Dental Professionals Hearings Service

PUBLIC HEARING

Professional Conduct Committee
Initial Hearing

25 November to 13 December 2024

Name:	MOBASSERI, Mohsen
Registration number:	81444
Case number:	CAS-195516

General Dental Council:	Natasha Tahta, counsel. Instructed by Capsticks.
Registrant:	Present Represented by Gavin Irwin, counsel. Instructed by Medical Protection.

Fitness to practise:	Impaired by reason of misconduct
Outcome:	Erased with immediate suspension
Duration:	n/a
Immediate order:	Immediate suspension order

Committee members:	Helen Wagner	Chair (Lay)
	Melissa Oura	(Dentist)
	Samantha Vowles	(DCP)
Legal adviser:	Kenneth Hamer	
Committee Secretary:	Paul Carson	

Dental Professionals Hearings Service

CHARGE (as amended)

Mohsen MOBASSERI, a dentist, Zahnarzt RWTH Aachen 2001 was summoned to appear before the Professional Conduct Committee on 25 November 2024 for an inquiry into the following charge:

"That, being registered as a dentist you treated the patients listed below at Schedule 1 and Schedule 2:

1. You failed to maintain an adequate standard of care between 14 May 2019 and 9 March 2020, in that you:

    (a) AMENDED TO READ: failed to adequately carry out a Basic Periodontal Examination (BPE) in relation to the patients and dates in Schedule 3;

    (b) failed to carry out sufficient treatment planning in relation to the patients and dates in Schedule 4;

2. You failed to maintain an adequate standard of radiographic record keeping on 30 January 2020 and another unknown date, in that you stored another patient's radiograph within the records of the patients in Schedule 5.

3. You failed to maintain an adequate standard of record keeping between 14 May 2019 and 14 September 2021 in that you failed to maintain contemporaneous records on the Software of Excellence record keeping software system in relation to the patients and dates in Schedule 6.

4. AMENDED TO READ: You retrospectively amended clinical records between 28 March 2020 and 1 November 2020 in relation to the patients and dates in Schedule 7.

5. You submitted inappropriate claims for treatment between 26 March 2018 and 29 March 2019 in respect of the patients and claims in Schedule 8.

6. On 19 October 2020 you retrospectively amended clinical records prior to submitting those records to the NHS Business Services Authority ("BSA"), in relation to the patients and dates in Schedule 9.

7. AMENDED TO READ: Your conduct at allegations 4 and/or 5 and/or 6 above was:

    (a) misleading;

    (b) dishonest.

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

Dental Professionals Hearings Service

Mr Mobasseri,

FINDINGS OF FACT - 11 December 2024

1. The allegations against you fall into two categories: (i) clinical concerns relating to your record keeping and standard of care (Charges 1-3); and (ii) probity concerns relating to the retrospective amendment of clinical records and the submission of inappropriate claims to the NHS (Charges 4-7). A total of 30 patients are referred to in the Charge. They have been anonymised for the purposes of these proceedings as Patients '1-15' and Patients 'A-O'.

   Procedural progress

2. At the outset of the hearing on 25 November 2024, Ms Tahta, on behalf of the General Dental Council (GDC), applied under Rules 18 and 25 of the General Dental Council (Fitness to Practise) Rules 2006 for the Charge to be amended and for further allegations to be joined. The applications were unopposed by you and the Committee acceded to them, being satisfied that these amendments and joiner were appropriate and that no prejudice would be caused to either party. The amendments were: (i) to confine the scope of charge 1(a) to Basic Periodontal Examinations ('BPEs') as further clinical records which you disclosed during the course of these proceedings showed that you had undertaken the orthodontic assessments which were initially alleged under charge 1(a) as having not been carried out; (ii) to make minor amendments to the details particularised in the various schedules to the Charge; (iii) to refine the timeframe pleaded in charge 4; and (iv) to join as charge 6 further allegations which came to light during the course of the GDC's investigation with a corresponding amendment to charge 7.

3. At the outset of the hearing you made admissions to the majority of the charges. The Committee noted your admissions but deferred making any findings of fact until all the evidence had been heard.

4. The Committee received witness statements from Ms McLauchlan, a caseworker at the GDC; Dental Nurse A, with whom you worked; Ms Van Loon, Senior Clinical Advisor (SCA) at NHS Business Services Authority. The Committee also received a witness statement from you.

5. The Committee heard oral evidence from Dental Nurse A and from you.

6. The Committee heard expert evidence from Mr E. Bateman and Mr J. Scott, who were dentists instructed on behalf of the GDC for an opinion in respect of the matters alleged under the clinical and probity charges respectively. During the hearing, the Committee received from the experts:

i. Clinical Examination and Record Keeping Good Practice Guidelines published by FGDP;
ii. A document published by the British Society of Periodontology; and
iii. An extract from the NHS regulations and guidance from the NHS Business Services Authority on claims for urgent treatment under Band 1 charge.

7. The Committee had regard to the submissions made on behalf of the GDC by Ms Tahta and to those made on your behalf by Mr Irwin.

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

9. The burden is on the GDC to prove each allegation on the balance of probabilities.

Background

10. You qualified as a dentist in Germany in 2001 and commenced practice in the United Kingdom the following year. In 2006 you purchased a dental surgery in Camden, London (the 'Practice') for which you held an NHS contract and became the practice principal. In 2019 the value of the NHS contract was approximately £650,000 per annum (equating to around 18,111 Units of Dental Activity ('UDAs')) and the practice staff consisted of three other associates (2 full-time and 1 part-time), 2 part-time dental hygienists, 3 dental nurses, a practice manager and a reception team.

11. From 2015 you also rented a surgery room in the Wimpole Street area of London from where you additionally practised.

12. The Practice used Kodak R4 ('R4') record keeping software until this was replaced in early 2019 by EXACT from Software of Excellence ('SoE'). Specialist Invisalign software was also used to record scans for your private Invisalign patients, which had become one of your main practice areas.

13. At some stage prior to 2018, you started using Microsoft Word to make most of your clinical notes instead of entering those notes directly onto the R4 system and later SoE. You stated that various factors, including your family life, postgraduate studies and IT issues at Wimpole Street, led you to seek an alternative method of record keeping.

14. You explained that you instead dictated your clinical notes to your dental nurse who would type these into Microsoft Word using a laptop. You stated that you would check each dictated record either at the end of the day or the following day, before those records were transferred using a USB stick to the Practice's computer systems and saved in sub-folders for each patient, so as to form part of their clinical record in conjunction with the R4/SoE records and any Invisalign records with the intention that those records would

eventually be uploaded into R4/SoE. It was accepted by all parties that the Word documents were a contemporaneous record.

15. From around the end of March 2020, when the Practice was closed during the first COVID-19 national lockdown, you started transferring some of the records contained in the Word documents directly into SoE, so that these would form part of the SoE record itself. You stated this was because you were using the large amount of free time which had become available to you to complete various administrative tasks at the Practice and to review your record keeping.

