HEARING HEARD IN PUBLIC

PHOTAY, Rekha Rani

Registration No: 256795

PROFESSIONAL CONDUCT COMMITTEE

MAY 2022

Outcome: Erased with Immediate suspension

PHOTAY Rekha Rani, a dentist, Lek Dent Poznan 2014 Registered under s15(1)(ba) of the Dentists Act 1984 2015, was summoned to appear before the Professional Conduct Committee on 16 May 2022 for an inquiry into the following charge:

CHARGE (as amended on 17 May 2022)

"That being a registered dentist:

Patient 1

1. From 26 October 2017 to 23 November 2017, you failed to provide an adequate standard of care to Patient 1, in that:
   a) You recorded an inaccurate Basic Periodontal Examination on the 26 October 2017;
   b) You provided a poor standard of treatment to Patient 1 on 13 November 2017, in that you left a composite overhang in relation to a restoration placed at Patient 1's UL5 and/or UL6;
2. On 26 October 2017 you failed to maintain an adequate standard of record keeping in respect of Patient 1's appointment, in that you inaccurately recorded smoking cessation was discussed.

Patient 2

3. On 9 November 2017 you failed to provide an adequate standard of care to Patient 2, in that you did not remove all of the crown at Patient 2's LL7 before taking impressions for a new one.
4. From 11 September 2017 to 9 November 2017, you failed to maintain an adequate standard of record keeping in respect of Patient 2's appointments, in that:
   a) On 11 September 2017 your evaluation of a peri-apical radiograph was incomplete;
   b) On 15 September 2017 you inaccurately recorded that the material you had used to restore Patient 2's LL7 was an "amalgam restoration";
   c) On 9 November 2017 you inaccurately recorded that the restoration material you had exposed at Patient 2's LL7 was "amalgam";
   d) WITHDRAWN
   e) You retrospectively amended a record for an appointment held on 9 November 2017 by adding the word "partially" to it, without recording:
      i. you had amended the record;
      ii. when you had amended the record;

iii. why you had amended the record.

5. You conduct in relation to Charge 4(e) was:

   a) Misleading;

   b) Dishonest, in that you amended the record following a complaint made by Patient 2 without making it clear that you had done so.

Patient 3

6. On 11 September 2017 you failed to provide an adequate standard of care to Patient 3, in that you provided a poor standard of treatment to Patient 3's UR6, in that:

   a) You did not adequately prepare the tooth in advance of placing a restoration;

   b) WITHDRAWN

7. From 31 August 2017 to 11 September 2017, you failed to maintain an adequate standard of record keeping in respect of Patient 3's appointments, in that:

   a) You did not provide an accurate record of how many radiographs were taken over this period;

   b) WITHDRAWN

8. WITHDRAWN

   a) WITHDRAWN

   b) WITHDRAWN

Patient 4

9. On 1 December 2017 you failed to provide an adequate standard of care to Patient 4, in that:

   a) You did not identify that Patient 4 was pregnant before attempting to take a radiograph;

   b) You did not discuss the risks involved with taking a radiograph during pregnancy with Patient 4 in advance of attempting to take a radiograph.

10. By reason of Charge 9(a) and/or Charge 9(b). you failed to obtain informed consent for the radiograph you attempted to take on 1 December 2017.

Patient 5

11. On 16 May 2017 you failed to provide an adequate standard of care to Patient 5, in that:

   a) You did not diagnose and/or provide treatment for caries found at Patient 5's:

      i. UR6;

      ii. UL7;

   b) You did not provide periodontal care, including removal of calculus deposits as indicated.

   c) You provided a poor standard of treatment to Patient 5's UR7, in that: you did not adequately prepare the tooth in advance of placing a restoration.

12. WITHDRAWN

Patient 15

13. From 1 October 2018 to 15 October 2018, you failed to provide an adequate standard of care to Patient 15, in that:

    a) You did not carry out a scale and polish of Patient 15's teeth in accordance with the treatment plan made on 1 October 2018;

    b) You recorded an inaccurate Basic Periodontal Examination on the 1 October 2018;

    c) You failed to properly diagnose and/or treat caries present at Patient 15's UL6 or UL7 on 10 October 2018;

    d) You inappropriately advised that Patient 15's UL6 or UL7 should be monitored.

Patient 17

14. On 1 October 2018 you failed to provide an adequate standard of care to Patient 17, in that you did not adequately evaluate the bitewing radiographs taken.

Patient 20

15. On 15 October 2018 you failed to provide an adequate standard of care to Patient 20, in that:

    a) You did not inform Patient 20 that extraction of her UR6 was the appropriate treatment option to address pain in her UR6;

    b) You provided an amalgam restoration to Patient 20's UR6 without adequate clinical justification;

16. By reason of Charge 15(a) you failed to obtain informed consent for the restoration placed at Patient 20's UR6.

Other Matters

17. On or around 6 December 2017 you told Witness A that you were shadowing at a dental practice in Darlington called Spring.

18. You conduct in relation to Charge 17 was:

    a) Misleading;

    b) Dishonest, in that you knew what you had told Witness A was untrue.

Patient A

19. On 20 September 2019 you failed to maintain an adequate standard of record keeping in respect of Patient A's appointment, in that you inaccurately recorded that you had undertaken special tests for Patient A's entire dentition;

Patient C

20. On 25 October 2019 you failed to maintain an adequate standard of record keeping in respect of Patient C's appointment, in that you inaccurately recorded that you had undertaken special tests for Patient C's entire dentition.

Patient D

21. On 27 August 2019 you failed to maintain an adequate standard of record keeping in respect of Patient D's appointment, in that:

    a) You inaccurately recorded that you had screened Patient D for cancer;

    b) You inaccurately recorded that you had undertaken special tests for Patient

D's entire dentition.

Patient E

22. From 2 May 2019 to 5 December 2019, you failed to maintain an adequate standard of record keeping in respect of Patient E's appointments, in that:

    a) You inaccurately recorded that you had taken two bitewing radiographs for Patient E on 2 May 2019; or, you failed to evaluate radiographs taken on 2 May 2019;

    b) You inaccurately recorded that you had undertaken special tests for Patient E's entire dentition on 5 December 2019.

Patient F

23. From 18 September 2019 to 29 July 2019, you failed to maintain an adequate standard of record keeping in respect of Patient F's appointments, in that you inaccurately recorded that you had undertaken special tests for Patient F's entire dentition on:

    a) 18 September 2019;

    b) 29 July 2020.

Patient G

24. From 12 April 2019 to 3 August 2020, you failed to maintain an adequate standard of record keeping in respect of Patient G's appointments, in that you inaccurately recorded that you had undertaken special tests for Patient G's entire dentition on:

    a) 12 April 2019;

    b) 8 November 2019;

    c) 3 August 2020;

Patient H

25. On 12 April 2019 you failed to maintain an adequate standard of record keeping in respect of Patient H's appointment, in that you failed to record your justification for not taking a radiograph for Patient H on 12 April 2019.

Patient J

26. From 15 August 2019 to 23 July 2020, you failed to maintain an adequate standard of record keeping in respect of Patient J's appointments, in that:

    a) You inaccurately graded radiographs taken for Patient J on:

        i. 15 August 2019;

        ii. 23 July 2020;

    b) On 15 August 2019 you inaccurately recorded that two bitewing radiographs had been taken for Patient J;

    c) You inaccurately recorded that you had undertaken special tests for Patient J's entire dentition on:

        i. 15 August 2019;

        ii. 5 December 2019;

        iii. 18 March 2020.

Patient L

27. On 6 September 2019 you failed to maintain an adequate standard of record keeping in respect of Patient L's appointment, in that:

    a) You inaccurately graded 2 radiographs taken for Patient L on 6 September 2019;

    b) You inaccurately recorded that you had undertaken special tests for Patient L's entire dentition.

Patient M

28. From 30 July 2019 to 4 November 2019, you failed to maintain an adequate standard of record keeping in respect of Patient M's appointments, in that:

    a) You inaccurately recorded that you had undertaken special tests for Patient M's entire dentition on:

        i. 30 July 2019;

        ii. 4 November 2019;

    b) You inaccurately recorded Patient M had an "immediate" denture fitted on 2 December 2019.

Patient N

29. From 22 March 2019 to 27 August 2019, you failed to maintain an adequate standard of record keeping in respect of Patient N's appointments, in that:

    a) You failed to make any adequate record of the fitting of Patient N's:

        i. upper denture on 7 May 2019;

        ii. lower denture on 14 May 2019;

    b) You inaccurately recorded that Patient N did not have any dentures on 27 August 2019;

    c) You inaccurately recorded that you had undertaken special tests for Patient N's entire dentition on:

        i. 22 March 2019;

        ii. 27 August 2019;

Patient O

30. From 15 May 2019 to 14 October 2019, you failed to maintain an adequate standard of record keeping in respect of Patient O's appointments, in that:

    a) You inaccurately recorded that you had undertaken special tests for Patient O's entire dentition on 15 May 2019;

    b) You failed to record any clinical notes for an appointment with Patient O on 14 October 2019.

Patient P

31. On 12 August 2019 you failed to maintain an adequate standard of record keeping in respect of Patient P's appointments, in that you inaccurately recorded that you had undertaken special tests for Patient P's entire dentition.

