Dental Professionals Hearings Service

PUBLIC HEARING

Professional Conduct Committee
Initial Hearing

10-11 March 2025

Name:	Brown, Robert
Registration number:	55986
Case number:	CAS-204252-R6F8D4

General Dental Council:	Ms Sian Priory counsel. Instructed by Amy Jones, IHLPS.
Registrant:	Not Present and unrepresented

Fitness to practise:	Impaired by reason of misconduct
Outcome:	Suspended with immediate suspension (with a review)
Duration:	12 months

Committee members:	Diane Meikle (Chair and lay member) Laura Owen (DCP member) Amita Janda-Dhami (Dentist member)
Legal adviser:	Megan Ashworth
Committee Secretary:	Jamie Barge

The Charge

The hearing will be held to consider the following charge against you:

That being registered as a dentist:

1. *From 05 October 2022 to 26 June 2023, you failed to fully cooperate with an investigation conducted by the GDC by not providing the GDC with patient records and indemnity evidence.*

And, by reason of the facts alleged, your fitness to practice is impaired by reason of misconduct.

PUBLIC DETERMINATION

FINDINGS OF FACT – 10 March 2025

BROWN, Robert [Registration Number: 59986]

1. This is a Professional Conduct Committee hearing. The members of the Committee, as well as the Legal Adviser and the Committee Secretary, conducted the hearing remotely via Microsoft Teams in line with current GDC practice. Mr Brown was not present at the hearing. Ms Sian Priory, Counsel, appeared on behalf of the General Dental Council (GDC).

Preliminary matters

2. The Committee first considered the issues of service and whether to proceed with the hearing in the absence of Mr Brown. The Committee accepted the advice of the Legal Adviser on both of these matters as to the provisions of the Rules and the approach it should take to its decision.

Decision on Service of the Notice of Hearing

3. The Committee first considered whether notice of the hearing had been served on Mr Brown in accordance with Rules 13 and 65 of the GDC's Fitness to Practise Rules 2006 ('the Rules') and Section 50A of the Dentists Act 1984 (as amended) ('the Act'). The Committee received from the GDC an indexed hearing bundle, which contained a copy of the Notice of Hearing ('the notice'), dated 5 February 2025. The hearing bundle also contained a Royal Mail 'Track and Trace' receipt confirming that the notice was sent to Mr Brown by Special Delivery. A copy of the notice was also sent by first-class post and emailed to Mr Brown. The Notice was also sent to an alternative address, via Special delivery, first class post and also via email.

4. The Committee was satisfied that the notice sent to Mr Brown contained proper notification of today's hearing, including its time, date and that it will be taking place remotely, and the other prescribed information including notification that the Committee had the power to proceed with the hearing in Mr Brown's absence.

5. On the basis of the information provided, the Committee was satisfied that notice of the hearing had been served on Mr Brown in accordance with the Rules and the Act.

Decision on Proceeding in the Registrant's Absence

6. The Committee next considered whether to exercise its discretion under Rule 54 of the Rules to proceed with the hearing in the absence of Mr Brown. The Committee approached the issue of proceeding in absence with the utmost care and caution. The Committee took into account the factors to be considered in reaching its decision, as set out in the case of *R v Jones [2003] 1 AC 1HL* and the case of *General Medical Council v Adeogba [2016] EWCA Civ 162*. It remained mindful of the need to be fair to both Mr Brown and the GDC, taking into account the public interest and Mr Brown's own interests.

7. The Committee note that various attempts were made by the GDC to contact Mr Brown, however, no response has been received from the Registrant. On the basis of the information

before it, the Committee concluded that Mr Brown had voluntarily absented himself from today's hearing. It noted that Mr Brown has not requested a postponement.

8. The Committee weighed the public interest in expeditious conclusion of the hearing against fairness to Mr Brown and any possible benefit in delaying the start of the hearing. However, the Committee determined that it was fair and in the public interest to proceed with the hearing in the absence of Mr Brown.

9. In those circumstances, the Committee was satisfied that Mr Brown had chosen not to take part in today's hearing. Therefore, it determined that it was fair and appropriate to proceed with the hearing in the absence of Mr Brown.

