrawn.

20. It was Ms Power's submission that there could be no conceivable prejudice to Ms Bevan from withdrawing the allegations. In providing the rationale for applying for the withdrawals, Ms Power told the Committee that the expert witness instructed by the GDC in this case, Ms Jane Ford, no longer supported the allegations in question, following a further review of the evidence.

21. Ms Power next applied to amend the allegations at heads of charge 1(b)(i) and 20(a)(i). The application was to amend the dates set out in these allegations. She highlighted that the rationales for the proposed changes were set out in Ms Ford's written expert evidence.

22. Ms Power told the Committee that Ms Bevan had not formally agreed the proposed amendments but nor had she expressed any disagreement. It was Ms Power's submission, with reference to Rule 18, that no injustice would be caused to Ms Bevan by making the proposed amendments.

23. Finally, Ms Power applied to join a number of additional allegations to the charge, pursuant to Rule 25(2), which states that:

> *Where—*
>
> > *(a) an allegation against a respondent has been referred to a Practice Committee,*
> >
> > *(b) that allegation has not yet been heard, and*
> >
> > *(c) a new allegation against the respondent which is of a similar kind or is founded on the same alleged facts is received by the Council,*
>
> *the Practice Committee may consider the new allegation at the same time as the original allegation, notwithstanding that the new allegation has not been included in the notification of hearing.*

24. Ms Power submitted that in accordance with Rule 25(3), Ms Bevan had been notified in good time of the GDC's intention to make an application for joinder. Ms Power further submitted that Ms Bevan had tacitly accepted the merits of the Rule 25 application, given that she has dealt substantively with the additional allegations in her witness statement provided for this hearing. Furthermore, Ms Power noted that Ms Bevan has admitted a number of the allegations that the GDC proposed to join to the charge.

25. It was Ms Power's submission that the additional allegations, which related to failures to provide adequate restorations and issues with radiography, were of a similar kind to multiple other allegations within the charge.

Decisions on the further preliminary applications – 11 November 2024

26. The Committee was satisfied that there could be no prejudice to Ms Bevan in withdrawing allegations from the charge. It therefore acceded to Ms Power's application in this regard. In relation to heads of charge 4(i) and 5(b)(i), where the application was to withdraw parts of the wording of those allegations, the Committee considered that these were effectively amendments, and it noted them as such on the amended charge.

27. The Committee also acceded to the proposed amendments to heads of charge 1(b)(i) and 20(a)(i). It noted that the two suggested changes were to dates within these allegations, both of which shorten the alleged timeframes. The Committee was satisfied that there would be no detriment to Ms Bevan in granting this application.

28. The Committee further considered and granted the GDC's Rule 25 application for joinder. It was satisfied that Ms Bevan was duly notified of the GDC's intention to apply to join additional allegations to the charge. The Committee was also satisfied that all the requirements of Rule 25(2) had been met, including that the additional allegations were of a similar kind to those already featured in the charge. The Committee noted that Ms Bevan has addressed the additional allegations in her witness statement and had made some admissions in respect of them. In all the circumstances, the

Committee determined that it would be expeditious and in the public interest to join the additional allegations to the charge, so that all matters could be considered together at this hearing.

Admissions to the charge

29. In relation to Ms Bevan's admissions to the alleged matters, Ms Power provided the Committee with a copy of the charge on which those matters admitted by Ms Bevan were highlighted. It was noted that Ms Bevan admitted the allegations at head of charge: 3(c), 7(i) to 7(v), 7(vii), 12(i), 14(ii), 16(iii), 17(c)(i), 18(i) to 18(iv), 20(c)(i), 21(i), 21(ii), 22(b), 23(ii) and 25(iii).

30. Ms Power told the Committee that Ms Bevan's legal representatives had carefully reviewed and agreed the admissions to be put before the Committee. In the circumstances, Ms Power invited the Committee to find the admitted matters proved in accordance with Rule 17(4).

31. The Committee accepted the advice of the Legal Adviser. It noted that the admissions had been approved by Ms Bevan's legal representatives. The Committee was satisfied that the admissions were clear and unequivocal, and it was content to accept them. Accordingly, the Committee announced heads of charge 3(c), 7(i) to 7(v), 7(vii), 12(i), 14(ii), 16(iii), 17(c)(i), 18(i) to 18(iv), 20(c)(i), 21(i), 21(ii), 22(b), 23(ii) and 25(iii) as 'found proved', with no further obligation on the GDC to present evidence in relation to these admitted allegations.

Summary of the case background

32. In her opening submissions, Ms Power provided an overview of the case. She submitted that this is a multiple patient case concerning Ms Bevan's care and treatment of 16 patients over the period 2007 to 2019.

33. Ms Power highlighted that the overriding allegation against Ms Bevan is one of misconduct and not deficient professional performance. This is because the sample of patients referred to in the charge was not chosen at random but came to the attention of the GDC in a complaint made by the original informant in this case, Witness 1.

34. Witness 1 is a dentist who bought the dental practice concerned ('the Practice') from Ms Bevan in August 2018. In his witness statement provided for this hearing, dated 13 June 2023, Witness 1 stated that he worked alongside Ms Bevan at the Practice following the purchase until April 2019.

35. Ms Power referred the Committee to Witness 1's written evidence that following his purchase of the Practice, issues concerning Ms Bevan's treatment of specific patients came to his attention. He stated that the majority of the issues stemmed from incomplete root canal treatments. In his witness statement, Witness 1 maintained that he had multiple conversations with Ms Bevan regarding the concerns, which he followed up with emails. Ms Power highlighted that Witness 1's evidence is challenged in part by Ms Bevan.

36. On 3 August 2019, Witness 1 referred concerns about Ms Bevan to the GDC. In doing so, he explained that the selected records were for patients who had either complained to the Practice regarding their treatment, or for patients he had subsequently seen himself and noted concerns.

37. Ms Power submitted that the charge against Ms Bevan includes allegations of clinical, radiographic and record keeping failings, and she outlined what she considered to be the broad themes, namely:

- alleged failures to provide definitive treatment to a number of the patients, such as restorations and extractions.
- alleged radiographic failings, including failing to take and/or record and/or report on bitewing and periapical radiographs when indicated.
- alleged failings of periodontal management, such as failing to take and/or record Basic Periodontal Examinations (BPEs) and alleged failures to act appropriately in relation to high BPE scores.
- alleged failings in the management of caries risk.
- alleged failings in record keeping.

38. Ms Power submitted that this was not an exhaustive list, and that some of the issues to be considered fall outside of these themes. However, in summary, the GDC's case is that there were multiple failings by Ms Bevan which affected multiple patients over a prolonged period of time. Ms Power submitted that the GDC's expert in this case, Ms Ford, had reviewed the evidence and had treated the concerns raised with due seriousness.

39. In setting out the case background and the issues to be considered, Ms Power also referred to Ms Bevan's witness statement provided in respect of this hearing. Ms Power noted that Ms Bevan had provided detailed written responses to the individual allegations. It was also noted that Ms Bevan raises a number of other matters, including criticisms regarding the GDC's investigation.

40. Ms Power highlighted that one of the matters raised by Ms Bevan is her belief that important documents pertaining to this case are missing, including some patient records. Ms Power drew the Committee's attention to a document dated 8 November 2024, containing supplementary comments made by Ms Ford, in relation to some of the matters raised by Ms Bevan in her witness statement. In particular, Ms Power asked the Committee to note that Ms Ford had considered the possibility of missing records, and had concluded that it was unlikely that any potential missing records would impact her opinion in relation allegations concerning standard of treatment. However, Ms Ford stated that if records were missing, this could potentially impact her opinion in relation to the allegations where she is critical of BPE records, 6-point pocket charts, radiographs and radiographic reports.

41. Ms Power submitted that the issue regarding any potential missing records would be a matter for the Committee in due course.

Decision on further application to amend the charge – 11 November 2024

42. Following her opening address, Ms Power made a further application to amend the charge under Rule 18. She applied to amend head of charge 1(a) in part, by removing the wording relating to the referral of Patient A for specialist treatment. Ms Power drew the Committee's attention to the supplementary comments made by Ms Ford in the document dated 8 November 2024. In her supplementary comments, Ms Ford noted the evidence that Patient A had declined a specialist referral due to concerns about cost and complexity. It was Ms Ford's opinion that this was an adequate justification for not referring the patient for specialist treatment.

43. Ms Power also applied to withdraw head of charge 26(b)(iv) in its entirety. This allegation related to a failure to provide an adequate and accurate report on a radiograph. Again, referring to the supplementary comments of Ms Ford, Ms Power asked the committee to take into account that Ms Ford had now identified an entry in the relevant clinical records that is likely to be the radiographic report.

44. Having heard from Ms Power, and having accepted the advice of the Legal Adviser, the Committee acceded to the application. It was satisfied that the proposed amendment and the withdrawal could be made without any prejudice to Ms Bevan.

Evidence

45. The Committee received documentary evidence from the GDC which comprised the clinical records for the 16 patients concerned in various forms. Also received were a number of witness statements, including from Patients A, C, D, J.

46. Further, there was a main and supplemental witness statement from a Paralegal at Capsticks, the solicitors acting on behalf of the GDC. The purpose of these witness statements, dated 21 December 2023 and 30 September 2024, was to introduce a number of documents obtained by the Council during the course of its investigation.

47. The remaining witness statements put before the Committee were from colleagues who work at the Practice. In particular, these were:

- The witness statement of Witness 1, Dentist and informant in this case, dated 13 June 2023.
- The first and second witness statements of Witness 2, Dental Nurse, dated 8 June 2023 and 20 December 2023.
- The witness statement of Witness 3, Practice Administrator, dated 30 September 2024.

48. In addition to their witness statements, the Committee heard oral evidence from Witnesses 1, 2 and 3.

49. The Committee did not consider it necessary to hear oral evidence from any of the patient witnesses. It was the view of the Committee that hearing from the patients would not assist it any further in dealing with the allegations, which are largely the subject of expert evidence.

50. In terms of the expert evidence, the Committee was provided with three reports prepared by Ms Ford: her main expert report, dated 15 June 2023; an addendum report dated 22 December 2023; and a second addendum report dated 30 September 2024.

51. In relation to Ms Bevan's defence case, the Committee had before it Ms Bevan's witness statement dated 21 October 2024 with associated exhibits.

52. The Committee also took into account the supplementary comments made by Ms Ford in the email of 8 November 2024, in response to a number of issues raised by Ms Bevan in her witness statement.

Decision on further application to amend the charge – 14 November 2024

53. It was noted during the course of Ms Ford's oral evidence that there was a typographical error in the stem of head of charge 24. The time period referred to in the stem was from 6 December 2012 to 9 May 2015, when it should in fact have been 6 December 2012 to 16 May 2019.

54. In acceding to Ms Power's application to amend '9 May 2015' to '16 May 2019', the Committee took into account that Ms Bevan had been aware of the allegations against her for some time, and that in her witness statement she addressed the sub-particulars of head of charge 24 with reference to broader period of time. Ms Ford also referred to the longer timeframe when giving her opinion in her expert report.

55. In all the circumstances, having accepted the Legal Adviser's advice, the Committee considered that there would be no prejudice to Ms Bevan amending the stem of head of charge 24.

FINDINGS OF FACT – 20 November 2024

56. The Committee considered all the evidence presented to it, both documentary and oral. It took account of the closing submissions on the alleged facts made by Ms Power on behalf of the GDC. The Committee accepted the advice of the Legal Adviser.

The Committee's finding on the issue of missing documentation

57. Before making its findings on the outstanding factual allegations, the Committee considered the issue raised by Ms Bevan regarding missing documentation. In her witness statement, Ms Bevan stated that she is concerned that there may be documents missing which could be helpful to her case.

58. It was the conclusion of the Committee, having reviewed all the information before it, and having heard oral evidence from Witnesses 1, 2 and 3, that it is more likely than not that it has been provided with all the available records for the 16 patients in question. The Committee found the evidence given by Witnesses 1, 2 and 3 in relation to the efforts made to disclose all the patient

records, to be clear, consistent and reliable. It also took into account the observation made by Ms Ford in her oral evidence that she gained the impression from the oral evidence of Witnesses 1, 2 and 3, that the Practice was well-run and organised. The Committee had no reason to doubt that all the available records had been provided.

59. In considering the issue of the documentation, the Committee noted that Ms Bevan refers in her witness statement to some missing radiographic diaries. However, the Committee heard from the witnesses from the Practice that these diaries were only used to record the name, date, type of view and grading of radiographs taken. The Committee had before it photographs of pages from some of the diaries. Given the nature of the information recorded in the diaries, the Committee did not consider that additional diary entries, even if they were missing, would assist any further in relation to the issue of radiographic reporting, which is the subject of a number of the allegations against Ms Bevan.

The Committee's findings on the factual allegations

60. Having determined that all the records in respect of the 16 patients have been provided, the Committee considered each of the outstanding factual allegations individually. It bore 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 alleged facts are proved on the balance of probabilities.