Patient S

32. On 18 March 2019 you failed to maintain an adequate standard of record

keeping in respect of Patient S's appointment, in that you inaccurately graded radiographs taken for Patient S.

Patient U

33. On 30 August 2019 you failed to maintain an adequate standard of record keeping in respect of Patient U's appointment, in that you inaccurately recorded that you had undertaken special tests for Patient U's entire dentition.

Patient X

34. From 26 March 2019 to 14 February 2020, you failed to maintain an adequate standard of record keeping in respect of Patient X's appointments, in that:

   a) You inaccurately recorded that you had undertaken special tests for Patient X's entire dentition on 26 March 2019;

   b) You inaccurately recorded that you had vitality tested Patient X's UL1 on 2 January 2020.

Patient Y

35. From 2 August 2019 to 29 November 2019, you failed to maintain an adequate standard of record keeping in respect of Patient Y's appointments, in that you inaccurately recorded that you had undertaken special tests for Patient Y's entire dentition on:

   a) 2 August 2019;

   b) 29 November 2019;

Patient Z

36. On 29 March 2019 you failed to maintain an adequate standard of record keeping in respect of Patient Z's appointment, in that:

   a) You did not record that you had taken an impression for a denture for Patient Z;

   b) You inaccurately recorded that you had undertaken special tests for Patient Z's entire dentition.

Patient BB

37. From 12 August 2019 to 19 March 2020, you failed to maintain an adequate standard of record keeping in respect of Patient BB's appointments, in that you inaccurately recorded that you had undertaken special tests for Patient BB's entire dentition on:

   a) 12 August 2019;

   b) 19 March 2020.

Patient CC

38. On 23 September 2019 you failed to maintain an adequate standard of record keeping in respect of Patient CC's appointments, in that you inaccurately recorded that you had undertaken special tests for Patient CC's entire dentition.

Patient DD

39. On 27 August 2019 you failed to maintain an adequate standard of record keeping in respect of Patient DD's appointments, in that you inaccurately recorded that you had undertaken special tests for Patient DD's entire dentition.

Patient LT

40. You failed to provide an adequate standard of care to Patient LT, in that:

    a. WITHDRAWN

    b. You inaccurately recorded that the radiograph you had taken on 15 May 2019 showed “canal present to full working length”;

    c. During an appointment on 31 May 2019, you provided Patient LT with a poor standard of treatment in that, you did not sufficiently remove caries from Patient LT’s LR5 before placing an amalgam filling;

    d. You inaccurately recorded that you had successfully obturated Patient LT’s LR5 with gutta percha during an appointment on 31 May 2019;

    e. You did not take a post operative radiograph following the treatment you provided to Patient LT on 31 May 2019;

    f. During an appointment on 9 July 2019, you failed to diagnose caries in Patient LT’s LR6.

41. On or before 4 December 2020, you:

    a. deliberately scratched a radiograph covering Patient LT’s LR5;

    b. provided that radiograph to your Workplace Supervisor, Witness B.

42. Your conduct in relation to Charge 40.d. was:

    a. Misleading;

    b. Dishonest, in that you knew you had not successfully obturated Patient LT’s LR5

43. Your conduct in relation to Charge 41 was:

    a. Misleading;

    b. Dishonest, in that you did so to give the impression Patient LT’s LR5 had been obturated on 31 May 2019, when it had not.

AND that by reason of the matters alleged above your fitness to practise is impaired by reason of misconduct and/or deficient professional performance.”

Mrs Photay was present and represented. On 24 May 2022, the Chairman announced the finding of facts as follows:

<u>FINDINGS OF FACT – 24 May 2022</u>

“Ms Photay,

The allegations against you comprise three separate referrals in relation to your work at different dental practices.

At the outset of the hearing, Mr Stevens, on behalf of the General Dental Council (GDC) applied for the following charges to be withdrawn following the disclosure of your witness statement and evidence and following a review of the factual and expert evidence relied upon by the GDC: charges 4(d), 6(b), 7(b), 8 (which had earlier been joined to the allegation contained in the notification of hearing) and 12. The application was uncontested by Mr Rich on your behalf. The Committee was satisfied that the charges could be withdrawn without injustice to either party and therefore acceded to the application.

You made admissions to a large number of the charges. The Committee noted your admissions but deferred making any findings of fact until all the evidence had been heard.

The Committee heard live factual evidence called by the GDC from Witness A (a Practice Manager), Witness B (referred to in this determination as Principal Dentist 2), Witness C (referred to in this determination as Principal Dentist 1).

The Committee heard live evidence from you.

The Committee heard expert opinion evidence from Mr C Mulcahy, a Specialist in Prosthodontics called by the GDC; and from Mr M Morris, a general dental practitioner.

The Committee accepted the advice of the Legal Adviser. The burden is on the GDC to prove each allegation on the balance of probabilities.

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

	Patient 1
1.	*From 26 October 2017 to 23 November 2017, you failed to provide an adequate standard of care to Patient 1, in that:*
1. a)	*You recorded an inaccurate Basic Periodontal Examination on the 26 October 2017;* **Admitted and found proved.**
1. b)	*You provided a poor standard of treatment to Patient 1 on 13 November 2017, in that you left a composite overhang in relation to a restoration placed at Patient 1's UL5 and/or UL6;* **Admitted and found proved.**
2.	*On 26 October 2017 you failed to maintain an adequate standard of record keeping in respect of Patient 1's appointment, in that you inaccurately recorded smoking cessation was discussed.* **Admitted and found proved.**
	Patient 2
3.	*On 9 November 2017 you failed to provide an adequate standard of care to Patient 2, in that you did not remove all of the crown at Patient 2's LL7 before taking impressions for a new one.* **Admitted and found proved.**
4.	*From 11 September 2017 to 9 November 2017, you failed to maintain an adequate standard of record keeping in respect of Patient 2's appointments, in that:*
4. a)	*On 11 September 2017 your evaluation of a peri-apical radiograph was incomplete;* **Admitted and found proved.**
4. b)	*On 15 September 2017 you inaccurately recorded that the material you had used to restore Patient 2's LL7 was an "amalgam restoration";* **Admitted and found proved.**
4. c)	*On 9 November 2017 you inaccurately recorded that the restoration material you had exposed at Patient 2's LL7 was "amalgam";*

	Admitted and found proved.
4. d)	WITHDRAWN
4. e)	*You retrospectively amended a record for an appointment held on 9 November 2017 by adding the word "partially" to it, without recording:*
4. e) i.	*you had amended the record;* **Admitted and found proved.**
4. e) ii.	*when you had amended the record;* **Admitted and found proved.**
4. e) iii.	*why you had amended the record.* **Admitted and found proved.**
5.	*You conduct in relation to Charge 4(e) was:*
5. a)	*Misleading;* **Admitted and found proved.**
5. b)	*Dishonest, in that you amended the record following a complaint made by Patient 2 without making it clear that you had done so.* **Not proved.** Patient 2 attended you on 9 November 2017 for the replacement of a poor fitting crown at LL7. The clinical notes for this appointment originally recorded that you removed the existing crown ("LL7 removal of crown, amalgam exposed") and took impressions for the replacement crown, with the patient to return 2 weeks later for that crown to be fitted. Patient 2 returned to the Practice on 21 November 2022, as the dental laboratory required the impressions to be taken again before they could manufacture the replacement crown. Patient 2 therefore reattended the Practice on 21 November 2022 for this purpose and was seen by another dentist who identified that only the porcelain part of the existing crown at LL7 had been removed with the metal part of the crown still in situ. He explained this to Patient 2 and there followed a complaint from the patient who was reported to be very angry that he had been informed by you that the whole of the crown had been removed. Following Patient 2's complaint you amended the clinical entry for 9 November 2017 by inserting the word "partially" so that the record now read "LL7 removal of crown partially, amalgam exposed". Although this was the insertion of a single word it was a substantial amendment to the clinical records. You were under a duty to mark up the amendment so that it would be clear to anyone reading the records that the amendment had been made. This is reflected in standard 4.1.5 of the GDC's *Standards for the Dental Team* (September 2013) which states that: "*If you need to make any amendments to a patient's records you must make sure that the changes are clearly marked up and dated.*" It is a basic and fundamental record keeping standard. As admitted and found proved under charge 5(a) above, the amendment you made was misleading as a matter of fact, as anyone reading the record would assume that the word "partially" had always formed part of the original record, rather than being a retrospective amendment following a complaint