16. When transferring the records, you headed each entry as being '*Transferred from* [date of the appointment]'. The SoE software also recorded a timestamped entry for the date on which the records were transferred. There was nothing objectionable about transferring the records in this way, provided that the contemporaneous clinical records either remained unaltered or were marked in a way which showed where alterations had been made. However, you made significant alterations when transferring the records into SoE but did not mark anywhere to indicate that such alterations had been made. As each entry was headed '*Transferred from* […]', the records gave the impression that what was being transferred was the contemporaneous record. The alterations which you made consisted of adding (and in some cases altering and deleting) significant clinical detail which was not included in the contemporaneous Word documents. This detail related to appointments which had taken place weeks, months or years earlier. The alterations were not minor or purely editorial, such as correcting typographical errors, but instead altered the substance of the clinical record and provided substantially more clinical detail than had originally been recorded.

17. You stated in evidence that you made the amendments to "enhance" the clinical records because you had reviewed your record keeping and were shocked and embarrassed by the poor standard of your records. You stated that, with the exception of BPE charting, the alterations you made reflected what would have taken place at each appointment. You stated you were either able to remember the appointments in question or to construct an understanding of what would have taken place based on wider clinical records and your recollection of other more recent appointments for each patient. With regard to BPE charting, you stated that you would have undertaken the BPE itself but that the scores had not been recorded at the time. You accepted that the scores which you retrospectively entered into the clinical records had been "made up" by you based on guesswork from examining the patients' scans and radiographs.

18. You admit that in altering the records in this way your conduct was misleading and dishonest.

19. In 2020 an anonymous informant raised concerns with the NHS which resulted in an investigation by it into your claims for UDAs. The details of the informant and their

disclosure were not before the Committee. As part of its investigation, the NHS wrote to you on 21 September 2020 to request certain patient records, including those of Patients A-O. The request explained that these records were required '*As part of our monitoring procedures*' and that the records should include, where applicable: "*Clinical and general notes, A chart of the dentition, Periodontal charting and notes, Soft tissue examination, Medical histories with updates, The FP17DC if applicable, the treatment plan or computerised equivalent*".

20. In response to this request, you transferred the contemporaneous records contained in the Word documents for each of these patients into SoE, in the same way you had done earlier in the year with other patient records. Again, when transferring the records you made significant alterations without indicating anywhere that you had done so. You saved the altered transferred records in SoE between 05:33 and 06:44 on 19 October 2020 and submitted these to the NHS in response to its request. The alterations consisted of adding sufficient clinical detail to support the corresponding claims for treatment which had been submitted to the NHS for payment and which would conform with the level of record keeping expected by the NHS, as indicated in its letter of 21 September 2020.

21. You admit that in altering the records in this way your conduct was misleading and dishonest. You stated that you had made the alterations because you were embarrassed and had panicked upon reviewing the poor quality of the requested records. You deny that you had made the alterations for any other purpose and deny that you were aware at the time that the NHS was investigating your claims for treatment.

22. As part of the GDC's ensuing investigation into your fitness to practise, a number of claims for treatment which you had submitted to the NHS were identified as being inappropriate, in that you either were not entitled to claim for the corresponding number of UDAs or because dates had been changed so that the course of treatment would fall within a different contract year, potentially avoiding a clawback for underperformance of the contract. You admit that these claims were inappropriate but deny that they were made dishonestly. Your position is that they instead appear to be the result of an administrative or system error when the Practice changed from using R4 to SoE.

23. The clinical concerns which form the subject of Charges 1-3 were also identified as part of the GDC's investigation into your fitness to practise following concerns which had been raised directly with it.

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

1.	*You failed to maintain an adequate standard of care between 14 May 2019 and 9 March 2020, in that you:*
1.(a)	AMENDED TO READ: *failed to adequately carry out a Basic Periodontal Examination (BPE) in relation to the patients and dates in Schedule 3;*

Admitted only as to a failure to record. Found proved in its entirety.

A BPE involves using a probe to measure pocket depths to screen for periodontal disease, with a score of between 0-4* to be recorded for each sextant of the mouth containing at least two teeth. A total of 14 appointments for Patients 1 and 2-15 are contained in Schedule 3. There is no record in the corresponding clinical notes of a BPE being carried out at any of these appointments. The Committee accepted Mr Bateman's opinion that you were under a duty to carry out a BPE at each appointment, as set out in the *Clinical Examination & Record-Keeping Good Practice Guidelines* from the Faculty of General Dental Practice (UK) (the 'FGDP Guidelines'). Mr Bateman's opinion was that carrying out a BPE is vital, as commencing orthodontic treatment in the presence of periodontal disease can lead to the disease being significantly worsened.

The FGDP Guidelines state:

> "*Careful assessment of the periodontal tissues is an essential component of patient management. The Basic Periodontal Examination (BPE) is a simple and rapid screening tool that is used to indicate the level of further examination needed and provide basic guidance on treatment needed. These BPE guidelines are not prescriptive but represent a minimum standard of care for initial periodontal assessment. BPE should be used for screening only and should not be used for diagnosis.*"

The Guidelines explain that "*For patients with codes 0, 1 or 2, the BPE should be recorded at every routine examination*" and "*more detailed periodontal charting is required*" for patients with a higher BPE score indicating the presence of periodontal disease.

The Committee accepted the opinion of Mr Bateman that, whilst not prescriptive, any departure from the FGDP Guidelines would need to be clearly justified in the clinical records. The Committee also accepted the opinion of Mr Bateman and satisfied itself with reference to the guidelines that recording the scores is an intrinsic part of undertaking a BPE and would be necessary for the purposes of treatment planning.

No justification for departing from the FGDP Guidelines in respect of carrying out a BPE was recorded in respect of the appointments. It was your evidence that you would have carried out a BPE at each appointment

	in accordance with your standard practice but that this did not appear to have been recorded by the dental nurse. You therefore admitted Charge 1(a) on the basis that the BPEs had been carried out but that they were not adequate as the scores had not been recorded. The Committee considered whether this was simply a matter of record keeping or whether no BPE had in fact been carried out at all by you on the occasions in question. The Committee had regard to the evidence of Dental Nurse A, who stated that sometimes you would undertake a BPE and that sometimes you would not. She stated that whenever you undertook a BPE she would record the scores which you called out. The Committee found her evidence to be clear and straightforward. She was an experienced dental nurse for whom recording BPE scores would have been a routine part of her day-to-day duties. If you had undertaken a BPE and called out the scores, it is more likely than not that she would have recorded these. The Committee did not hear evidence from the other two dental nurses with whom you worked but concluded for the same reasons that they too would have recorded any scores which you had called out as part of a BPE. The Committee noted that the absence of a BPE score from the clinical records was not limited to the notetaking of any particular dental nurse but occurred on multiple occasions with different dental nurses, each of whom you spoke highly of during the course of your evidence. The Committee considered whether you might have mentally noted the BPE scores rather than calling them out, but you confirmed in answer to questions from the Committee that you would call them out to be recorded by the dental nurse. You also confirmed in evidence that you would always check the records which had been made by the dental nurse. The Committee examined whether there was anything else in the contemporaneous records which indicated that a BPE might have been carried out even if no scores had been recorded. The Committee could not identify any such record for any of the patients in question. Having regard to the entirety of the evidence, the Committee determined that the reason there is no record of a BPE for the appointments in question is because you had failed to carry out a BPE on those occasions as opposed to simply failing to record this. In reaching its decision, the Committee had regard to the fact that the

