Dental Professionals Hearings Service

PUBLIC HEARING

Professional Conduct Committee
Initial Hearing

2 November 2023

Name:	DENBIGH-WHITE, Andrew Robin
Registration number:	53608
Case number:	CAS-200926

General Dental Council:	Louise Culleton, Case Presenter. Instructed by Capsticks
Registrant:	Not present

Fitness to practise:	Impaired by reason of misconduct
Outcome:	Erased with Immediate Suspension

Committee members:	Rhona Stevens Dentist Chair John Vellacott Lay Anjana Varshani Dentist
Legal adviser:	Margaret Obi and Angus Macpherson
Committee Secretary:	Lola Bird Paul Carson

1. This is a Professional Conduct Committee hearing in respect of a case brought against Mr Denbigh-White by the General Dental Council (GDC).

2. The hearing is being conducted remotely by Microsoft Teams Video-link. It first commenced commenced on 24 July 2023 and and adjourned part-heard on 4 August 2023, at the end of the GDC's evidence at Stage 1, the fact-finding stage. Following deliberations by the Committee on the alleged facts, the hearing has resumed today, 1 November 2023, for the handing down of the Committee's findings.

3. Mr Denbigh-White has not been present at the hearing, and he is not represented in his absence. The Case Presenter for the GDC is Ms Louise Culleton, Counsel.

PRELIMINARY MATTERS – 24 and 25 July 2023

Decision on application to proceed with the hearing in the absence of the registrant – 24 July 2023

4. At the outset, Ms Culleton made an application pursuant to Rule 54 of the *GDC (Fitness to Practise) Rules Order of Council 2006* ('the Rules'), to proceed with the hearing notwithstanding Mr Denbigh-White's absence.

5. The Committee took account of Ms Culleton's submissions in respect of the application, and it considered the supporting documentation provided. The Committee accepted the advice of the Legal Adviser on the issues of service and proceeding in the absence of a registrant.

Decision on service

6. The Committee first considered whether notice of the hearing had been served on Mr Denbigh-White in accordance with Rules 13 and 65. It had sight of the Notice of Hearing dated 14 June 2022 ('the notice'), which was sent to Mr Denbigh-White's registered address by Special Delivery and First Class post.

7. The Committee was provided with a Royal Mail 'Track and Trace' receipt showing that two attempts were made to deliver the copy of the notice sent to Mr Denbigh-White by Special Delivery, one attempt on 15 June 2023 and the other on 16 June 2023. The Committee took into account that there is no requirement within the Rules for the GDC to prove delivery of the notice, only that it was sent. The Committee was satisfied on the evidence before it that the Council had met this requirement.

8. The Committee further noted that a copy of the notice was sent to Mr Denbigh-White as an attachment within a secure email, and that there is evidence confirming that the attachment was received and downloaded.

9. The Committee was satisfied that the notice of 14 June 2023, which was sent to Mr Denbigh-White by post and by email, complied with the 28-day notice period required by the Rules. It was also satisfied that the notice contained all the required particulars, including the date and time of the hearing, confirmation that it would be conducted remotely by video-link on Microsoft Teams, and that the Committee had the power to proceed with the hearing in Mr Denbigh-White's absence.

10. On the basis of all the information before it, the Committee was satisfied that notice of the hearing had been served on Mr Denbigh-White in accordance with the Rules.

Decision on whether to proceed with the hearing in the absence of the registrant

11. The Committee next considered whether to exercise its discretion under Rule 54 to proceed with the hearing in the absence of Mr Denbigh-White. It approached this issue with the utmost care and caution. The Committee took into account the factors to be considered in reaching its decision, as set out in the case of *R v Jones* [2003] 1 AC 1HL, and as affirmed in subsequent regulatory cases.

12. The Committee remained mindful that fairness to Mr Denbigh-White was an important consideration, however, it also bore in mind the need to be fair to the GDC. The Committee further took into account the public interest in the expeditious disposal of this case.

13. The Committee's attention was drawn to the history of the GDC's communications with Mr Denbigh-White, both about this substantive hearing and other non-substantive proceedings concerning this case. In particular, the Committee was referred to an email exchange between Mr Denbigh-White and a solicitor from the GDC regarding a non-substantive hearing that was due to take place in June 2022. In an email dated 18 June 2022, Mr Denbigh-White responded to the GDC solicitor confirming that he would not be attending that non-substantive hearing. Mr Denbigh-White stated that "*I can confirm that I have not been working since retiring in November 2019 I have noted that I am still on the GDC register although I have not paid the retention fees .my suggestion is that they remove me from the register I have no intention of returning to dentistry".*

14. Ms Culleton submitted that since that email from Mr Denbigh-White on 18 June 2022, his position appears to have remained consistent, given his non-attendance at this substantive hearing. She told the Committee of the efforts made shortly before the start of this hearing, by the Hearings Support Officer at the GDC's request, to contact Mr Denbigh-White by email and by telephone. The attempts were unsuccessful, and Ms Culleton submitted that this was unsurprising, in light of Mr Denbigh-White's stance in relation to the earlier non-substantive proceedings in respect of this case.

15. The Committee, having taken into account the evidence before it, was satisfied that all reasonable efforts had been made by the GDC to notify Mr Denbigh-White of this hearing. It noted that there had been no request from him for an adjournment, and it received nothing to indicate that deferring this hearing would secure his attendance on a future date. On the contrary, the information before the Committee suggests that it would be highly unlikely that Mr Denbigh-White would attend a re-scheduled hearing. The Committee was satisfied that he had voluntarily absented himself from these proceedings.

16. The Committee remained mindful of its duty to act expeditiously in the public interest. It also took into account the potential inconvenience that would be caused to the GDC and to its witnesses, should this hearing be adjourned. The Committee heard from Ms Culleton that the GDC's case is ready to be presented, and that there are a number of GDC witnesses due to attend this hearing, including the Council's expert witness, who was in attendance.

17. In all the circumstances, in the absence of any good reason for an adjournment, the Committee determined that it was fair, in the public interest and in the interests of justice to proceed with the hearing in the absence of Mr Denbigh-White.

Rule 25 Application for joinder – 25 July 2023

18. Ms Culleton next made an application for joinder under Rule 25(2) of the Rules. That Rule states that:

> *"Where—*
>
> *(a) an allegation against a respondent has been referred to a Practice Committee,*
>
> *(b) that allegation has not yet been heard, and*
>
> *(c) a new allegation against the respondent which is of a similar kind or is founded on the same alleged facts is received by the Council,*
>
> *the Practice Committee may consider the new allegation at the same time as the original allegation, notwithstanding that the new allegation has not been included in the notification of hearing".*

19. Ms Culleton explained that the purpose of the GDC's application for joinder was to set out consistent date periods in respect Mr Denbigh-White's treatment of the patients in this case. She highlighted that the original notice of hearing, which set out the factual allegations referred to this Committee by the GDC Case Examiners, included differing date ranges in respect of each patient's treatment. Ms Culleton submitted that, in order to present a fairer picture of Mr Denbigh-White's practice, it was the application of the GDC that there should be a fixed date period, consistent for all the patients. She submitted that the Council considered a five year period to be proportionate in the circumstances of this case, as this would show a fair sample of Mr Denbigh-White's work across the 16 patients concerned.

20. Accordingly, the GDC's application under Rule 25(2) was for date periods of up to five years to be included in the charge in respect of each patient, working back from their last appointments. The proposal was that these new date periods would replace the dates ranges that were set out in the original notice of hearing. Ms Culleton submitted that in making this application, the GDC did not seek to make any substantial changes to the factual allegations referred to the Case Examiners by the GDC.

Decision on the Rule 25 application

21. In reaching its decision, the Committee took account of Ms Culleton's submissions. It heard and accepted the advice of the Legal Adviser in relation to joinder.

22. The Committee first satisfied itself that Mr Denbigh-White had been properly notified of the GDC's intention to make an application for joinder, as required by Rule 25(3). The Committee noted that a 'Rule 25 Notice', dated 22 June 2023, was sent to him at his registered address by Special Delivery and First Class post. A copy was also sent to him by email. That Notice included an appendix setting out the proposed 'new allegations' namely that it would be the application of the GDC that the concerns now relate to the date range January 2012 to October 2019 in relation to the factual allegations for each of the 16 patients.

23. Mr Denbigh-White was informed in the Rule 25 Notice of his right to reply to the GDC's proposed Rule 25(2) application within 28 days of the date of that Notice. The GDC stated that, *"We should be grateful if you would indicate,* ***by 20 July 2023*** *(and/or in advance of any preliminary meeting), whether there will be any objection to the Council's application for this matter to be included Under Rule 25…".* There was no evidence before the Committee to indicate any response from Mr Denbigh-White to the Rule 25 Notice.

24. In all the circumstances, the Committee was satisfied that Mr Denbigh-White had been duly notified of the GDC's intended Rule 25(2) application.

25. The Committee next considered the application itself. It had regard to the provisions of Rule 25(2) as set out above. The Committee was satisfied that the requirements of Rules 25(2)(a) and (b) were met, given that allegations against Mr Denbigh-White had been referred to it for consideration, and that those allegations were yet to be heard, as the hearing was still at the preliminary stage.

26. The Committee was also satisfied that the requirement in Rule 25(2)(c) had been met. It considered that the proposed 'new allegations', which include the more consistent date ranges in relation to Mr Denbigh-White's treatment of each patient, were founded on the same alleged facts. The Committee was satisfied that there was evidence before it to support the GDC's application for joinder, and therefore, if the application was accepted, the seriousness of the factual allegations against Mr Denbigh-White would not be heightened, nor would the GDC's case be fundamentally altered. In fact, the Committee considered that

applying the more consistent date ranges, as proposed, would further particularise the alleged clinical matters which, in its view, would be fairer to both parties.

27. Therefore, the Committee determined to accede to the GDC's application for joinder and the charge was revised accordingly.

FINDINGS OF FACT – 1 November 2023

28. Mr Denbigh-White is a registered dentist. This case involves the clinical care that he provided to 16 patients who, for the purposes of this hearing, are being referred to as Patient 1, Patients 3 to 14, and Patients 16 to 18.

Case background

29. In opening the case for the GDC, Ms Culleton outlined the background to the matters against Mr Denbigh-White. The Committee heard that on 12 September 2019, the GDC received a referral from NHS England (NHSE), which stated that Mr Denbigh-White had come to NHSE's attention via the NHS Business Services Authority (NHS BSA). It was reported that following a review of Mr Denbigh-White's performance, he had been identified as an outlier when measured against his peers.

30. The concerns raised by the NHS BSA included that no radiographs had been taken in respect of Mr Denbigh-White's patients over the period 2018 to 2019, he appeared to be providing a high rate of Band 3 NHS dental treatment, especially crowns, veneers and bridges, there was a low rate of recorded examinations for his patients, and in terms of patient recall and frequency of attendance, there appeared to be a higher rate than average for Mr Denbigh-White's patients.

31. In response to the concerns, NHSE carried out an audit of Mr Denbigh-White's clinical records. The conclusions from that audit were that his records were of a very poor standard, that they required significant development and that they did not conform to current standards.

32. The Committee was asked to note that in addition to a record card audit, NHSE would usually have observed Mr Denbigh-White's practice. However, whilst arrangements were made for such observation to take place, they were cancelled by Mr Denbigh-White. It was said that no observation was undertaken by NHSE, as Mr Denbigh-White sold his practice and later retired from dentistry.

33. Ms Culleton referred the Committee to the evidence received from NHSE in respect of the background matters in this case, which includes information relating to a meeting that took place between NHSE officials and Mr Denbigh-White at his practice on 25 June 2019.

34. As part of its investigation into the issues raised regarding Mr Denbigh-White's practice, the GDC obtained a report from its expert witness in this case, Dr Jennifer Ward. Ms Culleton stated that the allegations before the Committee reflect the matters of which Dr Ward is critical in relation to Mr Denbigh-White's treatment of the patients concerned.

35. In addition to the clinical allegations, the GDC's case against Mr Denbigh-White includes discrete allegations relating to his engagement with the Council. In particular, it is alleged that Mr Denbigh-White failed to maintain a correct and up-to-date registered address with the GDC. Also, that from 21 July 2020 to 16 February 2022, he failed to cooperate with an investigation conducted by the GDC, by not providing the GDC with any and/or insufficient evidence of indemnity.

Evidence

36. The factual evidence provided by the GDC includes copies of the clinical records for each of the 16 patients concerned. The Committee also received the following witness statements, along with associated exhibits:

- A witness statement from Mr Richard Krzeminski, NHSE Dental Advisor, dated 11 April 2023.
- A witness statement from Patient 1 dated 2 March 2023.
- A witness statement from Patient 4 dated 1 February 2023.
- A witness statement from Patient 7 dated 12 March 2023.
- A witness statement from a locum associate dentist who worked at Mr Denbigh-White's practice, dated 24 April 2023.
- A witness statement from a Case Work Manager at the GDC, dated 24 April 2023.

37. In addition, the Committee heard oral evidence from Patients 1, 4 and 7.

38. The Committee was given the opportunity to hear from the other factual GDC witnesses, but it was satisfied that it did not have any questions for them that would have assisted beyond their written evidence.

39. By way of expert evidence, the Committee received the report of Dr Ward dated 21 April 2023. It also heard oral evidence from her. The Committee noted Dr Ward's qualifications and career background, as set out in her CV, including her expertise as a Consultant in Restorative Dentistry. The Committee found Dr Ward's report to be clear and balanced. In answering questions from the Committee, Dr Ward was able to expand on certain clinical matters and provide relevant examples. The Committee found that Dr Ward was fair in giving her oral evidence which, it noted, included her willingness to make concessions when she considered it appropriate. The Committee was assisted by Dr Ward's evidence in its consideration of the clinical aspects of this case.

The Committee's findings on the alleged facts

40. The Committee considered all the evidence presented to it, both documentary and oral. It took account of the closing submissions made by Ms Culleton on behalf of the GDC and it accepted the advice of the Legal Adviser.

41. The Committee considered separately each of the allegations against Mr Denbigh-White, 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 proved on the balance of probabilities. This means that the Committee has had to decide whether it is more likely than not that the alleged matters occurred.

42. The Committee's findings are as follows:

PATIENT 1

Charge 1(a)(i)

1. *You failed to provide an adequate standard of care to Patient 1 (identified in Schedule A…), from 11 May 2015 to 5 August 2019 in that:*
    a. *You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –*
        i. *Medical history*

Found proved (on the basis that a medical history was not taken adequately).

43. The Committee was satisfied from the clinical records for Patient 1, that Mr Denbigh-White provided care and treatment to the patient over the period in question. It noted that Patient 1 attended numerous appointments with Mr Denbigh-White between May 2015 to August 2019.

44. The Committee took into account that Mr Denbigh-White had a duty to take a medical history from Patient 1 each time he treated the patient. It had regard to the evidence of Dr Ward who, in her expert report, referred to Standard 4.1.1 of the GDC's '*Standards for the Dental Team (September 2013*)' ('the GDC Standards'). Standard 4.1.1 states that:

> *"You must make and keep complete and accurate patient records, including an up-to-date medical history, each time that you treat patients".*

45. Dr Ward also referred to a similar duty within the *Faculty of General Dental Practice UK (FGDP) guidelines on Clinical Examination and Record Keeping*. She highlighted that these FGDP guidelines and the GDC Standards make clear that the taking of a current or updated medical history is a mandatory requirement.

46. The Committee noted that in the clinical records for Patient 1, there are entries next to Mr Denbigh-White's initials ('AD'), which appear to indicate the dates on which he updated the patient's medical notes. There are two such entries within the time period in question, one made on 5 August 2018 and the other on 11 July 2019. The Committee concluded from these entries that Mr Denbigh-White updated Patient 1's medical history on these dates. It noted, however, that no detail was recorded in the clinical records to explain the updates.

47. Notwithstanding the presence of the two entries in question, the Committee took into account that the requirement was for Mr Denbigh-White to take an updated medical history from Patient 1 each time he provided treatment to the patient. The clinical records show that Patient 1 was treated by Mr Denbigh-White on a number of other dates during the period concerned, and therefore updates to the patient's medical history on just two occasions did not meet the required standard.

48. The Committee considered the possibility that Mr Denbigh-White may have taken an updated medical history from Patient 1 each time he treated the patient but omitted to record having done so. In considering this likelihood, the Committee had regard to the evidence of Patient 1, who stated in his witness statement that, *"The Registrant never asked me about my medical history…"* Patient 1 further stated in his oral evidence that Mr Denbigh-White had never asked him verbally about his general health, any medication he was taking or whether he had any allergies.

49. The Committee considered that Patient 1's evidence that he was unaware that a medical history had ever been taken, suggested that Mr Denbigh-White had not been comprehensive in taking a medical history on those occasions that he updated the patient's medical notes.

50. Taking all the evidence into account, the Committee was satisfied on the balance of probabilities that Mr Denbigh-White did not take an adequate medical history from Patient 1 over the period in question. It was satisfied that it was more likely than not that Mr Denbigh-White did not take or update the patient's medical history beyond the two dates indicated in the clinical records. This was not sufficient to meet the prescribed duty in the GDC Standards and the relevant FGDP guidelines.

51. The Committee considered that in the circumstances, Mr Denbigh-White could not have obtained an up to date picture of Patient 1's health, given both the limited and infrequent way in which he took the patient's medical history. The Committee was satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 1 in this regard.

Charge 1(a)(ii)

1. *You failed to provide an adequate standard of care to Patient 1 (identified in Schedule A…), from 11 May 2015 to 5 August 2019 in that:*

    a. *You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –*

    ii. *extra and intra oral examinations*

Found proved (on the basis that no extra oral examinations were undertaken and the intra oral examinations undertaken were not adequate).

52. The Committee accepted the expert evidence of Dr Ward, who based her opinion on the *FGDP UK guidelines on Clinical Examination and Record Keeping*, that extra and intra oral examinations should form part of a standard clinical examination. Dr Ward stated in her report that *"Assessment should include a discussion of any problems the patient is experiencing, history of these problems, carrying out a full clinical examination, including an extra oral (to include tempero-mandibular joints (TMJ's) and lymph nodes) and intra-oral (to include soft tissues, teeth and gums) assessments".*

53. The Committee asked Patient 1 directly about this issue, and whilst he could recall Mr Denbigh-White looking and feeling in his mouth, he could not recall having been examined extra-orally during the period in question.

54. The Committee had regard to Mr Denbigh-White's clinical records for Patient 1 and found that they included very little information regarding standard clinical examinations. The Committee found no notes relating to an extra oral examination having been undertaken of the patient at any time. Whilst there was partial information relating to intra oral examinations, in that there were records to indicate that Mr Denbigh-White had looked in the patient's mouth and at his teeth, the Committee found nothing to indicate that a full clinical examination, as outlined by Dr Ward, had ever been undertaken. There was no recorded information to suggest that Mr Denbigh-White had examined Patient 1 extra-orally, for example, the TMJs and lymph nodes, or to indicate that intra-orally he had examined the patient's soft tissues, for example, the tongue or floor of the mouth.

55. On the basis of the evidence, including the limited nature of the clinical records in respect of standard clinical examinations, the Committee was satisfied on the balance of probabilities that Mr Denbigh-White did not undertake any extra-oral examinations of Patient 1 over the period in question, and that the intra-oral examinations he did undertake were inadequate. The Committee noted the evidence of Dr Ward regarding patient assessment, including examination and pre-treatment investigations. She stated in her report that *"These are an integral part of assessment and will all help the dentist to diagnose dental and oral diseases".* The Committee accepted Dr Ward's opinion and was satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 1 in this respect.

Charge 1(a)(iii)

1. *You failed to provide an adequate standard of care to Patient 1 (identified in Schedule A …), from 11 May 2015 to 5 August 2019 in that:*

    a. *You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –*

    iii. *additional special tests as appropriate*

Found not proved.

56. In her report, Dr Ward stated that *"Appropriate investigations, or special tests are also integral to full assessment and these include sensibility (or vitality) tests (to assess response of the pulp), tenderness to percussion test (TTP), palpation (to assess tenderness /swelling that may indicate infection)".*

57. The Committee considered Dr Ward's evidence in context of Patient 1's dental history, as documented within the clinical records. It noted that many of the patient's appointments with Mr Denbigh-White were routine appointments, at which no specific dental complaints were raised by the patient or identified by Mr Denbigh-White. The Committee concluded that, in the circumstances of those routine appointments, additional special tests would not have been required.

58. The Committee noted that there was an appointment on 11 July 2019, when Patient 1 attended and complained that the lower left area of his mouth was slightly painful to cold and while eating. Mr Denbigh-White recorded in the clinical notes that a large cavity was present and that he provided a filling to the patient's LL7. The note made by Mr Denbigh-White at the following appointment on 5 August 2019 stated that the patient was no longer having any trouble, which indicated to the Committee that the filling provided to LL7 had resolved the patient's complaint. This suggested to the Committee that, following clinical examination, Mr Denbigh-White had been able to identify and resolve the issue.

59. In all the circumstances, the Committee was not satisfied that it received sufficient evidence to prove that additional special tests were required in the context of the appointment on 11 July 2019, or any other appointment attended by Patient 1 over the period in question.

Charge 1(a)(iv)

1. *You failed to provide an adequate standard of care to Patient 1 (identified in Schedule A …), from 11 May 2015 to 5 August 2019 in that:*

    a. *You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –*

iv. BPE

Found proved (on the basis that no BPEs were undertaken).

60. Dr Ward stated in her report that "*Basic periodontal examination (BPE) should be carried out to screen for periodontal disease as recommended in 'The Good Practitioner's Guide to Periodontology …. This provides a quick screening of gums by inserting a probe to measure the space between teeth and gums. Based on the code recorded in each sextant of the mouth, it indicates the level of further examination and treatment required. When a code 1 or 2 are recorded scaling and oral hygiene instructions should be given. When codes of 3 and 4 are recorded then further assessment including full mouth probing and radiographic examination should be carried out. Where an inaccurate code is recorded, full assessment is delayed and periodontitis may not be diagnosed and appropriate treatment provided".*

61. The Committee had regard to the clinical records, and it found no evidence to indicate that Mr Denbigh-White had undertaken any BPEs of Patient 1 during the period in question. The absence of BPEs from the clinical records was also a matter highlighted by Dr Ward in her report. The Committee noted from her reference to the *British Society of Periodontology* guidelines, that a BPE should be undertaken at initial examination and at each recall interval.

62. Although not good practice, given that BPE scores should be recorded, the Committee considered the possibility that Mr Denbigh-White may have taken undertaken BPEs of Patient 1 but omitted to record having done so. In considering this likelihood, the Committee took into account the oral evidence of Patient 1 who, when questioned, did not recall Mr Denbigh-White using a probe around his gums.

63. In all the circumstances, the Committee was satisfied that this allegation at head of charge 1(a)(iv) is proved on the basis that Mr Denbigh-White did not undertake any BPEs in respect of Patient 1 during the almost four-year period in question. The Committee was also satisfied that this represented a failure by Mr Denbigh-White to provide an adequate standard of care to Patient 1, in view of Dr Ward's opinion regarding the integral nature of BPEs to assessment, diagnosis and treatment.

Charge 1(a)(v)

1. You failed to provide an adequate standard of care to Patient 1 (identified in Schedule A …), from 11 May 2015 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

v. Bitewing radiographs

Found proved (on the basis that no bitewing radiographs were undertaken).

64. The Committee noted that the only radiographs before it in respect of Patient 1 were taken in 2014, which was before the first date referred to in Charge 1. It found no radiographs within the clinical records for the relevant period 11 May 2015 to 5 August 2019. The evidence of Patient 1 was that no radiographs were taken by Mr Denbigh-White taken during this time.

65. The Committee also had regard to the witness statement and exhibits of Mr Richard Krzeminski, an NHSE Dental Advisor. Mr Krzeminski exhibited a copy of the NHS BSA '*Clinical Adviser Case Assessment report'* in relation to Mr Denbigh-White for the period 2018/19. This report showed that '0' radiographs were taken for Mr Denbigh-White's patients during that timeframe.

66. Further, Mr Krzeminski stated in his witness statement that he, and a NHSE colleague, attended a meeting with Mr Denbigh-White at his practice on 25 June 2019. Mr Krzeminski stated that he had asked Mr Denbigh-White at that meeting about the areas of concern highlighted by the NHS BSA. Mr Krzeminski stated that *"I found the Registrant's responses were very honest, and non-argumentative. For example, the Registrant was honest, in that he accepted that he did not take any radiographs…he explained he did not take radiographs as he felt this exposed the patient to unnecessary risk, he was unable to see the benefits of taking radiographs."*

67. The Committee was satisfied on the evidence that, it was more likely than not, that Mr Denbigh-White did not take any radiographs of Patient 1 during the period in question.

68. The Committee considered the evidence of Dr Ward who stated in her report that *"I agree that radiographs pose a threat to health and therefore their use is strictly regulated in dentistry".* In this regard, she referred to the *Ionising Radiation (Medical Exposure) Regulations 2017,* which provide that all radiographs taken must be justified, graded, and reported on. She also referred to the guidelines on the use of radiographs as set out in the *'Selection Criteria for Dental Radiography (published 2013, updated February 2018)'*. Dr Ward stated that *"Bitewing radiographs show the contact areas of posterior teeth and frequency of exposure is set depending on how at risk of decay a patient is"*. She highlighted that the recognised guidance, even for patients at low risk of caries, is for bitewing radiographs to be taken every two years.

69. The Committee accepted Dr Ward's evidence and was satisfied that Mr Denbigh-White's omission to take any radiographs of Patient 1 during the period concerned amounted to a failure to provide an adequate standard of care. It accepted Dr Ward's opinion that the relevant guidelines should be followed by all dentists to balance safety of radiographic exposure against the benefits of their use.

Charge 1(a)(vi)(1)

1. *You failed to provide an adequate standard of care to Patient 1 (identified in Schedule A …), from 11 May 2015 to 5 August 2019 in that:*

    a. *You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –*

    vi. *Pre-treatment/periapical radiographs*

    1. *to aid pain diagnosis on 11 July 2019*

Found not proved.

70. The clinical records show that at the appointment on 11 July 2019, Patient 1 complained that the lower left area of his mouth was slightly painful to cold and while eating. Mr Denbigh-White noted the presence of a large cavity and provided a filling at LL7, which appeared to resolve the patient's complaint. It was noted at the subsequent appointment on 5 August 2019 that the patient was not having any further problems.

71. Mr Denbigh-White was able to identify the cause of the patient's pain on clinical examination. Therefore, the Committee considered that it would not have been unreasonable for Mr Denbigh-White, as the treating practitioner, to have exercised his clinical judgment not to take a radiograph in the circumstances. The Committee noted the evidence regarding Mr Denbigh-White's views on radiography.

72. Whilst the Committee took into account the opinion of Dr Ward that Mr Denbigh-White failed to take a radiograph, it was not persuaded that there was sufficient evidence before it to explain why radiographic examination was necessary in the particular circumstances of this appointment.

Charge 1(a)(vi)(2)

1. *You failed to provide an adequate standard of care to Patient 1 (identified in Schedule A …), from 11 May 2015 to 5 August 2019 in that:*

    a. *You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –*

    vi. *Pre-treatment/periapical radiographs*

    2. *when discussing crowns on 18 May 2017 and/or 11 July 2019*

Found not proved.

73. The Committee noted that Mr Denbigh-White recorded in the clinical records on 18 May 2017 *"to do a crown",* if the filling placed at Patient 1's UR6 did not settle down. At an appointment on 5 August 2019, Mr Denbigh-White further recorded, *"…need to repair fillings and review for crown work posteriors".* These notes suggested to the Committee that Mr

Denbigh-White had not made a decision, as of August 2019, with regard to the provision of crowns, although the indication was that crown treatment had been considered.

74. The Committee had regard to Dr Ward's evidence on the requirement for pre-treatment/periapical radiographs before any crown or bridge preparation, in accordance with the "*FGDP Standards in Dentistry*". However, in this particular circumstance, where the evidence suggests that Mr Denbigh-White was only contemplating crowns, as opposed to planning them, the Committee was not satisfied that this allegation is proved. It was not satisfied that it received sufficient evidence to show that Mr Denbigh-White needed to take pre-treatment/periapical radiographs when considering crowns on 18 May 2017 and/or 11 July 2019.

Charge 1(b)

1. *You failed to provide an adequate standard of care to Patient 1 (identified in Schedule A …), from 11 May 2015 to 5 August 2019 in that:*

b. You did not adequately formulate and/or record formulation of treatment plans

Found proved (on the basis that treatment plans were not adequately formulated)

75. In her report, Dr Ward referred the Committee to the relevant GDC Standards in relation to treatment planning. Standard 2.3.6 states that:

"You must give patients a written treatment plan, or plans, before their treatment starts and you should retain a copy in their notes. You should also ask patients to sign the treatment plan.

76. Whilst Standard 2.3.7 states that:

"Whenever you provide a treatment plan you must include:

- *the proposed treatment;*
- *a realistic indication of the cost;*
- *whether the treatment is being provided under the NHS (or equivalent health service) or privately (if mixed, the treatment plan should clearly indicate which elements are being provided under which arrangement)".*

77. In her oral evidence, Dr Ward told the Committee that a treatment plan is usually an itemised document, which amongst other things, should set out the proposed items of treatment in the order in which the dentist plans to carry them out.

78. The Committee had regard to the clinical records for Patient 1, and whilst it found that Mr Denbigh-White recorded the treatment that he proposed to carry out for the patient, these notes read more as notes to himself, as opposed to a written treatment plan. The Committee

found nothing within the clinical records that would constitute a treatment plan, as outlined in the relevant GDC Standards, and as described by Dr Ward.

79. The Committee considered whether Mr Denbigh-White could have formulated treatment plans for Patient 1 but did not put them in writing. However, it took into account Patient 1's witness statement, in which he stated that *"The Registrant did not provide me with a treatment plan either verbally or in writing".*

80. In light of the patient's evidence, and the absence of a written treatment plan in the clinical records, the Committee was satisfied that it was more likely than not that Mr Denbigh-White did not formulate any adequate treatment plan in respect of his treatment of Patient 1 over the period in question.

81. It appeared to the Committee, on its assessment of the clinical records, that Mr Denbigh-White addressed dental complaints as and when they were presented to him, as opposed to formulating treatment plans. The Committee was satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 1 in the circumstances by not providing the patient with clear information in relation to his treatment, as required by the GDC Standards.

Charge 1(c)

You failed to provide an adequate standard of care to Patient 1 (identified in Schedule A …), from 11 May 2015 to 5 August 2019 in that:

c. You did not diagnose and/or treat caries on the LL7 and/or LL6 and/or LR5 and/or LR6

Found proved (on the basis that caries was not diagnosed in any of these teeth).

82. In her report, Dr Ward drew the Committee's attention to the clinical records of Patient 1's subsequent treating dentist, as well as the bitewing radiographs taken by that dentist on 2 September 2019 and 3 June 2021. She highlighted that extensive caries was identified by the subsequent treating dentist at the patient's LL7, LL6, LR5 and LR6.

83. The Committee accepted the evidence of Dr Ward that, given the extensive nature of the caries on the teeth, it would have been present clinically at previous appointments. It noted that Patient 1 was last seen by Mr Denbigh-White on 5 August 2019, less than a month before the first set of bitewing radiographs were taken by the subsequent treating dentist on 2 September 2019. The Committee found no evidence of a diagnosis of caries in respect of the LL7, LL6, LR5 and LR6 in Mr Denbigh-White's clinical records for the patient, only that he had commented on the presence of some broken fillings.

84. In all the circumstances, the Committee was satisfied that Mr Denbigh-White did not diagnose the caries present on the LL7, LL6, LR5 and LR6. The Committee was further satisfied that by not doing so, Mr Denbigh-White failed to provide Patient 1 with an adequate standard of care. As he did not diagnose the caries, he could not have treated it. Indeed, the Committee found nothing in the clinical records made by Mr Denbigh-White regarding proposed treatment for the caries.

Charge 1(d)

You failed to provide an adequate standard of care to Patient 1 (identified in Schedule A …), from 11 May 2015 to 5 August 2019 in that:

d. You did not discuss and/or record discussion of treatment options

Found proved (on the basis that treatment options were not discussed).

85. The written and oral evidence of Patient 1 was that Mr Denbigh-White did not provide him with any alternative treatment options. The Committee also noted that the patient stated in his witness statement that "*After examining my teeth the Registrant very rarely spoke about my teeth. On the appointment for my filling on 5 August 2019, I recall the Registrant stated that they needed to repair my tooth as the filling had cracked, but they did not say anything about what was wrong with the tooth, or what the filling repair would involve. The Registrant simply proceeded with the treatment."*

86. The Committee had regard to the clinical records for Patient 1 and it found nothing included in the notes to suggest that Mr Denbigh-White had discussed treatment options with the patient over the period in question. The absence of such information was also highlighted by Dr Ward in her report.

87. Having considered the evidence, the Committee was satisfied on the balance of probabilities that this allegation is proved. It appeared to the Committee from its consideration of the clinical notes and the patient's evidence, that Mr Denbigh-White simply informed the patient of the treatment he proposed and proceeded to carry it out, without any discussion about possible alternative treatment options. The Committee was satisfied that this represented a failure by Mr Denbigh-White to provide an adequate standard of care to Patient 1. It noted Dr Ward's evidence that the discussion of treatment options is an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 1(e)

You failed to provide an adequate standard of care to Patient 1 (identified in Schedule A …), from 11 May 2015 to 5 August 2019 in that:

e. You did not discuss and/or record risks and/or benefits of proposed treatment

Found proved (on the basis that risks and benefits of proposed treatment were not discussed).

88. The written and oral evidence of Patient 1 was that Mr Denbigh-White did not discuss the risks and benefits of proposed treatment with him. As previously highlighted from his witness statement, the patient stated that Mr Denbigh-White rarely had discussions with him about his teeth, and the patient gave an example of when Mr Denbigh-White had proceeded with a filling repair with little or no explanation.

89. The Committee had regard to the clinical records for Patient 1 and found no indication of the risks and benefits of any treatment having been discussed. The absence of such information was also noted by Dr Ward in her report.

90. Having considered the evidence, the Committee was satisfied on the balance of probabilities that Mr Denbigh-White did not discuss the risks and benefits of proposed treatment with Patient 1 over the period in question. The Committee was further satisfied that this represented a failure by Mr Denbigh-White to provide an adequate standard of care to the patient. It noted Dr Ward's evidence that discussions around risks and benefits is an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 1(f)

You failed to provide an adequate standard of care to Patient 1 (identified in Schedule A …), from 11 May 2015 to 5 August 2019 in that:

f. You inappropriately used glass ionomer for fillings on the following teeth and dates:-

i. LR6 (14/5/15 and/or 16/3/17)
ii. LR7 (14/5/15 and/or 16/3/17)
iii. LL7 (29/5/15 and/or 11/7/19)
iv. LL6 (29/5/15)
v. UR5 (13/3/17)
vi. UR6 (13/3/17 and/or 18/5/17)

Found proved in its entirety.

91. In making its findings, the Committee considered heads of charge 1(f)(i) to (vi) separately.

92. It was the evidence of Dr Ward that the glass ionomer (GI) fillings placed by Mr Denbigh-White at Patient 1's LR6, LR7, LL7, LL6, UR5 and UR6 were inappropriate. She explained that this was because these restorations are multi-surface, including the occlusal load bearing surface of the teeth, GI is not suitable for use in such a clinical situation. She stated in her report that GI *"cannot be handled and contoured as amalgam and composite, (the recommended materials for posterior restorations) and so does not produce a well contoured restoration. It does not provide sufficient mechanical properties to be used in high loading situations such as in posterior teeth. It is not usual practice to use GI as a permanent filling. My view is backed up by the manufacturer's recommendations and [FGDP] Standards in Dentistry, 2.8".*

93. In her oral evidence, Dr Ward conceded that there were certain clinical situations in which the use of GI fillings may be appropriate. She stated that GI fillings could be placed appropriately on buccal or non-loading bearing surfaces of the teeth, or as long-term temporary restorations or dressings.

94. The Committee accepted the evidence of Dr Ward. It had regard to the clinical records for Patient 1 and was satisfied that GI fillings were placed on each of the teeth listed at 1(f)(i) to (vi) and on the dates in question. The Committee noted that the GI fillings were all placed on load bearing surfaces of the teeth. It found nothing in Mr Denbigh-White's notes to suggest that any of the GI fillings fell into the accepted circumstances referred to by Dr Ward, nor was there anything written by Mr Denbigh-White to justify his use of the material in clinical situations that were not in accordance with the manufacturer's recommendations and the relevant FGDP guidelines. Accordingly, the Committee was satisfied that all the GI fillings were placed inappropriately.

95. The Committee was further satisfied that the use of the GI fillings amounted to a failure to provide Patient 1 with an adequate standard of care in the circumstances, given the risk highlighted by Dr Ward of using such material on loading bearing surfaces of the teeth.

Charge 2

As a result of 1 (a) (vi), (d) and/or (e) you failed to obtain informed consent for the treatment provided between 11 May 2015 to 5 August 2019:

Found proved in respect of 1(d) and 1(e).

96. Having found the allegations at 1(a)(vi)(1) and 1(a)(vi)(2) above not proved, the Committee considered this allegation at Charge 2 in respect of heads of charge 1(d) and 1(e) only.

97. The Committee had regard to the relevant GDC Standards on valid consent, including those highlighted by Dr Ward in her report. Standards 3.1, 3.1.2 and 3.1.3 state as follows:

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

3.1.2 *"You should document the discussions you have with patients in the process of gaining consent. Although a signature on a form is important in verifying that a patient has given consent, it is the discussions that take place with the patient that determine whether the consent is valid."*

3.1.3 "*You should find out what your patients want to know as well as what you think they need to know. Things that patients might want to know include:*

- *options for treatment, the risks and the potential benefits;*
- *why you think a particular treatment is necessary and appropriate for them;*
- *the consequences, risks and benefits of the treatment you propose*
- *the likely prognosis;*
- *your recommended option;*
- *the cost of the proposed treatment;*
- *what might happen if the proposed treatment is not carried out; and*
- *whether the treatment is guaranteed, how long it is guaranteed for and any exclusions that apply."*

98. The Committee's findings at heads of charge 1(d) and 1(e) are that Mr Denbigh-White did not discuss any alternative treatment options or risks and benefits of proposed treatment with Patient 1 over the period in question.

99. Taking into account the above GDC standards 3.1. 3.1.2 and 3.1.3, and the evidence of Dr Ward that discussions with patients about alternative treatment options and risks and benefits of proposed treatment are integral to patients being able to give informed consent, the Committee found this allegation at Charge 2 proved.

100. The Committee was satisfied on the balance of probabilities that Patient 1 could not have given his informed consent for any of the treatment provided to him by Mr Denbigh-White from 11 May 2015 to 5 August 2019, if he was unaware of what alternative treatment options were available and the risks and benefits of proposed treatment.

Charge 3

You failed to maintain an adequate standard of record keeping from 11 May 2015 to 5 August
2019.

Found proved.

101. The Committee took into account its findings that, in most instances, Mr Denbigh-White did not undertake the relevant actions, and therefore he could not have recorded

undertaking them. However, in relation to the taking of the patient's medical history, the undertaking of intra oral examinations, and treatment planning, the Committee noted that there is some information in the clinical records alluding to Mr Denbigh-White's actions, but the information included is very limited. The Committee found that there was insufficient information in the clinical records to explain what Mr Denbigh-White did in terms of his care of Patient 1 and why. This included his use of GI fillings in clinical situations that were not in accordance with the manufacturer's recommendations and the relevant FGDP guidelines, without any recorded justification.

102. The Committee accepted the opinion of Dr Ward that Mr Denbigh-White's clinical records in respect of Patient 1 were brief with major omissions.

PATIENT 3

Charge 4(a)(i)

4. You failed to provide an adequate standard of care to Patient 3 (identified in Schedule A…), from 11 December 2014 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

i. Medical history

Found proved (on the basis that a medical history was not taken adequately).

103. The Committee was satisfied from the clinical records for Patient 3, that Mr Denbigh-White provided care and treatment to the patient over the period in question.

104. The Committee took into account that Mr Denbigh-White had a duty to take an up to date medical history from Patient 3 each time he treated the patient, in accordance with Standard 4.1.1 of the GDC Standards and the *FGDP UK guidelines on Clinical Examination and Record Keeping*.

105. The Committee had regard to Patient 3's clinical records and it found three entries against Mr Denbigh-White's initials indicating that he had updated the patient's medical notes on 23 May 2019, 1 July 2019, and 5 August 2019.

106. The Committee noted however, that there were a number of other appointments at which Mr Denbigh-White had provided treatment to Patient 3, including an occasion when the patient was prescribed antibiotics. There was nothing in the clinical records to indicate that Mr Denbigh-White had updated the patient's medical notes at those other appointments.

107. The Committee took into account the lack of information in the clinical records to indicate that a medical history was taken each time Mr Denbigh-White treated Patient 3. It

also had regard to its previous finding above that Mr Denbigh-White had been less than comprehensive in taking and updating the medical history of another patient. In all the circumstances, the Committee concluded that it was more likely than not that Mr Denbigh-White did not take an updated medical history from Patient 3 each time he provided treatment to the patient. The Committee considered that Mr Denbigh-White could not have obtained an up to date picture of Patient 3's medical health, given the infrequent taking of the patient's medical history. It was therefore satisfied that he failed in his duty to provide the patient with an adequate standard of care.

Charge 4(a)(ii)

4. You failed to provide an adequate standard of care to Patient 3 (identified in Schedule A…), from 11 December 2014 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

ii. extra and intra oral examinations

Found proved (on the basis that no extra oral examinations were undertaken and the intra oral examinations undertaken were not adequate).

108. The Committee had regard to Mr Denbigh-White's clinical records for Patient 3 and found that they included very little information regarding examinations.

109. The Committee found no notes relating to an extra-oral examination having been undertaken of the patient at any time. Whilst there was partial evidence of intra-oral examinations, in that there was information in the notes to indicate that Mr Denbigh-White had looked in the patient's mouth and at aspects of the patient's teeth, it found nothing to indicate that a full clinical examination had ever been undertaken. There was no recorded information to suggest that Mr Denbigh-White had examined Patient 3 extra-orally, for example, the TMJs and lymph nodes, or to indicate that intra-orally he had examined the patient's soft tissues, for example, the tongue or floor of the mouth. The Committee noted Dr Ward's comment in her report regarding the lack of information relating to extra and intra oral examinations in Mr Denbigh-White's clinical notes for Patient 3.

110. In finding this allegation proved, the Committee took into account its previous findings above in relation to the same matters but concerning a different patient.

111. In all the circumstances, the Committee was satisfied on the balance of probabilities that Mr Denbigh-White did not undertake any extra-oral examinations of Patient 3 over the period in question, and that the intra-oral examinations that he did undertake were inadequate. The Committee was also satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 3, given that such examinations are an integral part of assessment, used to help dentists diagnose dental and oral diseases.

Charge 4(a)(iii)

4. You failed to provide an adequate standard of care to Patient 3 (identified in Schedule A…), from 11 December 2014 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

iii. additional special tests as appropriate

Found proved (on the basis that additional special tests were not undertaken as appropriate).

112. The Committee considered Dr Ward's evidence regarding the requirements for special tests in context of Patient 3's dental history, as documented within the clinical records. The Committee considered whether there were occasions when the patient presented with a complaint or condition that would have required Mr Denbigh-White to have undertaken any of the special tests referred to by Dr Ward, namely vitality tests, TTP testing and palpation.

113. The Committee noted that on 16 December 2014, Patient 3 attended an appointment with Mr Denbigh-White complaining of pain in the upper right area. On examination, Mr Denbigh-White recorded marginal inflammation at the UR4 and UR5 and prescribed antibiotics. A note made in the clinical records the next day, 17 December 2014, states *"Patient rang for advice as still had discomfort and now has swelling of the face".*

114. In her report, Dr Ward commented that no other action appeared to have been taken by Mr Denbigh-White, other than to prescribe antibiotics *"in an attempt to alleviate the patient's symptoms rather than treating the cause".* Dr Ward told the Committee in her oral evidence that, in light of the pain and swelling reported by Patient 3, additional special tests, such as percussion, sensitivity testing and probing, should have been undertaken to determine the cause of the patient's symptoms.

115. The Committee accepted the evidence of Dr Ward that additional special tests would have been appropriate in the circumstances. It noted that there was no information in the clinical records to suggest that Mr Denbigh-White had undertaken any investigations to determine the cause of the patient's pain and swelling. In the absence of any record relating to special tests, the Committee concluded that it was more likely than not that Mr Denbigh-White did not undertake any such tests. The Committee was further satisfied that this omission amounted to a failure to provide Patient 3 with an adequate standard of care, as in the absence of such tests, Mr Denbigh-White would not have had relevant information to aid a diagnosis.

Charge 4(a)(iv)

4. *You failed to provide an adequate standard of care to Patient 3 (identified in Schedule A…), from 11 December 2014 to 5 August 2019 in that:*

    a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

        iv. BPE

Found proved (on the basis that no BPEs were undertaken).

116. The Committee had regard to the clinical records, and it found no evidence to indicate that Mr Denbigh-White had undertaken any BPEs of Patient 3 during the period in question. The absence of BPEs from the clinical records was a matter highlighted by Dr Ward in her report. The Committee noted that a BPE should be undertaken at initial examination and at each recall interval.

117. In the absence of any reference to BPEs in the clinical records, and in view of its findings that Mr Denbigh-White did not take any BPEs of another patient under his care, the Committee was satisfied on the balance of probabilities that this allegation is proved. It was satisfied that Mr Denbigh White did not undertake any BPEs in respect of Patient 3 in over three years. The Committee was also satisfied that this represented a failure by Mr Denbigh-White to provide an adequate standard of care to the patient, in view of Dr Ward's opinion regarding the integral nature of BPEs to assessment, diagnosis and treatment.

Charge 4(a)(v)

4. *You failed to provide an adequate standard of care to Patient 3 (identified in Schedule A…), from 11 December 2014 to 5 August 2019 in that:*

    a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

        v. Bitewing radiographs

Found proved (on the basis that no bitewing radiographs were undertaken).