61. For completeness, the following findings made by the Committee include reference to those matters that were announced as admitted and found proved at the beginning of the hearing:

PATIENT A	
1(a)	*You failed to provide an adequate standard of care to Patient A (identified in Schedule A…) from 11 February 2009 to 13 February 2019 including by;* **Further amended by the Committee to read:** *not carrying out sufficient treatment planning, in that there was a failure to set in place a definitive plan for treating the LL5, LL6, LR6 and* ***UR5*** **Found proved.** This allegation originally included reference to Patient A's UR7. However, the clinical records show that Ms Bevan provided definitive treatment to UR7 during the period in question. The Committee noted that there had been a separate allegation in respect of UR7 at 1(b)(v) below, but that matter was withdrawn by the GDC at the outset of the proceedings. Taking these issues into account, it was the view of the Committee that the original reference to 'UR7' in this allegation at 1(a) was a typographic error. It considered the correct tooth to be 'UR5' and noted that this would be consistent with the matter alleged at 1(b)(i) below, which refers to UR5. Accordingly, before reaching any decision in respect of this allegation at 1(a), the Committee amended the wording by replacing the original reference to 'UR7' with 'UR5'.

	In finding this matter proved as amended, the Committee had regard to the expert evidence of Ms Ford. It noted her opinion in her main report regarding Patient A's *"prolonged and incomplete treatments".* In her oral evidence, Ms Ford confirmed her view that Ms Bevan provided a considerable amount of 'holding treatment' to the four teeth in question, in that they were repeatedly dressed, with no definitive treatment provided. The Committee reviewed the clinical records for Patient A and considered that there is a lack of detail to indicate definitive treatment planning in respect of the LL5, LL6, LR6 and UR5. The Committee noted that in her witness statement, Ms Bevan appears to suggest that Patient A was abroad for periods of time during his ongoing treatment with her. However, it did not accept this as a reasonable justification for not definitively treating the teeth concerned. The Committee preferred the evidence of Ms Ford, who highlighted that Patient A had a number of appointments with Ms Bevan. It was Ms Ford's opinion, which the Committee accepted, that Ms Bevan had several opportunities to complete the treatment of the four teeth. Furthermore, the Committee was satisfied on the evidence of Ms Ford that Ms Bevan had a duty to provide definitive treatment, given the highlighted risks to the patient. In her main report, Ms Ford referred on a number of occasions to the potential for an increased risk of re-infection, pain and swelling from delayed treatment. In all the circumstances, the Committee was satisfied on the balance of probabilities that this allegation is proved.
1(b)(i)	*You failed to provide an adequate standard of care to Patient A (identified in Schedule A …) from 11 February 2009 to 13 February 2019 including by;* *not adequately treating, including, at;* *UR5, in that between 14 June 2017 and 4 April 2019 there was a delay in providing definitive restoration or extraction of the grossly carious UR5.* **Found proved.** The Committee noted that on 22 July 2014, gross caries was diagnosed at Patient A's UR5 by another dentist. On 14 June 2017, Ms Bevan noted in the clinical records *'UR5 apical area'*, but made no reference in the notes to any treatment plan for the tooth. Instead, the evidence indicates that the UR5 was repeatedly dressed by Ms Bevan. The Committee found this allegation at 1(b)(i) proved for the same reasons given in respect of 1(a) above. It considered that Ms Bevan had several opportunities over the period in question to provide definitive treatment to UR5. The Committee noted Ms Bevan's evidence in her witness statement that her recollection was that Patient A had declined any invasive treatment to the UR5, despite being made aware of the apical area. However, the Committee found no such justification recorded in the clinical records. It considered that it could place more weight on the contemporaneous clinical records than Ms Bevan's recollection provided some years after the event.

1(b)(ii)	*You failed to provide an adequate standard of care to Patient A (identified in Schedule A …) from 11 February 2009 to 13 February 2019 including by;* *not adequately treating, including, at;* *LL6, in that between 11 September 2009 and 23 November 2014 there was a delay in performing definitive restoration of LL6.* **Found proved.** The Committee noted from the clinical records that Ms Bevan recorded a history of fractures and repairs to LL6 on a number of dates over the period concerned. Ms Ford commented that Patient A attended several appointments with Ms Bevan when the LL6 was dressed but no definitive treatment was provided by her. The Committee found this allegation at 1(b)(ii) proved for the same reasons given in respect of 1(a) and 1(b)(i) above. It considered that Ms Bevan had several opportunities over the period in question to provide definitive treatment to Patient A's LL6. It was satisfied on the evidence contained in the clinical records that she did not do so. The Committee found a lack of detail in the clinical notes to indicate any definitive treatment planning in respect of the LL6 by Ms Bevan.
1(b)(iii)	*You failed to provide an adequate standard of care to Patient A (identified in Schedule A…) from 11 February 2009 to 13 February 2019 including by;* *not adequately treating, including, at;* *LL5, in that between 9 May 2016 and 19 July 2017 you repeatedly dressed LL5 without justification notwithstanding that it was suitable for a root canal treatment*. **Found proved.** The Committee found this allegation at 1(b)(iii) proved for the same reasons given in respect of 1(a), 1(b)(i) and 1(b)(ii) above. This allegation at 1(b)(iii) covers a period of just over a year. The Committee considered that Ms Bevan had several opportunities to provide definitive treatment to Patient A's LL5. It was satisfied on the evidence contained in the clinical records that she did not do so. The Committee found a lack of detail in the clinical notes to indicate any definitive treatment planning in respect of the LL5 by Ms Bevan or any adequate justification for a delay.
1(b)(iv)	*You failed to provide an adequate standard of care to Patient A (identified in Schedule A …) from 11 February 2009 to 13 February 2019 including by;* *not adequately treating, including, at;* *LR6, in that between 4 April 2014 and 13 February 2019 you repeatedly dressed LR6 without adequate justification notwithstanding that it was suitable for a root canal treatment.* **Found proved.** The Committee found this allegation at 1(b)(iv) proved for the same reasons given in respect of 1(a), 1(b)(i), 1(b)(ii) and 1(b)(iii) above. This allegation at 1(b)(iv) covers a period of almost five years. The Committee considered that Ms Bevan

	had several opportunities over this lengthy period to provide definitive treatment to Patient A's LR6. It was satisfied on the evidence contained in the clinical records that she did not do so. The Committee found a lack of detail in the clinical notes to indicate any definitive treatment planning in respect of the LR6 by Ms Bevan or any adequate justification for a delay.
1(b)(v)	**Withdrawn.**
1(c)(i)	*You failed to provide an adequate standard of care to Patient A (identified in Schedule A…) from 11 February 2009 to 13 February 2019 including by;* *your radiographic practice in that:* *there was a failure to take and/ or record bitewing radiographs when indicated, which should have been at least annually.* **Found proved.** In reaching its decision, the Committee had regard to the expert evidence of Ms Ford. In her main report, she refers to the *'Selection Criteria for Dental Radiography'* 2004 and 2013, which set out guidance in relation to the frequency for taking bitewing radiographs. The guidance is that bitewing radiographs should be taken every year for moderate caries risk patients. It was Ms Ford's opinion, based on the clinical records provided, that bitewing radiographs should have been taken of Patient A *"every year if not more frequently".* Her evidence was that bitewing radiographs were not taken of Patient A at the recommended intervals, which increased the risk of undiagnosed dental disease being left untreated. Ms Bevan stated in her witness statement that she could not fully comment on this allegation at 1(c)(i), as she considered that some documents in this case were still missing, including some entries from radiographic diaries. However, Ms Bevan maintained that, according to the clinical records, bitewing radiographs were taken of Patient A on 11 February 2009, 17 April 2014 and 20 December 2017. The Committee, having determined that it had been provided with all Patient A's records, noted that there is reference in the clinical records to radiographs having been taken of the patient. In relation to the dates 11 February 2009 and 17 April 2014, it is stated in the clinical records that 'small radiographs' were taken of Patient A, but without specifying the type of radiograph. It was apparent to the Committee, having examined the clinical records that these were in fact periapical radiographs. On 20 December 2017 there is reference to right and left bitewings having been taken. Notwithstanding this, the Committee noted that even if all the radiographs referred to by Ms Bevan were bitewing radiographs, they were not taken at least annually as specified in the relevant guidance. The Committee took into account that the guidance outlined by Ms Ford in relation to this allegation is guidance and therefore not mandatory. However, it could not find any justification in the clinical notes for departing from the established recommendation of taking yearly radiographs. The Committee accepted the opinion of Ms Ford that yearly, or more frequent bitewing radiographs were required for Patient A.

	The Committee was satisfied that this allegation is proved on the balance of probabilities.
1(c)(ii)	*You failed to provide an adequate standard of care to Patient A (identified in Schedule A …) from 11 February 2009 to 13 February 2019 including by;* *your radiographic practice in that:* *there was a failure to take and/ or record periapical radiographs of any teeth of doubtful prognosis which should at least have included LL6, LL5 and LR6.* **Found proved.** Ms Ford stated in her main report that periapical radiographs *"of any teeth of doubtful prognosis or needing deep restorations would also be indicated".* The Committee accepted Ms Ford evidence and was satisfied that periapical radiographs should have been taken of LL6, LL5 and LR6, particularly as it noted that Ms Bevan proposed root canal treatment for at least two of these teeth. Having reviewed the clinical records for Patient A, the Committee found that sufficient periapical radiographs were not taken as recommended, and no justification was recorded from departing from the relevant radiography guidance. Accordingly, the Committee was satisfied that this allegation is proved on the balance of probabilities.
1(c)(iii)	*You failed to provide an adequate standard of care to Patient A (identified in Schedule A …) from 11 February 2009 to 13 February 2019 including by;* *your radiographic practice in that:* *on 21 March 2014, 1 May 2018 and 13 February 2019 there was a failure to provide an adequate and accurate report upon radiographs.* **Found proved in relation to 1 May 2018 and 13 February 2019.** The Committee noted from the radiographic diary entries that periapical radiographs were taken of Patient A on these dates. These radiographs are referred to by Ms Bevan in her witness statement. Whilst the diary entries show the grades of each radiograph, there are no radiographic reports included. The Committee also noted the absence of any reports in the patient's clinical records. The Committee bore in mind the expert evidence that reporting on a radiograph is a legal requirement, under the *'Ionising Radiation Medical Exposure Regulations 2000*' (IRMER) and it is a separate requirement to grading or justifying a radiograph. The Committee understood from the expert evidence that a radiographic report should include an analysis of what can be seen on a radiograph, including any pathology or lack thereof. The Committee did not consider the information recorded in the radiographic diaries to be reports. The diary entries for 1 May 2018 and 13 February 2019

	simply record that periapical radiographs were taken and the quality of the image in terms of the grading. The entries do not explain what is shown on the periapical radiographs. The Committee was therefore satisfied that this allegation is proved in respect of 1 May 2018 and 13 February 2019. **Found not proved in relation to 21 March 2014.** The Committee noted that the radiographs taken on this date were taken by another dentist and not Ms Bevan. Accordingly, the Committee found this allegation not proved in respect of 21 March 2014.
2(a)	*You failed to maintain an adequate standard of record keeping in respect of Patient A's appointments from 11 February 2009 to 13 February 2019 in that:* *on 3 January 2013, the expected examination detail, namely risk assessment, diagnosis and treatment plan is absent from the records.* **Found proved.** The Committee noted that Ms Bevan stated in her witness statement regarding Patient A's appointments that *"I admit that earlier in the patient's clinical notes my record keeping was minimal but over time there were improvements in my record keeping".* The Committee also had regard to the opinion of Ms Ford regarding Ms Bevan's record keeping in respect of Patient A's appointments, as set out in her main report. Ms Ford stated that "*The Registrant does not routinely record risk assessments, clear diagnoses, treatment plans or make clear in the records what the risks of leaving teeth with partially completed treatments or a clear clinical justification for delaying treatments".* The Committee reviewed Ms Bevan's clinical records for Patient A made on 3 January 2013. It did not find reference to the expected examination detail outlined by Ms Ford, in that there is no record of a risk assessment having been undertaken, and no record of a diagnosis or a treatment plan. The Committee was satisfied on the balance of probabilities that this allegation is proved.
2(b)	*You failed to maintain an adequate standard of record keeping in respect of Patient A's appointments from 11 February 2009 to 13 February 2019 in that:* *between 11 February 2009 – 13 February 2019 only three examinations were recorded, whereas at least one examination a year should have been recorded.* **Found proved.** Having reviewed the clinical records made by Ms Bevan in respect of Patient A's appointments, the Committee accepted the evidence of Ms Ford. She noted, as did the Committee, that only three examinations were recorded over this 10-year period. It was Ms Ford's opinion based on the relevant Faculty of General Dental Practitioners (FGDP) guidelines for clinical examination and record keeping, that *"this was exceptionally low for a patient who attended so frequently".*