Background

10. This case arises from a complaint on 1 November 2021 from a patient received by the Council which raised concerns about Mr Brown's fitness to practise as a dentist, relating to clinical matters. Mr Brown was sent letters between 5 October 2022 and 26 June 2023 which was the information gathering period, by the GDC requesting details of his indemnity insurance and patient records in accordance with its usual investigation process. During that period, there is a clear pattern of requests for the material over a period of over 8 months to which there has not been a satisfactory response by Mr Brown.

The charge

11. The charge against Mr Brown at this hearing is that from 05 October 2022 to 26 June 2023, Mr Brown failed to fully cooperate with an investigation conducted by the GDC by not providing the GDC with patient records and indemnity evidence.

Evidence

12. The factual evidence received by the Committee included a GDC hearing bundle provided by the GDC, which included the witness statement of Michelle Regis dated 30 October 2024, with associated exhibits. She was the GDC Practise Caseworker.

The Committee's findings on the facts

13. The Committee considered all the documentary evidence presented to it. It also took account of the closing submissions made Ms Priory on behalf of the GDC. The Committee has accepted the advice of the Legal Adviser. It has borne in mind that the burden of proof is on the GDC and that it must decide the facts according to the civil standard of proof, namely on the balance of probabilities. Mr Brown does not need not prove or disprove anything.

14. The Committee's findings in relation to each head of charge are as follows:

1.	From 05 October 2022 to 26 June 2023, you failed to fully cooperate with an investigation conducted by the GDC by not providing the GDC with patient records and indemnity evidence. **Found proved.**

	In considering this charge, the Committee was satisfied that there is an obligation for Mr Brown to cooperate with the GDC, as outlined in 'Standards for the dental team' (the Standards), as follows: Standard 9.4: *You must co-operate with any relevant formal or informal inquiry…* Michelle Regis, was the GDC Practise Case worker who had worked for some time in 2023 in this case. She confirms in her written statement that numerous attempts were made to contact Mr Brown from October 2022 until June 2023 to obtain information for their investigation, more particularly, patient records and indemnity insurance certificates. Ms Regis confirmed that Mr Brown had failed to fully cooperate with their investigation and provide the requested information within this timeframe. The Committee was satisfied that Mr Brown has a responsibility to cooperate with the GDC during the course of the investigation into his fitness to practise. It noted that there had been some engagement by Mr Brown by requesting an extension of time on 5 occasions, but that the requested information was not provided during that investigatory stage. It was satisfied that given Mr Brown's previous engagement, the Registrant was aware of the risks of not cooperating with his regulator. The letters sent to him requesting the information, reminded him of his duty to cooperate and warned him of the potential consequences of failing to cooperate. The Committee took account of the numerous and varied attempts that had been made by the GDC to contact Mr Brown but that he failed to fully cooperate, as required in Standard 9.4. In this regard, the Committee was satisfied that Mr Brown failed to cooperate with the GDC and finds this head of charge proved.

13. We move to Stage Two.

Decision on misconduct, impairment and sanction – 11 March 2025

14. Having announced its decision on the facts, the Committee then moved on to consider whether the facts found proved amount to misconduct and, if so, whether your practice is currently impaired. In accordance with Rule 20 of the Fitness to Practise Rules 2006, the Committee heard submissions from Ms Priory, on behalf of the GDC, in relation to the matters of misconduct, impairment and sanction. The Committee accepted the advice of the Legal Adviser.

Submissions

15. Ms Priory, on behalf of the GDC submitted that Mr Brown's failure to provide the requested information to the GDC, despite multiple requests over an 8-month period is serious and constitutes misconduct. She submitted that his conduct is a significant departure from the standards expected, namely Standard 9.4. She submitted that this standard is essential to allow the GDC to monitor and ensure that its registrants are practising safely, and the public

is protected from misconduct. Ms Priory submitted that Mr Brown failing to provide requested information blatantly flies in the face of all GDC's efforts.

16. Ms Priory submitted that a finding of impairment is required for public protection and public interest. She submitted that the consequences of failing to comply with requests for information clearly demonstrates an underlying attitudinal issue, which may be difficult to remediate. She submitted that in the absence of any engagement, there is a high risk of repeating the misconduct in this case. Cooperation with the GDC is a basic requirement for anyone wishing to hold continued registration, and failure to do so can bring the profession into disrepute.