118. The Committee found no radiographs within the clinical records for the relevant period 11 December 2014 to 5 August 2019. It took into account the witness statement of the locum associate dentist who worked at Mr Denbigh-White's practice, in which it was confirmed that all relevant clinical records, including radiographs, had been provided to the GDC.

119. The Committee also had regard to the evidence of Mr Krzeminski regarding Mr Denbigh-White's candour in stating that he did not routinely take radiographs of his patients because of the risk posed by radiation.

120. Having had regard to the evidence, the Committee was satisfied on the balance of probabilities that Mr Denbigh-White did not take any radiographs of Patient 3 during the time period in question. The Committee was also satisfied that Mr Denbigh-White's omission to

take any radiographs of Patient 3 amounted to a failure to provide an adequate standard of care. In particular, the Committee noted that Patient 3 had a number of heavily restored teeth. It accepted Dr Ward's opinion that the relevant guidelines should have been followed by Mr Denbigh-White to balance the safety of radiographic exposure against the benefits of its use.

Charge 4(a)(vi)(1)

4. You failed to provide an adequate standard of care to Patient 3 (identified in Schedule A…), from 11 December 2014 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

vi. Pre-treatment/periapical radiographs prior to

1. placing crowns on UL6 and/or UL7 on 1 October 2018 and/or 6 November 2018

Found proved (on the basis that no pre-treatment/periapical radiographs were undertaken).

121. The Committee accepted the evidence of Dr Ward, who referred in her report to the '*FGDP Standards in Dentistry',* that pre-operative radiographs should be taken before any crown or bridgework is undertaken. In her oral evidence, Dr Ward explained that pre-treatment radiographs are necessary to check the health of the teeth to be crowned, as without such radiographs, a dentist would not be able to know whether there are underlying issues which could affect the proposed treatment. Dr Ward also highlighted the potential financial implications for a patient if treatment should fail because their teeth were not radiographically assessed prior to crown placement or bridgework.

122. The Committee was satisfied that Mr Denbigh-White did prepare and place crowns on Patient 3's UL6 and UL7 on the dates specified in this charge. It found no radiographs of the patient in the clinical records made by Mr Denbigh-White over the period in question.

123. In the absence of any radiographs and given the evidence of Mr Denbigh-White's views on radiography, the Committee was satisfied on the balance of probabilities that he did not take a pre-treatment/periapical radiograph prior to placing the crowns at Patient 3's UL6 and UL7. On the basis of Dr Ward's expert evidence, the Committee was satisfied that he should have taken such radiographs, and to not have done so was a failure to provide an adequate standard of care to the patient.

Charge 4(a)(vi)(2)

4. You failed to provide an adequate standard of care to Patient 3 (identified in Schedule A…), from 11 December 2014 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

vi. Pre-treatment/periapical radiographs prior to

2. extraction of LL6 on 01/07/19

Found not proved.

124. The Committee was satisfied on the evidence before it that Mr Denbigh-White did not take a pre-treatment/periapical radiograph before extracting Patient 3's LL6 on 1 July 2019. Dr Ward stated in her report that, from the description in the clinical records, *"… it would appear that the LL6 was badly broken down with only roots remaining. A radiograph should be considered to show roots and adjacent structures prior to carrying out the extraction".*

125. It was the view of the Committee, taking into account the information in the clinical records, that Mr Denbigh-White could see clinically what he needed to know in order to carry out the extraction, without the need for a radiograph. Indeed, the evidence is that he carried out the extraction without any apparent issues.

126. Given that Dr Ward's expert evidence was that a radiograph should have been considered, and not that one was necessary, the Committee decided that it was not unreasonable for Mr Denbigh-White to have exercised his clinical judgement not to take a radiograph in the circumstances of this extraction.

Charge 4(b)

4. You failed to provide an adequate standard of care to Patient 3 (identified in Schedule A…), from 11 December 2014 to 5 August 2019 in that:

b. You did not adequately formulate and/or record formulation of treatment plans

Found proved (on the basis that treatment plans were not adequately formulated).

127. The Committee had regard to the clinical records for Patient 3, and whilst it found that Mr Denbigh-White made records in relation to treatment that he proposed to carry out for the patient, the Committee found nothing within the clinical records that would constitute a treatment plan, as outlined in the relevant GDC Standards, and as described by Dr Ward.

128. The Committee considered whether Mr Denbigh-White could have formulated treatment plans for Patient 3 but did not put them in writing. However, it considered that this was unlikely, given his limited assessment of the patient overall in terms of the lack of any radiographs, no BPEs having been undertaken, and the lack of any additional special tests when required. The Committee had regard to Dr Ward's evidence in her report that "*Treatment planning follows full assessment and diagnosis and after the consideration of*

treatment options, discussion of risks and benefits of treatment, along with consideration of the order and timing of treatment". It appeared to the Committee, on its assessment of the clinical records, that Mr Denbigh-White addressed the patient's dental complaints as and when they were presented to him, as opposed to formulating treatment plans.

129. The Committee was satisfied that it was more likely than not that Mr Denbigh-White did not formulate any adequate treatment plans in respect of his treatment of Patient 3 over the period in question. It was also satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 3 by not providing the patient with clear plans in relation to their treatment, as required by the GDC Standards.

Charge 4(c)

4. You failed to provide an adequate standard of care to Patient 3 (identified in Schedule A…), from 11 December 2014 to 5 August 2019 in that:

c. You did not diagnose and/or treat periodontitis

Found proved (on the basis that periodontitis was not diagnosed).

130. The Committee noted Dr Ward's evidence that Mr Denbigh-White did not diagnose, and therefore did not treat, Patient 3's periodontitis. Dr Ward drew the Committee's attention to the diagnosis of periodontal disease made by Patient 3's subsequent treating dentist, following a BPE undertaken on 26 September 2019. The BPE indicated scores of 3 and 4. A note was made by the subsequent treating dentist for the referral of Patient 3 to a Periodontist.

131. In accepting Dr Ward's opinion, the Committee noted that Patient 3 was last seen by Mr Denbigh-White on 5 August 2019, which was shortly before the patient's periodontal disease was diagnosed by the subsequent treating dentist. The Committee considered that in the circumstances, had Mr Denbigh-White undertaken the relevant assessments and pre-treatment investigations, the patient's periodontal disease would have been apparent to him. The Committee found that Mr Denbigh-White did not carry out any BPEs of the patient, which would have indicated the need for a full periodontal assessment.

132. Further, the Committee noted the evidence of Dr Ward that Mr Denbigh-White did not diagnose or treat the patient's periodontal disease, *"despite him noting mobility of lower anterior teeth on 29/12/16".* She told the Committee that, in view of the patient's mobile teeth, she would have expected six-point pocket charting to have been undertaken. The Committee noted that there is no such charting in the clinical records.

133. In all the circumstances, the Committee was satisfied that this allegation is proved on the basis that Mr Denbigh-White did not diagnose Patient 3's periodontitis. In the absence of a diagnosis, he could not have provided appropriate treatment to the patient. Indeed, the evidence is that the patient's periodontal disease was not addressed until the referral to a

periodontal specialist by the subsequent treating dentist. The Committee was satisfied that this represented a failure by Mr Denbigh-White to provide Patient 3 with an adequate standard of care.

Charge 4(d)

4. You failed to provide an adequate standard of care to Patient 3 (identified in Schedule A…), from 11 December 2014 to 5 August 2019 in that:

d. You did not diagnose and/or treat caries and/or periapical pathology on the LR7 and/or UR5

Found proved in relation to the LR7 (on the basis that caries and periapical pathology was not diagnosed)

Found not proved in relation to the UR5.

134. In the clinical records made by Patient 3's subsequent dentist on 26 September 2019, it was noted that a periapical radiograph of LR7 showed that the tooth had deep caries and "*pap present*" (periapical pathology).

135. The Committee noted that Mr Denbigh-White last saw the patient on 5 August 2019, which was just over a month before the deep caries in the LR7 was diagnosed by the subsequent treating dentist. The Committee accepted the evidence of Dr Ward that, given the extent of the caries seen on the radiograph of 26 September 2019, it would have been evident clinically at appointments prior to that date.

136. The Committee found nothing in Mr Denbigh-White's clinical records for Patient 3 to indicate that he had diagnosed caries at the LR7 or periapical pathology. Further, there is no information in the clinical notes to suggest that he provided treatment for caries or periapical pathology to the patient's LR7. In all the circumstances, the Committee was satisfied that it was more likely than not that Mr Denbigh-White did not make either diagnosis. It was also satisfied that this represented a failure on his part to provide an adequate standard of care to Patient 3, in that in the absence of a diagnosis, he could not have provided the treatment required.

137. In relation to the UR5, Dr Ward's opinion was that Mr Denbigh-White failed to diagnose or treat caries at Patient 3's UR5 bridge abutment, which she said was evident on a radiograph taken by the subsequent dentist on 26 September 2019.

138. The Committee had regard to the clinical records of the subsequent treating dentist. It noted that the dentist recorded there being a 'distal deficiency' at UR5, but there was no recorded diagnosis of caries. The Committee also had regard to the radiographic evidence referred to by Dr Ward but considered that it was not clear enough to conclude that there was caries and/or periapical pathology at the patient's UR5. Accordingly, the Committee

was not satisfied that this allegation had been proved to the requisite standard in respect of UR5.

Charge 4(e)

4. You failed to provide an adequate standard of care to Patient 3 (identified in Schedule A…), from 11 December 2014 to 5 August 2019 in that:

e. You did not discuss and/or record discussion of treatment options

Found proved (on the basis that treatment options were not discussed).

139. In finding this allegation proved, the Committee took into account the absence of any information in Mr Denbigh-White's clinical records for Patient 3 regarding discussions with the patient about treatment options.

140. The Committee also took into account its findings that Mr Denbigh-White did not take any radiographs in respect of this patient, did not undertake special tests as appropriate, and did not diagnose the presence of dental disease. The Committee also found that Mr Denbigh-White did not formulate any adequate treatment plans in respect of the treatment that he provided to Patient 3. Taking all these factors into account, the Committee concluded that it was more likely than not that Mr Denbigh-White did not discuss treatment options with the patient over the period in question. The Committee considered that it would have been difficult for him to have had any discussion about treatment options in any event, given the nature and extent of his omissions.

141. The Committee was satisfied that Mr Denbigh-White's omission to discuss treatment options with Patient 3 was a failure to provide an adequate standard of care, as such discussions are an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 4(f)

4. You failed to provide an adequate standard of care to Patient 3 (identified in Schedule A…), from 11 December 2014 to 5 August 2019 in that:

f. You did not discuss and/or record risks and/or benefits of proposed treatment

Found proved (on the basis that risks and benefits of proposed treatment were not discussed).

142. The Committee found no information in Mr Denbigh-White's clinical records for Patient 3 regarding discussions with the patient about the risks and benefits of the treatment he proposed.

143. The Committee found this allegation proved for the same reasons outlined above in relation to discussions about treatment options. It was satisfied that it was more likely than not that Mr Denbigh-White did not discuss the risks and benefits of proposed treatment with Patient 3 over the period in question.

144. The Committee was further satisfied that Mr Denbigh-White's omission to discuss the risks and benefits of proposed treatment with the patient was a failure to provide an adequate standard of care, given that such discussions are an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 4(g)

4. You failed to provide an adequate standard of care to Patient 3 (identified in Schedule A…), from 11 December 2014 to 5 August 2019 in that:

g. You inappropriately used glass ionomer for fillings on the following teeth and dates:-

i. UL6 (25/7/16)

ii. LL7 (11/12/14 and/or 7/12/15 and/or 5/6/18)

iii. LL6 (26/4/17)

iv. LL5 (5/6/18 and/or 23/5/19)

v. LL4 (23/5/19)

vi. LR7 (17/11/17)

Found proved in relation to UL6, LL7, LL5, LL4 and LR7.

Found not proved in relation to LL6.

145. In making its findings, the Committee considered heads of charge 4(f)(i) to (vi) separately.

146. The Committee had regard to the clinical records for Patient 3 and was satisfied that GI fillings were placed on each of the teeth listed at 4(f)(i) to (vi) and on the dates in question.

147. The Committee noted that all but one of the fillings were placed on load bearing surfaces of the teeth, and it accepted the evidence of Dr Ward that this was inappropriate for the reasons outlined previously. The Committee found nothing in Mr Denbigh-White's notes to suggest that any of the GI fillings fell into the accepted circumstances referred to by Dr Ward, nor was there anything written by Mr Denbigh-White to justify his use of the material in clinical situations that were not in accordance with the manufacturer's recommendations and the relevant FGDP guidelines.

148. In relation to the GI filling at LL6, the Committee was not satisfied that this was placed inappropriately. It noted from the clinical records that this filling was placed buccally, on a non-load bearing surface. The Committee took into account the evidence of Dr Ward that the use of a GI filling in such a clinical situation was not necessarily inappropriate. Accordingly, the Committee found this allegation not proved in respect of the GI filling placed at LL6 on 26 April 2017.

Charge 5

5. As a result of 4 (a) (vi) and/or (e) and/or (f) you failed to obtain informed consent for the treatment provided from 11 December 2014 to 5 August 2019.

Found proved in relation to 4(a)(vi)(1), 4(e) and 4(f).

149. Having found the allegation at 4(a)(vi)(2) above not proved, the Committee considered this allegation at Charge 5 in respect of heads of charge 4(a)(vi)(1), 4(e) and 4(f) only. These are the Committee's findings that Mr Denbigh-White did not take any pre-treatment/periapical radiographs prior to placing crowns at UL6 and UL7, and that he did not discuss any alternative treatment options or risks and benefits of proposed treatment with Patient 3 over the period in question.

150. In relation to the crowns placed at UL6 and UL7, the Committee took into account the evidence of Dr Ward, which it accepted, that in the absence of any pre-treatment/periapical radiographs, Mr Denbigh-White could not have known whether there were any underlying issues in those teeth which could have affected the success or longevity of the crown treatment. Given that Mr Denbigh-White did not have the radiographic information to assess this risk, he could not have conveyed any risks to the patient. The Committee considered that, in the circumstances, it was not possible for Patient 3 to have given informed consent for the crowns placed at UL6 and UL7.

151. The Committee found that there had been no discussions, throughout the period in question, between Mr Denbigh-White and Patient 3 regarding treatment options and any risks and benefits of proposed treatment. The Committee had regard to the GDC standards relating to the issue of valid consent. It also took into account the evidence of Dr Ward that discussions with patients about alternative treatment options and risks and benefits of proposed treatment are integral to patients being able to give informed consent.

152. Taking all the evidence into account, the Committee found this allegation at Charge 5 proved. It was satisfied on the balance of probabilities that Patient 3 could not have given informed consent for any of the treatment provided by Mr Denbigh-White from 11 December 2014 to 5 August 2019, if the patient was unaware of what alternative treatment options were available and the risks and benefits of proposed treatment.

Charge 6

6. You failed to maintain an adequate standard of record keeping from 11 December 2014 to 5 August 2019

Found proved.

153. The Committee took into account its findings that in most instances, Mr Denbigh-White did not undertake the relevant actions, and therefore he could not have recorded undertaking them. However, in relation to the taking of the patient's medical history, the undertaking of intra oral examinations, and treatment planning, the Committee noted that there is some information in the clinical records alluding to Mr Denbigh-White's actions, but that the information included is very limited. The Committee found that there was insufficient information in the clinical records to explain what Mr Denbigh-White did in terms of his care of Patient 3 and why. This included his use of GI fillings in clinical situations that were not in accordance with the manufacturer's recommendations and the relevant FGDP guidelines, without any recorded justification.

154. The Committee found Mr Denbigh-White's record keeping in respect of his care and treatment of Patient 3 to be of an inadequate standard. The clinical records were brief with major omissions.

PATIENT 4

Charge 7(a)(i)

7. You failed to provide an adequate standard of care to Patient 4 (identified in Schedule A…), from 19 February 2015 to 16 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

i. Medical history

Found proved (on the basis that a medical history was not taken adequately).

155. The Committee was satisfied from the clinical records for Patient 4, that Mr Denbigh-White provided care and treatment to the patient over the period in question.

156. The Committee took into account that Mr Denbigh-White had a duty to take an up to date medical history from Patient 4 each time he treated the patient, in accordance with Standard 4.1.1 of the GDC Standards and the *FGDP UK guidelines on Clinical Examination and Record Keeping*.

157. The Committee had regard to Patient 4's clinical records and it found three entries against Mr Denbigh-White's initials indicating that he had updated the patient's medical notes on 11 July 2016, 28 December 2018, and 5 August 2019.

158. The Committee noted, however, that there were a number of other appointments at which Mr Denbigh-White had provided treatment to Patient 4, and there was nothing in the clinical records to indicate that Mr Denbigh-White had updated the patient's medical notes at those other appointments.

159. The Committee took into account the evidence of Patient 4, who stated in her witness statement that she could not recall Mr Denbigh-White discussing her medical history with her before certain appointments. In her oral evidence, Patient 4 told the Committee that Mr Denbigh-White would ask about her health in a general way, but she could not recall being asked specific questions about her medical history or being asked to fill out a medical history form.

160. The Committee's conclusion from the evidence was that Mr Denbigh-White did not take an up to date medical history from Patient 4 each time he provided treatment to the patient, which was a failure in his duty. Further, that on the occasions he did take an updated medical history, he did not do so comprehensively.

161. The Committee considered that Mr Denbigh-White could not have obtained an up to date picture of Patient 4's medical health, given the infrequent and non-comprehensive taking of the patient's medical history. It was therefore satisfied that he failed in his duty to provide the patient with an adequate standard of care.

Charge 7(a)(ii)

7. You failed to provide an adequate standard of care to Patient 4 (identified in Schedule A…), from 19 February 2015 to 16 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

ii. extra and intra oral examinations

Found proved (on the basis that no extra oral examinations were undertaken and the intra oral examinations undertaken were not adequate).

162. The Committee had regard to Mr Denbigh-White's clinical records for Patient 4 and found that they included very little information regarding standard clinical examinations.

163. Patient 4 could not recall extra oral examinations being undertaken by Mr Denbigh-White, and the Committee found no notes relating to any extra-oral examinations in the clinical records.

164. Whilst there was some evidence of intra-oral examinations, in that there was information in the notes to indicate that Mr Denbigh-White had looked in the patient's mouth and at aspects of the patient's teeth, the Committee found nothing to indicate that a full clinical examination had ever been undertaken. There was no recorded information to

suggest that Mr Denbigh-White had examined Patient 4 extra-orally, for example, the TMJs and lymph nodes, or to indicate that intra-orally he had examined the patient's soft tissues, for example, the tongue or floor of the mouth. The Committee noted Dr Ward's comments in her report regarding the lack of information relating to extra and intra oral examinations in Mr Denbigh-White's clinical notes for Patient 4.

165. In finding this allegation proved, the Committee took into account the limited information included in the clinical records, as well as its findings above in relation to the same matters but concerning different patients.

166. In all the circumstances, the Committee was satisfied on the balance of probabilities that Mr Denbigh-White did not undertake any extra-oral examinations of Patient 4 over the period in question, and that the intra-oral examinations that he did undertake were inadequate. The Committee was also satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 4, given that such examinations are an integral part of an assessment, used to help dentists diagnose dental and oral diseases.

Charge 7(a)(iii)

7. You failed to provide an adequate standard of care to Patient 4 (identified in Schedule A…), from 19 February 2015 to 16 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

iii. additional special tests as appropriate

Found proved (on the basis that no additional special tests were undertaken as appropriate).

167. The Committee considered Dr Ward's evidence regarding the requirements for special tests in context of Patient 4's dental history as documented within the clinical records. The Committee considered whether there were occasions when the patient presented with a complaint or condition that would have required Mr Denbigh-White to have undertaken any of the special tests referred to by Dr Ward, namely vitality tests, TTP testing and palpation.

168. The Committee noted that Dr Ward highlighted in her report an appointment attended by the patient with Mr Denbigh-White on 16 June 2016. Dr Ward notes from the clinical records that the patient attends with a tooth that has *"crumbled".* The notes indicate that the UL2 was broken to gum level and that Mr Denbigh-White's proposal was to place a crown. Dr Ward commented that *"There is no record of full assessment, special tests and a radiograph that would be essential in this situation to assess the remaining root to see if it were restorable, if it needed RCT or if there was any periapical pathology present".*

169. The Committee accepted the evidence of Dr Ward that additional special tests would have been appropriate in the circumstances of the appointment of 16 June 2016. It noted that there was no information in the clinical records to suggest that Mr Denbigh-White had undertaken any investigations to determine the vitality of the UL2. In the absence of a record regarding special testing, the Committee concluded that it was more likely than not that Mr Denbigh-White did not undertake any such tests. The Committee was further satisfied that this omission amounted to a failure to provide Patient 3 with an adequate standard of care, as in the absence of such tests to check if the tooth was vital, Mr Denbigh-White could not have assessed whether crown treatment was the appropriate course of action.

Charge 7(a)(iv)

7. You failed to provide an adequate standard of care to Patient 4 (identified in Schedule A…), from 19 February 2015 to 16 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

iv. BPE

Found proved (on the basis that no BPEs were undertaken).

170. The Committee had regard to the clinical records, and it found no evidence to indicate that Mr Denbigh-White had undertaken any BPEs of Patient 4 during the period in question. The absence of BPEs from the clinical records was a matter highlighted by Dr Ward in her report. The Committee noted that a BPE should be undertaken at initial examination and at each recall interval.

171. The Committee noted that Patient 4 recalled in her witness statement that, during an examination, Mr Denbigh-White used a tool to touch her teeth and called out numbers, but when questioned she could not recall a probe being used on her gums. Further, given the nature and purpose of a BPE, the Committee considered that if Mr Denbigh-White had undertaken a BPE at any point, the BPE scores would have been recorded in the clinical notes.

172. In all the circumstances, the Committee was satisfied that this allegation at head of charge 7(a)(iv) is proved on the basis that Mr Denbigh-White did not undertake any BPEs in respect of Patient 4 in over four years. The Committee was also satisfied that this represented a failure by Mr Denbigh-White to provide an adequate standard of care to the patient, in view of Dr Ward's opinion regarding the integral nature of BPEs to assessment, diagnosis and treatment.

Charge 7(a)(v)

7. You failed to provide an adequate standard of care to Patient 4 (identified in Schedule A…), from 19 February 2015 to 16 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

v. Bitewing radiographs

Found proved (on the basis that no Bitewing radiographs were undertaken).

173. The Committee noted that Patient 4 was adamant in her evidence that Mr Denbigh White did not take any radiographs of her teeth during her time as his patient. She stated in her witness statement that *"The only x-rays taken were following an emergency appointment at another practice…on 23 April 2013".*

174. The Committee found no radiographs within the clinical records for the relevant period 19 February 2015 to 16 August 2019. It also took into account the evidence regarding Mr Denbigh-White's admission to an NHSE dental adviser that he did not routinely take radiographs of his patients because of the risk posed from the radiation.

175. Having had regard to the evidence, the Committee was satisfied on the balance of probabilities that Mr Denbigh-White did not take any radiographs of Patient 4 during the time period in question. The Committee was also satisfied that Mr Denbigh-White's omission to take any radiographs of Patient 4 amounted to a failure to provide an adequate standard of care. It accepted Dr Ward's opinion that the relevant guidelines should have been followed by Mr Denbigh-White to balance the safety of radiographic exposure against the benefits of its use.

Charge 7(a)(vi)(1)

7. You failed to provide an adequate standard of care to Patient 4 (identified in Schedule A…), from 19 February 2015 to 16 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

vi. Pre-treatment/periapical radiographs prior to

1. crowns on UL2 between 16 June 2016 and 11 July 2016

Found proved (on the basis that no pre-treatment/periapical radiographs were undertaken).

176. The Committee was satisfied from the clinical records that a crown was placed by Mr Denbigh-White on the UL2 on the dates in question. It was also satisfied that no pre-treatment/periapical radiograph was taken prior to the crown being placed. There were no radiographs included in Mr Denbigh-White's clinical records for Patient 4, and he had stated himself that he did not routinely take radiographs of his patients.

177. In finding this allegation proved, the Committee accepted the expert evidence of Dr Ward that it was essential that a pre-treatment radiograph was taken prior to the placing of the crown at Patient 4's UL2, "*to assess the remaining root to see if it were restorable, if it needed RCT or if there was any periapical pathology present".* The Committee was satisfied that by not taking a pre-treatment radiograph in the circumstances, Mr Denbigh-White failed to provide Patient 4 with an adequate standard of care.

Charge 7(a)(vi)(2)

7. You failed to provide an adequate standard of care to Patient 4 (identified in Schedule A…), from 19 February 2015 to 16 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

vi. Pre-treatment/periapical radiographs prior to

2. crowns on UL1 and/or UR1 between 3 November 2016 and 2 December 2016

Found proved (on the basis that no pre-treatment/periapical radiographs were undertaken).

178. The Committee was satisfied from the clinical records that crowns were placed by Mr Denbigh-White on UL1 and UR1 between the dates in question. It was also satisfied that no pre-treatment/periapical radiographs were taken prior to the crowns being placed. There were no radiographs included in Mr Denbigh-White's clinical records for Patient 4, and he had stated himself that he did not routinely take radiographs of his patients.

179. The Committee accepted the expert evidence of Dr Ward that pre-treatment radiographs were essential in the circumstances *"to ensure there was no pathology present prior to carrying out advanced restorative treatment".* The Committee was satisfied that by not taking a pre-treatment radiograph, Mr Denbigh-White failed to provide Patient 4 with an adequate standard of care.

Charge 7(b)

7. You failed to provide an adequate standard of care to Patient 4 (identified in Schedule A…), from 19 February 2015 to 16 August 2019 in that:

b. You did not adequately formulate and/or record formulation of treatment plans

Found proved (on the basis that treatment plans were not adequately formulated)

180. The Committee had regard to the clinical records for Patient 4, and whilst it found that Mr Denbigh-White made records in relation to treatment that he proposed to carry out for

the patient, the Committee found nothing within the clinical records that would constitute a treatment plan, as outlined in the relevant GDC Standards, and as described by Dr Ward.

181. The Committee considered whether Mr Denbigh-White could have formulated treatment plans for Patient 4 but did not put them in writing. However, it considered that this was unlikely, given his limited assessment of the patient overall in terms of the lack of any radiographs, no BPEs having been undertaken, and the lack of any additional special tests when required. The Committee took into account Dr Ward's evidence that "*Treatment planning follows full assessment and diagnosis and after the consideration of treatment options, discussion of risks and benefits of treatment, along with consideration of the order and timing of treatment".*

182. Further, the Committee noted the evidence of Patient 4, who stated in her witness statement, *"I do not recall what the Registrant said about my teeth, but in all my appointments with the Registrant, he did not speak very much, and I was not fully aware of what he was doing during the appointments."*

183. It appeared to the Committee, on its assessment of the evidence, that Mr Denbigh-White addressed the patient's dental complaints as and when they were presented to him, as opposed to formulating treatment plans. The Committee was satisfied that it was more likely than not that Mr Denbigh-White did not formulate any adequate treatment plans in respect of his treatment of Patient 3 over the period in question. It was also satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 4 by not providing the patient with clear plans in relation to her treatment, as required by the GDC Standards.

Charge 7(c)

7. You failed to provide an adequate standard of care to Patient 4 (identified in Schedule A…), from 19 February 2015 to 16 August 2019 in that:

c. You did not diagnose and/or treat caries on the UR8 and/or LR7 and/or UL7 and/or UL6 and/or LL6

Found proved (on the basis that caries was not diagnosed in any of these teeth)

184. In her report, Dr Ward drew the Committee's attention to the clinical records of Patient 4's subsequent treating dentist, which indicated that following radiographic examination of the patient on 21 February 2020, caries was identified on all the teeth in question. This included deep distal caries at UR8, deep distal caries at UL7, close to the pulp, and deep caries at LL6. Dr Ward noted that despite Patient 4 attending regular appointments with Mr Denbigh-White, there was no indication that he had diagnosed caries in the five teeth concerned. It was Dr Ward's opinion, which the Committee accepted, that the caries diagnosed by the subsequent treating dentist was extensive, and therefore it would have been present clinically at previous appointments attended with Mr Denbigh-White.

185. The Committee found no evidence of a diagnosis of caries in respect of the UR8, LR7, UL7, UL6 and LL6 in Mr Denbigh-White's clinical records for Patient 4. It also took into account the patient's evidence that she did not recall Mr Denbigh-White diagnosing her teeth with any issues or telling her about any issues with her teeth.

186. In all the circumstances, the Committee was satisfied that Mr Denbigh-White did not diagnose the caries present on the five teeth in question. The Committee was further satisfied that by not doing so, Mr Denbigh-White failed to provide Patient 4 with an adequate standard of care. As he did not diagnose the caries, he could not have treated it. Indeed, the Committee found nothing in the clinical records made by Mr Denbigh-White regarding proposed treatment for the caries.

Charge 7(d)

7. You failed to provide an adequate standard of care to Patient 4 (identified in Schedule A…), from 19 February 2015 to 16 August 2019 in that:

d. You did not discuss and/or record discussion of treatment options

Found proved (on the basis that treatment options were not discussed).

187. In finding this allegation proved, the Committee took into account the absence of any information in Mr Denbigh-White's clinical records for Patient 4 regarding discussions with the patient about treatment options.

188. The Committee also took into account its findings that Mr Denbigh-White did not take any radiographs in respect of this patient, did not undertake special tests as appropriate, and did not diagnose the presence of dental disease. The Committee also found that Mr Denbigh-White did not formulate any adequate treatment plans in respect of the treatment that he provided to Patient 4. It further noted the patient's evidence about not talking very much with Mr Denbigh-White at appointments, and not being fully aware in respect of the treatment that was provided. In her oral evidence, Patient 4 told the Committee that she could not recall having discussions with Mr Denbigh-White regarding any risks and benefits of treatment, or options regarding materials to be used, and that she would simply rely on his advice.

189. Taking all the evidence into account, the Committee concluded that it was more likely than not that Mr Denbigh-White did not discuss treatment options with Patient 4 over the period in question. The Committee considered that it would have been difficult for him to have had any discussion about treatment options in any event, given the nature and extent of his omissions.

190. The Committee was satisfied that Mr Denbigh-White's omission to discuss treatment options with Patient 4 was a failure to provide an adequate standard of care, as such

discussions are an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 7(e)

7. You failed to provide an adequate standard of care to Patient 4 (identified in Schedule A…), from 19 February 2015 to 16 August 2019 in that:

e. You did not discuss and/or record risks and/or benefits of proposed treatment

Found proved (on the basis that risks and benefits of proposed treatment were not discussed).

191. The Committee found no information in Mr Denbigh-White's clinical records for Patient 4 regarding discussions with the patient about the risks and benefits of the treatment he proposed. It also took into account the patient's evidence about the lack of discussions at her appointments. Patient 4 stated in her witness statement that *"Generally, from my recollection I do not recall the Registrant explaining the different treatment options, nor would he describe the risks and benefits of any one particular treatment. I would dread seeing the Registrant because I knew they would not tell me what they were doing, or talk me through any treatment…"*

192. The Committee found this allegation proved for the same reasons outlined above in relation discussions of treatment options. It was satisfied that it was more likely than not that Mr Denbigh-White did not discuss the risks and benefits of proposed treatment with Patient 4 over the period in question.

193. The Committee was further satisfied that Mr Denbigh-White's omission to discuss the risks and benefits of proposed treatment with the patient was a failure to provide an adequate standard of care, given that such discussions are an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 7(f)

7. You failed to provide an adequate standard of care to Patient 4 (identified in Schedule A…), from 19 February 2015 to 16 August 2019 in that:

f. You inappropriately used glass ionomer for fillings on the following teeth and dates:-

i. UL7 (07/09/16 and/or 03/11/16 and/or 30/01/17 and/or 16/08/19)

ii. UL6 (3/11/16)

iii. LL6 (28/12/17)

iv. LR7 (16/3/15 and/or 01/6/15 and/or 11/7/16)

v. LR5 (9/3/15)

Found proved in relation to UL7, UL6, LR7 (01/6/15 and 11/7/16 only) and LR5.

Found not proved in relation to LL6 and LR7 (16/3/15).

194. In making its findings, the Committee considered heads of charge 7(f)(i) to (v) separately.

195. The Committee had regard to the clinical records for Patient 4 and was satisfied that GI fillings were placed on each of the teeth listed at 7(f)(i),(ii),(iv) and (v) and on the dates in question.

196. In relation to the matters found proved, the Committee noted that all the fillings were placed on load bearing surfaces of the teeth, and it accepted the evidence of Dr Ward that this was inappropriate for the reasons previously outlined. The Committee found nothing in Mr Denbigh-White's notes to suggest that any of the GI fillings fell into the accepted circumstances referred to by Dr Ward, nor was there anything written by Mr Denbigh-White to justify his use of the material in clinical situations that were not in accordance with the manufacturer's recommendations and the relevant FGDP guidelines.

197. In relation to the GI filling placed at LR7 on 16 March 2015, the Committee was not satisfied that this was placed inappropriately. It noted from the clinical records that this filling was placed buccally, on a non-load bearing surface. The Committee took into account the evidence of Dr Ward that the use of a GI filling in such a clinical situation was not necessarily inappropriate. Accordingly, the Committee found this alleged matter not proved.

198. With regard to 7(f)(iii) which concerns the GI filling allegedly placed at LL6 on 28 December 2017, the Committee considered that there was some confusion in the evidence as to whether the tooth in question was 'LR6' or 'LL6'. In the light of this confusion, the Committee concluded that it would be inappropriate to amend the head of charge at this stage. It therefore found the allegation not proved in relation to the GI filling allegedly placed at 'LL6'.

Charge 8

8. As a result of 7 (a) (vi) and/or (d) and/or (e) you failed to obtain informed consent for the treatment provided from 19 February 2015 to 16 August 2019.

Found proved in relation to 7(a)(vi), 7(d) and 7(e).

199. The Committee's findings at 7(a)(vi), 7(d) and 7(e) are that Mr Denbigh-White did not take any pre-treatment/periapical radiographs prior to placing crowns at UL2, UL1 and UR1, and that he did not discuss any alternative treatment options or risks and benefits of proposed treatment with Patient 4 over the period in question.

200. In relation to the crowns placed at UL2, UL1 and UR1, the Committee took into account the evidence of Dr Ward, which it accepted, that in the absence of any pre-

treatment/periapical radiographs, Mr Denbigh-White could not have known whether there were any underlying issues in those teeth which could have affected the success or longevity of the crown treatment. The Committee noted that the UL2 in particular was described in the clinical records as *"crumbled"* and broken to gum level. In the absence of any pre-treatment radiographic examination, Mr Denbigh-White would not have been able to assess the remaining root to see if it was restorable, if it needed root canal treatment, or if there was any periapical pathology present.

201. Given that Mr Denbigh-White did not have the radiographic information to assess the highlighted risks, he could not have conveyed any risks to the patient. The Committee considered that, in the circumstances, it was not possible for Patient 4 to have given informed consent for the crowns placed at UL2, UL1 and UR1.

202. Furthermore, the Committee found that there had been no discussions, throughout the period in question, between Mr Denbigh-White and Patient 4 regarding treatment options and any risks and benefits of proposed treatment. The Committee had regard to the GDC standards relating to the issue of valid consent. It also took into account the evidence of Dr Ward that discussions with patients about alternative treatment options and risks and benefits of proposed treatment are integral to patients being able to give informed consent.

203. Taking all the evidence into account, including Patient 4's comments about not being fully aware of the treatment provided to her by Mr Denbigh-White, the Committee found this allegation at Charge 8 proved. It was satisfied on the balance of probabilities that Patient 4 could not have given informed consent for any of the treatment provided by Mr Denbigh-White from 19 February 2015 to 16 August 2019, if the patient was unaware of what alternative treatment options were available and the risks and benefits of proposed treatment.

Charge 9

You failed to maintain an adequate standard of record keeping from 19 February 2015 to 16 August 2019.

Found proved.

204. The Committee took into account its findings that in most instances, Mr Denbigh-White did not undertake the relevant actions, and therefore he could not have recorded undertaking them. However, in relation to the taking of the patient's medical history, the undertaking of intra oral examinations, and treatment planning, the Committee noted that there is some information in the clinical records alluding to Mr Denbigh-White's actions, but the information included was very limited. The Committee found that there was insufficient information in the clinical records to explain what Mr Denbigh-White did in terms of his care of Patient 4 and why. This included his use of GI fillings in clinical situations that were not in

accordance with the manufacturer's recommendations and the relevant FGDP guidelines, without any recorded justification.

205. The Committee found Mr Denbigh-White's record keeping in respect of his care and treatment of Patient 4 to be of an inadequate standard. The clinical records were brief with major omissions.

PATIENT 5

Charge 10(a)(i)

10. You failed to provide an adequate standard of care to Patient 5 (identified in Schedule A…), from 19 January 2012 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

i. Medical history

Found proved (on the basis that a medical history was not taken adequately).

206. The Committee was satisfied from the clinical records for Patient 5, that Mr Denbigh-White provided care and treatment to the patient over the period in question.

207. The Committee took into account that Mr Denbigh-White had a duty to take an up-to-date medical history from Patient 5 each time he treated the patient, in accordance with Standard 4.1.1 of the GDC Standards and the *FGDP UK guidelines on Clinical Examination and Record Keeping*.

208. The Committee had regard to Patient 5's clinical records and it found several entries against Mr Denbigh-White's initials, between January 2012 and February 2015, which indicated that he had updated the patient's medical notes on those occasions. However, it found that there were no such entries for a period of four years, between February 2015 and July 2019.

209. The Committee noted that Patient 5 attended a number of appointments with Mr Denbigh-White between February 2015 and July 2019, including for an extraction in 2018, when an update to the patient's medical history would have been required.

210. The Committee took into account the limited information in the clinical records to indicate that a medical history was taken each time Mr Denbigh-White treated Patient 5. It also had regard to its findings above that Mr Denbigh-White had been less than

comprehensive in taking and updating the medical histories of other patients. In all the circumstances, the Committee concluded that it was more likely than not that Mr Denbigh-White did not take an up to date medical history from Patient 5 each time he treated the patient.

211. The Committee concluded that Mr Denbigh-White could not have obtained an up to date picture of Patient 5's medical health, not having taken the patient's medical history from February 2015 to July 2019. It was therefore satisfied that he failed in his duty to provide the patient with an adequate standard of care.

Charge 10(a)(ii)

10. You failed to provide an adequate standard of care to Patient 5 (identified in Schedule A…), from 19 January 2012 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

ii. extra and intra oral examinations (except on 19/1/12 and 11/11/13

when these assessments are recorded)

Found proved (on the basis that no extra oral examinations were undertaken, except on 19/1/12 and 11/11/13, and that the intra oral examinations undertaken, except for on 19/1/12 and 11/11/13, were inadequate).

212. The Committee had regard to Mr Denbigh-White's clinical records for Patient 5 and found that they included limited information regarding extra and intra oral examinations.

Excluding the notes made on 19 January 2012, and 11 November 2013, which do not form part of this allegation, the Committee found nothing in the clinical records to suggest that extra-oral examinations had been carried out at any other appointments.

213. Whilst there was some evidence of intra-oral examinations having been undertaken, in that there was information in the clinical records to indicate that Mr Denbigh-White had looked in the patient's mouth and at aspects of the patient's teeth, the Committee found nothing to indicate that a full clinical examination had been carried out at any of the other appointments in question. Except for 19 January 2012 and 11 November 2013, there was no recorded information to suggest that Mr Denbigh-White had examined Patient 5 extra-orally, for example, the TMJs and lymph nodes, or to indicate that intra-orally he had examined the patient's soft tissues, for example, the tongue or floor of the mouth. The Committee noted Dr Ward's comments in her report regarding the lack of information relating to extra and intra oral examinations in Mr Denbigh-White's clinical notes for Patient 5.

214. The Committee took into account that Mr Denbigh-White made some records in respect of his findings following clinical examinations of the patient's mouth and teeth. The Committee also took into account its findings above in relation to the same matters but concerning different patients, namely that no extra oral examinations were undertaken of those patients, and that the intra oral examinations carried out were deficient.

215. In all the circumstances, the Committee was satisfied on the balance of probabilities that, excluding 19 January 2012 and 11 November 2013, Mr Denbigh-White did not undertake any extra-oral examinations of Patient 5 over the period in question. Further, the intra-oral examinations that he did undertake were inadequate. The Committee was also satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 5, given that such examinations are an integral part of assessment, used to help dentists diagnose dental and oral diseases.

Charge 10(a)(iii)

10. You failed to provide an adequate standard of care to Patient 5 (identified in Schedule A…), from 19 January 2012 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

iii. additional special tests as appropriate;

Found proved (on the basis that additional special tests were not undertaken as appropriate).

216. In her report, Dr Ward noted that prior to September 2019, whilst the patient was being treated by Mr Denbigh-White, there were references in the clinical notes to the patient having a number of mobile teeth. Dr Ward told the Committee in her oral evidence that, in the circumstances, she would have expected Mr Denbigh-White to have undertaken additional special tests, including grading the mobility of the teeth concerned and probing around them. She stated that she also would have expected six-point pocket charting to have been undertaken, given that on 19 January 2012 and 11 November 2013, Mr Denbigh-White recorded BPE scores of 3 for the patient, which indicated potential periodontal disease requiring further assessment.

217. The Committee accepted the evidence of Dr Ward that additional special tests would have been appropriate in the circumstances of Patient 5's clinical presentation. It noted that there was no information in Mr Denbigh-White's clinical records for the patient, regarding the amount of tooth mobility, or anything to suggest that Mr Denbigh-White had undertaken investigations such as probing around the mobile teeth and/or six-point pocket charting.

218. The Committee was satisfied on the evidence that it was more likely than not that Mr Denbigh-White did not undertake any special tests in respect of Patient 5. The Committee was further satisfied that this omission amounted to a failure to provide the patient with an

adequate standard of care, as in the absence of such tests, it was unlikely that Mr Denbigh-White could have provided appropriate treatment.

Charge 10(a)(iv)

10. You failed to provide an adequate standard of care to Patient 5 (identified in Schedule A…), from 19 January 2012 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

iv. BPE (except on 19/1/12 and 11/11/13 when these assessments are recorded)

Found proved (on the basis that BPEs were not undertaken except on 19/1/12 and 11/11/13).

219. The Committee had regard to the clinical records, and it found no evidence to indicate that Mr Denbigh-White had undertaken any other BPEs of Patient 5 during the period in question, save for those recorded on 19 January 2012 and 11 November 2013. The Committee noted that a BPE should be undertaken at initial examination and at each recall interval in accordance with the relevant guidelines.

220. In the absence of any reference to further BPEs in the clinical records, and in view of its findings that Mr Denbigh-White did not take any BPEs of another patient under his care, the Committee was satisfied on the balance of probabilities that this allegation is proved. The Committee was satisfied that Mr Denbigh-White did not undertake any other BPEs in respect of Patient 5 in over seven years. The Committee was satisfied that this represented a failure by Mr Denbigh-White to provide an adequate standard of care to the patient, in view of Dr Ward's opinion regarding the integral nature of BPEs to assessment, diagnosis and treatment.

Charge 10(a)(v)

10. You failed to provide an adequate standard of care to Patient 5 (identified in Schedule A…), from 19 January 2012 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

v. Bitewing radiographs

Found proved (on the basis that bitewing radiographs were not undertaken).

221. The Committee noted that it was indicated in the clinical records that a small x-ray was taken in respect of Patient 5 on 19 January 2012. However, the type of x-ray was not recorded, and there was no other information relating to the x-ray to suggest that these were bitewing radiographs.

222. Further, the Committee took into account that, if the relevant guidelines on radiography were being followed by Mr Denbigh-White, it would have expected to find several sets of radiographs in the patient's clinical records. The Committee noted that, even for patients at low risk of caries, bitewing radiographs are to be taken every two years. The Committee found no references to bitewing radiographs within the clinical records for the relevant period 19 January 2012 to 5 August 2019. It also took into account the evidence regarding Mr Denbigh-White's admission to an NHSE dental adviser that he did not routinely take radiographs of his patients because of the risk posed from the radiation.

223. Having had regard to all the evidence, the Committee was satisfied on the balance of probabilities that Mr Denbigh-White did not take any bitewing radiographs of Patient 5 during the time period in question. The Committee was also satisfied that Mr Denbigh-White's omission to take bitewing radiographs of Patient 4 amounted to a failure to provide an adequate standard of care. It accepted Dr Ward's opinion that the relevant guidelines should have been followed by Mr Denbigh-White to balance the safety of radiographic exposure against the benefits of its use.

Charge 10(a)(vi)(1) to (4)

10. You failed to provide an adequate standard of care to Patient 5 (identified in Schedule A…), from 19 January 2012 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

vi. Pre-treatment/periapical radiographs prior to extractions of

1. UR4 on 9/9/16

2. UR5 on 14/9/16

3. UR7 on 23/3/17

4. UR2 on 17/7/19

Found not proved.

224. In making its findings, the Committee considered heads of charge 10(vi) (1) to (4) separately.

225. The Committee had regard to the clinical records for Patient 5 and was satisfied that the above teeth were extracted by Mr Denbigh-White on the dates in question. It was also satisfied on the evidence that no radiographs were taken by Mr Denbigh-White prior to the extractions. The Committee took into account Dr Ward's evidence that radiographs should have been considered, as they would have shown the roots and adjacent structures.

226. However, the Committee noted from the clinical notes that all the teeth in question were found to be loose. In view of this and given that Dr Ward's expert evidence was that radiographs should have been considered, and not that they were essential, the Committee decided that it was not unreasonable for Mr Denbigh-White to have exercised his clinical judgement to not take radiographs in the circumstances of these extractions.

Charge 10(b)

10. You failed to provide an adequate standard of care to Patient 5 (identified in Schedule A…), from 19 January 2012 to 5 August 2019 in that:

b. Further to the BPE scores of 3 on 19/1/12 and 11/11/13, you did not carry out a full periodontal assessment

Found proved.

