PUBLIC HEARING

Professional Conduct Committee
Initial Hearing

14 – 18 August 2023
12 – 15 August 2024

Name:	**CARACUEL SANZ, Margarita**
Registration number:	**230807**
Case number:	**CAS-200964-G6W4F3**

General Dental Council:	Mr Ashley Hendron, Counsel. Instructed by Catlin Buckerfield, IHLPS
Registrant:	Present Represented by Ms Vivienne Tanchel, Counsel. Instructed by MDDUS

Fitness to practise:	Impaired by reason of misconduct
Outcome:	Suspension (with a review)
Duration:	Six months
Immediate order:	Immediate suspension order

Committee members:	Diane Meikle (Lay) (Chair) Rebecca Northover (Dentist) Donna Lightbody (Dental Care Professional)
Legal adviser:	Judith Walker
Committee Secretary:	Andrew Keeling

Miss Caracuel Sanz,

1. This is a Professional Conduct Committee (PCC) inquiry into the facts which forms the basis of the allegation against you that your fitness to practise is impaired by reason of misconduct. You attended the hearing and were represented by Ms Vivienne Tanchel, Counsel. Mr Ashley Hendron, Counsel, presented the General Dental Council's (GDC) case. The hearing was held remotely on Microsoft Teams. The hearing initially took place between 14 and 18 August 2023, when it was adjourned as there was insufficient time for the hearing to be completed. The hearing subsequently resumed on 12 August 2024.

Preliminary Matters

Application on whether permission is required from another State for a witness in a professional disciplinary hearing to give oral evidence from abroad (14 August 2023)

2. Ms Tanchel on your behalf raised as a preliminary matter, the issue of whether or not the giving of evidence before the Professional Conduct Committee is permitted where you and one other witness are abroad in two different Jurisdictions and where permission has not been sought from the relevant State.

3. Ms Tanchel conceded that there is no High Court or Court of Appeal authority which grapples with this issue, the closest is with the GMC v Lateef. She submitted that the law precludes evidence being heard in a UK court or tribunal from a witness who is in a foreign country without permission being granted from that country. She submitted that the considerations which must apply when a witness is to give evidence from abroad are those set out in the case of The Secretary of State for the Home Department v Agbabiaka [2021] UKUT 00286 (IAC). Ms Tanchel submitted that it is clear and plain that permission must be sought, or it may jeopardise the relationship between the United Kingdom and foreign States.

4. Ms Tanchel submitted that giving evidence from a foreign jurisdiction was considered by the Court of Appeal Criminal Division in R v Kadir [2022] EWCA Crim 1244. In this case the Court of appeal concluded that the long understanding between nation States that one state should not seek to exercise the powers of its courts within the territory of another state without the permission (on an individual or a general basis) of that other state. She further submitted that the case of Kadir is determinative as it has not been appealed.

5. Ms Tanchel submitted that the question for this Committee is whether this principle applies in these proceedings.

6. Ms Tanchel submitted that the starting point for this Committee to consider is Schedule 3, paragraph 4(1) of the Dentists Act 1984 which sets out that a Committee may

witness summons a witness and compel them to give evidence on oath. This Committee has the power to compel witnesses to attend and has the power to interfere with the jurisdictional requirements of another nation State. Ms Tanchel submitted that more compelling, is the very crux of the issue today, that this Committee may require a witness to give evidence on oath, which engages Section 1 of the Perjury Act 1911 which states as follows:

> *(1)…*
>
> ***(2) The expression "judicial proceeding" includes a proceeding before any court, tribunal, or person having by law power to hear, receive, and examine evidence on oath.***

7. Ms Tanchel submitted that this Committee falls well within that section. You are constituted as a Committee or a tribunal who has the power to compel witnesses on oath. In respect of the case of GMC v Lateef, Ms Tanchel submitted that there was a perfect opportunity for the High Court judge to say that this issue does not apply to disciplinary tribunals, but he did not do so, and that is of significance for consideration by this Committee. The Judge stated that there may not be a direct correlation between Courts and Disciplinary Tribunals, but it is noteworthy that neither the learned judge nor counsel for the GMC contended that the case of Nare did not apply.

8. Ms Tanchel in her written submissions stated that there is no authority or jurisprudence in support of the proposition that the legal position identified above does not apply to GDC hearings. She submitted that to assess whether the issue regarding foreign jurisdictions applies to GDC hearings consideration must be given to the purpose behind the Courts' rulings that evidence given from abroad may impact on the UK's diplomatic relations with other states. In the case of Agbabiaka, the Immigration Tribunal was concerned about the potential for a UK court to impose its own jurisdiction on the sovereign territory of another state.

9. Ms Tanchel submitted that one of the reasons why evidence given from abroad raises matters which may affect UK diplomatic relations is because if, for example, you did not attend the hearing and the GDC sought to compel your attendance they would in essence be exercising the jurisdiction of the UK within the territory of a foreign State without that State's consent. It is of importance that failure to attend pursuant to a witness summons is a contempt of court. She submitted that the GDC seeks to rely on the decision in GMC v BBC [1998] 1 W.L.R.1573 in which the Court of Appeal found that the GMC Fitness to Practice Committee was not a court of law as defined in the Contempt of Court Act 1981, but this case is not comparable or relevant to this current case.

