

**HEARING HEARD IN PUBLIC**

**MORENO CORREIA, Eva Catarina**

**Registration No: 101507**

**PROFESSIONAL PERFORMANCE COMMITTEE**

**MAY 2015 – MAY 2017**

**Most recent outcome: Suspended indefinitely \*\***

\*\* See page 25 for the latest determination.

Eva Catarina MORENO CORREIA, a dentist, LMD Portugal 2004 was summoned to appear before the Professional Performance Committee on 6 May 2015 for an inquiry into the following charge:

**Charge (as amended on 6 May 2015)**

“That, being a registered dentist:

1. At all material times you practised dentistry at the Padiham Road Dental Practice, 361 Padiham Road, Burnley, Lancashire, BB12 6SX where you provided dental care and treatment to Patients A, B, C, D, E, F, G, H, I, J, K and M as set out in Schedule 1<sup>1</sup>.
2. Your care and treatment of Patient A was inadequate, in that you:
  - a. failed to provide an adequate standard of care in respect of crown work at UR2;
  - b. failed to diagnose and/or provide adequate treatment for caries at LL6 in a timely manner after 28 July 2009;
  - c. placed an inadequate amalgam filling at UL6 on 3 November 2009;
  - d. failed to carry out and/or record basic periodontal examinations at appropriate intervals;
  - e. failed to make any, or any adequate, record of discussions regarding available treatment options and their risks and benefits.
3. Your care and treatment of Patient B was inadequate, in that you:
  - a. failed to adequately monitor the patient’s periodontal condition;
  - b. failed to provide adequate periodontal treatment;
  - c. inappropriately prescribed antibiotics on 27 November 2008;
  - d. took radiographs that were of inadequate diagnostic quality on or around 17 May 2007;
  - e. failed to retake each of the radiographs at paragraph 3d above;
  - f. failed to make any, or any adequate, record of:

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<sup>1</sup> Please note that the schedule is a private document and cannot be disclosed

- i. full details of the teeth treated on each of 27 November 2008, 1 December 2009 and 30 March 2013;
    - ii. discussions regarding available treatment options and their risks and benefits.
4. Your care and treatment of Patient C was inadequate, in that you:
  - a. failed to provide an adequate standard of care in respect of restorative work at UL1;
  - b. withdrawn by the GDC
  - c. took radiographs that were of inadequate diagnostic quality on or around each of 15 July 2010 and 10 August 2010;
  - d. failed to retake each of the radiographs at paragraph 4c above;
  - e. failed to provide adequate caries preventative care;
  - f. inappropriately prescribed antibiotics on each of 26 July 2007, 5 July 2010 and 15 July 2010.
5. Your care and treatment of Patient D was inadequate, in that you:
  - a. inappropriately prescribed antibiotics on each of 10 July 2007, 16 July 2007 and 20 October 2011;
  - b. failed to carry out and/or record basic periodontal examinations at appropriate intervals prior to 4 August 2010;
  - c. failed to provide an adequate standard of care in respect of:
    - i. crown work at UL3;
    - ii. root canal treatment at LR7;
    - iii. restorative work at LL1;
  - d. failed to take appropriate radiographs:
    - i. to investigate the patient's complaints of pain after extraction of UL2 in June 2007 and/or of UR4 in July 2007;
    - ii. after completing root canal treatment at LR7 in June 2008;
  - e. failed to make any, or any adequate, record of discussions regarding available treatment options and their risks and benefits.
6. Your care and treatment of Patient E was inadequate, in that you failed to provide adequate periodontal treatment.
7. Your care and treatment of Patient F was inadequate, in that you:
  - a. failed to carry out and/or record basic periodontal examinations at appropriate intervals;
  - b. failed to provide an adequate standard of care in respect of crown work at UR5.
8. Your care and treatment of Patient G was inadequate, in that you:

- a. failed to provide an adequate standard of care in respect of restorative work at LL2;
  - b. failed to carry out and/or record basic periodontal examinations at appropriate intervals prior to 24 March 2011.
9. Your care and treatment of Patient H was inadequate, in that you:
  - a. failed to diagnose and/or adequately manage an apical radiolucency at LR6;
  - b. failed to provide an adequate standard of care in respect of root canal treatment at LR7;
  - c. failed to carry out and/or record basic periodontal examinations at appropriate intervals;
  - d. failed to make any, or any adequate, record of:
    - i. your justification for providing tooth whitening treatment on 25 April 2012 given the state of the patient's dentition at that time;
    - ii. your justification for not completing root canal treatment at LR7 in 2012;
    - iii. the details of treatments provided in 2012;
10. Your care and treatment of Patient I was inadequate, in that you:
  - a. failed to provide an adequate standard of care in respect of:
    - i. crown work at UL5;
    - ii. root canal treatment at UR6;
  - b. Withdrawn by the GDC.
11. Your care and treatment of Patient J was inadequate, in that you:
  - a. failed to adequately investigate tenderness reported by the patient on 2 June 2011 following extraction of UR2;
  - b. failed to carry out and/or record basic periodontal examinations at appropriate intervals prior to 24 May 2012;
  - c. failed to provide adequate periodontal treatment;
  - d. failed to make any, or any adequate, record of your proposed treatment plan on 10 March 2010.
12. Your care and treatment of Patient K was inadequate, in that you:
  - a. failed to carry out and/or record basic periodontal examinations at appropriate intervals prior to 14 June 2012;
  - b. failed to make any, or any adequate, record of a report on the radiograph you took on or around 19 July 2010.
13. Your care and treatment of Patient M was inadequate, in that you:
  - a. failed to provide and/or record the provision of oral hygiene advice between approximately 5 February 2009 and 5 July 2012;
  - b. failed to assess and/or record an assessment of the patient's caries risk status.

And that, in consequence of the matters set out above, your fitness to practise is impaired by reason of your misconduct or deficient professional performance.”

As Ms Moreno Correia did not attend and was not represented at the hearing, the Chairman made the following statement regarding preliminary matters and proof of service. He addressed this to the Counsel for the GDC.

### **Preliminary matters**

“Mr Singh: You are representing the General Dental Council (GDC) at the Professional Performance Committee (the Committee) hearing of Miss Moreno Correia. Prior to the hearing commencing, Mr Johnstone, the Chair of the Committee informed parties that he knew Witness 1 in a professional capacity in that they both work as Clinical Support Managers for My Dentist for different areas in the North of England under the same Clinical Directors. He confirmed that he did not work with Witness 1 and that he had not spoken to her about this case. Mr Johnstone clarified that he had met Witness 1 in a professional capacity on three occasions at Clinical Support Managers Meetings, where a number of delegates had also attended. You sought instructions on whether the Chair’s knowledge of Witness 1 in the circumstances he described would prevent him from chairing this hearing, given that it could raise a question as to a possible bias. You confirmed that that the GDC had raised no objections to the Chair remaining in his role for this hearing, given that his professional connection with Witness 1 was limited. You also made the point that Witness 1’s evidence relates to background matters in this case where her credibility as a witness is not an issue.

The Committee has had regard to the submissions you have made on behalf of the GDC. It has accepted the advice of the Legal Adviser. It is aware that at all times it must be impartial and must be perceived to be so by a fair minded and well informed observer. The Committee is satisfied that the Chair’s professional connection with Witness 1 is of limited basis such that it could not give rise to a perception of bias by a fair minded and well informed observer, or indeed make him bias by virtue of that connection. Furthermore, it notes that Witness 1’s evidence relates to background matters, where her credibility is not an issue. Accordingly, the Committee has concluded that it is appropriate for Mr Johnstone to continue to Chair this hearing.

### **Service and decision to proceed in absence**

Miss Moreno Correia is neither present nor represented at her hearing. In her absence, the Committee first considered whether the notification of hearing had been served on Miss Moreno Correia in accordance with Rules 13 and 65 of the General Dental Council (Fitness to Practise) (GDC) Rules Order of Council 2006 (the Rules).

