PRIVATE (IN PART) HEARING

Professional Conduct Committee
Initial Hearing

10 – 21 June 2024

Name:	KAKKAD, Sunil
Registration number:	58751
Case number:	CAS-202225

General Dental Council:	Mr Tom Stevens, Counsel. Instructed by Rochelle Williams, IHLPS
Registrant:	Present Represented by Mr Peter Lownds, Counsel. Instructed by Dental Protection

---

Fitness to practise:	Impaired by reason of misconduct
Outcome:	Fitness to Practise Impaired. Reprimand Issued

Committee members:	Jane Everitt	(Lay, Chair)
	Janhvi Amin	(Dentist)
	Louise Fletcher	(Dental Care Professional)
Legal adviser:	Tehniat Watson	
Committee Secretary:	Andrew Keeling	

At this hearing the Committee made a determination that includes some private information. That information shall be omitted from any public version of this determination and the document marked to show where private material is removed.

Mr Kakkad,

1. This was a Professional Conduct Committee (PCC) inquiry into the facts which formed the basis of the allegation against you that your fitness to practise was impaired by reason of misconduct. You attended the hearing and were represented by Mr Peter Lownds, Counsel. Mr Tom Stevens, Counsel, presented the General Dental Council's (GDC) case. Stage 1 of the hearing (the factual inquiry) took place in person at the hearing suite of the Dental Professionals Hearing Service in Wimpole Street, London between 10 and 14 June 2024. Thereafter, the hearing was held remotely on Microsoft Teams.

Preliminary Matters

Rule 18 Application to Amend the Charge (12 June 2024)

2. Before the factual inquiry commenced, Mr Stevens made an application under Rule 18 of the *GDC (Fitness to Practise) Rules Order of Council 2006* ('the Rules'), to withdraw heads of charge 1(a) (including the deletion of the reference to this charge in head of charge 2),1(e) (i to xiii), 1(f) (i to viii), 1(g), 1(h) (i and ii), 1(i), 4(a) (v, vi, vii, ix and x), 4(b)(iv), 4(c)(i), 4(d) and 4(e)(i and ii).

3. In respect of head of charge 1(a), Mr Stevens submitted that following the disclosure of your witness statement, and in light of there being no formal witness statement from Patient A and the GDC not being able to call her, it did not consider that there was sufficient rebuttal evidence to continue with the charge. Similarly, in respect of heads of charge 1(e), 1(f) and 1(i), Mr Stevens submitted that in light of your position outlined in your witness statement, the GDC no longer had sufficient evidence to refute your position. In respect of head of charge 1(g), Mr Stevens submitted that both Mr Edward Bateman, the GDC expert witness, and your expert witness, Dr Sharon Caro, had considered this matter further and both expressed a view that a clinical diagnosis on 22 March 2016 was difficult in light of what you had observed. The GDC therefore considered that the evidential foundation for this head of charge no longer existed.

4. In respect of heads of charge 1(h)(i) and (ii), Mr Stevens submitted that although Mr Bateman was still critical of your practice, the extent of the failing was no more than below the required standard rather than far below. In light of this, Mr Stevens submitted that the GDC was conscious that the threshold for misconduct was set high and that it would not be appropriate to be critical of your alleged actions in respect of this head of charge. Therefore, he submitted that it should be withdrawn.

5. In light of the proposed withdrawal of head of charge 1(a), Mr Stevens submitted that the reference to head of charge 1(a) should be deleted from head of charge 2.

6. With regard to heads of charge 4(a) (v, vi, viii, ix and x), 4(b)(iv), 4(c)(i), and 4(d), Mr Stevens submitted that these were concerned with your record keeping. He submitted

that the GDC has reviewed the evidence, particularly in light of the findings within the joint expert report in which neither expert was critical of your alleged actions, and decided that these heads of charge should be withdrawn. In respect of heads of charge 4(e)(i and ii), he submitted that as these related to heads of charge 1(h)(i) and (ii), these should also be withdrawn.

7. Mr Lownds, on your behalf, submitted that he supported the application and had nothing further to add.

The Committee's decision on the Rule 18 application

8. The Committee accepted the advice of the Legal Adviser on the Rule 18 application. The Committee noted that the burden of proof was on the GDC to prove the heads of charge to the required standard. It also noted that the GDC stated that there was insufficient evidence to refute your position in respect of these heads of charge. Therefore, the Committee was satisfied that the amendments could be made without injustice to either party and that these heads of charge should be withdrawn.

9. The Committee, therefore, acceded to Mr Stevens' application to amend the charge.

Decision on Rule 53 Application for Hearing to be Part-held in Private (12 June 2024)

10. Mr Stevens then made an application to hear part of the hearing in private pursuant to Rule 53 of the Rules. He submitted that any reference to Patient A's health should be heard in private [IN PRIVATE: Text omitted]. He acknowledged that Patient A's name had been anonymised for this hearing, but submitted that he was still making this application out of an abundance of caution. Mr Lownds, on your behalf, had no objections to the application. The Committee heard and accepted the advice of the Legal Adviser.

11. The starting point for the Committee was that all hearings should be held in public as it is in the interests of justice to do so. However, a hearing may be heard in private where it concerns matters that are inextricably linked to the health or private and family life of the Registrant or any other person concerned, under Rule 53(2) (a) of the Rules. The Committee agreed that any references to Patient A's health, [IN PRIVATE: Text omitted], should be heard in private as and when they were discussed during the hearing. The Committee therefore acceded to the application.

Admissions

12. Mr Lownds, on your behalf, informed the Committee that you admitted the following heads of charge: 1(d), 2 (only in respect of 1(d)), 4(a)(i), 4(a)(ii), 4(a)(iii), 4(a)(vii), 4(a)(xii), 4(a)(xiii), 4(b)(ii), 4(b)(iii), 4(b)(v), 4(b)(vi), 4(b)(vii), 4(b)(viii), 4(c)(ii), 4(f) and 4(h).

Decision on Admissions (12 June 2024)

13. The Committee noted your admissions and considered its powers as described in the GDC's *'Guidance on Admissions made at the Preliminary Stage in Fitness to Practise Proceedings'* (issued in October 2022). In line with this guidance, the Committee announced all the admitted factual allegations as found proved.

Background and Summary of Allegations

14. The factual enquiry commenced with Mr Stevens providing the Committee with a background to the case. He stated that the case against you concerned the treatment of a single patient (Patient A). The GDC received a complaint against you from Patient A on 1 September 2021.