17. Ms Priory submitted that in 2020 Mr Brown was found by a PCC to have provided inadequate care to 5 patients and he received a conditions of practise order for 18 months. Ms Priory submitted that in the current case he has failed to provide information arising from a further patient complaint, which is cause for concern. She submitted that this conduct may demonstrate a deeper attitudinal issue.

18. Should the Committee find Mr Brown's fitness to practise is currently impaired by reason of his misconduct, Ms Priory submitted that the conduct found is serious and a suspension order of 12 months, with a review, would be the most proportionate and appropriate outcome in this case.

Misconduct

19. The Committee first considered whether the facts found proved against Mr Brown amount to misconduct. The Committee has found that Mr Brown failed to provide the requested information to the GDC, despite multiple requests over an 8-month period. The Committee is satisfied that Mr Brown's conduct is a significant departure from an acceptable practice.

20. The Committee considers that Mr Brown has breached the following GDC's Standard:

> *9.4: Co-operate with any relevant formal or informal inquiry and give full and truthful information*

21. The Committee considers that Mr Brown's actions fell far below the conduct expected of a registered dentist. In the Committee's view, Mr Brown's failure to cooperate with the GDC's investigation into his fitness to practise by failing to provide it with information falls far below the standards expected of a reasonably competent dentist. The Committee is satisfied that despite numerous requests, he persistently disregarded his regulator in its investigation. This undermined the role of the GDC as his regulator and was in clear breach of standard 9.4, which would bring the profession into disrepute.

22. The Committee determined that the facts found proved under head of charge 1 is a serious failing. Taking all these factors into account, the Committee is satisfied that the findings are serious and amount to misconduct.

Impairment

23. The Committee then considered whether Mr Brown's fitness to practise is currently impaired by reason of his misconduct.

24. The Committee was mindful of its role to protect patients from risk of harm and to uphold the public interest, which includes the need to declare and maintain proper standards of conduct and performance.

25. The Committee considered that Mr Brown's misconduct was serious and was not an isolated incident. His actions in failing to cooperate and provide information for the GDC's investigation have brought the profession into disrepute. His misconduct has breached a fundamental GDC standard.

26. The Committee next considered whether the misconduct found proved is remediable. It noted that it appears Mr Brown's conduct appears to be an attitudinal failing. Nonetheless, the Committee went on to consider whether Mr Brown has in fact remedied his failings.

27. The Committee noted that Mr Brown has not provided any evidence of remediation or demonstrated that he has any insight into his misconduct. There is no evidence of his understanding of the importance of all Registrant's requirement to follow the GDC's standards. The Committee considered that this risk of non-cooperation was compounded by the fact that Mr Brown had previously been the subject of an earlier GDC investigation and adverse findings of clinical misconduct. The Committee also took into account his non-engagement with this GDC investigation and on-going process. The Committee therefore considers that his failure to cooperate with his regulator's requests for information over a period of time, demonstrates an underlying attitudinal behaviour. In these circumstances, the Committee determined that there was a high risk of repetition of him failing to cooperate with his regulator, and this would pose an on-going risk to patient safety.

28. The Committee considers that Mr Brown has not expressed any insight into his actions or the potential impact or risk. The Committee considered that there is a high risk of repetition of the misconduct of failing to cooperate with his regulator. It therefore concluded that a finding of impairment by reason of Mr Brown's misconduct is necessary in the interest of public protection.

29. The Committee further considered that public confidence in the profession and in the GDC as its regulator would be severely undermined if a finding of impairment in relation to misconduct was not made given the serious nature of the findings in this case. Accordingly, it determined that a finding of impairment by reason of Mr Brown's misconduct is in the wider public interest.

Decision and reasons on sanction

30. The Committee next considered what sanction, if any, to impose on Mr Brown's registration. It recognised that the purpose of a sanction is not to be punitive, although it may have that effect. The Committee applied the principle of proportionality, balancing Mr Brown's interests with the public interest. It also took into account the Guidance.