227. The Committee accepted the evidence of Dr Ward, whose opinion was based on the *British Society of Periodontology* guidelines, that a periodontal assessment of Patient 5 should have been carried out by Mr Denbigh-White following the BPE scores of 3 on 19 January 2012 and 11 November 2013. Dr Ward stated in her report that *"BPE codes of 3 were recorded 19/01/12 and 11/11/13, indicating periodontal disease was present at this time. No full assessment, including full mouth periodontal probing, and radiographs were carried out as would be required for BPE codes of 3 and above".* The Committee further took into account Dr Ward's oral evidence that she would have expected six-point pocket charting to have been undertaken by Mr Denbigh-White.

228. The Committee had regard to Mr Denbigh-White's clinical records for Patient 5, and it found nothing to indicate that he had carried out a full periodontal assessment as described by Dr Ward.. In all the circumstances, the Committee concluded that it was more likely than not that he did not carry out a full periodontal assessment in response to the BPE scores of 3 on 19 January 2012 and 11 November 2013. The Committee was satisfied that this represented a failure to provide Patient 5 with an adequate standard of care, given the importance of such an assessment to diagnosis of the disease.

Charge 10(c)

10. You failed to provide an adequate standard of care to Patient 5 (identified in Schedule A…), from 19 January 2012 to 5 August 2019 in that:

c. You did not adequately formulate and/or record formulation of treatment plans

Found proved (on the basis that treatment plans were not adequately formulated)

229. The Committee had regard to the clinical records for Patient 5, and whilst it found that Mr Denbigh-White made records in relation to treatment that he proposed to carry out for

the patient, the Committee found nothing within the clinical records that would constitute a treatment plan, as outlined in the relevant GDC Standards, and as described by Dr Ward.

230. The Committee considered whether Mr Denbigh-White could have formulated treatment plans for Patient 5 but did not put them in writing. However, it considered that this was unlikely, given his limited assessment of the patient overall in terms of the lack of any radiographs, BPEs only having been undertaken on two occasions over seven years, the lack of any additional special tests and a full periodontal assessment. The Committee took into account Dr Ward's evidence that "*Treatment planning follows full assessment and diagnosis and after the consideration of treatment options, discussion of risks and benefits of treatment, along with consideration of the order and timing of treatment".*

231. It appeared to the Committee, on its assessment of the evidence, that Mr Denbigh-White addressed Patient 5's dental complaints as and when they were presented to him, as opposed to formulating treatment plans. The Committee was satisfied that it was more likely than not that Mr Denbigh-White did not formulate any adequate treatment plans in respect of his treatment of Patient 3 over the period in question. The Committee was satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 5 by not providing the patient with clear plans in relation to their treatment, as required by the GDC Standards.

Charge 10(d)

10. You failed to provide an adequate standard of care to Patient 5 (identified in Schedule A…), from 19 January 2012 to 5 August 2019 in that:

d. You did not diagnose and/or treat periodontitis.

Found proved (on the basis that periodontitis was not diagnosed)

232. Dr Ward stated in her report that *"Patient 5 had been seen for regular dental care. The patient was diagnosed with periodontal disease by the subsequent dentist however this was not diagnosed/ treated by the registrant, despite mobility of teeth necessitating extractions."*

233. The Committee had regard to Mr Denbigh-White's clinical records for Patient 5 and found no information that could be recognised as a diagnosis of periodontal disease, nor was there anything to suggest that Mr Denbigh-White had treated the patient for periodontal disease. In the circumstances, the Committee was satisfied that Mr Denbigh-White did not make such a diagnosis. The Committee was satisfied that this represented a failure to provide an adequate standard of care to Patient 5, given that the patient's periodontal disease remained undiagnosed for many years. The evidence before the Committee was that Patient 5 was not diagnosed with periodontal disease until seeing a subsequent treating dentist in September 2019, which was over seven years after the periodontal disease was first indicated from the BPE undertaken of the patient in January 2012.

Charge 10(e)

10. You failed to provide an adequate standard of care to Patient 5 (identified in Schedule A…), from 19 January 2012 to 5 August 2019 in that:

e. You did not diagnose and/or treat caries on the UL6 and/or LR6.

Found proved (on the basis that caries was not diagnosed on the LR6).

Found not proved in relation to the UL6.

234. The Committee took into account the evidence of Dr Ward, who highlighted from Patient 5's clinical records that, on 4 September 2019, the subsequent treating dentist diagnosed caries on both LR6 and UL6. A bitewing radiograph taken of the patient showed caries on the root of LR6, and UL6 was found to be grossly carious and unrestorable.

235. However, the Committee noted the information in the clinical records that Patient 5 had previously declined Mr Denbigh-White's offer to extract UL6. This suggested to the Committee that Mr Denbigh-White had identified a problem with the tooth whilst he was treating the patient, and that he had offered treatment by way of an extraction. Accordingly, the Committee was not satisfied that this allegation is proved in relation to UL6.

236. With regard to LR6, the Committee was satisfied on the evidence of Dr Ward and the radiographs taken by the subsequent treating dentist, that the caries found to be present on this tooth in September 2019 would have been evident clinically at previous appointments. The Committee noted that Patient 5 was seen by the subsequent treating dentist less than a month after their last appointment with Mr Denbigh-White. It found nothing in Mr Denbigh-White's records to indicate that he had diagnosed caries in the LR6 or provided treatment for caries in this tooth. In all the circumstances, the Committee was satisfied on the balance of probabilities that Mr Denbigh-White did not diagnose caries, and therefore he could not have treated it. The Committee was satisfied that this represented a failure to provide Patient 5 with an adequate standard of care.

Charge 10(f)

10. You failed to provide an adequate standard of care to Patient 5 (identified in Schedule A…), from 19 January 2012 to 5 August 2019 in that:

f. You did not discuss and/or record discussion of treatment options

Found proved (on the basis that treatment options were not discussed, except at an appointment on 17/7/19, when a record about a discussion was made).

237. The Committee found very limited information in Mr Denbigh-White's clinical records for Patient 5 regarding discussions with the patient about treatment options. It noted that in

respect of an appointment on 17 July 2019, it was indicated in the clinical notes that UR2 was loose, and that Mr Denbigh-White had advised an extraction. The clinical notes also stated, *"discused options [sic]",* albeit no details of the discussion were recorded. The Committee considered, however, that some kind of discussion had taken place on that occasion.

238. The Committee found no further information in the clinical records to suggest that there had been any other discussions with Patient 5 about treatment options during the period concerned. In the absence of such records, and in view of its findings about the lack of any discussion by Mr Denbigh-White with a number of other patients about treatment options, the Committee was satisfied on the balance of probabilities that Mr Denbigh did not discuss treatment options with Patient 5, save for on 17 July 2019.

239. In finding that Mr Denbigh-White failed to provide an adequate standard of care to the patient, the Committee was satisfied that a discussion about treatment options on one occasion over a period of seven years, in the context of the treatment of a single tooth, was not adequate. Discussions about treatment options are an important aspect in ensuring that a patient has the understanding to give consent to treatment, and the Committee considered that Mr Denbigh-White should have had such a discussion with Patient 5 each time treatment was proposed.

Charge 10(g)

10. You failed to provide an adequate standard of care to Patient 5 (identified in Schedule A…), from 19 January 2012 to 5 August 2019 in that:

f. You did not discuss and/or record risks and/or benefits of proposed treatment

Found proved (on the basis that risks and benefits of proposed treatment were not discussed).

240. The Committee found no information in Mr Denbigh-White's clinical records for Patient 5 regarding any discussions with the patient about the risks and benefits of proposed treatment. The Committee found this allegation proved for the same reasons given above in relation to the discussion of treatment options.

241. The Committee was further satisfied that Mr Denbigh-White's omission to discuss the risks and benefits of proposed treatment with the patient was a failure to provide an adequate standard of care, given that such discussions are an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 10(h)(i)

10. You failed to provide an adequate standard of care to Patient 5 (identified in Schedule A…), from 19 January 2012 to 5 August 2019 in that:

h. You inappropriately used glass ionomer for fillings on the following teeth and dates;-

i. LR6 (10/09/12 and/or 02/01/15 and/or 02/02/15 and/or 14/09/16)

Found proved in relation to 10/09/12, 02/02/15 and 14/09/16.

Found not proved in relation to 02/01/15.

242. The Committee had regard to the clinical records for Patient 5 and was satisfied that GI fillings were placed at LR6 on all the dates set out in this allegation, except for 02/01/15. The Committee could not find any indication that a GI filling was placed in the tooth on this date.

243. In respect of the other dates, which the Committee has found proved, it accepted the evidence of Dr Ward that the GI fillings were inappropriately used on the LR6 those occasions for the same reasons given previously.

Charge 11

11. As a result of 10 (a) (vi) and/or (f) and (g) you failed to obtain informed consent for the treatment provided from 19 January 2012 to 5 August 2019

Found proved in relation to 10(f) and 10(g) only.

244. As the Committee found the allegation at 10(a)(vi) not proved, it considered this allegation at Charge 11 in respect of 10(f) and 10(g) only.

245. The Committee findings at 10(f) and 10(g) are that Mr Denbigh-White did not discuss any alternative treatment options with Patient 5 over the period in question, save for at one appointment, and that he did not discuss the risks and benefits of proposed treatment with the patient at all over the period in question.

246. The Committee had regard to the GDC Standards which relate to the issue of valid consent. It also took into account the evidence of Dr Ward that discussions with patients about alternative treatment options and risks and benefits of proposed treatment are integral to patients being able to give informed consent.

247. Having had regard to all the evidence, the Committee found this allegation at Charge 11 proved. It was satisfied on the balance of probabilities that Patient 5 could not have given informed consent for any of the treatment provided by Mr Denbigh-White from 19 January 2012 to 15 August 2019, if the patient was unaware of what alternative treatment options were available and the risks and benefits of any proposed treatment.

Charge 12

12. You failed to maintain an adequate standard of record keeping from 19 January 2012 to 5 August 2019

Found proved.

248. The Committee took into account its findings that in most instances, Mr Denbigh-White did not undertake the relevant actions, and therefore he could not have recorded undertaking them. However, in relation to the taking of the patient's medical history, the undertaking of intra oral examinations, and treatment planning, the Committee noted that there is some information in the clinical records alluding to Mr Denbigh-White's actions, but the information included was very limited. This was also the case in relation to the small x-ray that he took in respect of Patient 5 on 19 January 2012. There is no information in the clinical records to indicate the type of x-ray, any report on the x-ray or the justification for taking it. Also, in relation to the one occasion that Mr Denbigh-White appeared to discuss treatment options with the patient on 17 July 2019, no detail of the discussion was recorded.

249. The Committee found that there was insufficient information in the clinical records to explain what Mr Denbigh-White did in terms of his care of Patient 5 and why. This included his use of GI fillings in clinical situations that were not in accordance with the manufacturer's recommendations and the relevant FGDP guidelines, without any recorded justification.

250. The Committee found Mr Denbigh-White's record keeping in respect of his care and treatment of Patient 5 to be of an inadequate standard. The clinical records were brief with major omissions.

PATIENT 6

Charge 13(a)(i)

13. You failed to provide an adequate standard of care to Patient 6 (identified in Schedule A…), from 22 September 2015 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

i. Medical history

Found proved (on the basis that a medical history was not taken adequately).

251. The Committee was satisfied from the clinical records for Patient 6, that Mr Denbigh-White provided care and treatment to the patient over the period in question.

252. The Committee took into account that Mr Denbigh-White had a duty to take an up-to-date medical history from Patient 6 each time he treated the patient, in accordance with Standard 4.1.1 of the GDC Standards and the *FGDP UK guidelines on Clinical Examination and Record Keeping*.

253. The Committee had regard to Patient 6's clinical records. It found entries against Mr Denbigh-White's initials which indicated that he had updated the patient's medical notes

at an appointment in May 2019 and at another appointment in August 2019. However, Patient 6 attended other appointments for treatment with Mr Denbigh-White over the period in question, when updates to the patient's medical history would also have been required.

254. The Committee took into account the lack of information in the clinical records to indicate that a medical history was taken each time Mr Denbigh-White treated Patient 6. It also had regard to its previous findings above that Mr Denbigh-White had been less than comprehensive in taking and updating the medical histories of other patients. In all the circumstances, the Committee concluded that it was more likely than not that Mr Denbigh-White did not take an up to date medical history from Patient 6 each time he treated the patient.

255. The Committee considered that Mr Denbigh-White could not have obtained an up-to-date picture of Patient 6's medical health, only having taken the patient's medical history on two occasions over an almost four-year period. It was therefore satisfied that he failed in his duty to provide the patient with an adequate standard of care.

Charge 13(a)(ii)

13. You failed to provide an adequate standard of care to Patient 6 (identified in Schedule A…), from 22 September 2015 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

ii. extra and intra oral examinations

Found proved (on the basis that no extra oral examinations were undertaken and the intra oral examinations undertaken were not adequate).

256. The Committee had regard to Mr Denbigh-White's clinical records for Patient 6 and found no information to indicate that he undertook any extra oral examinations over the period in question. Whilst there was some information relating to intra-oral examinations, in that there were records to indicate that Mr Denbigh-White had looked in the patient's mouth and at aspects of the patient's teeth, the Committee found nothing to indicate that a full clinical examination had ever been undertaken. There was no recorded information to suggest that Mr Denbigh-White had examined Patient 6 extra-orally, for example, the TMJs and lymph nodes, or to indicate that intra-orally he had examined the patient's soft tissues, for example, the tongue or floor of the mouth. The Committee noted Dr Ward's comments in her report regarding the lack of information relating to extra and intra oral examinations in Mr Denbigh-White's clinical records for Patient 6.

257. The Committee took into account the limited nature of information in the clinical records relating to standard clinical examinations. It also took into account its previous findings above in relation to the same matters but concerning different patients, namely that

no extra oral examinations were undertaken of those patients, and that the intra oral examinations carried out were inadequate.

258. In all the circumstances, the Committee was satisfied that it was more likely than not, that Mr Denbigh-White did not undertake any extra-oral examinations of Patient 6 over the period in question, and that the intra-oral examinations of the patient were inadequate. The Committee was also satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 6, given that such examinations are an integral part of assessment used to help dentists diagnose dental and oral diseases.

Charge 13(a)(iii)

13. You failed to provide an adequate standard of care to Patient 6 (identified in Schedule A…), from 22 September 2015 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

iii. additional special tests as appropriate

Found proved (on the basis that no additional special tests were undertaken as appropriate).

259. The Committee considered Dr Ward's evidence regarding the requirement for special tests in the context of Patient 6's dental history, as documented within the clinical records. The Committee considered whether there were occasions when the patient presented with a complaint or condition that would have required Mr Denbigh-White to have undertaken any of the special tests referred to by Dr Ward, namely vitality tests, TTP testing and palpation.

260. The Committee had regard to Dr Ward's evidence that no special tests were carried out in respect of Patient 6 at any appointment. It noted that over the period in question, aside from routine appointments, Patient 6 attended to see Mr Denbigh-White for the provision of several restorations to LR3. The clinical records show that a filling in this tooth was repeatedly lost and replaced, although the patient did not appear to have complained of any pain. However, the Committee considered that in the circumstances of the repeated failing of the filling, Mr Denbigh-White should have undertaken vitality testing to check if the LR3 was still vital.

261. The Committee found no information in the clinical records to suggest that Mr Denbigh-White had undertaken any investigations to determine the vitality of LR3, although he recorded other information relating to his treatment of the tooth. In the absence of a specific record about special tests, the Committee considered it more likely than not that Mr Denbigh-White did not undertake such tests. The Committee was further satisfied that this omission amounted to a failure to provide Patient 3 with an adequate standard of care, as in the absence of such tests to check if the LR3 was vital, Mr Denbigh-White could not have

assessed whether repeatedly replacing the filling was the appropriate course of action, or whether other work was required.

Charge 13(a)(iv)

13. You failed to provide an adequate standard of care to Patient 6 (identified in Schedule A…), from 22 September 2015 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

iv. BPE

Found proved (on the basis no BPEs were undertaken, except on 05/08/19, when a BPE was undertaken but not adequately recorded).

262. The Committee had regard to the clinical records for Patient 6 and found a note indicating that the patient's BPE chart was updated on 5 August 2019. In view of this note, the Committee considered that it was possible that a BPE was undertaken on that date, although it found no BPE scores incorporated in the clinical records.

263. There was no other information in the clinical notes to indicate that Mr Denbigh-White had undertaken any BPEs of Patient 6 at any other appointment during the period in question. Given the lack of any further record, the Committee concluded on the balance of probabilities that Mr Denbigh-White did not undertake BPEs of the patient at any other time. The Committee took into account that, in accordance with the relevant guidelines, a BPE should be undertaken at initial examination and at each recall interval.

264. In all the circumstances, the Committee was satisfied that this allegation at head of charge 13(a)(iv) is proved on the basis that Mr Denbigh-White only undertook one BPE in respect of Patient 6 in almost four years. Further, the record of that one BPE that was undertaken was inadequate, in that no BPE scores were included in the patient's record. The Committee was satisfied that this represented a failure by Mr Denbigh-White to provide an adequate standard of care to the patient, in view of Dr Ward's opinion regarding the integral nature of BPEs to assessment, diagnosis and treatment.

Charge 13(a)(v)

13. You failed to provide an adequate standard of care to Patient 6 (identified in Schedule A…), from 22 September 2015 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

v. Periodontal assessment

Found proved (on the basis that no periodontal assessment was undertaken).

265. The Committee noted Dr Ward's evidence that Mr Denbigh-White *"Failed to carry out full periodontal assessment …"*. In support of her opinion, she drew the Committee's attention to the information within the clinical records that on 9 September 2019, a subsequent treating dentist recorded BPE scores of 4 in each sextant. Further, that radiographs taken of Patient 6 by the subsequent treating dentist at that appointment, showed "*generalised severe periodontitis that would have been present for at least 5 years."*

266. In accepting Dr Ward's opinion, the Committee noted that Patient 6 was last seen by Mr Denbigh-White on 5 August 2019, which was shortly before the patient's periodontal disease was diagnosed by the subsequent treating dentist. In view of the evidence regarding the severity and longstanding nature of the patient's periodontal disease, the Committee was satisfied that it would have been present clinically at the appointment with Mr Denbigh-White on 5 August 2019 and at previous appointments.

267. The Committee found no information in Mr Denbigh-White's clinical notes for Patient 6 to indicate that he had undertaken a periodontal assessment of the patient. It noted Dr Ward's evidence that she would have expected to see information within the patient's notes regarding six-point pocket charting having been undertaken. The Committee further took into account its findings that, other than on 5 August 2019, Mr Denbigh-White did not carry out any BPEs of the patient, which would have guided the need for a full periodontal assessment.

268. In all the circumstances, the Committee was satisfied that this allegation is proved on the basis that Mr Denbigh-White did not undertake a periodontal assessment of Patient 6 at any point during the period in question. The Committee was satisfied that this represented a failure by Mr Denbigh-White to provide Patient 3 with an adequate standard of care, given the importance of such an assessment to diagnosis of the disease.

Charge 13(a)(vi)

13. You failed to provide an adequate standard of care to Patient 6 (identified in Schedule A…), from 22 September 2015 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

vi. Bitewing radiographs

Found proved (on the basis that no bitewing radiographs were undertaken).

269. The only radiograph before the Committee in respect of Patient 6, was one which was taken on a date before the period under consideration. The Committee found no radiographs within the clinical records for the relevant period 22 September 2015 to 5 August 2019.

270. The Committee also had regard to the evidence of Mr Krzeminski regarding Mr Denbigh-White stating that he did not routinely take radiographs of his patients because of the risk posed by radiation.

271. Having had regard to the evidence, the Committee was satisfied on the balance of probabilities that Mr Denbigh-White did not take any radiographs of Patient 6 during the time period in question. The Committee was also satisfied that Mr Denbigh-White's omission to take any radiographs of the patient amounted to a failure to provide an adequate standard of care for the same reasons stated previously.

Charge 13(b)

13. You failed to provide an adequate standard of care to Patient 6 (identified in Schedule A…), from 22 September 2015 to 5 August 2019 in that:

b. You did not adequately formulate and/or record formulation of treatment plans

Found proved (on the basis that treatment plans were not adequately formulated)

272. The Committee had regard to the clinical records for Patient 6, and whilst it found that Mr Denbigh-White made records in relation to treatment that he proposed to carry out for the patient, the Committee found nothing within the clinical records that would constitute a treatment plan, as outlined in the relevant GDC Standards, and as described by Dr Ward.

273. The Committee took into account Dr Ward's evidence that "*Treatment planning follows full assessment and diagnosis and after the consideration of treatment options, discussion of risks and benefits of treatment, along with consideration of the order and timing of treatment".*

274. The Committee had regard to its findings above regarding the limited assessment of Patient 6 by Mr Denbigh-White, in terms of the lack of radiographs, BPEs only having been undertaken on two occasions over the seven-year period, and where appropriate, the lack of any additional special testing and a full periodontal assessment. The Committee concluded that in the circumstances, Mr Denbigh-White would not have had all the relevant clinical information to adequately formulate treatment plans for the patient. The Committee was satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 6 by not providing the patient with clear plans in relation to their treatment, as required by the GDC Standards.

Charge 13(c)

13. You failed to provide an adequate standard of care to Patient 6 (identified in Schedule A…), from 22 September 2015 to 5 August 2019 in that:

c. You did not diagnose and/or treat periodontitis

Found proved (on the basis that periodontitis was not diagnosed)

275. The Committee had regard to the evidence of Dr Ward that Mr Denbigh-White did not diagnose or treat the patient's periodontal disease, *"despite him noting mobility of lower anterior teeth on 29/12/16".* Dr Ward's opinion was that Mr Denbigh-White *"Failed to carry out full periodontal assessment and radiographic examination that would have led to diagnosis of periodontitis at any appointment".*

276. In accepting Dr Ward's evidence, the Committee noted the absence of any diagnosis of periodontitis in Mr Denbigh-White's clinical records for Patient 6. It also took into account its finding above that Mr Denbigh-White did not undertake a periodontal assessment of the patient. In the circumstances, the Committee concluded that it was more likely than not that Mr Denbigh-White did not diagnose Patient 6's periodontitis.

277. The Committee was also satisfied that Mr Denbigh-White failed to provide Patient 6 with an adequate standard of care. In the absence of a diagnosis of periodontitis, he could not have provided appropriate treatment to the patient. Whilst the Committee noted from the clinical records that Patient 6 had attended appointments for routine scaling during the period that he was seen by Mr Denbigh-White, it found no information to suggest that the patient was treated specifically for periodontitis. The evidence before the Committee, which it accepted, was that Patient 6's periodontitis was not diagnosed until he saw the subsequent treating dentist in September 2019.

Charge 13(d)

13. You failed to provide an adequate standard of care to Patient 6 (identified in Schedule A…), from 22 September 2015 to 5 August 2019 in that:

d. You did not diagnose and/or treat caries on the LR8

Found proved (on the basis that caries was not diagnosed)

278. Dr Ward's opinion in respect of Patient 6's LR8, was that Mr Denbigh-White *"Failed to diagnose caries / apical pathology found by subsequent dentist 09/09/19".*

279. In accepting the evidence of Dr Ward, the Committee had regard to the subsequent treating dentist's report on the findings from the periapical radiograph in question. That dentist recorded the presence of caries on the LR8 *"under filling inside pulp",* as well as bone loss.

280. The Committee considered that, given the extensive nature of the caries in the LR8, it would have been present clinically at previous appointments. The Committee took into account that Patient 6 was last seen by Mr Denbigh-White on 5 August 2019, less than a month before the periapical radiograph was taken by the subsequent treating dentist on 9 September 2019. The Committee found no indication of a diagnosis of caries in respect of the LR8 in Mr Denbigh-White's clinical records for the patient.

281. In all the circumstances, the Committee was satisfied that Mr Denbigh-White did not diagnose the caries present on the LR8. The Committee was further satisfied that by not doing so, Mr Denbigh-White failed to provide Patient 6 with an adequate standard of care. As he did not diagnose the caries, he could not have treated it. The Committee found nothing in the clinical records made by Mr Denbigh-White regarding proposed treatment for the caries. The clinical notes made by the subsequent treating dentist on 9 September 2019 stated that the patient was advised that the LR8 was unrestorable, and that definitive treatment would be an extraction.

Charge 13(e)

13. You failed to provide an adequate standard of care to Patient 6 (identified in Schedule A…), from 22 September 2015 to 5 August 2019 in that:

e. You did not discuss and/or record discussion of treatment options

Found proved (on the basis that treatment options were not discussed)

282. The Committee took into account the absence of any information in Mr Denbigh-White's clinical records for Patient 6 regarding discussions with the patient about treatment options. It noted in particular that the filling at the patient's LR3 was replaced on several occasions, with no information recorded about any alternative treatment options or any choices of material in relation to the replacement fillings. Mr Denbigh-White used glass ionomer fillings each time with no recorded justification.

283. In addition to the absence of any record regarding discussions about treatment options, the Committee took into account its findings made in respect of the treatment of other patients, that treatment options were not discussed. It also had regard to the evidence it received from some patients regarding Mr Denbigh-White not having spoken to them much or at all about their treatment. Further, the Committee took into account its findings that Mr Denbigh-White did not take any radiographs of this patient, did not undertake special tests as appropriate, and did not diagnose the presence of dental disease. The Committee also found that Mr Denbigh-White did not formulate any adequate treatment plans. Taking all these factors into account, the Committee concluded that it was more likely than not that Mr Denbigh-White did not discuss treatment options with Patient 6 over the period in question. It considered that it would have been difficult for him to have had any discussion about

treatment options given the limited clinical information that would have been available to him on account of his omissions.

284. The Committee was satisfied that Mr Denbigh-White's omission to discuss treatment options with Patient 6 was a failure to provide an adequate standard of care, as such discussions are an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 13(f)

13. You failed to provide an adequate standard of care to Patient 6 (identified in Schedule A…), from 22 September 2015 to 5 August 2019 in that:

f. Did not discuss and/or record risks and/or benefits of proposed treatment

Found proved (on the basis that risks and benefits of proposed treatment were not discussed).

285. The Committee found no information in Mr Denbigh-White's clinical records for Patient 6 regarding any discussions with the patient about the risks and benefits of proposed treatment. The Committee found this allegation proved for the same reasons outlined about in relation to the lack of discussion about treatment options.

286. The Committee was satisfied that Mr Denbigh-White did not discuss the risks and benefits of proposed treatment with Patient 6, and that his omission to do so was a failure to provide the patient with an adequate standard of care. Such discussions are an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 14

14. As a result of 13 (e) and/or (f) you failed to obtain informed consent for the treatment provided from 22 September 2015 to 5 August 2019.

Found proved in relation to 13(e) and 13(f).

287. The Committee findings at 13(e) and 13(f) are that Mr Denbigh-White did not discuss any alternative treatment options with Patient 6 over the period in question, and that he did not discuss the risks and benefits of proposed treatment with the patient over the period concerned.

288. The Committee had regard to the GDC Standards relating to the issue of valid consent. It also considered the evidence of Dr Ward that discussions with patients about alternative treatment options and risks and benefits of proposed treatment are integral to patients being able to give informed consent.

289. Taking all the evidence into account, the Committee found this allegation at Charge 14 proved. It was satisfied on the balance of probabilities that Patient 6 could not have given

informed consent for any of the treatment provided by Mr Denbigh-White from 22 September 2015 to 5 August 2019, if the patient was unaware of what alternative treatment options were available and the risks and benefits of any proposed treatment.

Charge 15

15. You failed to maintain an adequate standard of record keeping from 22 September 2015 to 5 August 2019

Found proved.

290. The Committee took into account its findings that, in most instances, Mr Denbigh-White did not undertake the relevant actions, and therefore he could not have recorded undertaking them. However, in relation to the taking of the patient's medical history, the undertaking of intra oral examinations, and treatment planning, the Committee noted that there is some information in the clinical records alluding to Mr Denbigh-White's actions, but the information included is very limited. The Committee found that there was insufficient information in the clinical records to explain what Mr Denbigh-White did in terms of his care of Patient 6 and why.

291. The Committee found Mr Denbigh-White's record keeping in respect of his care and treatment of Patient 6 to be of an inadequate standard. The clinical records were brief with major omissions.

PATIENT 7

Charge 16(a)(i)

16. You failed to provide an adequate standard of care to Patient 7 [identified in Schedule A…], from 1 December 2014 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

i. Medical history

Found proved (on the basis that a medical history was not taken adequately).

292. The Committee was satisfied from the clinical records for Patient 7, that Mr Denbigh-White provided care and treatment to the patient over the period in question.

293. The Committee took into account that Mr Denbigh-White had a duty to take an up-to-date medical history from Patient 7 each time he treated the patient, in accordance with Standard 4.1.1 of the GDC Standards and the *FGDP UK guidelines on Clinical Examination and Record Keeping*.

294. The Committee had regard to Patient 7's clinical records. It found entries against Mr Denbigh-White's initials on 12 December 2014, 5 August 2015, 3 June 2019, and 5

August 2019. These entries indicated to the Committee that he had updated the patient's medical notes at these appointments. However, there was an absence of any information regarding medical history updates for a period of almost four years, between August 2015 and June 2019. The Committee noted that Patient 7 attended appointments for treatment with Mr Denbigh-White during this four-year period, when updates to the patient's medical history would also have been required.

295. Patient 7 stated in his witness statement that "…*I do not have any recollection of the Registrant ever discussing my medical history before an examination".* In his oral evidence, Patient 7 told the Committee that he would volunteer information about any medication he was taking, as opposed to Mr Denbigh-White asking him. The patient also stated that he was never asked by Mr Denbigh-White whether he had any allergies.

296. Taking all the evidence into account, the Committee was satisfied on the balance of probabilities that Mr Denbigh-White did not take an adequate medical history from Patient 7 over the period in question. It was satisfied that it was more likely than not that Mr Denbigh-White did not take or update the patient's medical history beyond the four dates indicated in the clinical records. This was not sufficient to meet the prescribed duty in the GDC Standards and the relevant FGDP guidelines for a medical history to be taken "*each time that you treat patients".* Further, in light of Patient 7's evidence, the Committee considered that on those occasions that Mr Denbigh-White took an updated medical history, he had not done so comprehensively.

297. The Committee considered that in the circumstances, Mr Denbigh-White could not have obtained an up to date picture of Patient 7's health, given both the limited and infrequent way in which he took the patient's medical history. The Committee was satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 7 in this regard.

Charge 16(a)(ii)

16. You failed to provide an adequate standard of care to Patient 7 [identified in Schedule A…], from 1 December 2014 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

ii. extra and intra oral examinations

Found proved (on the basis that no extra oral examinations were undertaken and the intra oral examinations undertaken were not adequate).

298. The Committee had regard to Mr Denbigh-White's clinical records for Patient 7 and found no information to indicate that he undertook any extra oral examinations over the period in question.

299. In relation to intra oral examinations, the Committee received evidence from Patient 7 that Mr Denbigh-White had probed his teeth and gums. However, the Committee found very little evidence in the clinical records to expand on the details provided by Patient 7, or to suggest that a full clinical examination, as outlined by Dr Ward, had ever been undertaken. There was no recorded information to suggest that Mr Denbigh-White had examined Patient 7 extra-orally, for example, the TMJs and lymph nodes, or to indicate that intra-orally he had examined the patient's soft tissues, for example, the tongue or floor of the mouth.

300. The Committee took into account the limited nature of information in the clinical records relating to standard clinical examinations. It also took into account its previous findings above in relation to the same matters but concerning different patients, namely that no extra oral examinations were undertaken of those patients, and that the intra oral examinations carried out were inadequate.

301. In all the circumstances, the Committee was satisfied that it was more likely than not, that Mr Denbigh-White did not undertake any extra-oral examinations of Patient 7 over the period in question, and that the intra-oral examinations of the patient were inadequate. The Committee was also satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 7, given that such examinations are an integral part of assessment used to help dentists diagnose dental and oral diseases.

Charge 16(a)(iii)

16. You failed to provide an adequate standard of care to Patient 7 [identified in Schedule A…], from 1 December 2014 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

iii. additional special tests as appropriate

Found proved (on the basis that the additional special tests undertaken were not adequate).

302. The Committee considered Dr Ward's evidence regarding the requirement for special tests in the context of Patient 7's dental history, as documented within the clinical records. The Committee considered whether there were occasions when the patient presented with a complaint or condition that would have required Mr Denbigh-White to have undertaken any of the special tests referred to by Dr Ward, namely vitality tests, TTP testing and palpation.

303. The Committee noted that Patient 7 attended an appointment with Mr Denbigh-White on 3 May 2018 complaining of pain in UR7 following the provision of a filling to that tooth. The records show that Mr Denbigh-White did carry out special tests, in that he tested whether the tooth was sensitive to cold and undertook TTP testing. Patient 7 told the

Committee that he could recall Mr Denbigh-White banging on the tooth and spraying air on it.

304. The Committee was therefore satisfied from the evidence that Mr Denbigh-White did undertake some special tests as appropriate during the period in question. However, the Committee considered whether this amounted to an adequate standard of special testing in the context of all the times that Mr Denbigh-White treated the patient.

305. The Committee noted Dr Ward's opinion in her report that no special tests had been recorded at a previous appointment on 26 March 2018, regarding the broken fillings identified at UR7 and UR4. The Committee noted from the clinical records that Mr Denbigh-White had repeatedly replaced the filling at UR7, and that Dr Ward had commented that *"This tooth had a history of pain and exposed pulp that had been dressed"*. At the appointment on 26 March 2018, Mr Denbigh-White had noted in the records that the filling had broken again and that UR7 was very deep. Whilst his records are unclear, he appears to have dressed the tooth and be considering its extraction. He also noted *"UR4 deep as well, rev at recall"*.

306. The Committee considered, having noted Dr Ward's comments, that vitality testing, particularly in relation to the UR7, should also have been undertaken by Mr Denbigh-White over the period in question, to check if the tooth was still vital. The Committee found no information in the clinical records to indicate that Mr Denbigh-White had undertaken such testing prior to repeatedly replacing the filling at UR7. The Committee noted that the tooth was eventually extracted on 31 May 2018. It also considered that, in view of the notes regarding a deep cavity at UR4, assessing the vitality of this tooth would also have been appropriate.

307. In the absence of a record in relation to vitality testing, the Committee concluded that it was more likely than not that Mr Denbigh-White did not undertake such testing, and it was satisfied that he should have done so. Therefore, although some special tests were carried out at the appointment on 3 May 2018, having considered the totality of Patient 7's dental issues over the period December 2014 to August 2019, particularly the repeated failing of the filling at UR7, and the deep cavity at UR4, the Committee considered that the special testing was inadequate. The Committee considered that the insufficiency of special testing was a failure to provide Patient 7 with an adequate standard of care. In the absence of vitality testing to see if the UR7 was vital, Mr Denbigh-White could not have assessed whether the treatment he provided in respect of that tooth was appropriate. No further assessment or treatment of the UR4 was recorded.

Charge 16(a)(iv)

16. You failed to provide an adequate standard of care to Patient 7 [identified in Schedule A…], from 1 December 2014 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

iv. BPE

Found proved (on the basis no BPEs were undertaken).

308. The Committee had regard to the clinical records, and it found no evidence to indicate that Mr Denbigh-White had undertaken any BPEs of Patient 7 during the period in question. The absence of BPEs from the clinical records was a matter highlighted by Dr Ward in her report. The Committee noted that a BPE should be undertaken at initial examination and at each recall interval.

309. Whilst the Committee took into account the evidence of Patient 7 regarding Mr Denbigh-White probing his teeth and gums, following its questioning of the patient, it did not consider that this was a reference to a BPE.

310. The Committee considered the evidence before it in relation to this allegation, as well as its previous findings made in relation to other patients, which indicate Mr Denbigh-White's habitual practice not to take BPEs. The Committee concluded on the balance of probabilities that Mr Denbigh-White did not undertake any BPEs of Patient 7 over the period in question. The Committee was satisfied that this represented a failure by Mr Denbigh-White to provide an adequate standard of care to the patient, in view of Dr Ward's opinion regarding the integral nature of BPEs to assessment, diagnosis and treatment.

Charge 16(a)(v)

16. You failed to provide an adequate standard of care to Patient 7 [identified in Schedule A…], from 1 December 2014 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

v. Bitewing radiographs

Found proved (on the basis that no bitewing radiographs were taken).

311. The Committee found no radiographs of Patient 7 within the clinical records for the relevant period 1 December 2014 to 5 August 2019. The recollection of Patient 7 was that Mr Denbigh-White did not take any x-rays of his teeth during this time, although he did recall x-rays having been taken prior to 1 December 2014, which is outside of the period concerned.

312. The Committee also had regard to the evidence of Mr Krzeminski regarding Mr Denbigh-White stating that he did not routinely take radiographs of his patients because of the risk posed by radiation.

313. Having considered the evidence, the Committee was satisfied on the balance of probabilities that Mr Denbigh-White did not take any radiographs of Patient 7 during the time period in question. The Committee was also satisfied that Mr Denbigh-White's omission to take any radiographs of the patient amounted to a failure to provide an adequate standard of care for the same reasons stated previously.

Charge 16(a)(vi)(1)

16. You failed to provide an adequate standard of care to Patient 7 [identified in Schedule A…], from 1 December 2014 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

vi. Pre-treatment/Periapical radiographs

1. to assist pain diagnosis 13/07/17 and/or 26/03/18 and/or 03/05/18

Found proved (on the basis that no pre-treatment/periapical radiographs were undertaken).

314. In relation to the appointment attended by the patient on 13 July 2017, Dr Ward stated in her report regarding the UR7 that "*This tooth had a history of pain and exposed pulp that had been dressed. As the tooth had settled no treatment was offered. In this situation unless the cause of the problem was addressed with RCT, or extraction symptoms would return".* The clinical records indicate that the patient attended on 23 March 2018 complaining of loose teeth and sensitivity. On that occasion it was noted by Mr Denbigh-White that the fillings at UR7 and UR4 had broken again. In relation to the patient's appointment on 3 May 2018, it was recorded that the UR7 had not settled, Mr Denbigh-White prescribed the patient with antibiotics and made a note to review and possibly extract the tooth. Dr Ward commented that no radiographic examination was carried out and also noted that the UR7 had caused the patient pain since 13 July 2017.

315. The Committee accepted the opinion of Dr Ward that radiographic assessment of the UR7 was required to assist diagnosis of the cause of the patient's pain in that tooth. The evidence before the Committee was that Mr Denbigh-White did not take any radiographs of Patient 7 during the period in question. Accordingly, it was satisfied that this allegation is proved on the basis that no pre-treatment/periapical radiographs were taken at the appointments in question. The Committee was further satisfied that Mr Denbigh-White failed to provide Patient 7 with an adequate standard of care in this regard, as in the absence of such radiographs he could not adequately assess the cause of the patient's pain.

Charge 16(a)(vi)(2)

16. You failed to provide an adequate standard of care to Patient 7 [identified in Schedule A…], from 1 December 2014 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

vi. Pre-treatment/Periapical radiographs

2. prior to extraction of UR7 on 31 May 2018

Found proved (on the basis that no pre-treatment/periapical radiographs were undertaken).

316. In finding this allegation proved, the Committee accepted the opinion of Dr Ward that radiographic assessment prior to the extraction of UR7 on 31 May 2018 was essential. She noted from the clinical records for Patient 7 that this tooth was extracted in sections and stated that despite this, no radiographs were taken. Dr Ward's opinion was that pre-treatment/periapical radiographs were necessary to show root form and proximity to the sinus.

317. The evidence is that Mr Denbigh-White did not take any radiographs of Patient 7 during the period in question. Accordingly, the Committee was satisfied that this allegation is proved on the basis that no pre-treatment/periapical radiographs were taken on 31 May 2018 and no previous radiographs were available to show root formation or local anatomical features. The Committee was further satisfied that Mr Denbigh-White failed to provide Patient 7 with an adequate standard of care in this situation. This was on the basis of Dr Ward's evidence that, in the absence of such radiographs, Mr Denbigh-White would not have been fully informed of essential information prior to carrying out the extraction.

Charge 16(b)

16. You failed to provide an adequate standard of care to Patient 7 [identified in Schedule A…], from 1 December 2014 to 5 August 2019 in that:

b. You did not adequately formulate and/or record formulation of treatment plans

Found proved (on the basis that treatment plans were not adequately formulated)

318. The Committee had regard to the clinical records for Patient 7, and whilst it found that Mr Denbigh-White made records in relation to treatment that he proposed to carry out for the patient, the Committee found nothing within the clinical records that would constitute a treatment plan, as outlined in the relevant GDC Standards, and as described by Dr Ward.

319. The Committee took into account Dr Ward's evidence that "*Treatment planning follows full assessment and diagnosis and after the consideration of treatment options,*

discussion of risks and benefits of treatment, along with consideration of the order and timing of treatment".

The Committee had regard to its findings above regarding the limited assessment of Patient 7 by Mr Denbigh-White, in terms of the lack of radiographs, no BPEs having been undertaken, and insufficient special testing where appropriate. The Committee concluded that in the circumstances, Mr Denbigh-White would not have had all the relevant clinical information to adequately formulate treatment plans for the patient. It was satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 7 in the circumstances by not providing the patient with clear plans in relation to their treatment, as required by the GDC Standards.

Charge 16(c)

16. You failed to provide an adequate standard of care to Patient 7 [identified in Schedule A…], from 1 December 2014 to 5 August 2019 in that:

c. You did not diagnose and/or treat periodontitis

Found not proved.

320. The Committee found the wording of the charge at 16(c) ambiguous in that "periodontitis" could relate to periodontal disease or periapical periodontitis. Throughout the rest of the charges, the GDC have referred to periodontitis in relation to periodontal disease. The Committee noted from the clinical records for Patient 7, that at an appointment on 2 September 2019, a subsequent dentist noted 'pap visible LL6'. The Committee further noted that in her report, Dr Ward referred to the 'periapical pathology' at LL6 as recorded by the subsequent treating dentist. There was no reference in the notes to the patient being diagnosed with periodontitis, which is a different condition. Indeed, the Committee noted that it was Dr Ward's opinion that Mr Denbigh-White "*Failed to diagnose / treat caries and apical periodontitis diagnosed by the subsequent dentist".*

321. The Committee took the interpretation of periodontitis to refer to periodontal disease, as it has throughout the remainder of the charges and was not satisfied that there was sufficient evidence that Patient 7 had periodontitis, and Mr Denbigh-White could not have diagnosed a dental disease that the patient did not have. Accordingly, this allegation is not proved to the requisite standard.

Charge 16(d)

16. You failed to provide an adequate standard of care to Patient 7 [identified in Schedule A…], from 1 December 2014 to 5 August 2019 in that:

d. You did not diagnose and/or treat caries on the UR6 and LL6

Found not proved.

322. The Committee was not satisfied that there was sufficient evidence to prove this allegation to the requisite standard. It noted Dr Ward's opinion that Mr Denbigh-White "*Failed to diagnose / treat caries and apical periodontitis diagnosed by the subsequent dentist".* Whilst it found references in the subsequent treating dentist's records to periapical pathology for Patient 7 at LL6, it found no mention of caries in respect of this tooth or the UR6. Further, the Committee noted that the radiograph referred to by Dr Ward in her evidence was taken in February 2022, which is outside the date range of this allegation and over two years after Mr Denbigh-White last saw the patient.

323. In all the circumstances, the Committee found this allegation not proved.

Charge 16(e)

16. You failed to provide an adequate standard of care to Patient 7 [identified in Schedule A…], from 1 December 2014 to 5 August 2019 in that:

e. You did not diagnose and/or treat the pain in respect of the UR7 from 5 July 2017 until extraction on 31 May 2018

Found proved (on the basis that the pain was not diagnosed)

324. The Committee accepted the evidence of Dr Ward that Mr Denbigh-White was obliged to take some action in respect of the UR7, which had a history of causing the patient pain. The evidence is that, whilst Mr Denbigh-White exposed the pulp and dressed the tooth on 5 July 2017, no definitive treatment was actually provided to the tooth until it was eventually extracted on 31 May 2018.

325. The Committee was satisfied on the evidence, which included the absence of any diagnosis in respect of the UR7 in the clinical records, that Mr Denbigh-White did not diagnose the pain in respect of the tooth. The Committee considered that this was a failure in the standard of care provided to Patient 7, as in the absence of a diagnosis the tooth remained untreated until it was extracted.

Charge 16(f)

16. You failed to provide an adequate standard of care to Patient 7 [identified in Schedule A…], from 1 December 2014 to 5 August 2019 in that:

f. You inappropriately prescribed antibiotics on 25 July 2016

Found proved.

326. In the clinical records in respect of this appointment on 25 July 2016, Mr Denbigh-White recorded *"c/o? infected gum"* and *"LR8 pericoronitis".*

327. The opinion of Dr Ward, which the Committee accepted, was based on the FGDP guidelines on 'Antimicrobial Prescribing for General Dental Practitioners'. She told the Committee in her oral evidence that antibiotics should only be prescribed when there is

evidence of severe infection, such as systemic illness and diffuse swelling, and that where appropriate, local treatment measures should be undertaken first.

328. The Committee noted the absence of any reference to swelling, systemic involvement or pain in the clinical records for 25 July 2016, or any information to suggest that Mr Denbigh-White had undertaken any local measures. The Committee considered that, in the absence of such notes, the prescription for antibiotics was inappropriate. The Committee was satisfied that prescribing antibiotics contrary to the guidelines was a failure to provide Patient 7 with an adequate standard of care.

Charge 16(g)

16. You failed to provide an adequate standard of care to Patient 7 [identified in Schedule A…], from 1 December 2014 to 5 August 2019 in that:

g. You did not discuss and/or record discussion of treatment options

Found proved (on the basis that treatment options were not discussed)

329. The Committee took into account the Patient 7's witness statement, in which he stated regarding the repeated re-filling of UR7 *"I do not recall the Registrant explaining any other treatment options".* In his oral evidence, Patient 7 stated that, whilst he felt like he knew at the time why the fillings were needed, there was no discussions around the type of material to be used. The Committee noted that Mr Denbigh-White always used glass ionomer fillings.

