General Dental Council | protecting patients, regulating the dental team

HEARING HEARD IN PUBLIC**

PONCZ, Erno

Registration No: 250267

PROFESSIONAL CONDUCT COMMITTEE

NOVEMBER 2017-NOVEMBER 2019[1]

Most recent outcome: Suspended indefinitely*

*See page 27 for the latest determination

****Information relating to a registrant whose case was heard in parallel with Mr Poncz, but whom the sanction imposed by the Committee has now expired, has now been removed or redacted from this determination.

Erno PONCZ, a dentist, DMD Semmelweis University 2010, was summoned to appear before the Professional Conduct Committee on 6 February 2017 for an inquiry into the following charge:

Charge (as amended on 6 and 8 February 2017)

"That being a Registered Dentist:

1. At all material times you were practising at Forest & Ray Dental.
2. You failed to provide an adequate standard of care to Patient A on and/or around 20 May 2014 in that you:
    a. Caused and/or allowed a referral for a CT examination of Patient A to be made when:
        i. You had not carried out any clinical examination of Patient A
        ii. In light of Head of Charge 2a(i) above, you did not have adequate clinical justification for a radiographic examination to be carried out.
        iii. The referrer, Person A, was not a recognised and authorised Referrer and /or Practitioner within the meaning of the IRMER regulations.
3. You failed to provide an adequate standard of care to Patient A on 17 June 2014 in that you:
    a. Did not obtain and/or update, adequately or at all, Patient A's medical history.
    b. Did not assess, adequately or at all, Patient A's:
        i. Oral hygiene.
        ii. Periodontal condition.
    c. Did not carry out, adequately or at all:

[1] The hearing adjourned part-heard on 17 February 2017. It resumed on 4 April 2017 and adjourned once again on 6 April 2017. The hearing then reopened on 7 November 2017.

i. Extra-oral examinations.

ii. Intra-oral examinations

d. [WITHDRAWN].

e. [WITHDRAWN].

f. Did not communicate, adequately or at all, details of the proposed treatment plan to Patient A.

g. Did not discuss, adequately or at all, the proposed treatment with Patient A and its risks, benefits and costs.

h. Did not discuss, adequately or at all, alternative treatment options with Patient A and their risks, benefits and costs.

i. Did not ensure that Patient A understood the proposed treatment.

j. Did not ensure Patient A had a stable periodontal condition prior to performing implant surgery.

k. Did not plan, adequately or at all, treatment for Patient A.

I. Inappropriately carried out treatment for Patient A

4. In light of 3f and I or 3g and/or 3h and I or 3i [WORDING WITHDRAWN] above, you did not obtain valid consent for the treatment provided to Patient A.

5. You failed to provide an adequate standard of care to Patient A on 29 September 2014 in that you:

a. Did not obtain and/or update, adequately or at all, Patient A's medical history.

b. Did not assess, adequately or at all, Patient A's:

i. Oral hygiene.

ii. Periodontal condition.

c. Did not carry out, adequately or at all:

i. Extra-oral examinations.

ii. Intra-oral examinations.

d. Did not communicate, adequately or at all, details of the proposed treatment plan to Patient A.

e. Did not discuss, adequately or at all, the proposed treatment with Patient A and its risks, benefits and costs.

f. Did not discuss, adequately or at all, alternative treatment options with Patient A and its risks, benefits and costs.

g. Did not plan, adequately or at all, treatment for Patient A.

h. Inappropriately carried out treatment for Patient A.

i. Prior to embarking on the surgical procedure, did not:

i. Take a periapical radiograph when it was appropriate to do so.

ii. Establish a diagnosis in relation to UR345.

j. Performed surgery on Patient A that was otherwise avoidable.

6. In light of 5d and/or 5e and/or 5f, you did not obtain valid consent for the treatment provided to Patient A.

7. You failed to provide an adequate standard of care to Patient A on or around 4 February 2015 in that you:

   a. Did not communicate, adequately or at all, details of the proposed treatment plan to Patient A in relation to the extraction of the UR2 and UR3.

   b. Did not discuss, adequately or at all, the proposed treatment with Patient A and its risks, benefits and costs.

   c. Did not discuss, adequately or at all, alternative treatment options with Patient A and its risks, benefits and costs.

   d. Did not ensure that Patient A understood the proposed treatment.

8. In light of 7a and/or 7b and/or 7c and/or 7d above, you failed to obtain valid consent for the treatment provided to Patient A

9. You failed to provide an adequate standard of care to Patient A between 17 June 2014 and on or around 4 February 2015 in that you:

   a. Did not collaborate, adequately or at all, with other members of the dental team involved in Patient A's care.

10. You failed to provide an adequate standard of care to Patient A between 29 September 2014 and on or around 4 February 2015 in that you:

    a. Did not treat the residual infection at the UR3, and/or in the alternative ensure appropriate delegation of the treatment to colleagues, in a timely manner.

11. You failed to maintain an adequate standard of record keeping in respect of Patient A's appointments between 17 June 2014 and 4 March 2015 in that you did not record, adequately or at all:

    a. Patient A's diagnosis.

    b. Patient A's medical history.

    c. Extra-oral examination findings.

    d. Intra-oral soft tissue findings.

    e. Patient A's periodontal condition.

    f. Patient A's oral hygiene status.

    g. Details of the surgery carried out on 17 June 2014 and/or 29 September 2014, including the:

       i. Location of surgical flaps.

       ii. Details of the administration of the local anaesthesia.

       iii. Site of sutures inserted.

       iv. Types of sutures inserted.

h. Details of the reasons for removing the roots of UR2 and UR3 on 4 February 2015.

i. Details of discussions with Patient A regarding the proposed treatment and the risks, benefits and costs.

j. Details of discussions with Patient A regarding alternative treatment options and their risks, benefits and costs.

k. Details of Patient A's complaints.

l. Details of your withdrawal from Patient A's treatment.

m. An assessment and/or analysis of the CT scan requested on 20 May 2014.

AND that by reason of the matters outlined above, your fitness to practise is impaired by reason of your misconduct."

On 7 November 2017 the Chairman made the following statement regarding the finding of facts:

"Mr Poncz

You were present at this hearing on 8, 9 and 16 February 2017. On those dates you were represented by Mr David Hanis and were assisted by an interpreter. You were not present, and were not represented, on the other days of the hearing. Ms Catharine Donnelly of Blake Morgan solicitors appears for the General Dental Council (GDC).

Rule 25 (1) application to join

At a preliminary meeting held on 14 December 2016 the Professional Conduct Committee (PCC) acceded to an application from the GDC to join your case with that of Ms Csilla Ehreth in accordance with Rule 25 (1) of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules'). Accordingly, the hearing of your case has taken place on a joint basis alongside the case relating to Ms Ehreth.

Service of notice

On behalf of the GDC Ms Donnelly submitted that service of this hearing has been properly effected in accordance with the Rules. Ms Donnelly stated that as required by Rule 13 a notice of hearing dated 5 January 2017 was sent to your known address in Hungary. The notice set out the date, time and location of this hearing. Ms Donnelly submitted that the notice was sent in accordance with Rule 65 of the Rules, having been sent to the registrant using the Royal Mail's International Delivery postal service. Ms Donnelly drew the Committee's attention to the Royal Mail's track and trace entry for the item, which records that the notice was delivered in Hungary on 12 January 2017. She also submitted that a copy of the notice was sent by email on 5 January 2017.

The Committee accepted the advice of the Legal Adviser. Having regard to the evidence put before it the Committee was satisfied that service has been properly effected in accordance with the Rules and that all reasonable efforts have been made to inform you of this hearing.

Proceeding in absence

The Committee then went on to consider whether to exercise its discretion to proceed in your absence in accordance with Rule 54 of the Rules. Ms Donnelly invited the Committee to do so on the basis that the GDC had made all reasonable efforts to notify you of this hearing.

The Committee accepted the advice provided by the Legal Adviser. The Committee was mindful that its discretion to hold a hearing in the absence of a registrant should be exercised with the utmost care and caution. After careful consideration the Committee was satisfied that it would be appropriate and fair to proceed in your absence on those days when you would not be present. The Committee considered that you have been fully and repeatedly informed of the fact of this hearing and of the importance of participating. It noted that the steps that the GDC has taken include providing you with a Hungarian translation of relevant correspondence. The Committee noted that you were first informed on 16 May 2016 of the likelihood of this hearing commencing on 6 February 2017. The Committee considered that you have voluntarily waived your right to attend each day of this hearing.

The Committee also considered that an adjournment would serve no purpose as it would be unlikely to secure your attendance. The Committee noted that you have obtained legal representation in Hungary and that neither you nor your representatives have sought an adjournment. The Committee also considered that there is a clear public interest in proceeding with the hearing for the purposes of securing an expeditious disposal of this matter, and it is mindful of the inconvenience that would be caused to other parties, including Ms Ehreth, if the hearing were not to proceed.

Preliminary matters

At the start of the hearing Ms Donnelly made an application to withdraw and amend a number of heads of charge pursuant to Rule 18 of the Rules.