10. Ms Tanchel submitted that it should not simply be presumed that all foreign governments permit people to give evidence from their jurisdiction to foreign courts. The Hague Convention recognises this and has a framework for cooperation between

countries to facilitate the taking of evidence between countries in commercial and civil courts. However, not all countries are signatories to the Hague Convention and even under the Convention permission must be sought, unless a country has specifically stated that they do not require permission to be sought. Ms Tanchel submitted that in establishing the Taking Of Evidence unit (TOE), the Foreign Commonwealth Development Office (FCDO) believes that permission must be sought.

11. Finally, Ms Tanchel submitted that the Committee is invited to conclude that in order to preserve the United Kingdom's diplomatic relationship with foreign jurisdiction, absent consent from the relevant authorities, the wider public interest would not be served by this evidence being heard. She submitted that the most recent response received from TOE to the GDC [14 August 2023] yesterday is quite robust in response to the question of whether permission is required from an overseas nation state for witnesses to give oral evidence to a UK disciplinary tribunal from Iceland. They do not have any information on this issue with Iceland and would need to contact the Icelandic authorities.

12. Mr Hendron on behalf of the GDC submitted that this Committee can accept the evidence of the two witnesses without permission from the authorities.

13. Mr Hendron invited the Committee to consider Rules1 57(1) and 57(2):

> *(1) A practice committee may in the course of proceedings receive oral, documentary or other evidence that is admissible in civil proceedings in the appropriate court in that part of the United Kingdom in which the hearing takes place.*
>
> *(2) A Practice committee may also, at their discretion, treat other evidence as admissible if after consultation with the legal adviser, they consider that it would be helpful to the Practice Committee, and in the interests of justice, for that evidence to be heard.*

14. Mr Hendron also referred the Committee to the authority of Agbabiaka, and in particular paragraphs 12 and 21:

> *(12) There has long been an understanding among Nation States that one State should not seek to exercise the powers of its courts within the territory of another, without having the permission of that other State to do so. Any breach of that understanding by a court or tribunal in the United Kingdom risks damaging this country's diplomatic relations with other States and is, thus, contrary to the public interest. The potential damage includes harm to the interests of justice since, if a court or tribunal acts in such a way as to damage international relations with another State, this risks permission being refused in subsequent cases, where evidence needs to be taken from within that State*

(21) It will be noted that Article 1 of the Hague Convention refers not only to obtaining evidence but also to the performing of "some other judicial act". That expression is restricted by the last paragraph of Article 1. It is also partly explained by the reference in Article 3 to the inspection of documents or other property

15. Mr Hendron submitted that the position of the GDC is that proceedings before the Professional Conduct Committee are distinguishable from Court proceedings and are not "part of the Judicial system of the state". He guided the Committee to the case of General Medical Council (GMC) v BBC, and in particular "*In this case, by contrast, the P.C.C. is a statutory committee of a professional body specially incorporated by statute. It exercises a function which is recognisably a judicial function, and does so in the public interest. It acts In accordance with detailed procedural rules which have close similarities to those followed in courts of law. Nevertheless it is not part of the judicial system of the state. Instead, it is exercising (albeit with statutory sanction) the self-regulatory power and duty of the medical profession to monitor and maintain standards of professional conduct.*"

16. Mr Hendron submitted that the interpretation of GMC v BBC in 1998 is confirmed in Bailey 2023. He submitted that the function of the Professional Conduct Committee can be properly described not as a Judicial power of the State akin to a Court or Parole Board but an administrative function exercised by a Professional Regulator to a specific Profession. Mr Hendron submitted that the Committee's powers are expressly set out in the GDC Rules. The Professional Conduct Committee is not a Court and so the use of a video link to obtain evidence in these proceedings is not in breach of the authority of Agbabiaka.

Committee's decision (15 August 2023)

17. The Committee has carefully considered the written documentation and oral submissions of both parties. The Committee has accepted the advice of the Legal Advisor.

18. In reaching its decisions the Committee has had regard to the case law as put forward by both parties, including GMC v Lateef*, The Secretary of State for the Home Department v Agbabiaka [2021] UKUT 00286 (IAC)*, *Court of Appeal Criminal Division in R v Kadir [2022] EWCA Crim 1244*, *GMC v BBC [1998] 1 W.L.R.1573*, and *R.(Bailey and another) v Secretary of State for Justice [2023] 2 Cr App R 7*.

19. The key issue for this Committee to consider is whether permission should be sought from the relevant State where a witness is giving oral evidence from abroad to a GDC Professional Conduct Committee (PCC) in the UK.

20. It took into account Ms Tanchel's submissions. It noted that there is no legal authority that states the proposition doesn't apply to the GDC's PCC and equally there is no case law that states that it does. However, the Committee took into account the legal authority of *The Secretary of State for the Home Department v Agbabiaka [2021] UKUT 00286 (IAC*), where it confirms the proposition does apply to chambers of the Upper and First Tier Tribunals.

21. The Committee also took into account the case of *Court of Appeal Criminal Division in R v Kadir [2022] EWCA Crim 1244*, *GMC v BBC [1998] 1 W.L.R.1573*, which also confirms the proposition of getting permission applies to criminal cases. In this case the Court of Appeal confirmed the understanding between nation States that one State should not seek to exercise the powers of its courts within the territory of another State without the permission (on an individual or a general basis) of that other State.

