General Dental Council | protecting patients, regulating the dental team

HEARING HEARD IN PUBLIC

MALATSI, Tryphosa Phillistus Shadi

Registration No: 83063

PROFESSIONAL CONDUCT COMMITTEE

OCTOBER 2016 - OCTOBER 2018*

Most recent outcome: Suspended indefinitely

***See page 16 for the latest determination**

Tryphosa Phillistus Shadi MALATSI, a dentist BChD MEDUNSA 1999, was summoned to appear before the Professional Conduct Committee on 3 October 2016 for an inquiry into the following charge:

Charge

"That, being a registered dentist:

1. Between 14 June 2011 and 8 February 2012 you provided dental care and treatment to Patient A including extensive bridgework to the upper jaw ("the Bridgework").
2. You failed to take and/or record taking a medical history.
3. You failed adequately and/or at all to carry out and/or record carrying out an examination of Patient A's:
   (a) extra-oral condition;
   (b) intra-oral soft tissues;
   (c) periodontal condition, including a BPE and/or pocket charting;
   (d) caries status;
   (e) existing teeth and/or restorations status.
4. You failed to carry out an assessment and/or treatment planning adequately in that you did not:
   (a) produce a written treatment plan;
   (b) produce study models;
   (c) mount and examine study models on a moveable articulator;
   (d) produce jaw records;
   (e) produce diagnostic wax ups;
   (f) assess the abutment teeth appropriately and/or at all.
5. You failed to discuss the risks and benefits of the bridgework with Patient A adequately and/or at all, including the poor prognosis.
6. In the circumstances described at (4)(a), 4(e) and (5) above you failed to obtain Patient A's informed consent to treatment.

7. You provided an inadequate standard of bridgework in that the tooth support was insufficient for the prosthesis.

8. On 5 July 2011 you caused or allowed periapical radiographs to be taken at UR3 and/or the UL2 ("the radiographs") but you failed to:

   (a) carry out/and or record carrying out a justification for the radiographs;

   (b) audit the radiographs for quality assurance purposes;

   (c) report on the radiographs adequately.

9. You failed to take radiographs which were clinically indicated for assessment purposes on one or more of the following dates:

   (a) 30 August 2011;

   (b) 29 September 2011;

   (c) 18 October 2011;

   (d) 21 November 2011;

   (e) 26 January 2012.

10. You failed timeously and/or at all to respond to Patient A's complaint set out in letters dated:

   (a) 7 November 2014;

   (b) 12 December 2014.

11. For a period of time between at least 22 April 2015 and 17 November 2015 you failed adequately and/or at all to co-operate with the General Dental Council's investigation including by not providing:

   (a) dental records;

   (b) details of indemnity insurance;

   (c) details of employment.

And in relation to the facts alleged above your fitness to practise is impaired by reason of misconduct."

Ms Malatsi was not present and was not represented. On 4 October 2016 the Chairman announced the findings of fact to the Counsel for the GDC:

"Ms Bruce,

Service

You appeared on behalf of the General Dental Council (GDC) at the Professional Conduct Committee (PCC) hearing of Ms Malatsi's case. Ms Malatsi was neither present nor represented at today's hearing. In her absence the Committee first considered whether the GDC had complied with service of the Notice of Hearing in accordance with Rules 13 and 65 of the GDC (Fitness to Practise) Rules Order of Council 2006 (the Rules).

The Committee took into account the submissions made by you on behalf of the GDC. It accepted the advice of the Legal Adviser.

The Committee received a copy of the Notification of Hearing, dated 23 August 2016, which was sent to Ms Malatsi's registered address, in South Africa, by way of International Special Delivery and by International Post. The Committee was satisfied that the letter contained proper notification of today's hearing, including its time, date and location, as well as notification that the Committee has the power to proceed with the PCC hearing in Ms Malatsi's absence. The Notification of Hearing also contained a copy of the charge against Ms Malatsi. The Committee was content that the Notification of Hearing complied with Rule 13. The Committee was provided with a copy of a Track and Trace receipt which confirmed a delivery attempt in 'SOUTH AFRICA before 14:47 on 19/09/16'. The Committee was also provided with an emailed copy of the Notification of Hearing which was sent to the email address held on file for Ms Malatsi. Taking all this into account, the Committee was satisfied that notification of this hearing had been served on Ms Malatsi in compliance with the rules.

Proceeding in the absence of Ms Malatsi

The Committee then considered whether to exercise its discretion under Rule 54 to proceed with this PCC hearing in Ms Malatsi's absence.

The Committee bore in mind the submissions made by you on behalf of the GDC. It accepted the advice of the Legal Adviser.

The Committee was mindful that this was a discretion that must be handled with the utmost care and caution. It also had regard to the need for fairness to both parties, as well as the public interest in the expeditious disposal of the hearing.

Ms Malatsi had been sent notification of this hearing. The Committee was provided with evidence of numerous attempts made by the GDC to contact Ms Malatsi in relation to this hearing. The Committee was therefore satisfied that she was or should be aware of today's hearing. The Committee noted that there had been no engagement from Ms Malatsi in relation to this PCC hearing. It also took into account that Ms Malatsi had not requested an adjournment of the hearing. It therefore concluded that she voluntarily absented herself from this hearing. The Committee was of the view that an adjournment would be unlikely to lead to Ms Malatsi's attending a future hearing.

Having weighed the interests of Ms Malatsi with those of the GDC and the public interest in the expeditious disposal of this hearing the Committee determined to proceed in Ms Malatsi's absence.