15. Mr Stevens stated that you had treated Patient A for many years and you were friends with her and her husband, Witness 1. [IN PRIVATE: Text omitted.]

16. [IN PRIVATE: Text omitted.]

17. Mr Stevens stated that the GDC's case against you focused on your referral practice and associated record keeping failures. In respect of the former, it was alleged that you did not refer Patient A for specialist advice/assessment when you saw her on 30 March 2016. At the same appointment, it was alleged that you did not check with Patient A whether her GP had made a referral for specialist advice/assessment. This followed a previous appointment with Patient A on 22 March 2016, when you offered a referral for assessment, but she informed you that she would be seeing her GP. You subsequently referred Patient A to Barnet General Hospital on 18 October 2016, but had not marked the referral letter as urgent. The GDC alleged that all your alleged actions amounted to a failure to provide an adequate standard of care to Patient A and put her safety at risk.

18. It was further alleged that in or around January 2021, you asked Patient A and/or Patient A's husband for 60% of the money you had paid to Patient A's implant surgeon for their treatment, having previously indicated to Patient A and/or Patient A's husband that you would pay for this treatment in full. It was alleged that this conduct was inappropriate, unprofessional and lacking in integrity.

19. In respect of the alleged record keeping failures, it was alleged that you failed to maintain an adequate standard of record keeping in respect of Patient A's appointments from 22 March 2016 to 12 April 2021. These included alleged failures in recording medical histories, sufficient details of Patient A's social history and sufficient details of the soft tissue examinations undertaken. Further alleged failures, which you had not admitted, included not recording that Patient A's hygienist had asked you to check Patient A's mouth during an appointment on 8 August 2016 and a failure to record details of the payment you made with Patient A and/or Witness 1 for Patient A's dental treatment.

Evidence

20. The Committee received factual evidence from the GDC, which included signed witness statements and associated exhibits from Witness 1, dated 29 January 2024 and 11 June 2024. It received a witness statement from a GDC employee, Islam Zaman, a Caseworker in the Fitness to Practise department, dated 4 January 2024, which exhibited Patient A's complaint, timeline and other documents requested from her. The Committee was also provided with the relevant hospital and dental records for Patient A.

21. The Committee heard oral evidence from Witness 1. Islam Zaman's witness statement was accepted into evidence without the need for him to attend the hearing.

22. Furthermore, the Committee received an expert report from Mr Edward Bateman, dated 9 January 2024. Mr Bateman also gave oral evidence.

23. The evidence the Committee received as part of your case included your witness statements, and associated exhibits, dated 3 May 2024, 4 June 2024, 7 June 2024 and 10 June 2024. It also heard oral evidence from you. A witness statement, dated 31 May 2024, was also received from Witness 2, a dental colleague who works at your practice. Witness 2 was not required to give oral evidence.

24. Furthermore, the Committee received an expert report, dated 7 May 2020, and a supplementary report, dated 14 June 2024, from Dr Sharon Caro. Dr Caro also provided two witness statements, both dated 13 June 2024, and she gave oral evidence at this hearing.

25. The Committee also received a joint expert report from Mr Bateman and Dr Caro, dated 6 June 2024, and extracts of guidance submitted by both experts.

Rule 18 Application to Amend the Charge (14 June 2024)

26. During the factual inquiry, Mr Stevens made a further application to amend the heads of charge. He submitted that head of charge 1(j) should be renamed as head of charge 3(i). Consequently, he submitted that head of charge 3 should be renamed as head of charge 3(ii) and the reference to 1(j) in that head of charge should be amended to 3(i). He submitted that as it was currently drafted, head of charge 1(j) fell under the stem of head of charge 1 which related to alleged failures in the adequate standard of care of Patient A. However, head of charge 1(j) related to allegations in respect of your professionalism and integrity, as outlined at head of charge 3. He submitted that this amendment could be made without any injustice to you.

27. Mr Lownds, on your behalf, submitted that this was a joint application and, therefore, did not oppose it.

The Committee's decision on the Rule 18 application (14 June 2024)

28. The Committee accepted the advice of the Legal Adviser on the Rule 18 application. The Committee noted that this was a joint application and that the amendment could be made without injustice to either party.

29. The Committee, therefore, acceded to Mr Stevens' application to amend the charge.

The Committee's Findings of Fact

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

31. At the outset of the proceedings, both the GDC and Mr Lownds on your behalf had jointly agreed for the hearsay evidence, which comprised Patient A's complaint to the GDC, the timeline of events based on her recollection and other documents that she had provided to the GDC, to be admitted within the proceedings. At the close of the facts stage, the Legal Adviser directed the Committee to consider what weight it could assign to hearsay evidence. The Legal Adviser advised that the Committee should consider the extent to which the hearsay evidence is agreed or disputed, its purpose and have regard to any circumstances from which any inference can reasonably be drawn as to its reliability or otherwise.

32. [IN PRIVATE: Text omitted].

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

1.	You failed to provide an adequate standard of care to patient A from 22 March 2016 to 12 April 2021, in that:
1 (a)	Withdrawn
1(b)	You did not check whether Patient A's GP had made a referral for specialist advice/assessment of their tongue during an appointment on 30 March 2016 and/or refer Patient A for specialist advice/assessment of their tongue, following an appointment on 30 March 2016; **Found Proved in its entirety**

