HEARING HEARD IN PUBLIC

MITTAL, Shikha
Registration No: 103490

PROFESSIONAL CONDUCT COMMITTEE

MARCH 2022

Outcome: Facts found proved did not amount to Misconduct. Case Concluded

MITTAL, Shikha, a dentist, BDS University of Wales 2006, was summoned to appear before the Professional Conduct Committee on 28 March 2022 for an inquiry into the following charge:

CHARGE (as AMENDED on 28 March 2022)

“That being a registered dentist;

1. You failed to provide an adequate standard of care to Patient A, from 21 April 2017 to 3 May 2019 in that:
   a. at an appointment on or around 21 April 2017:
      i. you did not accurately assess and/or accurately record the patient's BPE scores;
      ii. [Withdrawn]
   b. [Withdrawn];
   c. at an appointment on or around 24 April 2019 and/or 3 May 2019:
      i. you did not diagnose the cause of the infection in the UL3 area;
      ii. you did not plan any or any adequate definitive treatment for the infection.

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

On 28 March 2022 the Chairman made a statement regarding the preliminary application. On 30 March 2022 the Chairman announced the findings of fact:

“Ms Mittal,

This is a Professional Conduct Committee (PCC) hearing. The members of the Committee, as well as the Legal Adviser and the Committee Secretary, conducted the hearing remotely via Microsoft Teams in line with current General Dental Council (GDC) practice. You were present at the hearing and represented by Mr Anthony Haycroft, instructed by Clyde & Co Solicitors. Mr David Patience, Case Presenter, appeared on behalf of the GDC.
Preliminary matter

On 28 March 2022, the Chair made a statement regarding the following preliminary application:

Application to amend the charge

At the outset of the hearing, the Committee heard an application from Mr Patience, on behalf of the GDC, to withdraw charges 1a) ii) and 1b), as follows:

“That being a registered dentist;

1. You failed to provide an adequate standard of care to Patient A, from 21 April 2017 to 3 May 2019 in that:

   a. at an appointment on or around 21 April 2017:
   
      ii. you did not diagnose periodontal disease and/or periodontal bone loss;

   b. between 21 April 2017 and 15 August 2017, you did not treat and/or arrange for treatment to be undertaken in relation to the BPE score recorded on 21 April 2017.”

Mr Patience informed the Committee that the GDC has reassessed the evidence and there was no longer any realistic prospect of those charges being found proved. He explained that there was no mention in the records that the diagnosis or treatment had been undertaken. Mr Patience stated that your evidence was that you had undertaken the necessary diagnostics and treatment, but this was not recorded. He reminded the Committee that Patient A would not be providing evidence during this hearing and therefore there would be no way of determining what had or had not occurred.

In this regard, the GDC made the application to withdraw charges 1a) ii) and 1b).

Mr Haycroft, on your behalf, did not object to the application.

The Committee heard and accepted the advice of the Legal Adviser in this regard.

The Committee considered Mr Patience’s application and noted that the GDC is not offering any evidence on these allegations. In the absence of any evidence, the Committee would be unable to make any findings of fact in relation to these charges. It noted that you support the application to amend and considered that no injustice would be caused by allowing the amendment.

Therefore, the Committee accepted the application to withdraw charges 1a) ii) and 1b). The Committee will therefore be considering charges 1a) i), 1c) i) and 1c) ii).

Finding of facts

Mr Haycroft, on your behalf, informed the Committee that you have made an admission to charge 1c) i) and that you deny the remaining charges, 1a) and 1c) ii).

The Committee accepted your admission and went on to consider all the charges which had not been withdrawn.

Background

You obtained your primary Dental Degree (BDS) from Cardiff University Dental School in 2006, before completing vocational training with the London Deanery in August 2007.
Thereafter, you practiced as an Associate until you began at your current Practice in July 2013, where you have worked ever since as the Principal and owner, providing a mixture of private and NHS dental services. You have a patient list size of approximately 6,500 patients.