Evidence

The Committee heard oral evidence from Patient A. It considered her to be a credible and reliable witness who was doing her best to assist the Committee.

The Committee also heard oral evidence from Dr Marshall, the expert witness instructed by the GDC. It considered him to be a credible and reliable witness who did his best to give thorough answers.

The Committee was also provided with documentary material in relation to the heads of charge, namely: Patient A's dental records; a number of witness statements; an expert report prepared by Dr Marshall and a number of correspondence documents.

Committee's findings of fact

The Committee took into account all the evidence presented to it. It considered the submissions made by you on behalf of the GDC.

The Committee accepted the advice of the Legal Adviser.

The Committee reminded itself that the burden of proof lies with the GDC, and considered the heads of charge against the civil standard of proof, that is to say, on the balance of probabilities.

The Committee considered each head of charge separately although in respect of heads of charge 3.a - 3e, 8.a – 8.c, 10.a – 10.b and 11.a – 11.c its findings will be announced collectively.

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

1.	*Between 14 June 2011 and 8 February 2012 you provided dental care and treatment to Patient A including extensive bridgework to the upper jaw ("the Bridgework").* Found proved. The Committee noted in Patient A's dental records that on 26 January 2012 it was recorded 'fitted the bridge'. The Committee had sight of a photograph which showed a fixed bridge. The Committee also took into account Patient A's evidence that she had a bridge fitted during this timeframe. The Committee therefore found this charge proved.
2.	*You failed to take and/or record taking a medical history.* Found proved. The Committee noted there was no evidence of a medical history being taken in Patient A's dental records. The Committee also took account of Dr Marshall's written report in which he stated 'No *medical history* is evident'. The Committee therefore found it proved that Ms Malatsi failed to take and/or record taking a medical history.
3. 3.a 3.b 3.c 3.d 3.e	*You failed adequately and/or at all to carry out and/or record carrying out an examination of Patient A's:* *extra-oral condition;* *intra-oral soft tissues;* *periodontal condition, including a BPE and/or pocket charting;* *caries status;* *existing teeth and/or restorations status.* Found proved. The Committee accepted Dr Marshall's evidence contained in his written report, in which he stated, 'there is no evidence that clinical examination was carried out in a comprehensive manner as would be reasonably expected. No record exists of whether an appropriate peri-oral and intra-oral soft tissue examination was carried out, the process and mapping for this if any, and findings.' The Committee was of the view that, although there was some evidence of an examination being carried out and recorded in the records, the examination and recording of the examination

	were inadequate.
4.	*You failed to carry out an assessment and/or treatment planning adequately in that you did not:*
4.a	*produce a written treatment plan;* Found Proved. The Committee accepted Dr Marshall's evidence contained in his written report, in which he stated, 'There is no evidence of a written treatment plan being given to Patient A with detail of this recorded in the notes'. The Committee noted the dental records do state 'need to give treatment plan'. However, the Committee was of the view that it had no evidence that a treatment plan was ever given to Patient A. In light of this, the Committee found this charge proved.
4.b	*produce study models;* Found proved. The Committee took into account that in the dental records there was an entry for the 5 July 2011 in which it stated 'IMPS TAKEN AND SENT TO LAB PREVIOUSLY WITH PHOTOS:'. It also considered the entry of 14 June 2011 in which it stated 'IMPS TAKEN SENT TO LAB FOR TELESCOP[IC CROWNS QOUTATION'. The Committee was of the view these notes provided evidence that Ms Malatsi had an intention to provide study casts. However, the Committee considered it had no evidence before it that this intention was followed through and that the study casts were ever produced. The Committee therefore found this charge proved.
4.c	*mount and examine study models on a moveable articulator;* Found proved. In light of the Committee finding it proved that Ms Malatsi never produced study casts, the Committee was of the view that it would have been impossible for her to mount and examine study models on a moveable articulator. In light of this, the Committee found this charge proved.
4.d	*produce jaw records;* Found proved. The Committee accepted the evidence of Dr Marshall contained in his written report, in which he stated 'There is no information with regard to temporo-mandibular joint function…'. In light of this, the Committee found this charge proved.
4.e	*produce diagnostic wax ups;* Found proved. The Committee took into account the entry in Patient A's dental records for 5 July 2011 in which it was noted 'WE HAVE DECIDED WITH LAB TO DO A WAX UP TO SHOW PATIENT HOW THE TEETH WILL LOOK AND TO GET HER APPROVAL BEFORE WE GO AHEAD WITH THE PLAN'. The Committee was of the view this provided evidence of Ms Malatsi's intention to produce wax ups.