	record keeping template which you created in Word did not include a field for BPE scores to be recorded, indicating that it may not have been your intention necessarily to routinely carry out BPEs. The Committee also had regard to the answers you gave during the course of your evidence where you were repeatedly dismissive of the clinical significance and importance of BPEs and where you characterised the FGDP Guidelines as being indicative rather than a requirement in relation to a need to take a BPE at each routine appointment. You stated that any differences in BPE scores were marginal, and that scores 0-2 (and potentially 3) could change over the course of just a few days, depending on the oral health of the patient. You stated that if a BPE were to be carried out weekly on a patient, 52 different scores could be recorded for them over the course of a year. A clear and consistent underlying theme of your evidence was a professional attitude where you did not appear to regard BPEs as being clinically necessary in the way described in the FGDP Guidelines, which makes it even more likely that you would not have routinely carried them out. Accordingly, the Committee found this charge proved in its entirety.
1(b)	*failed to carry out sufficient treatment planning in relation to the patients and dates in Schedule 4;* **Found proved.** Schedule 4 refers to treatment planning on a total of 5 occasions in respect of Patients 6, 9, 10 and 12, who were Invisalign patients. The alleged failure to carry out sufficient treatment planning related to the presence of caries in respect of Patients 6 and 12 and related to the presence of periodontal disease in respect of Patients 9 and 10. The Committee accepted the opinion of Mr Bateman that caries and periodontal disease needed to be treated and stabilised prior to the commencement of the orthodontic treatment in accordance with FGDP Guidelines, which require "*All active dental disease* [to be] *under control prior to commencement of orthodontic treatment*". Mr Bateman's opinion was that orthodontic treatment could increase the risk of untreated caries and periodontal disease getting worse. In respect of Patient 6, it was not in dispute that caries were present at the LL7 and LR8 at the initial appointment on 23 December 2019 and that you did not treat this prior to commencing the elective aesthetic orthodontic treatment. When transferring your notes into SoE on 31 March 2020, you

	retrospectively added reference to having identified the presence of secondary caries at these two teeth at the appointment on 23 December 2019 and to having given advice to the patient on the treatment options in respect of this. However, there was nothing in the contemporaneous Word document to show that you had recognised the presence of caries at the time, far less that you had discussed this with the patient. There was no contemporaneous record of any radiographic report on the caries and no record of any corresponding treatment plan. The caries remained untreated. You initially suggested in evidence that, as the caries was secondary, the teeth did not need to be treated but later conceded that secondary caries still constituted active dental disease and should be treated no differently than primary caries for the purposes of the FGDP Guidelines. Active dental disease needs to be under control prior to the commencement of orthodontic treatment. You also stated in evidence that you would have monitored the caries but there was nothing in the clinical record to suggest that you undertook any monitoring. You conceded that you could not in any event have monitored secondary caries without taking a further radiograph, which you did not do. The Committee determined that you had failed to carry out sufficient treatment planning in respect of the caries which were present at Patient 6's LL7 and LR8 prior to commencing the elective aesthetic orthodontic treatment. In respect of Patient 12, it was not in dispute that caries were present at the UL6 when the patient attended you on 13 August 2019 and that you did not treat this prior to commencing the elective aesthetic orthodontic treatment. Whilst you asserted that it was acceptable to monitor rather than treat this tooth, there was no evidence in the records that any monitoring took place. As with Patient 6, the Committee determined that you had failed to carry out sufficient treatment planning in respect of the caries prior to commencing the elective aesthetic orthodontic treatment. In respect of Patients 9 and 10, radiographic images showed bone loss, indicating the presence of periodontal disease when the patients initially attended appointments with you on 28 November 2019 and 24 February 2020 respectively. There were no contemporaneous records of a BPE being carried out to screen for periodontal disease. You stated in evidence that you would in fact have carried out a BPE for each patient at the time and that this was simply not recorded. You retrospectively altered the clinical records to record BPE scores of 232/232 for Patient 9 and

	222/323 for Patient 10 but accepted that these were “made up” and that you could not be sure of the accurate score. As set out in its reasoning for Charge 1(a) above, the Committee did not accept your account that you would have carried out a BPE and that the scores were simply not recorded at the time. The Committee determined that there was nothing in the contemporaneous clinical records to suggest that you had recognised the presence of periodontal disease at the time, far less that you had carried out adequate treatment planning to stabilise this prior to commencing the elective aesthetic orthodontic treatment for each patient, which, in Mr Bateman’s opinion, would have required, as a minimum, pocket charting and a 3-month interval prior to commencing the orthodontic treatment. You stated that it was your opinion that Invisalign did not present a risk factor to periodontic disease. You stated in oral evidence that you were aware that Patients 9 and 10 were under the clinical care of other practitioners. You stated that you considered that monitoring or stabilising the periodontal disease would have been the clinical responsibility of those other practitioners and that your clinical role was confined to providing the orthodontic treatment. However, there was nothing in the clinical records (or even your detailed witness statement to the Committee) to indicate whether you were aware of any treatment carried out by those other practitioners or that you had attempted to identify when they had last seen their patient and whether the periodontal disease was being treated or monitored. The Committee determined that you had failed to carry out sufficient treatment planning in respect of the periodontal disease which was present in Patients 9 and 10 prior to commencing the elective aesthetic orthodontic treatment. Accordingly, the Committee found this charge proved in respect of all the patients and dates in Schedule 4.
2.	*You failed to maintain an adequate standard of radiographic record keeping on 30 January 2020 and another unknown date, in that you stored another patient’s radiograph within the records of the patients in Schedule 5.* **Admitted and found proved.**

	It was not in dispute that 3 periapical radiographs of another patient had been stored in the records of Patient 1 and that an orthopantomogram of Patient 8 had been stored in the records for Patient 7. This came to light as part of the GDC investigation into your fitness to practise, when a sample of dental records was reviewed. You stated that there appeared to have been an oversight by the Practice's administrative staff when uploading the radiographs and that you accept ultimate responsibility for this in your role as practice principal. It was not in dispute that storing a radiograph of one patient in the records of another self-evidently amounts to a failure to maintain an adequate standard of radiographic record keeping. Accordingly, the Committee found this charge proved.
3.	*You failed to maintain an adequate standard of record keeping between 14 May 2019 and 14 September 2021 in that you failed to maintain contemporaneous records on the Software of Excellence record keeping software system in relation to the patients and dates in Schedule 6.* **Admitted and found proved.** The FGDP guidelines require, '*a clinician to maintain sufficient clinical records so that it is clear to another clinician what was found, planned, discussed and what treatment carried out*'. Schedule 6 refers to your record keeping for Patients 1-15, whereby you made brief and sometimes incomplete contemporaneous notes using Microsoft Word which were saved separately and which would not have been easily accessible to other treating dentists. Whilst you 'transferred' some of the content of the Word documents into SoE some weeks, months or years after the appointments in question, you made significant alterations to the records in the process of doing so meaning that the clinical records saved in SoE were not contemporaneous or an accurate reflection of the appointment. It was not in dispute that this amounted to a failure to maintain an adequate standard of record keeping and the Committee found this charge proved in its entirety.
4.	AMENDED TO READ: *You retrospectively amended clinical records between 28 March 2020 and 1 November 2020 in relation to the patients and dates in Schedule 7.*