You, on behalf of the GDC, have referred the Committee to various documents which set out the steps taken by the GDC to contact Miss Moreno Correia about her Fitness to Practise case through her email address and her registered address in England. This includes the exchange of correspondence between the GDC and RadcliffesLeBrasseur Solicitors (Ms Moreno Correia’s legal representatives), the use of an enquiry agency, the GDC’s request for her address via the Portuguese Dental Association, and its email dated 13 February 2015 which confirms her registered address and her email. The Committee has seen the notification of hearing letter dated 2 April 2015 which was sent to Miss Moreno Correia’s registered address in England and the address provided in Portugal by recorded delivery on that day. The letter sets out the information required in accordance with Rule 13. The Royal Mail track and trace receipt confirms that the Royal Mail attempted delivery of the item to Ms

Moreno Correia's registered address in England on 4 April 2015 and the Fedix delivery paperwork confirms that the item was delivered to her address in Portugal on 13 April 2015. The Committee has concluded that the address in Portugal is Ms Moreno Correia's current address and that she has received notification of today's hearing. The Committee is satisfied that the GDC has taken extensive steps to establish Ms Moreno Correia's current address and to notify her of these proceedings. In these circumstances, the Committee is satisfied that the GDC has complied with Rules 13(1) and 65.

The Committee then went on to consider whether to hear this case in the absence of Ms Moreno Correia, in accordance with Rule 54. In so doing, it has had regard to the correspondence from the GDC to Ms Moreno Correia between 19 December 2014 and 8 April 2015 in connection with these proceedings, and the absence of any response from Ms Moreno Correia during that time.

You submitted that Ms Moreno Correia has voluntarily absented herself from this hearing and she has therefore waived her right to attend. You say that there is a strong public interest in proceeding with the hearing in view of the serious nature of the allegations against her and this Committee's statutory duty in making due enquiry into the allegations. You further say that there is nothing before the Committee to indicate that an adjournment would secure Ms Moreno Correia's attendance at a future hearing. She has not applied for an adjournment despite having had the opportunity to do so.

The Committee has considered the submissions you have made. It has accepted the advice of the Legal Adviser. It is aware that its discretion to proceed in the absence of the respondent should be exercised with the utmost care and caution. The Committee has also borne in mind the fairness to the registrant as well as to the GDC, including any inconvenience caused to either party if the hearing were to be adjourned.

The Committee has had regard to the various letters from the GDC to Ms Moreno Correia in connection with arrangements concerning this hearing, including the possibility of adjourning the hearing in May to allow her to attend or providing her with assistance if she intends to attend the hearing. She was also given the opportunity to submit written representations to the Committee. The GDC has received no response from her. It is clear from the documentation before it that the GDC has given Ms Moreno Correia a number of options to enable her to attend the hearing in person or, in the alternative, to provide written submissions. However, she has chosen not to engage over a period of several months. The Committee has drawn the inference that Ms Moreno Correia has voluntarily absented herself from this hearing and thereby waived her right to be present. It notes that she has not request an adjournment of today's hearing, although she was advised by the GDC that it was open to her to do so. The Committee has no evidence before it to satisfy it Ms Moreno Correia would attend her hearing at a future date, should it decide to adjourn. In addition, the Committee has borne in mind the serious nature of the allegations against the Registrant concerning her treatment of twelve patients, some of which date back to events that are said to have taken place in 2007. The Committee is aware of its statutory duty to make due enquiry into these matters and to act in the public interest in the timely disposal of this case. In all the circumstances, the Committee is satisfied that it is fair to hear this case in the absence of Ms Moreno Correia.

#### **Application to amend the charge**

At the outset of the hearing, you made an application under Rule 18(1) to amend the charge set out in the notification of the hearing as follows:

2(a) – delete ‘UL2’ and replace it with ‘UR2’

3(c) – delete the month of ‘August’ and replace it with the month of ‘November’

3(d) – delete the words ‘each of’ and ‘and 15 September 2009’

5(d)(i) – add the words ‘or swelling’ after the word ‘pain’ and delete the ‘2008’ and replace it with the year ‘2007’ in connection with both dates

5(d)(ii) – delete ‘UL3’ and replace it with ‘LR7’

10(a)(ii) – delete ‘UL6’ and replace it with ‘UR6’

11(a) – delete the word ‘pain’ and replace it with the word ‘tenderness’

Withdraw charges 4(b) and 10(b)

You submitted the proposed amendments, the majority of which relate to corrections to the dates and the tooth notation cited in the charges, are more in line with the evidence and they do not substantially alter the nature of the charges against Ms Moreno Correia. You therefore submitted that there would be no unfairness to Ms Moreno Correia in making these amendments. You further indicated that the GDC was not pursuing charges 4(b) and 10(b) and therefore invited the Committee to withdraw them. You confirmed that the GDC notified Ms Moreno Correia of its intention to make the above proposed amendments save for charges 3(d) and 5(d)(ii), as set out in its letter dated 27 April 2015. Regarding charges 3(d) and 5(d)(ii), you confirmed that the proposed amendments amounted to a lessening of the charge for 3(d) and a change in the tooth notification for charge 5(d)(ii). In its letter of April 2015 the GDC asked Ms Moreno Correia to indicate if she had any objections to these amendments by 6 May 2015. You confirmed that the GDC received no response from Ms Moreno Correia.

The Committee has considered the submissions you have made. It has accepted the advice of the Legal Adviser. It is satisfied that all of the proposed amendments can be made without any injustice, except for the inclusion of the words ‘or swelling’ in respect of Charge 5(d)(i), which it considers increases the criticism set out in the charge and therefore makes it more onerous to Ms Moreno Correia. Accordingly, the Committee has agreed to the amendments as set out above, save for the inclusion of the words ‘or swelling’ at Charge 5(d)(i).

#### **Application to rely on the witness statements of witnesses 1,2,3,4,5 and 6**

You made an application that the Committee receive in evidence the witness statements of witnesses 1,2,3,4,5 and 6, rather than to call them to give evidence in person. In effect, you asked the Committee to receive the hearsay evidence of these witnesses. You submitted that the evidence of these witnesses provide background information in respect of this case. You confirmed that Ms Moreno Correia had been put on notice of the GDC’s intention to rely on the witness statements of these witnesses by letter dated 27 April 2015 in which she was invited to indicate any objections to this proposal. Ms Moreno Correia did not respond to that letter.

The Committee has considered your application carefully. It has accepted the advice of the Legal Adviser, during the course of which he referred the Committee to a number of recent decisions of the High Court and Court of Appeal on the issue of the admissibility of hearsay evidence in disciplinary proceedings and in particular to the case of *Razzaq v Financial Services Authority* [2014] EWCA Civ 770. The Committee is satisfied that the evidence of these witnesses is relevant to the issues it has to decide and that it would not be unfair to

admit it. While it notes that it will not have the opportunity to ask questions of these witnesses in person, the Committee notes that their evidence relates to background matters and does not go to the heart of the allegations, this being a case which relies exclusively on dental records and the interpretation of those records. The expert relied on by the GDC to interpret the records is being called to give live evidence to the Committee. Furthermore, it will be for the Committee to decide in due course what weight it attaches to these statements, given that the evidence of these witnesses will not have been subjected to cross examination.”

Ms Moreno Correia was not present and was not represented. On 13 May 2015 the Chairman announced the findings of fact to the Counsel for the GDC:

### **Background to the case**

“Mr Singh:

The General Dental Council (GDC) alleges that Ms Moreno Correia (the Registrant) failed to provide an adequate standard of treatment in respect of twelve patients while she was working at the Padiham Road Dental Practice (the Practice) during the period between 2007 and 2012. This followed an investigation by East Lancashire Primary Care Trust (the PCT) into the Practice at Padiham Road. A targeted sample of patients was selected by the East Lancashire PCT Contract Manager, which raised concerns relating to the Registrant’s practice. Due to those concerns a referral was made to the GDC.

### **The factual evidence**

The GDC has received no indication from the Registrant as to whether she admits any or all of the charges against her. Furthermore, she has not provided any evidence to rebut the allegations against her. However, given the absence of any evidence from the Registrant, the Committee has scrutinised with care all of the evidence adduced by the GDC. The documentary evidence comprises the witness statements of witness 1, 2, 3, 4, 5 and 6, the patient records (contained in three files) and copies of some of the radiographs (together with the original radiographs in some cases). The Committee notes that the evidence of the six witnesses that were read provide background evidence and that it is the patients’ records, together with the evidence of Professor Morganstein (expert witness, called on behalf of the GDC) (Expert Witness), that are central to the allegations in this case.

The Committee received oral evidence from the Expert Witness, in which he confirmed the conclusions set out in his report dated 9.01.15. His opinions were based on his analysis of the patients’ records and radiographs produced and his judgement of the Registrant against the relevant standards applicable at the time. The Committee noted that his report contained a number of errors relating to the dates of the treatment and the incorrect tooth. Furthermore, the Committee has had in mind that his opinion was based on an assessment of the patients’ records, without having had the benefit of examining the patients in question at the material times. Nevertheless, the Committee found Professor Morganstein to provide an objective opinion in most of the matters under consideration and has broadly accepted his evidence where it considered it was supported by the patients’ records.