	In considering this head of charge, the Committee first sought to determine whether you had not referred Patient A for specialist advice/assessment of their tongue on 30 March 2016 and whether this amounted to a failure to provide an adequate standard of care to Patient A. In doing so, the Committee found that it would be assisted in reviewing what had occurred during your earlier appointment with Patient A on 22 March 2016. The Committee considered Patient A's dental records and noted that during the appointment on 22 March 2016, you had noted that Patient A had complained that the right lateral border of her tongue was "*sore on eating even mild spicy food*" for two to three months previously. You had also recorded that you had noticed a white line on the right lateral border of the tongue, which was 5mm long and very slightly raised. You had not made a diagnosis. You had recorded that you would, "*send for assessment*". However, this was not done as you had noted that Patient A was also seeing her GP on the same day in relation to other issues and that she would be discussing this matter with her. The Committee then reviewed the records for the appointment on 30 March 2016. It noted that this was an emergency appointment as Patient A had presented with "*bad pain*" at the Lower Left Quadrant (LLQ). The Committee noted that there was no reference in the records that you had checked with Patient A whether her GP had made a referral for specialist advice/assessment. The Committee also noted that there was no reference to the absence or otherwise of the white line on the right lateral border of the tongue recorded eight days earlier. The Committee noted that you accepted that you had not made a referral on 30 March 2016. However, you denied that this amounted to a failure to provide an adequate standard of care. In your witness statement of 7 June 2024, you stated that as it was an emergency appointment your focus was on the LL7, which was the source of the pain. However, your usual practice was to check the soft tissues and you would have recorded any abnormalities of the tongue. You stated that in all likelihood the white line on Patient A's tongue, which was present on 22 March 2016, had disappeared by 30 March 2016. Therefore, there was

	no clinical reason to refer for specialist assessment. However, you went on to state that even if the white line had been present, unless it had grown or changed in appearance, then it was reasonable to monitor the lesion. Your position was supported by Dr Caro. She stated in her expert report that she was not critical of your actions and it was reasonable to monitor the situation and not to refer. The Committee noted the following from her report: *"It is my opinion that given this set of complaints a large body of reasonably competent general dental practitioners would consider that the symptoms suggested geographic tongue or Lichen Planus and would monitor the situation at that point in time and not refer".* To support her opinion, Dr Caro referred to the National Institute for Health and Care Excellence (NICE) guidelines, which was provided to the Committee. It noted her view that the lesion may or may not have been present on 30 March 2016 and were it present as a white line, it would not have come within those guidelines and as such would not warrant a referral at that time. Mr Bateman, however, stated in oral evidence that even if the white line on Patient A's tongue had not been present on 30 March 2016 but Patient A was still experiencing sensitivity in that area, you still should have referred Patient A for specialist assessment if you were unable to diagnose a cause for the symptoms. In his expert report, Mr Bateman referred to the College of General Dentistry Clinical Examination and Record-Keeping Good Practice Guidelines (2016). Mr Bateman stated that as Patient A was presenting with an unknown aetiology, the guidance "*notes that the patient should be referred to hospital if a premalignant lesion or any oral lesion of unknown aetiology is present*". When making its decision the Committee reviewed Patient A's dental records. It firstly noted from 22 March 2016, that Patient A had presented with pain on the right lateral border of her tongue as it was "*sore on eating even mild spicy food*" for two to three months previously. In parallel to the symptoms you also noted a sign in that she presented with *"white line ~ 5 mm long R [right] lateral border of tongue v [very] slightly raised. To send for*

	assessment". It noted that you did not record any diagnosis or possible diagnosis. You had wanted to refer Patient A for specialist advice, but had not done so as she had informed you that she would discuss the matter with her GP. The Committee noted that the next appointment on 30 March 2016 was an emergency appointment in which Patient A presented with a different complaint, namely pain in her LLQ. In your records for this appointment, there was no record of whether there was still a white lateral line on her tongue or whether Patient A was still experiencing sensitivity to food. The Committee next considered Patient A's appointment with you on 13 October 2016, that resulted in your referral on 18 October 2016 to Barnet General Hospital. In particular, the Committee considered your referral letter, dated 18 October 2016. It noted from that letter that you refer to Patient A having two "*white dots*" on the right lateral border of the tongue. Furthermore, it noted that you had stated that there had been a white line type of lesion on a previous occasion also on the right lateral border of the tongue. Having considered these records, and the fact that Patient A had displayed signs of a white line on her tongue on 22 March 2016 and that this had changed to white dots on 13 October 2016, the Committee accepted Mr Bateman's opinion and considered it more likely than not that Patient A would have presented with similar signs on 30 March 2016. Furthermore, the Committee noted that on 22 March 2016, Patient A had been experiencing sensitivity to food for two to three months previously. Therefore, it considered that these symptoms would likely have still been present eight days later without any intervening treatment and noted resolution. Having determined that Patient A's signs and symptoms were more likely than not present on 30 March 2016, the Committee then considered whether you should have referred Patient A for assessment. To assist with this, the Committee considered the guidance that was available to you at the time as mentioned by Mr Bateman and Dr Caro. The Committee noted the guidance referred to by Mr Bateman in his expert report, which was the College of General Dentistry Clinical Examination and Record-Keeping Good Practice Guidelines (2016). It noted that the guidance stated that a

	referral should be made if a patient presented with an unknown aetiology. It noted that both experts agreed that the 5 mm line was a presentation of an unknown aetiology. The Committee carefully considered both experts' evidence. It noted that in her report, Dr Caro stated, "*where the initial complaint on 22/03/16 had not triggered enough of a response to meet the threshold for a referral the week previously, it is unlikely that this decision would have changed*". However, the Committee noted that this was incorrect as you had decided to make a referral on 22 March 2016, albeit this did not occur, at the suggestion of Patient A. Therefore, in the Committee's view this supported the view that you should have made a referral on 30 March. In respect of Mr Bateman's evidence on this matter, the Committee found him to be persuasive and cogent. It accepted his evidence that as it was more likely than not that Patient A had presented with a lesion of unknown aetiology on 30 March 2016, and therefore a referral should have been made. Furthermore, it determined that your failure to do so amounted to a failure to provide an adequate standard of care to Patient A. Accordingly, it found this aspect of the head of charge proved. The Committee then went on to consider if you had checked whether Patient A's GP had made a referral for specialist advice/assessment of their tongue during an appointment on 30 March 2016 In your supplementary witness statement, dated 7 June 2024, you stated that, "*It is not admitted that I did not check whether Patient A's GP had made a referral to a specialist on this occasion. Patient A and I may have discussed her appointment with her GP but, with the passage of time, I cannot remember and I did not make a note of doing so*". You re-iterated this position in your oral evidence. In his expert report, Mr Bateman stated that if you did not check whether Patient A's GP had made a referral, then this fell far below the standard expected. Dr Caro, in her expert report, stated that "*an absence of note does not mean that the appointment with the GP was not discussed only that it was not recorded*".