	Admitted and found proved. Schedule 7 refers to your records for Patients 1-15 and a total of 98 amendments relating to appointments in 2018, 2019 and 2020. As already set out, you made your contemporaneous clinical records for these patients using Microsoft Word and later 'transferred' these into SoE. You did so for these patients between 28 March 2020 and 1 November 2020 and it was not in dispute that you retrospectively amended the records when transferring them to SoE, to include additional substantial clinical details and alterations. Accordingly, the Committee found this charge proved.
5.	*You submitted inappropriate claims for treatment between 26 March 2018 and 29 March 2019 in respect of the patients and claims in Schedule 8.* **Admitted (except for Patient I).** **Found proved in its entirety.** Schedule 8 refers to a total of 7 claims for Patients B-F, I and K. With the exception of Patient I, it was not in dispute that these claims were inappropriate. The Committee found this charge proved in its entirety, including in respect of Patient I. Its reasons are set out under Charge 7(b) below.
6.	*On 19 October 2020 you retrospectively amended clinical records prior to submitting those records to the NHS Business Services Authority ("BSA"), in relation to the patients and dates in Schedule 9.* **Admitted and found proved.** Schedule 9 involves 14 patients and a total of 27 amended records. It was not in dispute that you retrospectively amended the records prior to submitting them to the NHS. The amendments were significant and dishonestly made as admitted under charge 7(b) below. The Committee therefore found this charge proved.
7.	AMENDED TO READ: *Your conduct at allegations 4 and/or 5 and/or 6 above was:*

7.(a)	*misleading;* **Admitted in relation to charges 4, 5 (except for Patient I) and 6.** **Found proved in its entirety in relation to charges 4, 5 and 6.** Conduct which is 'misleading' for the purposes of this charge means acting in a way which gives the wrong idea or impression, regardless of whether that was your intention. By retrospectively amending the clinical records under charges 4 and 6 you gave the misleading impression that the records had been made contemporaneously. The Committee found Charge 5 proved in its entirety, including in relation to Patient I, for the reasons set out under Charge 7(b) below. By submitting the inappropriate claims to the NHS under charge 5 you gave the misleading impression that those claims were valid and that you were entitled to claim for the UDAs for them. Accordingly, the Committee found this charge proved in its entirety.
7(b)	*dishonest.* **Admitted in relation to charges 4 and 6.** **Denied in relation to charge 5.** **Found proved in its entirety in relation to charges 4 and 6, and charge 5 save for Patient E.** The Committee accepted the advice of the Legal Adviser that dishonesty involves two concepts, a subjective element and an objective element. In *Ivey v. Genting Casinos (UK) Ltd v. Crockfords* [2018] AC 391, the Supreme Court at paragraph 74 said: *"When dishonesty is in question the fact-finding Tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those*

standards, dishonest."

The Committee accepted the advice of the Legal Adviser that the dishonesty alleged in respect of charge 5 must be considered entirely separately on its own: the fact that you admit dishonesty in respect of charges 4 and 6 has no bearing in the Committee's decision making on whether your conduct was dishonest in respect of charge 5, which Mr Irwin submitted involves a conceptually different form of dishonesty (venal dishonesty for financial gain as opposed to dishonesty to avoid embarrassment).

The Committee accepted your admissions of dishonesty in respect of charges 4 and 6. By retrospectively amending the clinical records you knew that you would be misleading the reader into believing that these records had been made contemporaneously.

As already stated, the amendments in question were not minor or purely editorial but involved the substantial addition (or in some cases alteration or deletion) of significant clinical detail which altered the substance of the record. These alterations were made weeks, months or even years after the appointments in question. In respect of the addition of BPE scores, you accepted that these were "made up" but maintained that you would have carried out the BPE at the appointment and that the retrospective scores (usually recorded by you as 222/222) were a rough estimate of what you think the scores were likely to have been based on other clinical data available to you. The Committee rejected your evidence and determined that the BPEs had not in fact been carried out. The Committee therefore found that your dishonesty in respect of the BPEs was not confined to simply retrospectively "making up" scores: you added those scores to give the impression that you had in fact carried out the BPE when you knew that this was not likely to be the case.

You maintained that in respect of charge 4, you amended patient records in order to "enhance" them upon reviewing the poor standard of your record keeping. You did so to create a permanent clinical record which would give the false impression to the reader that you had maintained an adequate standard of record keeping and had carried out more examinations and investigation than that which had been contemporaneously recorded. Clinical findings were also retrospectively included which did not appear in the contemporaneous notes.

Your dishonesty under charge 6 was in response to the NHS's requests for certain patient records as part of a "monitoring process". Whether or

not you knew at the time that you were under investigation by the NHS, it would have been apparent to you that it was auditing those records and on your own account you “panicked”. You knew that those records were deficient and you extensively falsified them in order to mislead the NHS as part of its monitoring process. You falsely added considerable clinical detail to support the corresponding claims for treatment which had been submitted to it for payment and gave the false impression that you had maintained a level of recording keeping which was consistent with the standards which it expected of you.

The Committee was satisfied that your conduct under charges 4 and 6 would be regarded as dishonest by the standards of ordinary decent people.

Accordingly, the Committee found charge 7(b) proved in respect of charges 4 and 6.

The dishonesty alleged under charge 5 depends on whether you submitted, or caused to be submitted, the inappropriate claims in the knowledge that they were dishonestly inappropriate and submitted for financial gain as opposed to doing so as the result of administrative or computer error.

Patients B and F

The claims in respect of Patients B and F were inappropriate as the clinical records, including laboratory dockets and invoices, conclusively establish that the courses of treatment which were being claimed were completed in April 2018. However, the treatment completion date had been altered on the claim form in SoE to record that the treatment was completed in March 2018. This had the effect of bringing the claims into the previous NHS contract year running from 1 April 2017 to 31 March 2018. The potential significance of this is that where the number of completed UDAs for a contract year falls below a certain threshold, the NHS becomes entitled to ‘claw back’ monies already paid in respect of the outstanding UDAs for that year.

The claims for Patients B and F were otherwise appropriate for the treatment provided.