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	form the patient that you had advised him that the entire crown had been removed. The Committee has not been asked to determine whether you had in fact advised Patient 2 that the entire crown had been removed. The GDC's case of dishonesty against you is confined to whether you had deliberately amended without marking it up, so that the record would not support a complaint that you had told Patient 2 that the whole crown had been removed. Your evidence was that you amended the record simply to make it accurate and you did not realise at the time that amendments to records needed to be marked up. You stated that you had only become aware of this record keeping standard when later completing CPD on record keeping and that your prior training and qualification was in Poland where this record keeping standard was not engaged as the records which you maintained were handwritten. However, whether you were aware or not of this record keeping standard is not determinative of the question of dishonesty. This is because you could have made the amendment (the insertion of a single word) and simply failed to mark the amendment as retrospective. That does not necessarily mean that you had any dishonest intent. You stated in evidence that you had discussed making the amendment with Witness A and that she had not objected to this. Witness A denies that any such discussion had taken place. The Committee determined that it is unlikely that any such discussion would have taken place. If Witness A had not objected to you amending the records it is unlikely that she would then have formally complained to the GDC about the amendment. The Committee could not be satisfied from the evidence that it was more likely than not that you had acted dishonestly in making the amendment. When Witness A alerted you to the complaint she stated to you that your note was not accurate. She also had in her possession a copy of the original note. That original note had also been reviewed by the other dentist when examining Patient 2 and explaining to him that the crown had only partially been removed. It is therefore not established from the evidence that it is more likely than not that your intention was to mislead in making the amendment without marking it up. It is equally plausible that, as you claim, you were simply amending the record to correctly record that the crown had only partially been removed. Accordingly, the Committee found this charge not proved. In its approach to this dishonesty charge, and to all the dishonesty charges alleged, the Committee has applied the two stage subjective and objective test set out in the decision of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67.
	Patient 3
6.	*On 11 September 2017 you failed to provide an adequate standard of care to Patient 3, in that you provided a poor standard of treatment to Patient 3's UR6, in that:*
6. a)	*You did not adequately prepare the tooth in advance of placing a restoration;*

	Admitted and found proved.
6. b)	WITHDRAWN
7.	*From 31 August 2017 to 11 September 2017, you failed to maintain an adequate standard of record keeping in respect of Patient 3's appointments, in that:*
7. a)	*You did not provide an accurate record of how many radiographs were taken over this period;* **Admitted and found proved.**
7. b)	WITHDRAWN
8.	WITHDRAWN
8. a)	WITHDRAWN
8. b)	WITHDRAWN
	Patient 4
9.	*On 1 December 2017 you failed to provide an adequate standard of care to Patient 4, in that:*
9. a)	*You did not identify that Patient 4 was pregnant before attempting to take a radiograph;* **Not proved.**
9. b)	*You did not discuss the risks involved with taking a radiograph during pregnancy with Patient 4 in advance of attempting to take a radiograph.* **Not proved.** Patient 4 reported to Witness A at reception that she was pregnant. This information was entered by Witness A into the clinical records. This information should have been visible to you when accessing Patient 4's clinical records. It does not appear that you had reviewed this information. However, the issue is ultimately whether you had asked Patient 4 if she was pregnant prior to attempting to take a radiograph. The Committee accepted Mr Mulcahy's opinion that, prior to taking radiographs on women of child-bearing age, a dental practitioner should ask the patient whether she might be pregnant so that the risk of exposing a radiograph on her in those circumstances can be explained. He stated that radiographs are generally not indicated for pregnant women unless there is an urgent need for the radiograph to be taken. Witness A had made a brief contemporaneous note of the incident on 1 December 2017. She completed a more detailed incident report three days later. She also provided an account in her complaint to the GDC and in her witness statement to the Committee dated 10 October 2020. The Committee found that Witness A genuinely believed that you were about to take a radiograph without realising that Patient 4 was pregnant. She had recorded and reported this matter in good faith. However, the Committee could not rely on her account in finding this charge proved. This is because there were inconsistencies in her account as to the precise sequence of events, and as to what she could hear and see. This charge turns on whether prior to attempting to take the radiograph you

	had asked Patient 4 if she was pregnant, or whether you were about to take a radiograph and only realised Patient 4 was pregnant when this information was relayed to you by Witness A. The original note Witness A made appears to record that you first came out of the surgery room to take the radiograph and that she had to shout to you from the reception desk that the patient was pregnant. In her incident report and subsequent accounts she describes that it was the dental nurse who first left the surgery room and that she had to shout to the dental nurse that the patient was pregnant, which was then relayed to you. She stated that she heard you saying "I didn't know" and that you then asked the patient if she was pregnant. It was unclear from her subsequent accounts whether you had also left the surgery room. It was unclear from Witness A's evidence whether and to what extent she could see the patient in the surgery room from the reception desk and whether and to what extent she could hear any discussions you had with the patient regarding pregnancy. Witness A was unclear whether the door to the surgery room (which she accepted was a self-closing fire door) was in fact open or closed. Witness A had originally stated that the bitewing film had already been placed in Patient 4's mouth. However, under cross-examination she conceded that she had not actually seen this, only that she had assumed they were there because the dental nurse had left the surgery room with the x-ray button in her hand and it was normal practice for the bitewing films to be placed in a patient's mouth prior to this happening. Your evidence was that the dental nurse had set up the room in anticipation that radiographs would be taken and placed the films on the side. You stated that no bitewing films had been placed in Patient 4's mouth. You explained that the reason the dental nurse left the surgery room with the x-ray button was because you had announced that it was now time to take a radiograph. You stated that you then asked Patient 4 whether she was pregnant and having ascertained that she was decided not to take the radiographs. You said you went outside the surgery as described by Witness A, but only to call the nurse back in. Whilst the Committee did not go so far as to accept your account, it was a plausible account for a busy practice environment and the Committee could not be satisfied from Witness A's evidence that it was more likely than not that it was her intervention which prevented the radiograph from being taken. Accordingly, the Committee found this charge not proved.
10.	*By reason of Charge 9(a) and/or Charge 9(b). you failed to obtain informed consent for the radiograph you attempted to take on 1 December 2017.* This charge falls away by reason of the Committee's finding charges 9(a)-(b) not proved.
	Patient 5
11.	*On 16 May 2017 you failed to provide an adequate standard of care to Patient 5, in that:*
11. a)	*You did not diagnose and/or provide treatment for caries found at Patient 5's:*
11. a) i.	*UR6;* **Not proved.**

11. a) ii.	*UL7;* **Not proved.**
11. b)	*You did not provide periodontal care, including removal of calculus deposits as indicated.* **Not proved.**
11. c)	*You provided a poor standard of treatment to Patient 5's UR7, in that: you did not adequately prepare the tooth in advance of placing a restoration.* **Not proved.** The issue before the Committee was whether the appointment in question was an examination appointment (as recorded in the clinical notes) or whether it was in fact an emergency appointment incorrectly recorded on your behalf as an examination appointment. There was no factual dispute that charges 11(a)-(c) would be proved if the appointment in question had been an examination appointment. Both experts agreed that at an examination appointment you would have been under a duty to do what is pleaded under charges 11(a)-(c), but not at an emergency appointment. You do not specifically recall the detail of the appointment but believe that it was an emergency appointment because the clinical notes record that you used glass ionomer. You stated that it was your usual practice to use glass ionomer for temporary restorations. You stated that you recall that the computer system crashed during the appointment and that it remained down for the rest of the day. You stated that you made handwritten notes to yourself and that you telephoned the practice the following morning to update the computer records. This was a sister practice to the practice where you normally worked. You stated that the receptionist advised you that the computer records had already been updated for you and that nothing further was required from you. The clinical notes were made in your name and record that the appointment in question was an examination appointment with a filling placed and was charged as a NHS Band 2 course of treatment. However, the evidence before the Committee was that any member of staff could make notes under the name of another practitioner, as the practice used a shared password. The Committee accepted therefore that the notes may have been entered by someone else, even though they were recorded under your name. The Committee could not rely upon the note in question in establishing that this was in fact an examination appointment. The Committee could not be satisfied who had made the note, when they made the note and in what circumstances. It is entirely plausible the note, unchecked by you at the time, could have been incorrectly entered on your behalf as a note of an examination (rather than an emergency) appointment. Accordingly, the Committee found this charge not proved.
12.	WITHDRAWN
	Patient 15
13.	*From 1 October 2018 to 15 October 2018, you failed to provide an adequate standard of care to Patient 15, in that:*

13. a)	*You did not carry out a scale and polish of Patient 15's teeth in accordance with the treatment plan made on 1 October 2018;* **Admitted and found proved.**
13. b)	*You recorded an inaccurate Basic Periodontal Examination on the 1 October 2018;* **Admitted and found proved.**
13. c)	*You failed to properly diagnose and/or treat caries present at Patient 15's UL6 or UL7 on 10 October 2018;* **Admitted and found proved.**
13. d)	*You inappropriately advised that Patient 15's UL6 or UL7 should be monitored.* **Admitted and found proved.**
	Patient 17
14.	*On 1 October 2018 you failed to provide an adequate standard of care to Patient 17, in that you did not adequately evaluate the bitewing radiographs taken.* **Admitted and found proved.**
	Patient 20
15.	*On 15 October 2018 you failed to provide an adequate standard of care to Patient 20, in that:*
15. a)	*You did not inform Patient 20 that extraction of her UR6 was the appropriate treatment option to address pain in her UR6;* **Admitted and found proved.**
15. b)	*You provided an amalgam restoration to Patient 20's UR6 without adequate clinical justification;* **Admitted and found proved.**
16.	*By reason of Charge 15(a) you failed to obtain informed consent for the restoration placed at Patient 20's UR6.* **Admitted and found proved.**
	Other Matters
17.	*On or around 6 December 2017 you told Witness A that you were shadowing at a dental practice in Darlington called Spring.* **Admitted and found proved.**
18.	*You conduct in relation to Charge 17 was:*
18. a)	*Misleading;* **Admitted and found proved.**
18. b)	*Dishonest, in that you knew what you had told Witness A was untrue.* **Admitted and found proved.**
	Patient A

