PUBLIC HEARING

Professional Conduct Committee
Initial Hearing

31 August 2023 - 7 November 2023

Name:	PHOTAY, Parkash Singh
Registration number:	44764
Case number:	CAS-190492

General Dental Council:	Miss Lydia Barnfather, Counsel Instructed by Capsticks Solicitors
Registrant:	Present Represented by Mr Andrew Kennedy KC

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

Committee members:	Nora Nanayakkara Gill Jones Louise Fletcher
Legal adviser:	Gerard Coll
Committee Secretary:	Andrew Keeling

Mr Photay,

1. This is a Professional Conduct Committee inquiry into the facts which form the basis of the allegation against you that your fitness to practise is impaired by reason of misconduct. You attended the hearing and you were represented by

Mr Andrew Kennedy KC. Miss Lydia Barnfather of Counsel presented the General Dental Council's (GDC) case. The hearing took place at Wimpole Street.

2. Your case was considered on a joint basis at this hearing with another registrant (Registrant 1). Registrant 1 attended the hearing and was represented by Miss Julia Furley of Counsel.

Application under Rule 57 to adduce evidence (31 August 2022 - 1 September 2022)

3. At the outset of the hearing, Miss Barnfather informed the Committee that a witness (Witness 2) was unable to attend the hearing due to ill health. She will therefore be submitting a preliminary application for that witness' statement to be adduced as hearsay evidence.

4. Miss Furley, on Registrant 1's behalf, submitted that the witness statement of Witness 2 provided significant evidence against Registrant 1. She submitted that if the witness statement was read by the Committee it would be almost impossible for it to put the contents out of its mind when considering the evidence in this case. She further submitted that the proper course would be for a separate Committee to deal with the GDC's hearsay application, pursuant to Rule 26 of the GDC (Fitness to Practise) Rules Order of Council 2006 (the Rules), and then for this Committee to deal with the substantive matters.

5. Mr Kennedy, on your behalf, submitted that he was neutral on the issue.

The Committee's Decision (31 August 2022)

6. The Committee took into account the submissions made by both parties and accepted the advice of the Legal Adviser. The Committee noted that it had not yet received any papers for the hearing.

7. The Committee determined that it would deal with the GDC's hearsay application as a preliminary matter under Rule 17(4). It considered that it appears common ground that the witness statement is relevant evidence that goes to some of the heads of charge. The Committee determined that it could see no basis for the application to be referred to another Committee under Rule 26.

8. The Committee subsequently invited Miss Barnfather to make her application and for Miss Furley and Mr Kennedy to make any submissions in response.

GDC Submissions

9. Miss Barnfather, on behalf of the GDC, submitted that the witness statement would be admissible in civil proceedings and it was in the interests of justice for the evidence to be admitted. She referred the Committee to Section 4 of the Civil Evidence Act 1995 and the relevant case law. She submitted that the witness stands by her evidence and states that it is her best recollection of events. She also submitted that, owing to her professional position, the witness understood the importance and significance of her evidence. She referred the Committee to the heads of charge against you and Registrant 1 that were relevant to Witness 2's witness statement. She submitted that it was important for the Committee to note that it appears Registrant 1's only objection to the admission of the witness statement was confined to his denial that he had said that conscious sedation was not provided at the practice. Registrant 1 has not stated that the witness statement was fabricated or unreliable.

10. Miss Barnfather further submitted that Witness 2 had previously been willing to attend the hearing in October 2020 and April 2022. However, she had been stood down at the last moment on both occasions and this has played a part in her non-attendance today. Miss Barnfather also informed the Committee that the GDC had undertaken all reasonable steps to secure Witness 2's attendance, however they had been informed by Witness 2's GP that attending the hearing would be detrimental to her health.

11. In conclusion, Miss Barnfather submitted that it would be in the interests of justice for the witness statement to be admitted and it would not be unfair. She submitted that Registrant 1 would be able to challenge this evidence via the evidence of other witnesses. Also, although she submitted that Witness 2's witness statement was the sole evidence relating to head of charge 12(b), that would not make it inadmissible.

Registrant 1's Submissions

12. Miss Furley, on Registrant 1's behalf, submitted that the fundamental issue that the Committee has to consider is one of fairness to Registrant 1, including the impact of this case on him and his ability to defend himself. She referred the Committee to the relevant case law. She submitted that the witness statement had gone through several iterations, and she had concerns about the reliability of the evidence. She submitted that the witness statement was clearly relied upon by the GDC and was a decisive piece of evidence against Registrant 1. Therefore, the evidence should be properly tested and

Registrant 1 should be entitled to ask the witness questions about her evidence.

13. With regard to the witness' non-attendance, Miss Furley submitted that it was clear that the witness was concerned about the financial implications of attending rather than the impact on her health. She submitted that the GP letter provided by Witness 2 goes nowhere near explaining why she would not be able to attend the hearing. Furthermore, it seemed that Witness 2 had continued to work during this period despite the health concerns cited. Miss Furley invited the Committee to refuse the GDC's application.

14. Mr Kennedy made no submissions on your behalf.

The Committee's decision on the Rule 57 application (1 September 2022)

15. The Committee took into account the submissions made by both parties and accepted the advice of the Legal Adviser. The Committee had regard to the interests of justice and remained mindful of the principle of fairness. It balanced the interests of the GDC with yours and Registrant 1's interests.

16. The Committee noted its powers under Rules 57(1) and 57(2), which are as follows:

(1) A Practice Committee may in the course of the proceedings receive oral, documentary or other evidence that is admissible in civil proceedings in the appropriate court in that part of the United Kingdom in which the hearing takes place.