31. The Committee considered the mitigating and aggravating factors in this case as outlined in paragraphs 5.17 and 5.18 of the Guidance.

32. The Committee did not find any mitigating factors in this case.

33. The aggravating factors in this case include:

- Lack of insight;
- Disregard of the GDC; and
- Previous adverse findings of a PCC.

34. The Committee decided that it would be inappropriate to conclude this case with no further action. It would not satisfy the public protection or the public interest, given the serious nature of the misconduct.

35. The Committee then considered the available sanctions in ascending order starting with the least serious.

36. The Committee concluded that misconduct of this nature cannot be adequately addressed by way of a reprimand. It cannot be said to be at the lower end of the spectrum of seriousness. In the Committee's view, the protection of the public and the public interest would not be upheld by the imposition of such a sanction. The Committee therefore determined that a reprimand would be inappropriate and inadequate.

37. The Committee next considered whether placing conditions on Mr Brown's registration would be a sufficient and appropriate response but was of the view that there are no practical or workable conditions that could be formulated given the nature of the conduct and the lack of meaningful engagement in these proceedings. It took into account that conditions of practice are more suited to remedying skill deficits and there have not been any identified in this case.

38. The Committee then went on to consider whether a suspension would be appropriate. It takes a serious view of the findings against Mr Brown. The Committee acknowledge that after the period in question, he did provide evidence of his indemnity insurance, but not withstanding this, he did fail to provide the necessary information at the material time. It notes that there was no evidence of actual patient harm in this case. However, the Committee is satisfied that the misconduct in this case, although serious, is not fundamentally incompatible with Mr Brown remaining on the register. The Committee considered that a period of suspension would be sufficient for the protection of the public and the maintenance of public confidence in the profession. It further considers that this sanction is sufficient to mark the seriousness of Mr Brown's misconduct. The Committee considers that it would be appropriate to give Mr Brown an opportunity to reflect on his misconduct and be able to address the issues in this case.

39. The Committee did go on to consider erasure but having regard to the aggravating factors in this case, determined that it would be disproportionate. Whilst there was a serious departure from the Standards, the Committee acknowledged that it would be unduly punitive to direct erasure at this time.

40. Balancing all these factors, the Committee directs that Mr Brown's registration be suspended for a period of 12 months. The Committee considers that the maximum period of 12 months is necessary to protect patients and to maintain and uphold public confidence in the

profession, whilst sending the public and the profession a clear message about the standards of practice required of a dentist.

41. The Committee noted the hardship the suspension may cause Mr Brown. However, this is outweighed by the public protection and public interest in this regard.

42. The Committee directs that this order be reviewed before its expiry, and Ms Brown will be informed of the date and time in writing. It would be advisable for Mr Brown to attend the review hearing. The reviewing Committee will consider what action it should take in relation to Mr Brown registration.

43. The reviewing Committee may be assisted to receive:

- *A detailed reflective statement demonstrating Mr Brown's insight into and understanding of the importance of cooperating with his regulator.*
- *By Mr Brown's participation in these proceedings.*

44. The Committee now invites submissions from Ms Priory as to whether the suspension should take immediate effect to cover the 28-day appeal period.

45. Ms Priory made an application for an immediate suspension to be imposed on Mr Brown's registration. She invited the Committee to impose an immediate order of suspension on the grounds of public protection and in the wider public interest.

46. The Committee accepted the advice of the Legal Adviser.

47. Due to the risk of repetition, as identified in its earlier findings, the Committee was satisfied that an immediate order is necessary for the protection of the public and in the wider public interest. To do otherwise would be incompatible with the Committee's earlier findings.

48. The Committee therefore determined to make an immediate order of suspension.

49. The immediate suspension will remain in place for at least 28 days from the date on which Mr Brown is deemed to have been served with the Committee's decision. If an appeal is made, it will remain in place until the appeal has concluded. If no appeal is made, the substantive suspension will replace the immediate suspension after 28 days and will run for the full term of 12 months.

50. The Committee's decision will be confirmed to Mr Brown in writing, in accordance with the Act.

51. Any Interim Order is hereby revoked.

52. That concludes this determination.