The Committee, having received advice from the Legal Adviser, considered that the proposed changes could be made with no injustice to either party and that it was fair and reasonable for the amendments to be made. The schedule of charge was duly amended.

Ms Donnelly made further applications to amend the charges during the course of the GDC's factual case. Mr Hanis on your behalf made no objection to the application. The Committee again accepted the advice of the Legal Adviser and was content to accede to the application.

Background to the case and summary of allegations

The concerns that have given rise to this hearing relate to the care and treatment that you provided to a patient, referred to for the purposes of these proceedings as Patient A, in the period of 20 May 2014 to 4 March 2015. The incidents giving rise to the allegations occurred whilst you were working at the Forest & Ray Dental Practice in central London.

The GDC has raised a number of allegations against you in relation to specific aspects of the care and treatment that you provided to Patient A. The GDC alleges that, because of these specific omissions in your care of Patient A, your care was inadequate and that this amounts to a culpable failure on your part.

The GDC alleges that, on or around 20 May 2014 and before you first saw the patient some weeks later, you caused or allowed a referral for a computerised tomography (CT) examination to be made in the absence of your clinical examination of the patient and, accordingly, without adequate clinical justification. It is also contended that the referral was made by an individual who was not authorised to do so.

It is also contended that, at the first appointment that you had with Patient A on 17 June 2014, you did not obtain or update, adequately or at all, Patient A's medical history, and did not, adequately or at all, assess and examine Patient A in a number of specific respects. It is further alleged that at that same appointment you did not discuss with the patient,

adequately or at all, details of the proposed treatment, including risks, costs and benefits, or such details of alternative treatment options. The GDC alleges that you did not ensure that Patient A understood the proposed treatment, and therefore that you did not obtain valid consent. It is also alleged that you did not stabilise the patient's periodontal condition before undertaking implant surgery, that you did not plan the treatment, either adequately or at all, and inappropriately carried out treatment.

Patient A's appointment with you on 29 September 2014 has also given rise to a number of allegations. It is alleged that you did not assess and examine her in a number of respects, either adequately or at all, and that you did not properly plan, discuss and undertake the treatment that you provided. It is alleged that some of these failures amounted to a failure to obtain valid consent, and it is also contended that the surgery that you performed was avoidable. Further patient discussion and consent issues have been raised in respect of the appointment that took place on 4 February 2015, with particular regard to proposed treatment and options for treatment.

As well as record-keeping failures associated with your care and treatment of Patient A in respect of the matters referred to above, it is also alleged that you did not collaborate, adequately or at all, with other members of the dental team who were involved in her care, and that you did not treat the residual infection at the UR3, or alternatively ensure appropriate delegation of the required treatment to your colleagues.

Evidence

The Committee heard oral evidence from Patient A; from the mother of Patient A, who is referred to for the purposes of these proceedings as Witness 1; from the expert witness instructed by the GDC, namely Mrs Heather Beckett; from the expert witness instructed by Ms Ehreth's defence team, namely Mr Don McGrath; from a former patient co-ordinator at the practice, referred to for the purposes of these proceedings as Person 1; and from Ms Ehreth. The Committee also heard an oral address made by you.

The Committee has been provided with documentary material in relation to the heads of charge that you face, including the witness statement, documentary exhibits and clinical records of Patient A; the witness statement and documentary exhibits of Witness 1; the exert reports and joint statements of Ms Beckett and Mr McGrath; a witness statement provided by Ms Ehreth; the witness statement of a former dental nurse at the practice, referred to for the purposes of these proceedings as Person 6; the witness statement of a former patient co-ordinator at the practice, referred to for the purposes of these proceedings as Person 1; and a letter of response to the allegations provided by you.

Committee's findings of fact

The Committee has taken into account all the evidence presented to it, both written and oral. It has considered the submissions made by Ms Donnelly on behalf of the GDC and those made by Mr Hanis on your behalf. The Committee has accepted the advice of the Legal Adviser.

The Committee has applied the civil standard of proof, namely the balance of probabilities, and has been reminded that the burden of proof lies with the GDC. The Committee has considered each head of charge separately, although in respect of some of the heads of charge its findings will be announced collectively.

The Committee found Witness 1 to be open and credible when giving evidence. She was careful to state when she was not able to recall a particular matter. Although the Committee

considered that her recollection was not always clear, she stated if she was not sure and was open about the gaps in her recollection and knowledge. The Committee accepts that there is a limit to the direct evidence that she could give, as she was not present at all of the appointments. Witness 1 placed some reliance on what her daughter, namely Patient A, could recall, and at the same time may not have sought clarification from her.

Patient A was a credible and honest witness. The Committee found that there was a degree of confusion in respect of the events relevant to this case, both at the time and now. Her recollection was not always reliable, in part due to the passage of time, and there were some inconsistencies in the evidence that she gave.

Person 1 was honest in evidence, and was clear about relying on the clinical notes for the purposes of her evidence.

Ms Ehreth gave honest and credible evidence to this Committee. She made a considerable number of admissions at the outset and made further acknowledgements under oath which precipitated further admissions. She listened carefully to the questions that were asked of her and made sure that she understood. Ms Ehreth then gave reflective and considered responses. The Committee noted that she often provided evidence based on your usual practice at the time.

The Committee was greatly assisted by the expert evidence of Mrs Beckett and Mr McGrath. Mrs Beckett was very clear and knowledgeable in her evidence, and had produced a very helpful written report in advance of the hearing. It is clear that Mrs Beckett is able to draw on a wealth of knowledge and experience of complex implantology cases. There were occasions when the Committee considers that she departed from the usual practice of a general dental practitioner, particularly in relation to the duties relevant to emergency appointments. Mr McGrath also gave helpful and knowledgeable evidence to the Committee, and was particularly helpful to the Committee in relation to the duties and practice of a general dental practitioner.

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

1.	Proved
	The Committee finds the facts alleged at head of charge 1 proved. The Committee is satisfied that the documentary evidence presented to it is sufficient to establish that you were in practice at the Forest & Ray Dental Practice at the time of the events giving rise to these proceedings. Accordingly it finds the facts alleged at this narrative head of charge proved.
2. a. i.	Proved
2. a. ii.	Proved
	The Committee finds the facts alleged at heads of charge 2 (a) (i) and 2 (a) (ii) proved. The Committee notes from the documentary evidence placed before it that a referral was made for a CT examination of Patient A on 20 May 2014. The referral was made by an individual who is not a GDC registrant and who appears to have worked in an administrative capacity at Forest & Ray. The referral, being dated 20 May 2014, was made some time before Patient A was first seen by you. Patient A's evidence to the Committee is that she had not seen you by or on 20 May 2014. Although there is some evidence that

	you saw Patient A briefly on 16 June 2014, it is clear that the referral for a CT was made before the first appointment that you had with Patient A on 17 June 2014 at which a clinical examination took place and implants were placed. In your written evidence to the Committee, you stated that you ordered that a CT scan referral be made prior to your clinical examination of the patient. The Committee accepts the expert evidence of Mrs Beckett that it was not appropriate for you to make such a referral without having carried out a clinical examination of Patient A. The Committee is mindful of the Ionising Radiation (Medical Exposure) Regulations 2000 ('IRMER regulations') which state that radiographic exposure must be justified. The Committee considers that you were under a duty to carry out a clinical examination before considering whether a CT scan was required, and that your failure to adhere to this duty amounts to an inadequate standard of care. Accordingly the Committee finds the facts alleged at heads of charge 2 (a) (i) and 2 (a) (ii) proved.
2. a. iii.	Not proved
	The Committee finds the facts alleged at head of charge 2 (a) (iii) not proved. The GDC has not established to the required standard that the person who made the referral, referred to for the purposes of these proceedings as Person 1, was not a recognised and authorised practitioner as designated by the IRMER regulations. The Committee therefore finds the facts alleged at this head of charge not proved.
3. a.	Proved
	The Committee finds the facts alleged at head of charge 3 (a) proved. Patient A attended an appointment with you on 17 June 2014 for the purposes of having the planned implants placed. Patient A's clinical records indicate that her medical history had most recently been taken in October 2013. Your evidence to this Committee is that you did update Patient A's medical history at the appointment on 17 June 2014, but there were no changes to that history and you did not record that fact. Patient A was not able to recall whether you updated her medical history. The Committee considers that the absence of a record of you having updated Patient A's medical history means that you did not adequately update her medical history. The Committee is further satisfied that you were under a duty to do so, given the invasive nature of the treatment that would take place on 17 June 2014 and the fact that this was the first appointment that you had had with the patient. The Committee further considers that your failure to update Patient A's medical history amounts to an inadequate standard of care. Accordingly the Committee finds the facts alleged at head of charge 3 (a) proved.
3. b. i.	Proved
3. b. ii.	Proved