22. The Committee also took into account the findings in the case of *GMC v BBC [1998] 1 W.L.R.1573*, and in particular "…*In this case, by contrast, the P.C.C. is a statutory committee of a professional body specially incorporated by statute. It exercises a function which is recognisably a judicial function and does so in the public interest. It acts in accordance with detailed procedural rules which have close similarities to those followed in courts of law. Nevertheless, it is not part of the judicial system of the state. Instead, it is exercising (albeit with statutory sanction) the self-regulatory power and duty of the medical profession to monitor and maintain standards of professional conduct."*

23. The Committee had regard to Ms Tanchel's submission that there is a risk of GDC PCC's imposing their own jurisdiction on other states, and damaging diplomatic relationships and considered whether such Committees are therefore subject to the requirement that permission should be sought for witnesses to give evidence from abroad. The Committee noted that there is authority from the case law that this requirement applies to the chambers of the Upper and First Tier tribunals and the courts within the UK court system, but there appears to be no authority confirming that this requirement applies to PCC's.

24. The Committee had regard to the case of GMC v BBC and placed weight on the statement that a Professional Conduct Committee is a statutory committee of a professional body, exercising a recognisably judicial function, but it is "*not part of the judicial system of the state*".

25. The Committee recognised the importance of States not exercising the powers of its courts within the territory of another State without permission , but it also placed weight on the extract of the case of GMC v BBC above and concluded that GDC disciplinary Committees are not part of the judicial system of the State and do not fall within the ambit of the term "*courts*" in this context.

26. Having carefully considered the submissions and information presented to it the Committee is not satisfied that this PCC can be said to be part of the judicial system of

the State, and therefore subject to the requirement to seek permission in respect of witnesses giving evidence from abroad. Accordingly, it has determined that the two witnesses proposing to give oral evidence from abroad may do so without the need for the party calling them to seek such permission.

27. The Committee has decided in accordance with Rule 57 that it would be appropriate and fair to proceed with the matter and allow both witnesses to give their oral evidence whilst abroad.

28. The preliminary matter has now been concluded.

Decision on Admissions (16 August 2023)

29. Miss Tanchel, on your behalf, informed the Committee that you admitted the following heads of charge: 1(a), 1(b), 1(c), 1(d), 1(e), 1(f), 1(g), 1(h), 1(i), 1(j), 1(k), 3(a), 3(b), 4(a), 4(b), 4(c), 4(d) and 4(e).

30. The Committee noted your admissions and announced all the admitted factual allegations as found proved.

Background

31. Patient 1 initially attended the practice on 25 October 2019 and was seen by another dentist. Patient 1 had completed Invisalign orthodontic treatment five years previously elsewhere and was not happy with the result. That dentist advised Patient 1 that extraction of both the lower left third molar (LL8) and upper left third molar (UL8) were needed for orthodontic purposes. Patient 1 attended the practice on 1 November 2019 for what she believed to be a consultation visit with you.

32. You took a dental panoramic tomograph (DPT) of Patient 1 and proceeded with the extraction of the LL8 at the same appointment. Patient 1 described a severely distressing experience during the extraction. She stated that she was in severe pain following the extraction, and when the anaesthetic wore off she became aware of severe pain and numbness in her left lip. On 2 November 2019, Patient 1 returned to the practice to seek help for her symptoms. Another DPT was taken by you and you identified that the mesial root of the LL8 had not been removed.

33. Patient 1’s severe pain and numbness continued, and she sought a second opinion elsewhere. She was seen by a doctor in oral surgery, at Kings College Hospital on 6 December 2019. A diagnosis of left iatrogenic alveolar nerve injury following the extraction of the LL8 by you on 1 November 2019 was made. On 9 December 2019, Patient 1’s mesial root fragment was removed under IV sedation. Plans were made for the removal of the bone sequestra, however, the sequestra spontaneously exfoliated on 25 December 2019 and no further surgical treatment was required.

34. On 23 December 2019, an appointment with a professor in Oral Surgery at Kings College Hospital showed that Patient 1's symptoms had not improved at all since the extraction by you. At a review appointment on 2 March 2020 at Kings College Hospital, it was noted that the medication prescribed was helping with the pain in the evening. At a further review appointment at Kings College Hospital on 18 March 2020, a diagnosis of persistent post-traumatic neuropathy following the surgical removal of the LL8 was made. On this date, Patient 1 presented with continuing symptoms of severe facial pain, lasting all day. Following an internal referral by Kings College Hospital, Patient 1 was seen by a clinical psychologist on 20 April 2020. Her findings showed that a severe detrimental psychological impact had been caused to Patient 1 since the treatment by you on 1 November 2019. On 16 June 2020, Patient 1 made a complaint to the GDC about the treatment you provided to her on 1 November 2019.

Evidence

35. The Committee had regard to a number of documents as contained in the main GDC hearing bundle. This included a witness statement from Patient 1, dated 12 February 2023. The Committee also heard oral evidence from Patient 1, the practice manager and the dental nurse who assisted you on the day. The documents also included an expert report provided by Mr Salman Malik, dated 16 December 2022. In addition, the Committee heard oral evidence from Mr Malik.

36. In respect of your evidence, the Committee received your witness statement, dated 29 March 2023, and heard oral evidence from you.

Rule 18 Application to Amend the Charge (18 August 2023)

37. Following the conclusion of the GDC's evidence, Mr Hendron made an application to withdraw head of charge 4(g) and submitted that there was no evidence to support this head of charge.