### **Further amendments to the charge**

During the course of the GDC’s case, the Committee made further amendments to the charge under Rule 18(1). The amendments were as follows:

3(f)(i) – under 30 March delete ‘2013’ and replace it with ‘2012’.

12(b) – delete ‘19 July 2010’ and replace it with ‘22 June 2010’.

You also invited the Committee to withdraw Charge 13(a) on the basis that there was insufficient evidence to support it. The Committee acceded to that application and accordingly Charge 13(a) has been withdrawn.

**Findings of fact**

The Committee has accepted the advice of the Legal Adviser. It has borne in mind that the burden of proof is on the GDC and that it must decide the facts according to the civil standard of proof, namely on the balance of probabilities. In accordance with that advice it has considered each head of charge separately.

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

1.	Found proved
2. a)	<p>Found not proved</p> <p>The Committee viewed the notes sequentially with great care around the dates dealing with the provision and replacement of the crown at UR2. The Committee noted the Expert Witness’s report dealing with how often the crown failed, but considered that there had been good communication and appropriate action from the Registrant, who appropriately explained to the patient the difficulty faced. The Committee noted that the Registrant was dealing with a post retained crown on a pre-molar which can be particularly challenging and which are associated with a high failure rate. The Committee was satisfied on the basis of the notes that the Registrant was acting in the best interests of the patient throughout and doing her utmost to avoid an extraction. A number of the failures noted by the Expert Witness were in situations where the crown was re-cemented following agreement with the patient that the crown was scheduled to be remade. In such circumstances the Committee concluded that the GDC had not proved on the balance of probabilities that the Registrant’s care and treatment of Patient A was inadequate.</p>
2. b)	<p>Found proved</p> <p>In support of this charge, the GDC relies on the Expert Witness’s evidence. He referred to the bitewing radiograph taken by the registrant on 28.07.09, which showed a small mesial lesion, but which was not recorded as being present on that date. A second bitewing radiograph was taken on 11.10.10, by which time the lesion was larger. The Committee accepts the Expert Witness’s opinion on this matter, there was no treatment offered to the patient until 13.12.10, when an amalgam filling was placed in the mesial cavity. This was well over a year after the bitewing radiograph had identified a small mesial lesion.</p>
2. c)	<p>Found proved</p> <p>The Committee accepted the Expert Witness’s opinion and viewed radiographic evidence that the Registrant replaced an amalgam that had an overhang with a restoration that had a larger overhang than the one it replaced.</p>

2. d)	<p>Found proved</p> <p>Between 28.7.09 and 4.11.11 there are no Basic Periodontal Examination (BPE) scores recorded in the clinical notes. The Committee accepts the Expert Witness's opinion that such scores should be recorded at least annually in order to be able to monitor the Patient's periodontal disease status. The Committee considered that a failure to take and/or record BPE scores for a period of over two years amounted to inadequate care and treatment of Patient A.</p>
2. e)	<p>Found proved</p> <p>The Committee found limited references to discussions of the treatment options available in the records. In addition, there is no record of any discussions of the risks and benefits of the treatment options. The Committee found this to be inadequate.</p>
3. a)	<p>Found proved</p> <p>Between 17.05.07 and 15.03.10 there are no BPE scores recorded in the clinical notes. The Committee accepts the Expert Witness's opinion that such scores should be recorded at least annually in order to be able to monitor the Patient's periodontal disease status. The Committee considered that a failure to take and/or record BPE scores for a period of nearly three years amounted to inadequate care and treatment of Patient B.</p>
3. b)	<p>Found proved</p> <p>The Committee accepted the Expert Witness's opinion that the Registrant failed to provide adequate periodontal treatment. The periodontal disease was identified on 17.05.07 and yet there was no treatment for a period of four months when on 11.09.07 the Registrant did a scale and polish. Although the Registrant saw the patient every three months there is no diagnosis, no treatment plan, no BPE scores and no pocket depth charted.</p>
3. c)	<p>Found proved</p> <p>The Committee accepts the Expert Witness's opinion that a prescription was not clinically justified when a patient complains of mobility of teeth and pressure pain. There was nothing in the notes to indicate that there was an infection.</p>
3. d)	<p>Found proved in relation to the periapical radiograph; found not proved in relation to the pan oral radiograph.</p> <p>The Registrant took two radiographs on 17.05.07 – a periapical and a pan oral, which she graded as a 2. The Expert Witness referred to the original radiographs, which the Committee has seen, and judged them both to be of a grade 3. His view was that both radiographs were of an inadequate diagnostic value. The Committee accepts the Expert Witness's opinion in relation to the periapical – namely that it was distorted, poorly exposed and it is slightly coned off. However, in exercising its professional judgement, having examined the radiograph carefully, it considers that the pan oral provides some diagnostic value and that there would be no need to retake it.</p>

3. e)	<p>Found proved in relation to the periapical radiograph only</p> <p>Given the poor quality of this radiograph and the fact that it has no clinical value, the Committee is satisfied that the radiograph should have been retaken. The Registrant failed to retake the radiograph, in accordance with the Irmer Regulations.</p>
3. f) i)	<p>Found proved in relation to 27.11.08 and 1.12.09; found not proved in relation to 30.03.12</p> <p>In respect of 27.11.08 there is no record in respect of the teeth for which the antibiotics were being prescribed.</p> <p>In respect of 1.12.09 there is reference to food packing but there is no record of the tooth involved.</p> <p>In respect of 30.03.12 – the patient complained of a broken tooth but the record does not indicate the tooth involved. However, given that the record confirms that the Registrant restored the patient's UR6 on that occasion, the Committee has drawn the inference that logically, the tooth in question must have been the UR6.</p>
3. f) ii)	<p>Found not proved</p> <p>The Committee has noted the Expert Witness's criticisms as to the adequacy of the notes in a number of entries. In assessing the alleged failure, the Committee has had regard to the whole period when the patient was treated between May 2007 and July 2012. The clinical notes demonstrate a record of the discussion of treatment options and the risks and benefits, such as possible future treatment options and the prognosis of teeth.</p>
4. a)	<p>Found not proved</p> <p>The Committee viewed the notes sequentially with great care around the dates dealing with the restorative work provided to the UL1. The Committee noted the Expert Witness's report dealing with how often the composite restoration failed. The clinical records demonstrate that there had been good communication and appropriate action by the Registrant. Following this period, the restoration placed by the Registrant on 29.8.07 was successful for over three years. In the Committee's view this demonstrates an adequate standard of care at the UL1.</p>
4. b)	<p>Withdrawn by the GDC</p>
4. c)	<p>Found proved</p> <p>The Committee has examined the radiographs which were taken on or around the dates specified in the charges and found that some were of inadequate diagnostic quality; one appeared almost black and the other was distorted.</p>
4. d)	<p>Found not proved</p> <p>The Committee noted the Expert Witness's opinion that the Registrant had failed to retake the radiographs which were of inadequate diagnostic quality. However, when checking the available radiographs, the Committee was satisfied that the Registrant had retaken the radiographs.</p>