	However, the Committee was of the view that it was never followed through and diagnostic wax ups were not produced. The Committee also noted the evidence of Dr Marshall, contained in his written report, in which he stated 'Diagnostic and demonstration wax-ups seemed to be intended following the visit on 5/07/2011 as narrative states "we have decided with lab to do a wax up to show patient how teeth will look and get her approval before we go ahead with the plan" but there is no specific indication as to how these were utilized thereafter in treatment planning'. The Committee therefore found this charge proved.
4.f	*assess the abutment teeth appropriately and/or at all.* Found proved. The Committee noted there was some assessment of the abutment teeth contained in the dental records. However, the Committee was of the view the assessment was not comprehensive and therefore not carried out appropriately or adequately. The Committee therefore found this charge proved. The Committee found charges 4.a – 4.f proved. In light of this, the Committee found it proved that Ms Malatsi failed to carry out an assessment and/or treatment planning adequately.
5.	*You failed to discuss the risks and benefits of the bridgework with Patient A adequately and/or at all, including the poor prognosis.* Found proved. The Committee accepted Patient A's evidence in her written statement, in which she explained, 'I cannot recall exactly what Ms Malatsi told me about the risks and benefits of the bridge treatment, but I know that I would never have had it done if she had given me an indication that it wouldn't last'. The Committee took into account that in oral evidence Patient A also stated that, had she known there was a chance the bridge would not have been a permanent solution, she would not have gone ahead with the treatment. The Committee noted the reference in Patient A's dental records on 5 July 2011, in which it stated, 'had a discussion with patient and the lab separately about the discussed treatment plan'. However, the Committee was not of the view that this was not an adequate discussion of the risk and benefits of such an advance fixed bridge treatment plan. In light of this, the Committee found it proved that Ms Malatsi failed to adequately discuss the risks and benefits of the bridgework, including the poor prognosis, with Patient A.
6.	*In the circumstances described at (4)(a), 4(e) and (5) above you failed to obtain Patient A's informed consent to treatment.* Found proved. The Committee was of the view that informed consent meant the patient was fully aware all aspects in relation to the treatment in order for her to make an informed decision. The Committee determined that, in light of a written treatment plan not being provided, the diagnostic wax ups not being produced and the risk and benefits of the treatment not being adequately discussed with Patient A, that Ms Malatsi had failed to obtain Patient A's informed consent to the treatment. The Committee therefore found this charge proved.

7.	*You provided an inadequate standard of bridgework in that the tooth support was insufficient for the prosthesis.* Found proved. The Committee accepted Patient A's evidence that the bridgework had failed. The Committee also accepted Dr Marshall's evidence, contained in his written report, in which he stated 'the likelihood of failure in the short term was high in my opinion as on the balance of probabilities early debonding on one or more of the abutments could possibly go unnoticed with consequent microleakage and resultant caries, which would further complicate the already compromised situation and accelerate the inevitable failure as has demonstrably occurred'. The Committee took into account the photographic evidence referred to by Dr Marshall of Patient A's failed cemented fixed bridge. The Committee therefore found this charge proved.
8. 8.a 8.b 8.c	*On 5 July 2011 you caused or allowed periapical radiographs to be taken at UR3 and/or the UL2 ("the radiographs") but you failed to:* *carry out/and or record carrying out a justification for the radiographs;* *audit the radiographs for quality assurance purposes;* *report on the radiographs adequately.* Found proved. The Committee took into account that in Patient A's dental records there was an entry for 5 July 2011 noting '3. PA'S TAKEN OF THE UR3 AND THE UL2'. The Committee accepted Dr Marshall evidence contained in his written report that 'at the following visit 5/07/2011 prior to, or as an integral part of, treatment planning for the bridgework for Patient A two periapical radiographs are taken of 13(UR3) and 22(UL2). These are not justified or the subject of audit for QA purposes as is required…'. The Committee considered that it is part of compliance with IRMER that a dentist carries out and records the justification for the radiographs, audits the radiographs for quality assurance purposes and reports on the radiographs adequately. The Committee was of the view that these three steps were not completed by Ms Malatsi. The Committee also noted Dr Marshall's evidence contained in his written report that 'the standard of radiographic practice fell far below reasonably expected normative standards for a general dentist because IRR99 and IR(ME)R2000 compliance was not recognised and achieved'. In light of these reasons, the Committee found this charge proved.
9.	*You failed to take radiographs which were clinically indicated for assessment purposes on one or more of the following dates:*
9.a	*30 August 2011;* Found proved. The Committee noted it had no radiograph before it for this date and no record of it being taken in the notes. The Committee was of the view that it had not been provided with any evidence to indicate a radiograph was taken on this date. In light of this, the Committee found this charge proved.

9.b	*29 September 2011;* Found proved. For the same reasons as outlined at charge 9.a.
9.c	*18 October 2011;* Found not proved. The Committee considered the entry on this date to be an administrative note and not a record of Patient A being seen that day. The Committee therefore concluded that a radiograph would not have been required on this date. In light of this, the Committee found this charge not proved.
9.d	*21 November 2011;* Found proved. For the same reasons as outlined at charge 9.a.
9.e	*26 January 2012.* Found proved. For the same reasons as outlined at charge 9.a.
10. 10.a 10.b	*You failed timeously and/or at all to respond to Patient A's complaint set out in letters dated:* *7 November 2014;* *12 December 2014.* Found proved. The Committee was provided with copies of the letters for each of these dates. The Committee accepted Patient A's evidence, contained in her written statement, that she had never received a response to either letter. In light of this, the Committee found it proved that Ms Malatsi failed to respond at all to Patient A's complaints. The Committee therefore found this charge proved.
11. 11.a 11.b 11.c	*For a period of time between at least 22 April 2015 and 17 November 2015 you failed adequately and/or at all to co-operate with the General Dental Council's investigation including by not providing:* *dental records;* *details of indemnity insurance;* *details of employment.* Found proved. The Committee noted it had no evidence before it to indicate Ms Malatsi had co-operated with the investigation at all. The Committee accepted that evidence of witness RB, contained in his witness statement, that 'I can confirm that I did not receive any response from Ms Malatsi for the entirety of the investigation'. In light of this, the Committee found this charge proved.

The hearing will now proceed to stage 2."