19.	*On 20 September 2019 you failed to maintain an adequate standard of record keeping in respect of Patient A's appointment, in that you inaccurately recorded that you had undertaken special tests for Patient A's entire dentition;* **Admitted and found proved.**
	Patient C
20.	*On 25 October 2019 you failed to maintain an adequate standard of record keeping in respect of Patient C's appointment, in that you inaccurately recorded that you had undertaken special tests for Patient C's entire dentition.* **Admitted and found proved.**
	Patient D
21.	*On 27 August 2019 you failed to maintain an adequate standard of record keeping in respect of Patient D's appointment, in that:*
21. a)	*You inaccurately recorded that you had screened Patient D for cancer;* **Admitted and found proved.**
21. b)	*You inaccurately recorded that you had undertaken special tests for Patient D's entire dentition.* **Admitted and found proved.**
	Patient E
22.	*From 2 May 2019 to 5 December 2019, you failed to maintain an adequate standard of record keeping in respect of Patient E's appointments, in that:*
22. a)	*You inaccurately recorded that you had taken two bitewing radiographs for Patient E on 2 May 2019; or, you failed to evaluate radiographs taken on 2 May 2019;* **Admitted and found proved.**
22. b)	*You inaccurately recorded that you had undertaken special tests for Patient E's entire dentition on 5 December 2019.* **Admitted and found proved.**
	Patient F
23.	*From 18 September 2019 to 29 July 2019, you failed to maintain an adequate standard of record keeping in respect of Patient F's appointments, in that you inaccurately recorded that you had undertaken special tests for Patient F's entire dentition on:*
23. a)	*18 September 2019;* **Admitted and found proved.**
23. b)	*29 July 2020.* **Admitted and found proved.**
	Patient G
24.	*From 12 April 2019 to 3 August 2020, you failed to maintain an adequate standard of record keeping in respect of Patient G's appointments, in that you inaccurately recorded that you had undertaken special tests for Patient G's*

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	entire dentition on:
24. a)	*12 April 2019;* **Admitted and found proved.**
24. b)	*8 November 2019;* **Admitted and found proved.**
24. c)	*3 August 2020;* **Admitted and found proved.**
	Patient H
25.	*On 12 April 2019 you failed to maintain an adequate standard of record keeping in respect of Patient H's appointment, in that you failed to record your justification for not taking a radiograph for Patient H on 12 April 2019.* **Admitted and found proved.**
	Patient J
26.	*From 15 August 2019 to 23 July 2020, you failed to maintain an adequate standard of record keeping in respect of Patient J's appointments, in that:*
26. a)	*You inaccurately graded radiographs taken for Patient J on:*
26. a) i.	*15 August 2019;* **Admitted and found proved.**
26. a) ii.	*23 July 2020;* **Admitted and found proved.**
26. b)	*On 15 August 2019 you inaccurately recorded that two bitewing radiographs had been taken for Patient J;* **Admitted and found proved.**
26. c)	*You inaccurately recorded that you had undertaken special tests for Patient J's entire dentition on:*
26. c) i.	*15 August 2019;* **Admitted and found proved.**
26. c) ii.	*5 December 2019;* **Admitted and found proved.**
26. c) iii.	*18 March 2020.* **Admitted and found proved.**
	Patient L
27.	*On 6 September 2019 you failed to maintain an adequate standard of record keeping in respect of Patient L's appointment, in that:*
27. a)	*You inaccurately graded 2 radiographs taken for Patient L on 6 September 2019;* **Admitted and found proved.**
27. b)	*You inaccurately recorded that you had undertaken special tests for Patient*

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	L's entire dentition. **Admitted and found proved.**
	Patient M
28.	*From 30 July 2019 to 4 November 2019, you failed to maintain an adequate standard of record keeping in respect of Patient M's appointments, in that:*
28. a)	*You inaccurately recorded that you had undertaken special tests for Patient M's entire dentition on:*
28. a) i.	*30 July 2019;* **Admitted and found proved.**
28. a) ii.	*4 November 2019;* **Admitted and found proved.**
28. b)	*You inaccurately recorded Patient M had an "immediate" denture fitted on 2 December 2019.* **Admitted and found proved.**
	Patient N
29.	*From 22 March 2019 to 27 August 2019, you failed to maintain an adequate standard of record keeping in respect of Patient N's appointments, in that:*
29. a)	*You failed to make any adequate record of the fitting of Patient N's:*
29. a) i.	*upper denture on 7 May 2019;* **Admitted and found proved.**
29. a) ii.	*lower denture on 14 May 2019;* **Admitted and found proved.**
29. b)	*You inaccurately recorded that Patient N did not have any dentures on 27 August 2019;* **Admitted and found proved.**
29. c)	*You inaccurately recorded that you had undertaken special tests for Patient N's entire dentition on:*
29. c) i.	*22 March 2019;* **Admitted and found proved.**
29. c) ii.	*27 August 2019;* **Admitted and found proved.**
	Patient O
30.	*From 15 May 2019 to 14 October 2019, you failed to maintain an adequate standard of record keeping in respect of Patient O's appointments, in that:*
30. a)	*You inaccurately recorded that you had undertaken special tests for Patient O's entire dentition on 15 May 2019;* **Admitted and found proved.**
30. b)	*You failed to record any clinical notes for an appointment with Patient O on 14 October 2019.*

	Not proved. It was not in dispute that Patient O attended an appointment on 14 October 2019. The appointment is recorded in the appointment list, and NHS declaration was completed in respect of the appointment and a medical history was updated at reception. No clinical notes are showing in the records available to the Committee. However, there appears to be a blank page where such notes would have been entered. It appears to the Committee to be more likely than not that the clinical notes were made by you for this appointment but are missing from the records provided. The Committee noted that it is apparent from other records, and from the GDC expert's report, that, at this time, you were trying very hard to keep full records albeit with some weaknesses, which makes its less likely that no clinical notes had been made by you in respect of this appointment. Accordingly, the Committee found this charge not proved.
	Patient P
31.	*On 12 August 2019 you failed to maintain an adequate standard of record keeping in respect of Patient P's appointments, in that you inaccurately recorded that you had undertaken special tests for Patient P's entire dentition.* **Admitted and found proved.**
	Patient S
32.	*On 18 March 2019 you failed to maintain an adequate standard of record keeping in respect of Patient S's appointment, in that you inaccurately graded radiographs taken for Patient S.* **Admitted and found proved.**
	Patient U
33.	*On 30 August 2019 you failed to maintain an adequate standard of record keeping in respect of Patient U's appointment, in that you inaccurately recorded that you had undertaken special tests for Patient U's entire dentition.* **Admitted and found proved.**
	Patient X
34.	*From 26 March 2019 to 14 February 2020, you failed to maintain an adequate standard of record keeping in respect of Patient X's appointments, in that:*
34. a)	*You inaccurately recorded that you had undertaken special tests for Patient X's entire dentition on 26 March 2019;* **Admitted and found proved.**
34. b)	*You inaccurately recorded that you had vitality tested Patient X's UL1 on 2 January 2020.* **Admitted and found proved.**
	Patient Y
35.	*From 2 August 2019 to 29 November 2019, you failed to maintain an adequate standard of record keeping in respect of Patient Y's appointments,*

	in that you inaccurately recorded that you had undertaken special tests for Patient Y's entire dentition on:
35. a)	*2 August 2019;* **Admitted and found proved.**
35. b)	*29 November 2019;* **Admitted and found proved.**
	Patient Z
36.	*On 29 March 2019 you failed to maintain an adequate standard of record keeping in respect of Patient Z's appointment, in that:*
36. a)	*You did not record that you had taken an impression for a denture for Patient Z;* **Admitted and found proved.**
36. b)	*You inaccurately recorded that you had undertaken special tests for Patient Z's entire dentition.* **Admitted and found proved.**
	Patient BB
37.	*From 12 August 2019 to 19 March 2020, you failed to maintain an adequate standard of record keeping in respect of Patient BB's appointments, in that you inaccurately recorded that you had undertaken special tests for Patient BB's entire dentition on:*
37. a)	*12 August 2019;* **Admitted and found proved.**
37. b)	*19 March 2020.* **Admitted and found proved.**
	Patient CC
38.	*On 23 September 2019 you failed to maintain an adequate standard of record keeping in respect of Patient CC's appointments, in that you inaccurately recorded that you had undertaken special tests for Patient CC's entire dentition.* **Admitted and found proved.**
	Patient DD
39.	*On 27 August 2019 you failed to maintain an adequate standard of record keeping in respect of Patient DD's appointments, in that you inaccurately recorded that you had undertaken special tests for Patient DD's entire dentition.* **Admitted and found proved.**
	Patient LT
40.	*You failed to provide an adequate standard of care to Patient LT, in that:*
40. a.	WITHDRAWN
40. b.	*You inaccurately recorded that the radiograph you had taken on 15 May 2019*