330. In addition to Patient 7's evidence, the Committee noted the absence of any information in Mr Denbigh-White's clinical records regarding discussions with the patient about treatment options. It further took into account its findings that Mr Denbigh-White did not take any radiographs of Patient 7, did not undertake sufficient special testing as appropriate, and did not diagnose pain in respect of the UR7. The Committee also found that Mr Denbigh-White did not formulate any adequate treatment plans. Taking all these factors into account, together with its findings that Mr Denbigh-White did not discuss treatment options with other patients, the Committee concluded that it was more likely than not that Mr Denbigh-White did not discuss treatment options with Patient 7 over the period in question. It considered that it would have been difficult for him to have had any discussion about treatment options given the limited clinical information that would have been available to him on account of his omissions.

331. The Committee was satisfied that Mr Denbigh-White's omission to discuss treatment options with Patient 7 was a failure to provide an adequate standard of care, as such discussions are an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 16(h)

16. You failed to provide an adequate standard of care to Patient 7 [identified in Schedule A…], from 1 December 2014 to 5 August 2019 in that:

h. You did not discuss and/or record risks and/or benefits of proposed treatment

Found proved (on the basis that risks and benefits of proposed treatment were not discussed).

332. The Committee found no information in Mr Denbigh-White's clinical records for Patient 7 regarding any discussions with the patient about the risks and benefits of proposed treatment. Further, the Committee noted that in his witness statement, the patient stated that *"It is my recollection that the Registrant did not explain the risks and benefits involved with each treatment option"*.

333. The Committee found this allegation proved for the same reasons outlined above in relation to the lack of discussion about treatment options.

334. The Committee was satisfied that Mr Denbigh-White did not discuss the risks and benefits of proposed treatment with Patient 7, and that his omission to do so was a failure to provide the patient with an adequate standard of care. Such discussions are an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 16(i)

16. You failed to provide an adequate standard of care to Patient 7 [identified in Schedule A…], from 1 December 2014 to 5 August 2019 in that:

i. You inappropriately used glass ionomer for fillings on the following teeth and dates:-

i. UR7 (12/12/14 and/or 13/7/17)

ii. UR6 (12/12/14)

iii. UR5 (05/08/15)

iv. UL6 (18/5/16)

v. UL7 (18/5/16)

vi. LL6 (10/6/19)

vii. LR6 (12/6/17 and/or 10/6/19)

viii. LR7 (05/08/15 and/or 12/6/17 and/or 10/6/19)

Found proved in its entirety.

335. In making its findings, the Committee considered heads of charge 16(i)(i) to (viii) separately.

336. The Committee had regard to the clinical records for Patient 7 and was satisfied that GI fillings were placed on each of the teeth listed at 16(i)(i) to (viii) and on the dates in question.

337. The Committee noted that all the fillings were placed on load bearing surfaces of the teeth, and it accepted the evidence of Dr Ward that this was inappropriate for the reasons outlined previously. The Committee found nothing in Mr Denbigh-White's notes to suggest that any of the GI fillings fell into the accepted circumstances referred to by Dr Ward, nor was there anything written by Mr Denbigh-White to justify his use of the material in clinical situations that were not in accordance with the manufacturer's recommendations and the relevant FGDP guidelines.

Charge 17

17. As a result of 16 (a) (vi) and/or (g) and/or (h) you failed to obtain informed consent for the treatment provided from 1 December 2014 to 5 August 2019.

Found proved in relation to 16(a)(vi), 16(g) and 16(h).

338. The Committee's findings at 16(a)(vi) are that Mr Denbigh-White did not take any pre-treatment/periapical radiographs to assist with the diagnosing the pain at Patient 7's UR7, or prior to the extraction of that tooth. The Committee accepted the evidence of Dr Ward that such radiographs were necessary, and by not having taken them, Mr Denbigh-White could not have been fully informed of the clinical situation in respect of the UR7. Accordingly, he could not have fully informed Patient 7 and highlighted any risks.

339. The Committee found at 16(g) and 16(h) that Mr Denbigh-White did not discuss any alternative treatment options or risks and benefits of proposed treatment with Patient 7 over the period in question. The Committee had regard to the GDC Standards which relate to the issue of valid consent, as well as to the evidence of Dr Ward that discussions with patients about alternative treatment options and risks and benefits of proposed treatment are integral to patients being able to give informed consent.

340. Taking all the evidence into account, the Committee found this allegation at Charge 17 proved. It was satisfied on the balance of probabilities that Patient 7 could not have given informed consent for any of the treatment provided by Mr Denbigh-White from 1 December 2014 to 5 August 2019, if the patient was unaware of what alternative treatment options were available and the risks and benefits of any proposed treatment.

Charge 18

18. You failed to maintain an adequate standard of record keeping from 1 December 2014 to 5 August 2019

Found proved.

341. The Committee took into account its findings that in most instances, Mr Denbigh-White did not undertake the relevant actions, and therefore he could not have recorded undertaking them. However, in relation to the taking of the patient's medical history, the undertaking of intra oral examinations, and treatment planning, the Committee noted that there is some information in the clinical records alluding to Mr Denbigh-White's actions, but the information included very limited. This was also the case on the occasions that he prescribed the Patient 7 with antibiotics without recording any justification for doing so.

342. The Committee found that there was insufficient information in the clinical records to explain what Mr Denbigh-White did in terms of his care of Patient 7 and why. This included his use of GI fillings in clinical situations that were not in accordance with the manufacturer's recommendations and the relevant FGDP guidelines, without any recorded justification.

343. The Committee found Mr Denbigh-White's record keeping in respect of his care and treatment of Patient 7 to be of an inadequate standard. The clinical records were brief with major omissions.

PATIENT 8

Charge 19(a)(i)

19. You failed to provide an adequate standard of care to Patient 8 [identified in Schedule A…], from 13 August 2010 to 16 February 2018 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

i. Medical history

Found not proved.

344. The Committee had regard to Patient 8's clinical records and found several entries against Mr Denbigh-White's initials, indicating that he had regularly updated the patient's medical notes between August 2010 and October 2015. Whilst there was an absence of any updates between October 2015 and August 2019, the Committee noted that the patient did not attend for treatment during this period. There was only one checkup appointment during that time.

345. In the circumstances, the Committee was not satisfied that this allegation is proved to the requisite standard as this was a failure on just one occasion in that period.

Charge 19(a)(ii)

19. You failed to provide an adequate standard of care to Patient 8 [identified in Schedule A…], from 13 August 2010 to 16 February 2018 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

ii. extra and intra oral examinations

Found proved (on the basis that no extra oral examinations were undertaken and the intra oral examinations undertaken were not adequate).

346. The Committee had regard to Mr Denbigh-White's clinical records for Patient 8 and found that they included very little information regarding standard clinical examinations. The Committee found no notes relating to an extra-oral examination having been undertaken of the patient at any time. Whilst there was partial information relating to intra-oral examinations, in that there were records to indicate that Mr Denbigh-White had looked in the patient's mouth and at his teeth, the Committee found nothing to indicate that a full clinical examination, as outlined by Dr Ward, had ever been undertaken. There was no recorded information to suggest that Mr Denbigh-White had examined Patient 8 extra-orally, for example, the TMJs and lymph nodes, or to indicate that intra-orally he had examined the patient's soft tissues, for example, the tongue or floor of the mouth.

347. The Committee took into account the limited nature of information in the clinical records relating to standard clinical examinations. It also took into account its previous findings above in relation to the same matters but concerning different patients, namely that no extra oral examinations were undertaken of those patients, and that the intra oral examinations carried out were inadequate.

348. In all the circumstances, the Committee was satisfied that it was more likely than not, that Mr Denbigh-White did not undertake any extra-oral examinations of Patient 8 over the period in question, and that the intra-oral examinations of the patient were inadequate. The Committee was also satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 8, given that such examinations are an integral part of assessment used to help dentists diagnose dental and oral diseases.

Charge 19(a)(iii)

19. You failed to provide an adequate standard of care to Patient 8 [identified in Schedule A…], from 13 August 2010 to 16 February 2018 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

iii. additional special tests as appropriate

Found proved (on the basis that additional special tests were not undertaken as appropriate).

349. The Committee considered Dr Ward's evidence regarding the requirements for special tests in context of Patient 8's dental history, as documented within the clinical

records. The Committee considered whether there were occasions when the patient presented with a complaint or condition that would have required Mr Denbigh-White to have undertaken any of the special tests referred to by Dr Ward, namely vitality tests, TTP testing and palpation.

350. The Committee noted from the clinical records that over the period in question Patient 8 experienced repeated problems in the upper left area around UL7 and UL6. However, there is no information in the clinical notes to indicate that Mr Denbigh-White undertook any special tests to check the vitality of these teeth or any TTP testing. The evidence of Dr Ward was that she would have expected to see a record of such special tests in the circumstances.

351. In reaching its decision, the Committee considered its findings made in relation to other patients in this case, which indicate that Mr Denbigh-White's undertaking of special tests was infrequent. In view of this, and in the absence of any reference to special tests in the clinical records for Patient 8, the Committee was satisfied that it was more likely than not that Mr Denbigh-White did not undertake any such tests in respect of this patient. The Committee was further satisfied that this omission amounted to a failure to provide Patient 8 with an adequate standard of care, as in the absence of such tests, Mr Denbigh-White would not have been assisted with making a diagnosis.

Charge 19(a)(iv)

19. You failed to provide an adequate standard of care to Patient 8 [identified in Schedule A…], from 13 August 2010 to 16 February 2018 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

iv. BPE

Found proved (on the basis that BPEs were not undertaken regularly, and therefore diagnostic assessment was not adequate).

352. The Committee had regard to the clinical records for Patient 8 and found that BPE scores were recorded for the patient on 20 September 2010, 16 April 2012, and 19 June 2013. The Committee was satisfied that Mr Denbigh-White undertook BPEs of the patient on these dates.

353. However, there was no other information in the clinical notes to indicate that Mr Denbigh-White had undertaken BPEs of Patient 8 since June 2013. The Committee took into account that, in accordance with the relevant guidelines, a BPE should be undertaken at initial examination and at each recall interval. Therefore, it would have expected to see BPEs recorded in the patients records more regularly. Given that there is no reference to BPEs in the clinical notes after June 2013, the Committee concluded, on the balance of probabilities, that Mr Denbigh-White did not undertake any other BPEs of the Patient 8, save for on the three occasions identified.

354. In all the circumstances, the Committee was satisfied that this allegation at head of charge 19(a)(iv) is proved on the basis that Mr Denbigh-White only undertook three BPEs in respect of Patient 8 in over seven years. The Committee was satisfied that this represented a failure by Mr Denbigh-White to provide an adequate standard of care to the patient, in view of Dr Ward's opinion regarding the integral nature of BPEs to assessment, diagnosis and treatment.

Charge 19(a)(v)

19. You failed to provide an adequate standard of care to Patient 8 [identified in Schedule A…], from 13 August 2010 to 16 February 2018 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

v. Periodontal assessment

Found proved (on the basis that no periodontal assessment was undertaken)

355. Dr Ward noted in her report that Patient 8 was seen by a hospital consultant on 4 March 2011, and the consultant diagnosed periodontal disease. Dr Ward stated in relation to Mr Denbigh-White's treatment of the patient that *"No full periodontal assessment was carried out and although BPE was recorded on 19/06/13, it is unlikely that this was accurate as bone loss had been noted on a radiograph taken by the hospital consultant, periodontitis diagnosed by the consultant, no periodontal treatment had been provided and mobile teeth were present".*

356. The Committee had regard to Mr Denbigh-White's clinical records for Patient 8, and it found nothing to indicate that he had carried out a full periodontal assessment involving full mouth probing and radiographic assessment, as described by Dr Ward. Although, the Committee took into account that BPE scores of 2 were recorded for the patient on 19 June 2013, which would not have necessarily indicated periodontal disease. However, it accepted the opinion of Dr Ward regarding the likely inaccuracy of those BPE scores, given the hospital consultant's findings in 2011, which included bone loss. The Committee also took into account that Mr Denbigh-White did not undertake regular BPEs of the patient after June 2013.

357. In all the circumstances, the Committee concluded that it was more likely than not that he did not carry out a full periodontal assessment of Patient 8 during the period in question. The Committee was satisfied that this represented a failure to provide the patient with an adequate standard of care, as in the absence of such an assessment, Mr Denbigh-White could not have been guided as to the appropriate treatment to provide.

Charge 19(a)(vi)

19. You failed to provide an adequate standard of care to Patient 8 [identified in Schedule A…], from 13 August 2010 to 16 February 2018 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

vi. Bitewing radiographs

Found proved (on the basis that no bitewing radiographs were undertaken).

358. The Committee found no bitewing radiographs within the clinical records of Patient 8 for the relevant period 13 August 2010 to 16 February 2018.

359. The Committee had regard to the evidence of Mr Krzeminski regarding Mr Denbigh-White stating that he did not routinely take radiographs of his patients because of the risk posed by radiation.

360. Having had regard to the evidence, the Committee was satisfied on the balance of probabilities that Mr Denbigh-White did not take any radiographs of Patient 8 during the time period in question. The Committee was also satisfied that Mr Denbigh-White's omission to take any radiographs of the patient amounted to a failure to provide an adequate standard of care for the same reasons previously stated.

Charge 19(a)(vii)(1)

19. You failed to provide an adequate standard of care to Patient 8 [identified in Schedule A…], from 13 August 2010 to 16 February 2018 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

vii. Pre-treatment/periapical radiographs

1. to assist diagnosis of pathology on

UL6 on 13 August 2010 and/or

20/09/10 and/or 01/10/10 and/or

22/11/10 and/or 07/12/10 and/or

21/12/10

Found proved in relation to all dates except 13 August 2010.

361. The Committee noted from the clinical records and Dr Ward's report, the chronology of treatment provided by Mr Denbigh-White to Patient 8's UL6.

362. With regard to the first date in this allegation, 13 August 2010, the Committee noted that whilst there is a letter dated 13 August 2010 from Patient 8's General Medical

Practitioner (GP), there is no record of the patient having attended an appointment with Mr Denbigh-White on that day. Accordingly, this allegation is not proved in relation to 13 August 2010.

363. It is stated in the letter from the patient's GP to Mr Denbigh-White, that the patient had attended the doctor's surgery complaining of intermittent pain on the left side with an unpleasant smell. It was noted that pus was coming from the lateral gum line around UL6. The patient's GP suggested apical disease but welcomed Mr Denbigh-White's opinion.

364. The patient was subsequently seen by Mr Denbigh-White on 20 September 2010, when the patient complained that he had been to his GP with sinusitis. On examination it was noted that UL5,6,7 had recession and UL6 was mobile. Sub-gingival deposits were cleaned, and a review arranged.

365. At Patient 8's next appointment with Mr Denbigh-White on 1 October 2010, it was noted that the patient complained of a swelling between UL6 and UL7 and antibiotics were given.

366. On 22 November 2010, the patient complained of no real pain but that the upper left does not feel quite right. The UL7 was cleaned buccally and Corsodyl on small brush was advised.

367. At the following appointment on 7 December 2010, the Committee noted that Mr Denbigh-White recorded *"? sinus and perio".* The patient was advised to try Corsodyl, and antibiotics were prescribed again.
368. On 21 December 2010, Patient 8 complained to Mr Denbigh-White of pain in sinus and was advised to go back to his GP.

369. The Committee found no information within the clinical records to indicate that Mr Denbigh-White took any pre-treatment/periapical radiographs in respect of Patient 8's complaints about the UL6. The evidence before the Committee was that Mr Denbigh-White had taken no radiographs of the patient at all during the period concerned.

370. The Committee accepted the evidence of Dr Ward that pre-treatment radiographs should have been taken to assist diagnosis of the pathology on the patient's UL6. She stated in her report that *"Patient 8 was seen with repeated bouts of infection. The GP suggested a dental abscess as pus was draining from UL6, in a letter to the registrant. This issue was only managed by the repeat prescribing of antibiotics…No radiographic assessment was carried out by the registrant and no diagnosis reached or appropriate treatment provided. When the patient was eventually seen by a hospital consultant on 04/03/11 an obvious abscess and caries was diagnosed UL6 and extraction advised. Symptoms resolved'.* Indeed, the Committee found nothing in Mr Denbigh-White's record of the appointment in

question to suggest that he reached a diagnosis. His last course of action in respect of this matter was to refer the patient back to his GP.

371. In all the circumstances, the Committee was satisfied that this allegation is proved in respect of all the dates, except 13 August 2010. It was further satisfied that Mr Denbigh-White's omission to take any pre-treatment/periapical radiographs was a failure to provide Patient 8 with an adequate standard of care. In the absence of such radiographs, he was not assisted in reaching any diagnosis.

Charge 19(a)(vii)(2)

19. You failed to provide an adequate standard of care to Patient 8 [identified in Schedule A…], from 13 August 2010 to 16 February 2018 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

vii. Pre-treatment/periapical radiographs

2. prior to extraction of UR2 on 18/7/14

Found not proved.

372. Dr Ward's opinion was that a pre-treatment radiograph should be considered to show roots and adjacent structures prior to carrying out an extraction. She did not state, however, that such radiographs were essential. The Committee considered that it received insufficient evidence to suggest that pre-treatment radiographs should have been taken by Mr Denbigh-White prior to extracting Patient 8's UR2 on 18 July 2014. It found nothing in the records to indicate that there was any difficulty in extracting this single rooted tooth.

373. The Committee concluded that it was not unreasonable for Mr Denbigh-White to have exercised his clinical judgement not to take a radiograph in the circumstances of this extraction.

Charge 19(a)(vii)(3)

19. You failed to provide an adequate standard of care to Patient 8 [identified in Schedule A…], from 13 August 2010 to 16 February 2018 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

vii. Pre-treatment/periapical radiographs

3. prior to bridge preparation on 30/6/14 and/or 18/07/14

Found proved (on the basis that pre-treatment/periapical radiographs were not taken).

374. The Committee was satisfied from the clinical records for Patient 8 that Mr Denbigh-White undertook bridge preparation on these dates. It found no information within the clinical records to indicate that he took any pre-treatment/periapical radiographs prior to the preparation.

375. The Committee accepted the evidence of Dr Ward that pre-operative radiographs should be taken before any crown or bridgework is undertaken. The Committee noted that pre-treatment radiographs before bridge preparation are necessary to assess the abutments before the bridge is placed.

376. In the absence of any radiographs and given the evidence of Mr Denbigh-White's views on radiography, the Committee was satisfied on the balance of probabilities that he did not take a pre-treatment/periapical radiograph prior to the bridge preparation on these dates. On the basis of Dr Ward's expert evidence that such radiographs were necessary, the Committee was satisfied that Mr Denbigh-White failed to provide Patient 8 with an adequate standard of care in this regard.

Charge 19(b)

19. You failed to provide an adequate standard of care to Patient 8 [identified in Schedule A…], from 13 August 2010 to 16 February 2018 in that:

b. You did not adequately formulate and/or record formulation of treatment plans

Found proved (on the basis that treatment plans were not adequately formulated)

377. The Committee had regard to the clinical records for Patient 8, and whilst it found that Mr Denbigh-White made records in relation to treatment that he proposed to carry out for the patient, the Committee found nothing within the clinical records that would constitute a treatment plan, as outlined in the relevant GDC Standards, and as described by Dr Ward.

378. The Committee took into account Dr Ward's evidence that "*Treatment planning follows full assessment and diagnosis and after the consideration of treatment options, discussion of risks and benefits of treatment, along with consideration of the order and timing of treatment".*

379. The Committee had regard to its findings above regarding the limited assessment of Patient 8 by Mr Denbigh-White, in terms of the lack of radiographs, infrequent BPEs, lack of special testing where appropriate, and the absence of a periodontal assessment. The Committee concluded that in the circumstances, Mr Denbigh-White would not have had all the relevant clinical information to adequately formulate treatment plans for the patient. It was satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 8 in the circumstances by not providing the patient with clear plans in relation to their treatment, as required by the GDC Standards.

Charge 19(c)

19. You failed to provide an adequate standard of care to Patient 8 [identified in Schedule A…], from 13 August 2010 to 16 February 2018 in that:

c. You did not diagnose and/or treat periodontitis

Found proved (on the basis that periodontitis was not diagnosed).

380. Dr Ward's evidence was that Mr Denbigh-White *"Failed to diagnose / treat periodontitis despite diagnosis and plan from consultant 04/03/11.*

381. In accepting Dr Ward's opinion, the Committee noted the absence of any diagnosis of periodontitis in Mr Denbigh-White's clinical records for Patient 8. It also took into account its finding above that Mr Denbigh-White did not undertake a periodontal assessment of the patient. In the circumstances, the Committee concluded that it was more likely than not that Mr Denbigh-White did not diagnose Patient 8's periodontitis.

382. The Committee was satisfied that Mr Denbigh-White failed to provide Patient 8 with an adequate standard of care, as in the absence of a diagnosis of periodontitis, he could not have provided appropriate treatment to the patient. Indeed, the Committee found nothing in the clinical records to indicate that Mr Denbigh-White treated the patient for periodontitis.

Charge 19(d)

19. You failed to provide an adequate standard of care to Patient 8 [identified in Schedule A…], from 13 August 2010 to 16 February 2018 in that:

d. You did not diagnose and/or treat an abscess at the UL6 from 13 August 2010 before diagnosis by a consultant on 4 March 2011.

Found proved (on the basis that the abscess at UL6 was not diagnosed).

383. In finding this allegation proved, the Committee noted that Patient 8 did not attend an appointment with Mr Denbigh-White on 13 August 2010. However, the Committee was satisfied that after that date, Patient 8 attended a number of appointments between September and December 2010, at which the patient raised complaints about the upper left area of his mouth including UL6. The Committee was satisfied that those subsequent appointments are covered by this charge.

384. For the same reasons stated in relation to 19(c) above, the Committee concluded on the evidence that Mr Denbigh-White did not diagnose the abscess at UL6, prior to the patient seeing the hospital consultant on 4 March 2011.

385. In the Committee's view, Mr Denbigh-White had not undertaken any or any adequate investigations of Patient 8's complaint regarding UL6, to aid diagnosis of the abscess. The Committee was satisfied that Mr Denbigh-White failed to provide the patient with an adequate standard of care in the circumstances, as in the absence of a diagnosis, he did

not treat the abscess. The clinical records show that Mr Denbigh-White repeatedly prescribed antibiotics in response to the patient's complaints regarding UL6, and eventually referred the patient back to his GP. The Committee accepted the evidence of Dr Ward that "*The registrant failed to adequately assess the clinical situation, provide diagnosis and appropriate treatment until this was carried out by a hospital consultant who diagnosed dental infection from UL6".*

Charge 19(e)

19. You failed to provide an adequate standard of care to Patient 8 [identified in Schedule A…], from 13 August 2010 to 16 February 2018 in that:

e. You inappropriately prescribed antibiotics on 13/08/10 and/or 01/10/10 and/or 07/12/10

Found not proved in relation 13/08/10.

Found proved in relation to 01/10/10 and 07/12/10.

386. The Committee found this head of charge not proved in relation to 13/08/10, as there is no evidence that Patient 8 attended an appointment with Mr Denbigh-White on that date.

387. However, the Committee was satisfied that this allegation is proved in relation to the dates 01/10/10 and 07/12/10. It accepted the evidence of Dr Ward, who stated in her report in relation to the antibiotics prescribed to Patient 8 *"…Antibiotics should only be prescribed when there is clear evidence of infection such as systemic illness or diffuse swelling".* Having considered the clinical records the Committee was satisfied that there was no such evidence.

Charge 19(f)

19. You failed to provide an adequate standard of care to Patient 8 [identified in Schedule A…], from 13 August 2010 to 16 February 2018 in that:

f. You did not discuss and/or record discussion of treatment options.

Found proved (on the basis that treatment options were not discussed).

388. The Committee took into account the absence of any information in Mr Denbigh-White's clinical records for Patient 8 regarding discussions with the patient about treatment options. The Committee noted that there is nothing recorded about any treatment options that might that have been appropriate for the patient's UL6. The evidence is that Mr Denbigh-White simply referred the patient back to their GP. The Committee also noted the absence of any recorded treatment options after the patient was referred back to Mr Denbigh-White by the hospital consultant for the extraction of UL6. In fact, nothing is recorded to explain why the tooth was extracted.

389. Also, the Committee found no indication in the clinical records of any discussion in respect of alternative treatment options to the bridge Mr Denbigh-White provided to replace the patient's UR2. It noted the evidence of Dr Ward in this regard, who stated in her report *"If this is a record keeping issue and options were clearly explained then consent may have been given, however it appears that bridge preparation was carried out at the time of extraction…".*

390. The Committee took into account its findings made in respect of the treatment of other patients, namely that treatment options were not discussed. It also had regard to the evidence it received from some patients regarding Mr Denbigh-White not having spoken to them much or at all about their treatment. Further, the Committee took into account its findings that Mr Denbigh-White did not take any radiographs of this patient, did not undertake special tests as appropriate, and did not diagnose the presence of dental disease. The Committee also found that Mr Denbigh-White did not formulate any adequate treatment plans. Taking all these factors into account, the Committee concluded that it was more likely than not that Mr Denbigh-White did not discuss treatment options with Patient 8 over the period in question. It considered that it would have been difficult for him to have had any discussion about treatment options given the limited clinical information that would have been available to him on account of his omissions.

391. The Committee was satisfied that Mr Denbigh-White's omission to discuss treatment options with Patient 8 was a failure to provide an adequate standard of care, as such discussions are an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 19(g)

19. You failed to provide an adequate standard of care to Patient 8 [identified in Schedule A…], from 13 August 2010 to 16 February 2018 in that:

g. You did not discuss and/or record risks and/or benefits of proposed treatment

Found proved (on the basis that risks and benefits of proposed treatment were not discussed).

392. The Committee found no information in Mr Denbigh-White's clinical records for Patient 8 regarding any discussions with the patient about the risks and benefits of proposed treatment. The Committee found this allegation proved for the same reasons outlined in relation to the lack of discussion about treatment options.

393. The Committee was satisfied that Mr Denbigh-White did not discuss the risks and benefits of proposed treatment with Patient 8, and that his omission to do so was a failure to provide the patient with an adequate standard of care. Such discussions are an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 19(h)

19. You failed to provide an adequate standard of care to Patient 8 [identified in Schedule A…], from 13 August 2010 to 16 February 2018 in that:

h. You provided inadequate treatment for the replacement of UR2 with preparation being carried out at the same time as extraction rather than allowing tissues to heal prior to preparation.

Found proved.

394. The Committee accepted the evidence of Dr Ward, who referred to the clinical notes made by Mr Denbigh-White, which indicate that the permanent bridge preparation was carried out on the same day as the UR2 was extracted. The Committee was satisfied on the evidence of Dr Ward that this represented treatment that was inadequate. She stated in her report that preparation of the bridge should have been carried out "…*after a healing period to allow bone and soft tissues to remodel.* Accordingly, the Committee was satisfied that this head of charge is proved.

Charge 20

20. As a result of 19 (a) (vii) and/or (g) and/or (h) you failed to obtain informed consent for the treatment provided from 13 August 2010 to 16 February 2018.

Found proved in relation to 19(a)(vii), 19(g) and 19(h).

395. The Committee's findings at 19(a)(vii) are that Mr Denbigh-White did not take any pre-treatment/periapical radiographs to assist with the diagnosis of pathology prior to bridge preparation to replace UR2. The Committee accepted the evidence of Dr Ward that a radiograph was necessary, and by not having taken it, Mr Denbigh-White could not have been fully informed of the clinical situation in respect of all the matters concerned. Accordingly, he could not have fully informed Patient 8 and highlighted any risks.

396. The Committee found at 19(g) and 19(h) that Mr Denbigh-White did not discuss any alternative treatment options or risks and benefits of proposed treatment with Patient 8 over the period in question. The Committee had regard to the GDC Standards which relate to the issue of valid consent, as well as to the evidence of Dr Ward that discussions with patients about alternative treatment options and risks and benefits of proposed treatment are integral to patients being able to give informed consent.

397. Taking all the evidence into account, the Committee found this allegation at Charge 20 proved. It was satisfied on the balance of probabilities that Patient 8 could not have given informed consent for any of the treatment provided by Mr Denbigh-White from 13 August 2010 to 16 February 2018, if the patient was unaware of what alternative treatment options were available and the risks and benefits of any proposed treatment.

Charge 21

21. You failed to maintain an adequate standard of record keeping from 13 August 2010 to 16 February 2018

Found proved.

398. The Committee took into account its findings that in most instances, Mr Denbigh-White did not undertake the relevant actions, and therefore he could not have recorded undertaking them. However, in relation to the undertaking of intra oral examinations, the taking of BPEs and treatment planning, the Committee noted that there is some information in the clinical records alluding to Mr Denbigh-White's actions, but the information included is very limited. This was also the case on the occasions that he prescribed Patient 8 with antibiotics without recording any justification for doing so.

399. The Committee found that there was insufficient information in the clinical records to explain what Mr Denbigh-White did in terms of his care of Patient 8 and why.

400. The Committee found Mr Denbigh-White's record keeping in respect of his care and treatment of Patient 8 to be of an inadequate standard. The clinical records were brief with major omissions.

PATIENT 9

Charge 22(a)(i)

22. You failed to provide an adequate standard of care to Patient 9 [identified in Schedule A…], from 4 November 2013 to 28 October 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

i. Medical history

Found proved (on the basis that a medical history was not taken adequately).

401. The Committee was satisfied from the clinical records for Patient 9, that Mr Denbigh-White provided care and treatment to the patient over the period in question.

402. The Committee took into account that Mr Denbigh-White had a duty to take an up-to-date medical history from Patient 9 each time he treated the patient, in accordance with Standard 4.1.1 of the GDC Standards and the *FGDP UK guidelines on Clinical Examination and Record Keeping*.

403. The Committee had regard to Patient 9's clinical records. It found entries against Mr Denbigh-White's initials which indicated that he had updated the patient's medical notes at regular intervals during 2013 and 2014. However, following the last update made in December 2014, the Committee noted that the next medical history update attributed to Mr Denbigh-White was in August 2019. This indicated that there was a period of four years over

which he did not update Patient 9's medical history in the clinical records. The Committee noted that the patient attended for treatment during the four-year period in question, when updates to the patient's medical history would have been required.

404. The Committee took into account the lack of information in the clinical records to indicate that a medical history was taken each time Mr Denbigh-White treated Patient 9. It also had regard to its previous findings above that Mr Denbigh-White had been less than comprehensive in taking and updating the medical histories of other patients. In all the circumstances, the Committee concluded that it was more likely than not that Mr Denbigh-White did not take an up to date medical history from Patient 9 each time he treated the patient.

405. The Committee considered that Mr Denbigh-White could not have obtained an up-to-date picture of Patient 9's medical health, not having updated the patient's medical history over a four-year period. It was therefore satisfied that he failed in his duty to provide the patient with an adequate standard of care.

Charge 22(a)(ii)

22. You failed to provide an adequate standard of care to Patient 9 [identified in Schedule A…], from 4 November 2013 to 28 October 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

ii. extra and intra oral examinations

Found proved (on the basis that no extra oral examinations were undertaken and the intra oral examinations undertaken were not adequate).

406. The Committee had regard to Mr Denbigh-White's clinical records for Patient 9 and found no information to indicate that he undertook any extra oral examinations over the period in question. Whilst there was some information relating to intra-oral examinations, in that there were records to indicate that Mr Denbigh-White had looked in the patient's mouth and at aspects of the patient's teeth, the Committee found nothing to indicate that a full clinical examination had ever been undertaken. There was no recorded information to suggest that Mr Denbigh-White had examined Patient 9 extra-orally, for example, the TMJs and lymph nodes, or to indicate that intra-orally he had examined the patient's soft tissues, for example, the tongue or floor of the mouth. The Committee noted Dr Ward's comments in her report regarding the lack of information relating to extra and intra oral examinations in Mr Denbigh-White's clinical records for Patient 9.

407. The Committee took into account the limited nature of information in the clinical records relating to standard clinical examinations. It also took into account its previous findings above in relation to the same matters but concerning different patients, namely that

no extra oral examinations were undertaken of those patients, and that the intra oral examinations carried out were inadequate.

408. In all the circumstances, the Committee was satisfied that it was more likely than not, that Mr Denbigh-White did not undertake any extra-oral examinations of Patient 9 over the period in question, and that the intra-oral examinations of the patient were inadequate. The Committee was also satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 9, given that such examinations are an integral part of assessment used to help dentists diagnose dental and oral diseases.

Charge 22(a)(iii)

22. You failed to provide an adequate standard of care to Patient 9 [identified in Schedule A…], from 4 November 2013 to 28 October 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

iii. additional special tests as appropriate

409. The Committee considered Dr Ward's evidence regarding the requirement for special tests in the context of Patient 9's dental history, as documented within the clinical records. The Committee considered whether there were occasions when the patient presented with a complaint or condition that would have required Mr Denbigh-White to have undertaken any of the special tests referred to by Dr Ward, namely vitality tests, TTP testing and palpation.

410. The clinical records show that Patient 9 attended to see Mr Denbigh-White on a number of occasions complaining of pain in certain teeth. The Committee noted that on 24 May 2017, the patient complained of pain in LL6 and Mr Denbigh-White recorded the tooth to be TTP with a broken filling. Decay and infection were also noted. The patient was already taking antibiotics at that time. Mr Denbigh-White advised the extraction of LL6 in one week, but the tooth was extracted under local anesthetic the next day on 25 May 2017, following the patient's request for an extraction.

411. Patient 9 attended further appointments complaining of pain, including in UR4, UR6 and UR8. However, no special tests were recorded in respect of those complaints.

412. The Committee accepted the evidence of Dr Ward, who told the Committee in her oral evidence that in the context of Patient 9's history of dental pain, she would have expected to see more in relation to special tests recorded in the patient's clinical records. Whilst it noted that a special test, namely TTP testing, was carried out by Mr Denbigh-White on the patient's LL6 on 24 May 2017, it found no other indication in the clinical notes of any further special testing having been undertaken. In the absence of such records, the Committee was satisfied that Mr Denbigh-White did not carry out any additional special testing.

413. Having considered the totality of Patient 9's dental issues over the period in question, the Committee considered that the special testing was inadequate, and it was satisfied that the insufficiency of special testing was a failure to provide Patient 9 with an adequate standard of care. In the absence of special tests as appropriate, Mr Denbigh-White could not have assessed whether the treatment he provided in response to the patient complaints was appropriate.

Charge 22(a)(iv)

22. You failed to provide an adequate standard of care to Patient 9 [identified in Schedule A…], from 4 November 2013 to 28 October 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

iv. BPE

Found proved (on the basis no BPEs were undertaken).

414. The Committee noted the presence of a BPE in Patient 9's clinical records undertaken in June 2013, however, that was before the period referred to in this charge. The Committee found no evidence to indicate that Mr Denbigh-White had undertaken any BPEs of Patient 9 between 4 November 2013 and 28 October 2019. The lack of BPEs in the clinical records was a matter highlighted by Dr Ward in her report. The Committee noted that a BPE should be undertaken at initial examination and at each recall interval.

415. The Committee considered the evidence before it in relation to this allegation, as well as its previous findings made in relation to other patients, which indicate that Mr Denbigh-White's habitual practice was to not take BPEs. The Committee concluded on the balance of probabilities that Mr Denbigh-White did not undertake any BPEs of Patient 9 over the period in question. The Committee was satisfied that this represented a failure by Mr Denbigh-White to provide an adequate standard of care to the patient, in view of Dr Ward's opinion regarding the integral nature of BPEs to assessment, diagnosis and treatment.

Charge 22(a)(v)

22. You failed to provide an adequate standard of care to Patient 9 [identified in Schedule A…], from 4 November 2013 to 28 October 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

v. Bitewing radiographs

Found proved (on the basis that no bitewing radiographs were taken)

416. The Committee noted that there is reference in the clinical records for Patient 9 to *"TC: X-RAY"* in respect of an appointment on 12 March 2014. However, the type of x-ray is not recorded, and there is no other information relating to the x-ray to suggest that these were bitewing radiographs. In fact, on this one occasion where a radiograph is referred to, it is in respect of an appointment dealing with a fractured incisor.

417. Further, the Committee took into account that, if the relevant guidelines on radiography were being followed by Mr Denbigh-White, it would have expected to find several sets of radiographs in the patient's clinical records. The Committee noted that, even for patients at low risk of caries, bitewing radiographs are to be taken every two years. The Committee found no references to bitewing radiographs within the clinical records for the relevant period. It also took into account the evidence regarding Mr Denbigh-White's admission to an NHSE dental adviser that he did not routinely take radiographs of his patients because of the risk posed from the radiation.

418. Having had regard to all the evidence, the Committee was satisfied on the balance of probabilities that Mr Denbigh-White did not take any bitewing radiographs of Patient 9 during the time period in question. The Committee was also satisfied that Mr Denbigh-White's omission to take bitewing radiographs of Patient 9 amounted to a failure to provide an adequate standard of care. It accepted Dr Ward's opinion that the relevant guidelines should have been followed by Mr Denbigh-White to balance the safety of radiographic exposure against the benefits of its use.

Charge 22(a)(vi)(1)

22. You failed to provide an adequate standard of care to Patient 9 [identified in Schedule A…], from 4 November 2013 to 28 October 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

vi. Pre-treatment/periapical radiographs

1. prior to and/or during RCT to LL6 on 04/11/13

Found proved (on the basis that no pre-treatment/periapical radiographs were undertaken).

419. The clinical records show that at an appointment on 8 July 2013, Mr Denbigh-White exposed and dressed the LL6, which indicated to the Committee that, at that time, he was thinking about providing endodontic treatment to the tooth. However, he did not provide root canal treatment until 4 November 2013.

420. The evidence before the Committee, as contained in the clinical records, indicates that Mr Denbigh-White only took one x-ray in respect of Patient 9 in or around March 2013. It found no information to suggest that he took any other radiographs of the patient, including any pre-treatment radiographs of LL6 in July 2013, when he appeared to be thinking about

providing root canal treatment to the tooth, and/or during the root canal treatment he eventually provided in November 2013.

421. The Committee noted Dr Ward's evidence in her report regarding root canal treatment, including the need to:

- *"….*
- *Assess working length (root length to plan length of root filling). This can be carried out using an electronic apex locator and some dentist would substitute use of this for a radiograph. Lengths of root canals should be recorded in the clinical notes.*
- *…"*

422. The Committee accepted Dr Ward's evidence about the need for radiographs in the absence of using an electronic apex locator. It found no indication in the clinical records to suggest that Mr Denbigh-White used either method in respect of the root canal treatment he provided to Patient 9's LL6. There is no record in the patient's notes of the working length of the canals. In the absence of such information, and given Mr Denbigh-White's views on radiography, the Committee was satisfied that it was more likely than not that he did not take any pre-treatment/periapical radiographs as required.

423. The Committee was further satisfied that not taking pre-treatment/periapical radiographs amounted to a failure to provide Patient 9 with an adequate standard of care. It took into account Dr Ward's opinion that Mr Denbigh-White provided a poor standard of root canal treatment to the patient's LL6 because of the lack of radiographs.

Charge 22(a)(vi)(2)

22. You failed to provide an adequate standard of care to Patient 9 [identified in Schedule A…], from 4 November 2013 to 28 October 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

vi. Pre-treatment/periapical radiographs

2. in respect of the UR6 on 15/5/18 and/or 30/5/18 and/or 20/8/19

Found proved (on the basis that no pre-treatment/periapical radiographs were undertaken).

424. The Committee had regard to the chronology in the clinical records regarding Patient 9's UR6. It noted that on 21 February 2018, Mr Denbigh-White recorded the presence of

deep caries. The tooth was dressed but left as it was indicated that the symptoms had settled. However, the patient again experienced pain in the tooth, and the pulp chamber was accessed, and infection drained. The tooth was left on open drainage.

425. It was the evidence of Dr Ward that there was poor endodontic management of Patient 9's UR6 from 21/02/18 to 28/10/19, including the lack of periapical radiographs having been taken on 15/05/18, 30/05/18, 20/08/19. In Dr Ward's opinion *"The patient had symptoms since 21/02/18 and from reported findings in the clinical records UR6 needed RCT or extraction from 15/05/18 rather than repeat redressing".* Dr Ward highlighted that on 2/09/19, the patient was seen by another dentist, who took radiographs which showed an extensive cavity extending into the pulp chamber at UR6 with a periapical radiolucency. The subsequent treating dentist recorded a diagnosis of chronic apical periodontitis and options for root canal treatment or extraction were discussed.

426. The Committee was satisfied that Mr Denbigh-White did not take any further radiographs of Patient 9 after March 2014. It accepted Dr Ward's expert evidence that he should have taken pre-treatment/periapical radiographs on 15/05/18, 30/05/18 and/or 20/08/19 in light of the patient's recurring pain. The Committee was satisfied that not taking radiographs on any of these occasions was a failure to provide an adequate standard of care to the patient. It noted Dr Ward's evidence that appropriate treatment was not provided to the patient in the circumstances.

Charge 22(a)(vii)

22. You failed to provide an adequate standard of care to Patient 9 [identified in Schedule A…], from 4 November 2013 to 28 October 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

vii. Periodontal assessment

Found not proved.

427. The Committee was not satisfied that there was sufficient evidence before it to explain why a periodontal assessment would have been needed for Patient 9. The issue is not explained in Dr Ward's report, and it heard nothing from her on this matter in her oral evidence. Accordingly, the Committee found this allegation not proved.

Charge 22(b)

22. You failed to provide an adequate standard of care to Patient 9 [identified in Schedule A…], from 4 November 2013 to 28 October 2019 in that:

b. You did not adequately formulate and/or record formulation of treatment plans

Found proved (on the basis that treatment plans were not adequately formulated)

428. The Committee had regard to the clinical records for Patient 9, and whilst it found that Mr Denbigh-White made records in relation to treatment that he proposed to carry out for the patient, the Committee found nothing within the clinical records that would constitute a treatment plan, as outlined in the relevant GDC Standards, and as described by Dr Ward.

429. The Committee took into account Dr Ward's evidence that "*Treatment planning follows full assessment and diagnosis and after the consideration of treatment options, discussion of risks and benefits of treatment, along with consideration of the order and timing of treatment".*

430. The Committee had regard to its findings above regarding the limited assessment of Patient 9 by Mr Denbigh-White, in terms of the lack of radiographs, no BPEs having been undertaken and the inadequacy of additional special testing, where appropriate. The Committee concluded that in the circumstances, Mr Denbigh-White would not have had all the relevant clinical information to adequately formulate treatment plans for the patient. The Committee was satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 9 by not providing the patient with clear plans in relation to their treatment, as required by the GDC Standards.

Charge 22(c)

22. You failed to provide an adequate standard of care to Patient 9 [identified in Schedule A…], from 4 November 2013 to 28 October 2019 in that:

c. You did not diagnose and/or treat periodontitis and/or caries on UR6 from 21 February 2018 to 28 October 2019.

Found not proved in relation to the diagnosis and treatment of periodontitis.

Found proved in relation to the treatment of caries only.

431. In considering this charge, the Committee has taken "periodontitis" to mean periodontal disease, as the GDC had taken this term to mean previously. The Committee noted from the clinical records that, on 2 September 2019, the subsequent treating dentist diagnosed Patient 9's UR6 with chronic apical periodontitis (CAP), which is an infection from within the tooth, and not periodontitis. The Committee was not satisfied that it received sufficient evidence to prove that Patient 9 had periodontal disease on UR6 and therefore this allegation is not proved in that regard.

432. On 21 February 2018, Mr Denbigh-White recorded the presence of deep caries at UR6. A subsequent treating dentist also diagnosed caries on this tooth on 2 September 2019. Mr Denbigh-White continued to treat Patient 9 until October 2019, but the Committee

found nothing in the clinical records to indicate that he treated the caries that had been identified.

433. Whilst the Committee noted that Mr Denbigh-White did provide treatment to UR6 on several occasions over the period in question, it took into account Dr Ward's evidence about the inappropriateness of that treatment, which did not address the caries. In all the circumstances, the Committee was satisfied that Mr Denbigh-White did not treat the caries on UR6 from 21 February 2018 to 28 October 2019.

Charge 22(d)

22. You failed to provide an adequate standard of care to Patient 9 [identified in Schedule A…], from 4 November 2013 to 28 October 2019 in that:

d. You inappropriately used glass ionomer for fillings on the following teeth and

dates: -

i. UL6 (14/2/18)

ii. UL7 (14/2/18)

iii. UR6 (21/2/18 and/or 30/5/18).

Found proved in its entirety.

434. In making its findings, the Committee considered heads of charge 22(d)(i) to (iii) separately.

435. The Committee had regard to the clinical records for Patient 9 and was satisfied that GI fillings were placed on each of the teeth listed at 22(d)(i) to (iii) and on the dates in question.

436. The Committee noted that all the fillings were placed on load bearing surfaces of the teeth, and it accepted the evidence of Dr Ward that this was inappropriate for the reasons outlined previously. The Committee found nothing in Mr Denbigh-White's notes to suggest that any of the GI fillings fell into the accepted circumstances referred to by Dr Ward, nor was there anything written by Mr Denbigh-White to justify his use of the material in clinical situations that were not in accordance with the manufacturer's recommendations and the relevant FGDP guidelines.

Charge 22(e)

22. You failed to provide an adequate standard of care to Patient 9 [identified in Schedule A…], from 4 November 2013 to 28 October 2019 in that:

e. You provided a poor standard of root canal treatment to the LL6 on 4 November

2013.

Found proved.

437. Dr Ward's evidence is that Mr Denbigh-White provided a poor standard of root canal treatment to Patient 9's LL6. In providing her opinion, Dr Ward relied on the '*Quality guidelines for endodontic treatment: consensus report of the European Society of Endodontology, IEJ, 2006 or FGDP 2.10 endo'.* She stated in her report that, Mr Denbigh-White's technique, as recorded in the clinical records for the patient, suggests that the root canal treatment was not carried out to acceptable endodontic standards. In particular, Dr Ward highlighted the following:

- No radiographs.
- No working length recorded from radiograph or apex locator.
- Inappropriate use of endomethasone, which she said was a filling substance that was out-dated.

438. The Committee was satisfied on the basis of Dr Ward's opinion that this allegation is proved. It was also satisfied that by not carrying out root canal treatment to the recognised endodontic standard, Mr Denbigh-White failed to provide Patient 9 with an adequate standard of care.