Patient K

The claim in respect of Patient K was also inappropriate in that the course

	of treatment in fact concluded in April 2019 but the dates of both treatment acceptance and treatment completion were deliberately manipulated to record that the treatment had concluded in March 2019, thus bringing the claim into the contract year ending 31 March 2019. The claim for Patient K was otherwise appropriate for the treatment provided. You could not offer any explanation to the Committee for the change in dates in respect of Patients B, F and K, save to suggest that it was the result of administrative error. You denied that you would have had any motive to have brought the claims into the previous contract year, as you stated there would not in any event have been a shortfall in the number of UDAs to tigger a 'claw back'. Having regard to the totality of the evidence, the Committee determined that you had deliberately changed the dates of completion (and, in the case of Patient K, the dates of acceptance and completion) in order to bring the claims into the previous contract year in order to increase the number of UDAs which had been completed for that contract year. Such conduct would clearly be regarded as dishonest by the standards of ordinary decent people. In reaching its decision, the Committee could identify no other reasonable explanation for the alteration of dates. The dates were changed and the claim submitted in your name using your login details and with a declaration that you were the one submitting the claim. Further, the Committee had heard and accepted evidence that under the NHS contract the performer (the treating clinician) is solely responsible for closing treatment given that only they would know when a course of treatment had been completed. It makes no sense at all for this to have happened except for the purpose of attempting to assign the UDAs to the previous contract year, for which you would have been the only person to have potentially benefitted. There would have been no reason for the administrative staff at the practice to have manipulated the dates in this way and submitted the claims for payment unless acting under your direction. The administrative staff would not have known the date on which treatment is complete, as this is a clinical matter for the treating dentist or other clinician to decide. There was also no evidence before the Committee that the claim could be opened and submitted in this way as a result of computer error. *Patient C*

The claim in respect of Patient C was inappropriate in that it replicated an earlier Band 3 claim which had already been submitted in respect of the supply and fit of a nightguard, with a treatment acceptance date of 9 January 2019 and treatment completion date of 23 January 2019. The second claim which is the subject of this charge referred to the same course of treatment as the earlier claim but the treatment acceptance and treatment completion dates were entered as 4 March 2019. No treatment was provided to the patient on that date (nor would it have been likely in any event for such treatment to have commenced and concluded on the same day). The claim was therefore false in that the nightguard had already been claimed for and no further treatment had been provided to the patient. You could not explain how this claim came to be made. You suggested that it might have been the result of administrative error by your practice staff, who may have inadvertently submitted the claim in both SoE and R4 during the changeover in software.

The Committee examined the explanation that this was a duplicate claim, but could not find any basis on which to conclude that this might have been the case due to the inconsistent dates. The appropriate claim was opened on 9 January 2019 and the course of treatment was completed on 23 January 2019 before the change in software was implemented. The false claim was opened and closed on 4 March 2019 using your name and login details. It makes no sense for this to have happened except for the purpose of attempting to claim twice for the same treatment, for which you would have been the only person to benefit.

There would have been no reason for the administrative staff at the Practice to have opened and closed the second course of treatment and submitted it for payment except if acting under your direction. The administrative staff would not have known the date on which treatment is complete, as this is a clinical matter for the treating dentist or other clinician to decide. There was also no evidence before the Committee that the claim could be opened and submitted in this way as a result of computer error.

You stated in evidence that you knew in the event of a duplicate claim being submitted to the NHS for the same course of treatment it would not have been paid. However, this was not a duplicate claim: the dates had been manipulated so that what was claimed would appear as a separate course of treatment.

The Committee noted that Patient C, as with all the other patients for

	whom inappropriate claims were submitted, was exempt from paying NHS charges. This meant that a second claim was less likely to have been challenged by the patient, as they would not have been asked by the Practice to pay any additional charges. Having regard to the totality of the evidence the Committee determined that it is more likely than not that you deliberately changed the dates in order to claim twice for the same course of treatment. Such conduct would clearly be regarded as dishonest by the standards of ordinary decent people. *Patient D* The claim in respect of Patient D was inappropriate in that it replicated an earlier Band 3 claim in relation to the provision of an acrylic denture. The original claim had a treatment acceptance date of 9 January 2019 and a treatment completion date of 25 January 2019, which was consistent with the clinical records. The second claim which is the subject of this charge referred to the same course of treatment but had a treatment acceptance and completion date of 16 February 2019 and the material of the denture claimed for was chrome instead of acrylic. There were no corresponding clinical records in support of this second claim and it would in any event be inherently unlikely that such treatment could be opened and completed on the same day. As with Patient C, the Committee could not find any basis on which to conclude that the second claim was the result of administrative error. The appropriate claim was opened and submitted before the change in software was implemented. The dates for the false claim were input in your name using your login details and with a declaration that you were the one submitting the claim. It makes no sense for this to have happened except for the purpose of attempting to claim twice for the same treatment, for which you would have been the only person to benefit. There would have been no reason for the administrative staff at the practice to have opened and closed the second course of treatment and submitted it for payment except if acting under your direction. There was also no evidence before the Committee that the claim could be opened and submitted in this way as a result of computer error. Again this was not a duplicate claim which would have automatically been detected by the NHS. The dates had been changed and the type of denture had been changed, meaning it would appear as a different course of treatment.

As with Patient C, Patient D was also exempt from NHS charges meaning that a second claim was less likely to have been challenged by the patient, as they would not have been asked by the Practice to pay any additional charges.

Having regard to the totality of the evidence the Committee determined that it is more likely than not that you deliberately changed the dates in order to claim twice for the same course of treatment. Such conduct would clearly be regarded as dishonest by the standards of ordinary decent people.

Patient E

The claim in relation to Patient E was inappropriate as it involved splitting a course of treatment whereby two Band 2 claims were submitted for what should have been the same course of treatment. The course of treatment commenced in the summer of 2018 and was for an extraction and two fillings. Following the extraction on 29 June 2018, your evidence was that the patient's parents decided to have the fillings done privately. You therefore closed the NHS course of treatment in respect of the extraction and submitted a Band 2 claim. You stated the parents subsequently changed their mind about wanting to have the fillings done privately and therefore returned to have them done on the NHS. You opened a new Band 2 course of treatment and carried out the fillings for her on 24 July 2018, but this was not closed and claimed for until March 2019. You should have reopened the earlier claim as it formed part of the original course of treatment with the extraction. The alleged dishonesty is therefore attempting to claim more than you were entitled to for the same course of treatment. Your explanation was that you did not intend to claim twice and had opened the second claim on the system without the intention of closing and submitting it.

Whilst this was an inappropriate and misleading claim which should not have been submitted the Committee did not find proved that your conduct was also dishonest. The Committee accepted that the second claim could have been opened on the system out of administrative convenience rather than having to reopen the earlier claim. The Committee could not rule out the possibility that the second claim might subsequently have been administratively closed in error and therefore could not be satisfied that dishonesty had been proved.

Patient I

The claim in respect of Patient I was alleged to be inappropriate because you claimed for an emergency course of treatment on 1 June 2018 in circumstances where it is alleged that the treatment in fact formed part of an existing planned course of treatment to redo a failed root canal which had been carried out by another dentist.

At an appointment on 14 March 2018 in relation to Patient I, you carried out an examination, an inlay prep, took an x-ray of the UR2 and identified that the UR2 required re-root canal treatment. During your oral evidence, you told the Committee the original RCT was insufficient and an abscess was present requiring the tooth to be re-treated. These were your findings having taken the x-ray of the UR2. Your only explanation for taking this x-ray was some discolouration to the tooth and this explanation was only given to the Committee for the first time during your oral evidence.