On 5 October 2016 the Chairman announced the determination as follows:

"Ms Bruce,

Background

The Committee found it proved that between 14 June 2011 and 8 February 2012 Ms Malatsi provided dental care and treatment to Patient A including extensive bridgework to the upper jaw. It also found it proved that Ms Malatsi: failed to take and/or record taking Patient A's medical history; failed to adequately carry out and record carrying out an examination of Patient A; failed to carry out an assessment and treatment planning adequately; failed to discuss adequately the risks and benefits of the bridgework with Patient A, including the poor prognosis; failed to obtain Patient A's informed consent.

The Committee also found proved that Ms Malatsi provided an inadequate standard of bridgework. It found proved that in relation to the radiographs taken at UR3 and UL2 Ms Malatsi failed to: carry out and record carrying out justification for the radiographs; audit the radiographs for quality assurance purposes and failed to report on the radiographs adequately. The Committee also found it proved that Ms Malatsi failed to take radiographs which were clinically indicated for assessment purposes on a number of occasions.

The Committee found it proved that Ms Malatsi failed to respond at all to both of Patient A's complaint letters and that for the period of at least 22 April 2015 to 17 November 2015 Ms Malatsi failed to cooperate with the GDC's investigation.

Submissions

Having announced its findings on all the facts, the Committee heard submissions from you on the matters of misconduct, impairment and sanction.

In accordance with Rule 20 (1) (a) you informed the Committee that Ms Malatsi has previous fitness to practice history. You provided the Committee with a copy of the notification of outcome letter of an Investigating Committee (IC) meeting which was held on 1 May 2014 in relation to Ms Malatsi's fitness to practice. The IC decided to close that matter with advice.

You submitted that the clinical failings in this case are of a serious nature and that they might be aggravated by the fact the Committee also found it proved that Ms Malatsi failed to respond to Patient A's complaint and failed to cooperate with the GDC's investigation. You outlined the standards which in your submission have been breached. You submitted that the facts found proved do amount to misconduct that is serious.

In relation to current impairment you submitted that, the Committee had nothing before them by way of evidence of remediation or the rehabilitative steps Ms Malatsi may have taken. You submitted that in light of the lack of evidence in relation to remediation and insight it must follow that Ms Malatsi's fitness to practise is currently impaired by reason of misconduct.

You addressed the Committee on the matter of sanction and referred it to the GDC's Guidance for the Practice Committees, including Indicative Sanctions Guidance (October 2015). You outlined to the Committee the mitigating and aggravating factors that it might want to consider. You submitted that the appropriate and proportionate sanction in this case was one of suspension for 12 months.

Committee's decision

The Committee had regard to all the evidence before it and took account of your submissions on behalf of the GDC. In its deliberations the Committee had regard to the GDC's Guidance for the Practice Committees, including Indicative Sanctions Guidance (October 2015).

The Committee accepted the advice of the Legal Adviser.

Decision on misconduct

The Committee first considered whether the facts found proved amounted to misconduct. In considering the matter, the Committee exercised its own independent judgement. The Committee reminded itself of the extent and nature of the findings made against Ms Malatsi. The Committee's reasons for its findings have been set out in full in its determination on the facts.

When determining whether the facts found proved amounted to misconduct the Committee had regard to the terms of the relevant professional standards in force at the time.

The Committee concluded that Ms Malatsi's conduct was in breach of the GDC's *Standards for Dental Professionals* (May 2005) as set out below:

1.3 Work within your knowledge, professional competence and physical abilities. Refer patients for a second opinion and for further advice when it is necessary, or if the patient asks. Refer patients for further treatment when it is necessary to do so.

1.4 Make and keep accurate and complete patient records, including a medical history, at the time you treat them. Make sure that patients have easy access to their records.

2.2 Recognise and promote patients' responsibility for making decisions about their bodies, their priorities and their care, making sure you do not take any steps without patients' consent (permission). Follow our guidance 'Principles of patient consent'.

2.4 Listen to patients and give them the information they need, in a way they can use, so that they can make decisions. This will include: communicating effectively with patients; explaining options (including risks and benefits); and giving full information on proposed treatment and possible costs.

5.1 Recognise that your qualification for registration was the first stage in your professional education. Develop and update your knowledge and skills throughout your working life.

5.2 Continuously review your knowledge, skills and professional performance. Reflect on them, and identify and understand your limits as well as your strengths.

5.3 Find out about current best practice in the fields in which you work. Provide a good standard of care based on available up-to-date evidence and reliable guidance.

The Committee also concluded that Ms Malatsi's conduct was in breach of the Standards for the Dental Team (2013) as set out below:

5.1 Make sure that there is an effective complaints procedure readily available for patients to use, and follow that procedure at all times.

5.3 Give patients who complain a prompt and constructive response.

9.4 Co-operate with any relevant formal or informal inquiry and give full and truthful information.

The Committee appreciated that whilst the above breaches do not automatically result in a finding of misconduct they are serious and capable of undermining public confidence in the profession.

The Committee was of the view that Ms Malatsi's clinical failings along with her failure to respond to Patient A's complaints and failure to cooperate with the GDC's investigation would be considered serious failings which fell far below the standard expected of a reasonably competent dentist. It felt that Ms Malatsi's clinical failings were serious enough that they would be considered deplorable by fellow practitioners. It took the same view in relation to Ms Malatsi's failure to respond to Patient A's complaint and her failure to engage with the GDC as her regulator.

Accordingly, the Committee determined that the facts found proved do amount to misconduct.