4. e)	<p>Found not proved</p> <p>Patient C had orthodontic treatment and was wearing a retainer, which, in the Expert Witness's view, placed the patient at risk of caries. His view was that caries preventative care should have been given to the patient, such as the use of a fluoride mouthwash, tooth brushing and a reduction of sugar consumption. There is no record of such advice having been given. However, the Committee found references in the notes to oral hygiene instruction, which in the Committee's judgement was sufficient. In addition, given that the patient was undergoing a course of orthodontic treatment, it is common practice that advice on caries prevention would have been given by the treating orthodontist. In this particular charge, the Committee does not accept the Expert Witness's criticisms of the Registrant, and considers that he has applied the gold standard as opposed to the reasonable standard expected of a registered dentist.</p>
4. f)	<p>Found proved</p> <p>The records indicate that antibiotics were prescribed on 26 July 2007, 5 July 2010 and 15 July 2010. There is no record as to the clinical justification for the prescriptions, and in the Expert's opinion, they were inappropriate in any event as they were not prescribed for identified infection. The Committee accepts the Expert Witness's opinion on this matter.</p>
5. a)	<p>Found proved in relation to 10.07.07 and 16.07.07; found not proved in relation to 20.10.11.</p> <p>In his report the Expert Witness said that the antibiotics prescribed on the three dates in the charge were not justified taking account of the clinical conditions described. However, when giving his oral evidence the Expert Witness accepted that the clinical conditions on 20.10.11 could justify the prescribing of antibiotics, but he remained critical of the choice of antibiotic. Looking at the clinical notes the Committee agreed that there was no clinical justification apparent for the provision of antibiotics on 10.7.07 and 16.7.07 and that therefore the Registrant's care and treatment of Patient D was inadequate in relation to the prescribing of antibiotics on those two dates. However, the Committee did not find that to be the case for the provision of antibiotics on 20.10.11, where it was accepted by the Expert Witness that antibiotics were clinically justified. It was clear that the gravamen of the charge was the prescribing of antibiotics when they were not clinically justified rather than the clinician's choice of antibiotic when there was justification.</p>
5. b)	<p>Found proved</p> <p>Between 24.4.07 and 4.8.10 there are no BPE scores recorded in the clinical notes. The Committee accepts the Expert Witness's opinion that such scores should be recorded at least annually in order to be able to monitor the Patient's periodontal disease status. The Committee considered that a failure to take and/or record BPE scores for a period of over three years amounted to inadequate care and treatment of Patient D.</p>
5. c) i)	<p>Found not proved</p> <p>The Committee viewed the notes sequentially with great care around the dates</p>

	<p>dealing with the provision and replacement of the crown at UL3. The Committee noted the Expert Witness's report dealing with how often the crown failed, but considered that there had been good communication and appropriate action from the Registrant, who appropriately explained to the patient the difficulty faced. The Committee noted that the Registrant was dealing with a post retained crown on a pre-molar which can be particularly challenging and which are associated with a high failure rate. The Committee was satisfied on the basis of the notes that the Registrant was acting in the best interests of the patient throughout and doing her utmost to avoid an extraction. A number of the failures noted by the Expert Witness were in situations where the crown was re-cemented following agreement with the patient that the crown was scheduled to be remade. In such circumstances the Committee concluded that the GDC had not proved on the balance of probabilities that the Registrant's care and treatment of Patient D was inadequate.</p>
5. c) ii)	<p>Found proved</p> <p>The Committee accepted the Expert Witness's opinion that the Registrant failed to provide an adequate standard of care in respect of root canal treatment at LR7. The Registrant commenced the root treatment on 27.2.08 and continued it on 3.4.08, 17.4.08 and 27.6.08, but never completed it. On 8.3.10 the patient is once again in pain and the Registrant opened LR7 again and provided a temporary solution by filling, but never finished the root canal treatment. On 10.1.11 the patient lost the filling in LR7 and the Registrant once again filled the tooth without revisiting the nerve.</p>
5. c) iii)	<p>Found not proved</p> <p>The Expert Witness said that the failure of two restorations so soon after placement indicated a failure of technique. The Committee noted, however, that despite the two early failures in a short time span the filling was still in place four years later. The Committee decided that the GDC had not satisfied it that this amounted to inadequate care</p>
5. d) i)	<p>Found not proved</p> <p>You have accepted that there was no complaint of pain from the patient in respect of UL2. Accordingly, the Committee did not find this charge proved in relation to UL2.</p> <p>In respect of UR4, the Committee noted that this tooth was x-rayed before its extraction on 12.7.07 and the patient returned four days later with pain at the extraction site. The Expert Witness was critical of the failure to take a further radiograph on this date, but the Committee considered this to be over critical. It is not unusual to experience pain at the site of an extraction four days later and the expert agreed with this. In such circumstances it is not mandatory to take a further radiograph and the lack of one did not, in the Committee's view, amount to a failure to provide adequate care.</p>
5. d) ii)	<p>Found not proved</p> <p>The Committee agreed with the Expert Witness that radiographs should be taken once root canal treatment is completed, however in this case the root</p>

	canal treatment was never completed and accordingly there cannot have been a failure to take radiographs after completing the procedure.
5. e)	<p>Found not proved</p> <p>The Committee looked with care through the clinical notes and found multiple examples of discussions about treatment options and risks involved, for example there were references to implants and the provision of a leaflet which would have contained information on the risks and benefits of implants. Accordingly, the Committee was not satisfied on the balance of probabilities that the care and treatment of Patient D was inadequate in this regard.</p>
6.	<p>Found proved</p> <p>The Committee agreed with the Expert Witness's comments that the Registrant had provided inadequate periodontal treatment to Patient E, who was first seen by the Registrant on 13.2.09 and yet no BPE was recorded until 6.12.10. On that occasion there were three sextants that scored a 3 and the Registrant should therefore have carried out pocket depth charts for these three sextants to aid her treatment planning. The Committee also found that the recalls arranged did not correlate to any identified periodontal treatment need. The Committee noted that there was no diagnosis in the clinical notes following these BPE scores.</p>
7. a)	<p>Found proved</p> <p>Between 24.07.06 and 14.07.10 there are no BPE scores recorded in the clinical notes. As mentioned above, the Committee accepts the Expert Witness's opinion that such scores should be recorded at least annually in order to be able to monitor the Patient's periodontal disease status. The Committee considered that a failure to take and/or record BPE scores for a period of nearly four years amounted to inadequate care and treatment of Patient F.</p>
7. b)	<p>Not proved</p> <p>The Committee viewed the notes sequentially with great care around the dates dealing with the provision and replacement of the crown at UR5. The Committee noted the Expert Witness's report dealing with how often the crown failed, but considered that there had been good communication from the Registrant, she had tried to solve the issues as they arose and ultimately she recognised that there was nothing further that could be done and that the tooth would have to be extracted. The Committee noted that once again the Registrant was dealing with a post retained crown on a pre-molar which can be particularly challenging and which are associated with a high failure rate. The Committee was satisfied on the basis of the notes that the Registrant was acting in the best interests of the patient throughout and doing her utmost to avoid an extraction. A number of the failures noted by the Expert Witness were in situations where the crown was re-cemented following agreement with the patient that the crown was scheduled to be remade. In such circumstances the Committee concluded that the GDC had not proved on the balance of probabilities that the Registrant's care and treatment of Patient F was inadequate.</p>

8. a)	<p>Found not proved</p> <p>The Committee viewed the notes sequentially with great care around the dates dealing with the restorative work at LL2. The Committee noted the Expert Witness's report dealing with how often the filling had to be replaced, but considered that there had been good communication and appropriate action from the Registrant. The clinical notes showed she had noted the difficulty with saliva isolation, she twice tried using ionomer as a filling and then after that failed she switched to a composite. The fact that she changed the type of filling was a possible solution to the problem, suggested by the Expert Witness in his oral evidence. The Committee was satisfied on the basis of the notes that the Registrant was acting in the best interests of the patient throughout and trying hard to make the filling work. In such circumstances the Committee concluded that the GDC had not proved on the balance of probabilities that the Registrant's care and treatment of Patient G was inadequate in relation to the restorative work at LL2.</p>
8. b)	<p>Found proved</p> <p>Between 4.7.07 and 24.3.11 there are no BPE scores recorded in the clinical notes. As mentioned above, the Committee accepts the Expert Witness's opinion that such scores should be recorded at least annually in order to be able to monitor the Patient's periodontal disease status. The Committee considered that a failure to take and/or record BPE scores for a period of nearly four years amounted to inadequate care and treatment of Patient G.</p>
9. a)	<p>Found proved</p> <p>The Expert Witness said that the radiograph taken on 21.12.11 showed an apical radiolucency in LR6, but that there was no record of any attention given to this tooth despite the need for root canal therapy. The Committee was shown the radiograph and could see the apical radiolucency. The clinical notes show that the Registrant identified lesions on the root and the need to discuss a treatment plan, however there is no diagnosis. The Committee accepted the opinion of the Expert Witness that this failure to diagnose and adequately manage the apical radiolucency meant that the Registrant's care and treatment of Patient H was inadequate.</p>
9. b)	<p>Found proved</p> <p>As with LR6, the radiographs taken on 21.12.11 showed lesions on LR7 indicating a need to carry out root canal therapy. However, although the Registrant begins root canal treatment she did not complete it despite the patient attending for other treatments thereafter and there was nothing in the records to indicate why this treatment had not been completed. The Committee accepted the opinion of the Expert Witness that this amounted to a failure to provide an adequate standard of care in respect of root canal treatment at LR7 and meant that the Registrant's care and treatment of Patient H was inadequate.</p>
9. c)	<p>Found proved</p> <p>Between 28.10.08 and 17.03.11 there are no BPE scores recorded by the Registrant in the clinical notes. As mentioned above, the Committee accepts</p>