Patient A

Patient A first became a patient of the Practice in April 2011, before it was owned by you. All treatment provided to Patient A prior to 21 April 2017 was performed by other dentists.

In December 2011, BPE gum screening was undertaken, UR2 and UL4 were extracted, and a full arch bridge was proposed. A denture was offered but Patient A wanted a bridge. Patient A had further treatment (extractions, a filling and bridge preparation) at two appointments in January 2012. He was subsequently fitted on 14 February 2012 with a 14-unit upper arch bridge with five teeth as abutments. He was due to attend a hygienist appointment on 11 April 2012, but did not attend.

His next visit to the Practice was his first appointment with you, on 21 April 2017, as an emergency appointment. At that point one of the five abutment teeth had a large cavity below the gum and was not restorable. A BPE gum screening was recorded as upper 2-2, lower 222. Treatment options were discussed with Patient A, who indicated that he did not want dentures but was open to implants in the future if the bridge failed. The decision was made to extract one tooth and replace the bridge using the remaining four teeth as abutments. You recorded the four abutment teeth as sound and plans were made to remove the bridge, fit a temporary denture and place crowns on the abutment teeth whilst a new bridge was made.

On 30 May 2017, Patient A attended for a further appointment with you. Periapical radiographs were taken and an impression was taken from the existing bridge. That bridge was removed and an extraction was performed. Bridge preparation work was undertaken. On 2 June 2017 the temporary denture was fitted, and the new bridge was fitted on 10 August 2017. Patient A attended a further appointment to review the new bridge on 22 September 2017. Options for the lower teeth were discussed and a provisional treatment plan was noted. Patient A was due to return to the Practice in January for treatment to the lower teeth and for a hygiene appointment. He did not return for these appointments.

On 15 March 2018, Patient A attended for an emergency appointment because the bridge had come out. The clinical records state that Patient A’s teeth were checked, the abutment teeth cleaned, and caries was removed. The bridge was re-cemented and the occlusion checked, and the need for oral hygiene was reinforced. Patient A was due to return for an examination and for a hygiene appointment on 1 May 2018, but he failed to attend.

On 24 April 2019, Patient A attended an emergency appointment reporting that the bridge was loose and there was a swelling on the upper left side. On examination a buccal swelling was noted in the UL3 area. The bridge could not be removed at this stage. A prescription for antibiotics was issued to address the swelling. A review appointment was planned to see whether the bridge could be removed, cleaned and re-cemented.

On 3 May 2019, Patient A attended the planned review appointment. The records indicate that the swelling had gone. The bridge was removed and cleaned, and the abutment teeth were cleaned. Caries was removed from the buccal wall of UL7 and the bridge was re-cemented. Patient A had not been flossing under the bridge as he was finding it difficult to do
so. He was advised to use interdental brushes and to see the hygienist every four months, otherwise there would be an increased chance of the bridge failing.

On 27 June 2019 Patient A attended for an emergency appointment as the bridge had come out. The bridge was cleaned with an ultrasonic scaler, re-cemented using different material, and the occlusion was checked. It was noted that there was slight mobility to UL7 due to poor oral hygiene. Patient A was again provided with oral hygiene advice, and was advised to use a Waterpik to improve longevity of the bridge.

On 1 August 2019, Patient A again attended the Practice. UL3 had fractured and was found to be unrestorable, and required extraction. Due to the impact on the remaining abutment teeth, a further bridge was not an option. Patient A was offered dentures or implants, subject to outcome of scans. As an emergency measure, the bridge was re-cemented and Patient A was advised that this was only a temporary solution.

Patient A visited another practice in October and November 2019 where UL7 and UR7 (the abutment teeth) were given a poor prognosis. A new denture was constructed and implants were planned, subject to scans. An OPG radiograph was taken which revealed moderately increased periodontal pocketing at the upper right and left molars, calculus deposits on the lower anterior teeth and bone loss at UR7 (around 30%) and UL7 (around 50%).