Charge 22(f)

22. You failed to provide an adequate standard of care to Patient 9 [identified in Schedule A…], from 4 November 2013 to 28 October 2019 in that:

f. You provided a poor standard of endodontic management in respect of the UR6 from 21 February 2018 to 28 October 2019 and/or left the tooth on open drainage on 20 August 2019 and/or 30/09/19.

Found proved.

439. The Committee accepted the evidence of Dr Ward, who stated in her report in respect of Patient 9's UR6 that: *"The tooth was left on open drainage. This technique is outdated and of poor standard".* She stated that *"…Open drainage is an antiquated technique whereby root canals are left open, with no restoration. This contaminates the root canal system and reduces the prognosis of the RCT".* Dr Ward told the Committee in her oral evidence that the use of open drainage as a dental technique stopped in the 1980s.

440. The Committee was satisfied on the basis of Dr Ward's opinion that Mr Denbigh-White provided a poor standard of endodontic management in respect of the Patient 9's UR6 from 21 February 2018 to 28 October 2019. This included inappropriately leaving the tooth on open drainage on 20 August 2019 and 30 September 2019. The Committee was also satisfied that this amounted to a failure by Mr Denbigh-White to provide Patient 9 with an adequate standard of care.

Charge 22(g)

22. You failed to provide an adequate standard of care to Patient 9 [identified in Schedule A…], from 4 November 2013 to 28 October 2019 in that:

g. You did not discuss and/or record discussion of treatment options.

Found proved (on the basis that treatment options were not discussed).

441. The Committee took into account the absence of any information in Mr Denbigh-White's clinical records for Patient 9 regarding discussions with the patient about treatment options. It noted that Mr Denbigh-White provided treatment to a number of the patient's teeth during the period in question, including the provision of several glass ionomer fillings. It appeared to the Committee on its reading of the clinical notes that on each occasion, Mr Denbigh-White simply advised the patient on the course of action he was going to take. The Committee noted Dr Ward's comments in her report regarding the absence of any information in the clinical notes about discussions of treatment options.

442. The Committee took into account its findings made in respect of the treatment of other patients, namely that treatment options were not discussed. It also had regard to the evidence it received from some patients regarding Mr Denbigh-White not having spoken to them much or at all about their treatment. Further, the Committee took into account its findings that Mr Denbigh-White did not take radiographs of this patient when required, and did not undertake sufficient special tests as appropriate. The Committee also found that Mr Denbigh-White did not formulate any adequate treatment plans. Taking all these factors into account, the Committee concluded that it was more likely than not that Mr Denbigh-White did not discuss treatment options with Patient 9 over the period in question. It considered that it would have been difficult for him to have had any discussion about treatment options given the limited clinical information that would have been available to him on account of his omissions.

443. The Committee was satisfied that Mr Denbigh-White's omission to discuss treatment options with Patient 9 was a failure to provide an adequate standard of care, as such discussions are an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 22(h)

22. You failed to provide an adequate standard of care to Patient 9 [identified in Schedule A…], from 4 November 2013 to 28 October 2019 in that:

h. You did not discuss and/or record risks and/or benefits of proposed treatment.

Found proved (on the basis that risks and benefits of proposed treatment were not discussed).

444. The Committee found no information in Mr Denbigh-White's clinical records for Patient 9 regarding any discussions with the patient about the risks and benefits of proposed treatment. The Committee found this allegation proved for the same reasons outlined above in relation to the lack of discussion about treatment options.

445. The Committee was satisfied that Mr Denbigh-White did not discuss the risks and benefits of proposed treatment with Patient 9, and that his omission to do so was a failure to provide the patient with an adequate standard of care. Such discussions are an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 23

23. As a result of 22 (a) (vi) and/or (g) and/or (h) you failed to obtain informed consent for the treatment provided from 4 November 2013 to 28 October 2019.

Found proved in relation to 22(a)(vi), 22(g) and 22(h).

446. The Committee's findings at 22(a)(vi) are that Mr Denbigh-White did not take any pre-treatment/periapical radiographs prior to and/or during root canal treatment to Patient 9's to LL6 and in respect of the patient's UR6, in which the patient complained of recurring pain. The Committee accepted the evidence of Dr Ward that such radiographs were necessary, and by not having taken them, Mr Denbigh-White could not have been fully informed of the clinical situations in respect of these teeth. Accordingly, he could not have fully informed Patient 8 and highlighted any risks.

447. The Committee found at 22(g) and 22(h) that Mr Denbigh-White did not discuss any alternative treatment options or risks and benefits of proposed treatment with Patient 9 over the period in question. The Committee had regard to the GDC Standards which relate to the issue of valid consent, as well as to the evidence of Dr Ward that discussions with patients about alternative treatment options and risks and benefits of proposed treatment are integral to patients being able to give informed consent.

448. Taking all the evidence into account, the Committee found this allegation at Charge 23 proved. It was satisfied on the balance of probabilities that Patient 9 could not have given informed consent for any of the treatment provided by Mr Denbigh-White from 4 November 2013 to 28 October 2019, if the patient was unaware of what alternative treatment options were available and the risks and benefits of any proposed treatment.

Charge 24

24. You failed to maintain an adequate standard of record keeping from 4 November 2013 to 28 October 2019

Found proved.

449. The Committee took into account its findings that in most instances, Mr Denbigh-White did not undertake the relevant actions, and therefore he could not have recorded undertaking them. However, in relation to the undertaking of intra-oral examinations, and treatment planning, the Committee noted that there is some information in the clinical records alluding to Mr Denbigh-White's actions, but the information included is very limited. The Committee further noted that on 25 May 2017, Mr Denbigh-White extracted the patient's LL6 under local anesthetic. It found nothing in the clinical records regarding the details of that local anesthetic. Also, a number of GI fillings were provided to Patient 9 in clinical situations that were not in accordance with the manufacturer's recommendations and the relevant FGDP guidelines, and there are no recorded justifications.

450. The Committee found that there was insufficient information in the clinical records to explain what Mr Denbigh-White did in terms of his care of Patient 9 and why.

451. The Committee found Mr Denbigh-White's record keeping in respect of his care and treatment of Patient 9 to be of an inadequate standard. The clinical records were brief with major omissions.

PATIENT 10

Charge 25(a)(i)

25. You failed to provide an adequate standard of care to Patient 10 [identified in Schedule A…], from 9 December 2014 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

i. Medical history

Found proved (on the basis that a medical history was not taken adequately).

452. The Committee was satisfied from the clinical records for Patient 10, that Mr Denbigh-White provided care and treatment to the patient over the period in question.

453. The Committee took into account that Mr Denbigh-White had a duty to take an up-to-date medical history from Patient 10 each time he treated the patient, in accordance with Standard 4.1.1 of the GDC Standards and the *FGDP UK guidelines on Clinical Examination and Record Keeping*.

454. The Committee had regard to Patient 10's clinical records. It found entries against Mr Denbigh-White's initials which indicated that he had updated the patient's medical notes on two occasions in 2015 and on two occasions in 2019. This indicated to the Committee that there was an intervening period of about four years, during which Mr Denbigh-White did not update Patient 10's medical history in the clinical records. The Committee noted that the patient attended for treatment during the four-year period in question, which included occasions when antibiotics were prescribed, and therefore updates to the patient's medical history would have been important.

455. The Committee took into account the lack of information in the clinical records to indicate that a medical history was taken each time Mr Denbigh-White treated Patient 10. It also had regard to its previous findings above that Mr Denbigh-White had been less than comprehensive in taking and updating the medical histories of other patients. In all the circumstances, the Committee concluded that it was more likely than not that Mr Denbigh-White did not take an up to date medical history from Patient 10 each time he treated the patient.

456. The Committee considered that Mr Denbigh-White could not have obtained an up-to-date picture of Patient 10's medical health, not having updated the patient's medical history over a four-year period. It was therefore satisfied that he failed in his duty to provide the patient with an adequate standard of care.

Charge 25(a)(ii)

25. You failed to provide an adequate standard of care to Patient 10 [identified in Schedule A…], from 9 December 2014 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

ii. extra and intra oral examinations

Found proved (on the basis that no extra oral examinations were undertaken and the intra oral examinations undertaken were not adequate).

457. The Committee had regard to Mr Denbigh-White's clinical records for Patient 10 and found no information to indicate that he undertook any extra oral examinations over the period in question. Whilst there was some information relating to intra-oral examinations, in that there were records to indicate that Mr Denbigh-White had looked in the patient's mouth and at aspects of the patient's teeth, the Committee found nothing to indicate that a full clinical examination had ever been undertaken. There was no recorded information to suggest that Mr Denbigh-White had examined Patient 10 extra-orally, for example, the TMJs and lymph nodes, or to indicate that intra-orally he had examined the patient's soft tissues, for example, the tongue or floor of the mouth. The Committee noted Dr Ward's comments in her report regarding the lack of information relating to extra and intra oral examinations in Mr Denbigh-White's clinical records for Patient 10.

458. The Committee took into account the limited nature of information in the clinical records relating to standard clinical examinations. It also took into account its previous findings above in relation to the same matters but concerning different patients, namely that no extra oral examinations were undertaken of those patients, and that the intra oral examinations carried out were inadequate.

459. In all the circumstances, the Committee was satisfied that it was more likely than not, that Mr Denbigh-White did not undertake any extra-oral examinations of Patient 10 over the period in question, and that the intra-oral examinations of the patient were inadequate. The Committee was also satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 10, given that such examinations are an integral part of assessment used to help dentists diagnose dental and oral diseases.

Charge 25(a)(iii)

25. You failed to provide an adequate standard of care to Patient 10 [identified in Schedule A…], from 9 December 2014 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

iii. additional special tests as appropriate.

Found proved (on the basis that additional special tests were not undertaken as appropriate).

460. The Committee considered Dr Ward's evidence regarding the requirement for special tests in the context of Patient 10's dental history, as documented within the clinical records. The Committee considered whether there were occasions when the patient presented with a complaint or condition that would have required Mr Denbigh-White to have undertaken any of the special tests referred to by Dr Ward, namely vitality tests, TTP testing and palpation.

461. The clinical records show that Patient 10 attended to see Mr Denbigh-White for a number of appointments, including occasions when the patient attended complaining of pain. Having considered the totality of Patient 10's dental issues over the period in question, the Committee considered some special testing, including vitality testing, was required.

462. The Committee accepted the evidence of Dr Ward, who indicated in her report that she would have expected to see information recorded in the clinical records about what special tests were undertaken in response to Patient 10's complaints of pain. The Committee found no such information included. In the absence of such records, the Committee was satisfied that Mr Denbigh-White did not carry out any additional special testing.

463. The Committee was satisfied on the evidence that the lack of special testing was a failure to provide Patient 10 with an adequate standard of care. In the absence of special tests as appropriate, Mr Denbigh-White could not have assessed whether the treatment he provided in response the patient complaints was appropriate.

Charge 25(a)(iv)

25. . You failed to provide an adequate standard of care to Patient 10 [identified in Schedule A…], from 9 December 2014 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

iv. BPE

Found proved (on the basis no BPEs were undertaken).

464. The Committee noted the presence of a BPE in Patient 10's clinical records undertaken in August 2011, however, that was before the period referred to in this charge. The Committee found no evidence to indicate that Mr Denbigh-White had undertaken any BPEs of Patient 10 from 9 December 2014 to 5 August 2019. The lack of BPEs in the clinical records was a matter highlighted by Dr Ward in her report. The Committee noted that a BPE should be undertaken at initial examination and at each recall interval.

465. The Committee considered the evidence before it in relation to this allegation, as well as its previous findings made in relation to other patients, which indicate that Mr Denbigh-White's habitual practice was not to take BPEs. The Committee concluded on the balance of probabilities that Mr Denbigh-White did not undertake any BPEs of Patient 10 over the period in question. The Committee was satisfied that this represented a failure by Mr Denbigh-White to provide an adequate standard of care to the patient, in view of Dr Ward's opinion regarding the integral nature of BPEs to assessment, diagnosis and treatment.

Charge 25(a)(v)

25. . You failed to provide an adequate standard of care to Patient 10 [identified in Schedule A…], from 9 December 2014 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

v. Periodontal assessment

Found proved (on the basis that no periodontal assessment was undertaken).

466. The Committee took into account its findings that Mr Denbigh-White did not carry out any BPEs of Patient 10 over the period in question, which would have guided the need for a full periodontal assessment. However, it was satisfied from the information he recorded in the patient's clinical notes that he was aware that Patient 10 had some gingival pocketing

and a number of mobile teeth, which would have necessitated such an assessment. These problems were noted at appointments on 4 April 2016 and 18 April 2016.

467. The Committee found nothing in the clinical records to suggest that Mr Denbigh-White undertook a periodontal assessment of Patient 10. In the absence of such records, the Committee was satisfied that he did not undertake a periodontal assessment of the patient over the period concerned.

468. Dr Ward highlighted in her report that Patient 10 was seen by a subsequent treating dentist on 24 January 2020, when BPE scores of 4 were recorded in each sextant and the patient was diagnosed with 'unstable chronic periodontitis'. It was Dr Ward's opinion that Mr Denbigh-White "*Failed to carry out full periodontal assessment at any appointment".*

469. The Committee was satisfied on the evidence that this allegation is proved. It was also satisfied that by not carrying out a periodontal assessment, Mr Denbigh-White failed to provide Patient 10 with an adequate standard of care. It took into account Dr Ward's evidence in her report that there was *"…no full periodontal assessment to enable diagnosis and treatment planning".*

Charge 25(a)(vi)

25. You failed to provide an adequate standard of care to Patient 10 [identified in Schedule A…], from 9 December 2014 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

vi. Bitewing radiographs

Found proved (on the basis that no bitewing radiographs were taken).

470. The Committee found no bitewing radiographs within the clinical records of Patient 10 for the relevant period 9 December 2014 to 5 August 2019.

471. The Committee had regard to the evidence of Mr Krzeminski regarding Mr Denbigh-White stating that he did not routinely take radiographs of his patients because of the risk posed by radiation.

472. Having had regard to the evidence, the Committee was satisfied on the balance of probabilities that Mr Denbigh-White did not take any radiographs of Patient 10 during the time period in question. The Committee was also satisfied that Mr Denbigh-White's omission to take any radiographs of the patient amounted to a failure to provide an adequate standard of care for the same reasons previously stated.

Charge 25(a)(vii)

25. You failed to provide an adequate standard of care to Patient 10 [identified in Schedule A…], from 9 December 2014 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

vii. Periapical radiographs to aid diagnosis of periodontitis.

Found proved.

473. The Committee found no indication in the clinical records of any periapical radiographs having been taken of Patient 10 during the period in question. The Committee took into account the evidence that Mr Denbigh-White tended not to take radiographs of his patients, and it was satisfied that it was more likely than not that he did not take any periapical radiographs to aid the diagnosis of the patient's periodontitis.

474. The Committee accepted the evidence of Dr Ward, whose opinion was that Mr Denbigh-White failed to undertake any radiographic examination to aid diagnosis. It was satisfied that this amounted to a failure on the part of Mr Denbigh-White to provide an adequate standard of care to Patient 10.

Charge 25(b)

25. You failed to provide an adequate standard of care to Patient 10 [identified in Schedule A…], from 9 December 2014 to 5 August 2019 in that:

b. You did not adequately formulate and/or record formulation of treatment plans.

Found proved (on the basis that treatment plans were not adequately formulated)

475. The Committee had regard to the clinical records for Patient 10, and whilst it found that Mr Denbigh-White made records in relation to treatment that he proposed to carry out for the patient, the Committee found nothing within the clinical records that would constitute a treatment plan, as outlined in the relevant GDC Standards, and as described by Dr Ward.

476. The Committee took into account Dr Ward's evidence that "*Treatment planning follows full assessment and diagnosis and after the consideration of treatment options, discussion of risks and benefits of treatment, along with consideration of the order and timing of treatment".*

477. The Committee had regard to its findings above regarding the limited assessment of Patient 10 by Mr Denbigh-White, in terms of the absence of any radiographs, no BPEs having been undertaken, the absence of special testing where appropriate, and no periodontal assessment. The Committee concluded that in the circumstances, Mr Denbigh-White would not have had all the relevant clinical information to adequately formulate treatment plans for the patient. The Committee was satisfied that Mr Denbigh-White failed

to provide an adequate standard of care to Patient 10 by not providing the patient with clear plans in relation to their treatment, as required by the GDC Standards.

Charge 25(c)

25. You failed to provide an adequate standard of care to Patient 10 [identified in Schedule A…], from 9 December 2014 to 5 August 2019 in that:

c. You did not diagnose and/or treat periodontitis.

Found proved (on the basis that periodontitis was not diagnosed).

478. The Committee found no information in Mr Denbigh-White's clinical records for Patient 10 which constituted a diagnosis of periodontitis. It noted that Mr Denbigh-White made references in the notes to the condition of the patient's gums and to mobile teeth, but he did not record a formal diagnosis.

479. The Committee also took into account the notes of the subsequent treating dentist who saw Patient 10 on 24 January 2020, less than six months after the patient's last appointment with Mr Denbigh-White. It is indicated in those notes that when that dentist diagnosed 'unstable chronic periodontitis', the patient was shocked and unaware of the issue.

480. Having considered the evidence, the Committee was satisfied that it was more likely than not that Mr Denbigh-White did not diagnose Patient 10's periodontitis. The Committee was further satisfied that this amounted to a failure to provide the patient with an adequate standard of care, as in the absence of a diagnosis, Mr Denbigh-White could not have provided appropriate treatment. Indeed, the Committee found nothing in his clinical records to suggest that he treated the patient's periodontitis.

Charge 25(d)

25. You failed to provide an adequate standard of care to Patient 10 [identified in Schedule A…], from 9 December 2014 to 5 August 2019 in that:

d. You did not diagnose and/or treat caries on the LR6 and LR7.

Found not proved.

481. In finding this allegation not proved, the Committee noted the report of the subsequent treating dentist in respect of bitewing radiographs taken of Patient 10 at the appointment on 24 January 2020. Whilst that dentist noted advanced bone loss on the radiographs and the presence of calculus, "*no caries"* was reported.

482. In the circumstances, the Committee concluded that the caries, which was later diagnosed at LR6 and LR7 after periapical radiographs were taken on 21 January 2021, may not have been clinically obvious to Mr Denbigh-White in August 2019 when he last saw Patient 10, even if bitewing radiographs were taken at that time.

Charge 25(e)

25. You failed to provide an adequate standard of care to Patient 10 [identified in Schedule A…], from 9 December 2014 to 5 August 2019 in that:

e. You inappropriately prescribed antibiotics on 16 July 2018.

Found proved.

483. In the clinical records in respect of this appointment on 16 July 2018, Mr Denbigh-White recorded that he had prescribed antibiotics to Patient 10 *"just in case"*, as previous issues he had identified with LL8 had *"not quite settled".* The Committee was satisfied on the evidence of Dr Ward that this was an inappropriate use of antibiotics.

484. Dr Ward's opinion was based on the FGDP guidelines on 'Antimicrobial Prescribing for General Dental Practitioners'. She told the Committee in her oral evidence that antibiotics should only be prescribed when there is evidence of infection, such as systemic illness and diffuse swelling, and that where appropriate, local treatment measures should be undertaken first.

485. The Committee noted the absence of any reference to swelling and pain in the clinical records for 16 July 2018, or any information to suggest that Mr Denbigh-White had undertaken any local measures. The Committee considered that in the absence of such notes, the prescription for antibiotics was inappropriate. It was satisfied that prescribing antibiotics contrary to the guidelines was a failure to provide Patient 10 with an adequate standard of care.

Charge 25(f)

25. You failed to provide an adequate standard of care to Patient 10 [identified in Schedule A…], from 9 December 2014 to 5 August 2019 in that:

f. You did not discuss and/or record discussion of treatment options.

Found proved (on the basis that treatment options were not discussed).

486. The Committee took into account the absence of any information in Mr Denbigh-White's clinical records for Patient 10 regarding discussions with the patient about treatment options. It noted that Mr Denbigh-White provided treatment to a number of the patient's teeth during the period in question, including the provision of several glass ionomer fillings. It appeared to the Committee on its reading of the clinical notes that on each occasion, Mr Denbigh-White simply advised the patient on the course of action he was going to take.

487. The Committee had regard to its findings made in respect of the treatment of other patients, which indicate that, generally, treatment options were not discussed. It also had regard to the evidence it received from some patients regarding Mr Denbigh-White not having spoken to them much or at all about their treatment. Further, the Committee took into account its findings that Mr Denbigh-White did not take radiographs of Patient 10, did not

undertake special tests as appropriate, and did not diagnose the patient's periodontitis. The Committee also found that Mr Denbigh-White did not formulate any adequate treatment plans for the patient. Taking all these factors into account, the Committee concluded that it was more likely than not that Mr Denbigh-White did not discuss treatment options with Patient 10 over the period in question. It considered that it would have been difficult for him to have had any discussion about treatment options given the limited clinical information that would have been available to him on account of his omissions.

488. The Committee was satisfied that Mr Denbigh-White's omission to discuss treatment options with Patient 10 was a failure to provide an adequate standard of care, as such discussions are an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 25(g)

25. You failed to provide an adequate standard of care to Patient 10 [identified in Schedule A…], from 9 December 2014 to 5 August 2019 in that:

g. You did not discuss and/or record risks and/or benefits of proposed treatment.

Found proved *(*on the basis that risks and benefits of proposed treatment were not discussed*).*

489. The Committee found no information in Mr Denbigh-White's clinical records for Patient 10 regarding any discussions with the patient about the risks and benefits of proposed treatment. The Committee found this allegation proved for the same reasons outlined above in relation to the lack of discussion about treatment options.

490. The Committee was satisfied that Mr Denbigh-White did not discuss the risks and benefits of proposed treatment with Patient 10, and that his omission to do so was a failure to provide the patient with an adequate standard of care. Such discussions are an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 25(h)

25. You failed to provide an adequate standard of care to Patient 10 [identified in Schedule A…], from 9 December 2014 to 5 August 2019 in that:

h. You inappropriately used glass ionomer for fillings on the following teeth and dates:-

i. LL4 (20/7/15)

ii. UR6 (1/5/19)

iii. UL7 (1/5/19)

iv. LR5 (22/5/19)

Found proved in its entirety.

491. In making its findings, the Committee considered heads of charge 25(h) (i) to (iv) separately.

492. The Committee had regard to the clinical records for Patient 10 and was satisfied that GI fillings were placed on each of the teeth listed at 25(h) (i) to (iv) and on the dates in question.

493. The Committee noted that all the fillings were placed on load bearing surfaces of the teeth, and it accepted the evidence of Dr Ward that this was inappropriate for the reasons outlined previously. The Committee found nothing in Mr Denbigh-White's notes to suggest that any of the GI fillings fell into the accepted circumstances referred to by Dr Ward, nor was there anything written by Mr Denbigh-White to justify his use of the material in clinical situations that were not in accordance with the manufacturer's recommendations and the relevant FGDP guidelines.

Charge 26

26. As a result of 25 (a) (vii) and/or (f) and/or (g) you failed to obtain informed consent for the treatment provided from 9 December 2014 to 5 August 2019.

Found proved in relation to 25(a)(vii), 25(f) and 25(g).

494. The Committee's finding at 25(a)(vii) is that Mr Denbigh-White did not take periapical radiographs to aid diagnosis of Patient 10's periodontitis. The Committee accepted the evidence of Dr Ward that such radiographs were necessary, and by not having taken them, Mr Denbigh-White was not able to provide appropriate treatment to the patient. Accordingly, he could not have fully informed Patient 10 and highlighted any treatment options, risks and/or benefits of proposed treatment.

495. The Committee found at 25(f) and 25(g) that Mr Denbigh-White did not discuss any alternative treatment options or risks and benefits of proposed treatment with Patient 10 over the period in question. The Committee had regard to the GDC Standards which relate to the issue of valid consent, as well as to the evidence of Dr Ward that discussions with patients about alternative treatment options and risks and benefits of proposed treatment are integral to patients being able to give informed consent.

496. Taking all the evidence into account, the Committee found this allegation at Charge 26 proved. It was satisfied on the balance of probabilities that Patient 10 could not have given informed consent for any of the treatment provided by Mr Denbigh-White from 9 December 2014 to 5 August 2019 if the patient was unaware of what alternative treatment options were available and the risks and benefits of any proposed treatment.

Charge 27

27. You failed to maintain an adequate standard of record keeping from 9 December 2014 to 5 August 2019

Found proved.

497. The Committee took into account its findings that in most instances, Mr Denbigh-White did not undertake the relevant actions, and therefore he could not have recorded undertaking them. However, in relation to the undertaking of intra-oral examinations and treatment planning, the Committee noted that there is some information in the clinical records alluding to Mr Denbigh-White's actions, but the information included is very limited. This was also the case on the occasion that he prescribed Patient 10 with antibiotics without recording any proper justification for doing so. Also, a number of GI fillings were provided to Patient 19 in clinical situations that were not in accordance with the manufacturer's recommendations and the relevant FGDP guidelines, and there are no recorded justifications.

498. The Committee found that there was insufficient information in the clinical records to explain what Mr Denbigh-White did in terms of his care of Patient 10 and why.

499. The Committee found Mr Denbigh-White's record keeping in respect of his care and treatment of Patient 10 to be of an inadequate standard. The clinical records were brief with major omissions.

PATIENT 11

Charge 28(a)(i)

28. You failed to provide an adequate standard of care to Patient 11 [identified in Schedule A…], from 19 June 2014 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

i. Medical history

Found proved (on the basis that a medical history was not taken adequately).

500. The Committee was satisfied from the clinical records for Patient 11, that Mr Denbigh-White provided care and treatment to the patient over the period in question.

501. The Committee took into account that Mr Denbigh-White had a duty to take an up-to-date medical history from Patient 11 each time he treated the patient, in accordance with Standard 4.1.1 of the GDC Standards and the *FGDP UK guidelines on Clinical Examination and Record Keeping*.

502. The Committee had regard to Patient 11's clinical records. It found entries against Mr Denbigh-White's initials which indicated that he had updated the patient's medical notes

on two occasions in 2014, in June and July of that year, and then the next occasion after that was an update in February 2019. This indicated to the Committee that there was an intervening period of about four and a half years, during which Mr Denbigh-White did not update Patient 11's medical history in the clinical records. The Committee noted that the patient attended for treatment during that intervening period, which included an appointment in 2016 when antibiotics were prescribed, and therefore an update to the patient's medical history would have been important.

503. The Committee took into account the lack of information in the clinical records to indicate that a medical history was taken each time Mr Denbigh-White treated Patient 11. It also had regard to its previous findings above that Mr Denbigh-White had been less than comprehensive in taking and updating the medical histories of other patients. In all the circumstances, the Committee concluded that it was more likely than not that Mr Denbigh-White did not take an up to date medical history from Patient 11 each time he treated the patient.

504. The Committee considered that Mr Denbigh-White could not have obtained an up-to-date picture of Patient 11's medical health, not having updated the patient's medical history over a four and a half year period. It was therefore satisfied that he failed in his duty to provide the patient with an adequate standard of care.

Charge 28(a)(ii)

28. You failed to provide an adequate standard of care to Patient 11 [identified in Schedule A…], from 19 June 2014 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

ii. extra and intra oral examinations.

Found proved (on the basis that no extra oral examinations were undertaken and the intra oral examinations undertaken were not adequate).

505. The Committee had regard to Mr Denbigh-White's clinical records for Patient 11 and found no information to indicate that he undertook any extra oral examinations over the period in question. Whilst there was some information relating to intra-oral examinations, in that there were records to indicate that Mr Denbigh-White had looked in the patient's mouth and at aspects of the patient's teeth, the Committee found nothing to indicate that a full clinical examination had ever been undertaken. There was no recorded information to suggest that Mr Denbigh-White had examined Patient 11 extra-orally, for example, the TMJs and lymph nodes, or to indicate that intra-orally he had examined the patient's soft tissues, for example, the tongue or floor of the mouth. The Committee noted that Dr Ward highlighted in her report the lack of information in the clinical records regarding extra and intra oral examinations of this patient.

506. The Committee took into account the limited nature of information in the clinical records relating to standard clinical examinations. It also took into account its previous findings above in relation to the same matters but concerning different patients, namely that no extra oral examinations were undertaken of those patients, and that the intra oral examinations carried out were inadequate.

507. In all the circumstances, the Committee was satisfied that it was more likely than not, that Mr Denbigh-White did not undertake any extra-oral examinations of Patient 11 over the period in question, and that the intra-oral examinations of the patient were inadequate. The Committee was also satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 11, given that such examinations are an integral part of assessment used to help dentists diagnose dental and oral diseases.

Charge 28(a)(iii)

28. You failed to provide an adequate standard of care to Patient 11 [identified in Schedule A…], from 19 June 2014 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

iii. additional special tests as appropriate.

Found proved (on the basis that additional special tests were not undertaken as appropriate).

508. The Committee considered Dr Ward's evidence regarding the requirement for special tests in the context of Patient 11's dental history, as documented within the clinical records. The Committee considered whether there were occasions when the patient presented with a complaint or condition that would have required Mr Denbigh-White to have undertaken any of the special tests referred to by Dr Ward, namely vitality tests, TTP testing and palpation.

509. The clinical records show that Patient 11 attended to see Mr Denbigh-White for a number of appointments, including an appointment on 19 June 2014 when the patient complained of a loose tooth in the lower right area. The patient had an infection and had been given antibiotics by an emergency dentist. It was shortly after this that the patient was seen by Mr Denbigh-White. Patient 11's clinical records show that Mr Denbigh-White had also carried out bridgework for the patient and that the patient had loose lower incisors.

510. It was Dr Ward's evidence that she would have expected special tests to have been carried out by Mr Denbigh-White in the particular circumstances of the appointment on 19 June 2014 and prior to the bridgework having been carried out, to assess the health of the abutment teeth. In her oral evidence she stated that special tests such as pocket probing depths, mobility and vitality tests, would be expected where there were mobile teeth.

511. The Committee accepted the evidence of Dr Ward. It found no information included in Mr Denbigh-White's clinical records for Patient 11 to suggest that he carried out any special testing in respect of the patient. In the absence of such records, the Committee was satisfied that Mr Denbigh-White did not carry out any additional special testing.

512. The Committee was satisfied on the evidence that the lack of special testing was a failure to provide Patient 11 with an adequate standard of care. In the absence of special tests as appropriate, Mr Denbigh-White could not have assessed whether the treatment he provided to Patient 11 was appropriate in all the circumstances.

Charge 28(a)(iv)

28. You failed to provide an adequate standard of care to Patient 11 [identified in Schedule A…], from 19 June 2014 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

iv. BPE

Found proved (on the basis no BPEs were undertaken).

513. The Committee found nothing in the clinical records to indicate that Mr Denbigh-White had undertaken any BPEs of Patient 11 from 19 June 2014 to 5 August 2019. The lack of BPEs in the clinical records was a matter highlighted by Dr Ward in her report. The Committee noted that a BPE should be undertaken at initial examination and at each recall interval.

514. The Committee considered the evidence before it in relation to this allegation, as well as its previous findings made in relation to other patients, which indicate that Mr Denbigh-White's habitual practice was not to take BPEs. The Committee concluded on the balance of probabilities that Mr Denbigh-White did not take undertake any BPEs of Patient 11 over the period in question. The Committee was satisfied that this represented a failure by Mr Denbigh-White to provide an adequate standard of care to the patient, in view of Dr Ward's opinion regarding the integral nature of BPEs to assessment, diagnosis and treatment.

Charge 28(a)(v)

28. You failed to provide an adequate standard of care to Patient 11 [identified in Schedule A…], from 19 June 2014 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

v. Periodontal assessment.

Found proved (on the basis no that no periodontal assessment was undertaken).

515. The Committee noted the information in the clinical records indicating that Patient 11 had extensive dental disease with a number of mobile teeth. It accepted the evidence of Dr Ward that a full periodontal assessment of the patient was needed in the circumstances. It was her opinion on the basis of Mr Denbigh-White's clinical records, that he failed to carry out a periodontal assessment for the patient at all appointments.

516. The Committee, having had regard to Mr Denbigh-White's clinical records for Patient 11, found nothing to suggest that he had carried out a full periodontal assessment as described by Dr Ward. It therefore concluded that it was more likely than not that Mr Denbigh-White did not carry out a full periodontal assessment in response to Patient 11's noted dental problems. The Committee was satisfied that this represented a failure to provide Patient 11 with an adequate standard of care, given the importance of such an assessment to diagnosing dental disease.

Charge 28(a)(vi)

28. You failed to provide an adequate standard of care to Patient 11 [identified in Schedule A…], from 19 June 2014 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

vi. Bitewing radiographs.

Found proved (on the basis that bitewing radiographs were not taken at appropriate intervals).

517. The Committee noted that there is reference in the clinical records for Patient 11 to *"TC:XRAY"*. However, there is no indication in the notes of what type of radiograph this was or of any bitewing radiographs being taken over the almost 5 year period.

518. The Committee took into account that, if the relevant guidelines on radiography were being followed by Mr Denbigh-White, it would have expected to find several sets of radiographs in the patient's clinical records. The Committee noted that, even for patients at low risk of caries, bitewing radiographs are to be taken every two years. The Committee noted the evidence regarding Mr Denbigh-White's admission to an NHSE dental adviser that he did not routinely take radiographs of his patients because of the risk posed from the radiation.

519. Having had regard to all the evidence, the Committee was satisfied on the balance of probabilities that Mr Denbigh-White did not take bitewing radiographs of Patient 11 at appropriate intervals during the time period in question. The Committee was satisfied that Mr Denbigh-White's lack of adequate radiographic screening amounted to a failure to provide an adequate standard of care to Patient 11. It accepted Dr Ward's opinion that the relevant guidelines should have been followed by Mr Denbigh-White to balance the safety of radiographic exposure against the benefits of its use.

Charge 28(a)(vii)(1)

28. You failed to provide an adequate standard of care to Patient 11 [identified in Schedule A…], from 19 June 2014 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

vii. Pre-treatment/periapical radiographs prior to:

1. extraction of UR3 broken root and a bridge to replace the UR3 on 14/2/19 and/or 13/3/19.

Found proved (on the basis that no pre-treatment/periapical radiographs were taken).

520. The Committee was satisfied from the clinical records for Patient 11 that Mr Denbigh-White undertook bridge preparation on these dates. It found no information within the clinical records to indicate that he took any pre-treatment/periapical radiographs prior to the preparation.

521. The Committee accepted the evidence of Dr Ward that pre-operative radiographs should be taken before any crown or bridgework is undertaken. The Committee noted that pre-treatment radiographs before bridge preparation are necessary to assess the abutments before the bridge is placed.

522. In the absence of any radiographs and given the evidence of Mr Denbigh-White's views on radiography, the Committee was satisfied on the balance of probabilities that he did not take a pre-treatment/periapical radiograph prior to the bridge preparation on these dates. On the basis of Dr Ward's expert evidence that such radiographs were necessary, the Committee was satisfied that Mr Denbigh-White failed to provide Patient 11 with an adequate standard of care in this regard.

Charge 28(a)(vii)(2)

28. You failed to provide an adequate standard of care to Patient 11 [identified in Schedule A…], from 19 June 2014 to 5 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –

vii. Pre-treatment/periapical radiographs prior to:

2. extraction of the UL8 on 5 August 2019.

Found not proved.

523. The Committee was satisfied on the evidence before it that Mr Denbigh-White did not take a pre-treatment/periapical radiograph before extracting Patient 11's UL8 on 5 August 2019. However, it noted the information that this tooth was already very loose.

524. It was the view of the Committee, taking into account the information in the clinical records, that Mr Denbigh-White could see clinically what he needed to know in order to carry out the extraction, without the need for a radiograph. Indeed, the clinical records suggest that the extraction was "*easy".*

525. Given that Dr Ward's expert evidence was that a radiograph should have been considered, and not that one was necessary, the Committee decided that it was not unreasonable for Mr Denbigh-White to have exercised his clinical judgement not to take a radiograph in the circumstances of this extraction.

Charge 28(b)

28. You failed to provide an adequate standard of care to Patient 11 [identified in Schedule A…], from 19 June 2014 to 5 August 2019 in that:

b. You did not adequately formulate and/or record formulation of treatment plans.

Found proved (on the basis that treatment plans were not adequately formulated).

526. The Committee had regard to the clinical records for Patient 11, and whilst it found that Mr Denbigh-White made records in relation to treatment that he proposed to carry out for the patient, the Committee found nothing within the clinical records that would constitute a treatment plan, as outlined in the relevant GDC Standards, and as described by Dr Ward.

527. The Committee took into account Dr Ward's evidence that "*Treatment planning follows full assessment and diagnosis and after the consideration of treatment options, discussion of risks and benefits of treatment, along with consideration of the order and timing of treatment".*

528. The Committee had regard to its findings above regarding the limited assessment of Patient 11 by Mr Denbigh-White, in terms of the insufficiency of radiographs, no BPEs having been undertaken, the absence of special testing when appropriate, and no periodontal assessment. The Committee concluded that in the circumstances, Mr Denbigh-White would not have had all the relevant clinical information to adequately formulate treatment plans for the patient. The Committee was satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 11 by not providing the patient with clear plans in relation to their treatment, as required by the GDC Standards.

Charge 28(c)

28. You failed to provide an adequate standard of care to Patient 11 [identified in Schedule A…], from 19 June 2014 to 5 August 2019 in that:

c. You did not diagnose and/or treat periodontitis.

Found proved (on the basis that periodontitis was not diagnosed).

529. The Committee noted the evidence of Dr Ward following her assessment of the clinical records. She stated that *"Patient 11 was seen by the registrant since 1997. Scaling and oral hygiene instruction was provided on several occasions. However no BPE's were recorded and no full periodontal assessment to enable diagnosis and treatment planning. When seen by a subsequent dentist teeth were extracted and dentures provided."* It was Dr Ward's opinion that Mr Denbigh-White failed to diagnose Patient 11 with periodontitis.

530. The Committee accepted Dr Ward's evidence. It noted that whilst Mr Denbigh-White recorded in the clinical records that Patient 11 had a number of mobile teeth, there is no information included to indicate that Mr Denbigh-White had future plans for these teeth. Furthermore, the Committee considered that, given the insufficiency of radiographs taken by Mr Denbigh-White, the absence of BPEs and any full periodontal assessment, the Committee considered that it was more likely than not that Mr Denbigh-White did not diagnose Patient 11's periodontitis. The Committee was satisfied that this amounted to a failure to provide the patient with an adequate standard of care, as in the absence of a diagnosis, Mr Denbigh-White could not have provided appropriate treatment. Indeed, the Committee found nothing in his clinical records to suggest that he treated the patient's periodontitis.

Charge 28(d)

28. You failed to provide an adequate standard of care to Patient 11 [identified in Schedule A…], from 19 June 2014 to 5 August 2019 in that:

d. You inappropriately prescribed antibiotics on 18 March 2016

Found proved.

531. In the clinical records in respect of this appointment on 18 March 2016, Mr Denbigh-White recorded *"ul 2 tender? rt (root treatment)"* and that penicillin was prescribed.

532. The opinion of Dr Ward, which the Committee accepted, was based on the FGDP guidelines on *'Antimicrobial Prescribing for General Dental Practitioners'*. She told the Committee in her oral evidence that antibiotics should only be prescribed when there is evidence of infection, such as systemic illness and diffuse swelling, and that where appropriate, local treatment measures should be undertaken first.

533. The Committee noted the absence of any reference to swelling or systemic involvement in the clinical records for 18 March 2016, or any information to suggest that Mr Denbigh-White had undertaken any local measures. The Committee considered that in the

absence of such notes, the prescription for antibiotics was inappropriate. It was satisfied that prescribing antibiotics contrary to the guidelines was a failure to provide Patient 11 with an adequate standard of care.

Charge 28(e)

28. You failed to provide an adequate standard of care to Patient 11 [identified in Schedule A…], from 19 June 2014 to 5 August 2019 in that:

e. Provided a poor standard of treatment to UR4 bridge to replace the UR3 20/02/19 and/or 13/03/19 and/or 04/04/19.

Found proved in respect of all dates.

534. In finding this allegation proved, the Committee noted the evidence about how quickly the bridge in question failed. The bridge was lost on 3 September 2020, some 17 months after it was fitted by Mr Denbigh-White.

535. The Committee took into account its findings in relation to heads of charge 28(a)(v) and 28(a)(vii)(1) above, regarding the lack of any periodontal assessment of Patient 11 by Mr Denbigh-White, and that he did not take any pre-treatment radiographs to assess bone support at the bridge abutment prior to fitting the bridge on 4 April 2019. The Committee also took into account the short space of time between the extraction of UR3 on 20 February 2019 and the fitting of the permanent bridge just over one month later.

536. The Committee accepted the evidence of Dr Ward that the treatment provided by Mr Denbigh-White in respect of the bridge was *"far below standard"* and it was satisfied that this represented a failure to provide Patient 11 with an adequate standard of care.

Charge 28(f)

28. You failed to provide an adequate standard of care to Patient 11 [identified in Schedule A…], from 19 June 2014 to 5 August 2019 in that:

f. You did not discuss and/or record discussion of treatment options

Found proved (on the basis that treatment options were not discussed).

537. The Committee took into account the absence of any information in Mr Denbigh-White's clinical records for Patient 11 regarding discussions with the patient about treatment options. It noted that Mr Denbigh-White provided treatment to a number of the patient's teeth during the period in question, including the provision of the bridge and ionomer fillings. It appeared to the Committee on its reading of the clinical notes that on each occasion, Mr Denbigh-White simply advised the patient on the course of action he was going to take.

538. The Committee had regard to its findings made in respect of the treatment of other patients, which indicate that, generally, treatment options were not discussed. It also had regard to the evidence it received from some patients regarding Mr Denbigh-White not

having spoken to them much or at all about their treatment. Further, the Committee took into account its findings that Mr Denbigh-White took only one radiograph of Patient 11 over the period in question, did not undertake special tests as appropriate, and did not diagnose the patient's periodontitis. The Committee also found that Mr Denbigh-White did not formulate any adequate treatment plans for the patient. Taking all these factors into account, the Committee concluded that it was more likely than not that Mr Denbigh-White did not discuss treatment options with Patient 11 over the period in question. It considered that it would have been difficult for him to have had any discussion about treatment options given the limited clinical information that would have been available to him on account of his omissions.

539. The Committee was satisfied that Mr Denbigh-White's omission to discuss treatment options with Patient 11 was a failure to provide an adequate standard of care, as such discussions are an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 28(g)

28. You failed to provide an adequate standard of care to Patient 11 [identified in Schedule A…], from 19 June 2014 to 5 August 2019 in that:

g. You did not discuss and/or record risks and/or benefits of proposed treatment.

Found proved *(*on the basis that risks and benefits of proposed treatment were not discussed*).*

540. The Committee found no information in Mr Denbigh-White's clinical records for Patient 11 regarding any discussions with the patient about the risks and benefits of proposed treatment. The Committee found this allegation proved for the same reasons outlined above in relation to the lack of discussion about treatment options.

541. The Committee was satisfied that Mr Denbigh-White did not discuss the risks and benefits of proposed treatment with Patient 11, and that his omission to do so was a failure to provide the patient with an adequate standard of care. Such discussions are an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 28(h)(i)

28. You failed to provide an adequate standard of care to Patient 11 [identified in Schedule A…], from 19 June 2014 to 5 August 2019 in that:

h. You inappropriately used glass ionomer for fillings on the following teeth and
dates:-

i. LL5 and/or LL4 (22/2/16).

Found proved in relation to LL5 and LL4

542. The Committee had regard to the clinical records for Patient 11 and was satisfied that GI fillings were placed on LL5 and LL4 on 22 February 2016.

543. The Committee noted that both fillings were placed on load bearing surfaces of the teeth, and it accepted the evidence of Dr Ward that this was inappropriate for the reasons outlined previously. The Committee found nothing in Mr Denbigh-White's notes to suggest that any of the GI fillings fell into the accepted circumstances referred to by Dr Ward, nor was there anything written by Mr Denbigh-White to justify his use of the material in clinical situations that were not in accordance with the manufacturer's recommendations and the relevant FGDP guidelines.

Charge 29

29. As a result of 28 (a) (vii) and/or (f) and/or (g) you failed to obtain informed consent for the treatment provided from 19 June 2014 to 5 August 2019.

Found proved in relation to 28(a)(vii)(1), 28(f) and 28(g).

544. The Committee's finding at 28(a)(vii)(1) is that Mr Denbigh-White did not take any pre-treatment/periapical radiographs prior to extraction of Patient 11's UR3 broken root and a bridge to replace the UR3 on 14/2/19 and 13/3/19. The Committee accepted the evidence of Dr Ward that such radiographs were necessary, and by not having taken them, Mr Denbigh-White could not have known whether the treatment he was providing was appropriate treatment. Accordingly, he could not have fully informed Patient 11 and highlighted any treatment options, risks and/or benefits of any proposed treatment.

545. The Committee found at 28(f) and 28(g) that Mr Denbigh-White did not discuss any alternative treatment options or risks and benefits of proposed treatment with Patient 11 over the period in question. The Committee had regard to the GDC Standards which relate to the issue of valid consent, as well as to the evidence of Dr Ward that discussions with patients about alternative treatment options and risks and benefits of proposed treatment are integral to patients being able to give informed consent.

546. Taking all the evidence into account, the Committee found this allegation at Charge 29 proved. It was satisfied on the balance of probabilities that Patient 11 could not have given informed consent for any of the treatment provided by Mr Denbigh-White from 19 June 2014 to 5 August 2019 if the patient was unaware of what alternative treatment options were available and the risks and benefits of any proposed treatment.

Charge 30

30. You failed to maintain an adequate standard of record keeping from 19 June 2014 to 5 August 2019

Found proved.

547. The Committee took into account its findings that in most instances, Mr Denbigh-White did not undertake the relevant actions, and therefore he could not have recorded undertaking them. However, in relation to the undertaking of intra-oral examinations and treatment planning, the Committee noted that there is some information in the clinical records alluding to Mr Denbigh-White's actions, but the information included is very limited. This was also the case on the occasion that he prescribed Patient 11 with antibiotics without recording any proper justification for doing so. Also, a number of GI fillings were provided to Patient 11 in clinical situations that were not in accordance with the manufacturer's recommendations and the relevant FGDP guidelines, and there are no recorded justifications.