	In the absence of any note in the records and your evidence that you could not be certain whether you had discussed this with Patient A, the Committee considered what your usual practice would have been. The Committee was satisfied that if you had checked this with Patient A, you would have made a record, particularly as you had recorded "*send for assessment*" and that she was due to see her GP on 22 March 2016. Furthermore, given the seriousness of your findings in respect of Patient A's tongue and your decision to refer only eight days previously on 22 March 2016, the Committee considered that if you had checked with Patient A then this would have been recorded. Therefore, the Committee determined that in the absence of any such record, it was more likely than not that you had not checked with Patient A whether her GP had made a referral. Such an omission, in the circumstances, was a failure to provide an adequate standard of care given your previous decision to refer. Accordingly, the Committee found this aspect of the head of charge proved.
1(c)	You did not mark the referral letter you sent to Barnet General Hospital on 18 October 2016 as urgent; **Found Proved** The Committee had sight of Patient A's records and noted Patient A's appointment with you on 13 October 2016, which resulted in your referral letter dated 18 October 2016. It noted that the letter was not marked as urgent and this was accepted by you. However, you deny that this amounted to a failure to provide an adequate standard of care to Patient A. In his expert report, Mr Bateman, stated: *"It is my opinion that given the previously discussed concerns regarding the site, signs and symptoms of this lesion that the Registrant had not made a diagnosis for, and the lack of resolution in the intervening 6 months, that the Registrant should have made an urgent referral at this point again, although the Registrant had not considered the presentation to be typical of a sinister lesion, and did not specify that the referral was urgent. The failure to mark the referral letter as urgent fell far below the standard expected of a competent GDP in my opinion as it made a timely referral less likely and increased the risk of serious harm*

	for this patient. A reasonable body of dentists would have made this referral urgently, marked it as urgent, and followed this up with a call to the department that the patient was being referred to." Mr Bateman also referred to the *Scottish Dental Clinical Effectiveness Programme Management of Acute Dental Problems Guidance for Healthcare Professionals (March 2013*). Dr Caro was not critical of you for not marking the referral letter as urgent. In her expert report, she referred to the NICE guidelines and stated that Patient A did not meet the threshold for an urgent referral at that time. She referred to the records and Patient A's presenting complaint and stated in her report: *"It would be reasonable to consider a diagnosis of 'Geographic Tongue' or Lichen Planus given this set of patient complaints. None of the red flag symptoms were evident at this point in time. I am therefore not critical that Dr Kakkad did not mark the referral letter sent to Barnet General Hospital on 18 October 2016 as urgent. Hindsight should not be applied to this situation.*" Both experts maintained their positions during oral evidence. In your oral evidence, you stated that you were following the NICE guidelines and Patient A's presenting symptoms did not meet the threshold for an urgent referral. In particular, the NICE guidelines refer to an urgent referral being required if there is a "*red or red and white patch*" on the tongue. You stated that, in your opinion, the two white dots on Patient A's tongue did not constitute a patch. It noted your evidence and Dr Caro's evidence that the two white dots on Patient A's tongue did not constitute a patch and therefore a referral was not required according to the NICE guidelines. However, the Committee was of the view that a reasonable body of dentists would also have taken into consideration Patient A's presenting historical signs and symptoms as mentioned by Dr Bateman in his oral evidence. Patient A had attended two appointments with you seven months previously in March 2016. She had attended on 22 March 2016 with a white line on her tongue and had been experiencing sensitivity to food for two to three months previously. The Committee has also now determined that it was more likely than

	not that those signs and symptoms would have been present on 30 March 2016. On 13 October 2016, Patient A now had two white dots on the same side of her tongue. In your referral letter you made reference to both the two white dots and the previous white line being on the right lateral border of the tongue. Furthermore, you stated in the referral letter that Patient A was still complaining of pain on eating "*sharp/acidic foods on the right lateral border of the tongue*". The Committee considered that in October 2016 in addition to the symptoms being present, the presentation of two white dots would be indicative of an alternate presentation of a sign. The Committee noted the guidance referred to in Mr Bateman's expert report, namely the *Scottish Dental Clinical Effectiveness Programme Management of Acute Dental Problems Guidance for Healthcare Professionals (March 2013*). It noted from this guidance that, *"if a red, white or mixed speckled red and white or pigmented area has been present for more than 3 weeks, refer the patient via the local rapid access pathway to investigate potential dysplasia or malignancy"*. Therefore, in line with this guidance, and taking into consideration Patient A's history of signs and symptoms on the right lateral border of the tongue, the Committee was of the view that a reasonable body of dentists would have marked the referral letter as urgent. Failure to do so, in the Committee's view, amounted to a failure to provide an adequate standard of care to Patient A as it made a timely assessment less likely. Accordingly, the Committee found this head of charge proved.
1(d)	Between 18 October 2016 and 28 May 2019, you failed to adequately check whether the referral you made to Barnet General Hospital on 18 October 2016 had been acted upon; **Admitted and Found Proved**
1(e)	Withdrawn, including sub-charges i to xii.
1(f)	Withdrawn, including sub-charges i to viii.
1(g)	Withdrawn
1(h)	Withdrawn, including sub-charges i and ii.
1(i)	Withdrawn

1(j)	Renamed as head of charge 3(i).
2.	You conduct in Charge 1.b. and/or 1.c. and/or. 1.d. put Patient A's safety at risk. **Admitted for 1(d).** **Found Proved in its entirety.** The Committee has found proved that your actions at 1(b), 1(c) and 1(d) amounted to a failure to provide an adequate standard of care to Patient A. The Committee noted from Mr Bateman's expert report that, *"…, failure to refer the patient at this stage* [30 March 2016] *created an unduly increased risk of very serious harm to the patient, thus fell far below the standard of care expected of a competent dentist, in my opinion."* Furthermore the Committee noted, in his report, Mr Bateman stated that, "*the failure to mark the referral letter* [of 18 October 2016] *as urgent fell far below the standard expected of a competent GDP in my opinion as it made a timely referral less likely and increased the risk of serious harm for this patient"*. The Committee was, therefore, satisfied that your actions at 1(b) and 1(c) put Patient A's safety at risk. Accordingly, it found this head of charge proved.
3 (i)	In or around January 2021 you asked Patient A and/or Patient A's husband for 60% of the money you had paid to Patient A's implant surgeon for their treatment, having previously indicated to Patient A and/or Patient A's husband that you would pay for this treatment in full. **Found Not Proved** The Committee firstly noted that it was not disputed that in or around January 2021 you had asked Patient A and/or Patient A's husband for 60% of the money you had paid to Patient A's implant surgeon for their treatment. The Committee had sight of the invoice, which detailed the total cost of the implant treatment, and the post-it attached, which detailed 60% of the cost.