	The Committee finds the facts alleged at heads of charge 3 (b) (i) and 3 (b) (ii) proved. In your evidence to this Committee you stated that you had no responsibility to assess Patient A's oral hygiene and periodontal condition. However, the Committee accepts and prefers the expert evidence of Mrs Beckett, who in her evidence stated that a patient's oral hygiene and periodontal condition will have a significant impact on the success of implants, and that as the treating clinician you needed to make a full and proper assessment of the patient, who was new to you, to ensure that the treatment plan for implants was appropriate. Your duty to properly assess Patient A's oral hygiene and periodontal condition did not fall away on account of the oral hygiene instructions that had been given to the patient on the previous day, namely 16 June 2014. For these reasons the Committee finds the facts alleged at heads of charge 3 (b) (i) and 3 (b) (ii) proved.
3. c. i.	Proved
3. c. ii.	Proved
	The Committee finds the facts alleged at heads of charge 3 (c) (i) and 3 (c) (ii) proved. The Committee accepts your oral account of you having carried out extraoral and intraoral examinations of Patient A, but having failed to record those examinations. The Committee considers that the absence of a record of any such examinations means that the examinations were not carried out adequately. Accordingly it finds the facts alleged at heads of charge 3 (c) (i) and 3 (c) (ii) proved.
3. d.	Withdrawn
3. e.	Withdrawn
3. f.	Proved
3. g.	Proved
3. h	Proved
3. i.	Proved
	The Committee finds the facts alleged at heads of charge 3 (f), 3 (g), 3 (h) and 3 (i) proved. Patient A's evidence is that she was expecting to receive seven implants at the appointment that took place on 17 June 2014. However, only four implants were placed. Her UR5 was also extracted, and Patient A was aware that that might need to happen. Patient A stated that she did not know which treatment plan was being followed at the appointment on 17 June 2014. A treatment plan was sent to her by email on the evening of 16 June 2014, and that treatment plan provided for the treatment that she received the following day. Patient A stated in evidence that she did not receive that treatment plan until she returned home after the treatment on 17 June 2014. Patient A further stated that you had not had a discussion with her about the treatment, including its risks, benefits and costs, and any alternative treatment options, and that even by the end of the

	appointment she did not know what treatment she had received. She also stated that the consent form that she signed in relation to this treatment was signed after the treatment had been provided. In your evidence to this Committee you stated that you considered that such matters had already been covered. The Committee considers that in the circumstances you did not adequately discuss details of the proposed treatment plan, including its risks, benefits and costs, and alternatives, with Patient A. The Committee is further satisfied that you were under a duty to explain and clarify these details, or to check that such matters had been discussed adequately on a previous occasion. Your failure to do so amounts to an inadequate standard of care. Accordingly the Committee finds the facts alleged at heads of charge 3 (f), 3 (g), 3 (h) and 3 (i) proved.
3. j.	Proved
	The Committee finds the facts alleged at head of charge 3 (j) proved. As set out above in respect of its findings at head of charge 3 (b) (ii), the finds that you failed in your duty to assess Patient A's periodontal condition before providing treatment to her on 17 June 2014. The Committee accepts the expert evidence of Mrs Beckett that you should have allowed time for her periodontal condition to stabilise following the hygienist intervention of 16 June 2014. Your failure to ensure that Patient A had a stable periodontal condition prior to placing implants amounts to a failure to provide an adequate standard of care. Accordingly the Committee finds the facts alleged at head of charge 3 (j) proved.
3. k.	Proved
	The Committee finds the facts alleged at head of charge 3 (k) proved. This finding follows the findings set out above at heads of charge 3 (a), 3 (b) (i), 3 (b) (ii), 3 (c) (i), 3 (c) (ii), 3 (f), 3 (g), 3 (h), 3 (i) and 3 (j). The Committee accepts the expert evidence of Mrs Beckett that, as the surgeon, you had a responsibility to ensure that the treatment that you proposed to provide was adequately planned. The Committee finds that you failed in this duty, and that this amounts to an inadequate standard of care. The Committee therefore finds the facts alleged at head of charge 3 (k) proved.
3. l.	Proved
	The Committee finds the facts alleged at head of charge 3 (l) proved. This finding follows the findings set out above at heads of charge 3 (a), 3 (b) (i), 3 (b) (ii), 3 (c) (i), 3 (c) (ii), 3 (f), 3 (g), 3 (h), 3 (i), 3 (j) and 3 (k). The Committee considers that in these circumstances you inappropriately carried out treatment for Patient A, and that this amounts to an inadequate standard of care. Accordingly the Committee finds the facts alleged at head of charge 3 (l) proved.
4.	Proved
	The Committee finds the facts alleged at head of charge 4 proved. In approaching this head of charge the Committee has taken the character 'l' to

	be a forward slash punctuation mark. The Committee's findings at head of charge 4 follow its findings at heads of charge 3 (f), 3 (g), 3 (h) and 3 (i). The Committee finds that, because of the omissions referred to at those heads of charge, you failed to obtain valid consent for the treatment that you provided to Patient A. The Committee therefore finds the facts alleged at head of charge 4 proved.
5. a.	Proved
	The Committee finds the facts alleged at head of charge 5 (a) proved. The appointment that took place on 29 September 2014 was a surgical appointment. Although the events are far from clear, it appears that you proposed to place the remaining implants and to uncover the four existing implants. However, during the course of the appointment you discovered that this treatment could not be provided as there was insufficient bone. A bone graft was required, but this in turn could not be done as there was still infection present around the patient's UR3. In your evidence to this Committee you stated that you verbally updated Patient A's medical history at the appointment. Patient A is not able to recall whether this happened, and the Committee accepts your account. However, the Committee considers that such a verbal update was not adequate, as you would have needed to ensure that the patient had sight of, and was referring to, her original medical history information when confirming this update. The Committee also again finds that the absence of a record of an update to the patient's medical history means that the update was inadequate. The Committee is further satisfied that you were under a duty to make an adequate update, as you were about to perform surgery. For these reasons the Committee finds the facts alleged at head of charge 5 (a) proved.
5. b. i.	Proved
5. b. ii.	Proved
	The Committee finds the facts alleged at heads of charge 5 (b) (i) and 5 (b) (ii) proved. The evidence presented to the Committee suggests that you did not adequately assess Patient A's oral hygiene and periodontal condition, and the Committee specifically considers that the absence of any record in that regard means that your assessments were inadequate. The Committee considers that you were under a duty to do so, and that your failure amounts to an inadequate standard of care. Accordingly the Committee finds the facts alleged at heads of charge 5 (b) (i) and 5 (b) (ii) proved.
5. c. i.	Proved
5. c. ii.	Proved
	The Committee finds the facts alleged at heads of charge 5 (c) (i) and 5 (c) (ii) proved. The Committee considers that the absence of a record of an extraoral and intraoral examination means that your examinations were inadequate. The Committee further considers that you were under a duty to undertake such adequate examinations in advance of an invasive

	procedure, and that as you did not so you failed to provide an adequate standard of care to Patient A. Accordingly the Committee finds the facts alleged at heads of charge 5 (c) (i) and 5 (c) (ii) proved.
5. d.	Proved
5. e.	Proved
	The Committee finds the facts alleged at heads of charge 5 (d) and 5 (e) proved. The treatment plan dated 16 June 2014 required clarification in terms of specifically explaining to the patient what treatment she would receive on 29 September 2014, and the evidence is that you provided no clarification or explanation to the patient before commencing treatment. The entries that you made in Patient A's clinical notes do not explain what treatment was planned for 29 September 2014. Patient A's recollection is that she anticipated that you would uncover her implants, as provided for in a treatment plan dated 15 May 2014. The Committee infers from that treatment plan that you intended to expose the implants on 29 September 2014 and place more. Patient A stated that there had been a conversation with you and that she understood that you would uncover her implants and place further ones. Patient A also stated that during the course of the appointment you informed her that there was an infection, and that you had discovered the need for a bone graft. She also stated that, although she signed a consent form on 29 September 2014, she did so after the treatment had been provided. The Committee considers that such communication was inadequate, particularly as the details of the proposed treatment was not set out in writing. The Committee finds that this amounts to a failure on your part to provide an adequate standard of care. Accordingly the facts alleged at heads of charge 5 (d) and 5 (e) are proved.
5. f.	Proved
	The Committee finds the facts alleged at head of charge 5 (f) proved. In your written statement to the Committee you stated that alternative treatment options, and their risks, costs and benefits, had been discussed with Patient A on an earlier occasion. The Committee considers that you were under a duty to discuss alternative options at the appointment in order to ensure ongoing consent and understanding. The Committee considers that your failure to do so amounts to an inadequate standard of care, and that accordingly the facts alleged at head of charge 5 (f) are proved.
5. g.	Proved
	The Committee finds the facts alleged at head of charge 5 (g) proved. This finding follows from the Committee's findings at heads of charge 5 (a), 5 (b) (i), 5 (b) (ii), 5 (c) (i), 5 (c) (ii), 5 (d), 5 (e) and 5 (f) above. The evidence provided to the Committee indicates that you had little, if any, input into the planning of the treatment that you provided to Patient A on 29 September 2014. It is apparent that, during the appointment of 29