The patient returned for an appointment on 1 June 2018 for re-root canal treatment on UR2. It was your evidence that this was an emergency appointment. However, within your contemporaneous notes for the appointment on 1 June 2018 you recorded that the patient continued to experience pain in respect of the failed root canal and stated: "*Next appt – pt to come back for 2nd stage of root canal treatment*".

When you transferred the Word document into SoE some 2 years later you made significant changes to what had been recorded, stating that this was an "*emergency appointment*" and that the patient had attended in "*severe pain*". You deleted the reference to the patient returning for the second stage of root canal treatment and replaced this with: "*Next appt – pat to come back to see if tooth can be saved*".

You also recorded: "*A course of antibiotics recommended, patient confirms not being allergic to any antibiotic, amxycillin 500mg 21 capsules for 7 days 3 times a day*" even though there was no contemporaneous record of antibiotics having been prescribed and you could not have recalled the detail of the prescription some 2 years later.

You also initially stated in oral evidence that the appointment would have lasted nearly two hours but changed your account when it was put to you that this would have been unusually long for an emergency appointment.

In the Committee's judgment, having carefully examined Patient I's records and the explanations you gave in evidence for her treatment, the Committee did not consider that Patient I attended you as a separate

	emergency appointment on 1 June 2018 to justify a Band 1 (urgent) claim under the relevant regulations. The Committee determined that it is more likely that you had retrospectively amended the records in SoE to characterise it as an emergency appointment to justify the additional claim you had made to the NHS for emergency treatment. You knew that the claim was inappropriate and such conduct would clearly be regarded as dishonest by the standards of ordinary decent people. In reaching its findings of fact in relation to the claims in Schedule 8, the Committee examined each claim individually and placed no reliance on Mr Scott's report and evidence as to the basis for the claims being false. Accordingly, the Committee found dishonesty proved in respect of the entirety of charges 4, 5 (except for the claim in respect of Patient E) and 6.

We move to Stage Two.

STAGE TWO – 13 December 2024

25. Between 2019 and 2020 you failed to carry out BPEs and sufficient treatment planning in respect of a number of patients for whom you were providing Invisalign orthodontic treatment.

26. Between 2019 and 2021 you also routinely failed to maintain contemporaneous records in the Practice's record keeping software. You instead used Microsoft Word to make most of your clinical notes. This was not an adequate standard of record keeping. The notes lacked sufficient clinical detail and were sometimes incomplete. They were also being created and stored separately to the Practice's record keeping software, and were not easily accessible to other treating clinicians.

27. When a sample of your clinical records was reviewed as part of the GDC's investigation into your fitness to practise, it came to light that, in two instances, radiographs had been stored in the records of the wrong patient. This too amounted to a failure to maintain an adequate standard of record keeping.

28. Between March and November 2020 you retrospectively altered the clinical records of 29 patients when transferring the notes you had made using Microsoft Word into the Practice's record keeping software. These alterations were made by you to the records for a total of 125 appointments which had taken place up to two years earlier and consisted of adding (and in some cases altering and deleting) significant clinical detail which was not included in the contemporaneous Word documents. The alterations were not minor or purely editorial, such as correcting typographical errors, but instead altered the substance

of the clinical record and provided substantially more clinical detail than had originally been recorded.

29. You made the alterations to create a permanent clinical record which would give the false impression that you had maintained an adequate standard of record keeping and had carried out more detailed examinations and investigations than that which had been contemporaneously recorded. Clinical findings were also retrospectively included which did not appear in the contemporaneous notes. False BPE scores were added by you in respect of numerous appointments to give the impression that you had carried out a BPE to screen for periodontal disease at those appointments, as required under the FGDP Guidelines, when you had not in fact carried out such examinations.

30. The records for 14 of the 29 patients had been retrospectively altered by you on 19 October 2020 in response to a request from the NHS for the disclosure of those records. You knew that those records were deficient and you extensively falsified them in order to mislead the NHS as part of its monitoring processes. You falsely added considerable clinical detail to support the corresponding claims for treatment which had been submitted to it for payment and to give the false impression that your recording keeping met an adequate standard.

31. Your conduct in altering the records of these 29 patients was dishonest.

32. Between 2018 and 2019 you dishonestly submitted 6 inappropriate claims for treatment to the NHS. You had deliberately manipulated the dates of treatment and other details either to claim for additional UDAs to which you were not entitled or to make it appear that you had completed more UDAs in the preceding contract year, potentially avoiding a clawback for underperformance of the contract.

33. At this stage of the hearing the Committee must decide whether any or all of the facts found proved amount to misconduct and, if so, whether your fitness to practise as a dentist is currently impaired by reason of that misconduct. If the Committee finds current impairment, it shall then decide on what action, if any, to take in respect of your registration.

34. The Committee received from you bundles containing evidence of your reflections, remedial steps and Continuing Professional Development (CPD) activity. The Committee also received numerous testimonials from patients and professional peers in support of your character and performance as a dentist.

35. The Committee heard evidence in support of your remediation from your workplace supervisor who had supervised your clinical work as part of the interim conditions currently on your registration. He spoke extremely highly of you both in terms of your clinical skill and performance and in terms of your professional attitude. He described you

as a caring practitioner who puts his patients' best interests first and who is fully committed to his remediation. He reports no concerns regarding your clinical performance or your attitude.

36. In terms of your fitness to practise history, Ms Tahta informed the Committee that you have no findings of misconduct, impairment or sanction at the GDC. She stated that a letter of advice which had been issued to you in 2013 by the Investigating Committee was of no relevance to the present proceedings and that she only mentioned it as passing reference had already been made to it earlier in the hearing.

37. Ms Tahta submitted that the facts found proved clearly amount to misconduct and that your fitness to practise is currently impaired by reason of that misconduct. By reference to the findings of dishonesty and the *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016, last revised December 2020) ('ISG') she submitted that erasure is the only appropriate outcome in this case.

38. Mr Irwin did not contest a finding of misconduct or impairment. He submitted that, whilst erasure is the likely sanction, it is not inevitable. He submitted that the indicative terms of the ISG are guidance only and are not binding: the Committee is not compelled to direct erasure and must decide each case according to its own facts. By reference to various mitigating factors, the remedial steps you have already taken and your commitment to your continued remediation, he submitted that this is a case where something less than erasure would be justified.

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

Misconduct

40. In assessing whether the facts found proved amount to misconduct, the Committee had regard to the following principles from the GDC's *Standards for the Dental Team* (September 2013):

> 1 Put patients' interests first
>
> 1.3.1 You must justify the trust that patients, the public and your colleagues place in you by always acting honestly and fairly in your dealings with them. This applies to any business or education activities in which you are involved as well as to your professional dealings.
>
> 1.3.2 You must make sure you do not bring the profession into disrepute.
>
> 1.7.1 You must always put your patients' interests before any financial, personal or other gain.