	However, you deny that you had previously indicated to Patient A and/or Witness 1 that you would pay for the treatment in full. In your witness statement, you stated that you and your wife attended a dinner party at Patient A and Witness 1's home on 18 July 2020. During the evening, you explained that Witness 1 had mentioned that they had incurred a lot of cost in respect of Patient A's restorative treatment and that you formed the impression that they were struggling with money. In your statement, you stated: *"I recall saying to them that I could pay for outstanding restorative treatment through the Practice and could save them 40 percent cost of the treatment.* *I have thought very hard about what was said during this conversation, and I am sure that I did not specifically say that I was offering a "loan". However, this is what I meant when I said that I could save them 40 percent of the cost of the restorative treatment. I thought therefore, that it was clear that they would have to repay me 60 percent of the cost of the treatment because I said I would be able to "save" them 40 percent of the … fees to complete the restorative treatment."* In your statement, you went on to state that you sent a message by WhatsApp to Patient A on 19 November 2020 stating that you had made the payment for the implant treatment. Then, on 22 January 2021, you visited Patient A at her home and gave her the invoice with the post-it note attached. Witness 1 denies your version of events. In his witness statement, he states that a conversation took place between you, Patient A and himself at your practice sometime at the end of June or beginning of July 2019. He stated that he felt reassured that during this conversation that you would settle the whole amount of Patient A's treatment. In his witness statement he stated that, "*I have been asked by the Council how I was assured. I was assured because the Registrant said he would be making remittances for further dental work*". Witness 1 went on to state that you, "*didn't say it was a loan or anything like that. It was only later he said it was a loan and he said it was because I didn't have enough to pay the surgeon*".

	Witness 1 reiterated this position in his oral evidence. Witness 1's evidence was also supported by the information provided by Patient A to the GDC as part of her complaint. The Committee also had sight of the WhatsApp messages between you and Witness 1 dated January 2021 in which Witness 1 disputes with you your request for payment. The Committee carefully considered the reliability of Witness 1's witness statement and oral evidence. It found both his oral and written evidence to be vague in respect of the terms of the financial arrangement. In particular, the Committee noted from his witness statement that he stated, *"I was very surprised that the Registrant did not offer to pay for the implants at that point however it was mentioned in passing that he is around to resolve matters which to me meant that he may reimburse the £9,000 for the operation*". The Committee also noted from his witness statement the following: *"At that point the Registrant implicated [sic - the Committee believe that this should read implied] that the Practice had reserve funds to resolve such issues in the event further dental treatments occurred"*. The Committee was of the view that Witness 1 did not refer to any evidence that categorically stated that you would be paying for the treatment on Patient A's behalf. The Committee then went on to carefully consider your witness statement and oral evidence. It noted that in your description of your conversation with Witness 1 and Patient A in January 2021 you were not sure whether you had told them that your intended payment was only a loan and, therefore, this may not have been clear to them. The Committee determined, therefore, that it appeared that at the outset of the discussions there was clearly potential for misunderstanding from both parties about the payment arrangements. The Committee considered that it was Witness 1's honestly held belief that you would be paying for the implant work on Patient A's behalf. The indignation and upset he showed in the WhatsApp messages supported this view. However, the Committee was also of the view that you had always intended it

	to be a loan, albeit that you may not have clearly expressed that to Patient A and Witness 1 at the time, as supported by the vague assertions regarding payment in witness 1's statement. Consequently, the Committee determined that you had not previously indicated to Patient A and/or Patient A's husband that you would pay for this treatment in full. Accordingly, the Committee found this head of charge not proved.
3. (ii) (a) to (c)	Your conduct in Charge 3(i) was: Inappropriate; Unprofessional; Lacking in integrity. As the Committee found head of charge 3(i) not proved, this head of charge fell away.
4.	You failed to maintain an adequate standard of record keeping in respect of A's appointments from 22 March 2016 to 12 April 2021, in that:
4(a)	You did not record any medical history update on:
4(a)(i)	22 March 2016; **Admitted and found proved**
4(a)(ii)	30 March 2016; **Admitted and found proved**
4(a)(iii)	13 October 2016; **Admitted and found proved**
4(a)(iv)	13 March 2017; **Found Proved** You had initially denied this head of charge as you stated that a medical history was taken from Patient A and documented on 6 March 2017, which you would have checked verbally at her appointment on 13 March 2017.

	However, during cross examination you accepted that you should have recorded a medical history on 13 March 2017. The Committee accepted your admission and, accordingly, found this head of charge proved.
4(a)(v)	Withdrawn
4(a)(vi)	Withdrawn
4(a)(vii)	30 October 2018;, **Admitted and Found Proved.**
4(a)(viii)	Withdrawn
4(a)(ix)	Withdrawn
4(a)(x)	Withdrawn
4(a)(xi)	18 November 2019; **Found Proved** You had initially denied this head of charge as you stated that you had not provided treatment to Patient A on this date and had only checked the healing of soft tissues, but you still would have asked her about any changes to her medical history as was your usual practice. However, during cross examination you accepted that you should have recorded a medical history on 18 November 2019. The Committee accepted your admission and, accordingly, found this head of charge proved.
4(a)(xii)	10 March 2020; **Admitted and Found Proved**
4(a)(xiii)	October 2020; **Admitted and Found Proved**
4(b)	You did not record sufficient details of Patient A's social history on:
4(b)(i)	22 March 2016;

	Found Proved You had initially denied this head of charge as you stated that you knew Patient A as a longstanding patient and a personal friend and knew that she did not drink alcohol or smoke. However, during cross examination you accepted that you should have recorded Patient A's social history on 22 March 2016. The Committee accepted your admission and, accordingly, found this head of charge proved.
4(b)(ii)	13 October 2016; **Admitted and Found Proved**
4(b)(iii)	12 May 2017; **Admitted and Found Proved**
4(b)(iv)	Withdrawn
4(b)(v)	30 October 2018; **Admitted and Found Proved**
4(b)(vi)	10 March 2020; **Admitted and Found Proved**
4(b)(vii)	26 October 2020; **Admitted and Found Proved**
4(b)(viii)	17 February 2021; **Admitted and Found Proved**
4(c)	You did not record sufficient details of the soft tissue examinations undertaken on:
4(c)(i)	Withdrawn
4(c)(ii)	13 March 2017; **Admitted and Found Proved**
4(c)(iii)	12 May 2017;