In October 2019, Patient A made complaints to the Practice (seeking a refund for his bridge), the Dental Complaints Service, and then the GDC.

In his complaint, Patient A stated he had had two bridges provided in three years from 2016 onwards, that they had both failed badly and that subsequently teeth had been removed unnecessarily. He alleged that his concerns were ignored, his phone calls not returned and that there was general obstruction placed in the way of him getting anything done.

Evidence

The Committee had regard to a number of documents, including the GDC hearing bundle, referred to as Exhibit 1 and Patient A's dental records, referred to as Exhibit 2. These bundles included, but were not limited to, the following documents:

- Expert report of Dr Nichols (instructed by the GDC), dated 1 November 2021;
- Expert report of Dr Caro (instructed by you), dated 11 February 2022;
- Joint expert report of Dr Nichols and Dr Caro, dated 27 February 2022;
- Your witness statement, dated 10 February 2022; and

The Committee heard oral evidence from Dr Nichols, on behalf of the GDC, and from Dr Caro, on your behalf. It also heard oral evidence from you.

Submissions

Mr Patience, on behalf of the GDC, invited the Committee to consider the expert report of Dr Nichols who identified a number of areas of deficient practice during the course of Patient A's treatment. She concluded that, based on the information, that it is unlikely that your BPE score for Patient A on 21 April 2019 was accurate.

Dr Nichols noted that there was no evidence that you attempted to diagnose the cause of the infection in the UL3 area on 24 April 2019 or at the follow-up appointment on 3 May 2019.
Her expert opinion was that without identifying the cause of the infection, an appropriate course of treatment could not be planned or provided.

Mr Haycroft invited the Committee to consider the expert report of Dr Caro, in which she stated that since BPE scores are assessed by a clinician at a particular point in time, it would not be possible for another clinician who was not there, and who did not carry out a clinical assessment at that point in time, to assume that a BPE score was not accurately assessed and/or recorded.

Dr Caro stated that there was no radiographic examination of the area on 24 April 2019 or 3 May 2019 and she was critical in that regard. However, she stated that if you were confident in your opinion that the infection was periodontal in origin, a radiographic examination may not have been necessary and may not have provided further information to aid diagnosis at that point in time.

Mr Haycroft submitted that a number of the conclusions in the expert reports were “merely speculation” as Patient A had not attended the hearing or given evidence. He stated that, in light of the expert reports, which contained a number of differing opinions, the GDC had not provided sufficient evidence upon which to find the remaining disputed allegations proved.

Committee’s findings

The Committee considered all the evidence presented to it and took account of the closing submissions made by Mr Patience, on behalf of the GDC, and by Mr Haycroft, on your behalf. The Committee accepted the advice of the Legal Adviser. It 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 facts are proved on the balance of probabilities.

The Committee considered both the expert witnesses to be credible and clear in their evidence.

The Committee also considered your evidence to be credible. It accepted that where there were inconsistencies in your evidence, this was as a result of the passage of time and your lack of experience as a witness, and this did not significantly undermine your evidence.

The Committee’s findings in relation to each head of charge are as follows:

| 1. | “You failed to provide an adequate standard of care to Patient A, from 21 April 2017 to 3 May 2019 in that…” |
| 1a) i) | “…at an appointment on or around 21 April 2017, you did not accurately assess and/or accurately record the patient's BPE scores.” |

**NOT PROVED**

The Committee considered the dental records of Patient A, the expert evidence and your evidence.

The Committee noted that only you were in a position to give direct factual evidence in relation to this charge.