	<p>the Expert Witness's opinion that such scores should be recorded at least annually in order to be able to monitor the Patient's periodontal disease status. The Committee considered that a failure to take and/or record BPE scores for a period of over two years amounted to inadequate care and treatment of Patient H.</p>
9. d) i)	<p>Found proved</p> <p>The Committee accepted the Expert Witness's evidence, as shown by the clinical notes, that there was no record of why the whitening treatment was started considering the poor state of the patient's dentition at the time with an uncompleted root treatment at LR7, a periodontal involved LR6 and continuing treatment to upper incisors. The Expert Witness said that it is possible to start whitening treatment when other treatments are still required but that this is a deviation from the "norm" and thus the reasons should be recorded. The Committee considered that there might have been an argument for doing the whitening at that stage but that there was nothing recorded in the notes. The Committee considered this amounted to a failure to provide adequate care and treatment of Patient H.</p>
9. d) ii)	<p>Not proved</p> <p>This allegation is that there was no justification for not completing the root canal treatment at LR7 in 2012. The Committee noted, however, that the treatment in relation to LR7 was still ongoing at the time that the Registrant handed over the care of Patient H to another dentist. It would therefore be unfair to expect her to justify why she had not completed it.</p>
9. d) iii)	<p>Found not proved</p> <p>The Committee noted that there was a record in the clinical notes of impressions for whitening trays, the colour for temporary crowns, the batch number and cartridge type for local anaesthetic and the materials inside root fillings. The Committee also noted that every treatment provided is described. In light of these records the Committee was not satisfied on the balance of probabilities that the record of details of treatments provided in 2012 was inadequate.</p>
10. a) i)	<p>Not proved</p> <p>The Committee viewed the notes sequentially with great care around the dates dealing with the provision and replacement of the crown at UL5. The Committee noted the Expert Witness's report dealing with how often the crown failed, but considered that there had been good communication from the Registrant, she had tried to solve the issues as they arose and ultimately she recognised that there was nothing further that could be done and that the tooth would have to be extracted. The Committee noted that once again the Registrant was dealing with a post retained crown on a pre-molar which can be particularly challenging and which are associated with a high failure rate. The Committee was satisfied on the basis of the notes that the Registrant was acting in the best interests of the patient throughout and doing her utmost to avoid an extraction. A number of the failures noted by the Expert Witness were in situations where the crown was re-cemented following agreement with the</p>

	<p>patient that the crown was scheduled to be remade, or extracted. In such circumstances the Committee concluded that the GDC had not proved on the balance of probabilities that the Registrant's care and treatment of Patient I was inadequate.</p>
10. a) ii)	<p>Not proved</p> <p>The GDC put its case in relation to 10(a)(ii) on the basis that the care and treatment was inadequate because of the number of visits and the time taken to complete the root canal work on UR6. The clinical records show that the treatment commenced on 1.2.07 and each time that the Patient returned thereafter they were still having symptoms from the tooth and in the Committee's opinion it would have been inappropriate to complete the root canal treatment in these circumstances. Therefore the GDC had not proved that the Registrant's care and treatment of Patient I was inadequate.</p>
10. b)	<p>Withdrawn by the GDC</p>
11. a)	<p>Found not proved</p> <p>The Expert Witness said in his report that "The patient reported pain and tenderness up to 2 June 2011 although there is no record of any specific treatment or advice offered." The Committee noted, however, that it was only on 2 June 2011 that the patient referred to UR2 and that the record states "pco feels a bit tender on the place ur2". The Expert Witness went on to say that "The pain reported on 2 June 2011 was not investigated ...". As mentioned, the Committee noted that the word "pain" does not appear in the records and it considered that there was a significant difference between a patient reporting pain at the site of an extraction and one referring to a bit of tenderness. The Committee noted that the records on the date of the extraction state "patient aware still part of root in will see how it goes". In the circumstances, the Committee did not think the GDC had proved that the Registrant's care and treatment of Patient J was inadequate because it was enough for her to have made a record of the fact that there was some tenderness.</p>
11. b)	<p>Found proved</p> <p>Between 15.2.08 and 24.5.12 there are no BPE scores recorded in the clinical notes. As mentioned above, the Committee accepts the Expert Witness's opinion that such scores should be recorded at least annually in order to be able to monitor the Patient's periodontal disease status. The Committee considered that a failure to take and/or record BPE scores for a period of over four years amounted to inadequate care and treatment of Patient J.</p>
11. c)	<p>Found not proved</p> <p>In the clinical record the Registrant recorded a BPE on 24.05.12 with a score of 3 for four sextants and a score of 2 for two sextants. The Committee noted that less than a year later when seen by a different dentist that score was much improved, indicating that any periodontal disease present on 24.05.12 had been successfully treated. The only treatment provided within that time in the clinical records had been provided by the Registrant on 6.08.12 when she had carried out root scaling and a scale and polish. This suggested that the periodontal treatment provided by the Registrant had been successful. The</p>

	Committee concluded, therefore, that there had not been a failure to provide adequate periodontal treatment to Patient J.
11. d)	<p>Found proved</p> <p>It is clear from the clinical notes that a Treatment Plan was agreed with Patient J on 10.3.10 and that she was happy with it. However, there is no record within the clinical notes of the actual Treatment Plan. Accordingly, if any other dentist were to take over the care of Patient J they would not know what the Treatment Plan contained. The failure to record the Treatment plan amounted to inadequate care of Patient J.</p>
12. a)	<p>Found proved</p> <p>The Registrant treated Patient K between 3.8.07 and 14.06.12 and had not recorded any BPE scores during this period. As mentioned above, the Committee accepts the Expert Witness's opinion that such scores should be recorded at least annually in order to be able to monitor the Patient's periodontal disease status. The Committee considered that a failure to take and/or record BPE scores for a period of nearly five years amounted to inadequate care and treatment of Patient K.</p>
12. b)	<p>Found proved</p> <p>The Committee noted that Expert Witness comments. The clinical record for 22.06.10 records "2 BWs was taken grade 2 2", but nothing else was provided by way of a report. The Committee considered that this did not amount to an adequate report. The provision of such a report is a statutory requirement of the IRMA Regulations and therefore the failure to make and record an adequate report amounted to inadequate care and treatment of Patient K.</p>
13. a)	Withdrawn by the GDC
13. b)	<p>Found proved</p> <p>Looking at the clinical records the Committee noted that there was evidence that the Registrant was assessing the caries risk by taking radiographs. However, there was no record of an assessment of the patient's caries risk status. The Committee considered that failing to record the patient's caries risk status amounted to inadequate care of Patient M and accordingly the Committee found 13(b) proved on this basis only.</p>

We move to Stage Two."

On 13 May 2015 the Chairman announced the determination as follows:

Misconduct/Deficient Professional Performance

"Mr Singh: The Committee has considered whether the facts found proved against Ms Moreno Correia amount to misconduct or, in the alternative, deficient professional performance. In so doing, it has considered all the evidence presented to it, including the expert evidence of Professor Morganstein. It has had regard to the GDC's publication 'Standards for Dental Professionals' (May 2005). The Committee has taken into account the

submissions you have made on behalf of the General Dental Council (GDC). It has accepted the advice of the Legal Adviser.

You submitted that the facts found proved are serious and amount to misconduct or in the alternative, deficient professional performance. You highlighted several areas of the Committee's findings where shortcomings into Ms Moreno Correia's practice were identified. You referred the Committee to relevant case law regarding the definitions of misconduct and deficient professional performance.

The findings against Ms Moreno Correia, which cover a period of six years between 2006 and 2012, relate to eleven patients and encompass the following areas:

- A failure to diagnose and/or provide adequate treatment for caries in respect of one tooth
- Poor placement of a restoration
- A failure to carry out and/or record basic periodontal examinations at appropriate intervals and a failure to provide proper periodontal treatment
- Inappropriate prescribing of antibiotics
- Failure to report adequately on radiographs
- Failure to provide an adequate standard of care in respect of root canal treatment
- Poor record keeping

Professor Morganstein's opinion was that Ms Moreno Correia's treatment of her patients fell seriously below in a number of areas, as judged against the standard of a reasonably competent general dental practitioner.