38. Ms Tanchel made no objection to this application.

39. The Committee accepted Mr Hendron's application. Accordingly, head of charge 4(g) was withdrawn.

Application of No Case To Answer (18 August 2023)

40. Ms Sanz: Ms Tanchel on your behalf, has made a submission under Rule 19(3) of the General Dental Council (GDC) (Fitness to Practise) Rules 2006 that there is no case to answer in respect of Heads of charges against you.

41. The charges against you that are the subject of Ms Tanchel's application are as follows:

    1 *On 1 November 2019, you failed to provide an adequate standard of care to*

Patient 1, in that:

1(l) You informed the patient that the treatment had been successful when you knew this was not the case

2 You conduct in charge 1(l) was:

a. Misleading;
b. Lacking integrity;

4. Between 1 November 2019 and 17 December 2019, you failed to maintain an adequate standard of records keeping in respect of Patient 1's appointments, in that:

4(f) You did not record the removal of bone on 2 November 2019;

42. Rule 19(3) of the General Dental Council (GDC) (Fitness to Practice) Rules Order of Council 2006 states:

"When the presenter has completed presenting evidence, the respondent or the respondent's representative may open the case for the defence, which may include a submission that there is no case to answer."

43. Ms Tanchel submitted that the GDC's case relies primarily on the evidence of the GDC expert. She submitted that on the GDC's case taken at its highest, the Committee could not find heads of charge 1(l), 2 and 4(f) proved to the required standards. Ms Tanchel referred to case law of *R v Galbraith [1981] 1 WLR 1039* at 1042C and also *Soni v GMC 2015 EWHC 364 Admin*. She submitted that you have admitted allegations at the start, and the Committee has sight of emails about the treatment from you, which is evidence presented by the GDC. Ms Tanchel submitted that you accept that this was bad treatment.

44. In respect of Head of charge 1(l), Ms Tanchel submitted that this head of charge is predicated on the reliability of Patient 1 as to whether this was said. She said that with regards to your knowledge on 1 November 2019 as to whether the treatment had been successful, no one knows what was in your mind at that time. Ms Tanchel invited the Committee to consider what success means. Patient 1 was in pain and the examination took over 3 and a half hours. There is no denial that it didn't go to plan. She submitted that success could relate to the actual extraction of the tooth, and to that extent, the treatment was successful, as the tooth had come out. She submitted that if success included extracting the tooth without causing damage to the nerve, then Mr Malik's evidence is relevant as Mr Malik stated in oral evidence that damage to the nerve would not be apparent on 1 November 2019, and would not then be known. Ms Tanchel submitted that the only communication between you and Patient 1 was in the

surgery. Later emails from Patient 1 voicing her discomfort, only came to your attention the following day. Ms Tanchel submitted that there is no basis to infer that you knew that the treatment had not been a success on that day and she emphasised that this head of charge relates to 1 November 2019. Ms Tanchel submitted that one reasonable explanation is that you were only thinking of the successful extraction of the tooth on that day and not about any nerve damage.

45. Ms Tanchel submitted there is no basis to infer by this Committee that you knew that the treatment had been unsuccessful on 1 November 2019. She invited this Committee to consider that the evidence offered by the GDC is so tenuous and so vague that this Head of charge should not proceed.

46. In respect of Head of charge 2, Ms Tanchel submitted that if she is right with respect of 1(l), therefore Head of charge 2 must fall.

47. In respect of the issue of Patient 1's bone removal, Ms Tanchel submitted that Mr Malik in his oral evidence yesterday made a considerable shift in his position. In his expert report, he sets out that the bone had unequivocally been removed. However, in his oral evidence during cross examination, he conceded that bone can be removed unintentionally by the use of improper instruments. Ms Tanchel submitted that therefore, you on 1 November 2019 may have been unaware of what had happened. She submitted that no radiograph was taken until 2 November 2019. She submitted that the evidence before this Committee, is that you were performing at a low standard and it was not apparent to you that you had removed the bone. Ms Tanchel submitted this this head of charge was about what you knew and not what a competent practitioner would know.

48. In respect of Head of charge 4(f), Ms Tanchel submitted that you only have a duty to record matters that you are aware of. She submitted that this Head of charge is formulated on the basis of Mr Malik's report that it was an intentional removal of the bone. However, during yesterday in his oral evidence conceded there was no flap and that the bone can be interfered with, in the course of an irregular extraction. She submitted that it is a whole shift away from the proposition of an intentional removal of the bone. Ms Tanchel submitted that given the change in position of the GDC expert's clinical opinion, she invited the Committee to consider that the evidence offered by the GDC is so tenuous and so vague that this Head of charge should not proceed.

49. Ms Tanchel submitted that given all the evidence and information these heads of charge fall fairly and squarely within the case law of Galbraith and Soni.

50. Mr Hendron, on behalf of the GDC, opposed your application. He invited the Committee to consider that there is a case to answer based on the evidence of Mr Malik and referred to examples of this in Mr Malik's expert report and elsewhere in the documents in support of this contention. Mr Hendron submitted that the evidence is not so tenuous that the Committee cannot properly take it into account.

51. Mr Hendron submitted that according to the expert report any extraction of the tooth includes the extraction of the roots. Mr Malik's opinion is to suggest that you should have been aware that the root remained. Mr Hendron submitted that there is no evidence before this Committee that you made efforts to ensure that the root had been removed, and that it is wrong to suggest that it was successful. He submitted that the definition of the word "*success*" comes from Mr Malik's expert report, in which he stated that a successful extraction includes the extraction of the roots.