	September 2004, you realised that Patient A had a periapical infection of a significant size at her UR3 which had previously been root filled as recently as May 2014. You suggested an extraction or re-root treatment. The Committee also accepts the expert evidence of Mrs Beckett, who is critical of you not undertaking appropriate examinations to identify earlier the loss, and lack, of bone at the patient's UR5. The root of the UR5 had been extracted by you in June 2014, and that earlier removal is likely to have precipitated further bone loss. The Committee considers that the previous treatment plans, more particularly the treatment plan of 16 June 2014, was not an adequate plan for the treatment that you provided to Patient A on 29 September 2014. For these reasons, the Committee finds that you did not adequately plan the treatment that you provided to Patient A on 29 September 2014, and that this amounts to an inadequate standard of care. Accordingly the facts alleged at head of charge 5 (g) are proved.
5. h.	Proved
	The Committee finds the facts alleged at head of charge 5 (h) proved. This finding follows the Committee's previous findings at heads of charge 5 (a), 5 (b) (i), 5 (b) (ii), 5 (c) (i), 5 (c) (ii), 5 (d), 5 (e), 5 (f) and 5 (g) above. The Committee finds that your failure to adequately prepare for and plan the treatment that you provided to Patient A on 29 September 2014 led to you providing unnecessary treatment, namely the lifting up of the flap at the upper right quadrant. You then made the discoveries referred to above which could have been seen via non-surgical and invasive means. The Committee again accepts the expert evidence of Mrs Beckett that a proper examination, or even a periapical radiograph, would have avoided the need for surgery. The patient's clinical records recorded the history of the area in question, and the sizeable infection at UR3 which had led to the re-root filling by Ms Ehreth in May 2014, as well as the state of the healing of the UR5 following the root extraction in June 2014, should have been reviewed and should have prompted you to undertake further examinations. The Committee therefore considers that you inappropriately carried out treatment for Patient A on 29 September 2014, and that by having done so you failed to provide an adequate standard of care to her. Accordingly the facts alleged at head of charge 5 (h) are proved.
5. i. i.	Proved
5. i. ii.	Proved
	The Committee finds the facts alleged at heads of charge 5 (I) (i) and 5 (i) (ii) proved. You did not take a periapical radiograph prior to performing surgery on 29 September 2014, and at this hearing you accepted that you should have done. You further conceded that you could have postponed the surgery that was planned for that day if necessary. A periapical radiograph would have revealed the extent of of the healing following the extraction of the root at UR5 three months earlier, and the progress of the healing of the periapical infection at UR3 which was root treated on 28 May 2014. As you

	did not take a periapical radiograph when indicated, you could not, and did not, establish a diagnosis in relation to the UR345. The Committee finds that this amounts to an inadequate standard of care, and that accordingly the facts alleged at heads of charge 5 (i) (i) and 5 (i) (ii) are proved.
5. j	Proved
	The Committee finds the facts alleged at head of charge 5 (j) proved for the same reasons as those given above in respect of head of charge 5 (h).
6.	Proved
	The Committee finds the facts alleged at head of charge 6 proved. The Committee's findings at head of charge 6 follow its findings at heads of charge 5 (a), 5 (b) (i), 5 (b) (ii), 5 (c) (i), 5 (c) (ii), 5 (d), 5 (e), 5 (f), 5 (g), 5 (h), 5 (i) (i), 5 (i) (ii) and 5 (j). The Committee finds that, because of the omissions referred to at those heads of charge, you failed to obtain valid consent for the treatment that you provided to Patient A. The Committee also finds that the consent form that Patient A signed on 29 September 2014 did not relate to the treatment that you provided to her that day, and was of a generic nature.
7. a.	Proved
7. b.	Proved
7. c.	Proved
7. d.	Proved
	The Committee finds the facts alleged at heads of charge 7 (a), 7 (b), 7 (c) and 7 (d) proved. On the date in question, namely 4 February 2015, you extracted the patient's UR2 and UR3, as well as the failed implant at UL4. A new treatment plan was then produced, which provided for further implants and bone grafting in two months' time, as well as crowns and bridgework. Although a conversation, albeit an inadequate one, had previously take place in relation to the infection at UR3 and the need for RCT or extraction, the Committee can see little evidence of you having discussed the treatment that you proposed to provide at the UR2 and UR3 on the specific date in question before that treatment took place. The absence of evidence of a discussion about the need to extract the patient's UR2, presumably because of the large cavity that was present, is particularly apparent. Patient A's evidence is that during the course of treatment on 4 February 2015 you stated to her that you needed to extract her UR2 and UR3 because of the presence of infection. In her written evidence Patient A also stated that you informed her that the implant at UL4 had failed and needed to be removed. There was some discussion of associated costs, and her consent was sought during, and not before, treatment. Following the appointment Patient A states that she asked you to email her with details of exactly what treatment you had provided that day, particularly as she had been under the

	impression that she would receive three further implants. A treatment plan was then sent to her. The Committee concludes that you did not adequately communicate the details of the proposed treatment, including risks, benefits, and alternatives such as dentures, re-root treatment or deferring treatment. The Committee further considers that this amounts to an inadequate standard of care, and accordingly the facts alleged at heads of charge 7 (a), 7 (b), 7 (c) and 7 (d) are proved.
8.	Proved
	The Committee finds the facts alleged at head of charge 6 proved. The Committee's findings at head of charge 6 follow its findings at heads of charge 7 (a), 7 (b), 7 (c) and 7 (d) above. The Committee finds that, because of the omissions referred to at those heads of charge, you failed to obtain valid consent for the treatment that you provided to Patient A.
9. a.	Proved
	The Committee finds the facts alleged at head of charge 9 (a) proved. The Committee accepts the expert evidence of Mrs Beckett, who in her evidence to the Committee stated that although it is not unusual for a number of different practitioners to be involved in patient treatment and care, it is all the more important to work collaboratively and that there are clear lines of responsibility for different aspects of the care. The Committee considers that you failed to work in a sufficiently collaborative manner. You were under a clear duty to collaborate when you knew that you were only providing one aspect of the treatment. For instance, the stabilisation of Patient A's periodontal condition required careful delegation and co-operation before implants were placed. Your failure to collaborate amounts to an inadequate standard of care, and the Committee therefore finds the facts alleged at head of charge 9 (a) proved.
10. a.	Proved
	The Committee finds the facts alleged at head of charge 10 (a) proved. Although the Committee is not satisfied that the GDC has established to the required standard that you were under a duty to treat Patient A's residual infection at the UR3, the Committee considers that you did not ensure that the necessary treatment was appropriately delegated. The patient's clinical notes indicate that you referred Patient A to Ms Ehreth for the necessary treatment, but the evidence presented to the Committee is that you did not follow up on this and ensure that the treatment was provided. You were under a duty to do so, particularly as the treatment that you planned to provide was dependent on the treatment of the residual infection at UR3. The Committee considers that your failure amounts to an inadequate standard of care, and accordingly the facts alleged at head of charge 10 (a) are proved.
11. a.	Proved

11. b.	Proved
11. c.	Proved
11. d.	Proved
11. e.	Proved
11. f.	Proved
11. g. i.	Proved
11. g. ii.	Proved
11. g. iii.	Proved
11. g. iv.	Proved
11. h.	Proved
	The Committee finds the facts alleged at heads of charge 11 (a), 11 (b), 11 (c), 11 (d), 11 (e), 11 (f), 11 (g) (i), 11 (g) (ii), 11 (g) (iii), 11 (g) (iv) and 11 (h) proved on the basis that you made no record at all of the features specified in those heads of charge. The Committee considers that this represents a failure on your part, as you had a responsibility to ensure that the records relating to your treatment of Patient A were adequate, including entries made by others. The Committee considers that its findings at these heads of charge amount to an inadequate standard of record-keeping. The Committee notes that, in respect of heads of charge 11 (g) (i), 11 (g) (ii), 11 (g) (iii) and 11 (g) (iv), there is some information about the surgery that was carried out, but the specific details set out at the sub-heads of charge are not recorded.
11. i.	Proved
11. j.	Proved
	The Committee finds the facts alleged at heads of charge 11 (i) and 11 (k) proved on the basis that your records of your discussions were inadequate. The Committee considers that its findings at these heads of charge amount to an inadequate standard of record-keeping.
11. k.	Not proved
	The Committee finds the facts alleged at head of charge 11 (k) not proved. In approaching this head of charge the Committee has interpreted the term 'complaints' to refer to any formal expression of dissatisfaction that Patient A, or Witness 1 on her behalf, may have had with the treatment that Patient A received from you. Your evidence is that you were not aware of the letters of complaint sent by Witness 1 to the practice, and the GDC has not adduced any evidence to prove that you were. The facts alleged at head of charge 11 (k) are therefore found not proved.
11. l.	Not proved
	The Committee finds the facts alleged at head of charge 11 (l) not proved. The Committee considers that the GDC has demonstrated that you withdrew

	from treating Patient A, and it follows that no associated record-keeping failure could be proved. The facts alleged at head of charge 11 (l) are therefore found not proved.
11. m.	Proved
	The Committee finds the facts alleged at head of charge 11 (m) proved. The IRMER regulations referred to above require that a registrant records a report on radiographic findings. Although the Committee has found at heads of charge 2 (a) (i) and 2 (a) (ii) above that the CT scan was made without sufficient clinical justification, the Committee nonetheless considers that you were under a duty to record your assessment and analysis of the results of the scan. The Committee considers that your failure to do so amounts to an inadequate standard of record-keeping.