The Committee also had regard to the following principles from the GDC's 'Standards for Dental Professionals', which it considers Ms Moreno Correia has breached:

**1 Put patients' interests first and act to protect them**

- 1.4** Make and keep accurate and complete patient records, including a medical history, at the time you treat them...

**5 Maintain your professional knowledge and competence**

- 5.1** Recognise that your qualification for registration was the first stage in your professional education. Develop and update your knowledge and skills throughout your working life.
- 5.2** Continuously review your knowledge, skills and professional performance. Reflect on them, and identify and understand your limits as well as your strengths.
- 5.3** Find out about current best practice in the fields in which you work. Provide a good standard of care based on available up-to-date evidence and reliable guidance.
- 5.4** Find out about laws and regulations which affect your work, premises, equipment and business, and follow them.

The Committee has concluded that the findings, taken cumulatively, amount to negligent acts and omissions in fundamental areas of dentistry. The Committee, having considered the

definitions of misconduct and deficient professional performance, is satisfied that the findings can be properly categorised as misconduct. Although taken individually some of Ms Moreno Correia's failings would not be considered deplorable by fellow members of the profession, collectively, the Committee considered they would be. In particular, her failure to monitor, record and appropriately treat periodontal disease for a number of patients over a period spanning up to six years was a serious failure, falling far short of the standard required. Having found misconduct, there was no need for the Committee to consider deficient professional performance.

### Impairment

The Committee next considered whether Ms Moreno Correia's fitness to practise is currently impaired by reason of her misconduct. It has borne in mind that its duty is to consider the public interest, which includes the protection of patients, the maintenance of public confidence in the profession and the declaring and upholding of proper standards of conduct and behaviour.

You submitted that Ms Moreno Correia's fitness to practise is currently impaired given that the findings against her are serious and there is limited evidence to satisfy the Committee that she has rectified the concerns identified in this case. You asked the Committee to have regard to the issue of the protection of patients in considering the issue of current impairment.

The Committee considers that all the failures identified in this case are remediable. The Committee has noted from her clinical records that Ms Moreno Correia had made some efforts to address some of the concerns by 2012, as evidenced by her recording BPEs on a more regular basis. However, apart from this slight improvement, the Committee has no evidence that she has maintained those efforts since 2012 or that she has addressed other areas of her practice that have been identified in this case. In the circumstances there was no evidence to satisfy the Committee that Ms Moreno Correia would not repeat her failures if allowed to practise unrestricted.

There is no evidence as to the standard of her clinical practice since 2012, if indeed she is still practising as a dentist. Furthermore, Ms Moreno Correia has not engaged with the GDC over a long period of time, which, in the Committee's judgement, raises concerns about her level of insight.

In the light of the widespread basic and fundamental failings and the absence of any recent evidence of Ms Moreno Correia's remediation, the Committee is concerned about the current standard of her clinical practice and the public protection. It has determined that Ms Moreno Correia's fitness to practise is currently impaired by reason of her misconduct.

### Sanction

The Committee next considered what sanction, if any, to impose on Ms Moreno Correia's registration. It recognises that the purpose of a sanction is not to be punitive, although it may have that effect, but to protect patients and the wider public interest. The Committee has applied the principle of proportionality, balancing the public interest with Ms Moreno Correia's own interests.

You submitted that the proportionate sanction in this case is one of suspension in order to protect the public. You submitted that conditions would not be appropriate given her lack of engagement with the GDC. During the course of your submissions, you drew the

Committee's attention to the GDC's 'Guidance for the Professional Conduct Committee, including Indicative Sanctions Guidance' (April 2015).

The Committee considered the range of sanctions available to it, starting with the least restrictive. In view of the extent of the findings against Mss Moreno Correia concerning deficiencies in her performance, with no evidence that they have been addressed, the Committee has determined that it would be inappropriate to conclude this case without taking any action in respect of her registration or with a reprimand.

The Committee considered whether to impose conditions on Ms Moreno Correia's registration, bearing in mind that any conditions imposed would have to be clear, workable, measurable and enforceable. It has no information as to whether Ms Moreno Correia is currently practising and it is thought she has returned to Portugal. Furthermore, she has not engaged with the GDC in connection with these proceedings over a long period of time, demonstrating a lack of insight. In these circumstances, the Committee cannot be confident that Ms Moreno Correia would comply with conditions or that any conditions could be formulated in such a way that they would be workable, enforceable or measurable. Therefore, the Committee has concluded that conditions would not be appropriate in this case.

The Committee considered whether to suspend Ms Moreno Correia's registration. It is satisfied that such a course of action is necessary for the protection of the public in light of the multiple clinical failings in relation to 11 patients over a period of six years. It therefore directs that Ms Moreno Correia's registration be suspended for 12 months. This period of time will be sufficient for her to take steps to provide evidence of remediation, should she wish to do so. The Committee considered the sanction of erasure but concluded that given the circumstances of this case, such a course of action would be disproportionate. Indeed, you did not seek such a sanction in this case.

A Committee will review Ms Moreno Correia's case at a resumed hearing to be held shortly before the end of the period of suspension. She will be informed of the date and time of that resumed hearing. It considers that a Committee reviewing her case would find it very helpful if Ms Moreno Correia attended the hearing.

The Committee reviewing Ms Moreno Correia's case may find it helpful to receive the following:

- Evidence of her current employment situation (if as a dentist)
- Testimonials from any employer for whom she has worked, or is working
- Evidence of any steps she has taken to remediate the failings identified by this Committee.

The Committee now invites submissions from you as to whether Ms Moreno Correia's registration should be suspended immediately."

### **Decision on immediate order**

"Mr Singh: Having directed that Ms Moreno Correia's registration be suspended for a period of 12 months, the Committee has considered whether to impose an order for immediate suspension in accordance with Rule 22(1) of the GDC (Fitness to Practise) Rules 2006.

You, on behalf of the General Dental Council (GDC), have submitted that such an order is necessary in the light of the Committee's findings, for the protection of the public.

The Committee has determined that it is necessary for the protection of the public to impose an order for the immediate suspension of Ms Moreno Correia's registration. In reaching its decision, the Committee has had regard to the serious findings in this case, for which it has suspended Ms Moreno Correia's registration. The Committee is satisfied that it would be inconsistent to allow her the opportunity to continue to practise during the intervening appeal period.

The effect of the foregoing determination and this immediate order is that Ms Moreno Correia's registration will be suspended from the date on which notice of this decision is deemed served upon her. Unless Ms Moreno Correia exercises her right of appeal, her registration will be suspended for a period of 12 months from the date of deemed service. Should Ms Moreno Correia exercise her right of appeal, this immediate order for suspension will remain in place until the resolution of any appeal.

The interim order of suspension on Ms Moreno Correia's registration is hereby revoked.

That concludes this case."

On 1 June 2016 at a review hearing, the Chairman announced the determination as follows:

"Miss Headley,

This is a resumed hearing pursuant to Section 27(C) of the Dentists Act 1984 (as amended).

Service of Notice of Hearing

Ms Moreno Correia is neither present nor represented at today's hearing. In her absence, the Committee first considered whether notice of this hearing had been served on her in accordance with Rules 28 and 65 of the *General Dental Council (GDC) (Fitness to Practise) Rules Order of Council 2006* (the rules).

The Committee received a copy of the Notification of Hearing, dated 18 April 2016, which was sent to Ms Moreno Correia's registered address by way of Special Delivery and by email. The email was returned undelivered. It was also provided with a second copy of the Notice of Hearing, dated 18 April 2016, which was sent to an alternative address for Ms Moreno Correia in Portugal. The Committee was satisfied that the letter contained proper notification of today's hearing, including its time, date and location, as well as notification that the Committee has the power to proceed with the Professional Performance Committee (PPC) review hearing in Ms Moreno Correia's absence.

Further, the Committee had sight of the Royal Mail Track and Trace receipts for both Ms Moreno Correia's registered address and the alternative address in Portugal. The receipt for Ms Moreno Correia's registered address showed the letter was delivered to the local delivery office on 19 April 2016. The receipt for the alternative address in Portugal confirmed the letter was delivered on 26 April 2016 and signed for by 'EVA CORREIA'.

The Committee was satisfied that the notice of this PPC review hearing was served on Ms Moreno Correia in compliance with the rules.

Decision on Proceeding in the absence of Ms Moreno Correia:

The Committee then went on to consider whether to exercise its discretion under Rule 54 to proceed with the hearing in Ms Moreno Correia's absence.