	showed "canal present to full working length"; **Admitted and found proved.**
40. c.	*During an appointment on 31 May 2019, you provided Patient LT with a poor standard of treatment in that, you did not sufficiently remove caries from Patient LT's LR5 before placing an amalgam filling;* **Admitted and found proved.**
40. d.	*You inaccurately recorded that you had successfully obturated Patient LT's LR5 with gutta percha during an appointment on 31 May 2019;* **Admitted and found proved.**
40. e.	*You did not take a post operative radiograph following the treatment you provided to Patient LT on 31 May 2019;* **Admitted and found proved.**
40. f.	*During an appointment on 9 July 2019, you failed to diagnose caries in Patient LT's LR6.* **Admitted and found proved.**
41.	*On or before 4 December 2020, you:*
41. a.	*deliberately scratched a radiograph covering Patient LT's LR5;* **Found proved.** Patient LT attended for an appointment with you on 31 May 2019 for the completion of root canal treatment at her LR5. You recorded for this appointment that you had filled the root canal of the tooth with gutta percha (a dental material used for root fillings, referred to as "GP" in the clinical entry quoted below) and that you had then placed an amalgam filling on top: …LR5 previous temporary restoration, cotton pellet removed, canal located and accessed again, WL confirmed at 21mm, rubber dam applied, copious amounts of chlorhexidine used to irrigate single canal, dried with paper points and GP inserted to length, condensed laterally well, excess removed using heated plugger and condensed well, amalgam placed and condensed well in increments, articulation paper used to check bite and sound, smoothened using burnisher, pt felt happy… Patient LT next attended on 5 June 2019 at an emergency appointment complaining of continuing pain in the lower right-hand side of her mouth. She was examined by Dentist 1. He could not find in the clinical records any post-operative radiograph for the root canal treatment provided on 31 May 2019: as now admitted and found proved under charge 40(e) above, you had failed to take one. Dentist 1 took a periapical radiograph of the LR5 at the appointment on 5 June 2019. He also removed the amalgam filling you had placed, opening up the tooth to dress it in order to treat Patient LT's pain. In the radiograph he had taken no gutta percha was visible at LR5, as recorded by him in the clinical notes. He also recorded that no gutta percha was present beneath the amalgam filling and that there remained caries: "*amalgam removed, revealing existing pulpal exposure/ opening- bleeding present, caries removed from cavity*". In his witness statement to the Committee dated 26 January 2022, Dentist 1

	explained that: "*There was still decay in the tooth and it looked more like a bleeding exposure rather than a completed root canal so I cleaned the decay as much as I could, dressed the tooth and placed the temporary filling in there*". Dentist 1 stated that he explained to Patient LT that the gutta percha might have been removed from the tooth during the appointment on 31 May 2019, when the gutta percha was being condensed with a plugger (the only explanation he could think of for the absence of the root filling). He explained to her that she would need to return to have the root canal treatment completed and he referred her back to you for the completion of the treatment. Following the appointment on 5 June 2016 Dentist 1 used his mobile telephone to take a photograph of the radiograph showing that no gutta percha was present at the LR5. In his witness statement he explained that the reason for this was "*because we only had wet film x-rays, not digital. I was concerned by what I had seen because the x-ray did not match the Patient's clinical notes from when the Registrant had seen the Patient the week before. As we only had wet film x-rays, sometimes they could go missing so I wanted to be sure there was a copy of this x-ray.*" Your note in the clinical records that you had successfully obturated the tooth with gutta percha on 31 May 2019 was inaccurate, as now admitted and found proved under charge 40(d) above. The radiograph and clinical examination of the LR5 undertaken by Dentist 1 on 5 June 2019 established that no gutta percha could have been present in the tooth at the conclusion of the appointment on 31 May 2019. This was because no gutta percha was found in the tooth upon clinical and radiographic examination six days later on 5 June 2019. Both experts agreed that the gutta percha could not have fallen out of the tooth in the intervening period, as you had placed an amalgam filling at the crown of the tooth which would have sealed the gutta percha (if any) inside the tooth. Both experts agreed that there were only two possible explanations for why no gutta percha was present in the tooth on 5 June 2019: (i) the gutta percha had not remained in the tooth during the treatment itself on 31 May 2019 (for example because the gutta percha had stuck to the hot plugger you were using when attempting to compress it into the tooth); or (ii) you had not placed any gutta percha into the tooth to begin with. Dentist 1 stated that he spoke to you in your surgery around a week after the appointment on 5 June 2019 to express his concerns in respect of Patient LT's treatment, but cannot "fully remember" what you had said during this discussion. Patient LT attended an appointment with you on 9 July 2019 for a review of her LR5. You made the following entry in the clinical notes in respect of the LR5: Pt attended today for a review of LR5 post initial RCT, explained to Pt that symptoms suggest a failure of RCT, Pt admitted to understanding this being the case and informed us was aware prior to beginning process symptoms may worse. Pt would prefer to leave temporary restoration as it is for now with monitoring, understanding pain may re-develop, TSL, abscess leading to

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tooth loss, pt accepts.

The notes do not suggest that you informed Patient LT that there was no root filling in her LR5 and that her root canal treatment had therefore not been completed. You had only suggested to her that the root canal treatment may have failed.

Patient LT next attended an appointment with you on 3 August 2020 (a telephone appointment owing to the COVID-19 pandemic) and on 8 October 2020. She continued to report pain in the lower right quadrant of her mouth, including at LR5. There are no notes to suggest that you informed her at either of these appointments that there was no root filling in her LR5 and that her root canal treatment had therefore not been completed. Rather, you continued to suggest to her that the root canal treatment had been provided but was likely to have failed.

On 15 October 2020 Patient LT was seen by another dentist at the practice. He formulated a treatment plan for her but then ceased working at the practice and so did not go on to provide any treatment.

On 26 November 2020 Patient LT was seen by Principal Dentist 1, one the of the principal dentists at the practice. Principal Dentist 1 took a periapical radiograph of the LR5 as part of her examination of the patient. She could see from that radiograph that the root canal treatment you recorded on 31 May 2019 had not been completed, as there was no gutta percha root filling present. She called you into the surgery room with the patient present to discuss this, as stated in her witness statement to the Committee dated 7 February 2022:

11. The Registrant's records suggested that a root canal filling had been done on the tooth in May 2019 and when I took a radiograph in November 2020, I could not see that so I wanted clarification from the

Registrant of what happened and whether she could remember the Patient. The Registrant told me that if she said in the clinical records that she had done a root filling she will have done a root filling…

You described this matter as follows in your witness statement dated 6 May 2022:

19. I was with a patient and was, I believe, about to carry out an aerosol generating procedure ("AGP") when I received messages indicating that [Principal Dentist 1] needed to see me immediately. [Principal Dentist 1] sent messages to my surgery computer which my nurse … informed me of and a member of reception staff … came to my surgery to tell me that [Principal Dentist 1] needed to see me. I thought that [Principal Dentist 1] might need me to help with a medical emergency, dental treatment or handling an aggressive patient. I explained to my patient that I was needed immediately and excused myself, apologising as now I would be running late for her appointment. I then left the patient with my dental nurse and I went to the surgery where [Principal Dentist 1] was seeing patients.

20. When I arrived, I found that [Principal Dentist 1] was with Patient LT and they were both being quite aggressive towards each other. [Principal Dentist 1] asked me whether I had carried out RCT and I explained that I had, as was recorded within the patient's notes. Patient LT seemed upset to be being told by [Principal Dentist 1] that the treatment had not been carried out.

	… 24. [Principal Dentist 1] said a number of times that it would not look good for me if the record was requested by NHS England as the record was missing. I explained that record cards often went missing as they were incorrectly filed by staff and that I had raised this multiple times with the manager and [Principal Dentist 2] and that nothing had been done. 25. [Principal Dentist 1] said that the record card needed to be found, with either me or staff looking for it. I commented on several occasions that I would not jeopardise my position, having GDC interim conditions and NHS voluntary undertakings, by not carrying out treatment. You left Principal Dentist 1's surgery room to look for Patient LT's records. Dentist 1 stated in his witness statement that he overheard you discussing this matter in the reception area, which prompted him to raise his concerns with you again about Patient LT's root canal treatment not being completed: "*15. I then spoke with the Registrant, and I cannot fully remember what she said but it was something along the lines of the Patient's x-ray taken by myself in June 2019 was not in the file. [Principal Dentist 1], a principal dentist at the practice, came out to speak with both of us. At that point, [Principal Dentist 1] was not sure what had gone on and she was wanting to ask what I had seen and what I had done.*" Dentist 1 stated that he also discussed his concerns privately with Principal Dentist 1 later on 26 November 2020 when he showed her the photograph he had taken of his radiograph on 5 June 2019. This was corroborated by Principal Dentist 1 in her evidence to the Committee. The matter was reviewed by Principal Dentist 2, another principal dentist at the practice and your workplace supervisor. Principal Dentist 1 instructed practice staff to search for Patient LT's records, including the post-operative radiograph which she and Principal Dentist 2 understood you would have taken following the root canal treatment you recorded on 31 May 2019. As now established, you had not in fact taken a post-operative radiograph. Your account of your actions was contained in your statement as follows: 27. The next day, I checked with reception staff whether the record card had been located. I was told that it had not and that no one was looking for it as they were too busy with reception related matters. 28. Over the next few days, when I had some free time, I looked through the filing cabinets where records are located. I found a card for Patient LT within the archive section where record cards are kept in filing cabinets in no chronological or alphabetical order. The record card (a brown NHS record card sleeve) had the patient's name written on the front and possibly also their date of birth but I do not remember and I have not seen the record card since I handed it to [Principal Dentist 2]. The sleeve only contained the odd looking x-ray. 29. I recall that the sleeve also said "duplicate" on the front. A duplicate record card would be created in circumstances where a patient's record card could not be located. Any hard copy records, radiographs, medical history, consent forms and treatment plans along with referrals or external letters would be kept inside the duplicate record card sleeve. If the original record card was subsequently located, the original and the duplicate card would be