We move to stage two."

On 10 November 2017 the Chairman announced the determination as follows:

"Mr Poncz was present at this hearing on 8, 9 and 16 February 2017 only. On those dates he was represented by Mr David Hanis and was assisted by an interpreter, namely Eva Forrai. He was not present, and was not represented, on the other days of the hearing.

Ms Catharine Donnelly of Blake Morgan solicitors appeared for the General Dental Council (GDC) at the factual inquiry stage of the case. Ms Jessica Holmes of the same firm of solicitors appeared for the Council on 7, 8, 9 and 10 November 2017.

Service of notice of resumed hearing

On behalf of the GDC Ms Holmes submitted that notice of this resumed hearing has been properly effected in accordance with the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules'). Ms Holmes stated that as required by Rule 58 (3) a notice of hearing dated 9 October 2017 was sent to Mr Poncz's registered address and other known address in Hungary. The notice set out the date, time and location of the resumed hearing. Ms Holmes submitted that the notice was sent in accordance with Rule 65 of the Rules, having been sent to the registrant using the Royal Mail's Special Delivery postal service and by the International Tracked and Signed postal service. Ms Holmes drew the Committee's attention to the Royal Mail's track and trace entry, which records that the notice was delivered in Hungary on 13 October 2017. She also submitted that a copy of the notice was also sent by email.

The Committee accepted the advice of the Legal Adviser. Having regard to the evidence put before it the Committee was satisfied that service has been properly effected in accordance with the Rules and that all reasonable efforts have been made to inform Mr Poncz of this resumed hearing.

Proceeding in absence

The Committee then went on to consider whether to exercise its discretion to proceed in Mr Poncz's absence in accordance with Rule 54 of the Rules.

The Committee accepted the advice provided by the Legal Adviser. The Committee was mindful that its discretion to hold a hearing in the absence of a registrant should be exercised with the utmost care and caution. After careful consideration the Committee was

satisfied that it would again be appropriate and fair to proceed in Mr Poncz's absence. The Committee considered that Mr Poncz had voluntarily waived his right to attend this resumed hearing. It considered that an adjournment would serve no purpose and noted that no adjournment has been sought. The Committee considered that there is a clear public interest in the expeditious disposal of the case. The Committee was again mindful of the inconvenience that would be caused to other parties, and particularly Ms Ehreth, if the hearing were not to continue. It also considered that the GDC should send a copy of the findings of fact to Mr Poncz on 7 November 2017 and invite any representations that he may wish to make by 1100 hours on 8 November 2017. This would minimise any prejudice to him in not being present, although the Committee was mindful that any prejudice was as a result of Mr Poncz's decision not to attend, and was in any event outweighed by the public interest.

The hearing continued on 9 November 2017 following an adjournment afforded to allow Mr Poncz the opportunity to comment on or respond to the Committee's findings of fact. The Committee was informed that no response was received.

The Committee has considered all the evidence presented to it, both written and oral. It also has taken into account the submissions made by Ms Holmes on behalf of the GDC. The Committee was not provided with any additional evidence relevant to the questions of misconduct, impairment and sanction by Mr Poncz. The Committee reminded itself of the content of Mr Poncz's oral statement that he gave during the course of the factual inquiry, as well as of the content of his earlier written statement which relates to the allegations which have since been found proved. During its deliberations, but before making its findings on misconduct, impairment and sanction, the Committee was provided with a copy of an email which was received whilst the Committee was *in camera* from Mr Poncz. In his email Mr Poncz acknowledged receipt of the Committee's factual findings and asked that he be kept informed of developments at the hearing following those findings. However Mr Poncz's email did not contain any representations.

In its deliberations the Committee has had regard to the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016). The Committee has accepted the advice of the Legal Adviser.

Fitness to practise history

In accordance with Rule 20 (1) (a) of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules') Ms Holmes confirmed that Mr Poncz has no fitness to practise history with the GDC.

Misconduct

The Committee first considered whether the facts that it has found proved constitute misconduct. In approaching this matter the Committee has exercised its own independent judgement.

The Committee has had regard to the following paragraphs of the GDC's *Standards for the Dental Team* (September 2013) in place at the time of the incidents giving rise to the facts. These paragraphs state that as a dentist you must:

1. Put patients' interests first.

1.9 […] find out about laws and regulations that affect your work and follow them.

2. Communicate effectively with patients.

3. Obtain valid consent.

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

6. Work with colleagues in a way that is in patients' best interests.

In light of the findings of fact that it has made, the Committee has concluded that Mr Poncz's conduct fell far short of the standards reasonably expected of a registered dentist. The facts that the Committee has found relate to serious and repeated failings in fundamental aspects of dentistry. Some of the individual failings are serious enough on their own to amount to misconduct. The Committee notes in particular the breach of radiography regulations and the failings which led to performing unnecessary surgery. All of the failings, when viewed cumulatively, amounted to serious, repeated, wide ranging and sustained departures in relation to his assessment, examination and diagnosis of Patient A, pre-treatment investigations and treatment planning, communication with patients and colleagues, radiography, periodontal case management, obtaining of informed consent, treatment of infection and recording keeping. Mr Poncz's acts and omissions placed Patient A at considerable risk of harm. Moreover, by undertaking an invasive and extensive surgical procedure when it was not appropriate to do so, he caused actual harm. In short, Mr Poncz abrogated his responsibility to provide safe and effective care and treatment to Patient A. Accordingly, the Committee has determined that the facts that it has found proved amount to misconduct.

Impairment

The Committee then went on to consider whether Mr Poncz's fitness to practise is currently impaired by reason of the misconduct that it has found. In doing so, the Committee again exercised its independent judgement. Throughout its deliberations, it has borne in mind that its primary duty is to address the public interest, which includes the protection of patients, the maintenance of public confidence in the profession and in the regulatory process, and the declaring and upholding of proper standards of conduct and behaviour.

The Committee considers that Mr Poncz's misconduct is capable of being remedied. However, other than limited concessions that Mr Poncz has previously made in relation to the standard of his record-keeping, the Committee has not been provided with any evidence to suggest that Mr Poncz has insight into the deficiencies in his practice or his responsibilities and accountability, or that he has taken steps to acknowledge, address and remedy the serious shortcomings that it has identified. Mr Poncz previously attended three days of this hearing but has subsequently disengaged from these proceedings, save for the email of 8 November 2017 referred to above. As noted above he has been afforded the opportunity to provide the Committee with information and evidence relevant to the question of current impairment. He has provided no such information about any remedial measures, or of any insight into conduct which is so damaging to his fitness to practise. Mr Poncz gave a statement to the Committee at the factual inquiry stage. This statement demonstrated a fundamental lack of appreciation of the seriousness and significance of his shortcomings when treating Patient A. Mr Poncz's response to the allegations was instead characterised by his avoidance of responsibility.

The Committee is mindful that no previous issues had been identified with Mr Poncz's practice and that these failings involved a single patient and episode of treatment in a difficult clinical setting. However, in the absence of any evidence of insight or remediation, the Committee considers that there is a real and ongoing risk of repetition of the acts and

omissions that caused harm to Patient A, and which also placed her at further risk of harm. The Committee therefore considers that Mr Poncz's fitness to practise is currently impaired.

The Committee also considers that a finding of impairment is further required to maintain public confidence in the profession and in the regulatory process, and to declare and uphold proper professional standards. It considers that trust and confidence in the profession would be undermined if a finding of impairment were not made in this case.

Sanction

The Committee then determined what sanction, if any, would be appropriate in light of the findings of facts, misconduct and impairment that it has made. The Committee recognises that the purpose of a sanction is not punitive, although it may have that effect, but is instead imposed in order to protect patients and safeguard the wider public interests referred to above.

In reaching its decision the Committee has again taken into account the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016). The Committee has applied the principle of proportionality, balancing the public interest with Mr Poncz's own interests.

The Committee has had regard to the mitigating and aggravating factors in this case. In terms of mitigation, the Committee notes the difficult circumstances in which Mr Poncz was working at the time, namely for a practice whose sites were split between London and Budapest and where a number of individuals were involved in making arrangements for Patient A's treatment. The Committee has also heard that Mr Poncz is otherwise of good character with no previous fitness to practise history with the GDC. The Committee also notes that a number of years have passed since the incidents giving rise to these proceedings, and that the case, whilst serious, relates to one patient.

There are however a number of aggravating factors present in this case. Mr Poncz's acts and omissions caused actual harm to a patient, and also placed her at a further risk of harm. His misconduct was serious and repeated, and he has not shown insight into his failings. His conduct also suggests a disregard for the systems regulating the safe practice of dentistry, more particularly the IRMER regulations referred to in the Committee's factual determination.