In your oral evidence, you stated that at the time you recorded Patient A’s BPE score, you had been undertaking similar assessments on a daily basis for approximately ten years. You stated that there have never been any other concerns about your BPE assessments or how you had recorded the scores.
It noted Dr Nichols’ opinion that the BPE scores you recorded in the clinical notes were likely to be inaccurate. This appeared to be based on several assumptions: that the score of 4, recorded by a different dentist in 2011, was accurate; that the bone loss recorded in a radiograph in 2019 was indicative of the presence of pocketing; and the evidence in the dental records that Patient A had exhibited poor oral hygiene.

The Committee did not consider that all of these assumptions could be considered reliable, for the following reasons. There was no evidence from or about the person who conducted the 2011 assessment, and no more reason to doubt the accuracy of your assessment than the accuracy of that person’s assessment. The Committee noted that there was a margin of error in assessing a BPE score, depending on factors such as whether the case was borderline, the precise technique used, and how much pressure was applied. The experts concurred that it was difficult to determine in retrospect what the BPE score would have been at any particular point in time. Further, the evidence of Dr Caro was clear that there was no direct correlation between the presence of bone loss and the existence of pocketing.

The Committee considered that the evidence in support of this charge was too speculative to support a finding on the balance of probabilities. Accordingly, the Committee finds charge 1a) i) not proved.

1a) ii) “…at an appointment on or around 21 April 2017, you did not diagnose periodontal disease and/or periodontal bone loss.”
WITHDRAWN

1b) “…between 21 April 2017 and 15 August 2017, you did not treat and/or arrange for treatment to be undertaken in relation to the BPE score recorded on 21 April 2017.”
WITHDRAWN

1c) i) “…at an appointment on or around 24 April 2019 and/or 3 May 2019, you did not diagnose the cause of the infection in the UL3 area.”

ADMITTED and PROVED

The Committee considered both your witness statement and your oral evidence in which you accepted that you did not diagnose the cause of the infection in the UL3 area. You told the Committee that you had made a provisional diagnosis of a periodontal infection on 24 April 2019. You accepted that you did not take the necessary steps to make a definitive diagnosis, for example, by taking a radiograph. You informed the Committee that you made this decision based on the presentation of the infection on 24 April 2019 and planned to re-examine the UL3 area at Patient A’s next visit on 3 May 2019.

The GDC submitted that you failed to ascertain whether the infection was of periodontal (gum) origin or periapical (root tip) origin. The expert evidence indicated that these require different treatments to prevent recurrence of the infection.

In Patient A’s dental records, you recorded on 24 April 2019 that there was a
swelling evident in the UL3 area and that the bridge could not be removed. You told the Committee that you made a “provisional diagnosis” that the infection was of periodontal origin based on the presentation of the area. You prescribed antibiotics to treat the infection. You planned to remove the bridge, clean, and re-cement it at the next appointment on 3 May 2019, which you proceeded to do on that date. You stated on 3 May 2019, that you were confident in the provisional diagnosis you had previously made.

The Committee took account of Dr Caro’s expert report which indicated that although radiographs should have been taken in the circumstances, a radiographic assessment may or may not have provided any further information to aid diagnosis at that point in time.

The Committee also considered the dental records from the 3 May 2019 appointment and found no indication in those notes that you attempted to confirm the source of the infection. It concluded that you did not reach a definitive diagnosis.

Therefore, the Committee concluded that you did not diagnose the cause of the infection in the UL3 area.

Accordingly, the Committee finds charge 1c) i) proved.

1c) ii) “…at an appointment on or around 24 April 2019 and/or 3 May 2019, you did not plan any or any adequate definitive treatment for the infection.”

NOT PROVED

The Committee had regard to the expert evidence of Dr Nichols and Dr Caro, and your witness statement and oral evidence.

The Committee noted that although you did not take any radiographs to assist your diagnosis, you stated that you made your provisional diagnosis based on the presentation of the swelling in the UL3 area. You prescribed a course of antibiotics and re-booked Patient A for a follow-up appointment on 3 May 2019.

You told the Committee that at the 3 May 2019 appointment, the swelling had reduced, and you were able to remove the bridge and make a further assessment. You stated that you “cleaned all teeth” and the notes show that you “cleaned UR73 and UL37”.