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	kept together. 30. I immediately tried to give the radiograph to [Principal Dentist 2] but, on each attempt, he was busy and did not respond to my requests to speak to him. I managed to catch him at the end of the day and gave him the X-ray. He went to put the X-ray on the viewing box and I said something along the lines of "here is the card to keep it safe", as he was just walking away from the viewing box towards his computer with the x-ray, in the wallet but without the brown card. I then gave him the brown card. 31. I emphasised to [Principal Dentist 2] that this was not my radiograph and that I just found it in the archive section. [Principal Dentist 2] commented that it was an odd looking x-ray and I agreed. He said to leave it with him. I had wanted to discuss the radiograph further but [Principal Dentist 2] just said to leave it with him. I understand from his witness statement that he was in a rush to leave that day. […] Dental Nurse, was present during our exchange. In his witness statement to the Committee dated 11 February 2022, Principal Dentist 2 stated: 6. On 4 December 2020, the Registrant came into my surgery in the daytime and gave me the post-operative radiograph which should have shown the completed root filling that the Registrant supposedly did back in May 2019. It was important because the x-ray taken by [Principal Dentist 1] did not show it had been completed. 7. I cannot recall the Registrant's exact words, but she said something to the effect of I have found the x-ray. It was right at the end of my session, and it was the day I collect my children, so I was in a rush, and I only had a brief look but straight away from my initial look it did not look right. I think I said something like that does not look quite right. I believe my nurse at the time, […] or […], might have been present, however I cannot remember who this was. I did not take a note of this conversation. I have seen thousands of radiographs and I know what one should look it. I did not have time to explore it further at that stage. Over the course of the weekend, I reviewed it further and came to the conclusion it was not correct. 8. I did not think the radiograph was genuine because the materials we use to fill in a root filling normally are rubberised material that will show up as a white line on an x-ray. The density of the x-ray was really, really white. You can only get something that white if you have metallic in the area because it will stop the x-ray going through. Secondly, it was the perfect colour and shape of the rubber in the shape of the canal. In most cases there should be a kink along the way somewhere. My initial assumption was that there must have been a metallic object placed there to fill in the root filling area. However, later it came to light that if you turned over the radiograph the section had been scratched out by a sharp knife or similar object. On 6 December 2020 Principal Dentist 2 wrote to you by email dismissing you from the practice over this matter. The issue for the Committee to determine under this charge is whether you had deliberately scratched the radiograph. This is an extremely serious allegation and one which the Committee considered with great care. Both experts examined the radiograph and agreed that it had been

	deliberately scratched to give the impression that a root filling was present at the LR5. Both experts agreed that the way which the radiograph had been altered could not have been accidental. The Committee accepted Mr Mulcahy's opinion that the radiograph which had been altered was likely to have been a pre-operative radiograph of LR5 taken on 12 March 2019 or 30 April 2019. One of those radiographs is missing from the records (it is not possible to tell which one) and is likely to have been the radiograph which was then deliberately scratched. The evidence before the Committee was that all practice staff had access to patient records and therefore any member of staff could have altered the radiograph. The Committee had regard to the content of the radiograph, the subject of the radiograph, what was altered on it, who was the treating dentist in relation to the subject matter of the alteration, the context of the investigation, the circumstances in which it came to be discovered and then presented to your supervisor and whether you would have had any motivation to have altered the radiograph. The Committee accepted Dentist 1's evidence that he had discussed his concerns about Patient LT's treatment with you around a week after his appointment with her on 5 June 2019. This was a significant and highly unusual matter regarding the care of one of your patients which required remedial action by you and which Dentist 1 would in all likelihood have discussed with you in person at the earliest opportunity. Indeed, the matter was so significant in his view that he had taken a photograph of the radiograph as additional evidence in support of his concerns, in the event that the original radiograph were to go missing. You stated that you do not recall any such discussion with Dentist 1 but accepted that it may have taken place. The Committee determined that it is more likely than not that you would have recalled the discussion. It would not have been a routine discussion or one about a minor matter. Rather, Dentist 1 drew to your attention a significant and highly unusual clinical event regarding your treatment of patient some two weeks earlier: you had recorded that you had provided root canal treatment to the patient but when Dentist 1 took a radiograph and examined the patient six days later no root filling was present in the tooth. The Committee determined that you would have been aware at this early stage (if you were not already aware) that you had failed to take a post-operative radiograph, as it is more likely than not that you would have reviewed Patient LT's records and would have searched for a post-operative radiograph in response to Dentist 1's concerns that no root filling was present when he subsequently examined her. You failed to explain to Patient LT that no root filling was present at her LR5 and that her root canal treatment had therefore not been completed. You stated that you did not recognise Patient LT when you saw her in the surgery with Principal Dentist 1 on 26 November 2020. The Committee rejected this. It determined that it is more likely than not that you would have recognised Patient LT given the number of appointments over which you had previously seen her (12 March 2019, 2 April 2019, 30 April 2019, 15 May 2019, 31 May 2019, 9 July 2019 and 8 October 2020, in addition to a telephone appointment on 3 August 2020) and the concerns previously

	discussed with you by Dentist 1 regarding her treatment. The Committee determined that when you entered Principal Dentist 1's surgery you would have recognised Patient LT and would have recognised her as the same patient which Dentist 1 had previously discussed with you. You would have recognised that this was the patient for whom you had recorded that root canal treatment had been provided on 31 May 2019 but that no root filling was present when she was examined by Dentist 1 six days later. You would have recognised that you had failed to take a post-operative radiograph for the patient. You would have recognised that you had failed to disclose to the patient at her subsequent appointments with you that no root filling was present in her tooth. At the appointment with Principal Dentist 1 on 26 November 2020 there was an inconsistency in your clinical records that you had provided a root filling to the patient on 31 May 2019 (which was also the patient's understanding) and the subsequent clinical examination undertaken by both Dentist 1 and now Principal Dentist 1 where no root filling was found to be present in the tooth. Principal Dentist 1 called for the post-operative radiograph which she believed you had taken and instructed practice staff to search for that radiograph. In the Committee's judgment this would have placed you under considerable pressure: you had a strong motive to produce a post-operative radiograph showing that Patient LT's LR5 had been successfully obturated by you with gutta percha on 31 May 2019, so as to corroborate what was recorded by you in the clinical notes and what Patient LT also understood to be the case. On your own evidence Patient LT believed that the root canal treatment had been completed and was acting aggressively towards Principal Dentist 1 over this matter. In the absence of such a radiograph you would have understood that your claim that you had completed the root canal treatment for Patient LT on 31 May 2019 would appear to be false, in light of the fact that no root filling was detected six days later when the patient was examined by Dentist 1. You would have also understood at the appointment on 26 November 2020 that it had become apparent to Principal Dentist 1, who was now responsible for Patient LT's care, that no root filling was present in the tooth. It is beyond doubt from the evidence before the Committee that the radiograph in question was deliberately altered to give the impression that a root filling had been placed at Patient LT's LR5. Whilst all practice staff had access to patient records, there is nothing to suggest to the Committee that any person other than you would have had any reason whatsoever to have altered the radiograph (whether out of malice, as a "prank" or for some other reason). The only person who had a motive to alter the radiograph was you. The Committee had regard to the principle that the more serious an allegation the less likely it is to have occurred. Here, the allegation is extremely serious. The Committee also had regard to the crude nature of the alteration to the radiograph and to the fact that, on close examination, it would have been obvious to Principal Dentist 2 and any other practitioner that the back of the radiograph had been deliberately scratched in order to alter the radiographic image. In the Committee's judgment, this does not make it less likely that you had deliberately scratched the radiograph. This is because people can act recklessly and demonstrate poor judgment when desperate or under considerable pressure.