	Found Proved You initially denied this head of charge as it was your standard practice not to record negative findings. You accepted during cross examination that this amounted to a failing from a record keeping point of view. The Committee accepted your admission and, accordingly, found this head of charge proved.
4(c)(iv)	19 April 2018; **Found Proved** You initially denied this head of charge as it was your standard practice not to record negative findings. You accepted during cross examination that this amounted to a failing. The Committee accepted your admission and, accordingly, found this head of charge proved.
4(c)(v)	30 October 2018; **Found Proved** You initially denied this head of charge as it was your standard practice not to record negative findings. You accepted during cross examination that this amounted to a failing. The Committee accepted your admission and, accordingly, found this head of charge proved.
4(c)(vi)	10 March 2020; **Found Proved** You initially denied this head of charge as you stated you carried out a soft tissue examination and recorded your findings. In cross examination, it was put to you that your recording was insufficient and you accepted that this amounted to a failing. The Committee accepted your admission and, accordingly, found this head of charge proved.

4(c)(vii)	26 October 2020; **Found Proved** You initially denied this head of charge as you stated you carried out a soft tissue examination and recorded your findings. In cross examination, it was put to you that your recording was insufficient and you accepted that this amounted to a failing. The Committee accepted your admission and, accordingly, found this head of charge proved.
4(c)(viii)	17 February 2021; **Found Proved** You initially denied this head of charge as you stated you carried out a soft tissue examination and recorded your findings. In cross examination, it was put to you that your recording was insufficient and you accepted that this amounted to a failing. The Committee accepted your admission and, accordingly, found this head of charge proved.
4(d)	Withdrawn
4(e)	Withdrawn, including sub-charges i and ii.
4(f)	Between the 18 October 2016 and 28 May 2019 you did not record any conversations you had with Patient A about the referral you made to Barnet Hospital on 13 October 2016; **Admitted and Found Proved**
4(g)	You did not record that Patient A's hygienist had asked you to check Patient A's mouth during an appointment on 8 August 2016; **Found Not Proved** In your witness statement, you denied that Patient A's hygienist had asked you to check Patient A's mouth during this appointment, as alleged by Patient A. You stated that Patient A was mistaken about this appointment and was confusing it with an appointment on 5 November 2012.

	The Committee noted from Patient A's dental records that she had seen the hygienist on 8 August 2016. However, there was no note within the record of the hygienist having asked you to check Patient A's mouth. The Committee considered that it had insufficient evidence before it to be satisfied that, on balance, Patient A's hygienist had asked you to check Patient A's mouth during her appointment on 8 August 2016, which you then had not recorded. Accordingly, the Committee found this head of charge not proved.
4(h)	You did not record a risk assessment for Medication Related Osteonecrosis of the jaw ['MRONJ'] on 13 March 2017; **Admitted and Found Proved**
4(i)	You did not record details of the payment arrangement you made with Patient A / Patient A's husband, on or around 20 June 2019, for her future dental treatment. **Found Not Proved** The Committee has already made a finding that the payment arrangement constituted a loan from you to Patient A and Witness 1. The Committee accepted Mr Bateman's opinion in this regard that a loan between friends would not need to be recorded in the patient's records. Accordingly, the Committee found this head of charge not proved.

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

Summary of the Committee's Findings of Fact

35. The Committee has found proved that you failed to provide an adequate standard of care to Patient A from 22 March 2016 to 12 April 2021 in that:

    - You did not check whether Patient A's GP had made a referral for specialist advice/assessment of their tongue during an appointment on 30 March 2016 and you did not refer Patient A for specialist advice/assessment of their tongue, following an appointment on 30 March 2016;

    - You did not mark the referral letter you sent to Barnet General Hospital on 18 October 2016 as urgent; and

    - Between 18 October 2016 and 28 May 2019, you failed to adequately check whether the referral you made to Barnet General Hospital on 18 October 2016 had been acted upon;

36. The Committee found proved that your actions above put Patient A's safety at risk.

37. The Committee also found proved that you failed to maintain an adequate standard of record keeping in respect of Patient A's appointments on various dates between 22 March 2016 and 17 February 2021. These record keeping failures included not recording any medical history update, not recording sufficient details of Patient A's social history and not recording sufficient details of soft tissue examinations undertaken.

38. The Committee further found proved, following your admissions, that between 18 October 2016 and 28 May 2019 you did not record any conversations you had with Patient A about the referral you made to Barnet Hospital on 13 October 2016 and you did not record a risk assessment for Medication Related Osteonecrosis of the jaw ['MRONJ'] on 13 March 2017.

Documents

39. The Committee had regard to further documents at this stage, namely your witness statement, dated 18 June 2024, and accompanying remediation bundle. This bundle included your Personal Development Plan (PDP), Continuing Professional Development (CPD) certificates and associated reflections, audits, logs, a workplace supervisor report and other documents. The Committee also reminded itself of the testimonials you provided at the factual inquiry stage.

Submissions

40. In accordance with Rule 20(1)(a), Mr Stevens informed the Committee that you have no previous fitness to practise history with the GDC.

41. With regard to misconduct, Mr Stevens submitted that he acknowledged that the scope of the case had reduced following the withdrawal of some of the heads of charge and the Committee's findings of fact. However, he submitted that what remained of the case could be categorised under two headings, namely your referral practice failings and the associated risks to patient safety, and record keeping failures. He submitted that both of these areas of concern comfortably passed the threshold for misconduct.

42. Mr Stevens submitted that the Committee has found proved repeated failures in respect of your referral practice that put Patient A's safety at risk. He also referred the Committee to Mr Bateman's conclusions in his expert report in which he stated that your failures in this regard were far below the standard expected. Furthermore, he referred to Standard 7.1 of the GDC's *Standards for the Dental Team (2013)* (the GDC Standards).

43. In respect of the record keeping failures, Mr Stevens drew the Committee's attention to the matters found proved at heads of charge 4(c)(ii) and 4(f). He submitted that it was agreed between both experts that these two failings were significant and far below the expected standard. With regard to the other record keeping failures, he submitted that Mr Bateman's conclusion was that they cumulatively amounted to far below the standard expected. This was due to their repeated nature and the time over which they occurred. He also referred to Standard 4.1 of the GDC Standards.