The Committee heard the submissions made by you on behalf of the GDC and took account of the advice of the Legal Adviser. It was mindful that this was a discretion that must be handled with the utmost care and caution.

The Committee noted that despite numerous attempts by the GDC to contact Ms Moreno Correia there has been no response. It was told by you that there had been no contact from Ms Moreno Correia in the last twelve months. Ms Moreno Correia has been sent notice of today's hearing and the Committee was therefore satisfied that she was or should be aware of today's hearing. The Committee was particularly mindful of the imminent expiry of the extant suspension order, noting that the period of suspension is due to expire on 15 June 2016. There is a clear public interest in ensuring that the suspension order is reviewed before its expiry.

The Committee has concluded that, as there has been no contact from Ms Moreno Correia, despite numerous attempts by the GDC, she has chosen voluntarily to absent herself. The Committee has no reason to believe that an adjournment would result in her attendance. Having weighed the interests of Ms Moreno Correia with those of the GDC and the public interest in an expeditious disposal of this hearing the Committee has determined to proceed in her absence.

#### Body of determination

This case was first considered by the PPC in May 2015, where that Committee imposed a 12 month suspension order on Ms Moreno Correia's registration. The case concerned Ms Moreno Correia's treatment of a number of patients over a significant period of time. At the initial hearing a number of allegations were found proved which included:

- A failure to diagnose and/or provide adequate treatment for caries in respect of one tooth
- Poor placement of a restoration
- A failure to carry out and/or record basic periodontal examinations at appropriate intervals and a failure to provide proper periodontal treatment
- Inappropriate prescribing of antibiotics
- Failure to report adequately on radiographs
- Failure to provide an adequate standard of care in respect of root canal treatment
- Poor record keeping

That Committee made the following statement regarding whether the facts found proved in the case amounted to misconduct:

"The Committee has concluded that the findings, taken cumulatively, amount to negligent acts and omissions in fundamental areas of dentistry. The Committee, having considered the definitions of misconduct and deficient professional performance, is satisfied that the findings can be properly categorised as misconduct. Although taken individually some of Ms Moreno Correia's failings would not be considered deplorable by fellow members of the profession, collectively, the Committee considered they would be. In particular, her failure to monitor, record and appropriately treat periodontal disease for a number of patients over a period spanning up to six years was a serious failure, falling far short of the standard required. Having found misconduct, there was no need for the Committee to consider deficient professional performance."

It went on to state the following regarding impairment:

“The Committee considers that all the failures identified in this case are remediable. The Committee has noted from her clinical records that Ms Moreno Correia had made some efforts to address some of the concerns by 2012, as evidenced by her recording BPEs on a more regular basis. However, apart from this slight improvement, the Committee has no evidence that she has maintained those efforts since 2012 or that she has addressed other areas of her practice that have been identified in this case. In the circumstances there was no evidence to satisfy the Committee that Ms Moreno Correia would not repeat her failures if allowed to practise unrestricted. There is no evidence as to the standard of her clinical practice since 2012, if indeed she is still practising as a dentist. Furthermore, Ms Moreno Correia has not engaged with the GDC over a long period of time, which, in the Committee’s judgement, raises concerns about her level of insight. In the light of the widespread basic and fundamental failings and the absence of any recent evidence of Ms Moreno Correia’s remediation, the Committee is concerned about the current standard of her clinical practice and the public protection. It has determined that Ms Moreno Correia’s fitness to practise is currently impaired by reason of her misconduct.”

The Committee determined that the appropriate sanction was to suspend Ms Moreno Correia’s registration for 12 months. It stated that any reviewing committee may find it helpful to receive the following from Ms Moreno Correia:

- Evidence of her current employment situation (if as a dentist)
- Testimonials from any employer for whom she has worked, or is working
- Evidence of any steps she has taken to remediate the failings identified by this Committee.

This Committee today has considered all the evidence presented to it and has taken account of your submissions on behalf of the GDC. You made reference to the fact that, at the initial PPC hearing the Committee provided helpful guidance to Ms Moreno Correia as to the steps that she may wish to take to demonstrate that she is no longer impaired. You submitted that she has not provided any information about the steps that she may have taken to remediate the serious deficiencies that have been identified in her practice. You further submitted from the lack of communication there has been no evidence of possible insight by Ms Moreno Correia into her failings. You went on to submit that in light of this the concerns identified by the initial PPC still remain and therefore Ms Moreno Correia’s fitness to practise remains impaired. You submitted that the appropriate and proportionate sanction in this case would be a further 12 month suspension order with a review prior to its expiry.

The Committee accepted the advice of the Legal Adviser.

#### Impairment

The Committee first considered whether Ms Moreno Correia’s fitness to practise remains impaired by reason of the misconduct found proved against her. In reaching its decision on the issue of impairment, the Committee exercised its own independent judgement. It bore in mind that its duty is to consider the public interest, which includes the protection of patients, the maintenance of public confidence in the profession and the declaring and upholding of proper standards of conduct and behaviour.

The Committee accepted your submission that there has been no communication or engagement from Ms Moreno Correia with the GDC and there is currently no evidence of

remediation or insight. The Committee further notes that there is no other information available from any other sources to suggest that she has addressed any of the issues which had been identified by the previous PPC as being of concern. In light of the lack of evidence of remediation or insight the Committee is of the view that there is a likelihood of repetition in this case. The Committee has therefore concluded that the same risks to patient safety and public confidence persist, and that accordingly Ms Moreno Correia's fitness to practise remains impaired. Further, public confidence in the profession and this regulatory process would be seriously undermined if a finding of impairment was not made today.

### Sanction

Notwithstanding the Committee's finding that Ms Moreno Correia's fitness to practise remains impaired it then went on to consider if ceasing or allowing the current suspension order to lapse would be the appropriate and proportionate outcome in this case. Given the Committee's reasons outlined above for finding Ms Moreno Correia's fitness to practise impaired the Committee consider it would be wholly inappropriate to allow Ms Moreno Correia to return to practice unrestricted.

The Committee next considered whether it could formulate conditions which would be workable and which would address the risks that have been identified. The Committee concluded that it could not formulate any conditions which would be practicable or workable, particularly in the absence of information about Ms Moreno Correia's current practice or any suggestion that she would engage and comply with any such conditions. The Committee also notes that potentially Ms Moreno Correia is presently outside of the UK and that this presents real difficulties for the imposition of any conditions that may in theory be capable of being formulated.

The Committee then went on to consider whether it is necessary and appropriate to extend the current period of suspension. It has determined that suspension remains the proportionate and appropriate sanction to impose. This is because of the serious failings identified, the consequential risks of harm being caused to public safety and to trust and confidence in the profession, and the fact that there is no evidence of any change in circumstances, positive or otherwise, since the last hearing. A further period of suspension is required to protect the public, to declare and uphold proper standards of conduct and behaviour and to maintain trust and confidence in the profession and in the regulatory process.

The Committee has therefore decided to extend the existing suspension on Ms Moreno Correia's registration. In determining the appropriate length of the further suspension, the Committee has decided that the appropriate period of time for this further extended period of suspension should be 12 months because of the serious failings that have been identified and the risks that continue to arise from those shortcomings. The Committee also considers that the steps that Ms Moreno Correia would need to take to remediate the identified shortcomings, if so minded, are extensive and 12 months would allow her sufficient time to do so.

In view of the risks to patients and to the wider public interest, as well as the total lack of evidence of insight and remediation, the Committee hereby directs that Ms Moreno Correia's registration be suspended for a further period of 12 months.

In accordance with section 27C of the Act this extended period of suspended registration will take effect from the date on which the existing period of suspension would otherwise expire,

namely on 15 June 2016. The Committee has further determined that the extended period of suspension should be reviewed prior to its expiry.

Although it is mindful that the task of reviewing this extended suspension is entirely one for the future PPC, the Committee considered that that review Committee may find it helpful to have sight of the information previously suggested as being of relevance by the initial PPC. This Committee endorses and adopts these suggestions, and therefore suggests that Ms Moreno Correia may wish to present the following information to the future reviewing PPC:

- Evidence of her current employment situation (if as a dentist)
- Testimonials from any employer for whom she has worked, or is working
- Evidence of any steps she has taken to remediate the failings identified by this Committee.

That concludes this case for today.”