Decision on current impairment

The Committee next considered whether Ms Malatsi's fitness to practice is currently impaired by reason of her misconduct. In reaching its decision on impairment, the Committee exercised its own independent judgement. It has borne in mind that its duty is to consider the public interest, which includes the protection of patients, the maintenance of public confidence in the profession and the declaring and upholding of proper standards of conduct and behaviour.

In reaching its decision the Committee had regard to whether Ms Malatsi's failings were remediable and whether it had been provided with evidence that these failings had been remediated. The Committee concluded that it had no evidence before it to demonstrate any remediation undertaken by Ms Malatsi to address her failings.

The Committee also considered whether it had been provided with any evidence to demonstrate Ms Malatsi had developed a level of insight into her failings. It concluded that it had no evidence that Ms Malatsi had any insight into her failings and therefore the Committee was of the view that there does remain a significant risk of repetition in this case. The Committee took into account that Ms Malatsi has not engaged at all with the GDC's investigation or this hearing.

The Committee bore in mind that its primary function is to protect patients. It has also taken into account the wider public interest, which includes maintaining confidence in the dental profession and the GDC as a regulator, and upholding proper standards and behaviour. The Committee concluded that to make a finding of no current impairment would send a message to the public and the profession that Ms Malatsi's conduct was acceptable.

The Committee had regard to the serious nature of the issues identified in the circumstances of this case when reaching this decision. The Committee concluded that Ms Malatsi's failings overall, which include significant concerns regarding her standard of clinical practice, her failure to respond to patient complaints and her failure to cooperate with the GDC as her regulator amounted to current impairment.

Having regard to all of this, the Committee concluded that Ms Malatsi's fitness to practise is currently impaired by reason of misconduct.

Decision on sanction

Having determined that Ms Malatsi's fitness to practise is currently impaired by reason of her misconduct, the Committee considered what sanction, if any, to impose on her registration.

It reminded itself that the purpose of a sanction is not to be punitive, but to protect patients and the wider public interest.

The Committee considered the range of sanctions available to it, starting with the least serious. It applied the principle of proportionality, balancing the public interest with Ms Malatsi's own interests.

In considering the matter of sanction, the Committee considered the mitigating and aggravating factors in this case. In mitigation:

- there appeared to be no financial motivation on Ms Malatsi's part; and
- the case involved a single patient complaint.

Aggravating factors include:

- there was actual harm or risk of harm to a patient;
- there has been a blatant and wilful disregard to the role of the GDC and the systems regulating the profession;
- Ms Malatsi has another adverse finding; and
- the Committee has no evidence of any insight on Ms Malatsi's part due to her failure to engage.

The Committee determined that it would be wholly inappropriate to conclude this case without taking any action in respect of Ms Malatsi's registration, given the serious nature of her clinical failings, her failure to respond at all to a patient complaint and her complete lack of cooperation with the GDC in its investigation into her fitness to practise. It reached the same conclusion in respect of a reprimand. It considered that such a sanction would be insufficient in that it would be inadequate to protect patients and the wider public interest in the circumstances of this case.

The Committee then went on to consider whether conditional registration would provide the necessary level of public protection and would protect the public interest. Whilst the Committee was of the view that it could formulate conditions to address Ms Malatsi's failings, central to this case was Ms Malatsi's failure to cooperate with the GDC during its investigation of her fitness to practise. The Committee concluded that no conditions could be formulated which would be sufficiently workable, practicable and measurable, in a case such as this where the registrant concerned consistently refused to engage with her regulator in its role to protect patients. The Committee determined that conditions would be inadequate to protect patients and the wider public interest in the circumstances of this case.

The Committee next considered whether a period of suspension would be appropriate in this case. The Committee determined that a period of suspension would be necessary to mark the gravity of the concerns regarding Ms Malatsi's clinical failings, her failure to respond to Patient A's complaint as well her failure to cooperate with the GDC. The Committee concluded that, due to the lack of evidence of any remediation or insight on Ms Malatsi's part into her failings, there remains a risk of repetition and therefore a period of suspension is needed to protect the public and the wider public interest. It was of the view that public protection and public confidence in the profession and the GDC, as its regulator, would not be upheld by any lesser sanction than one of suspension.

The Committee did consider whether erasure would be the appropriate and proportionate sanction but concluded that erasure would be disproportionate in this case.

In considering the length of suspension the Committee was of the view that the maximum, 12 month period of suspension was necessary because of the severity of the concerns raised. The Committee was of the view that 12 months would also provide enough time for Ms Malatsi to engage in this process and to demonstrate any insight and/or remediation she might have gained during this period.

The Committee therefore decided to suspend Ms Malatsi's registration for a period of 12 months, and for the case to be reviewed prior to the end of the period of suspension. A Committee will review Ms Malatsi's case at a resumed hearing to be held shortly before the end of the period of suspension on her registration.

A reviewing Committee may be assisted by receiving the following:

- a reflective statement from Ms Malatsi;
- evidence of Ms Malatsi completing relevant continuing professional development (CPD);
- Ms Malatsi providing evidence that she understands the complaints handling procedure;
- demonstration from Ms Malatsi that she has engaged with the GDC as her regulator.

The Committee will now invite submissions on whether an immediate order should be imposed."

Immediate order

"Having directed that Ms Malatsi's name be suspended from the register, the Committee considered whether to impose an order for her immediate suspension in accordance with section 30. (1) of the Dentists Act 1984 (as amended).