	This is not a decision which the Committee reached lightly or with any enthusiasm. The Committee very carefully examined and deliberated on the evidence. From whichever angle it approached the matter it reached the irresistible inference that it could only have been you who had deliberately scratched the radiograph covering the LR5, which you then provided to your workplace supervisor, Principal Dentist 2. Accordingly, the Committee found this charge proved.
41. b.	*provided that radiograph to your Workplace Supervisor, Witness B.* **Admitted and found proved.**
42.	*Your conduct in relation to Charge 40.d. was:*
42. a.	*Misleading;* **Admitted and found proved.**
42. b.	*Dishonest, in that you knew you had not successfully obturated Patient LT's LR5* **Proved.** As a matter of fact, the LR5 had not been successfully obturated with gutta percha as no gutta percha was present in the tooth at the conclusion of the appointment on 31 May 2019. You had intentionally made a clinical note describing in detail that the LR5 had been successfully obturated with gutta percha. As admitted and found proved under charge 42(a) above, that note was misleading as a matter of fact. The issue under this charge is whether you knew that the note was misleading at the time you made the note, or whether you genuinely but mistakenly believed that you had successfully obturated the LR5 with gutta percha. The Committee determined that it is more likely than not that you had not in fact placed any gutta percha into the tooth to begin with. This is because Dentist 1 found evidence of an exposed pulp and caries in the LR5 when he opened up the tooth six days later: there had not been even a basic standard of endodontic preparation in advance of the placement of gutta percha as a root filling. In any event, the Committee determined that it would have been obvious to you if the gutta percha fallen out of the tooth during the treatment or if it had otherwise been removed from the tooth by becoming stuck to the heated plugger. The Committee accepted the expert opinion evidence that gutta percha was of a distinctive appearance to any other material which would have been used during the procedure. You accepted in evidence that you had used a rubber dam when placing the gutta percha into the tooth. The rubber dam would have isolated the tooth and this would have further increased the visibility of any gutta percha falling or being removed from the tooth. In the Committee's judgment, there was no basis on which you could have reasonably believed that you had successfully obturated the LR5 with gutta percha. The Committee determined it was more likely than not that you knew you had not successfully obturated Patient LT's LR5 and that you knew your note in the clinical records was inaccurate. The Committee determined that knowingly making an inaccurate note of this nature in the clinical records is conduct which would be regarded as

	dishonest by the (objective) standards of ordinary decent people. Accordingly, the Committee has found this charge proved.
43.	*Your conduct in relation to Charge 41 was:*
43. a.	*Misleading;* **Proved.**
43. b.	*Dishonest, in that you did so to give the impression Patient LT's LR5 had been obturated on 31 May 2019, when it had not.* **Proved.** The Committee has found that you deliberately scratched the radiograph to give the impression that Patient LT's LR5 had been obturated on 31 May 2019, when it had not. Such conduct would be regarded as dishonest by the (objective) standards of ordinary decent people. Accordingly, the Committee found this charge proved.

We move to Stage Two."

On 25 May 2022 the Chairman announced the determination as follows:

"Ms Photay,

The allegations against you were presented to this Committee under three separate referrals relating to your work at different dental practices.

The Committee announced its findings of fact in a determination dated 24 May 2022:

a. In respect of referral one (charges 1-18) the Committee found proved clinical and record keeping failings in relation to six patients between September and December 2017. In addition, the Committee found proved that a comment you had made on 6 December 2017 to your then former Practice Manager was dishonest.

b. In respect of referral two (charges 19-39) the Committee found proved record keeping failings in 2019 and 2020 in respect of 21 patients.

c. In respect of referral three (charges 40-43) the Committee found proved clinical failings in relation to your provision of root canal treatment to a patient on 31 May 2019. The Committee also found proved that an entry made by you in the clinical notes for that appointment was dishonest and that in 2020 you dishonestly scratched a radiograph of the patient.

d. At this stage of the proceedings, the Committee shall decide whether the facts found proved amount to misconduct and/or deficient professional performance and, if so, whether your 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 your registration.

You provided the Committee with a bundle comprising: (i) your written reflections in respect of your clinical failings and the corresponding steps you have taken to address them; (ii) your Continuing Professional Development (CPD) record; and (iii) testimonials in support of your character and performance as a dentist.

In addition, your evidence during the factual inquiry also contained reflections by you which are relevant to this stage of the proceedings.

The Committee had regard to the comprehensive submissions made by both Counsel.

Mr Stevens, on behalf of the General Dental Council (GDC), confirmed that you have no other fitness to practise history. He made submissions on the law, including the caselaw relating to the threshold for a finding of misconduct and to the concept of deficient professional performance. He submitted that the facts found proved under referrals one and three meet the threshold for misconduct. As to referral two, he submitted that the facts found proved amount to deficient professional performance. He also confirmed that the GDC does not in the alternative pursue a finding of misconduct in respect of the facts found proved under referral two.

Mr Stevens submitted that your fitness to practise is currently impaired by reason of both misconduct and deficient professional performance. By reference to the Committee's findings of dishonesty, he submitted that erasure is the only appropriate outcome in this case.

Mr Rich, on your behalf, conceded that the record keeping failings identified under referral two represented a fair sample of your work; however those failings are not so significant as to currently impair your fitness to practise by reason of deficient professional performance. In respect of the clinical failings identified under referral one, he submitted that the threshold for misconduct is not met where either or both experts considered the failing to have fallen only below (as opposed to far below) the standard reasonably expected of you; where there was a conflict of expert opinion on this point, he submitted that the conflict should be resolved in your favour. This was because there was only limited disagreement between the experts and Mr Mulcahy, the GDC instructed expert, had stated in evidence that any difference between himself and Mr Morris, the expert instructed on your behalf, was merely a difference of opinion which was open to the other expert to express.

Mr Rich did not otherwise contest a finding of current impairment by reason of misconduct in respect of referrals one and three. As to sanction, Mr Rich made submissions in support of suspension (rather than erasure) in respect of the dishonesty which the Committee has found proved. He submitted that a review should be held at the end of the period of suspension to allow a reviewing Committee to then address any remaining clinical concerns through the imposition of a period of conditional registration.

<u>Decision</u>

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, last revised December 2020) (the "ISG").

Deficient Professional Performance

The Committee first considered whether the facts found proved under referral two amount to deficient professional performance which currently impairs your fitness to practise as a dentist. As stated at paragraph 4.1.iii of the ISG:

> …deficient professional performance involves an unacceptably low standard of professional performance, and will normally only be found if there is evidence of such low standard based upon review of a fair sample of the Registrant's work.

The Committee was satisfied that the patient records provided under referral two represented a fair sample of your work in respect of your record keeping standards. In

the Committee's judgment, this sample does not, however, amount to an unacceptably low standard of professional performance which goes to fitness to practise. Mr Mulcahy (the only expert witness instructed in respect of referral two) expressed the opinion that these record keeping failings fell only below the standard reasonably expected of you. Whilst that does not in itself preclude a finding of deficient professional performance, the Committee had regard to the context in which these record keeping failings occurred. As stated by Mr Mulcahy under section 4 of his report dated 30 January 2021:

> …I have identified a number of omissions/failures in relation to record keeping. It is my opinion that both individually and cumulatively these omissions/failures represent a standard below that expected. This is because: the records are substantially complete (with the possible exception of Patient O); largely comply with statutory and professional obligations; there is no evidence that any entries (e.g. un-adapted templates) were intended to mislead; and there is no evidence that any errors/omissions compromised patient care.

In the Committee's judgment, having regard to context, your record keeping failings under referral two were the result of the overuse of record keeping templates in an attempt by you to improve your record keeping to a gold standard. Your record keeping failings arose largely because you had failed to delete or correct relevant parts of those templates for each appointment. The records in question were substantially complete and your record keeping failings did not compromise patient care. This does not in the Committee's view represent an unacceptably low standard of professional performance which could impair fitness to practise.

Accordingly, the Committee determined that the facts found proved under referral two do not amount to deficient professional performance and that your fitness to practise is therefore not currently impaired on that ground.

The GDC has not pursued any alternative finding of misconduct in respect of referral two. The Committee in any event determined that the threshold for misconduct would not have been met as the failings in question were not so serious as to meet the threshold of misconduct.

Misconduct

The Committee next considered the question of misconduct in respect of the facts found proved under referrals one and three.

Misconduct connotes 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 regard to the following principles from *Standards for Dental Professionals* (September 2013):

1.1.1 You must discuss treatment options with patients and listen carefully to what they say. Give them the opportunity to have a discussion and to ask questions.

1.2.4 You should manage patients' dental pain and anxiety appropriately.

2.3: You must give patients the information they need, in a way they can understand, so that they can make informed decisions

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

Standard 1.3: You must be honest and act with integrity

1.3.1 You must justify the trust that patients, the public and your colleagues place in you by always acting honestly and fairly in your dealings with them. This applies to any business or education activities in which you are involved as well as to your professional dealings.

1.3.2 You must make sure you do not bring the profession into disrepute.

9.1: You must ensure that your conduct, both at work and in your personal life, justifies patients' trust in you and the public's trust in the dental profession

The Committee accepted Mr Rich's submission that, in respect of the clinical and record keeping failings found proved under referral one, the threshold for misconduct would not be met where either or both experts expressed the opinion that the failing in question fell only below standard.

The Committee determined that the remaining clinical and record keeping failings under referral one are serious enough to meet the threshold of misconduct. These are charges 1(a), 3, 4(e)(i)-(iii) (and the corresponding charge 5(a) which, although not itself the subject of expert opinion, is engaged), 6(a), 13(a), 13(c), 13(d), 15(a), and 16. These encompass wide ranging errors in basic dental care, including: record keeping failings; inaccurate taking of BPE scores; failing to diagnose and treat caries; inadequate diagnosis and treatment planning in respect of placing a crown for one patient and a restoration for another, and inadequate clinical skills in then carrying out the treatment for each patient; provision of inappropriate treatment; failure to evaluate radiographs adequately and failure to obtain informed consent. These failures had the potential to put your patients at a risk of harm.