On 30 May 2017 at a second review hearing, the Chairman announced the determination as follows:

“This is a resumed hearing pursuant to section 27C of the Dentists Act 1984, as amended (‘the Act’). Ms Moreno Correia is neither present nor represented today. Mr Middleton is the Case Presenter for the General Dental Council (GDC).

At the outset, Mr Middleton made an application to proceed with the hearing in the absence of Ms Moreno Correia under Rule 54 of the ‘*GDC (Fitness to Practise) Rules Order of Council 2006*’ (‘the Rules’). The Committee took into account Mr Middleton’s submissions in respect of the application and accepted the advice of the Legal Adviser.

#### **Decision on service of the Notification of Hearing**

The Committee first considered whether notice of this resumed hearing had been served upon Ms Moreno Correia in accordance with Rules 28 and 65 of the Rules. It received a bundle of documents containing a copy of the Notification of Hearing, dated 28 April 2017 and an associated Royal Mail ‘Track and Trace’ receipt confirming that the letter was sent to Ms Moreno Correia’s registered address by Special Delivery. A copy of the letter was also sent to her by email. The Committee noted that a further copy of the letter was sent to an alternative address obtained by the GDC for Ms Moreno Correia in Portugal.

The Committee was satisfied that the letter contained proper notification of today’s hearing, including its time, date and location, as well as notification that the Committee had the power to proceed with the hearing in Ms Moreno Correia’s absence. On the basis of the information provided to it, the Committee determined that notice of this hearing had been served upon Ms Moreno Correia in accordance with the Rules.

#### **Decision on proceeding with the hearing in the absence of the registrant**

The Committee next considered whether to exercise its discretion under Rule 54 to proceed with the hearing in the absence of Ms Moreno Correia. It approached this issue with the utmost care and caution. The Committee took into account the need to be fair to both parties and it had regard to the public interest in the expeditious review of Ms Moreno Correia’s case.

The Committee noted from the information before it that Ms Moreno Correia has not engaged with the GDC in the last two years. It has received nothing further today to suggest that she now wishes to engage with these proceedings. In the circumstances, the Committee was satisfied that Ms Moreno Correia had voluntarily absented herself from this hearing. It was further satisfied that an adjournment would not make her attendance any more likely on a future occasion. Taking all of this into account, the Committee determined that it was fair and in the public interest to proceed with the hearing in the absence of Ms Moreno Correia.

### **Background to Ms Moreno Correia's case**

Ms Moreno Correia's case was initially considered by the Professional Performance Committee at a hearing held in May 2015. Ms Moreno Correia was neither present nor represented at that hearing. The Committee in May 2015 considered and made findings in relation to her treatment of a number of patients, over a significant period of time. The allegations found proved against Ms Moreno Correia included:

- A failure to diagnose and/or provide adequate treatment for caries in respect of one tooth.
- Poor placement of a restoration.
- A failure to carry out and/or record basic periodontal examinations at appropriate intervals and a failure to provide proper periodontal treatment.
- Inappropriate prescribing of antibiotics.
- Failure to report adequately on radiographs.
- Failure to provide an adequate standard of care in respect of root canal treatment.
- Poor record keeping.

The Committee in 2015 concluded that its findings, taken cumulatively, amounted to negligent acts and omissions in fundamental areas of dentistry. That Committee, having considered the definitions of misconduct and deficient professional performance, was satisfied that its findings against Ms Moreno Correia could be properly categorised as misconduct. The Committee in 2015 deemed Ms Moreno Correia's failure to monitor, record and appropriately treat periodontal disease for a number of patients over a period spanning up to six years to be a serious failure, falling far short of the standard required.

That Committee went on to determine that Ms Moreno Correia's fitness to practise was impaired by reason of her misconduct. It determined to suspend her registration for a period of 12 months and imposed an immediate order. It directed a review of her case shortly before the end of the period of suspension and in doing so stated that, "*any reviewing committee may find it helpful to receive the following from Ms Moreno Correia:*

- *Evidence of her current employment situation (if as a dentist)*
- *Testimonials from any employer for whom she has worked, or is working*
- *Evidence of any steps she has taken to remediate the failings identified by this Committee."*

At a resumed hearing held in June 2016, a reviewing Committee noted that there had been no communication or engagement from Ms Moreno Correia with the GDC. That Committee found that there was no evidence of remediation or insight. It further noted that there was no

information available from any other sources to suggest that Ms Moreno Correia had addressed any of the concerns identified by the Committee in 2015.

The Committee in 2016 concluded that the same risks to patient safety and public confidence persisted and that accordingly Ms Moreno Correia's fitness to practise remained impaired by reason of her misconduct. It determined to extend the period of her suspension by 12 months and directed a further review of her case shortly before the end of the extended period. In directing a review, the Committee in 2016 endorsed and adopted the suggestions made by the previous Committee in relation to what evidence the next Committee may find helpful.

### **Today's review**

This is the second resumed hearing of Ms Moreno Correia's case. In reviewing her case today, this Committee considered all the evidence presented to it. It took account of the submissions made by Mr Middleton on behalf of the GDC and accepted the advice of the Legal Adviser.

### **Decision on impairment**

The Committee considered whether Ms Moreno Correia's fitness to practise remains currently impaired by reason of her misconduct.

In reaching its decision, the Committee exercised its 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 noted that Ms Moreno Correia has not engaged with the GDC in any form since the substantive determination of the Committee in May 2015. Consequently, there is no evidence before this Committee today of any remediation undertaken by Ms Moreno Correia. Nor is there any evidence to suggest that she has any insight into the concerns about her clinical practice, as highlighted by the two previous Committees. In the absence of such evidence, this Committee has concluded that these concerns must remain and that the risk of repetition is outstanding.

In the circumstances, the Committee is of the view that the same risks to patient safety and public confidence, as previously identified in 2015 and 2016, are ongoing in this case. Accordingly, it has determined that Ms Moreno Correia's fitness to practise is currently impaired by reason of her misconduct.

### **Decision on sanction**

The Committee next considered what action to take in respect of Ms Moreno Correia's registration. It had regard to section 27C(1) of the Act, which sets out the options available to the Committee.

In reaching its decision, the Committee took into account the '*Guidance for the Practice Committees including Indicative Sanctions Guidance (effective from October 2016)*'. It noted that the purpose of any sanction is not to be punitive, although it may have that effect, but to protect the public and the wider public interest. The Committee applied the principle of proportionality, balancing the public interest with Ms Moreno Correia's own interests.

In the absence of any evidence to indicate that the serious concerns about Ms Moreno Correia's clinical practice have been addressed, the Committee determined that it would be wholly inappropriate to terminate the current suspension and take no further action.

The Committee considered whether to impose a period of conditional registration. It concluded that conditions would not be suitable or proportionate in this case. Ms Moreno Correia has not made any contact with the GDC throughout the history of these proceedings. There is therefore no evidence that she would comply with any conditions that could be formulated. The Committee decided that in the absence of such evidence, conditional registration would not serve to protect the public, nor would such an outcome satisfy the public interest.

The Committee next considered whether to suspend Ms Moreno Correia's registration for a further specified period. In doing so, the Committee took into account that an extension of the current suspension order would safeguard the public from any repetition of the kind of misconduct found by the Committee in May 2015. However, this Committee considered the public interest in these matters, in particular the expense that is incurred by continued review hearings. Ms Moreno Correia has failed to engage with all of her fitness to practise hearings to date and there is nothing to indicate any future engagement on her part. There has been no evidence to suggest that she has even acknowledged the serious findings made against her. In these circumstances, the Committee determined that a further extension of the suspension order would serve no meaningful purpose.

In reaching its conclusion, the Committee considered Ms Moreno Correia's interests and the potential consequences that an ongoing suspension may have for her. However, it decided that the public interest outweighs Ms Moreno Correia's own interests in this particular instance.

The evidence of Ms Moreno Correia's non-engagement is clear and the Committee has decided that the onus should now rest with her to contact the GDC if and when she is willing to engage with its processes.

Accordingly, the Committee directs the indefinite suspension of Ms Moreno Correia's registration in accordance with section 27C(1)(d) of the Act. In making this direction, the Committee was satisfied that the criteria for imposing an indefinite suspension are met.

Unless Ms Moreno Correia exercises her right of appeal, her registration will be suspended indefinitely, 28 days from the date that notice of this direction is deemed to have been served upon her. In the event that she does exercise her right of appeal, the suspension order currently on her registration will remain in force until the resolution of the appeal.

That concludes this determination."