The Committee has considered the range of sanctions available to it, starting with the least serious. In the light of the findings made against Mr Poncz, the Committee has determined that it would not be appropriate to conclude this case by taking no action or by imposing a reprimand. The Committee has determined that, as Mr Poncz has not provided any information to suggest that he has developed insight into his misconduct, or has taken any steps to remedy that misconduct, the acts and omissions which the Committee have identified are liable to recur. Therefore, the Committee has determined that no action or a reprimand would fail to provide the necessary degree of protection for the public. The Committee also considers that no action, or a reprimand, would undermine public confidence and trust in the profession and would be insufficient to declare and uphold proper standards of conduct and behaviour.

The Committee next considered whether a period of conditional registration would be appropriate. Although the misconduct that the Committee has found is capable of being remedied, Mr Poncz is not now engaging with these proceedings in any meaningful or constructive way. The Committee in particular notes that there is a lack of information about his current whereabouts and employment circumstances, and a lack of evidence of insight or

remediation. The Committee is therefore not able to formulate conditions as it cannot be satisfied that Mr Poncz would be able or willing to comply with any such conditions. A period of conditional registration would therefore not meet the risks arising from Mr Poncz's unremedied conduct. The Committee also considers that such a sanction would therefore also be insufficient to maintain trust and confidence in the profession, as the public would be concerned if a sanction were imposed which would not provide adequate protection. A higher sanction is therefore also required for public interest considerations.

The Committee then went on to consider whether to suspend Mr Poncz's registration. The Committee has found that Mr Poncz's conduct was repeated, that he has not shown significant insight into his misconduct and that he continues to pose a significant risk to patients. The Committee does not consider that Mr Poncz has a deep-seated personality or attitudinal problem which might make erasure the appropriate sanction.

The Committee has determined that Mr Poncz's name should be suspended from the register. It has concluded that a lesser sanction would not provide the necessary degree of protection for the public or safeguard the public interest. The Committee gave consideration to whether the higher sanction of erasure was appropriate, but considered that public protection and confidence and trust in the profession and in the regulatory process could be secured by a period of suspension. An order of erasure would therefore be disproportionate.

The Committee has determined, and hereby directs, that Mr Poncz's registration be suspended for a period of 12 months. It considers that this period of time is necessary to mark the seriousness of the Committee's findings of facts, misconduct and impairment. Such a period of time would also be needed for Mr Poncz to develop and demonstrate sufficient insight into, and remediation of, his misconduct. The Committee further directs that this period of suspension be reviewed prior to its expiry.

Although the Committee in no way wishes to bind the Committee which will review this suspension 12 months hence, it considers that the reviewing Committee may be assisted by seeing evidence of Mr Poncz having developed insight and undertaken remediation in the key areas of his practice as referred to above. This might include, but is not limited to, a targeted personal development plan (PDP), focussed continuing professional development (CPD), and testimonial letters.

Existing interim order

In accordance with Rule 21 (3) of the Rules and section 27B (9) of the Dentists Act 1984 (as amended) the interim order of conditions in place on Mr Poncz's registration is hereby revoked.

Immediate order of suspension

Having directed that Mr Poncz's registration be suspended, the Committee has considered whether to impose an order for his immediate suspension in accordance with section 30 (1) of the Dentists Act 1984 (as amended).

The Committee has heard the submissions made by Ms Holmes on behalf of the GDC that an immediate order is necessary for the purposes of protecting the public and is otherwise in the public interest. Mr Poncz has been afforded the opportunity to make submissions on the question of an immediate order, but the Committee has been informed that Mr Poncz has not responded.

The Committee has determined that it is necessary for the protection of the public and is otherwise in the public interest to impose an order for immediate suspension. It has decided that, given the risk of harm that it has identified, it would not be appropriate to allow Mr Poncz to practise until the substantive order takes effect. The Committee considers that an immediate order for suspension is proportionate to the risks identified and is consistent with the findings that the Committee has set out in its determination.

The effect of the foregoing determination and this immediate order is that Mr Poncz's registration will be suspended from the date on which notice of this decision is deemed served upon him. Unless he exercises his right of appeal, the substantive direction of suspension will be recorded in the Dentists' Register 28 days from the date of deemed service. Should he so decide to exercise his right of appeal, this immediate order of suspension will remain in place until the resolution of any appeal.

That concludes this case."

At a review hearing on 23 November 2018 the chairman announced the determination as follows:

Decision on service of the Notification of Hearing

"The Committee considered whether notice of the hearing had been served on Mr Poncz in accordance with Rules 28 and 65 of the *General Dental Council (Fitness to Practise) Rules 2006* (the 'rules'). It received a bundle of documents containing a copy of the Notification of Hearing letter, dated 19 October 2018, and a Royal Mail 'Track and Trace' receipt confirming that the letter was sent to Mr Poncz's registered address by Special Delivery. A copy of the letter was also sent to him by email.

The Committee was satisfied that the letter contained proper notification of today's review hearing, including its time, date and venue, as well as notification that the Committee had the power to proceed with the hearing in Mr Poncz's absence. On the basis of the information provided, the Committee was satisfied that notice of the hearing had been served on Mr Poncz in accordance with the Rules.

Decision on proceeding with the hearing in the absence of Mr Poncz

The Committee next considered whether to exercise its discretion under Rule 54 of the Rules to proceed with the hearing in the absence of Mr Poncz. It approached this issue with the utmost care and caution. The Committee took into account the factors to be considered in reaching its decision as set out in the case of *R v Jones [2003] 1 AC 1HL*. It remained mindful of the need to be fair to both Mr Poncz and the GDC, and it had regard to the public interest in the expeditious review of the suspension order in place on Mr Poncz's registration.

The Committee noted from the Notification of Hearing letter of 19 October 2018 that Mr Poncz was asked to confirm by 12 November 2018, whether he would be attending today's hearing and/or whether he would be represented. On 19 October 2018 an email was sent to Mr Poncz using an email address held for him by the GDC. In that email, Mr Poncz was sent a copy of the Notification of Hearing letter. He was asked again to confirm whether he would be attending today's hearing and whether he would be legally represented. Mr Poncz was also informed that if he was unable to attend in person, he could request to attend remotely by Skype or by telephone. Mr Poncz responded via email dated 5 November 2018 confirming that *"This is to confirm that I am unable to attend the hearing either in*

person or via Skype. I have no objection to proceeding on the papers in the absence of both parties."

The information before the Committee shows Mr Poncz has indicated that he will not be travelling from Hungary to attend in person nor will he attend remotely; he did not request an adjournment and expressed his agreement for the hearing to be heard in his absence on the papers.

The Committee therefore concluded that Mr Poncz had voluntarily absented himself from today's proceedings. It decided that an adjournment was unlikely to secure his attendance on a future date.

In all the circumstances, the Committee determined that it was fair and in the public interest to proceed with the hearing in the absence of Mr Poncz and/or any representative on his behalf.

Background to Mr Poncz's case

Mr Poncz's case was first considered by the PCC at a hearing in November 2017. That Committee considered and found proved allegations in relation to the standard of care Mr Poncz provided to Patient A in the period of 20 May 2014 to 4 March 2015. The incidents giving rise to the allegations occurred whilst he was working at the Forest & Ray Dental Practice in central London.

> *"The GDC alleges that, on or around 20 May 2014 and before you first saw the patient some weeks later, you caused or allowed a referral for a computerised tomography (CT) examination to be made in the absence of your clinical examination of the patient and, accordingly, without adequate clinical justification. It is also contended that the referral was made by an individual who was not authorised to do so.*
>
> *It is also contended that, at the first appointment that you had with Patient A on 17 June 2014, you did not obtain or update, adequately or at all, Patient A's medical history, and did not, adequately or at all, assess and examine Patient A in a number of specific respects. It is further alleged that at that same appointment you did not discuss with the patient, adequately or at all, details of the proposed treatment, including risks, costs and benefits, or such details of alternative treatment options. The GDC alleges that you did not ensure that Patient A understood the proposed treatment, and therefore that you did not obtain valid consent. It is also alleged that you did not stabilise the patient's periodontal condition before undertaking implant surgery, that you did not plan the treatment, either adequately or at all, and inappropriately carried out treatment.*
>
> *Patient A's appointment with you on 29 September 2014 has also given rise to a number of allegations. It is alleged that you did not assess and examine her in a number of respects, either adequately or at all, and that you did not properly plan, discuss and undertake the treatment that you provided. It is alleged that some of these failures amounted to a failure to obtain valid consent, and it is also contended that the surgery that you performed was avoidable. Further patient discussion and consent issues have been raised in respect of the appointment that took place on 4 February 2015, with particular regard to proposed treatment and options for treatment.*
>
> *As well as record-keeping failures associated with your care and treatment of Patient A in respect of the matters referred to above, it is also alleged that you did not collaborate, adequately or at all, with other members of the dental team who were*

involved in her care, and that you did not treat the residual infection at the UR3, or alternatively ensure appropriate delegation of the required treatment to your colleagues."

The Committee that sat in November 2017 considered that the breaches of the GDC's standards, as highlighted by its findings, were serious, concerned basic and fundamental areas of dentistry and were capable of putting patients at risk and undermining public confidence in the profession.