52. In respect of Head of charge 2, Mr Hendron submitted that if the Committee finds there is a case to answer in respect of Head of charge 1(l) therefore this charge stays.

53. In respect of Head of charge 4(f), Mr Hendron submitted that the GDC relies on the radiographs taken between the two dates. Mr Malik stated in his written expert report that these images show that bone was removed. Mr Hendron submitted that the reason that it was a failure on your part, is that upon reviewing the 2nd radiograph, it would have been clear to you that bone removal had taken place and no note of this has been made.

54. Mr Hendron submitted that there is evidence for the Committee to consider and this application should be rejected in respect of Heads of charges 1(l), 2 and 4(f).

55. The Committee has considered the submissions made by both Counsel. The Committee has been referred to the law applicable to a no case to answer application, and to the cases of *R v Galbraith [1981] 1 WLR 1039* at 1042C and also *Soni v GMC 2015 EWHC 364 Admin*.

56. The Committee has accepted the Legal Adviser's advice as to the approach it should follow. It has borne in mind that the burden of proof is on the GDC and that the civil standard of proof applies, namely on the balance of probabilities. The Committee is aware that it is not reaching any findings of fact at this stage of proceedings. In its deliberations, the Committee has had regard to the oral and documentary evidence presented by the GDC.

57. In respect of Mr Maliks evidence, the Committee had regard to only his clinical opinions within his clinical expertise.

58. In respect of Head of charge 1(l), The Committee noted that Patient 1 is adamant that she was told that her treatment was successful. It noted that the treatment on 1 November 2019 lasted over 3 and a half hours. You have acknowledged that Patient 1 was in pain and the treatment on that day did not go to plan. The Committee concluded that "successful treatment" included extraction of the tooth and the root. The Committee has considered that you may have been thinking only that the tooth had been successfully extracted on 1 November 2019. However, in light of the evidence regarding the length of the treatment, the difficulties encountered and your admissions

that the treatment did not go to plan, the Committee considers there is evidence upon which the Committee could conclude that you knew on 1 November 2019 that the treatment had not been successful.

59. It therefore determines to reject the application of no answer in respect of this this head of charge.

60. Having found that there may be a case to answer in respect of Head of charge 1(l), it therefore it follows that Head of charge 2 remains for the Committee to consider.

61. In respect of head of charge 4(f) the Committee had regard to Mr Malik's evidence that on 2 November 2019 a second radiograph was taken showing that some bone had been removed, and he accepted that this could have been caused by the use of an inappropriate instrument. The Committee considered Ms Tanchel's submission that you were performing at a low standard, and it was not apparent to you that you had removed the bone. However, the Committee noted that you had access to the radiograph taken on 2 November 2019 and therefore would have been able to see that bone had been removed. The Committee therefore considers that there is evidence upon which it could conclude that you were aware that bone had been removed and did not record it.

62. The Committee therefore rejects the defence application of no case to answer in respect of the above Heads of charge.

The Committee's Findings of Fact (14 August 2024)

63. The Committee has considered all the documentary and oral evidence presented to it. It took account of the closing submissions made by Mr Hendron, on behalf of the GDC, and from Ms Tanchel, on your behalf. The Committee heard and accepted the advice of the Legal Adviser. In accordance with that advice, it has considered each head of charge separately, bearing in mind that the burden of proof rests with the GDC and that the standard of proof is the civil standard, that is, whether the alleged matters are found proved on the balance of probabilities.

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

1.	On 1 November 2019, you failed to provide an adequate standard of care to Patient 1, in that:
1 (a)	The extraction of LL8 was not clinically justified; **Admitted and Found Proved**
1(b)	You did not carry out sufficient pre-treatment assessments;

	Admitted and Found Proved
1 (c)	You did not conduct proper treatment planning; **Admitted and Found Proved**
1 (d)	You did not discuss the full risks and benefits of the proposed treatment; **Admitted and Found Proved**
1 (e)	You did not discuss any other treatment options; **Admitted and Found Proved**
1 (f)	You did not gain informed consent for the extraction of LL8; **Admitted and Found Proved**
1 (g)	You failed make arrangements for Patient 1 to be referred to a suitably qualified clinician for the extraction of LL8; **Admitted and Found Proved**
1 (h)	You did not ensure the appropriate equipment and/or materials were available prior to commencing the extraction; **Admitted and Found Proved**
1 (i)	you did not remove the mesial root of LL8;, **Admitted and Found Proved**
1 (j)	You damaged Patient 1's hard palate; **Admitted and Found Proved**
1 (k)	You damaged to the inferior alveolar nerve; **Admitted and Found Proved**
1 (l)	You informed Patient 1 that the treatment had been successful when you knew this was not the case;