548. The Committee found that there was insufficient information in the clinical records to explain what Mr Denbigh-White did in terms of his care of Patient 11 and why.

549. The Committee found Mr Denbigh-White's record keeping in respect of his care and treatment of Patient 11 to be of an inadequate standard. The clinical records were brief with major omissions.

PATIENT 12

Charge 31(a)(i)

31. You failed to provide an adequate standard of care to Patient 12, [identified in Schedule A…], from 17 February 2015 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including –

i. Medical history

Found proved (on the basis that a medical history was not taken adequately).

550. The Committee was satisfied from the clinical records for Patient 12, that Mr Denbigh-White provided care and treatment to the patient over the period in question.

551. The Committee took into account that Mr Denbigh-White had a duty to take an up-to-date medical history from Patient 12 each time he treated the patient, in accordance with Standard 4.1.1 of the GDC Standards and the *FGDP UK guidelines on Clinical Examination and Record Keeping*.

552. The Committee had regard to Patient 12's clinical records. It found entries against Mr Denbigh-White's initials which indicated that he had updated the patient's medical notes on two occasions in 2015, in February and April of that year, and then the next occasion after that was an update in November 2018. This indicated to the Committee that there was an intervening period of about three and a half years, during which Mr Denbigh-White did not update Patient 12's medical history in the clinical records. The Committee noted that the

patient attended for treatment during that intervening period, and therefore an update to the patient's medical history would have been required.

553. The Committee took into account the lack of information in the clinical records to indicate that a medical history was taken each time Mr Denbigh-White treated Patient 12. It also had regard to its previous findings above that Mr Denbigh-White had been less than comprehensive in taking and updating the medical histories of other patients. In all the circumstances, the Committee concluded that it was more likely than not that Mr Denbigh-White did not take an up to date medical history from Patient 12 each time he treated the patient.

554. The Committee considered that Mr Denbigh-White could not have obtained an up-to-date picture of Patient 12's medical health, not having updated the patient's medical history over a four and a half year period. It was therefore satisfied that he failed in his duty to provide the patient with an adequate standard of care.

Charge 31(a)(ii)

31. You failed to provide an adequate standard of care to Patient 12, [identified in Schedule A…], from 17 February 2015 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including –

ii. extra and intra oral examinations

Found proved (on the basis that no extra oral examinations were undertaken and the intra oral examinations undertaken were not adequate).

555. The Committee had regard to Mr Denbigh-White's clinical records for Patient 12 and found no information to indicate that he undertook any extra oral examinations over the period in question. Whilst there was some information relating to intra-oral examinations, in that there were records to indicate that Mr Denbigh-White had looked in the patient's mouth and at aspects of the patient's teeth, the Committee found nothing to indicate that a full clinical examination had ever been undertaken. There was no recorded information to suggest that Mr Denbigh-White had examined Patient 12 extra-orally, for example, the TMJs and lymph nodes, or to indicate that intra-orally he had examined the patient's soft tissues, for example, the tongue or floor of the mouth. The Committee noted that Dr Ward highlighted in her report the lack of information in the clinical records regarding extra and intra oral examinations of this patient.

556. The Committee took into account the limited nature of information in the clinical records relating to standard clinical examinations. It also took into account its previous findings above in relation to the same matters but concerning different patients, namely that no extra oral examinations were undertaken of those patients, and that the intra oral examinations carried out were inadequate.

557. In all the circumstances, the Committee was satisfied that it was more likely than not, that Mr Denbigh-White did not undertake any extra-oral examinations of Patient 12 over the period in question, and that the intra-oral examinations of the patient were inadequate. The Committee was also satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 12, given that such examinations are an integral part of assessment used to help dentists diagnose dental and oral diseases.

Charge 31(a)(iii)

31. You failed to provide an adequate standard of care to Patient 12, [identified in Schedule A…], from 17 February 2015 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including –

iii. additional special tests

Found proved (on the basis the additional special testing was not adequate).

558. The Committee considered Dr Ward's evidence regarding the requirement for special tests in the context of Patient 12's dental history, as documented within the clinical records. The Committee considered whether there were occasions when the patient presented with a complaint or condition that would have required Mr Denbigh-White to have undertaken any of the special tests referred to by Dr Ward, namely vitality tests, TTP testing and palpation.

559. The clinical records show that Patient 12 attended to see Mr Denbigh-White for a number of appointments, including occasions when the patient complained repeatedly in relation to their LL6. Whilst the Committee noted that at an appointment on 25 January 2017, Mr Denbigh-White recorded that this tooth was TTP, no other special tests are mentioned.

560. It was Dr Ward's evidence that she would have expected other special tests to have been carried out by Mr Denbigh-White in the circumstances. She noted that as at the appointment on 25 January 2017, Patient 12 *"had been in pain for a couple of weeks and pain was constant now".*

561. The Committee accepted the evidence of Dr Ward. In the absence of any records to suggest that Mr Denbigh-White carried out special testing beyond percussion testing, the Committee was satisfied on the balance of probabilities that he did not carry out any additional special tests. It was further satisfied on the expert evidence that he should have undertaken further investigations in this regard.

562. The Committee was satisfied that the limited additional special testing in this instance was a failure to provide Patient 12 with an adequate standard of care. Without adequate

special testing, Mr Denbigh-White could not have assessed whether the treatment he provided to Patient 12 was appropriate in all the circumstances.

Charge 31(a)(iv)

31. You failed to provide an adequate standard of care to Patient 12, [identified in Schedule A…], from 17 February 2015 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including –

iv. BPE

Found proved (on the basis no BPEs were undertaken).

563. The Committee found nothing in the clinical records to indicate that Mr Denbigh-White had undertaken any BPEs of Patient 12 from 17 February 2015 to 6 August 2019. The lack of BPEs in the clinical records was a matter highlighted by Dr Ward in her report. The Committee noted that a BPE should be undertaken at initial examination and at each recall interval.

564. The Committee considered the evidence before it in relation to this allegation, as well as its previous findings made in relation to other patients, which indicate that Mr Denbigh-White's habitual practice was not to take BPEs. The Committee concluded on the balance of probabilities that Mr Denbigh-White did not undertake any BPEs of Patient 12 over the period in question. The Committee was satisfied that this represented a failure by Mr Denbigh-White to provide an adequate standard of care to the patient, in view of Dr Ward's opinion regarding the integral nature of BPEs to assessment, diagnosis and treatment.

Charge 31(a)(v)

31. You failed to provide an adequate standard of care to Patient 12, [identified in Schedule A…], from 17 February 2015 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including –

v. Bitewing radiographs

Found proved (on the basis that no bitewing radiographs were undertaken).

565. The Committee found no bitewing radiographs within the clinical records of Patient 12 for the relevant period 17 February 2015 to 6 August 2019.

566. The Committee had regard to the evidence of Mr Krzeminski regarding Mr Denbigh-White stating that he did not routinely take radiographs of his patients because of the risk posed by radiation.

567. Having had regard to the evidence, the Committee was satisfied on the balance of probabilities that Mr Denbigh-White did not take any radiographs of Patient 12 during the

time period in question. The Committee was also satisfied that Mr Denbigh-White's omission to take any radiographs of the patient amounted to a failure to provide an adequate standard of care for the same reasons previously stated.

Charge 31(a)(vi)(1)

31. You failed to provide an adequate standard of care to Patient 12, [identified in Schedule A…], from 17 February 2015 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including –

vi. Pre-treatment/periapical radiographs before

1. a crown to the LL6 on 8/10/18

Found proved (on the basis that no pre-treatment/periapical radiographs were undertaken).

568. The Committee was satisfied from the clinical records that Mr Denbigh-White prepared Patient 12's LL6 for a crown on 8/10/18. It accepted the evidence of Dr Ward that pre-treatment/periapical radiographs should have been taken in the clinical situation. She noted in her report that "*LL6 was crowned (08/10/18) without full assessment, despite the patient reporting an abscess and symptoms on biting…".*

569. The Committee found nothing in the clinical records to indicate that Mr Denbigh-White took any radiographs of Patient 12 during the entire period in question. In the absence of such information, and given Mr Denbigh-White's views on radiography, the Committee was satisfied that it was more likely than not that he did not take any pre-treatment/periapical radiographs as required.

570. The Committee was further satisfied that not taking pre-treatment/periapical radiographs amounted to a failure to provide Patient 12 with an adequate standard of care.

Charge 31(a)(vi)(2)

31. You failed to provide an adequate standard of care to Patient 12, [identified in Schedule A…], from 17 February 2015 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including –

vi. Pre-treatment/periapical radiographs before

2. RCT to LL6 on 15/11/18

Found proved (on the basis that no pre-treatment/periapical radiographs were undertaken).

571. The Committee was satisfied from the clinical records that Mr Denbigh-White provided root canal treatment Patient 12's LL6 on 15/11/18. It accepted the evidence of Dr

Ward that *"Radiographic assessment of the working length and pre and post treatment should be examined to ensure a good quality root filling prior to crown fit".*

572. Having found that Mr Denbigh-White did not take any radiographs of Patient 12 during the period in question, pre-treatment or otherwise, the Committee was satisfied that this allegation is proved.

573. The Committee was further satisfied that not taking pre-treatment/periapical radiographs amounted to a failure to provide Patient 12 with an adequate standard of care. It took into account Dr Ward's opinion that Mr Denbigh-White provided a poor standard of root canal treatment to the patient's LL6 including because of the lack of radiographs.

Charge 31(b)

31. You failed to provide an adequate standard of care to Patient 12, [identified in Schedule A…], from 17 February 2015 to 6 August 2019 in that:

b. You did not adequately formulate and/or record formulation of treatment plans.

Found proved (on the basis that treatment plans were not adequately formulated).

574. The Committee had regard to the clinical records for Patient 12, and whilst it found that Mr Denbigh-White made records in relation to treatment that he proposed to carry out for the patient, the Committee found nothing within the clinical records that would constitute a treatment plan, as outlined in the relevant GDC Standards, and as described by Dr Ward.

575. The Committee took into account Dr Ward's evidence that "*Treatment planning follows full assessment and diagnosis and after the consideration of treatment options, discussion of risks and benefits of treatment, along with consideration of the order and timing of treatment".*

576. The Committee had regard to its findings above regarding the limited assessment of Patient 12 by Mr Denbigh-White, in terms of the lack of radiographs, no BPEs having been undertaken and, the limited special testing when appropriate. The Committee concluded that in the circumstances, Mr Denbigh-White would not have had all the relevant clinical information to adequately formulate treatment plans for the patient. In the Committee's view, Mr Denbigh-White was just treating Patient 12's dental concerns as and when they arose, rather than looking at the patient's mouth holistically.

577. The Committee was satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 12 by not providing the patient with clear plans in relation to their treatment, as required by the GDC Standards.

Charge 31(c)

31. You failed to provide an adequate standard of care to Patient 12, [identified in Schedule A…], from 17 February 2015 to 6 August 2019 in that:

c. You did not discuss and/or record discussion of treatment options

Found proved (on the basis that treatment options were not discussed).

578. The Committee took into account the absence of any information in Mr Denbigh-White's clinical records for Patient 12 regarding discussions with the patient about treatment options. It noted that Mr Denbigh-White provided treatment to a number of the patient's teeth during the period in question, including root canal treatment, the provision of a crown and GI fillings. It appeared to the Committee on its reading of the clinical notes that on each occasion, Mr Denbigh-White simply advised the patient on the course of action he was going to take.

579. The Committee had regard to its findings made in respect of the treatment of other patients, which indicate that, generally, treatment options were not discussed. It also had regard to the evidence it received from some patients regarding Mr Denbigh-White not having spoken to them much or at all about their treatment. Further, the Committee took into account its findings that Mr Denbigh-White did not take any radiographs of Patient 12 over the period in question, did not undertake any BPEs and did not undertake sufficient special testing as appropriate. The Committee also found that Mr Denbigh-White did not formulate any adequate treatment plans for the patient. Taking all these factors into account, the Committee concluded that it was more likely than not that Mr Denbigh-White did not discuss treatment options with Patient 12 over the period in question. It considered that it would have been difficult for him to have had any discussion about treatment options given the limited clinical information that would have been available to him on account of his omissions.

580. The Committee was satisfied that Mr Denbigh-White's omission to discuss treatment options with Patient 12 was a failure to provide an adequate standard of care, as such discussions are an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 31(d)

31. You failed to provide an adequate standard of care to Patient 12, [identified in Schedule A…], from 17 February 2015 to 6 August 2019 in that:

d. You did not discuss and/or record discussion of treatment options.

Found proved *(*on the basis that risks and benefits of proposed treatment were not discussed).

581. The Committee found no information in Mr Denbigh-White's clinical records for Patient 12 regarding any discussions with the patient about the risks and benefits of proposed treatment. The Committee found this allegation proved for the same reasons outlined above in relation to the lack of discussion about treatment options.

582. The Committee was satisfied that Mr Denbigh-White did not discuss the risks and benefits of proposed treatment with Patient 12, and that his omission to do so was a failure to provide the patient with an adequate standard of care. Such discussions are an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 31(e)

31. You failed to provide an adequate standard of care to Patient 12, [identified in Schedule A…], from 17 February 2015 to 6 August 2019 in that:

e. You inappropriately used glass ionomer for fillings on the following teeth and dates:

i. UL6 (4/7/19)
ii. LR6 (4/7/19)
iii. UL6 16/8/17)
iv. UL7 (16/8/17)
v. LL6 (27/2/15 and/or 31/1/17)

Found proved in relation to UL6 and UL7
Found not proved in relation to UR6, LR6 and LL6

583. In making its findings, the Committee considered heads of charge 31(e)(i) to (v) separately.

584. In finding this allegation not proved in relation to UR6 and LR6, the Committee could not find any indication in the clinical records for the relevant date, 4/7/19, of any GI fillings having been provided to these teeth. The clinical records indicate a nominal examination on this date.

585. The Committee also found this allegation not proved in relation to LL6. It noted from the clinical records that Mr Denbigh-White planned to root fill this tooth. The Committee took into account the evidence of Dr Ward that, whilst it is not usual practice to use GI fillings as a permanent fillings, they can be used as long term temporary restorations. Therefore, the Committee was not satisfied that Mr Denbigh-White's use of a GI filling in the clinical situation concerning LL6 was inappropriate.

586. However, the Committee did find this head of charge proved in relation to UL6 and UL7 for the same reasons given previously. Both fillings were placed on load bearing surfaces of the teeth, and the Committee accepted the evidence of Dr Ward that this was inappropriate. The Committee found nothing in Mr Denbigh-White's notes to suggest that either of these GI fillings fell into the accepted circumstances referred to by Dr Ward, nor was there anything written by Mr Denbigh-White to justify his use of the material in clinical situations that were not in accordance with the manufacturer's recommendations and the relevant FGDP guidelines.

Charge 31(f)

31. You failed to provide an adequate standard of care to Patient 12, [identified in Schedule A…], from 17 February 2015 to 6 August 2019 in that:

f. You provided a poor standard of root canal treatment to the LL6 on 15 November 2018

Found proved.

587. Dr Ward's evidence is that Mr Denbigh-White provided a poor standard of root canal treatment to Patient 12's LL6. In providing her opinion, Dr Ward relied on the '*Quality guidelines for endodontic treatment: consensus report of the European Society of Endodontology, IEJ, 2006 or FGDP 2.10 endo'.* She stated in her report that, Mr Denbigh-White's technique, as recorded in the clinical records for the patient, suggests that the root canal treatment was not carried out to recognised endodontic standards. In particular, Dr Ward highlighted the following:

- No radiographs.
- No working length recorded.
- Inappropriate use of endomethasone as root filling.

588. The Committee was satisfied on the basis of Dr Ward's opinion that this allegation is proved. It was also satisfied that by not carrying out root canal treatment to the recognised endodontic standard, Mr Denbigh-White failed to provide Patient 12 with an adequate standard of care.

Charge 32

32. As a result of 31 (a) (vi) and/or (c) and/or (d) you failed to obtain informed consent for the treatment provided from 17 February 2015 to 6 August 2019.

Found proved in relation to 31(a)(vi), 31(c) and 31(d).

589. The Committee's findings at 31(a)(vi) are that Mr Denbigh-White did not take any pre-treatment/periapical radiographs before crown preparation and the provision of root canal treatment to Patient 12's LL6. The Committee accepted the evidence of Dr Ward that such radiographs were necessary, and by not having taken them, Mr Denbigh-White was not able to provide appropriate treatment to the patient. Accordingly, he could not have fully informed Patient 12 and highlighted any treatment options, risks and/or benefits of proposed treatment.

590. The Committee found at 31(c) and 31(d) that Mr Denbigh-White did not discuss any alternative treatment options or risks and benefits of proposed treatment with Patient 12 over the period in question. The Committee had regard to the GDC Standards which relate to the issue of valid consent, as well as to the evidence of Dr Ward that discussions with

patients about alternative treatment options and risks and benefits of proposed treatment are integral to patients being able to give informed consent.

591. Taking all the evidence into account, the Committee found this allegation at Charge 32 proved. It was satisfied on the balance of probabilities that Patient 12 could not have given informed consent for any of the treatment provided by Mr Denbigh-White from 17 February 2015 to 6 August 2019 if the patient was unaware of what alternative treatment options were available and the risks and benefits of any proposed treatment.

Charge 33

33. You failed to maintain an adequate standard of record keeping from 17 February 2015 to 6 August 2019

Found proved.

592. The Committee took into account its findings that in most instances, Mr Denbigh-White did not undertake the relevant actions, and therefore he could not have recorded undertaking them. However, in relation to the undertaking of intra-oral examinations and treatment planning, the Committee noted that there is some information in the clinical records alluding to Mr Denbigh-White's actions, but the information included is very limited. Also, two GI fillings were provided to Patient 12 in clinical situations that were not in accordance with the manufacturer's recommendations and the relevant FGDP guidelines, and there are no recorded justifications.

593. The Committee found that there was insufficient information in the clinical records to explain what Mr Denbigh-White did in terms of his care of Patient 12 and why.

594. The Committee found Mr Denbigh-White's record keeping in respect of his care and treatment of Patient 12 to be of an inadequate standard. The clinical records were brief with major omissions.

PATIENT 13

Charge 34(a)(i)

34. You failed to provide an adequate standard of care to Patient 13 [identified in Schedule A…], from 3 July 2013 to 16 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including -

i. Medical history

Found proved (on the basis that a medical history was not taken adequately).

595. The Committee was satisfied from the clinical records for Patient 13, that Mr Denbigh-White provided care and treatment to the patient over the period in question.

596. The Committee took into account that Mr Denbigh-White had a duty to take an up-to-date medical history from Patient 13 each time he treated the patient, in accordance with Standard 4.1.1 of the GDC Standards and the FGDP UK guidelines on Clinical Examination and Record Keeping.

597. The Committee had regard to Patient 13's clinical records. It found entries against Mr Denbigh-White's initials which indicated that he had updated the patient's medical notes regularly until April 2015. However, following an update to the patient's medical notes on 9 April 2015, the next update made by Mr Denbigh-White was in August 2019. This indicated to the Committee that there was an intervening period of over four years, during which Mr Denbigh-White did not update Patient 13's medical history in the clinical records. The Committee noted that the patient attended for treatment during that intervening period and therefore an update to the patient's medical history would have been required.

598. The Committee took into account the lack of information in the clinical records to indicate that a medical history was taken each time Mr Denbigh-White treated Patient 13. It also had regard to its previous findings above that Mr Denbigh-White had been less than comprehensive in taking and updating the medical histories of other patients. In all the circumstances, the Committee concluded that it was more likely than not that Mr Denbigh-White did not take an up to date medical history from Patient 13 each time he treated the patient.

599. The Committee considered that Mr Denbigh-White could not have obtained an up-to-date picture of Patient 13's medical health, not having updated the patient's medical history over a four and a half year period. It was therefore satisfied that he failed in his duty to provide the patient with an adequate standard of care.

Charge 34(a)(ii)

34. You failed to provide an adequate standard of care to Patient 13 [identified in Schedule A…], from 3 July 2013 to 16 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including -

ii. extra and intra oral examinations.

Found proved (on the basis that no extra oral examinations were undertaken and the intra oral examinations undertaken were not adequate).

600. The Committee had regard to Mr Denbigh-White's clinical records for Patient 13 and found no information to indicate that he undertook any extra oral examinations over the period in question. Whilst there was some information relating to intra-oral examinations, in that there were records to indicate that Mr Denbigh-White had looked in the patient's mouth and at aspects of the patient's teeth, the Committee found nothing to indicate that a full clinical examination had ever been undertaken. There was no recorded information to suggest that Mr Denbigh-White had examined Patient 13 extra-orally, for example, the TMJs

and lymph nodes, or to indicate that intra-orally he had examined the patient's soft tissues, for example, the tongue or floor of the mouth. The Committee noted that Dr Ward highlighted in her report the lack of information in the clinical records regarding extra and intra oral examinations of this patient.

601. The Committee took into account the limited nature of information in the clinical records relating to standard clinical examinations. It also took into account its previous findings above in relation to the same matters but concerning different patients, namely that no extra oral examinations were undertaken of those patients, and that the intra oral examinations carried out were inadequate.

602. In all the circumstances, the Committee was satisfied that it was more likely than not, that Mr Denbigh-White did not undertake any extra-oral examinations of Patient 13 over the period in question, and that the intra-oral examinations of the patient were inadequate. The Committee was also satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 13, given that such examinations are an integral part of assessment used to help dentists diagnose dental and oral diseases.

Charge 34(a)(iii)

34. You failed to provide an adequate standard of care to Patient 13 [identified in Schedule A…], from 3 July 2013 to 16 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including -

iii. additional special tests as appropriate.

Found proved (on the basis that additional special tests were not undertaken as appropriate).

603. The Committee considered Dr Ward's evidence regarding the requirement for special tests in the context of Patient 13's dental history, as documented within the clinical records. The Committee considered whether there were occasions when the patient presented with a complaint or condition that would have required Mr Denbigh-White to have undertaken any of the special tests referred to by Dr Ward, namely vitality tests, TTP testing and palpation.

604. The clinical records show that Patient 13 attended to see Mr Denbigh-White for a number of appointments, including for root canal treatment and the provision of a crown at UL6. The Committee noted that at appointments on 3 July 2013 and 26 June 2014, prior to the crowning of the UL6, Mr Denbigh-White noted on both occasions that the tooth was TTP. No other special tests are mentioned.

605. In accordance with Dr Ward's evidence, the Committee would have also expected to see reference in the clinical notes to Mr Denbigh-White having checked the vitality of UL6 before proceeding with the crown treatment. In the absence of any records to suggest that Mr Denbigh-White carried out special testing beyond percussion testing, the Committee was satisfied on the balance of probabilities that he did not carry out any additional special tests.

It was further satisfied on the expert evidence that he should have undertaken further investigations in this regard.

606. The Committee was satisfied that the limited nature of the special testing in relation to UL6 was a failure to provide Patient 13 with an adequate standard of care. In the absence of special tests as appropriate, Mr Denbigh-White could not have assessed whether the crown treatment he provided was appropriate in all the circumstances.

Charge 34(a)(iv)

34. You failed to provide an adequate standard of care to Patient 13 [identified in Schedule A…], from 3 July 2013 to 16 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including -

iv. BPE

Found proved (on the basis no BPEs were undertaken).

607. The Committee found nothing in the clinical records to indicate that Mr Denbigh-White had undertaken any BPEs of Patient 13 from 3 July 2013 to 16 August 2019. The lack of BPEs in the clinical records was a matter highlighted by Dr Ward in her report. The Committee noted that a BPE should be undertaken at initial examination and at each recall interval.

608. The Committee considered the evidence before it in relation to this allegation, as well as its previous findings made in relation to other patients, which indicate that Mr Denbigh-White's habitual practice was not to take BPEs. The Committee concluded on the balance of probabilities that Mr Denbigh-White did not undertake any BPEs of Patient 13 over the period in question. The Committee was satisfied that this represented a failure by Mr Denbigh-White to provide an adequate standard of care to the patient, in view of Dr Ward's opinion regarding the integral nature of BPEs to assessment, diagnosis and treatment.

Charge 34(a)(v)

34. You failed to provide an adequate standard of care to Patient 13 [identified in Schedule A…], from 3 July 2013 to 16 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including -

v. Bitewing radiographs

Found proved (on the basis that no bitewing radiographs were undertaken).

609. The Committee noted that there is reference in the clinical records for Patient 13 to a radiograph having been taken around the beginning of the period in question on 18 July 2013. However, there is no record of the type of radiograph.

610. Taking into account all the evidence, which indicates that it was not Mr Denbigh-White's usual practice to take bitewing radiographs, the Committee concluded, on the balance of probability, that the radiograph taken on 18 July 2013 was not a bitewing radiograph. In reaching its conclusion, the Committee also noted that at this appointment on 18 July 2013 Mr Denbigh-White commenced root canal treatment on the UL6. In the circumstances, the Committee considered it more likely that the radiograph in question was a periapical radiograph.

611. The Committee took into account that, if the relevant guidelines on radiography were being followed by Mr Denbigh-White, it would have expected to find several sets of radiographs in the patient's clinical records. The Committee noted that, even for patients at low risk of caries, bitewing radiographs are to be taken every two years.

612. Having had regard to all the evidence, the Committee was satisfied on the balance of probabilities that Mr Denbigh-White did not take any bitewing radiographs of Patient 13. The Committee was satisfied that Mr Denbigh-White's lack of radiographic screening amounted to a failure to provide an adequate standard of care to Patient 13. It accepted Dr Ward's opinion that the relevant guidelines should have been followed by Mr Denbigh-White to balance the safety of radiographic exposure against the benefits of its use.

Charge 34(a)(vi)(1)

34. You failed to provide an adequate standard of care to Patient 13 [identified in Schedule A…], from 3 July 2013 to 16 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including -

vi. Pre-treatment/periapical radiographs prior to

1. treatment to the UL6 on 18/7/13

Found not proved.

613. In view of its conclusion above, that it was more likely that the radiograph taken by Mr Denbigh-White on 18 July 2013 was a periapical radiograph taken prior to commencing root canal treatment on the UL6, the Committee found this allegation not proved.

Charge 34(a)(vi)(2)

34. You failed to provide an adequate standard of care to Patient 13 [identified in Schedule A…], from 3 July 2013 to 16 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including -

vi. Pre-treatment/periapical radiographs prior to

2. crowns on UL6 26/6/14 and/or 17/7/14

Found proved (on the basis that no pre-treatment/periapical radiographs were undertaken).

614. The Committee found nothing in the clinical records to indicate that Mr Denbigh-White took any other radiographs of Patient 13 during the entire period in question. In the absence of such information, and given Mr Denbigh-White's views on radiography, the Committee was satisfied that it was more likely than not that he did not take any pre-treatment/periapical radiographs on 26/6/14 and 17/7/14.

615. The Committee accepted the evidence of Dr Ward that such radiographs should have been taken in the circumstances. Her opinion was that there was inadequate assessment of the tooth prior to crowning. The Committee was satisfied on the evidence that not taking pre-treatment/periapical radiographs amounted to a failure to provide Patient 13 with an adequate standard of care.

Charge 34(a)(vi)(3)

34. You failed to provide an adequate standard of care to Patient 13 [identified in Schedule A…], from 3 July 2013 to 16 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including -

vi. Pre-treatment/periapical radiographs prior to

3. crowns to the UL5 between 21/12/17 – 17/1/18

Found proved (on the basis that no pre-treatment/periapical radiographs were undertaken).

616. The Committee found this allegation proved for the same reasons given in relation to head of charge 34(a)(vi)(2) above.

Charge 34(a)(vi)(4)

34. You failed to provide an adequate standard of care to Patient 13 [identified in Schedule A…], from 3 July 2013 to 16 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including -

vi. Pre-treatment/periapical radiographs prior to

4. crowns to the LR7 on 5/7/19 and/or 16/7/19

Found proved in relation to 16/7/19 (on the basis that no pre-treatment/periapical radiographs were undertaken).

617. The Committee found this allegation proved for the same reasons given in relation to head of charge 34(a)(vi)(2) above. The Committee noted that Patient 13's LR7 was prepared

for a crown on 16/7/19 and it was satisfied that pre-treatment/periapical radiographs should have been taken at that appointment.

Charge 34(b)

34. You failed to provide an adequate standard of care to Patient 13 [identified in Schedule A…], from 3 July 2013 to 16 August 2019 in that:

b. You did not adequately formulate and/or record formulation of treatment plans.

Found proved (on the basis that treatment plans were not adequately formulated).

618. The Committee had regard to the clinical records for Patient 13, and whilst it found that Mr Denbigh-White made records in relation to treatment that he proposed to carry out for the patient, the Committee found nothing within the clinical records that would constitute a treatment plan, as outlined in the relevant GDC Standards, and as described by Dr Ward.

619. The Committee took into account Dr Ward's evidence that "*Treatment planning follows full assessment and diagnosis and after the consideration of treatment options, discussion of risks and benefits of treatment, along with consideration of the order and timing of treatment".*

620. The Committee had regard to its findings above regarding the limited assessment of Patient 13 by Mr Denbigh-White, in terms of the insufficiency of radiographs, no BPEs having been undertaken and the limited special testing when appropriate. The Committee concluded that in the circumstances, Mr Denbigh-White would not have had all the relevant clinical information to adequately formulate treatment plans for the patient. The Committee was satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 13 by not providing the patient with clear plans in relation to their treatment, as required by the GDC Standards.

Charge 34(c)

34. You failed to provide an adequate standard of care to Patient 13 [identified in Schedule A…], from 3 July 2013 to 16 August 2019 in that:

c. You did not discuss and/or record discussion of treatment options

Found proved (on the basis that treatment options were not discussed).

621. The Committee took into account the absence of any information in Mr Denbigh-White's clinical records for Patient 13 regarding discussions with the patient about treatment options. It noted that Mr Denbigh-White provided treatment to a number of the patient's teeth during the period in question, including the provision of crowns. It appeared to the Committee on its reading of the clinical notes that on each occasion, Mr Denbigh-White simply advised the patient on the course of action he was going to take.

622. The Committee had regard to its findings made in respect of the treatment of other patients, which indicate that, generally, treatment options were not discussed. It also had regard to the evidence it received from some patients regarding Mr Denbigh-White not having spoken to them much or at all about their treatment. Further, the Committee took into account its findings that Mr Denbigh-White took only one radiograph of Patient 13 over the period in question, did not undertake any BPEs and only carried out limited special testing. The Committee also found that Mr Denbigh-White did not formulate any adequate treatment plans for the patient. Taking all these factors into account, the Committee concluded that it was more likely than not that Mr Denbigh-White did not discuss treatment options with Patient 13 over the period in question. It considered that it would have been difficult for him to have had any discussion about treatment options given the limited clinical information that would have been available to him on account of his omissions.

623. The Committee was satisfied that Mr Denbigh-White's omission to discuss treatment options with Patient 13 was a failure to provide an adequate standard of care, as such discussions are an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 34(d)

34. You failed to provide an adequate standard of care to Patient 13 [identified in Schedule A…], from 3 July 2013 to 16 August 2019 in that:

d. You did not discuss and/or record risks and/or benefits of proposed treatment.

Found proved *(on the basis that risks and benefits of proposed treatment were not discussed).*

624. The Committee found no information in Mr Denbigh-White's clinical records for Patient 13 regarding any discussions with the patient about the risks and benefits of proposed treatment. The Committee found this allegation proved for the same reasons outlined above in relation to the lack of discussion about treatment options.

625. The Committee was satisfied that Mr Denbigh-White did not discuss the risks and benefits of proposed treatment with Patient 13, and that his omission to do so was a failure to provide the patient with an adequate standard of care. Such discussions are an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 34(e)

34. You failed to provide an adequate standard of care to Patient 13 [identified in Schedule A…], from 3 July 2013 to 16 August 2019 in that:

e. You inappropriately prescribed antibiotics on 3/7/13.

Found not proved.

626. The Committee noted from the clinical records that the antibiotics prescribed to Patient 13 on 3/7/13 was in relation to UL6, which was noted to be TTP on examination and left on open drainage. Whilst the Committee noted the absence of any record to justify the prescribing of the antibiotics, it considered from the action taken by Mr Denbigh-White, in leaving the tooth on open drainage, implied that there was an infection.

627. The Committee took into account that the onus is upon the GDC to prove that the antibiotic prescription was inappropriate. It was not satisfied that the Council discharged its burden in relation to this head of charge. It therefore found it not proved.

Charge 34(f)(i)

34. You failed to provide an adequate standard of care to Patient 13 [identified in Schedule A…], from 3 July 2013 to 16 August 2019 in that:

f. You provided a poor standard of treatment in respect of

i. root canal treatment UL6 03/07/13 and/or 18/07/13

Found proved in relation to 03/7/13 and 18/07/13.

628. Dr Ward's evidence is that Mr Denbigh-White provided a poor standard of root canal treatment to Patient 13 on these dates. In providing her opinion, Dr Ward relied on the '*Quality guidelines for endodontic treatment: consensus report of the European Society of Endodontology, IEJ, 2006 or FGDP 2.10 endo'.* In particular, Dr Ward highlighted the following as areas of poor practice:

- Tooth left on open drainage, which she described as an antiquated technique.
- No rubber dam recorded.
- No working length recorded from radiograph or apex locator.
- Inappropriate use of endomethasone filling.

629. The Committee was satisfied on the basis of Dr Ward's opinion that this allegation is proved. It was also satisfied that by not carrying out root canal treatment to the recognised endodontic standard, Mr Denbigh-White failed to provide Patient 13 with an adequate standard of care.

Charge 34(f)(ii)

34. You failed to provide an adequate standard of care to Patient 13 [identified in Schedule A…], from 3 July 2013 to 16 August 2019 in that:

f. You provided a poor standard of treatment in respect of

ii. scaling

Found not proved.

630. The Committee noted that Dr Ward based her opinion of a poor standard of scaling on the presence of calculus seen on a radiograph taken by a subsequent treating dentist on 7 February 2020. Indeed, that subsequent treating dentist noted the presence of sub-gingival calculus. However, the Committee took into account that the observation of the calculus was some six months after Mr Denbigh-White had last seen Patient 13 on 6 August 2019. The Committee considered that six months is a significant period, during which the calculus in question could have built up on the patient's teeth.

631. The Committee considered that unless there was radiographic evidence of the extent of the calculus in August 2019, it was difficult to make an assessment as to the standard of the scaling provided by Mr Denbigh-White when he was treating the patient. The Committee was not satisfied that this allegation is proved.

Charge 34(f)(iii)

34. You failed to provide an adequate standard of care to Patient 13 [identified in Schedule A…], from 3 July 2013 to 16 August 2019 in that:

f. You provided a poor standard of treatment in respect of

iii. a crown to the LR7 fitted on 16 August 2019

Found not proved.

632. The Committee noted that Dr Ward regarded the provision of this crown to be a poor standard of treatment, as Mr Denbigh-White drilled through the surface when adjusting the occlusion. However, the Committee noted that in the clinical records, Mr Denbigh-White had recorded that he needed to re-do the crown. This indicated to the Committee that he recognised that there was a problem that needed to be addressed. It took into account that Patient 13 did not return to see Mr Denbigh-White again after 16 August 2019, and therefore there was no opportunity for him to re-do the crown as he had intended.

633. In the circumstances, the Committee was not satisfied that this head of charge is proved, given that the crown provided was not intended to be the final crown.

Charge 34(g)

34. You failed to provide an adequate standard of care to Patient 13 [identified in Schedule A…], from 3 July 2013 to 16 August 2019 in that:

g. You inappropriately used glass ionomer for fillings on the following teeth and dates:-

i. UR5 (5/1/17 and/or 29/6/17 and/or 17/10/18)

ii. LR7 (9/4/15 and/or 5/1/17 and/or 17/10/18)

34(g)(i) - Found not proved in relation 5/1/17 but found proved in relation to 29/6/17 and 17/10/18.

34(g)(ii) - Found proved in its entirety.

634. In reaching its findings, the Committee considered heads of charge 34(g)(i) and 34(g)(ii) separately.

635. In relation to UR5 on 5/1/17, the Committee could find no information in the clinical records to indicate that a GI filling was placed on this tooth on this date.

636. The Committee was satisfied from the clinical records that GI fillings were placed on the UR5 on the remaining dates listed in 34(g)(i), as well as on the LR7 on all the dates listed in 34(g)(ii).

637. The Committee noted that all of the GI fillings were placed on load bearing surfaces of the teeth, and it accepted the evidence of Dr Ward that this was inappropriate for the reasons outlined previously. The Committee found nothing in Mr Denbigh-White's notes to suggest that any of the GI fillings fell into the accepted circumstances referred to by Dr Ward, nor was there anything written by Mr Denbigh-White to justify his use of the material in clinical situations that were not in accordance with the manufacturer's recommendations and the relevant FGDP guidelines.

Charge 35

35. As a result of 34 (a) (vi) and/or (c) and/or (d) you failed to obtain informed consent for the treatment provided from 3 July 2013 to 16 August 2019.

Found proved in relation to 34(a)(vi)(2 to 4 only), 34(c) and 34(d).

638. The Committee's findings at 34(a)(vi)(2) to (4) are that Mr Denbigh-White did not take any pre-treatment/periapical radiographs prior to placing a number of crowns. The Committee accepted the evidence of Dr Ward that such radiographs were necessary, and by not having taken them, Mr Denbigh-White could not have been fully informed that he was providing appropriate treatment to the patient. Accordingly, he could not have fully informed Patient 13 and highlighted any treatment options, risks and/or benefits of proposed treatment.

639. The Committee found at 34(c) and 34(d) that Mr Denbigh-White did not discuss any alternative treatment options or risks and benefits of proposed treatment with Patient 13 over the period in question. The Committee had regard to the GDC Standards which relate to the issue of valid consent, as well as to the evidence of Dr Ward that discussions with patients about alternative treatment options and risks and benefits of proposed treatment are integral to patients being able to give informed consent.

640. Taking all the evidence into account, the Committee found this allegation at Charge 35 proved. It was satisfied on the balance of probabilities that Patient 13 could not have given informed consent for any of the treatment provided by Mr Denbigh-White from 3 July

2013 to 16 August 2019 if the patient was unaware of what alternative treatment options were available and the risks and benefits of any proposed treatment.

Charge 36

36. You failed to maintain an adequate standard of record keeping from 3 July 2013 to 16 August 2019.

Found proved.

641. The Committee took into account its findings that in most instances, Mr Denbigh-White did not undertake the relevant actions, and therefore he could not have recorded undertaking them. However, in relation to the undertaking of intra-oral examinations and treatment planning, the Committee noted that there is some information in the clinical records alluding to Mr Denbigh-White's actions, but the information included is very limited. This was also the case on the occasion that he prescribed Patient 13, antibiotics without recording his rationale for doing so. Also, a number of GI fillings were provided to Patient 13 in clinical situations that were not in accordance with the manufacturer's recommendations and the relevant FGDP guidelines, and there are no recorded justifications.

642. The Committee found that there was insufficient information in the clinical records to explain what Mr Denbigh-White did in terms of his care of Patient 13 and why.

643. The Committee found Mr Denbigh-White's record keeping in respect of his care and treatment of Patient 13 to be of an inadequate standard. The clinical records were brief with major omissions.

PATIENT 14

Charge 37(a)(i)

37. You failed to provide an adequate standard of care to Patient 14 [identified in Schedule A…], from 7 May 2015 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –-

i. Medical history

Found proved (on the basis that a medical history was not taken adequately).

644. The Committee was satisfied from the clinical records for Patient 14, that Mr Denbigh-White provided care and treatment to the patient over the period in question.

645. The Committee took into account that Mr Denbigh-White had a duty to take an up-to-date medical history from Patient 14 each time he treated the patient, in accordance with

Standard 4.1.1 of the GDC Standards and the *FGDP UK guidelines on Clinical Examination and Record Keeping*.

646. The Committee had regard to Patient 14's clinical records. It found entries against Mr Denbigh-White's initials which indicated that he had updated the patient's medical notes on one occasion in 2016, and on two occasions in 2019. The Committee noted the sporadic nature in which the patient's medical history was updated by Mr Denbigh-White, which included the lack of any updates during the three-year period between 2016 and 2019. The Committee noted that Patient 14 attended for treatment during that three-year period, which included the provision of fillings, and therefore an update to the patient's medical history would have been required.

647. The Committee took into account the lack of information in the clinical records to indicate that a medical history was taken each time Mr Denbigh-White treated Patient 14. It also had regard to its previous findings above that Mr Denbigh-White had been less than comprehensive in taking and updating the medical histories of other patients. In all the circumstances, the Committee concluded that it was more likely than not that Mr Denbigh-White did not take an up to date medical history from Patient 14 each time he treated the patient.

648. The Committee considered that Mr Denbigh-White could not have obtained an up-to-date picture of Patient 14's medical health, not having updated the patient's medical history over a three-year period. It was therefore satisfied that he failed in his duty to provide the patient with an adequate standard of care.

Charge 37(a)(ii)

37. You failed to provide an adequate standard of care to Patient 14 [identified in Schedule A…], from 7 May 2015 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –-

ii. extra and intra oral examinations

Found proved (on the basis that no extra oral examinations were undertaken and the intra oral examinations undertaken were not adequate).

649. The Committee had regard to Mr Denbigh-White's clinical records for Patient 14 and found no information to indicate that he undertook any extra oral examinations over the period in question. Whilst there was some information relating to intra-oral examinations, in that there were records to indicate that Mr Denbigh-White had looked in the patient's mouth and at aspects of the patient's teeth, the Committee found nothing to indicate that a full clinical examination had ever been undertaken. There was no recorded information to suggest that Mr Denbigh-White had examined Patient 14 extra-orally, for example, the TMJs and lymph nodes, or to indicate that intra-orally he had examined the patient's soft tissues,

for example, the tongue or floor of the mouth. The Committee noted that Dr Ward highlighted in her report the lack of information in the clinical records regarding extra and intra oral examinations of this patient.

650. The Committee took into account the limited nature of information in the clinical records relating to standard clinical examinations. It also took into account its previous findings above in relation to the same matters but concerning different patients, namely that no extra oral examinations were undertaken of those patients, and that the intra oral examinations carried out were inadequate.

651. In all the circumstances, the Committee was satisfied that it was more likely than not, that Mr Denbigh-White did not undertake any extra-oral examinations of Patient 14 over the period in question, and that the intra-oral examinations of the patient were inadequate. The Committee was also satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 14, given that such examinations are an integral part of assessment used to help dentists diagnose dental and oral diseases.

Charge 37(a)(iii)

37. You failed to provide an adequate standard of care to Patient 14 [identified in Schedule A…], from 7 May 2015 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –-

iii. additional special tests as appropriate

Found proved (on the basis that additional special tests were not undertaken as appropriate).

652. The Committee considered Dr Ward's evidence regarding the requirement for special tests in the context of Patient 14's dental history, as documented within the clinical records. The Committee considered whether there were occasions when the patient presented with a complaint or condition that would have required Mr Denbigh-White to have undertaken any of the special tests referred to by Dr Ward, namely vitality tests, TTP testing and palpation.

653. The clinical records show that Patient 14 attended to see Mr Denbigh-White for a number of appointments, including in relation to repeated problems with the LL6 and LL7. Dr Ward indicated in her report that she would have expected special tests to have been undertaken, as part of investigations in relation to these teeth.

654. The Committee accepted the evidence of Dr Ward. It found no information included in Mr Denbigh-White's clinical records for Patient 14 to suggest that he carried out any special testing in respect of the patient. In the absence of such records, the Committee was satisfied that Mr Denbigh-White did not carry out special testing as appropriate.

655. The Committee was satisfied on the evidence that the lack of special testing was a failure to provide Patient 14 with an adequate standard of care. In the absence of special tests as appropriate, Mr Denbigh-White could not have assessed whether the treatment he provided to Patient 14's LL6 and LL7 was appropriate in all the circumstances.

Charge 37(a)(iv)

37. You failed to provide an adequate standard of care to Patient 14 [identified in Schedule A…], from 7 May 2015 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –-

iv. BPE

Found proved (on the basis that BPEs were not undertaken adequately).

656. The Committee noted that a BPE should be undertaken at initial examination and at each recall interval. It found only one BPE in the clinical records for Patient 14, which was undertaken by Mr Denbigh-White on 6 August 2019.

657. The Committee considered the evidence before it in relation to this allegation, as well as its previous findings made in relation to other patients, which indicate that Mr Denbigh-White's habitual practice was not to take BPEs. The Committee concluded on the balance of probabilities that Mr Denbigh-White did not undertake any other BPEs of Patient 14 over the four-year period in question. The Committee was satisfied that this represented a failure by Mr Denbigh-White to provide an adequate standard of care to the patient, in view of Dr Ward's opinion regarding the integral nature of BPEs to assessment, diagnosis and treatment.

Charge 37(a)(v)

37. You failed to provide an adequate standard of care to Patient 14 [identified in Schedule A…], from 7 May 2015 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –-

v. Periodontal assessment

Found not proved.

658. The Committee noted that Dr Ward's opinion that Mr Denbigh-White should have undertaken a periodontal assessment of Patient 14, is based on the clinical findings from a radiograph taken by a subsequent treating dentist on 12 July 2021. However, the Committee took into account that the radiograph was taken almost two years after the patient last saw Mr Denbigh-White which, in its view, is a significant period of time. The Committee noted that Dr Ward does not comment on this intervening time period. It also took into account that

the BPE undertaken of Patient 14 by Mr Denbigh-White on 6 August 2019 recorded BPE scores of 1 and 2, which would not usually necessitate a periodontal assessment.

659. Having considered the evidence, the Committee was not satisfied that this allegation is proved to the requisite standard.

Charge 37(a)(vi)

37. You failed to provide an adequate standard of care to Patient 14 [identified in Schedule A…], from 7 May 2015 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –-

vi. Bitewing radiographs

Found proved (on the basis that no bitewing radiographs were undertaken).

660. The Committee found no bitewing radiographs within the clinical records of Patient 14 for the relevant period 7 May 2015 to 6 August 2019.