44. Mr Stevens then moved on to the issue of current impairment and first addressed the Committee in respect of public protection. He submitted that the proven matters in this case related to the discrete area of your clinical practice. He submitted that your clinical failings were remediable and referred the Committee to the remediation bundle you produced for this stage. He submitted that Mr Bateman has reviewed your remediation evidence and was impressed by how extensive it was and that it was tailored to the specific areas of concern. He submitted, therefore, that it was a matter for the Committee's considered judgement as to whether it finds your fitness to practise to be impaired on public protection grounds and he made no positive submissions in this regard.

45. Mr Stevens submitted, however, that a finding of current impaired was required in the public interest. He submitted that your failings placed Patient A at unwarranted serious risk of harm and that it was conduct capable of bringing the profession into disrepute. Furthermore, he submitted that not to make a finding would fundamentally undermine public confidence in the profession and would fail to maintain and uphold proper standards in the dental profession.

46. Mr Stevens next addressed the Committee on the matter of sanction. He submitted that the appropriate and proportionate sanction would be one of suspension for a period of three months with no immediate order or review hearing. He submitted that this would be sufficient to mark the seriousness of your wrongdoing and satisfy the public interest concerns. Alternatively, he submitted that if the Committee were to find your fitness to

practise impaired on both public protection and public interest grounds, then a suspension of six months would be reasonable and appropriate. This should also include an immediate order and a review hearing before the suspension order expires.

47. Mr Lownds, on your behalf, first addressed the Committee on the matter of misconduct. He submitted that the referral failures related to the treatment of one patient and it had not been suggested that they caused actual harm to Patient A. He submitted that this fell short of amounting to serious misconduct for the purposes of a fitness to practice case. In respect of the record keeping failures, he submitted that they fell under two categories, namely those that fell far below the expected standards and those that fell below the expected standard. In respect of heads of charge 4(c)(ii) and 4(f), you accepted that your actions fell far below the expected standard. However, he queried whether they were sufficiently serious to constitute misconduct as they were not causative of harm. In respect of your actions that were below the expected standard, he submitted that it would not be appropriate for the Committee to consider these cumulatively and conclude that they amounted to far below the expected standard.

48. In respect of impairment, Mr Lownds submitted that your fitness to practise was not currently impaired. He submitted that the referral failings took place eight years ago and the most recent record keeping failures took place three years ago. Since that time, you have taken effective action to remedy the shortcomings in your practice and have practised safely. He submitted that during your oral evidence at Stage 1, you showed remorse and insight and took responsibility for your failings. He submitted that you have presented remediation evidence that was precise and detailed and which showed you have reflected carefully on all areas found proved. He submitted that you have attended relevant CPD courses and properly reflected on those courses. Furthermore, you have been under the supervision of a workplace supervisor and have been subject to regular and random auditing. He submitted that you have also made changes in respect of your referral practice. In conclusion, he submitted that you have remediated the failings extensively, impressively and fully, and that the risk of repetition of the failings was extremely low.

49. Mr Lownds submitted, therefore, that your fitness to practise was not impaired on either public protection or public interest grounds. He submitted that the failings amounted to one patient and one referral, and you did not cause any actual harm to Patient A. Taking this together with the level of insight shown and remediation undertaken, he submitted that it would not be appropriate to make a finding of current impairment on either of these grounds.

50. In respect of sanction, Mr Lownds submitted that if the Committee found impairment the only proportionate and appropriate sanction would be a reprimand. He submitted that most of the factors listed in the GDC's *Guidance for The Practice Committees including Indicative Sanctions Guidance (October 2016, revised December 2020) (the*

GDC's Guidance) in respect of a reprimand were present. He submitted that a suspension would be utterly disproportionate.

Committee's Decision

51. The Committee has borne in mind that its decisions on misconduct, impairment and sanction were matters for its own independent judgment. There is no burden or standard of proof at this stage of the proceedings. The Committee had regard to the GDC's Guidance. The Committee also received advice from the Legal Adviser which it accepted. The Committee first considered whether the facts found proved amounted to misconduct.

Misconduct

52. The Committee first considered the referral failings. It had regard to the GDC's Standards and determined that you had breached the following sections in particular:

> *1.4.2 You must provide patients with treatment that is in their best interests, providing appropriate oral health advice and following clinical guidelines relevant to their situation. You may need to balance their oral health needs with their desired outcomes.*
>
> *If their desired outcome is not achievable or is not in the best interests of their oral health, you must explain the risks, benefits and likely outcomes to help them to make a decision.*
>
> *7.1 You must provide good quality care based on current evidence and authoritative guidance.*

53. The Committee considered that your actions in not referring Patient A for assessment in March 2016 including your failure to check with Patient A whether her GP had made a referral, your failure to mark your subsequent referral letter of Patient A in October 2016 as urgent and your failure to check over a two and half year period whether it had been acted upon, were serious failings. The Committee determined that these failings could have had an adverse impact on Patient A's subsequent diagnosis and treatment and placed her safety at risk. The Committee further noted the conclusions in Mr Bateman's expert report that your actions were far below the expected standard, and Dr Caro's conclusion in respect of your failure not to check that the referral had been acted upon, which also stated that your actions were far below the expected standard.

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

55. The Committee then went on to consider the record keeping matters. It found that your actions were in breach of the following section in the GDC's Standards:

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

56. In respect of your failure to record sufficient details of a soft tissue examination on 13 March 2017 (head of charge 4(c)(ii)), the Committee noted that this occurred six months after you had referred Patient A for specialist advice. The Committee also had regard to Mr Bateman's conclusion that this was far below the expected standard. The Committee, therefore, considered this was a serious failing as it could have impacted on Patient A's subsequent care. Similarly, your failure not to record any conversations with Patient A for two and a half years after your referral (head of charge 4(f)), could also have had an impact on Patient A's subsequent care and treatment. Both experts were of the view this was far below the expected standard. The Committee also considered this to be a serious failing.

57. In respect of the other record keeping failings, the Committee was mindful of the need to be cautious in considering the cumulative effect of these to determine whether they could amount to far below the expected standard. However, the Committee was of the strong view that due to the number of record keeping omissions over a period of time, a pattern had emerged of a failure to maintain an adequate standard of record keeping. The Committee was therefore satisfied that when looked at cumulatively the failings were serious and passed the threshold for misconduct. In particular, the Committee noted that the effect of you not recording sufficient details of Patient A's social history and soft tissue examinations on individual dates resulted in these not being recorded for two years. The Committee, therefore, determined that owing to the repeated nature of the individual failings and the time period over which they occurred, they amounted to misconduct.