	Found Not Proved When considering this head of charge, the Committee first considered what would have constituted successful treatment. The Committee had sight of Mr Malik's expert report and accepted his definition of successful treatment in the context of this case, which was the complete removal of the tooth and the root. You denied this head of charge. In oral evidence, you stated that you never used the word '*successful*', but that you sought to reassure the patient and check that she was okay many times during the treatment. At the end of the treatment on 1 November, you had believed that the extraction had been successful, even though this was not the case. The Committee noted and accepted your evidence that you would have tried to reassure the patient and check she was okay many times during the treatment as it was long and complex. The Committee considered that while you did not specifically say that the treatment had been a success, you gave reassurance to Patient 1 and in the absence of any specific advice that the treatment was not successful, Patient 1 may have taken this as confirmation that the treatment was successful. The Committee took into account Patient 1's oral evidence that you had told her that the treatment had been successful. However, the Committee noted that Patient 1 had not mentioned in the complaint letters that she submitted to the practice immediately after the treatment that you had specifically told her that the treatment had been successful. The Committee considered that given Patient 1's emphasis that she had been told that the treatment had been successful, the Committee would have expected that point to have been raised in her communications. In light of the above, the Committee determined that there was insufficient evidence that you had informed the patient that the treatment had been successful, when speaking about the treatment with Patient 1 on 1 November 2019. In any event, the Committee accepted your evidence that although the extraction did not go to plan, you felt at the time

	that you had successfully removed the tooth and roots. Accordingly, the Committee found this head of charge not proved.
1 (m)	You did not prescribe any post-operative medication at the time of Patient 1 leaving the surgery. **Found Proved** You denied this head of charge. You stated that you had asked the receptionist at the practice to prepare the prescription, which was printed, and that you had signed it to give to Patient 1. However, you could not confirm when this took place or when you left the clinic that day and you accepted that you did not check whether Patient 1 had received the prescription before she left the practice. Patient 1 stated that she had not been given a prescription when she left the surgery. The Committee also had sight of the email that showed that the prescription was emailed to Patient 1 at 8:11 p.m. on 1 November 2019. The Committee also had sight of Mr Malik's expert report, which stated that this was, "*…inappropriate in that the registrant should have made arrangements to prescribe any post-operative medication at the time of the patient leaving the surgery*". The Committee noted your evidence that you asked reception to prepare the prescription when Patient 1 was still there. In the Committee's view, this indicated that Patient 1 required the medication in question and that you should have ensured it was prescribed to her before she left the surgery. In light of this evidence, the Committee determined that it was more likely than not that you did not prescribe any post-operative medication at the time of Patient 1 leaving the surgery. Accordingly, the Committee found this head of charge proved.

2. 2 (a) 2 (b)	You conduct in charge 1(l) was: Misleading Lacking integrity The Committee found charge 1(l) not proved and, therefore, head of charge 2 falls away in its entirety.
3.	On 4 November 2019, you failed to:
3 (a)	Inform Patient 1 of the likelihood that the inferior alveolar nerve had been damaged; **Admitted and Found Proved**
3 (b)	Immediately refer Patient 1 to a specialist setting for a second opinion and/or treatment; **Admitted and Found Proved**
4.	Between 1 November 2019 and 17 December 2019, you failed to maintain an adequate standard of records keeping in respect of Patient 1's appointments, in that:
4 (a)	You did not record any discussion of the risks and benefits of the treatment; **Admitted and Found Proved**
4 (b)	You did not record any discussions with regards to other treatment options; **Admitted and Found Proved**
4 (c)	You did not clinically justify, grade or report the radiographs taken; **Admitted and Found Proved**
4 (d)	You did not make any record of the medications prescribed; **Admitted and Found Proved**
4 (e)	You did not record that the mesial root of LL8 was left in situ on 1 November 2019;

	Admitted and Found Proved
4 (f)	You did not record the removal of bone on 2 November 2019; **Found Not Proved** You denied this head of charge. You stated in oral evidence that you used a handpiece to section the tooth but had not intended to remove any bone nor did you believe at the time that you did. The Committee noted that Mr Malik confirmed in his oral evidence that there was a possibility of bone being removed unintentionally by using improper instruments. Mr Malik stated in his report that you should have been aware of the removal of bone from the x-ray taken on 2 November 2019. The Committee accepted your oral evidence that you did not notice a change in opacity on the x-ray on 2 November. The Committee accepted that this was something that you should have been aware of. However, the Committee also accepted your evidence that you had not intended to remove bone and that you did not see this from the x-ray. Therefore, you were not able to record this in the notes. Accordingly, the Committee found this head of charge not proved.
4 (g)	WITHDRAWN

65. Having announced its decision at Stage 1, the Committee then went on to consider whether the facts found proved amounted to misconduct and, if so, whether your fitness to practise is currently impaired by reason of your misconduct, and if so, what sanction, if any, should be imposed. In accordance with Rule 20 of the *GDC (Fitness to Practise) Rules Order of Council 2006* ('the Rules'), the Committee heard submissions from Mr Hendron, on behalf of the GDC, and Ms Tanchel, on your behalf, in relation to the matters of misconduct, impairment and sanction.

Summary of the Committee's Findings of Fact

66. The Committee has found proved that you failed to provide an adequate standard of care to Patient 1 on 19 November 2019 in that:

- The extraction of LL8 was not clinically justified;
- You did not carry out sufficient pre-treatment assessments;
- You did not conduct proper treatment planning;

- You did not discuss the full risks and benefits of the proposed treatment;
- You did not discuss any other treatment options;
- You did not gain informed consent for the extraction of LL8;
- You failed to make arrangements for Patient 1 to be referred to a suitably qualified clinician for the extraction of LL8;
- You did not ensure the appropriate equipment and/or materials were available prior to commencing the extraction;
- You did not remove the mesial root of LL8;
- You damaged Patient 1's hard palate;
- You damaged to the inferior alveolar nerve;
- You did not prescribe any post-operative medication at the time of Patient 1 leaving the surgery.