661. The Committee had regard to the evidence of Mr Krzeminski regarding Mr Denbigh-White stating that he did not routinely take radiographs of his patients because of the risk posed by radiation.

662. Having had regard to the evidence, the Committee was satisfied on the balance of probabilities that Mr Denbigh-White did not take any radiographs of Patient 14 during the time period in question. The Committee was also satisfied that Mr Denbigh-White's omission to take any radiographs of the patient amounted to a failure to provide an adequate standard of care for the same reasons previously stated.

Charge 37(b)

37. You failed to provide an adequate standard of care to Patient 14 [identified in Schedule A…], from 7 May 2015 to 6 August 2019 in that:

b. You did not adequately formulate and/or record formulation of treatment plans.

Found proved (on the basis that treatment plans were not adequately formulated).

663. The Committee had regard to the clinical records for Patient 14, and whilst it found that Mr Denbigh-White made records in relation to treatment that he proposed to carry out

for the patient, the Committee found nothing within the clinical records that would constitute a treatment plan, as outlined in the relevant GDC Standards, and as described by Dr Ward.

664. The Committee took into account Dr Ward's evidence that "*Treatment planning follows full assessment and diagnosis and after the consideration of treatment options, discussion of risks and benefits of treatment, along with consideration of the order and timing of treatment".*

665. The Committee had regard to its findings above regarding the limited assessment of Patient 14 by Mr Denbigh-White, in terms of the lack of bitewing radiographs, only one BPE having been undertaken in almost four years, and the absence of special testing when appropriate. The Committee concluded that in the circumstances, Mr Denbigh-White would not have had all the relevant clinical information to adequately formulate treatment plans for the patient. In the Committee's view, Mr Denbigh-White was just treating Patient 14's dental concerns as and when they arose, rather than looking at the patient's treatment as a whole.

666. The Committee was satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 14 by not providing the patient with clear plans in relation to their treatment, as required by the GDC Standards.

Charge 37(c)

37. You failed to provide an adequate standard of care to Patient 14 [identified in Schedule A…], from 7 May 2015 to 6 August 2019 in that:

c. You did not discuss and/or record discussion of treatment options.

Found proved (on the basis that treatment options were not discussed).

667. The Committee took into account the absence of any information in Mr Denbigh-White's clinical records for Patient 14 regarding discussions with the patient about treatment options. It noted that Mr Denbigh-White provided treatment to a number of the patient's teeth during the period in question, including the provision of a gold inlay and GI fillings. It appeared to the Committee on its reading of the clinical notes that on each occasion, Mr Denbigh-White simply advised the patient on the course of action he was going to take.

668. The Committee had regard to its findings made in respect of the treatment of other patients, which indicate that, generally, treatment options were not discussed. It also had regard to the evidence it received from some patients regarding Mr Denbigh-White not having spoken to them much or at all about their treatment. Further, the Committee took into account its findings that Mr Denbigh-White did not take any bitewing radiographs of Patient 14 over the period in question, only undertook one BPE and did not undertake special testing as appropriate. The Committee also found that Mr Denbigh-White did not formulate any adequate treatment plans for the patient. Taking all these factors into account, the Committee concluded that it was more likely than not that Mr Denbigh-White did not discuss treatment options with Patient 14 over the period in question. It considered that it would have

been difficult for him to have had any discussion about treatment options given the limited clinical information that would have been available to him on account of his omissions.

669. The Committee was satisfied that Mr Denbigh-White's omission to discuss treatment options with Patient 14 was a failure to provide an adequate standard of care, as such discussions are an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 37(d)

37. You failed to provide an adequate standard of care to Patient 14 [identified in Schedule A…], from 7 May 2015 to 6 August 2019 in that:

d. You did not discuss and/or record risks and/or benefits of proposed treatment.

Found proved (on the basis that risks and benefits of proposed treatment were not discussed).

670. The Committee found no information in Mr Denbigh-White's clinical records for Patient 14 regarding any discussions with the patient about the risks and benefits of proposed treatment. The Committee found this allegation proved for the same reasons outlined above in relation to the lack of discussion about treatment options.

671. The Committee was satisfied that Mr Denbigh-White did not discuss the risks and benefits of proposed treatment with Patient 14, and that his omission to do so was a failure to provide the patient with an adequate standard of care. Such discussions are an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 37(e)

37. You failed to provide an adequate standard of care to Patient 14 [identified in Schedule A…], from 7 May 2015 to 6 August 2019 in that:

e. You inappropriately used glass ionomer for fillings on the following teeth and dates:

i. LL6 (12/5/15 and/or 6/8/19)

ii. LL7 (6/8/19)

iii. LR6 (12/5/15 and/or 11/7/19)

Found proved in its entirety.

672. In making its findings, the Committee considered heads of charge 37(e)(i) to (iii) separately.

673. The Committee was satisfied that all the fillings in question were placed on load bearing surfaces of the teeth, and the Committee accepted the evidence of Dr Ward that

this was inappropriate. The Committee found nothing in Mr Denbigh-White's notes to suggest that any of the GI fillings fell into the accepted circumstances referred to by Dr Ward, nor was there anything written by Mr Denbigh-White to justify his use of the material in clinical situations that were not in accordance with the manufacturer's recommendations and the relevant FGDP guidelines.

Charge 37(f)

37. You failed to provide an adequate standard of care to Patient 14 [identified in Schedule A…], from 7 May 2015 to 6 August 2019 in that:

f. You provided an inadequate standard of treatment in respect of the restorations to the LL6 and/or LL7.

Found proved.

674. In finding this allegation proved, the Committee took into account its findings at 37(e)(i) to (iii) above regarding Mr Denbigh-White's inappropriate use of GI fillings in these teeth. It also had regard to the clinical findings of the subsequent treating dentist of Patient 14 in July 2021. That dentist noted from the bitewing radiographs taken on 12 July 2021 that both the LL6 and LL7 had *"failing GIC's with large open contact and defective margins".*

675. The Committee also took into account Dr Ward's assessment of the radiographic evidence as outlined in her report. It was her opinion that Patient 14's LL6 and LL7 had been restored to a poor standard by Mr Denbigh-White and she stated that *"LL6 poorly shaped restoration with no contact area distally to prevent food packing"* and *"LL7 poorly shaped with open contact area and a defect between the tooth and restoration".*

676. The Committee was satisfied on the evidence presented to it, that this head of charge is proved on the balance of probabilities. It was satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 14 in all the circumstances.

Charge 38

38. As a result of 37 (c) and/or (d) you failed to obtain informed consent for the treatment provided from 7 May 2015 to 6 August 2019.

Found proved in relation to heads of charge 37(c) and 37(d).

677. The Committee found at 37(c) and 37(d) that Mr Denbigh-White did not discuss any alternative treatment options or risks and benefits of proposed treatment with Patient 17 over the period in question. The Committee had regard to the GDC Standards which relate to the issue of valid consent, as well as to the evidence of Dr Ward that discussions with patients about alternative treatment options and risks and benefits of proposed treatment are integral to patients being able to give informed consent.

678. Taking all the evidence into account, the Committee found this allegation at Charge 38 proved. It was satisfied on the balance of probabilities that Patient 14 could not have given informed consent for any of the treatment provided by Mr Denbigh-White from 7 May 2015 to 6 August 2019 if the patient was unaware of what alternative treatment options were available and the risks and benefits of any proposed treatment.

Charge 39

39. You failed to maintain an adequate standard of record keeping from 7 May 2015 to 6 August 2019

Found proved.

679. The Committee took into account its findings that in most instances, Mr Denbigh-White did not undertake the relevant actions, and therefore he could not have recorded undertaking them. However, in relation to the undertaking of intra-oral examinations and treatment planning, the Committee noted that there is some information in the clinical records alluding to Mr Denbigh-White's actions, but the information included is very limited. Also, a number GI fillings were provided to Patient 12 in clinical situations that were not in accordance with the manufacturer's recommendations and the relevant FGDP guidelines, and there are no recorded justifications.

680. The Committee found that there was insufficient information in the clinical records to explain what Mr Denbigh-White did in terms of his care of Patient 14 and why.

681. The Committee found Mr Denbigh-White's record keeping in respect of his care and treatment of Patient 14 to be of an inadequate standard. The clinical records were brief with major omissions.

PATIENT 16

Charge 40(a)(i)

40. You failed to provide an adequate standard of care to Patient 16 (identified in Schedule A…), from 9 January 2014 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –-

i. Medical history

Found proved (on the basis that a medical history was not taken adequately).

682. The Committee was satisfied from the clinical records for Patient 16, that Mr Denbigh-White provided care and treatment to the patient over the period in question.

683. The Committee took into account that Mr Denbigh-White had a duty to take an up-to-date medical history from Patient 16 each time he treated the patient, in accordance with

Standard 4.1.1 of the GDC Standards and the *FGDP UK guidelines on Clinical Examination and Record Keeping*.

684. The Committee had regard to Patient 16's clinical records. It found entries against Mr Denbigh-White's initials which indicated that he had updated the patient's medical notes on a number of occasions in 2014, once in 2015 and then the next occasion after that was an update in 2019. The Committee noted that between the updates in 2015 and 2019 there was an intervening period of approximately three years and seven months. There was no indication that Mr Denbigh-White updated Patient 16's medical history in the clinical records during this period. The Committee noted that the patient attended for treatment during that intervening period and therefore an update to the patient's medical history would have been required.

685. The Committee took into account the lack of information in the clinical records to indicate that a medical history was taken each time Mr Denbigh-White treated Patient 16. It also had regard to its previous findings above that Mr Denbigh-White had been less than comprehensive in taking and updating the medical histories of other patients. In all the circumstances, the Committee concluded that it was more likely than not that Mr Denbigh-White did not take an up to date medical history from Patient 16 each time he treated the patient.

686. The Committee considered that Mr Denbigh-White could not have obtained an up-to-date picture of Patient 16's medical health, not having updated the patient's medical history in over three years. It was therefore satisfied that he failed in his duty to provide the patient with an adequate standard of care.

Charge 40(a)(ii)

40. You failed to provide an adequate standard of care to Patient 16 (identified in Schedule A…), from 9 January 2014 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –-

ii. extra and intra oral examinations.

Found proved (on the basis that no extra oral examinations were undertaken and the intra oral examinations undertaken were not adequate).

687. The Committee had regard to Mr Denbigh-White's clinical records for Patient 16 and found no information to indicate that he undertook any extra oral examinations over the period in question. Whilst there was some information relating to intra-oral examinations, in that there were records to indicate that Mr Denbigh-White had looked in the patient's mouth and at aspects of the patient's teeth, the Committee found nothing to indicate that a full clinical examination had ever been undertaken. There was no recorded information to suggest that Mr Denbigh-White had examined Patient 16 extra-orally, for example, the TMJs

and lymph nodes, or to indicate that intra-orally he had examined the patient's soft tissues, for example, the tongue or floor of the mouth. The Committee noted that Dr Ward highlighted in her report the lack of information in the clinical records regarding extra and intra oral examinations of this patient.

688. The Committee took into account the limited nature of information in the clinical records relating to standard clinical examinations. It also took into account its previous findings above in relation to the same matters but concerning different patients, namely that no extra oral examinations were undertaken of those patients, and that the intra oral examinations carried out were inadequate.

689. In all the circumstances, the Committee was satisfied that it was more likely than not, that Mr Denbigh-White did not undertake any extra-oral examinations of Patient 16 over the period in question, and that the intra-oral examinations of the patient were inadequate. The Committee was also satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 16, given that such examinations are an integral part of assessment used to help dentists diagnose dental and oral diseases.

Charge 40(a)(iii)

40. You failed to provide an adequate standard of care to Patient 16 (identified in Schedule A…), from 9 January 2014 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –-

iii. additional special tests as appropriate.

Found proved (on the basis that additional special tests were not undertaken as appropriate).

690. The Committee considered Dr Ward's evidence regarding the requirement for special tests in the context of Patient 16's dental history, as documented within the clinical records. The Committee considered whether there were occasions when the patient presented with a complaint or condition that would have required Mr Denbigh-White to have undertaken any of the special tests referred to by Dr Ward, namely vitality tests, TTP testing and palpation.

691. The clinical records show that Patient 16 attended to see Mr Denbigh-White for a number of appointments, including appointments on 1 February 2016 and 18 August 2016, when the patient had issues with LR7 and LR8. Whilst Mr Denbigh-White noted on 1 February 2017 that the LR7 was TTP, Dr Ward highlighted the absence of any diagnoses in the clinical records for either tooth. It was her opinion that additional special tests should have been carried out in relation to the LR7 and special tests in relation to the LR8 performed to establish the cause of the patient's pain. The clinical records show that at both appointments, Mr Denbigh-White prescribed antibiotics.

692. The Committee accepted the evidence of Dr Ward. It found no information included in Mr Denbigh-White's clinical records for Patient 16 to suggest that he carried out any special testing beyond percussion testing. In the absence of such records, the Committee was satisfied that Mr Denbigh-White did not carry out any additional special testing.

693. The Committee was satisfied on the evidence that the lack of special testing was a failure to provide Patient 16 with an adequate standard of care. In the absence of special tests as appropriate, Mr Denbigh-White could not have assessed whether the treatment he provided to Patient 16 was appropriate in all the circumstances.

Charge 40(a)(iv)

40. You failed to provide an adequate standard of care to Patient 16 (identified in Schedule A…), from 9 January 2014 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –-

iv. BPE.

Found proved (on the basis that BPEs were not undertaken adequately).

694. The Committee noted that a BPE should be undertaken at initial examination and at each recall interval. It found only one BPE in the clinical records for Patient 16, which was undertaken by Mr Denbigh-White on 9 January 2014.

695. The Committee considered the evidence before it in relation to this allegation, as well as its previous findings made in relation to other patients, which indicate that Mr Denbigh-White's habitual practice was not to take BPEs. The Committee concluded on the balance of probabilities that Mr Denbigh-White did not undertake any other BPEs of Patient 16 over the five-year period in question. The Committee was satisfied that this represented a failure by Mr Denbigh-White to provide an adequate standard of care to the patient, in view of Dr Ward's opinion regarding the integral nature of BPEs to assessment, diagnosis and treatment.

Charge 40(a)(v)

40. You failed to provide an adequate standard of care to Patient 16 (identified in Schedule A…), from 9 January 2014 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –-

v. Periodontal assessment

Found proved (on the basis no that no periodontal assessment was undertaken).

696. The Committee noted from the BPE undertaken of Patient 16 on 4 January 2014 that Mr Denbigh-White recorded BPE scores of 3 in each sextant. It noted that Dr Ward stated in her report that "This patient was seen on a regular basis. BPE codes of 3 were recorded 09/01/14 however this was not followed up with further periodontal assessment…". It was her opinion on the basis of Mr Denbigh-White's clinical records, that he failed to carry out a periodontal assessment for Patient 16.

697. The Committee, having had regard to the clinical records, found nothing to suggest that Mr Denbigh-White had carried out a full periodontal assessment as described by Dr Ward. It therefore concluded that it was more likely than not that Mr Denbigh-White did not carry out a full periodontal assessment, or further periodontal investigation of any sort, in response to Patient 16's BPE, which he should have done. The Committee was satisfied that this represented a failure to provide Patient 16 with an adequate standard of care, given the importance of such an assessment to diagnosing dental disease.

Charge 40(a)(vi)

40. You failed to provide an adequate standard of care to Patient 16 (identified in Schedule A…), from 9 January 2014 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –-

vi. Bitewing radiographs

Found proved (on the basis that bitewing radiographs were not taken at appropriate intervals).

698. The Committee noted that there is reference in the clinical records for Patient 16 to an x-ray having been taken of the patient at the first appointment with Mr Denbigh-White on 9 January 2014. However, there is no indication in the notes to the type of x-ray. Nonetheless, the Committee considered it possible that this could have been a bitewing radiograph as part of a standard examination, as there is no information in the records to suggest that the patient had any complaints at that time.

699. Notwithstanding this, the Committee took into account that, if the relevant guidelines on radiography were being followed by Mr Denbigh-White, it would have expected to find several sets of bitewing radiographs in the patient's clinical records. The Committee noted that, even for patients at low risk of caries, bitewing radiographs are to be taken every two years. The Committee noted the evidence regarding Mr Denbigh-White's admission to an NHSE dental adviser that he did not routinely take radiographs of his patients because of the risk posed from the radiation.

700. Having had regard to all the evidence, the Committee was satisfied on the balance of probabilities that Mr Denbigh-White did not take bitewing radiographs of Patient 16 at appropriate intervals during the time period in question. The Committee was satisfied that

Mr Denbigh-White's lack of adequate radiographic screening amounted to a failure to provide an adequate standard of care to Patient 16. It accepted Dr Ward's opinion that the relevant guidelines should have been followed by Mr Denbigh-White to balance the safety of radiographic exposure against the benefits of its use.

Charge 40(a)(vii)(1)

40. You failed to provide an adequate standard of care to Patient 16 (identified in Schedule A…), from 9 January 2014 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –-

vii. Pre-treatment/periapical radiographs

1. to aid diagnosis in respect of the LR8 and/or LR7 on 01/02/16 and/or

15/06/16 and/or 20/06/16 and/or 18/08/16.

Found proved (on the basis that no pre-treatment/periapical radiographs were taken).

701. The Committee noted from the clinical records that Patient 16 was experiencing pain in LR7 and LR8 and attended appointments with Mr Denbigh-White on the various dates in question. It accepted the opinion of Dr Ward that radiographic examination should have formed part of Mr Denbigh-White's assessment of these teeth to reach a definitive diagnosis.

702. The Committee found no information within the clinical notes to indicate that Mr Denbigh-White took any pre-treatment/periapical radiographs of Patient 16. It was satisfied on the evidence, including Mr Denbigh-White's stated views on radiography, that he did not take any such radiographs. The Committee was also satisfied that by not doing so, Mr Denbigh-White failed to provide an adequate standard of care to Patient 16. It noted Dr Ward's conclusion that *"This is an example of very poor planning as a consequence of lack of assessment, special tests and radiographic examination".*

Charge 40(a)(vii)(2)

40. You failed to provide an adequate standard of care to Patient 16 (identified in Schedule A…), from 9 January 2014 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pre-treatment investigations, including –-

vii. Pre-treatment/periapical radiographs

2. before extraction of LR7 on 5/9/16.

Found proved (on the basis that no pre-treatment/periapical radiographs were taken).

703. The information included in the clinical records suggested to the Committee that Mr Denbigh-White was uncertain about which tooth, the LR7 or LR8, was causing an issue for Patient 16. It noted that in respect of the appointment on 1 February 2016, Mr Denbigh-White recorded *"pain ttp lr 7"* and prescribed antibiotics. At a subsequent appointment on 15 June 2016, Mr Denbigh-White recorded *"lr infection again…advised ext lr 8".* The Committee noted Dr Ward's comment about the absence of a definitive diagnosis in the clinical records, which she attributed to inadequate assessment, including a lack of radiographic examination.

704. The Committee was satisfied that in the circumstances, Mr Denbigh-White should have taken pre-treatment/periapical radiographs prior to extracting the patient's LR7. It considered that by not doing so, he failed to provide Patient 16 with an adequate standard of care. In the absence of such a radiograph, he did not have the relevant clinical information to assess whether extraction of the LR7 was an appropriate treatment option.

Charge 40(b)

40. You failed to provide an adequate standard of care to Patient 16 (identified in Schedule A…), from 9 January 2014 to 6 August 2019 in that:

b. You did not adequately formulate and/or record formulation of treatment plans.

Found proved (on the basis that treatment plans were not adequately formulated).

705. The Committee had regard to the clinical records for Patient 16, and whilst it found that Mr Denbigh-White made records in relation to treatment that he proposed to carry out for the patient, the Committee found nothing within the clinical records that would constitute a treatment plan, as outlined in the relevant GDC Standards, and as described by Dr Ward.

706. The Committee took into account Dr Ward's evidence that "*Treatment planning follows full assessment and diagnosis and after the consideration of treatment options, discussion of risks and benefits of treatment, along with consideration of the order and timing of treatment".*

707. The Committee had regard to its findings above regarding the limited assessment of Patient 16 by Mr Denbigh-White, in terms of the insufficiency of radiographs, only one BPE having been undertaken over the entire period in question, insufficient special testing where appropriate, and no periodontal assessment. The Committee concluded that in the

circumstances, Mr Denbigh-White would not have had all the relevant clinical information to adequately formulate treatment plans for the patient. The Committee was satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 16 by not providing the patient with clear plans in relation to their treatment, as required by the GDC Standards.

Charge 40(c)

40. You failed to provide an adequate standard of care to Patient 16 (identified in Schedule A…), from 9 January 2014 to 6 August 2019 in that:

c. You did not diagnose and/or appropriately treat periodontitis.

Found proved (on the basis that periodontitis was not diagnosed).

708. The Committee noted Dr Ward's evidence that Mr Denbigh-White did not diagnose, and therefore did not treat, Patient 16's periodontitis. In her report, Dr Ward drew the Committee's attention to the diagnosis made by the patient's subsequent treating dentist, following a BPE undertaken on 1 June 2021. The BPE indicated scores of 4 in all sextants and a diagnosis of unstable advanced generalised periodontitis was recorded.

709. In accepting Dr Ward's opinion, the Committee noted that Mr Denbigh-White recorded BPE scores of 3 for Patient 16 on 9 January 2014, which was at the beginning of this period in question. However, he did not follow up the BPE with any further periodontal investigation or conduct a full periodontal assessment. There is no diagnosis of periodontitis in the clinical notes made by Mr Denbigh-White. The Committee was satisfied, given the BPE scores of 3 as far back as 2014, and the extent of the disease recorded by the subsequent treating dentist in 2021, the patient was suffering from periodontitis during the period that Mr Denbigh-White was providing the patient with treatment.

710. In all the circumstances, the Committee was satisfied that this allegation is proved on the basis that Mr Denbigh-White did not diagnose Patient 16's periodontitis. In the absence of a diagnosis, he could not have provided appropriate treatment to the patient. Indeed, the Committee found nothing in the clinical records made by Mr Denbigh-White to suggest that the patient was treated for periodontitis. The Committee was satisfied that this represented a failure to provide Patient 16 with an adequate standard of care.

Charge 40(d)

40. You failed to provide an adequate standard of care to Patient 16 (identified in Schedule A…), from 9 January 2014 to 6 August 2019 in that:

d. You did not discuss and/or record discussion of treatment options.

Found proved (on the basis that treatment options were not discussed).

711. The Committee took into account the absence of any information in Mr Denbigh-White's clinical records for Patient 16 regarding discussions with the patient about treatment options. It noted that Mr Denbigh-White provided treatment to a number of the patient's teeth

during the period in question, including the provision of GI fillings. It appeared to the Committee on its reading of the clinical notes that on each occasion, Mr Denbigh-White simply advised the patient on the course of action he was going to take.

712. The Committee had regard to its findings made in respect of the treatment of other patients, which indicate that, generally, treatment options were not discussed. It also had regard to the evidence it received from some patients regarding Mr Denbigh-White not having spoken to them much or at all about their treatment. Further, the Committee took into account its findings that Mr Denbigh-White took only one radiograph of Patient 16 over the period in question, did not undertake additional special testing as appropriate, and did not diagnose the patient's periodontitis. The Committee also found that Mr Denbigh-White did not formulate any adequate treatment plans for the patient. Taking all these factors into account, the Committee concluded that it was more likely than not that Mr Denbigh-White did not discuss treatment options with Patient 16 over the period in question. It considered that it would have been difficult for him to have had any discussion about treatment options given the limited clinical information that would have been available to him on account of his omissions.

713. The Committee was satisfied that Mr Denbigh-White's omission to discuss treatment options with Patient 16 was a failure to provide an adequate standard of care, as such discussions are an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 40(e)

40. You failed to provide an adequate standard of care to Patient 16 (identified in Schedule A…), from 9 January 2014 to 6 August 2019 in that:

e. You did not discuss and/or record discussion of treatment options.

Found proved *(on the basis that risks and benefits of proposed treatment were not discussed).*

714. The Committee found no information in Mr Denbigh-White's clinical records for Patient 16 regarding any discussions with the patient about the risks and benefits of proposed treatment. The Committee found this allegation proved for the same reasons outlined above in relation to the lack of discussion about treatment options.

715. The Committee was satisfied that Mr Denbigh-White did not discuss the risks and benefits of proposed treatment with Patient 16, and that his omission to do so was a failure to provide the patient with an adequate standard of care. Such discussions are an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 40(f)

40. You failed to provide an adequate standard of care to Patient 16 (identified in Schedule A…), from 9 January 2014 to 6 August 2019 in that:

f. You inappropriately prescribed antibiotics on 1/2/16 and/or 15/6/16 and/or 18/8/16.

Found proved in relation to all dates.

716. The Committee was satisfied from the clinical records that Mr Denbigh-White prescribed antibiotics to Patient 16 on the dates in question.

717. The opinion of Dr Ward, which the Committee accepted, was based on the FGDP guidelines on 'Antimicrobial Prescribing for General Dental Practitioners'. She told the Committee in her oral evidence that antibiotics should only be prescribed when there is evidence of infection, such as systemic illness and diffuse swelling, and that where appropriate, local treatment measures should be undertaken first.

718. The Committee noted the absence of any reference to swelling or systemic involvement in the clinical records for these appointments, or any information to suggest that Mr Denbigh-White had undertaken any local measures. The Committee noted in relation to the appointment of 1 February 2016 in particular, that Mr Denbigh-White seemed uncertain as to the cause of Patient 16's pain at LR7, noting in the records *"?abscess".* The Committee considered that in the absence of information indicating proper justifications, all the prescriptions for antibiotics were inappropriate. It was satisfied that prescribing antibiotics contrary to the guidelines was a failure to provide Patient 16 with an adequate standard of care.

Charge 40(g)

40. You failed to provide an adequate standard of care to Patient 16 (identified in Schedule A…), from 9 January 2014 to 6 August 2019 in that:

g. You inappropriately used glass ionomer for fillings on the following teeth and dates:

i. UL8 (11/6/15 and/or 5/6/18)

ii. UL7 (5/6/18)

iii. LL6 (3/4/14 and/or ~~6/4/14~~) ***6/4/17) (as amended).***

Found proved in its entirety.

719. In making its findings, the Committee considered heads of charge 40(g)(i) to (iii) separately.

720. Prior to making its finding in respect of 40(g)(iii), the Committee amended the second date in this allegation from 6/4/14 to 6/4/17, which is the correct date of the appointment as noted in the clinical records. The Committee was satisfied that it had the power to make this

amendment pursuant to Rule 18 of the Rules. It was further satisfied that no injustice would be caused by the change of date, which is clearly reflected in the evidence. The Committee considered that the original date of 6/4/14 was simply a typographical error.

721. The Committee was satisfied that all the fillings in question were placed on load bearing surfaces of the teeth, and the Committee accepted the evidence of Dr Ward that this was inappropriate. The Committee found nothing in Mr Denbigh-White's notes to suggest that any of the GI fillings fell into the accepted circumstances referred to by Dr Ward, nor was there anything written by Mr Denbigh-White to justify his use of the material in clinical situations that were not in accordance with the manufacturer's recommendations and the relevant FGDP guidelines.

Charge 40(h)

40. You failed to provide an adequate standard of care to Patient 16 (identified in Schedule A…), from 9 January 2014 to 6 August 2019 in that:

h. You provided an inadequate standard of treatment in respect of scaling.

Found not proved.

722. The Committee noted that Dr Ward based her opinion of a poor standard of scaling on the presence of calculus seen on a radiograph taken by a subsequent treating dentist on 1 June 2021. However, the Committee took into account that this observation of the calculus was almost two years after Mr Denbigh-White had last seen Patient 16 on 6 August 2019. The Committee considered this to be a significant period time, during which the calculus in question could have built up on the patient's teeth.

723. The Committee considered that unless there was radiographic evidence of the extent of the calculus in August 2019, it was difficult to make an assessment as to the standard of the scaling provided by Mr Denbigh-White when he was treating the patient. The Committee was not satisfied this allegation is proved.

Charge 41

41. As a result of 40 (a) (vii) and/or (d) and/or (e) you failed to obtain informed consent for the treatment Patient 16 provided 9 January 2014 to 6 August 2019

Found proved in relation to 40(a)(vii), 40(d) and 40(e).

724. The Committee's findings at 40(a)(vii) are that Mr Denbigh-White did not take any pre-treatment/periapical radiographs to aid diagnosis in respect of Patient 16's LR7 and LR8 or prior to the extraction of LR7. The Committee accepted the evidence of Dr Ward that such radiographs were necessary, and by not having taken them, Mr Denbigh-White was not able to assess whether he was providing appropriate treatment to the patient. Accordingly, he

could not have fully informed Patient 16 and highlighted any treatment options, risks and/or benefits of proposed treatment.

725. The Committee found at 40(d) and 40(e) that Mr Denbigh-White did not discuss any alternative treatment options or risks and benefits of proposed treatment with Patient 16 over the period in question. The Committee had regard to the GDC Standards which relate to the issue of valid consent, as well as to the evidence of Dr Ward that discussions with patients about alternative treatment options and risks and benefits of proposed treatment are integral to patients being able to give informed consent.

726. Taking all the evidence into account, the Committee found this allegation at Charge 41 proved. It was satisfied on the balance of probabilities that Patient 16 could not have given informed consent for any of the treatment provided by Mr Denbigh-White from 9 January 2014 to 6 August 2019 if the patient was unaware of what alternative treatment options were available and the risks and benefits of any proposed treatment.

Charge 42

42. You failed to maintain an adequate standard of record keeping from 9 January 2014 to 6 August 2019.

Found proved.

727. The Committee took into account its findings that in most instances, Mr Denbigh-White did not undertake the relevant actions, and therefore he could not have recorded undertaking them. However, in relation to the undertaking of intra-oral examinations and treatment planning, the Committee noted that there is some information in the clinical records alluding to Mr Denbigh-White's actions, but the information included is very limited. This was also the case on the occasion that he prescribed Patient 16 with antibiotics without recording any proper justification for doing so. Also, a number of GI fillings were provided to Patient 16 in clinical situations that were not in accordance with the manufacturer's recommendations and the relevant FGDP guidelines, and there are no recorded justifications.

728. The Committee found that there was insufficient information in the clinical records to explain what Mr Denbigh-White did in terms of his care of Patient 16 and why.

729. The Committee found Mr Denbigh-White's record keeping in respect of his care and treatment of Patient 16 to be of an inadequate standard. The clinical records were brief with major omissions.

PATIENT 17

Charge 43(a)(i)

43. You failed to provide an adequate standard of care to Patient 17, [identified in Schedule A…], from 17 December 2013 to 21 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including –

i. Medical history

Found proved (on the basis that a medical history was not taken adequately).

730. The Committee was satisfied from the clinical records for Patient 17, that Mr Denbigh-White provided care and treatment to the patient over the period in question.

731. The Committee took into account that Mr Denbigh-White had a duty to take an up-to-date medical history from Patient 17 each time he treated the patient, in accordance with Standard 4.1.1 of the GDC Standards and the *FGDP UK guidelines on Clinical Examination and Record Keeping*.

732. The Committee had regard to Patient 17's clinical records. It found entries against Mr Denbigh-White's initials which indicated that he had updated the patient's medical notes in December 2014, but the next update was not until 14 January 2019. This indicated to the Committee that there was an intervening period of four years, during which Mr Denbigh-White did not update Patient 17's medical history in the clinical records. The Committee noted that the patient attended for treatment during that intervening period, and therefore an update to the patient's medical history would have been required. It also noted that certain medications are listed for this patient, but no information is included in the records to explain what they were for.

733. The Committee took into account the lack of information in the clinical records to indicate that a medical history was taken each time Mr Denbigh-White treated Patient 17. It also had regard to its previous findings above that Mr Denbigh-White had been less than comprehensive in taking and updating the medical histories of other patients. In all the circumstances, the Committee concluded that it was more likely than not that Mr Denbigh-White did not take an up to date medical history from Patient 17 each time he treated the patient.

734. The Committee considered that Mr Denbigh-White could not have obtained an up-to-date picture of Patient 17's medical health, not having updated the patient's medical history in a four year period. It was therefore satisfied that he failed in his duty to provide the patient with an adequate standard of care.

Charge 43(a)(ii)

43. You failed to provide an adequate standard of care to Patient 17, [identified in Schedule A…], from 17 December 2013 to 21 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including –

ii. extra and intra oral examinations.

Found proved (on the basis that no extra oral examinations were undertaken and the intra oral examinations undertaken were not adequate).

735. The Committee had regard to Mr Denbigh-White's clinical records for Patient 17 and found no information to indicate that he undertook any extra oral examinations over the period in question. Whilst there was some information relating to intra-oral examinations, in that there were records to indicate that Mr Denbigh-White had looked in the patient's mouth and at aspects of the patient's teeth, the Committee found nothing to indicate that a full clinical examination had ever been undertaken. There was no recorded information to suggest that Mr Denbigh-White had examined Patient 17 extra-orally, for example, the TMJs and lymph nodes, or to indicate that intra-orally he had examined the patient's soft tissues, for example, the tongue or floor of the mouth.

736. The Committee took into account the limited nature of information in the clinical records relating to standard clinical examinations. It also took into account its previous findings above in relation to the same matters but concerning different patients, namely that no extra oral examinations were undertaken of those patients, and that the intra oral examinations carried out were inadequate.

737. In all the circumstances, the Committee was satisfied that it was more likely than not, that Mr Denbigh-White did not undertake any extra-oral examinations of Patient 17 over the period in question, and that the intra-oral examinations of the patient were inadequate. The Committee was also satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 17, given that such examinations are an integral part of assessment used to help dentists diagnose dental and oral diseases.

Charge 43(a)(iii)

43. You failed to provide an adequate standard of care to Patient 17, [identified in Schedule A…], from 17 December 2013 to 21 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including –

iii. additional special tests as appropriate.

Found proved (on the basis the additional special testing was not adequate).

738. The Committee considered Dr Ward's evidence regarding the requirement for special tests in the context of Patient 17's dental history, as documented within the clinical records. The Committee considered whether there were occasions when the patient presented with a complaint or condition that would have required Mr Denbigh-White to have undertaken

any of the special tests referred to by Dr Ward, namely vitality tests, TTP testing and palpation.

739. The clinical records show that Patient 17 attended to see Mr Denbigh-White for a number of appointments, including an appointment on 1 January 2018, when the patient had pain to cold and the UL6 was noted as TTP. There was also an appointment on 14 January 2019, when the LR8 was noted to be sore. On both occasions, Mr Denbigh-White prescribed the patient with antibiotics.

740. It was Dr Ward's evidence that she would have expected additional special tests to have been carried out by Mr Denbigh-White in relation to UL6. She noted the absence of any special testing in relation to LR8.

741. The Committee accepted the evidence of Dr Ward. In the absence of any records to suggest that Mr Denbigh-White carried out special testing beyond percussion testing on UL6, the Committee was satisfied on the balance of probabilities that he did not carry out any additional special tests as appropriate. It was further satisfied on the expert evidence that he should have undertaken further investigations in this regard.

742. The Committee was satisfied that the limited additional special testing was a failure to provide Patient 17 with an adequate standard of care. Without adequate special testing, Mr Denbigh-White could not have assessed whether the treatment he provided to Patient 17 was appropriate in all the circumstances.

Charge 43(a)(iv)

43. You failed to provide an adequate standard of care to Patient 17, [identified in Schedule A…], from 17 December 2013 to 21 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including –

iv. BPE

Found proved (on the basis that BPEs were not undertaken adequately).

743. The Committee noted that a BPE should be undertaken at initial examination and at each recall interval. It found reference to only one BPE in the clinical records for Patient 17, which was undertaken by Mr Denbigh-White 23 December 2013 around the beginning of the period concerned.

744. The Committee considered the evidence before it in relation to this allegation, as well as its previous findings made in relation to other patients, which indicate that Mr Denbigh-White's habitual practice was not to take BPEs. The Committee concluded on the balance of probabilities that Mr Denbigh-White did not undertake any other BPEs of Patient 17 over the almost six-year period in question. The Committee was satisfied that this represented a

failure by Mr Denbigh-White to provide an adequate standard of care to the patient, in view of Dr Ward's opinion regarding the integral nature of BPEs to assessment, diagnosis and treatment.

Charge 43(a)(v)

43. You failed to provide an adequate standard of care to Patient 17, [identified in Schedule A…], from 17 December 2013 to 21 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including –

v. Periodontal assessment.

Found proved (on the basis no that no periodontal assessment was undertaken).

745. The Committee noted from the clinical notes made by Patient 17's subsequent treating dentist on 19 April 2021, that the patient had severe gum disease. The bitewing radiographs taken by that dentist also showed bone loss in the posterior region.

746. Whilst the Committee took into account that the clinical findings of the subsequent treating dentist were around 18 months after the patient had last since Mr Denbigh-White, it considered it unlikely that this amount of disease would have developed in that intervening period. The Committee's view of the evidence was that there would have been some indication of gum disease in the lower anterior region during the period that the patient was under the care of Mr Denbigh-White. In all the circumstances, the Committee accepted the evidence of Dr Ward that Mr Denbigh-White should have undertaken a periodontal assessment in respect of Patient 17.

747. The Committee found nothing in the clinical records to suggest that Mr Denbigh-White had carried out a full periodontal assessment of the patient, as described by Dr Ward. It therefore concluded that it was more likely than not that Mr Denbigh-White did not carry out a full periodontal assessment. The Committee was satisfied that this represented a failure to provide Patient 17 with an adequate standard of care, given the importance of such an assessment to diagnosing dental disease.

Charge 43(a)(vi)

43. You failed to provide an adequate standard of care to Patient 17, [identified in Schedule A…], from 17 December 2013 to 21 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including –

vi. Bitewing radiographs.

Found proved (on the basis that bitewing radiographs were not taken at appropriate intervals).

748. The Committee noted that there is reference in the clinical records for Patient 17 to a radiograph having been taken of the patient on 23 December 2013. However, there is no indication in the notes to the type of radiograph or any other details relating to the radiograph.

749. The Committee took into account that, if the relevant guidelines on radiography were being followed by Mr Denbigh-White, it would have expected to find several sets of bitewing radiographs in the patient's clinical records. The Committee noted that, even for patients at low risk of caries, bitewing radiographs are to be taken every two years. The Committee noted the evidence regarding Mr Denbigh-White's admission to an NHSE dental adviser that he did not routinely take radiographs of his patients because of the risk posed from the radiation.

750. Having had regard to all the evidence, the Committee was satisfied on the balance of probabilities that this allegation is proved. It considered that even if the radiograph of 23 December 2013 was a bitewing radiograph, the indication is that Mr Denbigh-White did not take bitewing radiographs of the patient at appropriate intervals during the time period in question. The Committee was satisfied that Mr Denbigh-White's insufficient radiographic screening amounted to a failure to provide an adequate standard of care to Patient 17. It accepted Dr Ward's opinion that the relevant guidelines should have been followed by Mr Denbigh-White to balance the safety of radiographic exposure against the benefits of its use.

Charge 43(a)(vii)

43. You failed to provide an adequate standard of care to Patient 17, [identified in Schedule A…], from 17 December 2013 to 21 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including –

vii. Pre-treatment radiographs to aid diagnosis in respect of the UL6 (11/1/18 and/or 18/1/18 and/or 10/7/19 and/or 17/7/19).

Found proved in relation to all of the dates in question.

751. The Committee noted from the clinical records that at the first of these appointments, Patient 17 complained of pain to cold at UL6 after hearing a crunch in the upper left. The tooth was noted as tender to percussion. In her report, Dr Ward provides the opinion that there was a lack of assessment by Mr Denbigh-White to establish the cause of the patient's pain and reach a diagnosis. She highlights the absence of any information of a radiographic examination, which she maintains should have been undertaken.

752. The Committee accepted the evidence of Dr Ward. It was satisfied that in the circumstances, Mr Denbigh-White should have taken pre-treatment/periapical radiographs to aid diagnosis in respect of UL6. The Committee found nothing in the clinical records to suggest that he took any such radiographs on the dates in question, and it concluded that it was more likely than not that he did not take any. The Committee considered that by not doing so, Mr Denbigh-White failed to provide Patient 17 with an adequate standard of care. In the absence of such a radiograph, he did not have the relevant clinical information to assess whether the treatment he provided to the patient's UL6 was appropriate.

Charge 43(b)

43. You failed to provide an adequate standard of care to Patient 17, [identified in Schedule A…], from 17 December 2013 to 21 August 2019 in that:

b. You did not adequately formulate and/or record formulation of treatment plans.

Found proved (on the basis that treatment plans were not adequately formulated).

753. The Committee had regard to the clinical records for Patient 17, and whilst it found that Mr Denbigh-White made records in relation to treatment that he proposed to carry out for the patient, the Committee found nothing within the clinical records that would constitute a treatment plan, as outlined in the relevant GDC Standards, and as described by Dr Ward. The Committee considered that Mr Denbigh-White simply addressed the patient's dental problems as and when they attended. It also noted that on a number of occasions, Mr Denbigh-White provided temporary solutions without providing definitive treatment.

754. The Committee took into account Dr Ward's evidence that "*Treatment planning follows full assessment and diagnosis and after the consideration of treatment options, discussion of risks and benefits of treatment, along with consideration of the order and timing of treatment".*

755. The Committee had regard to its findings above regarding the limited assessment of Patient 17 by Mr Denbigh-White, in terms of the insufficiency of radiographs, only one BPE having been undertaken, the absence of additional special testing where appropriate, and no periodontal assessment. The Committee concluded that in the circumstances, Mr Denbigh-White would not have had all the relevant clinical information to adequately formulate treatment plans for the patient. The Committee was satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 17 by not providing the patient with clear plans in relation to their treatment, as required by the GDC Standards.

Charge 43(c)

43. You failed to provide an adequate standard of care to Patient 17, [identified in Schedule A…], from 17 December 2013 to 21 August 2019 in that:

c. You did not diagnose and/or appropriately treat periodontitis.

Found proved (on the basis that periodontitis was not diagnosed).

756. The Committee noted Dr Ward's evidence that Mr Denbigh-White did not diagnose, and therefore did not treat, Patient 17's periodontitis. In her report, Dr Ward drew the Committee's attention to the diagnosis of severe gum disease, especially around LL1, made by the patient's subsequent treating dentist following radiographs taken on 19 April 2021.

757. In accepting Dr Ward's opinion, the Committee took into account the extent of the disease identified by the subsequent treating dentist which, in its view, would have been obvious during the time that Patient 17 was being treated by Mr Denbigh-White. The Committee also took into account that Mr Denbigh-White did not carry out a periodontal assessment of the patient.

758. The Committee was satisfied that it was more likely than not that Mr Denbigh-White did not diagnose Patient 17's periodontitis. In the absence of a diagnosis, he could not have assessed whether he was providing appropriate treatment to the patient. Indeed, the Committee found nothing in the clinical records made by Mr Denbigh-White to suggest that the patient was treated for periodontitis. The Committee was satisfied that this represented a failure to provide Patient 17 with an adequate standard of care.

Charge 43(d)

43. You failed to provide an adequate standard of care to Patient 17, [identified in Schedule A…], from 17 December 2013 to 21 August 2019 in that:

d. You did not adequately assess and/or diagnose of the source of pain at LR8 and/or UL6.

Found proved in relation to both LR8 and UL6 (on the basis that the source of pain was not adequately assessed or diagnosed).

759. The Committee noted the chronology of information in relation to Patient 17's LR8 and UL6 as set out in the clinical records. It noted that the patient attended several appointments complaining of pain in LR8, and that on a number of those occasions Mr Denbigh-White prescribed antibiotics in response. The Committee found nothing in the clinical records to indicate that Mr Denbigh-White carried out an assessment to diagnose the source of the pain.

760. Patient 17 also attended on a number of occasions complaining of pain in UL6. The Committee noted that whilst Mr Denbigh-White recorded in the clinical notes at an appointment on 11 January 2018 *"to do new flg ? rt"* (to do a new filling or root canal treatment?), he did not record a definite reason for treating the tooth. At a following

appointment on 18 January 2018, Mr Denbigh-White opened up and dressed the tooth without having undertaking sufficient special testing or any pre-treatment radiographs.

761. The Committee accepted the evidence of Dr Ward that Mr Denbigh-White failed to diagnose the source of the patient's pain, instead managing the pain LR8 with antibiotics and accessing UL6 without fully assessing the pulpal health of that tooth. The Committee was satisfied that this amounted to a failure to provide Patient 17 with an adequate standard of care.

Charge 43(e)

43. You failed to provide an adequate standard of care to Patient 17, [identified in Schedule A…], from 17 December 2013 to 21 August 2019 in that:

e. You did not diagnose and/or appropriately treat caries at LR8 and/or UL6.

Found proved in relation to the LR8 (on the basis that caries was not diagnosed).

Found not proved in relation to UL6.

762. The evidence is that when Patient 17 was seen by another dentist on 26 April 2021, and bitewing radiographs were taken, LR8 was shown to have gross caries and UL6 extensive caries.

763. The Committee was satisfied that this allegation is proved in relation to LR8. It took into account the lack of radiographic assessment and that Mr Denbigh-White did not carry out any special testing in relation to this tooth. The Committee found no reference in the records to a diagnosis of caries. In view of the extent of the caries radiographically on 26 April 2021 and the symptoms the patient had presented with under Mr Denbigh-White's care, the Committee regard it more likely than not that this caries was present whilst Patient 17 was under Mr Denbigh-White's care and that he failed to diagnose it.

764. The Committee decided in relation to UL6, that there is insufficient evidence to suggest that this tooth was carious during the time that Mr Denbigh-White treated Patient 17. In reaching its decision, the Committee took into account that the radiograph taken by the subsequent treating dentist in April 2021 was some one and a half years after Mr Denbigh-White last saw the patient. Whilst there is a mesial radiolucency that could indicate caries, this radiolucency could also be attributed to tooth fracture or temporary restorative material from the attempted root filling. The Committee was not satisfied that there was sufficient evidence to indicate that a diagnosis of caries should have been made at that time. The Committee noted that Mr Denbigh-White provided treatment to UL6 following what appeared to be a fracture of the tooth. It was not satisfied that there was sufficient evidence to indicate what the status of the tooth was under the fracture before Mr Denbigh-White opened up and dressed the tooth with the view to carrying out root canal treatment. Accordingly, it was not satisfied that this allegation is proved in relation to UL6.