	The Committee noted Ms Bevan's comments in her witness statement about the standard of some of her record keeping during this time period. She stated that from her recollection, it would have been her normal clinical practice to carry out examinations and assessments during the patient's treatment visits. She stated that "*I am sorry that full details were not recorded in the notes".* In all the circumstances, the Committee was satisfied that this allegation, which relates to record keeping, is proved.
2(c)	*You failed to maintain an adequate standard of record keeping in respect of Patient A's appointments from 11 February 2009 to 13 February 2019 in that:* *between 11 February 2009 – 13 February 2019 there were no recorded caries risk assessments, whereas a minimum of one caries risk assessment per year should have been recorded.* **Found proved.** The Committee accepted the evidence of Ms Ford that in accordance with the National Institute of Clinical Excellence (NICE) guidelines 2004, a minimum of one caries risk assessment per year should have been recorded. Ms Ford comments in her main report on the lack of caries risk assessments in the clinical records for Patient A. Having reviewed the clinical records for this patient, the Committee was satisfied on the balance of probabilities that this allegation is proved. It noted the absence of any recorded caries risk assessments for Patient A over this 10-year period. The Committee also took into account Ms Bevan's evidence that her record keeping for part of the period in question was less than full.
2(d)	*You failed to maintain an adequate standard of record keeping in respect of Patient A's appointments from 11 February 2009 to 13 February 2019 in that:* *there was a failure to record BPE at least annually;* **Found proved.** In her witness statement, Ms Bevan referred to what her normal practice would have been in respect of recording BPEs in a patient's notes. Her evidence is that Patient A attended a number of hygienist appointments at the Practice and BPE scores would have been recorded at those appointments. However, the Committee, having been satisfied that all the clinical records for Patient A have been provided, noted that only one BPE is recorded for Patient A over the 10-year period concerned. The Committee accepted the opinion of Ms Ford, who referred to the British Society of Periodontology (BSP) guidelines, that a BPE should have been recorded at least annually for Patient A. It was the view of the Committee that one recording of a BPE over 10 years is far below the expected minimum and therefore represented a record-keeping failure.
2(e)	**Withdrawn.**
2(f)	**Withdrawn.**
PATIENT C	

3(a)(i)	*You failed to provide an adequate standard of care to Patient C (identified in Schedule A…) from 18 February 2008 to 14 February 2019 including:* *by not adequately managing the patient's periodontal condition in that:* *on around 28 February 2012 and 7 January 2013 you failed to adequately investigate the patient's BPE scores of 3;* **Found proved.** In her main expert report, Ms Ford drew the Committee's attention to the BSP guidelines on BPE, which indicate that if BPE scores of 3 or 4 are recorded, it is expected, for consenting patients, that a 6-point pocket chart is carried out. She explained that this is to measure the pocket depths around each tooth in the sextants with the BPE scores of 3 or 4, for the purpose of assessing outcomes of treatment and planning appropriate care. Ms Ford also referred to the possible need for radiographs. The Committee accepted Ms Ford's evidence. It was satisfied from the clinical records that Patient C did have BPE scores of 3 on the dates in question, and it was also satisfied that Ms Bevan was required to adequately investigate those scores to manage the patient's periodontal condition. However, the Committee noted that there is no reference in the clinical notes to a 6-point pocket chart or any radiographic examination. In deciding on the adequacy of Ms Bevan's investigation of Patient C's BPE scores of 3, the Committee had regard to her witness statement, in which she indicated that Patient C had previously declined treatment due to financial restrictions. The Committee noted that it is recorded in the clinical notes for 28 February 2012 that *"patient requests 6/12 with hygienist and 18/12 with FLB due to financial issues"*. However, the Committee considered that this note provides insufficient detail as to what the patient was declining and why it impacted on any pre-treatment investigations being carried out, including 6-point pocket charting. In the absence of such detail, the Committee was satisfied on the balance of probabilities that this allegation is proved. It was satisfied that Ms Bevan failed to adequately investigate the patient's BPE scores of 3.
3(a)(ii)	**Withdrawn**.
3(a)(iii)	**Withdrawn.**
3(b)(i)	*You failed to provide an adequate standard of care to Patient C (identified in Schedule A …) from 18 February 2008 to 14 February 2019 including:* *in relation to your radiographic practice in that;* *there was a failure to take bitewing radiographs when indicated.* **Found proved.** Having reviewed the clinical records for Patient C, the Committee accepted the expert evidence of Ms Ford that Ms Bevan did not take bitewings radiographs of the patient when indicated. The Committee could not identify from the clinical records any bitewing radiographs taken of the patient by Ms Bevan.

	In her main report, Ms Ford noted that two bitewing radiographs were taken of Patient C by another dentist on 29 August 2019. Ms Ford stated that those radiographs showed horizontal bone loss and *"a very large distal cavity (caries) at UR6"*, which in her view was not restorable by that time. It was Ms Ford's opinion that, had Ms Bevan taken bitewing radiographs at an examination of Patient C on 11 October 2018, the caries would have been visible, and the tooth may have been restorable at that stage. The Committee noted Ms Bevan's evidence that her recollection was that she did not take bitewing radiographs of Patient C because the patient declined due to financial reasons. However, the Committee considered that there was insufficient information in the clinical records to explain why this would have impacted on the taking of bitewing radiographs for investigation purposes. Taking into account the evidence of Ms Ford, the Committee was satisfied that bitewing radiographs, if taken by Ms Bevan when indicated, would have supported her investigation of Patient C's dental health. The Committee was satisfied that it was a failure on Ms Bevan's part not to take any bitewing radiographs
3(b)(ii)	*You failed to provide an adequate standard of care to Patient C (identified in Schedule A …) from 18 February 2008 to 14 February 2019 including:* *in relation to your radiographic practice in that;* *on or around 28 February 2012 and 7 January 2013 there was a failure to take and/ or record periapical radiographs notwithstanding the patient's BPE scores of 3.* **Found not proved.** The Committee was satisfied from the evidence that no periapical radiographs were taken of Patient C during this time. However, in finding this allegation not proved, the Committee distinguished the need for pre-treatment investigations from actual treatment. The Committee accepted that there is some information to suggest that Patient C was reluctant to proceed with definitive treatment due to financial reasons. It noted from the clinical records that "*patient requests 6/12 with hygienist and 18/12 with FLB due to financial issues".* In view of this, the Committee concluded that it was not unreasonable for Ms Bevan not to have taken periapical radiographs. Also, the Committee was not satisfied from the expert evidence that there was a duty on Ms Bevan to take periapical radiographs in any event. The Committee's understanding of the relevant guidelines is that there is an obligation to consider the taking of periapical radiographs when there are BPE scores of 3. However, the Committee was not satisfied that it had been proved that BPE scores of 3 are always, in and of themselves, a reason to take periapical radiographs. The Committee noted that Ms Ford's evidence was that such radiographs may be indicated, as opposed to them being mandatory.

3(c)	*You failed to provide an adequate standard of care to Patient C (identified in Schedule A…) from 18 February 2008 to 14 February 2019 including:* *your failure to prescribe additional fluoride such as high fluoride toothpaste notwithstanding the patient's high caries rate/risk.* **Admitted and found proved.**
4(i)	*You failed to maintain an adequate standard of record keeping in respect of Patient C's appointments from 18 February 2008 to 14 February 2019 in that* *on 28 February 2012 and 7 January 2013 the expected examination detail, namely diagnosis and treatment, is absent from the records.* **Found proved.** The Committee reviewed Ms Bevan's clinical records for Patient C on these dates and did not find reference to the expected examination detail outlined by Ms Ford, in that there is no record of a diagnosis and treatment. The Committee was satisfied on the balance of probabilities that this allegation is proved.
4(ii)	*You failed to maintain an adequate standard of record keeping in respect of Patient C's appointments from 18 February 2008 to 14 February 2019 in that* *between 1 February 2007 – 14 February 2019 there were no recorded caries risk assessments, whereas a minimum of one caries risk assessment per year should have been recorded.* **Found proved.** The Committee accepted the evidence of Ms Ford that a minimum of one caries risk assessment per year should have been recorded. Having reviewed the clinical records for this patient, the Committee was satisfied on the balance of probabilities that this allegation is proved. It noted the absence of any recorded caries risk assessments for Patient A over this 12-year period.
4(iii)	**Withdrawn.**
PATIENT D	
5(a)	**Withdrawn.**
5(b)(i)	*You failed to provide an adequate standard of care to Patient D (identified in Schedule A …) from 3 September 2015 to 25 October 2018 including:* *in relation to your radiographic practice in that:* *you failed to record bitewing radiographs when indicated, which should have been at least every two years.* **Found proved.** The Committee accepted the evidence of Ms Ford regarding the recommendation to take bitewing radiographs of patients with low risk of caries at least every two years in accordance with the relevant guidance.

	The Committee was satisfied, having considered Ms Ford's assessment of Ms Bevan's clinical records for Patient D, and having reviewed the records itself, that there was a failure to record bitewing radiographs when indicated. The Committee also noted that when there was evidence of bitewing radiographs having been taken, they were not mentioned in the records. In all the circumstances, the Committee was satisfied that this alleged matter is proved.
5(b)(ii)	**Withdrawn.**
5(b)(iii)	*You failed to provide an adequate standard of care to Patient D (identified in Schedule A…) from 3 September 2015 to 25 October 2018 including:* *in relation to your radiographic practice in that:* *on 28 January 2016 and 5 April 2017 there was a failure to provide an adequate and accurate report upon radiographs.* **Found proved.** The Committee noted Ms Bevan's evidence, as set out in her witness statement that the clinical records for 28 January 2016 indicate that radiographs were recorded and discussed with the patient. Whilst the Committee noted that the clinical notes indicate that a periapical radiograph was taken by Ms Bevan on 28 January 2016, the criticism is that it was not adequately and accurately reported upon. Having reviewed the relevant record, the Committee found no report recorded. The Committee reminded itself that a radiographic report should include an analysis of what is shown on a radiograph. This information is missing from the clinical notes. The Committee also took into account Ms Bevan's belief that the bitewing radiographs for 5 April 2017 were incorrectly dated. However, the Committee had sight of the radiographs in question, which are computer generated radiographs. Given that they are computer generated, the Committee considered it more likely than not that the date of 5 April 2017 is correct. These bitewing radiographs were also not reported upon. The Committee was satisfied on the basis of all the evidence that this allegation is proved.
PATIENT F	
6(a)(i)	*You failed to provide an adequate standard of care to Patient F (identified in Schedule A…) from 07 February 2008 to 24 January 2019 including by;* *providing a poor standard of treatment, including, at;* *LL6, in that between 19 February 2007 and 7 September 2017 you repeatedly dressed LL6 in the course of 38 visits without any or any adequate justification and without finishing root canal treatment.* **Found proved.** The Committee noted Ms Bevan's evidence that Patient F had requested treatment of LL6 to be deferred for various reasons. Whilst the Committee

	acknowledged that this may have made treating the tooth more difficult, it accepted the expert opinion of Ms Ford that there was still sufficient opportunity to complete the root canal treatment. In reaching its decision, the Committee had regard to the significant number of appointments attended by Patient F with Ms Bevan. The Committee was not satisfied that there was adequate justification in these circumstances for not completing the treatment. Accordingly, this allegation is proved.
6(a)(ii)	*You failed to provide an adequate standard of care to Patient F (identified in Schedule A…) from 07 February 2008 to 24 January 2019 including by;* *providing a poor standard of treatment, including, at;* *UR6, in that between 7 February 2008 and 24 January 2017 you repeatedly dressed UR6 without finishing root canal treatment.* **Found proved.** The Committee found this allegation at 6(a)(ii) proved for the same reasons given in respect of 6(a)(i) above.
7(i)	*You failed to maintain an adequate standard of record keeping in respect of Patient F's appointments from 07 February 2008 to 24 January 2019 in that:* *on 2 July 2013 expected examination detail, namely risk assessment, diagnosis and treatment, is absent from the records.* **Admitted and found proved.**
7(ii)	*You failed to maintain an adequate standard of record keeping in respect of Patient F's appointments from 07 February 2008 to 24 January 2019 in that:* *between 7 February 2008 and 24 January 2019 only three examinations were recorded, whereas at least one examination per year should have been recorded.* **Admitted and found proved.**
7(iii)	*You failed to maintain an adequate standard of record keeping in respect of Patient F's appointments from 07 February 2008 to 24 January 2019 in that:* *between 7 February 2008 and 24 January 2019 there were no recorded caries risk assessments, whereas a minimum of one caries risk assessment per year should have been recorded.* **Admitted and found proved.**
7(iv)	*You failed to maintain an adequate standard of record keeping in respect of Patient F's appointments from 07 February 2008 to 24 January 2019 in that:* *there was a failure to record BPE at recommended intervals, whereas this should have been recorded at least annually.* **Admitted and found proved**.