67. The Committee also found proved that on 4 November 2019, you failed to inform Patient 1 of the likelihood that the inferior alveolar nerve had been damaged and failed to immediately refer Patient 1 to a specialist setting for a second opinion and/or treatment.

68. Lastly, it was found proved that between 1 November 2019 and 17 December 2019, you failed to maintain an adequate standard of records keeping in respect of Patient 1's appointments, in that:

- You did not record any discussion of the risks and benefits of the treatment;
- You did not record any discussions with regards to other treatment options;
- You did not clinically justify, grade or report the radiographs taken;
- You did not make any record of the medications prescribed; and
- You did not record that the mesial root of LL8 was left in situ on 1 November 2019.

Document

69. The Committee had regard to a further document at this stage, namely your witness statement, dated 14 August 2024, and accompanying remediation bundle. This bundle included your Personal Development Plans (PDP) between 2022 and 2025, details of Continuing Professional Development (CPD) courses undertaken with reflective notes and your reading list with reflective notes.

Submissions

70. Mr Hendron, on behalf of the GDC, submitted that the Committee should give careful consideration to the fact that serious harm was caused to Patient 1 as a result of your clinical failings and the impact, both physically and psychologically, this has had on her. He submitted that these failings occurred during what should have been a relatively straightforward extraction. He submitted that your actions amounted to serious misconduct.

71. Mr Hendron submitted that despite the passage of time since the incident, your fitness to practise is currently impaired owing to the severity of your clinical failings. He submitted that public confidence in the dental profession would be damaged if a finding of impairment were not made in your case.

72. With regard to sanction, Mr Hendron invited the Committee to impose a suspension order on your registration for a period between of six to nine months with a review hearing, but with no immediate order.

73. Ms Tanchel, on your behalf, accepted that the matters found proved in this case amounted to misconduct.

74. In respect of impairment, however, Ms Tanchel submitted that your fitness to practise is not currently impaired on either public protection or public interest grounds. She submitted that you have shown a significant degree of understanding and insight into your clinical failings in this case. She submitted that you accepted that your failings resulted in serious consequences for Patient 1 and that you have apologised to her and the GDC. She referred the Committee to the remediation you have undertaken. She submitted that the CPD courses you have undertaken were specifically targeted to the clinical failings in this case and that you have completed detailed reflections on all these courses. She submitted that the insight you have shown and the remediation undertaken significantly mitigated any future risk of repetition of your clinical failings.

75. With regard to sanction, Ms Tanchel submitted that if the Committee does find your fitness to practise is currently impaired and the Committee find it necessary to impose a conditions of practice order then you would comply. Ms Tanchel further submitted that a period of suspension would be disproportionate in the circumstances of this case. However, if the Committee does not agree, she invited the Committee to impose a limited period of suspension on your registration.

Committee's Decision

76. The Committee has borne in mind that its decisions on misconduct, impairment and sanction were matters for its own independent judgment. There is no burden or standard of proof at this stage of the proceedings. The Committee had regard to the GDC's *Guidance for The Practice Committees including Indicative Sanctions Guidance (October 2016, revised December 2020)* (the GDC's Guidance). The Committee also received advice from the Legal Adviser which it accepted. The Committee first considered whether the facts found proved amounted to misconduct.

Misconduct

77. The Committee had regard to the GDC's *Standards for the Dental Team (2013)* (the GDC Standards) and determined that you had breached the following sections in particular:

1.1 You must listen to your patients.

2.1 You must communicate effectively with patients – listen to them, give them time to consider information and take their individual views and communication needs into account.

2.2 You must recognise and promote patients' rights to and responsibilities for making decisions about their health priorities and care.

2.3 You must give patients the information they need, in a way they can understand, so that they can make informed decisions.

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

3.2 You must make sure that patients (or their representatives) understand the decisions they are being asked to make.

3.3 You must make sure that the patient's consent remains valid at each stage of investigation or treatment.

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

5.3 You must give patients who complain a prompt and constructive response.

6.3 Delegate and refer appropriately and effectively.

78. The Committee considered that the 19 clinical and record keeping failings in this case were serious and constituted a serious departure from the standards expected of dental professionals. The Committee also noted that Patient 1 underwent a three and a half hour extraction procedure, which resulted in her suffering serious longlasting harm, both physically and psychologically.

79. The Committee determined, therefore, that the failings in this case were sufficiently serious to amount to a finding of misconduct.

Impairment

80. The Committee then considered whether your fitness to practise was currently impaired by reason of your misconduct. The Committee first noted that as the failings in this

case only related to your clinical practice they were capable of being remedied. The Committee then went on to consider whether they had been sufficiently remedied and carefully considered your remediation evidence.

81. With regard to your insight into your clinical failings, the Committee had regard to your witness statement, dated 14 August 2024, and noted that you accepted that you were at fault, had shown remorse for your actions and had apologised to Patient 1 and the GDC. The Committee also acknowledged the admissions you made at this hearing. The Committee further noted that you had fully reflected on the incident and had recognised what you should have done differently. The Committee was satisfied, therefore, that you had shown full insight into your failings in this case.

82. The Committee then went on to consider your remaining remediation evidence. The Committee noted that this consisted of copies of your PDP, CPD certificates and a reading list. However, the Committee noted that there was no objective evidence before it of your current clinical practice. The Committee noted that following this incident you continued to work in the UK until mid 2022 and since then you have been practising in Spain, but there was no evidence of any testimonials or reports on your practice since the incident or whether the learning from your CPD courses had been sufficiently embedded in your clinical practice. The Committee considered therefore, that without this evidence of remediation, there was a significant risk that you could repeat the misconduct it has found.