4.1 You must make and keep contemporaneous, complete and accurate patient records

7.1.2 If you deviate from established practice and guidance, you should record the reasons why and be able to justify your decision.

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

41. In the Committee's judgment, the facts found proved amount to serious breaches of the above standards. There were substantial failures in your standard of record keeping and significant clinical failings in terms of diagnostic assessments and treatment planning, which put patients at a real risk of harm. According to the opinion of Mr Bateman, which the Committee accepted, the failure to recognise and control active dental disease prior to commencing orthodontic treatment places patients at a risk of harm, as their dental disease remains untreated and the orthodontic treatment itself is capable of making the disease worse. These failings fell far below the standards expected of a reasonably competent dentist.

42. Your dishonesty in retrospectively altering numerous patient records, including to mislead the NHS as part of its monitoring process, and your dishonesty in submitting inappropriate claims for treatment are matters which clearly breach basic professional standards and fundamental tenets of the profession.

43. The Committee determined that the facts found proved in respect of both the clinical and probity failings are serious and amount to misconduct.

Impairment

44. The Committee considered whether your misconduct is remediable, whether it had been remedied and the risk of repetition. The Committee also had regard to the wider public interest, which includes the need to uphold and declare appropriate standards of conduct and behaviour in order to maintain public confidence in the profession.

45. At paragraph 25.67 of her Fifth Shipman Report, Dame Janet Smith identified the following as an appropriate test for panels considering impairment of a doctor's fitness to practise, which have received judicial approval and apply equally to the case of a dentist as they do to a doctor: "*Do our findings of fact in respect of the doctor's misconduct …. show that his/her fitness to practise is impaired in the sense that s/he:*

(a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

(b) has in the past brought and/is liable in the future to bring the medical profession into disrepute; and/or

(c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or

(d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.*"

46. The Committee considered that your clinical failings are remediable through continued learning, reflection and evidence of embedded improvement in practice. The Committee recognised the substantial remedial steps you have already taken, including comprehensive CPD activity and substantial changes in your record keeping practices, whereby your records are now contemporaneously maintained to a high standard. The evidence of your workplace supervisor is that you are a highly skilled, caring and competent practitioner who has taken these proceedings seriously and who has worked well under supervision to embed substantial improvements in his clinical practice.

47. The Committee commends you on the steps you have already taken towards your remediation and recognises that you have insight into the importance of record keeping and have updated your practices. In the Committee's judgment, you have not yet fully remedied the other clinical concerns. Your admissions before the Committee on the clinical matters were limited to record keeping failings. You denied the clinical charges relating to the taking of BPEs and the diagnosis and treatment of caries and periodontal disease prior to commencing Invisalign treatment.

48. Whilst it was your right to deny the charge and to put the GDC to proof, nothing prevented you from reflecting upon the clinical importance of carrying out BPEs in accordance with FGDP Guidelines (or of justifying in the records any departure from those expected standards). A failure to routinely carry out and record BPEs places patients at a risk of harm, as it means that periodontal disease can develop and progress without being screened. No meaningful reflection on this was provided by you to the Committee, either at this stage of the hearing or as part of the factual inquiry, where your evidence to the Committee tended to be dismissive of the clinical importance and significance of BPE charting notwithstanding the CPD activity which you have undertaken.

49. You denied the allegations with regard to treatment planning, as was your right, but again nothing prevented you from reflecting upon the importance of ensuring that active dental disease is under control prior to commencing orthodontic treatment. The Committee found proved that in some instances you had failed to recognise or treat caries and periodontal disease prior to commencing elective aesthetic orthodontic treatment on a number of patients. You provided no meaningful reflection to the Committee on this, either at this stage of the hearing or during the factual inquiry when you appeared to lack insight into the clinical importance of not commencing orthodontic treatment until all active dental disease was under control. You suggested that treating caries or periodontal disease was

instead the responsibility of the dentist or hygienist which each patient normally attended, with your clinical role being confined only to carrying out the orthodontic treatment.

50. Your clinical failings appeared to the Committee to be the result of attitudinal failings, rather than a lack of clinical skill or competence. You placed less importance on record keeping, periodontal screening and treatment planning when proceeding to provide the Invisalign treatment. There was only limited evidence before the Committee of insight and remediation in this attitudinal respect which was also evident in your oral evidence. Whilst your clinical failings are remediable, the Committee could not be satisfied at this stage that you have fully remedied them or that the risk of repetition is low. You had placed patients at an unwarranted risk of harm in the past and, in the absence of further reflection and insight, are liable to do so again in the future.

51. In respect of your dishonesty in retrospectively altering clinical records and making inappropriate claims for treatment to the NHS, the Committee considered that this is difficult to remedy, as it goes to your character. Repeated acts of dishonesty were carried out by you in various ways over an extended period in the course of your practice as a dentist. You falsified the clinical records of 29 patients, including with the intention of misleading the NHS as part of its monitoring processes in respect of 14 of those patients. You also dishonestly submitted inappropriate claims to the NHS for 6 patients. Whilst the sums involved were modest, the principle involved remains the same: you abused the trust which the NHS placed in you as a registered dentist when claiming from the public purse.

52. Your altering of the clinical records placed patients at an unwarranted risk of harm. Your altering of clinical records and inappropriate claiming were also acts of dishonesty which have breached fundamental tenets of the profession and which bring the profession into disrepute. In the Committee's judgment, although you have taken significant targeted CPD, you remain liable to act dishonestly in the future due to the attitudinal nature of your misconduct.

53. You showed some insight into your dishonesty in respect of altering the records and you are remorseful, albeit you have some way to go before full insight as recognised by Mr Irwin.

54. You have changed your record keeping practices and are not currently undertaking NHS work, meaning that the same circumstances in which your dishonesty occurred are less likely to occur again. However, your dishonesty was carried out in the course of your professional practice. The extent of the dishonesty which you have demonstrated means that, in the absence of full insight, you remain liable to act in this way again in the future. In any event, the Committee determined that your dishonesty was so serious that public confidence in the profession and its regulation would be undermined if no finding of impairment were to be made.

55. Accordingly, the Committee determined that all four limbs of Dame Janet's examples were engaged and that your fitness to practise as a dentist is currently impaired in respect of both the clinical and probity concerns. There remains a risk of repetition which puts the public at a risk of harm. The wider public interest also requires a finding of impairment to mark the seriousness of your dishonesty.

Sanction

56. The purpose of a sanction is not to be punitive, although it might have that effect, but to protect the public and the wider public interest. In deciding on what, if any, sanction to impose, the Committee had regard to the aggravating and mitigating factors present in this case.

57. The aggravating factors include:

- a risk of harm to patients in respect of both your clinical failings and your retrospective alteration of clinical records;

- premeditated dishonesty, including the deliberate alteration of clinical records;

- financial gain in respect of the NHS claims;

- misconduct sustained and repeated over an extended period;

- a blatant or wilful disregard of the systems regulating the profession, in that you falsified contemporaneous records to mislead the NHS and also made inappropriate claims to the NHS;

- attempts by you to cover up wrongdoing by retrospectively altering the contemporaneous records; and

- you demonstrate a lack of insight in that your insight in respect of both the clinical and probity failings is still developing.