7(v)	*You failed to maintain an adequate standard of record keeping in respect of Patient F's appointments from 07 February 2008 to 24 January 2019 in that:* *there was a failure to take and/ or record bitewing radiographs when indicated (at least every two years).* **Admitted and found proved.**
7(vi)	*You failed to maintain an adequate standard of record keeping in respect of Patient F's appointments from 07 February 2008 to 24 January 2019 in that:* *on or around 20 March 2017 and 2 December 2013 there was a failure to provide an adequate and accurate report upon radiographs.* **Found proved in relation to 2 December 2013.** The Committee could see from the clinical records that *"RADS (x2), Xray Small Film"* were taken on 2 December 2013, but there is no corresponding radiographic report. The Committee therefore found this allegation proved in respect of 2 December 2013. **Found not proved in relation to 20 March 2017.** It was acknowledged by the GDC in its closing submissions that this allegation in respect of 20 March 2017 is no longer supported by the evidence. This is because there was some evidence of a report in the clinical records. Accordingly, the Committee found this alleged matter not proved.
7(vii)	*You failed to maintain an adequate standard of record keeping in respect of Patient F's appointments from 07 February 2008 to 24 January 2019 in that:* *between 19 February 2007 and 24 January 2017 there was a failure to record any justification for delaying definitive treatment to the LL6 and UR6.* **Admitted and found proved.**
PATIENT G	
8(a)(i)	*You failed to provide an adequate standard of care to Patient G (identified in Schedule A …) from 17 January 2008 to 04 April 2019 including;* *by providing a poor standard of treatment, including, at;* *UL6, in that between 17 January 2008 and 23 September 2014 there was a delay in providing definitive treatment to the UL6;* **Found proved.** Patient G's UL6 was a heavily restored tooth with a large amalgam restoration covering multiple surfaces. The Committee noted that the period concerned, between 17 January 2008 and 23 September 2014, involved approximately 51 appointments for Patient G. It

	found no indication in the patient's clinical records that definitive treatment was provided to the UL6 during this time. Whilst the Committee took into account Ms Bevan's written evidence regarding the erratic nature of Patient G's attendance for treatment, it was not satisfied that this fully explained the lack of definitive treatment to the tooth. The Committee accepted the expert opinion of Ms Ford, taking into account the high number of appointments, that Ms Bevan had ample opportunity to complete the treatment to the UL6.
8(a)(ii)	**Withdrawn.**
8(b)	*You failed to provide an adequate standard of care to Patient G (identified in Schedule A …) from 17 January 2008 to 04 April 2019 including;* *in your relation to your radiographic practice, in that bitewing radiographs were not taken at recommended intervals (every 12 – 18 months).* **Found proved.** Ms Bevan's evidence was that Patient G's financial situation impacted on her ability to pay for items such as radiographs. The oral evidence of Ms Ford was that as an NHS patient, there would have been no extra cost to the patient from having bitewing radiographs taken. The Committee also took into account that Ms Bevan referred in her written evidence to the presence of some acetate radiographs. However, she acknowledged that those radiographs could not be dated or identified. In reviewing the clinical records for Patient G made over this timeframe, neither Ms Ford nor the Committee could find any entries relating to bitewing radiographs. The Committee was satisfied on the balance of probabilities that this allegation is proved.
9(a)	*You failed to provide an adequate standard of record keeping in respect of Patient G's appointments from 17 January 2008 to 04 April 2019 in that:* *between 17 January 2008 and 4 April 2019 there were no recorded caries risk assessments;* **Found proved.** The Committee accepted the evidence of Ms Ford that a minimum of one caries risk assessment per year should have been recorded. Having reviewed the clinical records for this patient, the Committee was satisfied on the balance of probabilities that this allegation is proved. It noted the absence of any recorded caries risk assessments for Patient A over this 11-year period.
9(b)	*You failed to provide an adequate standard of record keeping in respect of Patient G's appointments from 17 January 2008 to 04 April 2019 in that:* *there was a failure to record the treatment plan or diagnosis in respect of UL5;* **Found proved.**

	The Committee reviewed the clinical records for Patient G over this period and found no indication of the treatment plan or diagnosis in respect of UL5. It noted that Ms Ford opined in her main report that *"The records do not show a clear treatment plan or diagnosis in relation to UL5".* In her written evidence, Ms Bevan admitted that there were times when she failed to record every detail for this patient. She maintained however, that she did undertake treatment planning, which involved providing a diagnosis, but that this evidence was not saved on the Software of Excellence (SOE) computer system being used at the time, as ultimately, the treatment was not completed. The Committee noted that Ms Ford disagreed with Ms Bevan's contention in this regard. It was Ms Ford's evidence that if a treatment plan or diagnosis had been recorded in respect of Patient G's UL5, that information would be retained within the patient's clinical records on the SOE software system. Having considered all the evidence, including Ms Bevan's own evidence regarding the standard of some of her record keeping, the Committee was satisfied that this allegation is proved to the requisite standard.
9(c)	*You failed to provide an adequate standard of record keeping in respect of Patient G's appointments from 17 January 2008 to 04 April 2019 in that:* *on 4 January 2016, 4 February 2016, 3 May 2016, 1 September 2016, 18 April 2017, 12 June 2017, 26 June 2017 and 5 July 2017 there was a failure to record options, diagnosis and treatment plan for the UR2* **Found proved.** The Committee reviewed the clinical records for Patient G and had regard to the notes made on the dates in question. The Committee noted the absence of any records in respect of options, diagnosis and a treatment plan for the patient's UR2. It accepted the evidence of Ms Ford that this information should have been included. Accordingly, the Committee was satisfied on the balance of probabilities that this allegation is proved.
9(d)	*You failed to provide an adequate standard of record keeping in respect of Patient G's appointments from 17 January 2008 to 04 April 2019 in that:* *on 7 June 2007, 17 January 2008, 21 May 2008, 7 March 2012, 23 August 2012, 10 September 2013 and 20 December 2013 there was a failure to record options, diagnosis and treatment plan for the UL6.* **Found proved in relation to all the dates except for 7 June 2007.** The Committee noted that 7 June 2007 falls outside the stem of the charge (head of charge 9) and therefore the Committee did not consider it. Taking into account the principle of proportionality, the Committee did not consider it appropriate to amend the allegation to include this single date at this late stage. In finding this allegation proved in respect of all the other dates, the Committee relies on the same reasoning outlined at 9(c) above.

10(i)	*You failed to maintain an adequate standard of record keeping in relation to radiographs, in that;* *radiographs taken on 2 August 2007, 30 August 2007 and 17 January 2008 are not reported upon.* **Found proved.** Having accepted the expert evidence on what a radiographic report should include, the Committee found this allegation proved. It reviewed the clinical records for Patient G and found no reports recorded for the radiographs taken on these dates.
10(ii)	*You failed to maintain an adequate standard of record keeping in relation to radiographs, in that;* *the radiograph of 3 August 2017 is not recorded in the records.* **Found proved.** The Committee noted that the relevant radiographic diary indicated that a radiograph had been taken of Patient G on 3 August 2017, however, there is no record of the radiograph in the clinical records. The Committee accepted that opinion of Ms Ford that the radiograph in question should have been included and reported upon in the patient's clinical notes.
PATIENT H	
11(a)(i)	*You failed to provide an adequate standard of care to Patient H (identified in Schedule A …) from 23 April 2013 to 12 July 2018 including by;* *not adequately managing the patient's periodontal condition in that:* *on 23 April 2013, 19 June 2014 and 7 June 2018 you failed to provide and/ or record adequate investigations following the patient's BPE scores of 3;* **Found not proved.** The Committee took into account that Patient H's first appointment with Ms Bevan was on 23 April 2013. It did not consider it unreasonable of her not to have taken radiographs at this initial appointment, and it noted the evidence that she did take bitewing radiographs within two months of this first visit. In respect of 19 June 2014, the Committee noted that BPE scores of 3 were recorded for the patient. The Committee took into account Ms Ford's evidence that further investigation was needed in light of those scores. In this regard, it noted that the patient was referred to the hygienist. Whilst the Committee noted Ms Ford's evidence regarding the possible need for periapical radiographs with BPE scores of 3, it was not satisfied that it had been demonstrated that there was an absolute duty to take periapical radiographs. The Committee was not satisfied from the expert evidence that there was a duty on Ms Bevan to take periapical radiographs in the circumstances. The Committee's understanding of the relevant guidelines is that there is an obligation to consider the taking of periapical

	radiographs when there are BPE scores of 3. However, the Committee was not satisfied that it had been proved that BPE scores of 3 are always, in and of themselves, a reason to take periapical radiographs. The Committee noted that Ms Ford's evidence was that such radiographs may be indicated, as opposed to them being mandatory. Furthermore, there were available bitewing radiographs of the patient that were relatively recent. In relation to 7 June 2018, the Committee noted that there had been no change in the patient's BPE scores, and bitewing radiographs were taken. With regard to the clinical records themselves, whilst the Committee considered that the recorded information may fall short of what Ms Ford considered to be ideal, in its view, the notes made in respect of the three appointments were adequate.
11(a)(ii)	**Withdrawn.**
11(b)(i)	*You failed to provide an adequate standard of care to Patient H (identified in Schedule A…) from 23 April 2013 to 12 July 2018 including by;* *your radiographic practice in that* *there was a failure to take bitewing radiographs when indicated, which should have been at least every two years* **Found proved.** The Committee accepted the evidence of Ms Ford that in accordance with the relevant guidance, bitewing radiographs should have been taken of Patient H at least every two years. The Committee noted that the bitewing radiographs taken by Ms Bevan in respect of the patient were five years apart. This was considerably below what is regarded as usual in the circumstances and the Committee was satisfied this allegation is proved.
11(b)(ii)	*You failed to provide an adequate standard of care to Patient H (identified in Schedule A…) from 23 April 2013 to 12 July 2018 including by;* *your radiographic practice in that* *there was a failure to take periapical radiographs to investigate periodontal disease between 23 April 2013 and 7 June 2018;* **Found not proved.** The Committee was not satisfied from the expert evidence that there was a duty on Ms Bevan to take periapical radiographs in the circumstances. The Committee's understanding of the relevant guidelines is that there is an obligation to consider the taking of periapical radiographs when there are BPE scores of 3, as there was in this patient's case. However, the Committee was not satisfied that it had been proved that BPE scores of 3 are always, in and of themselves, a reason to take periapical radiographs. The Committee noted that Ms Ford's evidence was that such radiographs may be indicated, as opposed to them being mandatory. In all the circumstances, the Committee found this allegation not proved.

11(b)(iii)	*You failed to provide an adequate standard of care to Patient H (identified in Schedule A…) from 23 April 2013 to 12 July 2018 including by;* *your radiographic practice in that* *on 6 June 2013 there was a failure to provide an adequate and accurate report upon radiographs* **Found proved.** Having accepted the expert evidence on what a radiographic report should include, the Committee found this allegation proved. It reviewed the clinical records for Patient G and found no report recorded for the radiographs taken on 6 June 2013.
12(i)	*You failed to maintain an adequate standard of record keeping in respect of Patient H's appointments from 23 April 2013 to 12 July 2018 in that:* *on 23 April 2013 expected examination detail, namely risk assessment, diagnosis and treatment, is absent from the records.* **Admitted and found proved.**
12(ii)	*You failed to maintain an adequate standard of record keeping in respect of Patient H's appointments from 23 April 2013 to 12 July 2018 in that:* *there was a failure to record 6 point pocket charts on 23 April 2013, 19 June 2014 and 7 June 2018 notwithstanding the BPE scores of 3.* **Found proved.** The Committee took into account Ms Ford's evidence that she would not be critical of Ms Bevan's care in this instance if she discussed the matter with the patient. The Committee has regard to the clinical records and could find nothing to indicate what was discussed with the patient in relation to the carrying out of 6-pocket charting on the dates in question. The Committee noted from the evidence that due to Patient H's medical history, antibiotic cover was required prior to any periodontal treatment. Ms Bevan's recollection in her witness statement is that she was unable to complete the 6-point pocket charting required, as the patient was reluctant to take antibiotics over several visits. The Committee was of the view that a 6-point pocket chart could have been performed and thus recorded without the need for any additional antibiotic prescription, if performed concurrently with periodontal treatment. In summary, having paid careful regard to the quantity and quality of the records before it, taken with the observations of Ms Bevan and Ms Ford, the lack of detail and information within the clinical records supports the GDC's contention that there is an absence of adequate clinical reasoning or discussion within the patient's records.
PATIENT J	
13(a)	*You failed to provide an adequate standard of care to Patient J (identified in Schedule A…) from 06 September 2016 to 17 July 2019 including by;*

	providing a poor standard of treatment, including at UR1, in that between 23 October 2017 and 14 January 2019 you repeatedly dressed UR1 rather than providing timely definitive treatment by way of root canal treatment. **Found proved.** The Committee noted that Ms Bevan cited in her witness statement a number of reasons for the delay in treating Patient J's UR1. These included that the patient cancelled or deferred appointments, as well as the patient's anxiety to treatment. In relation to the issue of the patient's anxiety, it was highlighted by Ms Ford that Patient J accepted root canal treatment on 23 October 2017 and 6 November 2017, which had involved the placing of a rubber dam. The inference being that the patient could withstand complex procedures. Taking all the evidence into account, the Committee found this allegation proved. It accepted Ms Ford's opinion that Ms Bevan had sufficient opportunity to provide timely definitive treatment during what was a considerable period of time.
13(b)	*You failed to provide an adequate standard of care to Patient J (identified in Schedule A…) from 06 September 2016 to 17 July 2019 including by;* *not adequately managing the patient's risk of caries in that you failed to prescribe additional fluoride such as high fluoride toothpaste notwithstanding the patient's high caries rate/risk.* **Found proved.** In her witness statement, Ms Bevan stated that her focus in managing Patient J's caries risk had been on providing dietary advice and good oral hygiene, and that fluoride toothpaste was prescribed to patients with underlying medical conditions. Ms Bevan further noted that the patient was using fluoridated toothpaste at home. The Committee was satisfied from Ms Bevan's evidence, and the clinical records, that she did not prescribe additional fluoride to Patient J. In reaching its conclusion that Ms Bevan should have done so, the Committee accepted the evidence of Ms Ford, who told the Committee that Patient J should have been given the option of additional fluoride. Ms Ford stated that this would have given the patient the best chance to moderate the rate of caries progression.
13(c)	*You failed to provide an adequate standard of care to Patient J (identified in Schedule A…) from 06 September 2016 to 17 July 2019 including by;* *by your radiographic management in that bitewing radiographs were not taken and/ or recorded when indicated.* **Found proved.** The Committee accepted the evidence of Ms Ford that bitewing radiographs should have been taken at six-month intervals for patients with a high caries risk. The Committee reviewed the clinical records for Patient J and found no indication that bitewings radiographs were taken in accordance with this recommended interval. Accordingly, it found this allegation proved.