That Committee found that the facts found proved against Mr Poncz amounted to misconduct and it determined that his fitness to practise was impaired by reason of that misconduct. In its determination on impairment, that Committee stated as follows:

"The Committee considers that Mr Poncz's misconduct is capable of being remedied. However, other than limited concessions that Mr Poncz has previously made in relation to the standard of his record-keeping, the Committee has not been provided with any evidence to suggest that Mr Poncz has insight into the deficiencies in his practice or his responsibilities and accountability, or that he has taken steps to acknowledge, address and remedy the serious shortcomings that it has identified. Mr Poncz previously attended three days of this hearing but has subsequently disengaged from these proceedings, save for the email of 8 November 2017 referred to above. As noted above he has been afforded the opportunity to provide the Committee with information and evidence relevant to the question of current impairment. He has provided no such information about any remedial measures, or of any insight into conduct which is so damaging to his fitness to practise."

That Committee also took into account the wider public interest and it concluded that to make a finding of no current impairment would send a message to the public and the profession that Mr Poncz's conduct was acceptable.

The Committee in November 2017 determined to suspend Mr Poncz's registration for a period of 12 months and imposed an immediate order of suspension. It directed a review of his case prior to the end of the 12-month period. In doing so, it stated that the reviewing Committee may be assisted by seeing evidence of Mr Poncz having developed insight and undertaken remediation in the key areas of his practice where he had failed. It considered this might include, but was not limited to, a targeted personal development plan (PDP), focussed continuing professional development (CPD), and testimonial letters.

Today's review

In comprehensively reviewing Mr Poncz's case today, the Committee considered all the evidence before it. It took account of the written submissions made by the GDC and accepted the advice of the Legal Adviser. No material or written submissions were received from, or on behalf of, Mr Poncz.

The Committee noted that there is no evidence that Mr Poncz has practised dentistry in the UK in contravention of his current suspension order. It noted that to date, there is no evidence that Mr Poncz has remedied any of the failings identified by the previous Committee. It noted there was no evidence of Mr Poncz's engagement with the GDC subsequent to the suspension order, save for his email of 5 November 2018, where he stated he was content for the hearing to proceed in his absence. The Committee also noted that in earlier correspondence, including emails of 22 March 2017 and 15 September 2017, he stated that he did not intend to return to the UK to continue practising.

Decision on impairment

In reaching its decision on whether Mr Poncz's fitness to practise remains impaired, the Committee exercised its own independent judgement. It had regard to the over-arching objective of the GDC, which involves: the protection, promotion and maintenance of the health, safety and well-being of the public; the promotion and maintenance of public confidence in the dental profession; and the promotion and maintenance of proper professional standards and conduct for the members of the dental profession.

The Committee considered that Mr Poncz's clinical failings, as found by the initial PCC, were serious, concerned basic and fundamental areas of dentistry and were capable of undermining public confidence in the dental profession. They also resulted in actual patient harm.

This Committee accepted the advice of the Legal Adviser regarding the case of *Abrahaem v GMC [2008] EWHC 183 (Admin)* to the effect that there is a persuasive burden on Mr Poncz to demonstrate that he has addressed his past impairment.

The information before this reviewing Committee today indicates that Mr Poncz has failed to engage meaningfully with the GDC, and it has received no evidence to indicate that he has remedied his failings or that the risk of repetition is reduced.

In this Committee's view, it has no material before it to demonstrate that Mr Poncz has developed insight into the concerns identified at the hearing in November 2017. Taking this and the absence of any evidence of remediation into account, this Committee concluded that the serious clinical concerns must remain.

Having reviewed all the information before it, the Committee continues to be concerned that there remains a risk of repetition. In all the circumstances, the Committee decided that a finding of current impairment is necessary for the protection of the public. The Committee also decided that public confidence in the dental profession would be undermined if such a finding were not made in the circumstances of this case.

Accordingly, the Committee has determined that the position is little different than it was at the time of Mr Poncz's substantive PCC hearing in November 2017. In the circumstances, it determined that Mr Poncz's fitness to practise remains impaired.

Decision on Sanction

The Committee considered what action, if any, to take in respect of Mr Poncz's registration. It had regard to its powers under Section 27C(1) of the *Dentists Act 1984 (as amended)*, which sets out the options available to it. The Committee took into account that the purpose of any sanction is not to be punitive, although it may have that effect, but to protect patients and the wider public interest.

The Committee had regard to the '*Guidance for the Practice Committees including Indicative Sanctions Guidance (effective from October 2016)*'. It applied the principle of proportionality, balancing the public interest with Mr Poncz's own interests. It considered the available sanctions in ascending order.

In the light of the Committee's outstanding concerns about public safety, it determined that it would be wholly inappropriate to terminate the current suspension order or to allow it to lapse. It decided that some ongoing restriction of Mr Poncz's registration is necessary to safeguard the public and to uphold the wider public interest.

The Committee next considered whether to terminate Mr Poncz's suspension order and replace it with an order of conditions. However, the Committee concluded that conditional registration would not be suitable in this case, where the registrant is not practising in the UK and has no intention to do so. It therefore determined that the imposition of conditions would not be appropriate or workable.

In all the circumstances, the Committee determined to extend the period of the suspension order on Mr Poncz's registration. This Committee has found that he has failed to engage meaningfully with the GDC and the remedial process. As a result, the failings identified in his practice remain a real concern. In view of this, the Committee concluded that members of the public and the wider public interest would not be sufficiently protected by a lesser sanction than suspension.

The Committee has decided to extend the suspension order by a period of 12 months. In deciding on this period, the Committee took into account the absence of any evidence of progress made by Mr Poncz since the findings made against him in November 2017. It considered that a significant amount of engagement and remediation will now be required on his part to address all the identified failings. The Committee concluded that a 12-month suspension would afford him such an opportunity, whilst ensuring that members of the public and the wider public interest remain protected adequately.

A Committee will review Mr Poncz's case at a resumed hearing to be held shortly before the end of the extended period of suspension. That Committee will consider whether it should take any further action in relation to his registration. He will be informed of the date and time of that resumed hearing.

As suggested by the previous Committee, the next reviewing Committee would be assisted by:

- *demonstration from Mr Poncz that he has engaged with the GDC as his regulator;*
- *evidence of a PDP, relevant CPD courses and a reflective piece;*
- *evidence that Mr Poncz has developed insight into the concerns identified by the Committee; and*
- *evidence that Mr Poncz has taken steps to remedy his failings.*

Unless Mr Poncz exercises his right of appeal, his current suspension order will be extended by a period of 12 months, 28 days from the date when notice of this Committee's direction is deemed to have been served upon him. In the event that Mr Poncz does lodge an appeal against this decision, the current suspension order will continue to remain in force until the appeal has been decided.

That concludes this determination."

At the review hearing on 13 November 2019 the chairman announced the determination as follows:

Service of Notice of Hearing

"This is a Professional Conduct Committee (PCC) review hearing of Mr Poncz's case, listed for 13 November 2019, which is being held in accordance with Section 27C of the Dentists Act 1984 (the Act). Mr Poncz is neither present nor represented at the hearing. In his absence, the Committee first considered whether the Notice of Hearing had been served on Mr Poncz in accordance with Rule 28 and 65 of the GDC (Fitness to Practise) Rules Order of Council 2006 (the Rules) and Sections 50A(2) of the Act. In so doing, the Committee has had regard to the General Dental Council's (GDC) undated written submissions. The Committee has accepted the Legal Adviser's advice.

The Committee has seen a copy of the Notice of Hearing dated 18 September 2019, addressed to Mr Poncz at his registered address in England. The Committee is satisfied that the Notice of Hearing contains the information required by Rule 28, including the date, time and venue of the review hearing, his right to attend and the purpose of the hearing. The letter also asked Mr Poncz to notify the GDC as to whether he intended to attend the hearing and/or be legally represented. The Royal Mail track and trace receipt confirms that the item was delivered to Mr Poncz's registered address in England on 23 September 2019 but was returned, marked "addressee gone away".

The Committee also notes that the Notice of Hearing, containing the same information as the letter sent to his registered address in England, was sent by recorded airmail to Mr Poncz's last known address, which is in Hungary. The GLS parcel tracking receipt and the Royal Mail track and trace receipt confirm that attempts were made to deliver the item on 26 September 2019, but it was unable to do so as the recipient refused acceptance. However, the Committee is aware that the GDC is only required to demonstrate that it has sent the Notice of Hearing to the Registrant and is not required to show that it has arrived.

In the light of all of the documents, the Committee is satisfied that the Notice of Hearing was sent to Mr Poncz's registered address, as well as his last known address, more than 28 days in advance of today's hearing. In addition, the Committee has seen a copy of an email dated 18 September 2019 from the GDC to Mr Poncz, attaching a copy of the Notice of Hearing and the bundle.

Having regard to all the documents before it the Committee is satisfied that the requirements of service have been met in accordance with the Rules and the Act.