Impairment

58. The Committee then considered whether your fitness to practise was currently impaired by reason of your misconduct. The Committee first noted that as the failings in this case only related to your clinical practice they were capable of being remedied. The Committee then went on to consider whether they had been sufficiently remedied and carefully considered your remediation evidence. The Committee noted that you had now changed your referral and record keeping practice. It noted your excel spreadsheet in which you track all referrals made and that you are now sending photos with your referrals. The Committee also noted the examples of urgent referrals you have made and the email correspondence that accompanied them. In respect of your record keeping, the Committee noted that you are using new templates that include prompts to remind you to ask patients relevant questions. It also noted that in some instances you have asked your Dental Nurse to take notes to allow you to engage more fully with your patients. You have also put up leaflets in your practice in order to educate staff and patients.

59. The Committee also considered your CPD evidence. It noted that you had undertaken multiple training courses, which were relevant to the matters in this case, and that these were accompanied by thoughtful and in depth written reflections. The Committee further noted that you had attended in person for some of these courses in addition to the online courses. The Committee also had sight of the report from your workplace supervisor, which was positive and showed that there were no concerns regarding your clinical practice. Furthermore, the results of the audits undertaken show an improvement in your practice. In addition, the Committee considered the positive testimonials submitted about you.

60. In terms of insight, the Committee noted from your witness statement, dated 18 June 2024, that you were remorseful about your failings and you had apologised to Patient A and her family. The Committee noted that you had identified and acknowledged the failings in your clinical practice and sought to address them. The Committee was satisfied that you had shown full insight into your clinical failings and the risk of repetition was very low.

61. In conclusion, the Committee found your remediation evidence to be significant, thorough and tailored to the particular clinical failings in this case. It noted that you had no previous fitness to practice history and that there had now been eight years since the clinical failings and three years since the most recent record keeping failings. The Committee further noted that there had been no repeat of the misconduct it has found since then and was satisfied that you had fully remediated the clinical failings in this case.

62. Accordingly, the Committee determined that your fitness to practice was not currently impaired on public protection grounds.

63. The Committee then went on to consider whether your fitness to practice was impaired on public interest grounds.

64. The Committee was mindful of its role to protect the public interest, which includes:

- The protection of patients, colleagues and the wider public from the risk of harm;
- Maintaining public confidence in the dental professions;
- Upholding the reputation of the dental professions; and:
- Declaring and upholding appropriate standards of conduct and competence among dental professionals.

65. In considering impairment, the Committee also reviewed the Fifth Shipman report by Dame Janet Smith, which set out the following four potential grounds to consider when determining current impairment:

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

- *He/she has in the past brought and/or is liable in the future to bring the medical profession into disrepute;*
- *He/she has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession;*

  …

66. The Committee considered that your failings had placed Patient A at unwarranted risk of harm and you had breached fundamental tenets of the dental profession in failing to provide an adequate standard of care and failing to maintain an adequate standard of record keeping and, accordingly, had brought the dental profession into disrepute.

67. The Committee determined that a finding of impairment for your misconduct was necessary in the wider public interest to maintain public confidence in the profession and to uphold proper standards in relation to referral practice and record keeping.

68. The Committee therefore determined that your fitness to practise was currently impaired by reason of your misconduct on public interest grounds only.

Sanction

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

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

71. The mitigating factors in this case include:

- Evidence of good conduct following the incident in question, particularly your remedial action;
- Evidence of previous good character;
- Evidence of remorse shown, insight and apology given, and admissions made;
- Evidence of steps taken to avoid a repetition;
- Time elapsed since the incident.

72. The aggravating factors in this case include:

- Unwarranted risk of harm to a patient;
- Misconduct sustained or repeated over a period of time, albeit in relation to one patient.

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

74. The Committee next considered whether it would be appropriate to conclude the case with a reprimand. The Committee had regard to the GDC's Guidance and noted the following:

> *"A reprimand does not impose requirements on a registrant's practice and should therefore only be used in cases where he or she is fit to continue practicing without restrictions. A reprimand might be appropriate if the circumstances do not pose a risk to patients or the public which requires rehabilitation or restriction of practice."*

75. Furthermore, the Committee noted from the GDC's Guidance that a reprimand may be suitable where the following factors were present:

- There is no evidence to suggest that the dental professional poses any danger to the public;
- The dental professional has shown insight into his failings;
- The behaviour was not deliberate;
- The dental professional has genuinely expressed remorse
- There is evidence that the dental professional has taken rehabilitative/corrective steps;
- The dental professional has no previous history.

76. The Committee considered that these aspects were present in this case.

77. Having given the matter careful consideration, the Committee has determined that a reprimand was the appropriate sanction to impose in the particular circumstances of this case. The Committee was satisfied that you had fully remediated the clinical concerns and there was no evidence to suggest that you posed a risk to patients. You have no fitness to practise history and you have also shown remorse for and insight into your misconduct.

78. In all the circumstances the Committee considered that the issuing of a reprimand was sufficient to mark the seriousness of the matters identified by this case. A reprimand meets the public interest considerations of trust and confidence in the profession and the declaring and upholding of proper professional standards engaged in this case. The Committee was satisfied that a reasonable informed observer would note the Committee's findings of facts, misconduct and impairment, and would consider that the sanction of a reprimand represents a suitable and proportion disposal of this case.

79. Having determined that a reprimand was the commensurate and appropriate sanction to impose, the Committee found that to impose a higher sanction would be disproportionate in the circumstances of the case. A period of conditional registration

would not be proportionate or appropriate given that the finding of current impairment was made purely in the public interest. Furthermore, in respect of suspension, the Committee considered that public confidence in the profession would be sufficiently protected by a lesser sanction.

80. The Committee has therefore determined that a reprimand should be recorded against your name in the Register. The fact of this reprimand, and a copy of this determination, will appear alongside your name in the Register for a period of 12 months. The reprimand forms part of your fitness to practise history and is disclosable to prospective employers and prospective registrars in other jurisdictions.

81. The Committee also directed that the interim order currently in place on your registration should be revoked forthwith.

82. That concludes this case.