14(i)	*You failed to maintain an adequate standard of record keeping in relation to radiographs in respect of Patient J's appointments of 6 September 2016 to 17 July 2019 in that:* *on 23 November 2017 there was a failure to provide an adequate and accurate report upon radiographs.* **Found proved.** Having accepted the expert evidence on what a radiographic report should include, the Committee found this allegation proved. It reviewed the clinical records for Patient J and found no report recorded for the radiographs taken on 23 November 2017.
14(ii)	*You failed to maintain an adequate standard of record keeping in relation to radiographs in respect of Patient J's appointments of 6 September 2016 to 17 July 2019 in that:* *there was a failure to record any justification for repeatedly dressing UR1;* **Admitted and found proved.**
14(iii)	*You failed to maintain an adequate standard of record keeping in relation to radiographs in respect of Patient J's appointments of 6 September 2016 to 17 July 2019 in that:* *there was a failure to record whether additional fluoride was advised or provided*. **Found proved.** The Committee noted the absence of clinical discussion or reasoning within the clinical records which it would have expected to see in the circumstances outlined in the allegation.
PATIENT K	
15(a)(i)	**Withdrawn.**
15(b)	*You failed to provide an adequate standard of care to Patient K (identified in Schedule A…) from 04 December 2017 to 22 May 2019 including by;* *not adequately managing the patient's risk of caries in that you failed to perform and/ or record any caries risk assessments between 4 December 2017 and 22 May 2019.* **Found proved.** In her witness statement, Ms Bevan noted that a caries risk assessment for Patient K was recorded by another dentist on 14 March 2017. However, that date is outside the timeframe being considered in respect of this allegation. Whilst the Committee noted that Ms Bevan also referred to a caries risk assessment undertaken by her on 22 May 2019, this was at the very end of this period. The Committee was not satisfied that this was adequate. The Committee further had regard to Ms Ford's opinion that, the one caries assessment that was

	carried out was incorrect, in that the risk was recorded as low, instead of high risk. The Committee was satisfied on the balance of probabilities that this allegation is proved.
16(i)	*You failed to provide an adequate standard of record keeping in respect of Patient K's appointments from 04 December 2017 to 22 May 2019 in that:* *between 4 December 2017 and 22 May 2019 there were no recorded caries risk assessments;* **Found proved.** The Committee accepted the evidence of Ms Ford that in accordance with the relevant guidelines, a minimum of one caries risk assessment per year should have been recorded. Having reviewed the clinical records for this patient, the Committee was satisfied on the balance of probabilities that this allegation is proved. It noted the absence of any recorded caries risk assessments for Patient K until 22 May 2019, when it was recorded incorrectly.
16(ii)	**Withdrawn.**
16(iii)	*You failed to provide an adequate standard of record keeping in respect of Patient K's appointments from 04 December 2017 to 22 May 2019 in that:* *only one examination was recorded between 4 December 2017 and 22 May 2019;* **Admitted and found proved.**
16(iv)	*You failed to provide an adequate standard of record keeping in respect of Patient K's appointments from 04 December 2017 to 22 May 2019 in that:* *no BPE scores were recorded prior to 22 May 2019* **Found proved.** Having reviewed the clinical records for Patient K over this period, the Committee was satisfied on the balance of probabilities that this allegation is proved as a matter of fact. The BPE scores from 14 March 2017 referred to by Ms Bevan in her witness statement were recorded by another dentist and 14 March 2017 falls outside the timeframe of this allegation.
PATIENT L	
17(a)(i)	*You failed to provide an adequate standard of care to Patient L (identified in Schedule A…) from 29 January 2008 to 05 June 2019 including;* *by providing a poor standard of treatment, including, at;* *UR6, in that between 12 March 2012 and 12 February 2018 you repeatedly dressed UR6 rather than providing timely definitive treatment.* **Found proved.**

	The Committee noted that Patient L attended approximately 100 appointments during the period in question. It had regard Ms Bevan's written evidence that the patient had opted to defer treatment on a number of occasions and the UR6 was dressed instead. The Committee took into account Ms Ford's evidence that she was not critical of Ms Bevan deferring treatment at the request of the patient on the dates mentioned in the clinical records. However, it was Ms Ford's opinion that there were other opportunities for providing definitive treatment to the tooth. The Committee accepted the evidence of Ms Ford. Whilst it acknowledged that the patient's requests to defer treatment applied to some of the appointments, there were a significant number of other appointments at which the root canal treatment could have been continued and completed.
17(b)	*You failed to provide an adequate standard of care to Patient L (identified in Schedule A…) from 29 January 2008 to 05 June 2019 including;* *by not providing the patient with full information regarding their treatment* **Found proved.** It was Ms Bevan's evidence that Patient L was fully aware at the start of treatment of the treatment options and risks, including the risk of leaving the root canal treatment of UR6 uncompleted. Ms Ford noted in her evidence that Patient L attended 58 times for the dressing or review of UR6. Ms Ford stated in her main report that "*In my opinion, UR6 was not restorable by 1.12.15 and this should have been explained to the patient, if UR6 was not restorable RCT was not indicated".* The Committee reviewed the clinical records for Patient L made over the period in question and found no indication of a discussion with the patient in which the full information about regarding their treatment was provided. Whilst the Committee had regard to Ms Bevan's contention that she did provide all necessary information, in the absence of supporting contemporaneous records, the Committee concluded, on balance, that such information was not provided to Patient L. This allegation is proved.
17(c)(i)	*You failed to provide an adequate standard of care to Patient L (identified in Schedule A….) from 29 January 2008 to 05 June 2019 including;* *in relation to radiographic management in that:* *between 29 January 2008 and 5 June 2019 there was a failure to take and/ or record bitewing radiographs when indicated, which should have been at least every two years;* **Admitted and found proved.**
17(c)(ii)	*You failed to provide an adequate standard of care to Patient L (identified in Schedule A…) from 29 January 2008 to 05 June 2019 including;* *in relation to radiographic management in that:*

	on 1 December 2015 there was a failure to provide an adequate and accurate report upon radiographs. **Found proved.** The Committee noted from the relevant radiographic diary entry that a radiograph was taken on 1 December 2015. However, it found no accompanying radiographic report in the clinical records.
18(i)	*You failed to maintain an adequate standard of record keeping in respect of Patient L's appointments from 29 January 2008 to 05 June 2019 in that:* *on 22 March 2011 and 10 November 2011 expected examination detail, namely risk assessment, diagnosis and treatment, is absent from the records;* **Admitted and found proved.**
18(ii)	*You failed to maintain an adequate standard of record keeping in respect of Patient L's appointments from 29 January 2008 to 05 June 2019 in that:* *between 10 November 2011 and 6 March 2019 only one examination is recorded;* **Admitted and found proved.**
18(iii)	*You failed to maintain an adequate standard of record keeping in respect of Patient L's appointments from 29 January 2008 to 05 June 2019 in that:* *between 29 January 2008 – 5 June 2019 there were no recorded caries risk assessments,* **Admitted and found proved.**
18(iv)	*You failed to maintain an adequate standard of record keeping in respect of Patient L's appointments from 29 January 2008 to 05 June 2019 in that:* *there is no justification recorded for the delay in providing definitive treatment to the UR6 on multiple occasions.* **Admitted and found proved.**
PATIENT O	
19(a)(i)	**Withdrawn**.
19(a)(ii)	*You failed to provide an adequate standard of care to Patient O (identified in Schedule A…) from 22 November 2010 to 10 April 2019 including;* *by providing a poor standard of treatment, including, at;* *UL7, in that there was a failure to provide restoration to the UL7 between 3 April 2017 and 10 April 2019.* **Found proved.** The Committee noted the information from the clinical records, as outlined by Ms Ford in her main report. On 3 April 2017, the UL7 was filled with MO amalgam by another dentist. On 20 August 2018, Ms Bevan removed the filling, the nerves

	were exposed, and the canals were cleaned and dressed. It was noted by Ms Ford that by 18 March 2019, the dressing remained on the UL7 with no apparent treatment plan for the tooth. Ms Bevan stated in her witness statement that she last saw Patient O on 7 February 2019 and the UL7 was not included in the discussion in the clinical, as it was her recollection that the patient wished to postpone treatment as he was undecided about an extraction or root canal treatment. Whilst the Committee took into account Ms Bevan's recollection, it noted the absence of any information the contemporaneous clinical records of Patient O requesting to postpone treatment. Having considered all the evidence, the Committee found proved that it was more likely than not that Ms Bevan failed to provide restoration to UL7.
19(b)(i)	**Withdrawn.**
19(b)(ii)	*You failed to provide an adequate standard of care to Patient O (identified in Schedule A…) from 22 November 2010 to 10 April 2019 including;* *in relation to your radiographic practice in that there was:* *failure to report upon radiographs of 20 March 2017.* **Found proved.** In reaching its decision, the Committee noted that no radiographs were provided to the Committee by the GDC, although there is an entry in the radiographic diary indicating that a radiograph was taken. The Committee considered that it was more likely than not that a radiograph was taken in the circumstances. It noted that there was no report on the radiograph either in the radiographic diary or in the clinical records.
PATIENT T	
20(a)(i)	*You failed to provide an adequate standard of care to Patient T (identified in Schedule A…) from 14 January 2008 to 20 February 2019 including;* *by providing a poor standard of treatment, including, at;* *UR8, in that between 28 December 2011 and 18 January 2018 there was a failure to provide an adequate restoration.* **Found not proved.** The Committee noted that Patient T had over 100 appointments scheduled during the period in question, with approximately half of those cancelled by the patient. There were also a number of instances when the patient arrived late to appointments. The Committee acknowledged that not all the scheduled appointments were in respect of the UR8, but the patient was seen on a number of occasions in respect of this tooth. The Committee also had regard to the information that Patient T consumed a large amount of energy drinks and gels, which adversely impacted his dental health. Ms Bevan stated in her written evidence that this issue was discussed with patient in the context of caries risk. The indication was Patient T was reluctant to address these factors. Ms Bevan further stated in her witness statement that the patient declined to book

	appointments as his teeth were symptomless. She also mentioned that the patient's availability for attending appointments was limited. In these particular circumstances, the Committee was not satisfied that it had been proved to the requisite standard that Ms Bevan failed to provide an adequate restoration to Patient T's UR8. In reaching its decision, the Committee took into account that Ms Ford did not set out in her written or oral evidence what definitive treatment Ms Bevan failed to carry out. Therefore, this alleged matter is found not proved.
20(a)(ii)	*You failed to provide an adequate standard of care to Patient T (identified in Schedule A…) from 14 January 2008 to 20 February 2019 including;* *by providing a poor standard of treatment, including, at;* *LL5, in that between 19 May 2015 and 15 February 2018 there was a failure to provide an adequate restoration.* **Found not proved.** Ms Ford noted that Ms Bevan restored the LL5 on multiple occasions. Ms Ford highlighted that on 13 March 2019, deep caries was diagnosed at LL5 by Witness 1. The inference being that it was possible that caries had not been fully removed from the tooth when it was last restored by Ms Bevan. However, the Committee took into account that the patient had a high caries risk on account of lifestyle and dietary factors, which could have been an alternative cause for the presence of the deep caries by 13 March 2019. The Committee considered that there was insufficient evidence to prove on the balance of probabilities that the deep caries was due a failure by Ms Bevan to provide an adequate restoration between 19 May 2015 and 15 February 2018.
20(a)(iii)	*You failed to provide an adequate standard of care to Patient T (identified in Schedule A…) from 14 January 2008 to 20 February 2019 including;* *by providing a poor standard of treatment, including, at;* *UR6, in that between 11 October 2012 and 5 November 2018 there was a failure to provide an adequate restoration.* **Found proved.** The Committee noted the evidence that Ms Bevan dressed Patient T's UR6 on a number of occasions between 2012 and 2017. Initial root canal therapy was commenced between January and November 2018. Ms Ford highlighted that by 8 March 2019 a radiograph showed that the UR6 had broken down and required extraction. It was subsequently extracted by another dentist. Having reviewed all the evidence, the Committee accepted Ms Ford's opinion that Ms Bevan failed to provide a suitable quality restoration to Patient T's UR6 over a number of years. It therefore found this allegation proved.