In your oral evidence, you explained that this cleaning included deep scaling and root surface debridement. You stated, “I have generically said ‘cleaned’, not sub and supra gingivally. I’ve not specified what or the way I did it. I’m implying [root surface debridement] RSD. I know they’re different things, my error is not recording RSD specifically”. The Committee noted the consistency in the language you used in your notes and in your witness statement, namely that you used the word ‘cleaning’ when referring to deep scaling or RSD.

You told the Committee that you remember using an ultrasonic cleaner to perform deep scaling. This treatment was required due to the periodontal nature of the infection. You informed the Committee that, although some years had passed, you remembered Patient A well as the 14-unit bridge was uncommon.
The Committee bore in mind the evidence of the expert witnesses, who considered that without adequate investigation of the source of the infection, it would be difficult to provide adequate treatment. However, it noted that this aspect of concern was addressed by the finding in charge 1c) i).

The evidence of the experts was that if the infection was periodontal, as you believed it to be, then the appropriate treatment would be the prescription of antibiotics with deep scaling of the affected tooth. If the infection was periapical, then root canal treatment or extraction might be indicated (although Dr Caro pointed out that this might not be possible as the tooth was being used as an abutment and that ‘doing nothing’ might be an option in the circumstances).

The Committee noted that neither expert was critical of your decision to prescribe antibiotics on 24 April 2019 and review the tooth on 3 May 2019. It noted your account that on 3 May 2019 you were confident in your provisional diagnosis, performed deep scaling of UL3 and gave oral hygiene advice.

The Committee was mindful that, again, you were the only person who could give direct factual evidence about what happened at this appointment. The Committee was also mindful that the burden of proof is not on you, and saw no evidence to undermine your account of what you did. It accepted that, not being familiar with the process of giving evidence, you may not have appreciated the importance of including detail of the ‘cleaning’ you undertook in your statement. It was mindful that you were of good character and had made admissions and concessions where you accepted that you had fallen short.

The Committee noted that you had used the term ‘cleaning’ in more than one place in your witness statement to describe a process going beyond simply cleaning the cement off an abutment tooth. You accepted that your records in relation to this appointment fell short of what was required and that you should have included more detail of the treatment you provided. The Committee found it somewhat surprising that you had used such a general and imprecise term as ‘cleaning’ to describe a process of deep scaling and debridement. It found your records of this appointment to be lacking in detail, however, on the balance of probabilities it accepted your account of the treatment you provided.

The Committee noted that both experts agreed that it was now not possible to say whether the infection in the UL3 area on 24 April 2019 and 3 May 2019 was periodontal or periapical in source. It considered that the treatment you provided would, according to the expert evidence, have been sufficient to treat a periodontal infection, which is what you believed it to be. The Committee therefore considered that the treatment you provided was adequate for the infection you had identified.

Therefore, the Committee found charge 1c) ii) not proved.

We now move to Stage 2.”

On 31 March 2022 the Chairman announced the determination as follows:

“Ms Mittal,

On 31 March 2022, the Chair announced the determination as follows:
Having announced its decision on Stage 1, the Committee then moved on to consider whether the fact found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. In accordance with Rule 20 of the Fitness to Practise Rules 2006, the Committee heard submissions from Mr Patience, on behalf of the GDC and Mr Haycroft’s submissions, on your behalf, in relation to the matters of misconduct, impairment and sanction. The Committee accepted the advice of the Legal Adviser.

Evidence

The Committee also had regard to further documents, referred to as Exhibit 4 and Exhibit 5. These bundles consisted of the following documents:

- Testimonials;
- Personal Development Plan;
- CPD Logs;
- Peer review log;
- Audits;
- Targeted CPD evidence (letters and certificates); and
- A supplemental witness statement prepared by you, dated 29 March 2022.