The Committee took into account your submissions on behalf of the GDC. It accepted the advice of the Legal Adviser.

The Committee determined that an immediate order was necessary to protect the public and was otherwise in the public interest.

If, at the end of the appeal period of 28 days, Ms Malatsi has not lodged an appeal, this immediate order will lapse and will be replaced by the substantive direction of suspension for a period of 12 months. If Ms Malatsi does lodge an appeal, this immediate order will continue in effect until that appeal is determined.

The Committee hereby revokes the current interim order on Ms Malatsi's registration.

That concludes the case for today."

At a review hearing on 17 October 2017 the Chairman announced the determination as follows:

"This is a resumed hearing for the purposes of s 27C of the Dentists Act 1984. Ms Malatsi is neither present nor represented. On behalf of the General Dental Council (GDC), Mr Ahmed submitted that service of the notification of hearing had been effected in accordance with the General Dental Council (Fitness to Practise) Rules 2006 (the Rules) and that the hearing should proceed, notwithstanding Ms Malatsi's absence.

Service and absence

The notification of hearing, dated 1 September 2017, incorrectly states that the hearing is being held at the 4-12 Norton Folgate venue when, due to a late change in the listing of the case, the Committee are in fact convened at 37 Wimpole Street. Mr Ahmed assured the Committee that full arrangements were in place at the other venue to identify and transport Ms Malatsi and any of her representatives to the correct venue, in the event that any of them arrived at 4-12 Norton Folgate for the hearing, which is scheduled to start at 9:30. The Committee was therefore satisfied that the notification of hearing was not invalid by reason of the incorrect venue being stated.

In the event, as at 9:55, neither Ms Malatsi nor any representative on her behalf attended at either venue.

The notification of hearing otherwise correctly contained all the prescribed information and the Committee was satisfied that it had been served on Ms Malatsi in accordance with the requirements of Rules 28 and 65.

The Committee next considered whether to exercise its discretion to proceed, notwithstanding the absence of Ms Malatsi. This is a discretion which must be exercised with the utmost care and caution. The notification of hearing, which had also been sent to Ms Malatsi by email, stated that Ms Malatsi was required to confirm whether she would be attending the hearing and/or whether she would be represented. She was asked to do so by 15 September 2017. The notification stated that the Committee had the power to proceed in her absence and that this could be "severely prejudicial" to her case.

By emails sent on 4 and 10 October 2017 the GDC also asked Ms Malatsi to confirm whether she would be attending this hearing or be represented.

No response was received from Ms Malatsi and there had been no other engagement from her regarding these proceedings. She also did not attend or otherwise engage with the initial Professional Conduct Committee (PCC) hearing in October 2016. On 13 October 2017 attempts were made by the GDC to contact Ms Malatsi regarding this hearing using the home and mobile telephone numbers she had provided, but it was unable to do so.

The Committee was satisfied that the GDC have made all reasonable efforts to notify Ms Malatsi of the hearing. There has been no engagement from her, including no application for a postponement. Ms Malatsi did not attend her initial hearing last year. There is therefore nothing to suggest that an adjournment would make her attendance more likely at a future date. Having regard to all the circumstances, including the pending expiry of the suspension of Ms Malatsi's registration, the Committee concluded that she had voluntarily absented herself and that it would be fair and in the interests of justice to proceed, notwithstanding her absence.

The Committee drew no adverse inferences from Ms Malatsi's absence.

Background

On 5 October 2016 the PCC found Ms Malatsi's fitness to practise to be impaired by reason of her misconduct, the background to which it summarised as follows:

> The Committee found it proved that between 14 June 2011 and 8 February 2012 Ms Malatsi provided dental care and treatment to Patient A including extensive bridgework to the upper jaw. It also found it proved that Ms Malatsi: failed to take and/or record taking Patient A's medical history; failed to adequately carry out and record carrying out an examination of Patient

> A; failed to carry out an assessment and treatment planning adequately; failed to discuss adequately the risks and benefits of the bridgework with Patient A, including the poor
>
> prognosis; failed to obtain Patient A's informed consent.
>
> The Committee also found proved that Ms Malatsi provided an inadequate standard of bridgework. It found proved that in relation to the radiographs taken at UR3 and UL2 Ms Malatsi failed to: carry out and record carrying out justification for the radiographs; audit the radiographs for quality assurance purposes and failed to report on the radiographs adequately. The Committee also found it proved that Ms Malatsi failed to take radiographs which were clinically indicated for assessment purposes on a number of occasions.
>
> The Committee found it proved that Ms Malatsi failed to respond at all to both of Patient A's complaint letters and that for the period of at least 22 April 2015 to 17 November 2015 Ms Malatsi failed to cooperate with the GDC's investigation.

In finding misconduct, the initial PCC stated:

> …Ms Malatsi's clinical failings along with her failure to respond to Patient A's complaints and failure to cooperate with the GDC's investigation would be considered serious failings which fell far below the standard expected of a reasonably competent dentist. It felt that Ms Malatsi's clinical failings were serious enough that they would be considered deplorable by fellow practitioners. It took the same view in relation to Ms Malatsi's failure to respond to Patient A's complaint and her failure to engage with the GDC as her regulator.