20(a)(iv)	*You failed to provide an adequate standard of care to Patient T (identified in Schedule A…) from 14 January 2008 to 20 February 2019 including;* *by providing a poor standard of treatment, including, at;* *UL7, in that between 16 November 2017 and 11 October 2018 there was a failure to provide an adequate restoration.* **Found proved.** In her witness statement, Ms Bevan referred to the clinical records of 6 September 2018 which explained that root canal treatment was commenced on UL7, but she was unable to complete the treatment due to sensitivity preparing the root canals. The root canal treatment was however completed on 4 October 2018. Whilst the Committee took into account that the UL7 was eventually restored by Ms Bevan, it had regard to Ms Ford's opinion that the root filling provided was of poor quality and incomplete. The Committee noted that only one canal of the three was filled, which was suboptimal. Further, the Committee found nothing in the records to show that the outcome of the root canal treatment was discussed with the patient. In all the circumstances, the Committee was satisfied that Ms Bevan did not provide an adequate restoration.
20(b)(i)	*You failed to provide an adequate standard of care to Patient T (identified in Schedule A…) from 14 January 2008 to 20 February 2019 including;* *by not diagnosing the need for further treatment, including, at;* *UR5, in that around July 2018 you failed to recognise the need for root canal treatment at UR5 in or around July 2018.* **Found not proved.** It was Ms Ford's expert opinion that the UR5 had a very large filling covering multiple surfaces and therefore Ms Bevan should have considered vitality testing and a radiograph should have been taken. Ms Bevan did not undertake any of the diagnostic tests referred to by Ms Ford. Ms Bevan's written evidence was that Patient T had no clinical symptoms with the UR5 around this time to suggest that the tooth was non-vital. It was the view of the Committee that in the absence of the relevant diagnostic tests, Ms Bevan had no way of confirming that root canal treatment was needed. Furthermore, it was not satisfied that there was sufficient evidence to suggest that Ms Bevan was required to undertake such tests in the absence of any symptoms. Ms Bevan highlighted in her witness statement that the clinical records indicate that when Patient T was seen subsequently on 5 April 2019 by another dentist, UR5 was restored with composite with no mention of root canal treatment. The Committee was not satisfied that the GDC discharged its burden of proof in relation to this allegation.

20(c)(i)	*You failed to provide an adequate standard of care to Patient T (identified in Schedule A…) from 14 January 2008 to 20 February 2019 including;* *in relation to your radiographic practice in that* *there was a failure to take and/ or record bitewing radiographs when indicated, which would have been at least every two years;* **Admitted and found proved.**
20(c)(ii)	*You failed to provide an adequate standard of care to Patient T (identified in Schedule A…) from 14 January 2008 to 20 February 2019 including;* *in relation to your radiographic practice in that* *on 30 December 2008, 5 June 2018 and 19 July 2018 there was a failure to report upon radiographs.* **Found proved.** In her witness statement, Ms Bevan maintains that there are reports on the three radiographs in question and she referred the Committee to what she considered to be the available evidence. Whilst the Committee acknowledged that all three radiographs are recorded as having been taken, there are no corresponding reports recorded in the clinical records. A note indicating the taking of a radiograph is not a report.
21(i)	*You failed to maintain an adequate standard of record keeping in respect of Patient T's appointments from 14 January 2008 to 20 February 2019 in that;* *there was a failure to explain the repeated failures to the restorations of UR8, LL5, UR6 and UL7,* **Admitted and found proved**.
21(ii)	*You failed to maintain an adequate standard of record keeping in respect of Patient T's appointments from 14 January 2008 to 20 February 2019 in that;* *there was a failure to record treatment planning in relation to restoration options for UR8, LL5, UR6 and UL7.* **Admitted and found proved.**
PATIENT V	
22(a)(i)	*You failed to provide an adequate standard of care to Patient V (identified in Schedule A…) from 22 February 2008 to 24 January 2019 including;* *by providing a poor standard of treatment, including, at;* *UL5, in that between 8 December 2008 and 11 February 2013 there was a failure to provide definitive treatment to the UL5,* **Found proved.** In her written evidence, Ms Bevan stated that on 12 February 2009 treatment commenced at UL5, but that during this course of treatment teeth in other areas

	of Patient V's mouth required treatment. Ms Bevan indicated that the UL5 was stable and symptomless, enabling her to prioritise the other teeth. Whilst the Committee took into account Ms Bevan's evidence, it also took into account that the UL5 was dressed 13 times over a number of years and was eventually lost. In this context, the Committee was not satisfied that Ms Bevan's explanation of prioritising other teeth is a reasonable one. In its view, she failed to provide definitive treatment to the UL5, when there was ample opportunity to do so.
22(a)(ii)	*You failed to provide an adequate standard of care to Patient V (identified in Schedule A…) from 22 February 2008 to 24 January 2019 including;* *by providing a poor standard of treatment, including, at;* *UR7, in that between 22 February 2008 and 29 March 2009 there was a failure to provide definitive treatment to the UR7,* **Found proved.** The Committee noted that Patient V made 12 visits to see Ms Bevan during this period and the UR7 was repeatedly dressed or reviewed. The tooth was eventually lost. Ms Bevan again referred in her written evidence to the need to stabilise other teeth. The Committee accepted the expert evidence of Ms Ford that Ms Bevan had sufficient opportunity to provide definitive treatment to the UR7 over the period in question, but root canal treatment to the tooth was *"severely delayed".*
22(a)(iii)	*You failed to provide an adequate standard of care to Patient V (identified in Schedule A…) from 22 February 2008 to 24 January 2019 including;* *by providing a poor standard of treatment, including, at;* *UL3, in that between 25 March 2010 and 8 June 2011 there was a failure to provide definitive treatment to the UL3.* **Found proved.** The Committee noted that the treatment to be provided to Patient V's UL3 was root canal treatment to a single canal, which it understood was not overly complicated treatment. However, the patient attended on 18 occasions over the 15-month period concerned, during which time the UL3 was repeatedly dressed or reviewed. The Committee found no real justification in the clinical records for what Ms Ford described as a severe delay to providing the root canal treatment. The Committee was satisfied on the evidence that Ms Bevan failed to provide definite treatment to the UL3.
22(b)	*You failed to provide an adequate standard of care to Patient V (identified in Schedule A…) from 22 February 2008 to 24 January 2019 including;* *On or around 4 July 2018, there was a failure to diagnose caries at the UR7.*

	Admitted and found proved
22(c)(i)	*You failed to provide an adequate standard of care to Patient V (identified in Schedule A…) from 22 February 2008 to 24 January 2019 including;* *your radiographic practice in that* *between 22 February 2008 and 24 January 2019 there was a failure to take and/ or record bitewing radiographs when indicated, which should have been at least every two years;* **Found proved.** Whilst Ms Bevan refers to several 'small films' having been taken during this timeframe, these were found to be periapical radiographs and not bitewing radiographs. Having reviewed the evidence before it, the Committee found only one instance of bitewings being taken and this was on 4 July 2018. The Committee accepted the expert opinion of Ms Ford that bitewing radiographs should have been taken of Patient V at least every two years. The Committee considered that one set of bitewing radiographs in almost 11 years, without any adequate justification, was a clear failure to take radiographs when indicated.
22(c)(ii)	*You failed to provide an adequate standard of care to Patient V (identified in Schedule A…) from 22 February 2008 to 24 January 2019 including;* *your radiographic practice in that* *on 4 July 2018 there was a failure to report upon two radiographs.* **Found proved.** The Committee found no accompanying report in the clinical records for the radiographs taken by Ms Bevan on this date. It was satisfied on the balance of probabilities that this allegation is proved.
23(i)	*You failed to maintain an adequate standard of record keeping in respect of Patient V's appointments from 22 February 2008 to 24 January 2019 in that* *between 22 February 2008 to 24 January 2019 there was no recorded caries risk assessment;* **Found proved.** Having reviewed the clinical records Patient V in relation to the almost 11-year period concerned, the Committee was satisfied on the balance of probabilities that this allegation is proved. It noted the absence of any recorded caries risk assessments.
23(ii)	*You failed to maintain an adequate standard of record keeping in respect of Patient V's appointments from 22 February 2008 to 24 January 2019 in that*

	there was no adequate recorded justification for the delay in treatment to the UL5, UR7 and UL3. **Admitted and found proved**
PATIENT W	
24(a)(i)	*You failed to provide an adequate standard of care to Patient W (identified in Schedule A…) from 06 December 2012 to 16 May 2019 including by;* *by providing a poor standard of treatment, including, at;* *UL2, in that between 26 September 2013 and 24 July 2018 you repeatedly dressed the UL2 without providing timely definitive treatment.* **Found proved.** In reaching its decision, the Committee took into account the evidence of the challenges Ms Bevan faced trying to treat Patient W. It noted that the patient was late for a majority of the appointments concerned or the appointments were cancelled by the patient. However, the Committee accepted the opinion of Ms Ford that there remained sufficient opportunity to provide definite treatment to Patient W's UL2 over the period in question. Instead, the evidence indicates that Ms Bevan repeatedly dressed the tooth without completing any treatment. The Committee noted from the clinical records that from at least 7 September 2015, the patient had consented to the completion of root canal treatment on the tooth. The Committee was satisfied that the treatment should have been completed on or around that date.
24(a)(ii)	*You failed to provide an adequate standard of care to Patient W (identified in Schedule A…) from 06 December 2012 to 16 May 2019 including by;* *by providing a poor standard of treatment, including, at;* *LR6, in that between 6 April 2017 and 16 May 2019 you repeatedly dressed the LR6 without providing definitive treatment.* **Found proved.** The evidence indicates that Patient W's LR6 was repeatedly dressed by Ms Bevan. In her witness statement, Ms Bevan stated that "*It would be my normal clinical practice to examine the tooth, discuss findings with the patient, stabilise the tooth and ask the patient to arrange a visit to further investigate the tooth…It would be my normal clinical practice to stabilise a fractured filling with a Glass Ionomer and arrange an appointment to carry out further investigations".* Ms Bevan further stated that *"During this period of time other teeth in other areas of the mouth were treated. The LR6 was stable and it is my recollection that other teeth in other areas of the mouth were focussed on.".* Ms Ford stated that, if Ms Bevan's evidence that she had a discussion with Patient W about the LR6 in the terms set out in her witness statement is accepted, then she (Ms Ford) would only be critical of Ms Bevan's record keeping and not the standard of care provided. However, the Committee found that there was an

	absence of contemporaneous records to support Ms Bevan's recollection of the discussion she said she had with Patient W. The Committee therefore decided that it could not rely on Ms Bevan's evidence in this regard. It was satisfied on the balance of probabilities that over the two-year period in question, Ms Bevan did not provide definitive treatment to the LR6 and that this was without adequate justification.
24(b)(i)	*You failed to provide an adequate standard of care to Patient W (identified in Schedule A…) from 06 December 2012 to 16 May 2019 including by;* *your radiographic practice in that* *there was a failure to take and/ or record bitewing radiographs when indicated, which should have been at least every two years;* **Found proved.** Having reviewed the clinical records, the Committee accepted the evidence Ms Ford that Ms Bevan did not take bitewing radiographs of Patient W when indicated, which should have been at least every two years. The Committee noted that bitewing radiographs were taken on 4 December 2012, and a singular bitewing was taken on 4 September 2014. The Committee accepted that this was insufficient for a period of over six years.
24(b)(ii)	*You failed to provide an adequate standard of care to Patient W (identified in Schedule A…) from 06 December 2012 to 16 May 2019 including by;* *your radiographic practice in that* *on or around 26 September 2013 there was a failure to take periapical radiographs notwithstanding the patient's BPE score of 3;* **Found not proved.** The Committee was not satisfied from the expert evidence that there was a duty on Ms Bevan to take periapical radiographs in the circumstances. The Committee's understanding of the relevant guidelines is that there is an obligation to consider taking periapical radiographs when there are BPE scores of 3, as there was in this patient's case. However, the Committee was not satisfied that it had been proved that BPE scores of 3 are always, in and of themselves, a reason to take periapical radiographs. The Committee noted that Ms Ford's evidence was that such radiographs may be indicated, as opposed to them being mandatory.
24(b)(iii)	*You failed to provide an adequate standard of care to Patient W (identified in Schedule A…) from 06 December 2012 to 16 May 2019 including by;* *your radiographic practice in that* *on 4 December 2012, 4 September 2014 and 16 November 2018 there was a failure to provide an adequate and accurate report upon radiographs.* **Found proved.**

	The Committee had regard to the clinical records in respect of all three dates and found no accompanying reports for the radiographs taken.
24(c)(i)	*You failed to provide an adequate standard of care to Patient W (identified in Schedule A…) from 06 December 2012 to 16 May 2019 including by;* *periodontal management in that on or around 26 September 2013 you failed to* *adequately investigate the patient's BPE score of 3 by way of periapical radiographs.* **Found not proved.** The Committee was not satisfied from the expert evidence that there was a duty on Ms Bevan to take periapical radiographs in the circumstances. The Committee's understanding of the relevant guidelines is that there is an obligation to consider taking periapical radiographs when there are BPE scores of 3. However, the Committee was not satisfied that it had been proved that BPE scores of 3 are always, in and of themselves, a reason to take periapical radiographs. The Committee noted that Ms Ford's evidence was that such radiographs may be indicated, as opposed to them being mandatory.
24(c)(ii)	*You failed to provide an adequate standard of care to Patient W (identified in Schedule A…) from 06 December 2012 to 16 May 2019 including by;* *periodontal management in that on or around 26 September 2013 you failed to* *provide any or any adequate treatment for the patient's periodontal condition, which should at least have included root surface debridement (RSD).* **Found proved.** The Committee accepted the expert opinion of Ms Ford that RSD was indicated in the circumstances with Patient W's BPE scores of 3. The Committee reviewed the clinical records, and whilst there was reference to the patient attending the Practice for full mouth treatment, including scaling, there was no reference to RSD or any similar treatment having been carried out. In the absence of such information in the clinical notes, the Committee was satisfied on the balance of probabilities that RSD was not provided.
25(i)	*You have failed to maintain an adequate standard of record keeping in respect of Patient W's appointments from 7 March 2007 to 09 May 2015 in that* *on 6 November 2012 and 26 September 2013 expected examination detail, namely risk assessment, diagnosis and treatment, is absent from the records.* **Found proved.** The Committee reviewed Ms Bevan's clinical records for Patient W on 6 November 2012 and 26 September 2013 and did not find reference to the expected examination detail outlined by Ms Ford, in that there is no record of a risk assessment having been undertaken, and no record of a diagnosis or treatment