Submissions

Mr Patience informed the Committee that the GDC takes a neutral stance on the question of misconduct. He submitted that the Committee might consider that your failure to diagnose the infection in the UL3 area fell far below the standard expected of a reasonably competent General Dental Practitioner. This, he submitted, was supported by both Dr Nichols and Dr Caro. He also submitted that the Committee might consider that your failure breached a number of the ‘Standards of the Dental Team’, (“the Standards”).

In relation to impairment, Mr Patience informed the Committee that the GDC takes a neutral stance on the question of whether your fitness to practise is currently impaired.

If the Committee was to find impairment, Mr Patience invited it to consider the imposition of a reprimand, as it could fairly be said that the misconduct in question is at the lower end of the spectrum and most of the factors detailed in the reprimand section of the GDC document, ‘Guidance for the Practice Committees including Indicative Sanctions Guidance’, (“the ISG”) are present in your case.

Mr Haycroft, on your behalf, submitted that as this isolated incident occurred over three years ago with no similar matters before or since, and due to your assessment, provisional diagnosis, and subsequent treatment provided, your failing was not ‘serious’ enough to amount to misconduct. Mr Haycroft further submitted that your fitness to practise is not currently impaired. He said that there is no public interest element as this was an isolated clinical failing. In addition, he said that whilst it could be argued that there is a public protection issue, this would only be relevant where there is a lack of insight or a risk of repetition and that neither applies in your case.

Mr Haycroft addressed the Committee on the matter of sanction and submitted that if a finding of impairment alone did not mark the misconduct sufficiently, a reprimand is the only other proportionate sanction.
Misconduct

The Committee took into account Mr Patience's submissions in which it was invited to consider misconduct as 'being acts or omissions which amounts to a serious departure from the standards expected of a reasonably competent practitioner, or which other members of the profession would consider deplorable'. The Committee also bore in mind the submissions of Mr Haycroft and the advice of the Legal Adviser.

The Committee bore in mind that Patient A's case was a difficult one: Patient A had four remaining teeth in the upper jaw, and establishing the integrity of those teeth was important in order to be able to plan treatment effectively.

The Committee accepted your evidence that when faced with the situation that presented on 24 April 2019, you prescribed antibiotics, having made a provisional diagnosis of periodontal infection. The treatment provided at that appointment was appropriate in the circumstances. However, at the follow-up appointment on 3 May 2019, the opportunity should have been taken to carry out further investigation into the source of the infection, despite your belief that your diagnosis and treatment were correct. It could therefore be characterised as negligent not to explore the source of the infection fully at the time.

The Committee considered that this incident represented a significant departure from standards and amounted to poor practice. The Committee noted that both experts had agreed that the failure to reach a definitive diagnosis fell far below required standards.

The Committee was mindful of the principle that not every departure from required standards will be sufficiently serious to amount to misconduct. The departure must be sufficiently serious to be characterised properly as misconduct going to fitness to practise. The Committee bore in mind that in order to meet that threshold, the failure must be such that it would be regarded as ‘deplorable’ by fellow members of the profession. In addition, mere negligence would not amount to misconduct unless particularly serious, and a single negligent act or omission would be less likely to amount to misconduct, unless particularly grave.

The Committee considered that, although serious, the departure from standards in this case was isolated and not sufficiently serious to cross the threshold of misconduct. In the circumstances, it was unlikely to be characterised as ‘deplorable’ by fellow members of the profession. The Committee noted that Patient A’s presentation and dental history was challenging and difficult to manage. You took appropriate steps to manage the infection at the time based on the provisional diagnosis you had reached, and there is no evidence that the failure to reach a definitive diagnosis had any detrimental effect. The Committee did not consider that this single clinical failure fell far enough short of required standards, in isolation, to be characterised as misconduct.

Accordingly, the Committee concluded that the fact found proved, namely charge 1c) i), did not amount to misconduct.

That concludes this hearing."