As Ms Malatsi did not attend the hearing or otherwise engage in the proceedings, there was no evidence of any remediation or insight. The initial PCC therefore concluded that there was a "*significant risk*" of repetition and that Ms Malatsi's misconduct was so serious that "*to make a finding of no current impairment would send a message to the public and the profession that Ms Malatsi's conduct was acceptable.*"

The initial PCC directed that Ms Malatsi's name be suspended for a period of 12 months with a review, noting that:

> A reviewing Committee may be assisted by receiving the following:
>
> - a reflective statement from Ms Malatsi;
> - evidence of Ms Malatsi completing relevant continuing professional development (CPD);
> - Ms Malatsi providing evidence that she understands the complaints handling procedure;
> - demonstration from Ms Malatsi that she has engaged with the GDC as her regulator.

Emailed letters dated 11 October 2016 and 17 February 2017 were also sent to Ms Malatsi by the GDC Case Review Team to remind her of the relevance of that advice for the review hearing.

Decision

The role of the Committee today is to review the suspension. In so doing, it heard the submissions made by Mr Ahmed. The Committee accepted the advice of the Legal Adviser. The Committee had regard to the *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016).

There is a persuasive burden on Ms Malatsi to demonstrate to this reviewing Committee that she acknowledges the deficiencies in her practice and has adequately addressed them. Given her complete lack of engagement, there is no evidence at all of any insight, reflection or remediation. Although Ms Malatsi's failings are potentially remediable, the Committee is in

no different a position to that of the initial PCC a year ago. There remains a significant risk of repetition of Ms Malatsi's misconduct. There continues to be a real risk of harm to patients should Ms Malatsi be allowed to practise without restriction. Further, given the seriousness of her misconduct, and her failure to demonstrate any insight, reflection or remediation, public confidence in the profession and this regulatory process would also be seriously undermined if a finding of impairment were not made.

Accordingly, the Committee finds that Ms Malatsi's fitness to practise as a dentist continues to be impaired by reason of her misconduct. The Committee considered what sanction, if any, to impose on her registration. The purpose of a sanction is not to be punitive, although it may have that effect, but to protect the public and the wider public interest. To conclude this case with no further action would be inappropriate, given the risk of harm to both patients and public confidence in the profession. No conditions of practice could be formulated in the absence of any engagement from Ms Malatsi which would be measurable, workable or proportionate. There is no indication that she would comply with conditions on her registration.

The suspension of Ms Malatsi's registration therefore remains necessary and proportionate. The Committee directs that the period of suspension be extended by a further period of 12 months, beginning with the date on which it would otherwise expire. The suspension shall be reviewed prior to its expiry.

That concludes the hearing today."

At a review hearing on 23 October 2018, the Chairman announced the determination as follows:

"Service and Proceeding in absence

This is a Professional Conduct Committee (PCC) review hearing of Ms Malatsi's case which is being held in accordance with Section 27C of the Dentists Act 1984 (the Act). Ms Malatsi is neither present nor represented today. In her absence, the Committee first considered whether the Notification of Hearing had been served on Ms Malatsi at her registered address in accordance with Rule 28 and Section 50A(2) of the Act. The Committee has received a bundle of documents which contains a copy of the Notification of Hearing dated 10 September 2018, addressed to Ms Malatsi at her registered address in South Africa, which contains a track and trace barcode at the top of the letter. The Royal Mail track and trace receipt confirms that the item with the same barcode shown on the Notification of Hearing was despatched on 12 September 2018. The Committee is satisfied that the Notification of Hearing set out the information required by Rule 28 and that it was sent to Ms Malatsi's registered address more than 28 days in advance of today's hearing, also in accordance with Rule 28. The Committee also notes that the GDC sent notification of today's hearing to Miss Malatsi by email on 10 September. The Committee, having heard the Legal Adviser's advice, is satisfied that the GDC has complied with Rule 28 and Section 50(A)(2) of the Act.

The Committee went on to consider whether to proceed in the absence of Ms Malatsi and on the basis of the papers, in accordance with Rule 54. It has considered the GDC's written submissions dated October 2018 which invites the Committee to do so. The GDC refers to the telephone attendance note dated 15 October 2018 regarding the attempts made by the GDC that day to contact Ms Malatsi by telephone (two international numbers in South Africa), but with an indication that there was no one by that name at those numbers. The GDC's position is that no response has been received from Ms Malatsi in respect of any of

the efforts made by to the GDC to contact her. It submits that there would be little benefit in adjourning today's hearing as there is no indication that Ms Malatsi would attend at a future hearing, given her pattern of non-attendance on previous occasions. Furthermore, the GDC reminds the Committee that the current suspension order needs to be reviewed before its expiry on 6 November 2018.

The Committee notes the absence of any response from Ms Malatsi in connection with today's hearing and indeed at the initial hearing in October 2016 and at the review hearing in October 2017. There is nothing before the Committee today to suggest that Ms Malatsi might attend the hearing on a future occasion, given her history of non-attendance at these proceedings. In these circumstances, the Committee has concluded that Ms Malatsi has voluntarily absented herself from today's hearing. In addition, the Committee considers that there is a clear public interest in reviewing the order today, given its imminent expiry. Accordingly, the Committee has determined that it is fair to proceed with today's review hearing on the basis of the papers and in the absence of both parties.

Background

Ms Malatsi's case was first considered by the PCC at a hearing on 5 October 2016. At that hearing the PCC found proved that between 14 June 2011 and 8 February 2012 Ms Malatsi provided dental care and treatment to Patient A, which included extensive bridgework to the upper jaw. It found proved that Ms Malatsi: failed to take and/or record taking Patient A's medical history; failed to adequately carry out and record carrying out an examination of Patient A; failed to carry out an assessment and treatment planning adequately; failed to discuss adequately the risks and benefits of the bridgework with Patient A, including the poor prognosis; failed to obtain Patient A's informed consent.