58. In mitigation, the Committee had regard to:

- your personal circumstances leading up to the incidents in question;

- the evidence of good conduct following these incidents;

- that you are otherwise of good character with no previous adverse fitness to practise history and have undertaken substantial remediation action in respect of the clinical aspects of your clinical failings, wholeheartedly embracing the interim conditions to which your registration is currently subject;

- the steps you have taken to avoid a repetition of your clinical failings, including substantial changes to your record keeping practices;

- the fact that you are remorseful; and

- the passage of time, with the last incident occurring in 2021.

59. The Committee also had regard to the numerous testimonials in support of your character and performance as a dentist, all of which speak extremely highly of your clinical skills and your warm and personable nature. They are substantial and impressive and come from both colleagues and patients.

60. The Committee considered sanction in ascending order of restrictiveness.

61. To conclude this case with no further action or a reprimand would be wholly inappropriate given the risk of repetition of your clinical failings and the seriousness of your acts of dishonesty. A reprimand would be insufficient to protect the public and to maintain wider public confidence in the profession and its regulation.

62. The Committee next considered whether to direct that your registration be made subject to your compliance with conditions for a period of up to 36 months, with or without a review. Whilst conditions of practice might be sufficient to address the clinical concerns in this case, the Committee could not identify any conditions which would be measurable, workable and proportionate in relation to the probity concerns. Conditional registration would in any event be insufficient to mark the seriousness of your dishonesty and therefore to meet the wider public interest. The Committee noted that your registration is currently subject to an order for interim conditional registration which appears to be working well but recognised that an interim order serves a different purpose to a substantive sanction following findings of fact and a finding of impairment. Whilst interim conditions have been sufficient to protect the public and to meet the wider public interest pending the determination of the allegations at this final hearing, conditions are now no longer sufficient.

63. The next consideration for the Committee was whether to direct that your registration be suspended for a period of up to 12 months, with or without a review. The Committee had regard to the factors indicated in support of suspension at paragraph 6.28 of the ISG, namely whether:

- 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).

64. The Committee considered each of these factors to be present, except the last. The scale and extent of your dishonesty in retrospectively altering clinical records both in order to conceal inadequate clinical practice and to mislead the NHS, does suggest a harmful deep-seated professional attitudinal problem which engages the question of erasure.

65. The Committee had regard to the indicated factors in support of erasure at paragraph 6.34 of the ISG and identified the following factors to be present to varying degrees:

- serious departure(s) from the relevant professional standards;
- serious dishonesty, particularly where persistent or covered up;
- a persistent lack of insight into the seriousness of actions or their consequences.

66. The Committee noted that '*submitting fraudulent NHS claims*' and '*falsifying and/or improperly amending patient records*' are among the factors indicated at paragraph 59 of the ISG as being examples of dishonesty in professional practice which are capable of being '*highly damaging to the dental professional's fitness to practise and to public confidence in the profession*'.

67. The Committee also had regard to the over-arching objective set out under section 1 of the Dentists Act 1984, namely: '*(a) to protect, promote and maintain the health, safety and well-being of the public; (b) to promote and maintain public confidence in the professions regulated under this Act; and (c) to promote and maintain proper professional standards and conduct for members of those professions.*'

68. This was not an easy decision for the Committee to make and was one which it deliberated over at considerable length. The Committee was mindful of your extensive CPD records, testimonials and your reflective statements. The Committee accepted the

submissions of Mr Irwin and the advice of the Legal Adviser that the ISG is only guidance and that erasure is not an inevitability but is rather a matter for the careful judgment of the Committee in the circumstances of any given case. The Committee determined that a period of suspension would be insufficient to mark the seriousness of your dishonesty and to meet the wider public interest. You abused the trust placed in you as a registered dentist to repeatedly falsify the clinical records for numerous patients in order to dishonestly give the impression that substantially more clinical information had been recorded than appears in the contemporaneous notes. In respect of 14 patients, these retrospective alterations were done to mislead the NHS as part of its monitoring processes. You also abused the trust placed in you as a registered dentist by dishonestly submitting inappropriate claims for treatment. Such conduct is fundamentally incompatible with your remaining on the Register and being allowed to enjoy the benefits and privilege of professional registration as a dentist.

69. Having regard to all the circumstances, the Committee determined that no lesser sanction than erasure would be sufficient to meet the aspects of the over-arching objective of promoting and maintaining public confidence in the dental profession and of promoting and maintaining proper professional standards and conduct for members of that profession.

70. The Committee therefore directs that the name of Mohsen Mobasseri (81444) be erased from the Register.

71. The Committee now invites submissions on the question of an immediate order.

IMMEDIATE ORDER – 13 December 2024

72. The order for interim conditional registration is hereby revoked in accordance with section 27B(9) of the Dentists Act 1984 (the 'Act'). In accordance with section 27B(10) the revocation shall not take effect unless and until (whichever is sooner) the making of an immediate order of suspension under section 30 of the Act, or the taking effect of the direction of erasure. Accordingly, if the Committee were to make no immediate order, your registration would still continue to be subject to the order for interim conditional registration during the 28-day appeal period (or later if there is an appeal).

73. Ms Tahta applied for an immediate suspension order on the grounds that it is necessary for the protection of the public and is otherwise in the public interest.

74. Mr Irwin submitted that an immediate order of suspension is not necessary. He submitted that not imposing an immediate order would permit you to formally withdraw from practice during the 28-day appeal period, allowing you to make arrangements for the continuity of care for your patients. He referred to your compliance with the interim conditions on your

registration and the meaningful engagement with your workplace supervisor throughout the period of interim conditional registration, with evidence of remediation in respect of the clinical concerns.

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

76. The Committee determined that it is necessary for the protection of the public and is otherwise in the public interest to order that your registration be suspended forthwith under section 30 of the Act. In reaching its decision, the Committee balanced the public interest with your interests. It would be inconsistent with the decision the Committee has made not to make an immediate order.

77. The Committee considered that the continuation of the interim conditions requiring you to continue working under supervision might provide some level of protection for the public in respect of the clinical concerns pending the expiry of the 28-day appeal period and the disposal of any appeal. However, the Committee determined that there still remains a risk of harm to the public. The interim conditions were imposed and continued as part of a risk assessment pending this final hearing. The Committee has now made findings of fact and had found your fitness to practise to be impaired in respect of both clinical and probity failings.

78. In the Committee's judgment, there would continue to be a risk of harm to the public under the interim conditions. Further, the dishonesty which the Committee has found proved is highly damaging to the reputation of the profession. To allow you to continue practising, even for only the 28-day appeal period, would undermine public confidence in the profession and its regulation.

79. Accordingly, the Committee makes an order for immediate suspension.

80. The effect of this order is that your registration shall be suspended forthwith. Unless you exercise your right of appeal, the substantive direction for erasure shall take effect upon the expiry of the 28-day appeal period. Should you exercise your right of appeal, this immediate order shall remain in force pending the disposal of the appeal.

81. That concludes the hearing.