In respect of charges 4(e)(i)-(iii) (and the corresponding charge of "misleading" under charge 5(a)), you had retrospectively amended a patient's records without marking up that the record had been amended by you retrospectively. Whilst the Committee did not find proved that you had acted dishonestly or that you had otherwise intended to mislead in making the amendment, your conduct was still misleading as a matter of fact, as it would have misled any person reviewing the patient's records into believing that the amendment had formed part of the original record for the appointment, as opposed to it being a retrospective amendment after the patient had made a complaint about the information you had given to him at that appointment. This was a serious breach of a basic and fundamental record keeping standard.

In respect of charges 17-18, on 6 December 2017 your told Witness B, your then former practice manager, that you were shadowing at another dental practice. This was dishonest as you knew what you had told her was not true. In the Committee's judgment, it was a spontaneous and isolated act for which there was no apparent personal gain or benefit to you, other than potentially to save face. In the Committee's judgment it is dishonesty which falls at the lower end of the spectrum. However, any act of dishonesty by a dental professional is inherently serious and in the Committee's view the dishonesty here meets the threshold for misconduct.

Both experts were agreed that the clinical failings found proved under referral three (charges 40(b), (c), (e) and (f)) fell far below standard. In the Committee's judgment, these were serious clinical failings in relation to the provision of root canal treatment to Patient LT's LR5 in May 2019 and a failure to diagnose caries at her LR6 at an appointment on 9 July 2019.

You dishonestly recorded for the appointment on 31 May 2019 that you had successfully obturated Patient LT's LR5 with gutta percha when in fact you had not done so (charge 40(d)): as would have been obvious to you, the patient left this

appointment without a root filling (gutta percha) beneath an amalgam filling you had placed in her LR5.

This was discovered by another dentist when Patient LT attended the following week complaining of continuing pain in her lower right jaw. That dentist informed you that you had recorded in the clinical notes that a root filling had been placed in the LR5 but that no such root filling was visible on a radiograph he had taken on 5 June 2019 and was not present when he opened up the tooth. He referred the patient back to you for the completion of the root canal treatment, but you did complete that treatment. Instead of explaining to the patient that you had not in fact placed a root filling in the tooth, the records suggest that you merely informed her that the root canal treatment was likely to have failed. You had not in fact completed the root canal treatment on 31 May 2019.

This matter further came to light on 26 November 2020 when Patient LT attended a principal dentist at the practice. The Committee noted that in the intervening period the patient had attended you complaining of pain at each appointment, including pain at her LR5. To cover up the fact that you had not placed the root filling recorded by you in the notes for the appointment on 31 May 2019, you allowed your practice principal to believe that you had taken a post-operative radiograph of that root filling so she initiated a practice-wide search for that radiograph. You then scratched a radiograph covering Patient LT's LR5 in a way which altered the radiographic image of the tooth to give the impression that, post-operatively, a root filling had been placed in the LR5 on 31 May 2019. In the Committee's judgment, the dishonesty in respect of the inaccurate record in the clinical notes and your subsequent deliberate scratching of the radiograph to alter the radiographic image fall at the higher end of the spectrum of seriousness.

Accordingly, the Committee determined that there had been significant breaches of the above quoted standards in respect of the matters found proved (and taken forward) under referral one and in respect of all the matters found proved under referral three. The Committee determined that the threshold for misconduct is met.

Impairment

In assessing whether your fitness to practise as a dentist is currently impaired, the Committee had regard to the whether your 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 appropriate standards of conduct and behaviour, so as to maintain public confidence in the profession and in the GDC as a regulator.

Your clinical failings and record keeping failings are clearly remediable through continued training, supervision and evidence of embedded improvement in practice. You last practised as a dentist in December 2020 and so you are unable to demonstrate any embedded improvement in practice. You have taken a number of remedial steps, as set out in your reflective statement to the Committee and in your CPD record.

You have taken the some steps towards remediation of your clinical failings but your remediation is not yet complete in the Committee's judgment, as you are yet to demonstrate embedded improvement in practice. You have also shown some insight into your clinical failings, both through your admissions to most of the charges and your written reflections.

The Committee acknowledges that, between February 2019 and December 2020, there is no evidence of any repetition of your earlier clinical failings, save for your

failings in respect of Patient LT's treatment on 2019. However, during this period you were practising under workplace supervision as part of interim conditions on your registration. Further, you have not practised since December 2020. The Committee is therefore not in a position to conclude that the risk of your repeating your clinical failings in low. In the Committee's judgment there remains a real risk of repetition should you be allowed to practise without restriction and therefore a real risk of harm to patients. These were failings in basic and fundamental aspects of dentistry.

Your dishonesty is more difficult to remedy, as it is a matter which goes to your character. The Committee accepts that the dishonesty in 2017 was likely to be an isolated and spontaneous act, which as the Committee has already stated, falls at the lower end of the spectrum of seriousness.

Your dishonesty in 2019 and 2020 on any view falls at the higher end of the spectrum. There is no evidence before the Committee of any insight, remorse or acknowledgement of wrongdoing. You had denied as part of the factual inquiry that you had acted dishonestly in respect of the entry you had made in Patient LT's records on 31 May 2019 and in respect of altering the radiograph in 2020 (you denied that you had scratched the radiograph).

The Committee could not be satisfied that there is a low risk of you acting dishonestly again, particularly when under pressure.

In the Committee's judgment, your fitness to practise is clearly impaired by reason of both your clinical and record keeping failings and your dishonesty. There is a real risk of harm to patients should you be allowed to practise without restriction.

Further, public confidence in the profession and this regulatory process would also be undermined if no finding of impairment were to be made. Your clinical failings involved basic errors in fundamental aspects of dental practice. Through these failings you had put patients at an unwarranted risk of harm in the past and you are liable to do so again if allowed to practise without any restriction on your registration. You have acted dishonestly and are liable to do so again. You have breached a fundamental tenet of the profession by acting dishonestly. Your misconduct has the potential to bring the profession into disrepute.

Accordingly, the Committee determined that your fitness to practise as a dentist is currently impaired by reason of your misconduct.

Sanction

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. In deciding on sanction, the Committee must act proportionately and should impose the least restrictive sanction necessary to protect the public and to meet the wider public interest.

In assessing what sanction, if any, to impose, the Committee had regard to the aggravating and mitigating factors present in this case.

The aggravating factors include the following: you put patients at risk of actual harm through wide ranging failings in basic aspects of dentistry, repeated over a lengthy period; you have acted dishonestly on more than one occasion; your dishonesty in respect of Patient LT's records and radiograph was premeditated and in respect of the radiograph was calculated as an attempt to cover up the earlier dishonesty.

In mitigation the Committee accepted that you had an otherwise unblemished record; there is evidence of some insight through your written reflections; you have taken steps towards your remediation through CPD and your ability to take further steps has been hindered by the fact that you have not practised since December 2020.

The Committee considered each sanction in ascending order of severity.

To conclude this case with no further action or a reprimand would be wholly inappropriate in the Committee's judgment, owing to the risk of repetition and to the seriousness of your misconduct. A reprimand would be insufficient to protect the public and to maintain public confidence in the profession.

The Committee next considered whether to direct that your registration be made subject to your compliance with conditions. In the Committee's judgment, conditions requiring you to work under close supervision might be indicated for the clinical failings in this case, as they would provide a framework which would protect the public whilst allowing you to continue your remediation (albeit the Committee noted that your clinical failings in respect of Patient LT occurred whilst you were working under supervision as part of your interim conditions). However, the Committee could not be satisfied that conditions would meet the probity concerns identified in this case. It could not identify any conditions which could address your dishonesty, which, in any event, is too serious for conditions of practice to be an appropriate sanction at this stage.

The Committee next considered whether to direct that your registration be suspended for a period of up to 12 months, with or without a review. The Committee had careful regard to the factors indicated in the ISG for suspension and erasure. In the Committee's judgment suspension would not be sufficient to protect the public and to maintain public confidence in the profession. Your dishonesty in respect of Patient LT's clinical records and your subsequent scratching of a radiograph of her LR5 is too serious for a period of suspension.

The Committee acknowledges that your dishonesty occurred whilst you were under pressure and it appears that it may have been the result of desperation. Had your dishonesty been limited only to the inaccurate record on 31 May 2019 then suspension may be proportionate. However, your dishonesty persisted with the subsequent alteration of the radiograph. This demonstrates a deep seated underlying professional attitudinal problem which is fundamentally incompatible with continued registration. Your having engaged in such a calculated attempt to alter a dental radiograph to cover up your earlier dishonesty is so serious that the Committee does not believe that either patients or fellow members of the profession could be expected to place their trust in you not to act dishonestly in the future, particularly if you again felt under pressure. Furthermore, your dishonesty was so serious that public confidence in the profession and this regulatory process would be seriously undermined if you were allowed to remain on the Register.

Having regard to all the circumstances, the Committee determined that erasure is the necessary and proportionate outcome in this case.

Accordingly, the Committee directs that the name of Rekha Rani Photay (256795) be erased from the Register.

The Committee now invites submissions on the question of an immediate order.

The interim order on your registration is hereby revoked.

The Committee determined that it is necessary for the protection of the public and is otherwise in the public interest to order that your registration be suspended forthwith 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 of suspension.

The effect of this order is that your registration is now suspended. Unless you exercise your right of appeal, your name will be erased from the Register upon the expiry of the

28-day appeal period. Should you exercise your right of appeal this immediate order shall remain in force pending the disposal of the appeal.

That concludes this hearing."