The PCC also found proved that Ms Malatsi provided an inadequate standard of bridgework. It found proved that in relation to the radiographs taken at UR3 and UL2 Ms Malatsi failed to: carry out and record carrying out justification for the radiographs; audit the radiographs for quality assurance purposes and failed to report on the radiographs adequately. The Committee also found it proved that Ms Malatsi failed to take radiographs which were clinically indicated for assessment purposes on a number of occasions.

Finally, the PCC found proved that Ms Malatsi failed to respond at all to Patient A's complaint letters and that for the period of at least 22 April 2015 to 17 November 2015 Ms Malatsi failed to cooperate with the GDC's investigation.

The PCC took a serious view of the findings against Ms Malatsi and determined that they amounted to misconduct. As Ms Malatsi did not attend the hearing or otherwise engage in the proceedings, there was no evidence of any remediation or insight. The PCC concluded that there was a "significant risk" of repetition and that a finding of current impairment was also necessary in the public interest given the serious nature of the findings against Ms Malatsi. The PCC directed that Ms Malatsi's registration be suspended for a period of 12 months. It was satisfied that any lesser sanction would not be sufficient for the protection of patients or the wider public interest issues identified in the case, particularly given the lack of any evidence of any remediation or insight on the part of Ms Malatsi. It considered that 12 months would provide enough time for Ms Malatsi to engage in the process and to demonstrate any insight and/or remediation she might have gained during this period. The PCC also set out information that a reviewing PCC might be assisted with receiving, including the following:

- a reflective statement from Ms Malatsi;

- evidence of Ms Malatsi completing relevant continuing professional development (CPD);
- Ms Malatsi providing evidence that she understands the complaints handling procedure;
- demonstration from Ms Malatsi that she has engaged with the GDC as her regulator

The PCC reviewed the order at a hearing which took place on 17 October 2017. Ms Malatsi was not present or represented and she had not engaged with the GDC in relation to the hearing, despite attempts made by the GDC to secure her involvement. The PCC decided to proceed in her absence. It noted the absence of any evidence of insight, reflection or remediation. The PCC was, in effect in no different a position to that of the initial PCC a year ago. In the PCC's view, there remained a significant risk of repetition of Ms Malatsi's misconduct and thus a real risk of harm to patients should she be allowed to practise without restriction. The PCC determined that Ms Malatsi's fitness to practise remained impaired. It directed that Ms Malatsi's registration be suspended for a further period of 12 months, beginning on the date on which it would otherwise expire.

Today's review

At today's hearing this Committee has comprehensively reviewed the current order. In so doing, the Committee has had regard to the GDC prosecution bundle, which contains copies of letters and emails from the GDC's Case Review Team to Ms Malatsi, reminding her of the recommendations made by the PCC on 17 October 2017 and the date(s) by which she was required to provide the information. Ms Malatsi has not replied to the GDC's requests for information, despite being given ample opportunity to do so.

The GDC submits that Ms Malatsi's fitness to practise remains impaired. The GDC refers to Ms Malatsi's complete lack of engagement over a prolonged period of time and the absence of any evidence of insight into her failings. There is no information before the Committee to suggest that this position would change in the short-term future. It is the GDC's position that the Committee should consider directing that Ms Malatsi's registration be suspended indefinitely, in light of the cost involved of additional hearings and the absence of any engagement by the Registrant. This direction would be in accordance with section of 27C(1)(d) of the Dentists Act 1984 (as amended) (the Act).

The Committee has considered carefully the submissions made by the GDC, there being no information from Ms Malatsi. Throughout its deliberations, it has borne in mind that its primary duty is to address the public interest, which includes the protection of patients, the maintenance of public confidence in the profession and in the regulatory process, and the declaring and upholding of proper standards of conduct and behaviour. The Committee has accepted the advice of the Legal Adviser.

There is no evidence before this Committee that Ms Malatsi has addressed any of the deficiencies identified by the PCC at the initial hearing in October 2016 or at the review hearing in October 2017. During that time Ms Malatsi has not engaged with the GDC. The position is that there is no evidence before the Committee to satisfy it that any of the concerns identified by the previous PCCs have been addressed adequately or at all. Given these factors, the Committee considers that Ms Malatsi remains a risk to the public. It has determined that her fitness to practise remains impaired.

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

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

The Committee considered whether to replace the current suspension order with one of conditions. In so doing, it had regard to the absence of any evidence of remediation from Ms Malatsi and her non-engagement with the GDC over the last two years. Further, it has no information as to her current working situation. In these circumstances, the Committee is not satisfied that conditions are appropriate, workable or sufficient for the protection of the public.

The Committee then went on to consider whether to direct that the current period of suspension be extended for a further period. It has borne in mind Ms Malatsi's continuing lack of engagement with the GDC over a long period of time, despite being given the opportunity to do so, as well as the absence of any insight or remediation. Ms Malatsi's decision not to participate in these proceedings over the last two years has exacerbated the situation. In these circumstances, the Committee has concluded that a further period of suspension of 12 months would not be in Ms Malatsi's interests or that of the GDC. Accordingly, the Committee directs that Ms Malatsi's registration be suspended indefinitely. It is satisfied that this is the proportionate and appropriate outcome and that the provisions of Sections 27C(1)(d)(i) and (ii) of the Act are met.

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

That concludes this case for today."