	The Committee was satisfied on the balance of probabilities that this allegation is proved.
25(ii)	*You have failed to maintain an adequate standard of record keeping in respect of Patient W's appointments from 7 March 2007 to 09 May 2015 in that:* *between 6 November 2012 and 9 May 2015 there were no recorded caries risk assessments;* **Found proved.** The Committee accepted the evidence of Ms Ford that a minimum of one caries risk assessment per year should have been recorded. Having reviewed the clinical records for this patient, the Committee was satisfied on the balance of probabilities that this allegation is proved. It noted the absence of any recorded caries risk assessments for Patient A over two-and-a-half-year period.
25(iii)	*You have failed to maintain an adequate standard of record keeping in respect of Patient W's appointments from 7 March 2007 to 09 May 2015 in that* *there was no or no adequate justification recorded for the delay in providing definitive treatment to the UL2 and LR6.* **Admitted and found proved.**
PATIENT Z	
26(a)(i)	*You failed to provide an adequate standard of care to Patient Z (identified in Schedule A…) from 10 November 2015 to 20 June 2019 including;* *by not adequately treating the patient's periodontal condition in that* *on 10 November 2015 you failed to record BPE scores notwithstanding the periodontally involved LR5;* **Found proved.** The Committee accepted the evidence of Ms Ford that BPE scores should have been recorded for Patient Z on this date, given that LR5 was periodontally involved. The Committee reviewed the clinical records for 10 November 2015 and found no BPE scores were recorded. It considered Ms Bevan's written evidence that it was agreed with the patient that her periodontal condition would be managed with *"improved OHI and hygiene visits".* However, in the Committee's view, this did not explain why BPE scores were not recorded when they should have been.
26(a)(ii)	**Withdrawn.**
26(a)(iii)	**Withdrawn.**
26(a)(iv)	**Withdrawn.**
26(b)(i)	*You failed to provide an adequate standard of care to Patient Z (identified in Schedule A…) from 10 November 2015 to 20 June 2019 including;* *your radiographic practice in that*

	there was a failure to take and/ or record bitewing radiographs when indicated; **Found proved.** Having reviewed the clinical records, the Committee accepted the evidence Ms Ford that Ms Bevan did not take bitewing radiographs of Patient Z when indicated. The only bitewing radiographs noted were taken in 2015. The Committee accepted that this was insufficient for a period of almost four years.
26(b)(ii)	*You failed to provide an adequate standard of care to Patient Z (identified in Schedule A…) from 10 November 2015 to 20 June 2019 including;* *your radiographic practice in that* *there was a failure to adequately report on the radiographs of 10 November 2015 in that the extent of bone loss is not recorded;* **Found proved.** The Committee noted that Ms Bevan did report on the radiographs of 10 November 2015, save for the extent of the bone loss. Whilst the presence of bone loss is noted in the clinical records, a report on the nature and extent of the bone loss is absent. The Committee considered that such information was significant for the treatment of Patient Z's LR5. It therefore accepted the opinion of Ms Ford that Ms Bevan failed to report on the radiographs adequately.
26(b)(iii)	*You failed to provide an adequate standard of care to Patient Z (identified in Schedule A…) from 10 November 2015 to 20 June 2019 including;* *your radiographic practice in that* *on or around 9 January 2018 there was a failure to take and/ or record periapical radiographs notwithstanding the patient's BPE score of 4;* **Found proved.** The Committee was satisfied from Ms Ford's expert evidence that a BPE score of 4 would indicate that a periapical radiograph should be taken. The Committee had regard to the clinical records and found that no periapical radiograph was taken in respect of the BPE score of 4.
26(b)(iv)	**Withdrawn.**
27	*You failed to maintain an adequate standard of record keeping in respect of patient Z's appointments from 10 November 2015 to 20 June 2019 in that the records lack an adequate recorded diagnosis, a clear explanation of treatment options and a clear explanation of risks.* **Found proved.** The Committee accepted the evidence of Ms Ford regarding what she would have expected to be recorded in the Patient Z's clinical records. Whilst the Committee noted that some records were made by Ms Bevan in relation to the patient's treatment, it found very little information in diagnostic terms, treatment options and

	explanation of risks. The Committee was satisfied from the expert evidence that Ms Bevan's record keeping for Patient Z fell significantly short over this protracted period of time.
PATIENT AA	
28(a)(i)	*You failed to provide an adequate standard of care to Patient AA (identified in Schedule A…) from 21 February 2008 to 11 September 2018 including:* *your radiographic practice, in that* *there was a failure to take and/ or record bitewing radiographs when indicated, which should have been at least every two years;* **Found proved.** The evidence before the Committee indicated that only one set of bitewings were taken of Patient AA and this was on 2 January 2014. Ms Bevan's evidence in her witness statement was that the patient declined all subsequent radiographs. The Committee had regard to clinical records and noted that on 5 April 2017 there is a note stating that FGDP guidelines were discussed with Patient AA, but the patient *"declined radiographs today".* It was noted that it was agreed with the patient to review taking bitewing radiographs in October 2017. However, there was no indication in the clinical records to any further bitewing radiographs being taken. The Committee had regard to Ms Ford's opinion that most patients would accept radiographs after a fuller explanation. The Committee had regard to the contemporaneous information as well as Ms Bevan's representations. There is an absence of discussion within the records – aside from the note of 5 April 2017, to support Ms Bevan's contention that cost may have been a factor in this case. The Committee considered it implausible that a patient would refuse radiographs over the course of a 10-year period if adequate explanation had been given. If such discussions did take place, then the Committee would have expected to see them recorded.
28(a)(ii)	*You failed to provide an adequate standard of care to Patient AA (identified in Schedule A…) from 21 February 2008 to 11 September 2018 including:* *your radiographic practice, in that* *on or around 1 November 2017 there was a failure to take and/ or record periapical radiographs notwithstanding the patient's BPE score of 3;* **Found not proved.** The Committee was not satisfied from the expert evidence that there was a duty on Ms Bevan to take periapical radiographs in the circumstances. The Committee's understanding of the relevant guidelines is that there is an obligation to consider taking periapical radiographs when there are BPE scores of 3. However, the Committee was not satisfied that it had been proved that BPE scores of 3 are always, in and of themselves, a reason to take periapical radiographs. The Committee noted that Ms Ford's evidence was that such radiographs may be indicated, as opposed to them being mandatory.
PATIENT DD	

29(a)(i)	*You failed to provide an adequate standard of care to Patient DD (identified in Schedule A…) from 25 January 2008 to 04 July 2019 including by;* *by not adequately managing the patient's periodontal condition, in that:* *On or around 14 September 2010 and 14 August 2014 you failed to adequately investigate the patient's BPE scores of 3 and 4 by way of periapical radiographs;* **Found proved.** The Committee was satisfied from Ms Ford's expert evidence that BPE scores of 4 indicate that periapical radiographs should be taken. The Committee had regard to the clinical records and found that none were taken on the dates in question. Ms Bevan's recollection is that the taking of radiographs was discussed with Patient DD, however the patient declined radiographs as she *"only had a few teeth".* The Committee found nothing to support a Patient DD declining radiographs in the clinical records. Furthermore, it considered that Ms Bevan's evidence about discussing radiographs with the patient indicated that she considered radiographs should have been taken. In all the circumstances, the Committee was satisfied on the balance of probabilities that Ms Bevan failed to adequately investigate Patient DD's BPE scores of 4 by way of periapical radiographs.
29(a)(ii)	*You failed to provide an adequate standard of care to Patient DD (identified in Schedule A…) from 25 January 2008 to 04 July 2019 including by;* *by not adequately managing the patient's periodontal condition, in that:* *On or around 14 September 2010 and 14 August 2014 you failed to provide any or any adequate treatment for the patient's periodontal disease. Adequate treatment should have included root surface debridement (RSD) rather than simple scaling.* **Found proved.** The Committee accepted the expert opinion of Ms Ford that RSD was indicated in the circumstances with Patient DD's BPE scores of 3 and 4. Ms Bevan's written evidence was that Patient DD did not want any complex treatment. However, the Committee did not find any information in the clinical notes to support this contention. The Committee noted that the patient attended to see the hygienist on a number of occasions for routine visits of up to 20 minutes duration. The Committee did not consider that these appointments provided adequate time for RSD to be performed. Taking into account all the evidence, the Committee concluded that there was no indication that Patient DD's periodontal disease had been adequately treated.

30(i)	*You failed to maintain an adequate standard of record keeping in relation to Patient DD's appointments from 25 January 2008 to 04 July 2019, in that:* *On 15 January 2019 you noted "no areas of concern" in relation to the patient's face, neck, forehead, scalp, ears, nose, cheek and chin. You failed to record the presence of a lump on the patient's neck and you failed to record any discussions with the patient in respect of the plan for the lump.* **Found proved.** Whilst the Committee took into account Ms Bevan's written evidence about having had discussions with Patient DD about a lump on the patient's neck, this discussion is not recorded in the clinical records on 15 January 2019. As this allegation and Ms Ford's criticism is in relation to a record keeping failure, the Committee was satisfied on the evidence that this alleged matter is proved.
30(ii)	*You failed to maintain an adequate standard of record keeping in relation to Patient DD's appointments from 25 January 2008 to 04 July 2019, in that:* *On 4 July 2019 you failed to record any discussions with the patient in respect of the plan for the lump on the patient's neck.* **Found not proved.** The Committee noted that there was a degree of uncertainty as to whether the records on this date were written by Ms Bevan or someone else. Ms Ford said that she was unsure. This point was conceded by the GDC in its closing submissions.

62. The hearing moves to Stage Two.

Stage Two of the hearing – 20 to 21 November 2024

63. The Committee's task at this second stage of the hearing has been to determine whether the facts found proved against Ms Bevan amount to misconduct, and if so, whether her fitness to practise is impaired by reason of that misconduct. The Committee took into account that if it found current impairment, it would need to determine what sanction, if any, to impose on Ms Bevan's registration.

64. The Committee considered all the evidence presented to it at the fact-finding stage, both oral and documentary. It also considered the additional evidence received at this stage, which comprised a bundle of documents including:

- an Investigating Committee (IC) decision sheet, dated 5 December 2014 in respect of previous allegations against Ms Bevan which were closed with advice;
- a letter dated 16 November 2024 from Ms Jane Ford, the GDC's expert witness in this case, in which she comments on the IC decision of 2014; and

- a letter dated 20 November 2024, from Ms Bevan's legal representatives at the MDU addressing the IC decision in 2014 and the comments made on it by Ms Ford.

65. The Committee took account of the submissions made by Ms Power, Counsel on behalf of the GDC, in relation to misconduct, impairment, and sanction.

66. Ms Bevan's legal representatives did not provide any submissions on the issue of misconduct, impairment or sanction in their letter of 20 November 2024, but they did confirm that Ms Bevan has retired from clinical practice and that she has no intention of returning to dentistry.

67. The Committee accepted the advice of the Legal Adviser. It bore in mind that its decisions were for its independent judgement. There is no burden or standard of proof at this stage of the proceedings.

Summary of the facts found proved

68. The factual findings made by the Committee, some of which were admitted by Ms Bevan, relate to the standard of care that she provided to 16 patients, over the period 2007 to 2019. The Committee found that there were a substantial number of clinical failings on Ms Bevan's part during her treatment of the patients, which in broad terms were:

- Failings in radiography, including failing to take, record or report on radiographs.
- Failing to provide definitive treatment to multiple patients, including root canal treatment. and restorations.
- Failing to manage patients' periodontal conditions.
- Inappropriate management of caries and caries risk.
- Significant failings in record keeping.

Summary of the submissions made by the GDC

69. Ms Power invited the Committee to consider the opinion of the GDC's expert witness, Ms Jane Ford, regarding the factual matters that she considered fell far below the expected standard, as well as Ms Ford's evidence on the potential for patient harm. Ms Power also asked the Committee to take into account the length of time covered by the charge, that the findings encompass multiple patients, and that there were multiple areas of deficiency in Ms Bevan's clinical practice. It was Ms Power's submission that, taking into account this overview, there could be little doubt that misconduct is made out in this case.

70. With regard to current impairment, Ms Power submitted that at the very highest, the insight shown by Ms Bevan is incomplete. Ms Power noted that Ms Bevan made some admissions and offered some apologies, but not in respect of the majority of the charge. Ms Power submitted that the explanations given by Ms Bevan in her witness statement were not always insightful, particularly in terms of her own analysis of her conduct in certain areas of her clinical practice.

71. Ms Power further highlighted that Ms Bevan's witness statement does not address the issue of remediation. Ms Power noted that there is reference to Ms Bevan's remediation in the letter dated 20 November 2024, from her legal representatives, in which they state that *"Following consideration of her case in 2014, Ms Bevan continued with her remediation until her retirement in September 2019…".* Ms Power noted, however, that no information had been provided regarding the nature and extent of that remediation. She also asked the Committee to take into account that no evidence of remediation has been provided pertaining to the findings made at this hearing.