Proceeding in the absence of Mr Poncz

The Committee went on to consider whether to proceed in the absence of Mr Poncz and the GDC and on the basis of the papers, in accordance with Rule 54. The GDC, in their undated written submissions, refer to the further efforts made by the GDC on 30 September 2019 and 14 October 2019 to contact Mr Poncz and find out from him whether he would be attending the hearing and/or whether he would be represented and/or had the ability to attend via skype. Further, the Notice of Hearing letter dated 18 September 2019 advised Mr Poncz that the GDC intended for the hearing to be held on the papers and invited him to contact the GDC by 25 September 2019 if he wished the hearing to take place by way of oral representations. The GDC has received no response from Mr Poncz.

The Committee has considered the submissions made by the GDC. It notes the absence of any response from Mr Poncz in respect of the Notice of Hearing or indeed subsequent attempts by the GDC to contact him. In these circumstances, the Committee has concluded that Mr Poncz has voluntarily absented himself from today's hearing. In addition, the Committee considers that there is a clear public interest in reviewing the order today, given that it is due to expire on or around 12 December 2019. Accordingly, the Committee has determined that it is fair to proceed with today's review hearing on the basis of the papers and in the absence of both parties.

Background to Mr Poncz's case

Mr Poncz's case was first considered by the PCC in February 2017. It adjourned, part-heard, on 17 February 2017. It resumed on 4 April 2017 and adjourned once again on 6 April 2017. The hearing resumed on 7 November 2017. That PCC considered and found proved allegations in relation to the standard of care Mr Poncz provided to Patient A from 20 May 2014 to 4 March 2015. The incidents giving rise to the allegations occurred whilst he was working at the Forest & Ray Dental Practice in central London. The PCC found the majority of the charges proved. It also determined that the findings of fact amounted to conduct that fell short of the standards reasonably expected of a registered dentist. In the PCC's view, they amounted to breaches of the GDC's standards, which were serious, concerning basic and fundamental areas of dentistry and were capable of putting patients at risk and undermining public confidence in the profession.

The PCC was of the view that Mr Poncz's misconduct was capable of being remedied. However, other than limited concessions that Mr Poncz had made previously in relation to the standard of his record-keeping, the PCC was not provided with any evidence to suggest that Mr Poncz had insight into the deficiencies in his practice or his responsibilities and accountability, or that he had taken steps to acknowledge, address and remedy the serious shortcomings identified. Further, although Mr Poncz had previously attended three days of the hearing, he subsequently disengaged. In the absence of evidence of insight or remediation, the PCC considered that there was an ongoing risk of repetition of the acts and omissions that had caused harm to Patient A. The PCC determined that Mr Poncz's fitness to practise was impaired by reason of his misconduct. The PCC also considered that a finding of impairment was necessary in the wider public interest so as to declare and uphold proper professional standards.

The PCC in November 2017 determined to suspend Mr Poncz's registration for a period of 12 months and imposed an immediate order of suspension. It was satisfied that 12 months was sufficient to mark the seriousness of the PCC's findings of fact, misconduct and impairment. The PCC also directed a review of Mr Poncz's case prior to the expiry of the 12-month period. It stated that the reviewing Committee may be assisted by seeing evidence of Mr Poncz having developed insight and undertaken remediation in the key areas of his practice where he had failed. It suggested that this might include a targeted personal development plan (PDP), focussed continuing professional development (CPD) as well as testimonial letters.

The first review of the order took place at a PCC hearing on 23 November 2018. Mr Poncz was neither present nor represented, having notified the GDC by email dated 5 November 2018 that he would not be able to attend in person or participate via skype. Mr Poncz did not request an adjournment and indicated that he was content for the hearing to be heard in his absence on the papers. The PCC hearing therefore took place on the papers.

At that hearing, the PCC noted that there was no evidence that Mr Poncz has practised dentistry in the UK. It also noted that there was no evidence that Mr Poncz had remedied any of the failings identified by the previous PCC. It noted there was no evidence of Mr Poncz's engagement with the GDC subsequent to the suspension order, save for his email of 5 November 2018, where he stated he was content for the hearing to proceed in his absence. The PCC also noted that in earlier correspondence, including emails of 22 March 2017 and 15 September 2017, he stated that he did not intend to return to the UK to continue practising.

The PCC in November 2018 considered that there had been no material change since the initial PCC hearing in November 2017 to demonstrate that Mr Poncz had developed insight into his misconduct. In these circumstances, the PCC concluded that the serious clinical concerns remained. It determined that a finding of current impairment was necessary for the protection of the public. The PCC also determined that public confidence in the dental profession would be undermined if such a finding were not made in the circumstances of this case.

In the PCC's judgement, the position was little different from that before the PCC at the initial hearing of Mr Poncz's case. It concluded that a further period of suspension of 12 months would afford Mr Poncz an opportunity to address the failings identified. It also echoed the initial PCC's recommendations as to the information which would assist a reviewing PCC.

Today's review

At today's hearing this Committee has comprehensively reviewed the current order. In so doing, the Committee has had regard to the GDC bundle. This contains copies of letters and emails from the GDC's Case Review Team to Mr Poncz, reminding him of the recommendations made by the PCC . There has been no response from Mr Poncz, despite repeated attempts by the GDC to seek his engagement. There is no evidence of any insight, reflection or remediation of the failings identified by the PCC in 2017.

The GDC's position is that Mr Poncz's fitness to practise remains impaired. In support of that contention, it refers to Mr Poncz's lack of engagement with the GDC and the absence of any evidence of remediation or insight, or of any response to the recommendations made by the PCC.

In terms of sanction, the GDC says that it has concerns with regard to the imposition of an order of conditions on Mr Poncz's registration, given his lack of engagement with the GDC. It further says that given Mr Poncz's lack of engagement with the GDC and the absence of any evidence of insight or remediation from him, nothing would be gained by extending the period of suspension for a period of 12 months. It submits that it would be open to this Committee to consider imposing an indefinite suspension on Mr Poncz's registration and advises that it had reminded Mr Poncz of its intention to seek this direction. The GDC refers to the dates when Mr Poncz's registration was first suspended and then further suspended. It submits that the provisions of 27C(1)(d)(i) and (ii) of the Act have been met, given that he will have been suspended for two years from the date in which the direction is likely to take effect.

The Committee considered carefully the submissions made. Throughout its deliberations, it has borne in mind that its primary duty is to address the public interest, which includes the protection of patients, the maintenance of public confidence in the profession and in the regulatory process, and the declaring and upholding of proper standards of conduct and behaviour. The Committee has accepted the advice of the Legal Adviser.

The Committee has been referred to the case of *Abrahaem v General Medical Council [2008] EWHC 183 (Admin)* where it was held at paragraph 23 that "there is a persuasive burden on the practitioner at a review to demonstrate that he or she has fully acknowledged why past professional performance was deficient and through insight, application, education, supervision or other achievement sufficiently addressed the past impairments."

There is no evidence before this Committee that Mr Poncz has addressed any of the deficiencies identified by the PCC at the initial hearing November 2017 or at the review hearing in November 2018, despite being given the opportunity to do so. Further, Mr Poncz's engagement with the GDC throughout the two years when his registration has been suspended has been extremely limited. In the absence of any evidence to show any material change in circumstances since the last hearing, the Committee considers that Mr Poncz remains a risk to the public. Accordingly, it has determined that his fitness to practise remains impaired.

The Committee next considered what direction to give. In so doing, it has had regard to the GDC's "Guidance for the Practice Committees including Indicative Sanctions Guidance" (October 2016, updated May 2019). It has had regard to the GDC's written submissions.

In the Committee's judgement, Mr Poncz has not demonstrated any commitment to remediate his deficiencies or engage with the GDC, despite being given the opportunity to do so. In these circumstances, the Committee concluded that terminating the current suspension order would not be appropriate or sufficient for the protection of the public.

The Committee considered whether to replace the current suspension order with one of conditions. In so doing, it had regard to the absence of any evidence of remediation from Mr Poncz and his extremely limited engagement with his regulator over the last two years, with no indication that he would engage in the future. In these circumstances, the Committee is not satisfied that conditions are appropriate, workable or sufficient for the protection of the public.

The Committee then went on to consider whether to direct that the current period of suspension be extended for a further period. It has borne in mind Mr Poncz's continuing lack of engagement with the GDC over a long period of time, despite being given the opportunity to do so, as well as the absence of any insight or remediation. Indeed, Mr Poncz's decision not to participate at any of these proceedings over the last two years has exacerbated the situation. In these circumstances, the Committee has concluded that a further period of suspension of 12 months would serve no useful purpose and not be in Mr Poncz's interests.

Accordingly, the Committee directs that Mr Poncz's registration be suspended indefinitely. Having careful regard to the dates when Mr Poncz's registration was first suspended and the extension of that order, the Committee is content that the provisions of Sections 27C(1)(d)(i) and (ii) of the Act are met. It is satisfied that this is the proportionate and appropriate outcome whilst ensuring that members of the public and the wider public interest remain protected adequately.

The effect of the foregoing direction is that, unless Mr Poncz exercises his right of appeal, his registration will be suspended indefinitely from the date on which the direction takes effect. The intervening period between the current order expiring and the new order coming into effect will be covered by the extension of the current order of suspension.

That concludes this case for today."