83. Accordingly, the Committee determined that a finding of impairment is necessary in the interests of public protection.

84. The Committee also determined that a finding of impairment is necessary in the wider public interest to maintain public confidence and uphold proper standards of conduct and behaviour. Your actions fell far below the required standard and resulted in serious and permanent harm to Patient 1. The Committee concluded that a reasonable and informed member of the public, fully aware of the facts of the case, would lose confidence in the profession and the dental regulator if a finding of impairment were not made in the circumstances of this case.

85. The Committee therefore determined that your fitness to practise is also currently impaired on the ground of public interest.

Sanction

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

87. The Committee considered the mitigating and aggravating factors in this case as outlined in the GDC's guidance at paragraphs 5.17 and 5.18.

88. The mitigating factors in this case include:

- Evidence of previous good character;
- Evidence of remorse shown, insight and an apology given;

89. The aggravating factors in this case include actual harm being caused to a patient.

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

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

92. 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. The likelihood of the misconduct being repeated also means that patients and the public interest would not be sufficiently protected by the imposition of such a sanction. The Committee therefore determined that a reprimand would be inappropriate and inadequate.

93. The Committee considered whether a conditions of practice order would be appropriate. It noted that the failings in this case were clinical and could be addressed by the imposition of conditions. The Committee noted that you have been subject to interim order conditions since 2022 but these have remained inactive as you have not practised in the UK since the imposition of those, although you have been working in Spain. However, the Committee noted that there was no evidence before it from employers, supervisors or colleagues in the UK or in Spain attesting to your clinical competence and providing independent confirmation that you have applied your learning and that your deficiencies have been fully remediated. The Committee also considered the serious nature of the misconduct, which resulted in permanent harm being caused to a patient, and concluded that imposing conditions on your practice would not be sufficient or proportionate to maintain public confidence in the profession.

94. The Committee then considered whether an order of suspension would be appropriate to mark the nature and severity of the misconduct. It noted in the GDC's *Guidance* that suspension is appropriate for more serious cases when:

- The registrant poses a significant risk of repeating the behaviour;
- Public confidence in the profession would be insufficiently protected by a lesser sanction.

- There is no evidence of deep-seated personality or professional attitudinal problems (which might make erasure the appropriate order).

95. While recognising that the failings in this case are serious, the Committee does not consider it to be so serious that your conduct is fundamentally incompatible with continued registration. The Committee gave consideration to the option of erasure but determined that such a step would be disproportionate. In coming to that view, the Committee has borne in mind that the misconduct is capable of being remedied and that you had shown full insight into your clinical failings.

96. Accordingly, having had regard to all of the evidence, the Committee has determined to direct that your registration be suspended for a period of six months. The Committee is satisfied that this period of time is sufficient to mark the nature and extent of your failings in this case, to uphold professional standards and to maintain public confidence in the profession and the regulatory system. The Committee has also had regard to the principle of proportionality.

97. The Committee also directs that the suspension order be reviewed before its expiry. It considered that a future reviewing Committee will wish to consider whether your clinical deficiencies have been fully remediated and would be assisted by the following evidence:

    - Testimonials;
    - Character references; and
    - Evidence of how you have already embedded the remediation you have undertaken into your clinical practice and/or how you plan to do so in the future.

98. The Committee now invites submissions as to whether your registration should be suspended immediately.

Decision on Immediate Order (15 August 2024)

99. The Committee has considered whether to make an order for the immediate suspension of your registration in accordance with Section 30 of the Dentists Act 1984 (as amended).

100. Mr Hendron, on behalf of the GDC, submitted that he does not seek the imposition of an immediate order.

101. Ms Tanchel, on your behalf, submitted that an immediate order of suspension was not necessary in the circumstances of this case.

102. The Committee has considered the submissions made. It has accepted the advice of the Legal Adviser.

103. The Committee is satisfied that an immediate order of suspension is necessary for the protection of the public and is otherwise in the public interest. The Committee concluded that given the nature of its findings and its reasons for the substantive order of suspension in your case, it is necessary to direct that an immediate order of suspension be imposed on both of these grounds. The Committee considered that, given its findings on impairment and sanction, if an immediate order was not made in the circumstances, there would be a risk to public safety and public confidence in the profession would be undermined.

104. Therefore, the Committee directs that your registration is suspended immediately to cover the appeal period. Should you exercise your right of appeal, this immediate order of suspension will remain in place until the resolution of any appeal.

105. The Committee then went on to consider the judgment made in the case of *Aga v GDC [2023] EWHC 3208* (Admin). The Committee acknowledged that the GDC is currently appealing this judgement. However, until such time that the appeal is allowed, the Committee was satisfied that in light of the current legal position from the Aga judgment, it would be correct to deduct any time spent on an immediate order from the substantive order of suspension. Furthermore, the Committee noted that in its findings on sanction it had determined that six months was sufficient time 'to mark the nature and extent of your failings in this case, to uphold professional standards and to maintain public confidence in the profession and the regulatory system'.

106. In making the order for immediate suspension, the Committee has borne in mind the Aga case and, in accordance with that case, expects that any time spent under the immediate order of suspension be deducted from the six-month duration of the substantive order.

107. The Committee also directs that the interim order currently in place on your registration should be revoked.

108. That concludes this hearing.