72. Addressing the case in 2014, Ms Power disagreed with the suggestion made by Ms Bevan's legal representatives in their letter of 20 November 2014 that the IC decision is not relevant to this current case. Ms Power contended that the 2014 decision is directly relevant, in that the matters considered by the IC included radiographic failings and issues of record keeping. Ms Power further submitted that the 2014 decision is relevant in a wider sense, in that Ms Bevan was given clear and unequivocal advice to improve her clinical practice which, in Ms Power's submission, Ms Bevan did not follow. Ms Power asked the Committee to consider the comments made by Ms Ford on the IC decision.

73. Ms Power noted that Ms Bevan has now retired from clinical practice. She asked the Committee to take into account the law and guidance when considering the likelihood of repetition in the context of retirement, as set out in the '*Guidance for the Practice Committees, including Indicative Sanctions Guidance'* (Effective from October 2016; last revised in December 2020) ('the PC Guidance') and in the case of *General Optical Council v Clarke* [2018] EWCA Civ 1463. Ms Power invited the Committee to find that Ms Bevan's fitness to practise is impaired notwithstanding her retirement.

74. In her submissions on sanction, Ms Power focused on the sanctions of suspension and erasure. It was her submission that it would not be appropriate or proportionate to impose any of the lesser sanctions. In relation to suspension, Ms Power submitted that this case is somewhat more serious than a suspension case, given the depth and scope of the Committee's findings. She further submitted that it may be considered that the fact of the IC decision in 2014 tipped the balance towards erasure. Ms Power noted that factors relating to erasure apply in the circumstances of this current case. She submitted that if the Committee were minded to impose a suspension order, it should be a suspension for the maximum period of 12 months, with a review.

Decision on misconduct

75. The Committee considered whether the facts found proved against Ms Bevan amount to misconduct. It took into account that a finding of misconduct in the regulatory context requires a serious falling short of the professional standards expected of a registered dental professional. The Committee had regard to its findings and to the current GDC Standards as set out in *'Standards for the Dental Team'* (Effective from September 2013). Whilst the Committee noted that some of the findings made against Ms Bevan pre-date the current GDC Standards, it was satisfied that similar professional principles and guidance were contained in previous Standards publications.

76. Having had regard to the current *'Standards for the Dental Team'*, the Committee considered that the following GDC Standards are engaged in this case:

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

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

77. The Committee considered and accepted the opinion of the GDC's expert, Ms Ford, as to which of its factual findings fell below or far below the expected standard.

78. The Committee accepted that its findings at heads of charge 5(b)(i), 7(i), 16(i), 16(iv), 18(iv), 25(i), 26(a)(i) and 26(b)(ii) were aspects of Ms Bevan's clinical practice that fell below standard, as opposed to far below. These individual findings relate to isolated issues of record keeping and whilst the Committee was satisfied that these matters represented deficient practice on the part of Ms Bevan, it did not consider that these failings were, in and of themselves, so egregious as to amount to misconduct.

79. The Committee was satisfied that all of its other findings, individually and cumulatively, represented conduct that fell far below what was expected of Ms Bevan as a general dental practitioner. In summary, these were the findings concerning Ms Bevan's failure to take radiographs when indicated, to report on radiographs that were taken, to provide definitive treatment to multiple patients, to appropriately manage caries, caries risk and patients' periodontal conditions, and prolonged periods of poor record keeping. These were not single isolated events. They were failings that were repeated, persisted over a number of years and affected the care and treatment of multiple patients, placing them at risk of harm. In the Committee's view, Ms Bevan's shortcomings in the areas outlined represented a pattern of failure across a wide scope of her clinical practice in basic and fundamental aspects of dentistry. In all the circumstances, the Committee was satisfied that the facts found proved in relation to these particular matters fell seriously short of the expected professional standards and do amount to misconduct.

Decision on impairment

80. The Committee next considered whether Ms Bevan's fitness to practise is currently impaired by reason of her misconduct. It had regard to the over-arching objective of the GDC, which is: the protection, promotion and maintenance of the health, safety, and well-being of the public; the promotion and maintenance of public confidence in the dental profession; and the promotion and maintenance of proper professional standards and conduct for the members of the dental profession.

81. The Committee considered that the clinical failings identified in this case, although serious and wide-ranging, are capable of being remedied. However, it found that there was little or no evidence before it to indicate what steps Ms Bevan has taken to address the concerns raised in respect of her clinical practice. Ms Bevan's witness statement does not address the issue of remediation, and no evidence has been provided in relation to any remediation that she has undertaken since the matters in this current case came to light.

82. The Committee noted that advice was issued to Ms Bevan in the IC decision of 2014, including in relation to similar concerns about her clinical practice in radiography and record keeping. As such, the Committee considered the IC decision was clearly relevant to the matters under

consideration at this hearing. The Committee noted that there was evidence of some improvement in Ms Bevan's clinical practice following the 2014 decision, particularly in relation to her record keeping, and this was noted by Witness 1 in his evidence. The Committee also noted that during the sale of the Practice in 2018, Ms Bevan engaged with Health Inspectorate Wales (HIW). She provided a copy of the HIW inspection report with her witness statement, and the Committee noted some of the positive observations outlined in it.

83. Notwithstanding this, Ms Bevan's remedial efforts and improvements appear not to have been developed or sustained. In the Committee's view, the remediation that she undertook following the consideration of her case in 2014 could not have been embedded, given the recurrence of some of the same issues in this case which covers a period up to 2019. It was the view of the Committee that Ms Bevan's past remediation has had little or no positive effect when considering the nature and extent of the concerns before it.

84. The Committee considered that Ms Bevan has failed to recognise the seriousness of the criticisms made about the standard of care she provided to the patients in this case. Whilst Ms Bevan provided a lengthy and detailed witness statement in response to the then allegations, the Committee found her written evidence to be more descriptive than insightful.

85. The Committee considered that it received very little evidence to reassure it that Ms Bevan has undertaken sufficient remediation to address the serious and wide-ranging concerns outlined in its findings, or that she has anything other than a partial level of insight. In these circumstances, the Committee concluded that there would be a continuing risk of harm to patients if Ms Bevan were permitted to practice without any restriction on her registration. Whilst the Committee noted the information that Ms Bevan has retired from clinical practice, it took into account that in the absence of any restriction on her registration, she could return to working as a dentist, should she wish to do so. The Committee therefore determined that a finding of impairment is necessary for the protection of the public.

86. The Committee also determined that a finding of impairment is in the wider public interest. Ms Bevan's clinical failings were serious, widespread, related to multiple patients and persisted over a protracted period of time. It was the view of the Committee that Ms Bevan breached a fundamental tenet of the dental profession by not providing the patients with the standard of care that they were entitled to expect. She has presented little or no evidence of remediation and has demonstrated limited insight into the identified shortcomings in the clinical practice. The Committee considered that public confidence in the dental profession would be seriously undermined if a finding of impairment were not made in the circumstances of this case. It considered that such a finding is also necessary to maintain and promote proper professional standards.

87. Accordingly, the Committee determined that Ms Bevan's fitness to practise is currently impaired by reason of her misconduct.

Decision on sanction

88. The Committee next considered what sanction, if any, to impose on Ms Bevan's registration. It noted that the purpose of a sanction is not to be punitive, although it may have that effect, but to

protect the public and the wider public interest. In reaching its decision, the Committee had regard to the Practice Committee Guidance. It applied the principle of proportionality, balancing the public interest with Ms Bevan's interests.

89. In deciding on the appropriate sanction, the Committee considered the mitigating and aggravating factors in this case. It considered the following in mitigation:

- That Ms Bevan made some admissions to the allegations.
- That Ms Bevan issued some apologies for her shortcomings in her witness statement.
- That Ms Bevan has engaged to some extent with these proceedings.

90. The Committee identified the following as aggravating features in this case:

- The risk of harm to patients.
- That Ms Bevan's misconduct was sustained or repeated over a period of time.
- That Ms Bevan received advice issued by the IC in 2014 in relation to some similar matters.
- Ms Bevan's limited insight.

91. Taking all of the above factors into account, the Committee considered the available sanctions. It started with the least restrictive, as it is required to do.

92. The Committee noted that it was open to it to conclude this case without taking any action in relation to Ms Bevan's registration. However, given its serious ongoing concerns about patient safety, the Committee concluded that such an outcome would not serve to protect the public. The Committee also considered that taking no action would undermine public confidence in the dental profession and would fail to uphold proper professional standards.

93. The Committee considered a reprimand but decided that this sanction would not be appropriate or proportionate. It considered that the matters in this case are too serious for the issuing of a reprimand. It also noted that a reprimand would not impose any restriction on Ms Bevan's registration and therefore would not protect the public or satisfy the wider public interest.

94. The Committee also determined that a conditions of practice order would not be appropriate or proportionate. It was not satisfied that Ms Bevan would engage with conditional registration, given the information that she has retired from clinical practice. In any event, the Committee considered that an order of conditions would not address the gravity of Ms Bevan's sustained and widespread failings. It further took into account the absence of any real evidence of remediation and its concerns about the level of Ms Bevan's insight. In all the circumstances, the Committee considered that a conditions of practice order would not be sufficient or workable.

95. The Committee went on to consider whether to suspend Ms Bevan's registration for a specified period up to a maximum of 12 months. It had regard to paragraph 6.28 of the PC Guidance, which states that:

"Suspension is appropriate for more serious cases and may be appropriate when all or some of the following factors are present (this list is not exhaustive):

- *there is evidence of repetition of the behaviour;*
- *the Registrant has not shown insight and/or poses a significant risk of repeating the behaviour;*
- *patients' interests would be insufficiently protected by a lesser sanction;*
- *public confidence in the profession would be insufficiently protected by a lesser sanction;*
- *there is no evidence of harmful deep-seated personality or professional attitudinal problems (which might make erasure the appropriate order)".*

96. The Committee considered the above factors from paragraph 6.28, and it noted that the first four factors are applicable in this case. The Committee considered that there is also evidence of an attitudinal problem. In the Committee's view, Ms Bevan was given a clear signal from her regulator in 2014 in the form of the IC decision that she should reflect and improve upon her clinical practice in fundamental areas of dentistry. Whilst there is evidence that she took some steps following that advice, the Committee considered that she did not make sufficient efforts to effect any real or sustained change in her day to day practice.

97. The findings in this current case involve concerns that are more serious and extensive than those matters considered in 2014. The evidence indicates that following the advice that was issued to her, Ms Bevan continued to act so as to put multiple patients at risk. The Committee has received little or no evidence of remediation in relation to the matters that have been under consideration at this hearing which, in its view, demonstrates that Ms Bevan lacks the appropriate attitude or approach to improving the deficiencies in her clinical practice.

98. Having taken all matters into account, the Committee was not reassured that there is any real prospect of Ms Bevan taking steps to remedy the misconduct found in this case. Accordingly, it concluded that the suspension of her registration would serve no meaningful purpose and ultimately would not be in the public interest.

99. In reaching its decision, the Committee noted that factors for erasure are present in this case in that, there have been serious departures from relevant professional standards, a continuing risk to patients had been identified, and Ms Bevan continues to show a persistent lack of insight into the seriousness of her actions or their consequences.

100. In all the circumstances, the Committee determined that the only appropriate and proportionate sanction is one of erasure.

101. Unless Ms Bevan exercises her right of appeal, her name will be erased from the Dentists Register, 28 days from the date that this Committee's direction is deemed to have been served upon her.

102. The Committee now invites submissions from Ms Power as to whether an immediate order of suspension should be imposed on Ms Bevan's registration pending the taking effect of its substantive direction.

Decision on an immediate order – 21 November 2024

103. In considering whether to impose an immediate order of suspension on Ms Bevan's registration, the Committee took account of Ms Power's submission that such an order should be imposed to cover the statutory appeal period, or for longer, in the event of an appeal by Ms Bevan.

104. Ms Power submitted that the Committee could not be reassured by Ms Bevan's retirement, as she could change her mind about returning to clinical practice. Ms Power therefore submitted that an immediate order is necessary to protect the public and the wider public interest.

105. The Committee accepted the advice of the Legal Adviser, who drew its attention to the relevant guidance contained at paragraphs 6.35 to 6.38 of the Practice Committee Guidance which deal with immediate orders.

106. The Committee determined that the imposition of an immediate order of suspension on Ms Bevan's registration is necessary for the protection of the public and is otherwise in the public interest.

107. The Committee has made serious findings in this case and has identified an ongoing risk to the public. It took into account that in the absence of an immediate order, Ms Bevan could return to unrestricted clinical practice during the 28-day appeal period should she wish to do so, or for potentially longer, in the event that she appeals the Committee's substantive decision. An immediate order is therefore necessary to protect the public.

108. The Committee was also satisfied that an immediate order is required in the wider public interest. It has determined that Ms Bevan's conduct is incompatible with continued GDC registration, and it therefore considered that immediate action is warranted in this case to maintain public confidence in the dental profession and to uphold proper professional standards.

109. The effect of the foregoing substantive determination and this order is that Ms Bevan's registration will be suspended to cover the appeal period. Unless she exercises her right of appeal, the substantive direction for erasure will take effect 28 days from the date of deemed service.

110. Should Ms Bevan exercise her right of appeal, this immediate order will remain in place until the resolution of the appeal.

111. That concludes this determination.