Charge 43(f)

43. You failed to provide an adequate standard of care to Patient 17, [identified in Schedule A…], from 17 December 2013 to 21 August 2019 in that:

f. You inappropriately prescribed antibiotics:

i. on 17/12/13 and/or 11/11/15 and/or

14/1/19 (LR8)

ii. on 11/1/18 (UL6)

iii. on 6 August 2019 (no tooth recorded).

Found proved in respect of all occasions.

765. The opinion of Dr Ward, which the Committee accepted, was based on the FGDP guidelines on 'Antimicrobial Prescribing for General Dental Practitioners'. She told the Committee in her oral evidence that antibiotics should only be prescribed when there is evidence of infection, such as systemic illness and diffuse swelling, and that where appropriate, local treatment measures should be undertaken first.

766. The Committee noted the absence of any reference to swelling or systemic involvement in the clinical records for any of the dates in question, or any information to suggest that Mr Denbigh-White had undertaken any local measures. It noted in relation to the prescription for antibiotics on 6 August 2019 that, not only was there an absence of a reason for the prescription, but no tooth was recorded in the records. The Committee considered that in the absence of such notes, the prescriptions for antibiotics were inappropriate. It was satisfied that prescribing antibiotics contrary to the guidelines was a failure to provide Patient 17 with an adequate standard of care.

Charge 43(g)(i)

43. You failed to provide an adequate standard of care to Patient 17, [identified in Schedule A…], from 17 December 2013 to 21 August 2019 in that:

g. You did not provide an adequate standard of treatment in respect of

i. Root canal treatment and endodontic management of the UL6 on 18 January

2018 and/or 10 July 2019 and/or 17 July 2019.

Found proved in relation to all the dates in question.

767. The Committee accepted the opinion of Dr Ward which is based on the *'Quality guidelines for endodontic treatment: consensus report of the* European Society of Endodontology, IEJ, 2006 or FGDP 2.10 endo'. She stated in her report that *"Root treatment technique appears poor with no radiographic assessment, no rubber dam, no working length*

and then a dressing placed when the registrant was not able to complete the root filling. This is a good example of why radiographic examination is essential."

768. The Committee was satisfied that by not carrying out root canal treatment to the recognised endodontic standard, Mr Denbigh-White failed to provide Patient 17 with an adequate standard of care.

Charge 43(g)(ii)

43. You failed to provide an adequate standard of care to Patient 17, [identified in Schedule A…], from 17 December 2013 to 21 August 2019 in that:

g. You did not provide an adequate standard of treatment in respect of

ii. scaling

Found not proved.

769. The Committee noted that Dr Ward based her opinion of a poor standard of scaling on the presence of calculus seen on a radiograph taken by a subsequent treating dentist on 1 June 2021. However, the Committee took into account that the observation of the calculus was almost two years after Mr Denbigh-White had last seen Patient 17 on 21 August 2019. The Committee considered this is a significant period, during which the calculus in question could have built up on the patient's teeth.

770. The Committee considered that unless there was radiographic evidence of the extent of the calculus in August 2019, it was difficult to make an assessment as to the standard of the scaling provided by Mr Denbigh-White when he was treating the patient. The Committee was not satisfied that this allegation is proved.

Charge 43(h)

43. You failed to provide an adequate standard of care to Patient 17, [identified in Schedule A…], from 17 December 2013 to 21 August 2019 in that:

h. You did not discuss and/or record discussion of treatment options.

Found proved (on the basis that treatment options were not discussed).

771. The Committee took into account the absence of any information in Mr Denbigh-White's clinical records for Patient 17 regarding discussions with the patient about treatment options. It noted that Mr Denbigh-White provided treatment to a number of the patient's teeth during the period in question, including preparing a tooth for root canal treatment and prescribing antibiotics. It appeared to the Committee on its reading of the clinical notes that on each occasion, Mr Denbigh-White simply advised the patient on the course of action he was going to take.

772. The Committee had regard to its findings made in respect of the treatment of other patients, which indicate that, generally, treatment options were not discussed. It also had

regard to the evidence it received from some patients regarding Mr Denbigh-White not having spoken to them much or at all about their treatment. Further, the Committee took into account its findings that Mr Denbigh-White did not take sufficient radiographs of Patient 17 over the period in question, undertook only one BPE, did not undertake sufficient special testing as appropriate and did not carry out a periodontal assessment. The Committee also found that Mr Denbigh-White did not formulate any adequate treatment plans for the patient. Taking all these factors into account, the Committee concluded that it was more likely than not that Mr Denbigh-White did not discuss treatment options with Patient 17 over the period in question. It considered that it would have been difficult for him to have had any discussion about treatment options given the limited clinical information that would have been available to him on account of his omissions.

Charge 43(i)

43. You failed to provide an adequate standard of care to Patient 17, [identified in Schedule A…], from 17 December 2013 to 21 August 2019 in that:

i. You did not discuss and/or record risks and/or benefits of proposed treatment.

Found proved (on the basis that risks and benefits of proposed treatment were not discussed).

773. The Committee found no information in Mr Denbigh-White's clinical records for Patient 17 regarding any discussions with the patient about the risks and benefits of proposed treatment. The Committee found this allegation proved for the same reasons outlined above in relation to the lack of discussion about treatment options.

774. The Committee was satisfied that Mr Denbigh-White did not discuss the risks and benefits of proposed treatment with Patient 17, and that his omission to do so was a failure to provide the patient with an adequate standard of care. Such discussions are an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 44

44. As a result of 43 (a) (vii) and/or (h) and/or (i) you failed to obtain informed consent for the treatment provided from 17 December 2013 to 21 August 2019

Found proved in relation 43(a)(vii), 43(h) and 43(i).

775. The Committee's finding at 43(a)(vii) is that Mr Denbigh-White did not take any pre-treatment/periapical radiographs to aid diagnosis in respect of Patient 17's UL6. The Committee accepted the evidence of Dr Ward that such radiographs were necessary, and by not having taken them, Mr Denbigh-White was not able to assess whether he was providing appropriate treatment to the patient or assess potential difficulties. Accordingly, he could not have fully informed Patient 17 and highlighted any treatment options, risks and/or benefits of proposed treatment.

776. The Committee found at 43(h) and 43(i) that Mr Denbigh-White did not discuss any alternative treatment options or risks and benefits of proposed treatment with Patient 17 over the period in question. The Committee had regard to the GDC Standards which relate to the issue of valid consent, as well as to the evidence of Dr Ward that discussions with patients about alternative treatment options and risks and benefits of proposed treatment are integral to patients being able to give informed consent.

777. Taking all the evidence into account, the Committee found this allegation at Charge 32 proved. It was satisfied on the balance of probabilities that Patient 17 could not have given informed consent for any of the treatment provided by Mr Denbigh-White from 17 February 2015 to 6 August 2019 if the patient was unaware of what alternative treatment options were available and the risks and benefits of any proposed treatment.

Charge 45

45. You failed to maintain an adequate standard of record keeping from 17 December 2013 to 21August 2019,

Found proved.

778. The Committee took into account its findings that in most instances, Mr Denbigh-White did not undertake the relevant actions, and therefore he could not have recorded undertaking them. However, in relation to the undertaking of intra-oral examinations and treatment planning, the Committee noted that there is some information in the clinical records alluding to Mr Denbigh-White's actions, but the information included is very limited. This was also the case on the occasions that he prescribed Patient 17 with antibiotics without recording any proper justification for doing so, and the opening up of UL6 to provide root canal treatment without recording a rationale or sufficient detail of the procedure.

779. The Committee found that there was insufficient information in the clinical records to explain what Mr Denbigh-White did in terms of his care of Patient 17 and why.

780. The Committee found Mr Denbigh-White's record keeping in respect of his care and treatment of Patient 17 to be of an inadequate standard. The clinical records were brief with major omissions.

PATIENT 18

Charge 46(a)(i)

46. You failed to provide an adequate standard of care to Patient 18 [identified in Schedule A…], from 26 March 2014 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including –

i. Medical history

Found proved (on the basis that a medical history was not taken adequately).

781. The Committee was satisfied from the clinical records for Patient 18, that Mr Denbigh-White provided care and treatment to the patient over the period in question.

782. The Committee took into account that Mr Denbigh-White had a duty to take an up-to-date medical history from Patient 18 each time he treated the patient, in accordance with Standard 4.1.1 of the GDC Standards and the *FGDP UK guidelines on Clinical Examination and Record Keeping*.

783. The Committee had regard to Patient 18's clinical records. It found entries against Mr Denbigh-White's initials which indicated that he had updated the patient's medical notes on a regular basis up until and including 13 July 2015. However, the next update after July 2015 was on 30 January 2019, which was a gap of about three and a half years. This indicated to the Committee that in that intervening period Mr Denbigh-White did not update Patient 18's medical history in the clinical records. The Committee noted that the patient attended for treatment on a number of occasions between July 2015 and January 2019, and therefore an update to the patient's medical history would have been required.

784. The Committee took into account the lack of information in the clinical records to indicate that a medical history was taken each time Mr Denbigh-White treated Patient 18. It also had regard to its previous findings above that Mr Denbigh-White had been less than comprehensive in taking and updating the medical histories of other patients. In all the circumstances, the Committee concluded that it was more likely than not that Mr Denbigh-White did not take an up to date medical history from Patient 18 each time he treated the patient.

785. The Committee considered that Mr Denbigh-White could not have obtained an up-to-date picture of Patient 18's medical health, not having updated the patient's medical history in three and a half years. It was therefore satisfied that he failed in his duty to provide the patient with an adequate standard of care.

Charge 46(a)(ii)

46. You failed to provide an adequate standard of care to Patient 18 [identified in Schedule A…], from 26 March 2014 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including –

ii. extra and intra oral examinations.

Found proved (on the basis that no extra oral examinations were undertaken and the intra oral examinations undertaken were not adequate).

786. The Committee had regard to Mr Denbigh-White's clinical records for Patient 18 and found no information to indicate that he undertook any extra oral examinations over the period in question. Whilst there was some information relating to intra-oral examinations, in that there were records to indicate that Mr Denbigh-White had looked in the patient's mouth and at aspects of the patient's teeth, the Committee found nothing to indicate that a full clinical examination had ever been undertaken. There was no recorded information to suggest that Mr Denbigh-White had examined Patient 18 extra-orally, for example, the TMJs and lymph nodes, or to indicate that intra-orally he had examined the patient's soft tissues, for example, the tongue or floor of the mouth. The Committee noted that Dr Ward highlighted in her report the lack of information in the clinical records regarding extra and intra oral examinations of this patient.

787. The Committee took into account the limited nature of information in the clinical records relating to standard clinical examinations. It also took into account its previous findings above in relation to the same matters but concerning different patients, namely that no extra oral examinations were undertaken of those patients, and that the intra oral examinations carried out were inadequate.

788. In all the circumstances, the Committee was satisfied that it was more likely than not, that Mr Denbigh-White did not undertake any extra-oral examinations of Patient 18 over the period in question, and that the intra-oral examinations of the patient were inadequate. The Committee was also satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 18, given that such examinations are an integral part of assessment used to help dentists diagnose dental and oral diseases.

Charge 46(a)(ii)

46. You failed to provide an adequate standard of care to Patient 18 [identified in Schedule A…], from 26 March 2014 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including –

iii. additional special tests as appropriate.

Found proved (on the basis that additional special tests were not undertaken as appropriate).

789. The Committee considered Dr Ward's evidence regarding the requirement for special tests in the context of Patient 18's dental history, as documented within the clinical records. The Committee considered whether there were occasions when the patient presented with a complaint or condition that would have required Mr Denbigh-White to have undertaken any of the special tests referred to by Dr Ward, namely vitality tests, TTP testing and palpation.

790. The clinical records show that Patient 18 attended to see Mr Denbigh-White for a number of appointments, including an appointment on 18 November 2015, when the patient complained of pain, swelling and a possible abscess. Mr Denbigh-White noted that the LL4 was TTP and prescribed antibiotics. The records do not indicate that any other special tests were carried out. It was Dr Ward's evidence that she would have expected additional special tests to have been carried out by Mr Denbigh-White in the particular circumstances of the appointment on 18 November 2015.

791. Dr Ward also highlighted other appointments at which she would have expected to see information relating to special tests in the records. There was an appointment on 30 January 2019, when Mr Denbigh-White noted a cavity at LR7 and advised a filling. The Committee had regard to the clinical notes in respect of the filling appointment on 6 February 2019, which noted LR7 was quite deep, and found nothing to indicate that any special tests, such as vitality testing, was carried out in line with Dr Ward's opinion, which it accepted. In the absence of such records, the Committee was satisfied that Mr Denbigh-White did not carry out any special testing on either occasion.

792. The Committee was satisfied on the evidence that the lack of special testing was a failure to provide Patient 18 with an adequate standard of care. In the absence of special tests as appropriate, Mr Denbigh-White could not have assessed whether the treatment he provided to Patient 18 was appropriate in all the circumstances.

Charge 46(a)(iv)

46. You failed to provide an adequate standard of care to Patient 18 [identified in Schedule A…], from 26 March 2014 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including –

iv. BPE

Found proved (on the basis no BPEs were undertaken).

793. The Committee found nothing in the clinical records to indicate that Mr Denbigh-White had undertaken any BPEs of Patient 18 from 26 March 2014 to 6 August 2019. The lack of BPEs in the clinical records was a matter highlighted by Dr Ward in her report. The Committee noted that a BPE should be undertaken at initial examination and at each recall interval.

794. The Committee considered the evidence before it in relation to this allegation, as well as its previous findings made in relation to other patients, which indicate that Mr Denbigh-White's habitual practice was not to take BPEs. The Committee concluded on the balance of probabilities that Mr Denbigh-White did not undertake any BPEs of Patient 18 over the period in question. The Committee was satisfied that this represented a failure by Mr

Denbigh-White to provide an adequate standard of care to the patient, in view of Dr Ward's opinion regarding the integral nature of BPEs to assessment, diagnosis and treatment.

Charge 46(a)(v)

46. You failed to provide an adequate standard of care to Patient 18 [identified in Schedule A…], from 26 March 2014 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including –

v. Periodontal assessment.

Found proved (on the basis no that no periodontal assessment was undertaken).

795. The Committee noted that on 1 March 2021 a subsequent treating dentist diagnosed Patient 18 with *"periodontitis stage 2 grade b"*. The Committee also noted that this diagnosis was made some 18 months after the patient was last seen by Mr Denbigh-White in August 2019. However, it considered that in light of the extent of the bone loss, also recorded by the subsequent treating dentist, it was likely that Patient 18 had been suffering from periodontitis at the time the patient was being treated by Mr Denbigh-White. Accordingly, the Committee accepted the evidence of Dr Ward that Mr Denbigh-White should have undertaken a full periodontal assessment of the patient.

796. The Committee, having had regard to Mr Denbigh-White's clinical records for Patient 18, found nothing to suggest that he had carried out a full periodontal assessment as described by Dr Ward. It found no reference to any BPEs or six-point pocket charting, or to any bitewing or periapical radiographs. The Committee concluded that it was more likely than not that Mr Denbigh-White did not carry out a full periodontal assessment of Patient 18 and it was satisfied that this represented a failure to provide the patient with an adequate standard of care, given the importance of such an assessment to diagnosing dental disease.

Charge 46(a)(vi)

46. You failed to provide an adequate standard of care to Patient 18 [identified in Schedule A…], from 26 March 2014 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including –

vi. Bitewing radiographs

Found proved (on the basis that no bitewing radiographs were undertaken).

797. The Committee found no bitewing radiographs within the clinical records of Patient 18 for the relevant period 26 March 2014 to 6 August 2019.

798. The Committee had regard to the evidence of Mr Krzeminski regarding Mr Denbigh-White stating that he did not routinely take radiographs of his patients because of the risk posed by radiation.

799. Having had regard to the evidence, the Committee was satisfied on the balance of probabilities that Mr Denbigh-White did not take any radiographs of Patient 18 during the time period in question. The Committee was also satisfied that Mr Denbigh-White's omission to take any radiographs of the patient amounted to a failure to provide an adequate standard of care for the same reasons previously stated.

Charge 46(a)(vii)(1)

46. You failed to provide an adequate standard of care to Patient 18 [identified in Schedule A…], from 26 March 2014 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including –

vii. Pre-treatment/periapical radiographs prior to:

1. crowns UL4

Found proved (on the basis that no pre-treatment/periapical radiographs were undertaken).

800. The Committee accepted the evidence of Dr Ward, who referred in her report to the '*FGDP Standards in Dentistry',* that pre-operative radiographs should be taken before any crown or bridgework is undertaken. In her oral evidence, Dr Ward explained that pre-treatment radiographs are necessary to check the health of the teeth to be crowned, as without such radiographs, a dentist would not be able to know whether there are underlying issues which could affect the proposed treatment. Dr Ward also highlighted the potential financial implications for a patient if treatment should fail because their teeth were not radiographically assessed prior to crown placement or bridgework.

801. The Committee was satisfied that Mr Denbigh-White did place a crown on Patient 18's UL4. It found no radiographs of the patient in the clinical records made by Mr Denbigh-White over the period in question.

802. In the absence of any radiographs and given the evidence of Mr Denbigh-White's views on radiography, the Committee was satisfied on the balance of probabilities that he did not take a pre-treatment/periapical radiograph prior to placing the crown at UL4. On the basis of Dr Ward's expert evidence, the Committee was satisfied that he should have taken such radiographs, and to not have done so was a failure to provide an adequate standard of care to the patient.

Charge 46(a)(vii)(2)

46. You failed to provide an adequate standard of care to Patient 18 [identified in Schedule A…], from 26 March 2014 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including –

vii. Pre-treatment/periapical radiographs prior to:

2. crowns UL5 26/03/14 and/or 02/04/14

Found proved (on the basis that no pre-treatment/periapical radiographs were undertaken).

803. The Committee was satisfied from the clinical records that these were the dates on which Mr Denbigh-White planned and then prepared Patient 18's UL5 for a crown. It was also satisfied on the basis of Dr Ward's opinion that pre-treatment/periapical radiographs should have been undertaken prior to preparing the tooth for the crown. It therefore found this allegation proved for the same reasons given in respect of 46(a)(vii)(1) above.

Charge 46(a)(vii)(3)

46. You failed to provide an adequate standard of care to Patient 18 [identified in Schedule A…], from 26 March 2014 to 6 August 2019 in that:

a. You did not undertake and/or record having undertaken adequate diagnostic assessments and/or pretreatment investigations, including –

vii. Pre-treatment/periapical radiographs prior to:

3. and during RCT LL4 on 25/11/15 and/or 26/11/15

Found proved (on the basis that no pre-treatment/periapical radiographs were undertaken).

804. The clinical records indicate that at the appointment on 25 November 2015, Mr Denbigh-White advised in relation to Patient 18's LL4, re-doing a filling distally and possibly providing a root canal treatment. The LL4 was root filled the following day, 26 November 2015.

805. The Committee found no information in the clinical records to suggest that Mr Denbigh-White took any pre-treatment or periapical radiographs prior to providing root canal treatment to LL4. In the absence of such a record the Committee was satisfied that he did not take any such radiographs. It accepted the opinion of Dr Ward that pre-treatment or periapical radiographs were necessary in the circumstances, as they would have been essential to diagnosis and treatment planning. The Committee was satisfied that to not take such radiographs was a failure to provide Patient 18 with an adequate standard of care, as

without pre-treatment radiographic examination, Mr Denbigh-White could not have assessed whether root canal treatment was the appropriate course of action.

Charge 46(b)

46. You failed to provide an adequate standard of care to Patient 18 [identified in Schedule A…], from 26 March 2014 to 6 August 2019 in that:

b. You did not adequately formulate and/or record formulation of treatment plans.

Found proved (on the basis that treatment plans were not adequately formulated).

806. The Committee had regard to the clinical records for Patient 18, and whilst it found that Mr Denbigh-White made records in relation to treatment that he proposed to carry out for the patient, the Committee found nothing within the clinical records that would constitute a treatment plan, as outlined in the relevant GDC Standards, and as described by Dr Ward.

807. The Committee took into account Dr Ward's evidence that "*Treatment planning follows full assessment and diagnosis and after the consideration of treatment options, discussion of risks and benefits of treatment, along with consideration of the order and timing of treatment".*

808. The Committee had regard to its findings above regarding the limited assessment of Patient 18 by Mr Denbigh-White, in terms of the lack of radiographs, no BPEs having been undertaken, the insufficiency of special testing where appropriate, and no periodontal assessment. The Committee concluded that in the circumstances, Mr Denbigh-White would not have had all the relevant clinical information to adequately formulate treatment plans for the patient. The Committee was satisfied that Mr Denbigh-White failed to provide an adequate standard of care to Patient 18 by not providing the patient with clear plans in relation to their treatment, as required by the GDC Standards.

Charge 46(c)

46. You failed to provide an adequate standard of care to Patient 18 [identified in Schedule A…], from 26 March 2014 to 6 August 2019 in that:

c. You did not diagnose and/or treat periodontitis.

Found proved (on the basis that periodontitis was not diagnosed).

809. Dr Ward's opinion is that Mr Denbigh-White failed to diagnose, and therefore did not treat, Patient 18's periodontitis. In her report, Dr Ward drew the Committee's attention to the

diagnosis of *"periodontitis stage 2 grade b"*, made by the patient's subsequent treating dentist at an appointment on 1 March 2021.

810. In accepting Dr Ward's opinion, the Committee took into account the extent of the disease identified by the subsequent treating dentist which, in its view, would have been obvious during the time that Patient 18 was being treated by Mr Denbigh-White. The Committee also took into account that Mr Denbigh-White did not carry out a periodontal assessment of the patient.

811. The Committee was satisfied that it was more likely than not that Mr Denbigh-White did not diagnose Patient 18's periodontitis. In the absence of a diagnosis, he could not have assessed whether he was providing appropriate treatment to the patient. Indeed, the Committee found nothing in the clinical records made by Mr Denbigh-White to suggest that the patient was treated for periodontitis. The Committee was satisfied that this represented a failure to provide Patient 18 with an adequate standard of care.

Charge 46(d)

46. You failed to provide an adequate standard of care to Patient 18 [identified in Schedule A…], from 26 March 2014 to 6 August 2019 in that:

d. You did not diagnose and/or treat caries on the LR8.

Found not proved.

812. The Committee considered it unclear from the evidence what was being charged by the GDC. In giving her opinion that Mr Denbigh-White did not diagnose caries, Dr Ward relied on the diagnosis of caries made by the subsequent treating dentist on 1 March 2021. However, the clinical notes, charting and radiographic evidence produced in relation to that March 2021 appointment indicate that the caries was identified in LR7, not LR8 as charged in this allegation. Furthermore, in her report, Dr Ward refers to Patient 18 as having been diagnosed on 1 March 2021 with *"recurrent caries UR7".*

813. The Committee considered that the confusion in the evidence surrounding this allegation went beyond a simple typographical error, and therefore it would be unfair to Mr Denbigh-White to make any amendment to the charge at this stage. In all the circumstances, the Committee was not satisfied that this allegation is proved to the requisite standard.

Charge 46(e)

46. You failed to provide an adequate standard of care to Patient 18 [identified in Schedule A…], from 26 March 2014 to 6 August 2019 in that:

e. You did not discuss and/or record discussion of treatment options.

Found proved (on the basis that treatment options were not discussed).

814. The Committee took into account the absence of any information in Mr Denbigh-White's clinical records for Patient 18 regarding discussions with the patient about treatment options. It noted that Mr Denbigh-White provided treatment to a number of the patient's teeth during the period in question, including the provision of a crown, root canal treatment and GI fillings. It appeared to the Committee on its reading of the clinical notes that on each occasion, Mr Denbigh-White simply advised the patient on the course of action he was going to take.

815. The Committee had regard to its findings made in respect of the treatment of other patients, which indicate that, generally, treatment options were not discussed. It also had regard to the evidence it received from some patients regarding Mr Denbigh-White not having spoken to them much or at all about their treatment. Further, the Committee took into account its findings that Mr Denbigh-White did not take any radiographs in respect of Patient 18 over the period in question, did not undertake sufficient special testing as appropriate, and did not diagnose the patient's periodontitis. The Committee also found that Mr Denbigh-White did not formulate any adequate treatment plans for the patient. Taking all these factors into account, the Committee concluded that it was more likely than not that Mr Denbigh-White did not discuss treatment options with Patient 18 over the period in question. It considered that it would have been difficult for him to have had any discussion about treatment options given the limited clinical information that would have been available to him on account of his omissions.

816. The Committee was satisfied that Mr Denbigh-White's omission to discuss treatment options with Patient 18 was a failure to provide an adequate standard of care, as such discussions are an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 46(f)

46. You failed to provide an adequate standard of care to Patient 18 [identified in Schedule A…], from 26 March 2014 to 6 August 2019 in that:

f. You did not discuss and/or record risks and/or benefits of proposed treatment.

Found proved *(*on the basis that risks and benefits of proposed treatment were not discussed*).*

817. The Committee found no information in Mr Denbigh-White's clinical records for Patient 18 regarding any discussions with the patient about the risks and benefits of proposed treatment. The Committee found this allegation proved for the same reasons outlined above in relation to the lack of discussion about treatment options.

818. The Committee was satisfied that Mr Denbigh-White did not discuss the risks and benefits of proposed treatment with Patient 18, and that his omission to do so was a failure

to provide the patient with an adequate standard of care. Such discussions are an important aspect in ensuring that a patient has the understanding to give consent to treatment.

Charge 46(g)

46. You failed to provide an adequate standard of care to Patient 18 [identified in Schedule A…], from 26 March 2014 to 6 August 2019 in that:

g. You provided a poor standard of RCT to the LL4 on 26/11/15

Found proved.

819. The Committee accepted the evidence of Dr Ward who relied on the *'Quality guidelines for endodontic treatment: consensus report of the European Society of Endodontology, IEJ, 2006 or FGDP 2.10 endo'.* She stated in her report that Mr Denbigh-White's technique, as recorded in the clinical records for the patient, suggests that the root canal treatment was not carried out to recognised endodontic standards. In particular, Dr Ward highlighted the following concerns:

- *No pre-operative clinical and radiographic assessment.*
- *Poor technique with no record of rubber dam, working length assessment, or irrigation.*
- *Root filling short on radiograph taken by subsequent dentist 01/03/21.*

820. The Committee was satisfied on the basis of Dr Ward's opinion that this allegation is proved. It was also satisfied that by not carrying out root canal treatment to the recognised endodontic standard, Mr Denbigh-White failed to provide Patient 18 with an adequate standard of care.

Charge 46(h)

46. You failed to provide an adequate standard of care to Patient 18 [identified in Schedule A…], from 26 March 2014 to 6 August 2019 in that:

h. You inappropriately used glass ionomer for fillings on the following teeth and

dates:-

i. UL6 (1/2/17)
ii. LR7 (6/2/19)

Found proved in its entirety.

821. In making its findings, the Committee considered heads of charge 46(h)(i) and (ii) separately.

822. The Committee had regard to the clinical records for Patient 18 and was satisfied that GI fillings were placed on the teeth listed at 46(h)(i) and (ii) and on the dates in question.

823. The Committee noted that the fillings were placed on load bearing surfaces of the teeth, and it accepted the evidence of Dr Ward that this was inappropriate for the reasons outlined previously. The Committee found nothing in Mr Denbigh-White's notes to suggest that any of the GI fillings fell into the accepted circumstances referred to by Dr Ward, nor was there anything written by Mr Denbigh-White to justify his use of the material in clinical situations that were not in accordance with the manufacturer's recommendations and the relevant FGDP guidelines.

Charge 47

47. As a result of 46 (a) (vii) and/or (e) and/or (f) you failed to obtain informed consent for the treatment provided from 26 March 2014 to 6 August 2019.

Found proved in relation to 46(a)(vii), 46(e) and 46(f).

824. The Committee's findings at 46(a)(vii) are that Mr Denbigh-White did not take any pre-treatment/periapical radiographs prior to crowning teeth and prior to root canal treatment. The Committee accepted the evidence of Dr Ward that such radiographs were necessary, and by not having taken them, Mr Denbigh-White was not able to assess whether the treatment he proposed was appropriate in all the circumstances. Accordingly, he could not have fully informed Patient 18 and highlighted any treatment options, risks and/or benefits of proposed treatment.

825. The Committee found at 46(e) and 46(f) that Mr Denbigh-White did not discuss any alternative treatment options or risks and benefits of proposed treatment with Patient 18 over the period in question. The Committee had regard to the GDC Standards which relate to the issue of valid consent, as well as to the evidence of Dr Ward that discussions with patients about alternative treatment options and risks and benefits of proposed treatment are integral to patients being able to give informed consent.

826. Taking all the evidence into account, the Committee found this allegation at Charge 47 proved. It was satisfied on the balance of probabilities that Patient 18 could not have given informed consent for any of the treatment provided by Mr Denbigh-White from 26 March 2014 to 6 August 2019 if the patient was unaware of what alternative treatment options were available and the risks and benefits of any proposed treatment.

Charge 48

48. You failed to maintain an adequate standard of record keeping from 26 March 2014 to 6 August 2019.

Found proved.

827. The Committee took into account its findings that in most instances, Mr Denbigh-White did not undertake the relevant actions, and therefore he could not have recorded undertaking them. However, in relation to the undertaking of intra-oral examinations and treatment planning, the Committee noted that there is some information in the clinical records alluding to Mr Denbigh-White's actions, but the information included is very limited. Also, a number of GI fillings were provided to Patient 18 in clinical situations that were not in accordance with the manufacturer's recommendations and the relevant FGDP guidelines, and there are no recorded justifications.

828. The Committee found that there was insufficient information in the clinical records to explain what Mr Denbigh-White did in terms of his care of Patient 18 and why.

829. The Committee found Mr Denbigh-White's record keeping in respect of his care and treatment of Patient 18 to be of an inadequate standard. The clinical records were brief with major omissions.

Charge 49

49. You failed to maintain a correct and up to date registered address with the GDC.

Found not proved.

830. The Committee had regard to the evidence of the GDC Casework Manager, who provided in her witness statement dated 24 April 2023, a chronology of the correspondence sent to Mr Denbigh-White by the Council. The Committee had no reason to doubt her evidence and took into account the exhibits she provided in support of her account.

831. The evidence before the Committee is that the correspondence sent by the GDC to Mr Denbigh-White at his registered address was unable to be delivered and/or 'returned to sender'. However, the Committee was not satisfied that this proved this allegation. It considered that, in the absence of any information to suggest that Mr Denbigh-White was no longer using that registered address, it was more likely than not that he was simply ignoring the GDC and/or refusing to take delivery of the correspondence sent to him.

Charge 50

50. From 21 July 2020 – 16 February 2022, you failed to cooperate with an investigation conducted by the GDC, by not providing the GDC with any and/or insufficient evidence of indemnity.

Found proved.

832. The Committee was satisfied from the exhibits produced by the GDC Casework Manager that a number of letters were sent to Mr Denbigh-White by the GDC including requests for evidence of his indemnity. This included copies of letters that were sent to him as secure attachments within emails. The Committee noted the evidence indicating that on one occasion, 18 January 2021, one of these attachments was received at Mr Denbigh-White's email address and downloaded. There is nothing to indicate that he responded to the GDC on that occasion or that he provided the evidence sought.

833. The Committee also took into account that, on 18 June 2022, Mr Denbigh-White corresponded with the GDC to confirm that he would not be attending a hearing in 2022. It was satisfied that he was aware of all the allegations against him at that stage, including his alleged failure to cooperate with the GDC's investigation. However, no evidence of indemnity has been provided by him at any point.

834. In all the circumstances, the Committee was satisfied that this allegation is proved. It concluded that it was more likely than not that Mr Denbigh-White received the emails sent to him, and that he chose not to respond to them or to the postal correspondence.

835. The hearing now moves to Stage 2.

Stage Two 2 November 2023

1. The factual inquiry stage of the hearing commenced on 24 July 2023 and adjourned part-heard on 4 August 2023, whilst the Committee remained in camera on the facts. The Committee resumed in camera on 30-31 October 2023 and handed down its findings of fact on 1 November 2023.

2. As set out in the Committee's determination on the facts, Mr Denbigh-White failed to provide an adequate standard of care to sixteen patients. His clinical failings spanned a period of several years and included:

    - failures to take medical histories;
    - inadequate extra and intra-oral examinations, including not undertaking Basic Periodontal Examinations and other indicated periodontal assessments and special tests;
    - inadequate radiographic screening at examinations and in relation to root canal treatment, extraction and crown and bridgework;
    - inadequate treatment planning prior to, and poor quality of, endodontic treatments;
    - failures to obtain informed consent;
    - failures to diagnose caries and periodontal disease;
    - inappropriate use of glass ionomer as a permanent restorative material;
    - inappropriate prescribing of antibiotics;
    - poor record keeping.

3. In addition, Mr Denbigh-White failed to diagnose pain in one patient and provided a poor standard of bridgework to another. Many of his clinical failings were characterised by an apparent failure to adhere to relevant clinical guidelines and good practice guidance.

4. Between 21 July 2020 and 16 February 2022, Mr Denbigh-White also failed to cooperate with an investigation conducted by the General Dental Council (GDC) by not providing it with any evidence of indemnity, despite its repeated requests for this information.

5. At this stage of the hearing, the Committee has to decide whether the facts found proved (or any of them) amount to misconduct and/or deficient professional performance and, if so, whether Mr Denbigh-White's fitness to practise as a dentist is currently impaired on either or both grounds. If the Committee finds current impairment, it shall then decide on what action (if any) to take in respect of his registration.

6. The Committee had regard to the submissions made by Ms Culleton, on behalf of the GDC. She submitted that the facts found proved amount to misconduct and that Mr Denbigh-White's fitness to practise is currently impaired on that ground and/or on the ground of deficient professional performance. She submitted that a period of suspension for 9 months with a review might be the appropriate outcome in this case, but that it was also open to the Committee to consider directing erasure.

7. Mr Denbigh-White was neither present nor represented throughout the hearing. The Committee therefore did not have the benefit of receiving any evidence or submissions from him.

8. The Committee accepted the advice of the Legal Adviser.

9. The Committee had regard to the *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016, last revised December 2020).

Misconduct

10. The Committee first considered whether the facts found proved amount to misconduct. Misconduct is a serious departure from the standards reasonably expected of a dental professional. In assessing whether the facts found proved amount to misconduct, the Committee had particular regard to the following principles from *Standards for the Dental Team* (September 2013):

> 1.4: You must take a holistic and preventative approach to patient care which is appropriate to the individual patient
>
> 1.4.1 A holistic approach means you must take account of patients' overall health, their psychological and social needs, their long term oral health needs and their desired outcomes.
>
> 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.

2.2.1 You must listen to patients and communicate effectively with them at a level they can understand. Before treatment starts you must: explain the options (including those of delaying treatment or doing nothing) with the risks and benefits of each; and […]

2.3.6 You must give patients a written treatment plan, or plans, before their treatment starts and you should retain a copy in their notes. You should also ask patients to sign the treatment plan.

2.3.7 Whenever you provide a treatment plan you must include:

- the proposed treatment;
- a realistic indication of the cost;
- whether the treatment is being provided under the NHS (or equivalent health service) or privately (if mixed, the treatment plan should clearly indicate which elements are being provided under which arrangement).

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

4.1.1 You must make and keep complete and accurate patient records, including an up-to-date medical history, each time that you treat patients.

Radiographs, consent forms, photographs, models, audio or visual recordings of consultations, laboratory prescriptions, statements of conformity and referral letters all form part of patients records where they are available.

4.1.2 You should record as much detail as possible about the discussions you have with your patients, including evidence that valid consent has been obtained. You should also include details of any particular patient's treatment needs where appropriate.

7.1.1 You must find out about current evidence and best practice which affect your work, premises, equipment and business and follow them.

7.1.2 If you deviate from established practice and guidance, you should record the reasons why and be able to justify your decision.

9.4.1 If you receive a letter from the GDC in connection with concerns about your fitness to practise, you must respond fully within the time specified in the letter. You should also seek advice from your indemnity provider or professional association.

11. In the Committee's judgement, there have been substantial breaches of each of the above standards. Mr Denbigh-White's clinical failings were wide-ranging and serious.

The Committee accepted the opinion evidence of the GDC's expert witness that these failings fell far below the standard reasonably expected of him. In many cases, his clinical failings put his patients at a real risk of harm and, in some cases, caused actual harm resulting in the need for the patients to undergo further or remedial treatment. The Committee had regard to the number of patients involved and timeframe of several years over which many of the clinical failings were sustained and repeated. The Committee also had regard to the fact that many of the clinical failings related to basic and fundamental aspects of clinical practice. Mr Denbigh-White failed to adhere to relevant clinical guidelines and best practice guidance. He also failed to adhere to mandatory statutory requirements relating to radiography. His responses to the NHSE dental adviser indicate that he fully understood the relevant clinical guidelines, best practice guidelines and mandatory statutory requirements, but chose not to adhere to them or otherwise to implement them into his routine clinical practice. There was nothing to indicate to the Committee that any alternative approaches he had adopted to mainstream clinical practice were evidence-based or otherwise reflected a body of competent dental opinion.

12. Having regard to all the circumstances, the Committee determined that Mr Denbigh-White's clinical failings were serious and that they meet the threshold for misconduct.

13. The Committee also determined that his non-cooperation with the GDC's investigation was in clear breach of the professional standards to which he and all other registered dental professionals are subject. His non-cooperation was an attitudinal failing which undermined the regulatory role of the GDC in relation to its investigation into his fitness to practise in response to the clinical concerns which had been raised against him by the NHS. In the Committee's judgement, his breach of professional standards by not cooperating with the GDC investigation was serious and meets the threshold for misconduct.

14. Having determined that all of the facts found proved amount to misconduct, it was unnecessary for the Committee to consider whether the clinical failings would alternatively have amounted to deficient professional performance. Whilst the patient records appear to represent a fair sample of Mr Denbigh-White's work over a period of several years, his clinical failings, which are serious, are characterised more by an unwillingness to follow clinical guidelines and good practice guidance, rather than by an inability to do so or by any underlying lack of clinical skill or competence. The clinical failings are more properly characterised as misconduct than deficient professional performance.

Impairment

15. The Committee considered whether Mr Denbigh-White's misconduct is remediable, whether it had been remedied and the risk of repetition. The Committee also had regard to the wider public interest, which includes the need to uphold and declare proper standards of conduct and behaviour in order to maintain public confidence in the profession and its regulation.

16. The Committee was satisfied that Mr Denbigh-White's clinical failings would, in principle at least, be remediable through reflection, mentorship, further learning, targeted Continuing Professional Development (CPD) activity and evidence of

embedded improvement in practice. There was, however, no evidence before the Committee that these, or any other, remedial steps had been undertaken. Mr Denbigh-White has not engaged in these proceedings. He provides no evidence to the Committee of any insight, reflection or remediation. He also provides no testimonials or references in support of his character and performance as a dentist. He appears to have taken the decision to retire from clinical practice in response to the widespread clinical concerns which were initially raised with him by the NHS, rather than to address and remedy those concerns.

17. The Committee also considered that Mr Denbigh-White's clinical failings were largely attitudinal in nature, as opposed to being indicative of an underlying lack of clinical skill or ability. He was a highly experienced practitioner who appeared to be fully aware of relevant clinical guidelines and good practice guidance but chose not to adhere to them. In the Committee's judgement, this attitudinal aspect of his misconduct would make his clinical failings more difficult to remedy.

18. Mr Denbigh-White's failure to have co-operated with the GDC's investigation was also an attitudinal failing. His decision to have retired from clinical practice did not entitle him to avoid the regulatory process. By not cooperating with the GDC's investigation, he undermined the ability of his regulatory body to investigate his fitness to practise in response to significant and wide-ranging clinical concerns which had been raised against him by the NHS in response to its audit of his patient records.

19. In the absence of any evidence of insight, reflection or remediation, the Committee could not be satisfied that the risk of Mr Denbigh-White repeating his misconduct is low. In the Committee's judgement, there is a real risk that he would repeat his clinical failings were he to resume unrestricted practice. This would give rise to a high risk of harm to patients. Whilst Mr Denbigh-White states that he is now retired, there would be nothing to prevent him from changing his mind and resuming practice if he so wished.

20. In respect of Mr Denbigh-White's failure to have cooperated with the GDC's investigation, this was an attitudinal failing whereby he had shown a disregard for the importance of the GDC's regulatory process. In the Committee's judgement, this aspect of his misconduct would have been remediable through engagement, reflection and an expression of remorse. Mr Denbigh-White does not demonstrate any of these matters. He does not engage in the proceedings, expresses no acknowledgment of his misconduct and demonstrates no remorse. In those circumstances, the Committee found that there remains a real risk of repetition that Mr Denbigh-White might fail to cooperate with the GDC in respect of its important regulatory activities.

21. The Committee therefore determined that the unremedied clinical failings and the non-cooperation with the GDC give rise to a real risk of harm to the public should Mr Denbigh-White be allowed to resume practice without any restriction on his registration.

22. The Committee also determined that wider public confidence in the profession and its regulation would be seriously undermined if no finding of impairment were to be made. This is because of the seriousness of Mr Denbigh-White's misconduct, his lack of any apology to the Committee or to the NHS, his lack of engagement in the proceedings and his corresponding lack of any evidence of reflection, insight or remediation. He had put patients at an unwarranted risk of harm and had caused actual harm in some

cases. He has acted in a way which was liable to bring the profession into disrepute and has breached fundamental tenets of the profession.

23. Accordingly, the Committee determined that Mr Denbigh-White's fitness to practise as a dentist is currently impaired by reason of misconduct.

Sanction

24. The purpose of a sanction is not to be punitive, although it may have that effect, but to protect the public and to maintain wider public confidence in the profession.

25. The Committee had regard to the aggravating and mitigating features present in this case.

26. The aggravating factors include the length of time (several years) over which Mr Denbigh-White's clinical failings occurred, and the number of patients involved; the basic and fundamental nature of his clinical failings; his breaches of relevant clinical guidelines and good practice guidance; his putting his patients at an unwarranted risk of harm and, in some cases, causing actual harm to them resulting in their need undergo further or remedial treatment. In addition, he demonstrated a lack of insight.

27. In mitigation, the Committee recognised that Mr Denbigh-White has no other fitness to practise history over a long practising career.

28. The Committee considered sanction in ascending order of restrictiveness.

29. To conclude this case with no further action or a reprimand would be wholly inappropriate in the Committee's judgement. There remains a real risk of repetition. A reprimand would not protect the public and would in any event be insufficient to mark the seriousness of Mr Denbigh-White's misconduct, both in relation to his clinical failings and to his failure to have cooperated with the GDC's investigation.

30. The Committee next considered whether to direct that Mr Denbigh-White's registration be made conditional on his compliance with conditions for a period of up to 36 months, with or without a review.

31. The Committee could not identify any conditions which could be formulated to be workable, measurable and proportionate. Whilst conditions of practice might be capable of addressing clinical failings, the clinical failings in the present case encompass attitudinal issues which would be more difficult to address through conditional registration. Moreover, there has been no engagement from Mr Denbigh-White in these proceedings and he has previously failed to co-operate with the GDC's investigation. The Committee could not therefore be satisfied that he would now comply with any conditions on his registration. Further, he has stated that he is retired from practice, meaning that it would be difficult in any event for conditions of practice to be effective and to facilitate remediation of the clinical failings.

32. The Committee then considered whether to direct that Mr Denbigh-White's registration be suspended for a period of up to 12 months, with or without a review.

33. The Committee gave careful consideration to suspension and was satisfied that a period of suspension with a review would be sufficient to protect the public, in that it would prevent Mr Denbigh-White from being able to practise and to hold that status of a registered dentist for the duration of the suspension.

34. In considering the adequacy of suspension, the Committee also had regard to erasure. Whilst the facts of this case might not in themselves meet the threshold for erasure, the Committee had regard to Mr Denbigh-White's non-cooperation with the GDC's investigation and his lack of engagement in the proceedings. There is a lack of any evidence whatsoever of remorse, reflection, insight or remediation. There remains a real risk of repetition of both the clinical failings and the non-cooperation with the GDC. There was nothing to indicate to the Committee that Mr Denbigh-White acknowledges the matters which have been found proved against him or that he has any intention to attempt to remedy them. In the Committee's judgement, any committee reviewing this case at the end of a period of suspension would be in no different a position to that which currently presents itself.

35. It is likely in the Committee's judgement that Mr Denbigh-White would continue to not engage in the proceedings. In particular, it is likely that there would continue to be no evidence of any reflection, insight or remediation from him, including no acknowledgement by him of his misconduct and its seriousness; and no expression of remorse. Whilst erasure is a severe sanction of last resort, the fact of the matter is that Mr Denbigh-White has not shown any willingness to change, any acknowledgement of his shortcomings, offered no apology to his patients, offered no explanation to the GDC and has not engaged meaningfully at all with the hearing to give the Committee any confidence that he has a future consistent with proper professional practice. On the contrary, he has expressed a willingness to be removed from the Register. Having regard to all the circumstances, the Committee determined that a period of suspension with a review would be insufficient to meet the wider public interest in the upholding and declaring of proper standards of conduct and behaviour so as to maintain public confidence in the profession and its regulation.

36. Accordingly, the Committee directs that the name of Mr Denbigh-White be erased from the Register.

37. The Committee now invites submissions on the question of an immediate order.

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38. The interim order of suspension on Mr Denbigh-White's registration is hereby revoked.

39. The Committee determined that it is necessary for the protection of the public and is otherwise in the public interest to make an immediate order of suspension under section 30(1) of the Dentists Act 1984. It would be inconsistent with the decision the Committee has made not to make an immediate order.

40. The effect of this immediate order is that Mr Denbigh-White's registration shall be immediately suspended. Unless he exercises his right of appeal, his name will be erased from the Register upon the expiry of the 28-day appeal period. Should he exercise his right of appeal, this immediate order of suspension shall remain in force pending the disposal of the appeal.

41. That concludes the hearing.