(2) A Practice Committee may also, at their discretion, treat other evidence as admissible if, after consultation with the legal adviser, they consider that it would be helpful to the Practice Committee, and in the interests of justice, for that evidence to be heard.

17. In making its decision, the Committee noted that the witness statement was relevant to heads of charge 12 and 13 against Registrant 1 and was contested. With regard to fairness, the Committee then considered whether reasonable steps had been taken by the GDC to secure the witness's attendance. The Committee noted that, although reasonable steps had been taken by the GDC, a witness summons had not been issued to Witness 2. The Committee also considered the medical evidence provided by Witness 2 as a reason for her non-attendance. It noted that the GP letter provided did not explain in sufficient detail why her health condition would prevent her from attending either in person or remotely. The Committee also had sight of Witness 2's emails to the GDC in August 2022 and the note of her telephone

call on 25 August 2022. Furthermore, it noted that it appeared that Witness 2 had continued to work in the role of CQC inspector as described at head of charge 12.

18. Mindful of its obligations to ensure fairness to all parties, the Committee considered the degree to which the evidence was contested and took account of the insufficient detail of the medical evidence explaining why Witness 2 could not attend the hearing, in refusing the GDC's application for Witness 2's statement to be admitted into evidence.

Preliminary Matter – Decision on Recusal of Committee (1 September 2022)

19. Following the Committee's decision to decline to accept Witness 2's witness statement into evidence, Miss Furley, on Registrant 1's behalf, made an application for the Committee to recuse itself.

20. Miss Furley submitted that she is making this application as she had concerns that the Committee would find it difficult to disregard Witness 2's statement owing to its nature and detail. In addition, she submitted that the Committee had already heard submissions regarding the evidence. She submitted that she was not being critical of the Committee, but the risk of bias was too high if the Committee continued hearing this case. Miss Furley acknowledged that for another Committee to hear this case would cause further delay. However, she submitted that this should not be a matter for the Committee to consider when making its decision. Accordingly, she invited the Committee to recuse itself before Patient A gives his evidence.

21. Miss Barnfather, on behalf of the GDC, referred the Committee to the case of *Porter v Magill* [2002] 2 AC 35, which set out the relevant consideration as whether the fair-minded and informed observer, having considered the facts, would conclude there was a real possibility that the Committee was biased. She submitted that a fair-minded observer would consider that this was a professional Committee and well used to putting from their minds evidence that has been excluded. She also submitted that the excluded evidence was confined to a small number of heads of charge, and that there was other evidence relating to those charges. There was only one head of charge where potentially it was the sole evidence. Miss Barnfather concluded that an informed observer would not conclude that there was a possibility of this Committee being biased.

22. Mr Kennedy, on your behalf, submitted that he was neutral on the issue.

23. The Committee took into account the submissions made by both parties and accepted the advice of the Legal Adviser.

24. The Committee considered Miss Furley's application and was satisfied that it would be able to hear Registrant 1's case fairly. The Committee noted that it was an experienced and professional Committee, which was assisted by an independent Legal Adviser. It further noted that the excluded evidence was confined to narrow issues relating to only one or two of the heads of charge. The Committee noted that any submissions it had heard about the evidence were confined to its admissibility rather than the detail of the evidence itself. Therefore, the Committee determined that a fair-minded observer, who has considered all the relevant facts, would not perceive there was a real possibility that the Committee would be biased. The Committee concluded, therefore, that it did not need to recuse itself from this hearing.

Preliminary Matter – Rule 18 Application to Amend the Charge (5 September 2022)

25. As a result of the Committee's decision not to accept Witness 2 statement into evidence, Miss Barnfather made an application, on behalf of the GDC, under Rule 18 of the GDC (Fitness to Practise) Rules Order of Council 2006 (the Rules) to amend the charges for your case and Registrant 1's case.

26. Miss Barnfather submitted that head of charge 12(b) and the reference to 12(b) in the stem of head of charge 13 should be deleted in respect of Registrant 1's case.

27. With regard to your case, Miss Barnfather submitted that head of charge 13(c) and the reference to 13(c) in the stem of head of charge 14 should be deleted.

28. You and Registrant 1 accepted the amendment as it was a deletion of a charge.

29. The Committee accepted the advice of the Legal Adviser on the Rule 18 application.

30. The Committee acceded to Miss Barnfather's application to amend the charge.

Preliminary Matters - Decision on Adjournment (17 October 2021)

Application for Adjournment

31. Miss Furley, on behalf of Registrant 1, made an application to adjourn the hearing. She submitted that Registrant 1 was currently unwell and was not fit enough to attend the hearing today. She drew the Committee's attention to a doctor's letter, dated 14 October 2023, which confirmed that Registrant 1 was not well enough to attend. She further submitted that Registrant 1 was due to be re-assessed by a doctor tomorrow, but she will request an update today from the surgery. She invited the Committee to adjourn the hearing today with a view to Registrant 1 attending tomorrow either in person or via video-link with his camera turned off. She submitted that it was important for Registrant 1 to hear Witness 3's evidence, which was scheduled to take place today.

32. Mr Kennedy, on your behalf, submitted that he was neutral on the application if Witness 3, who was due to give evidence today, was available tomorrow instead.

33. Miss Barnfather, on behalf of the GDC, informed the Committee that she was not sure whether Witness 3 was available to give evidence tomorrow. Until that is known, she submitted that she did not want to say anything more with regard to the application.

Decision

34. The Committee took into account the submissions made by Miss Furley, Mr Kennedy and Miss Barnfather. It has accepted the advice of the Legal Adviser.

35. The relevant statutory provisions for the Committee to consider are:

    Rule 58 of the General Dental Council (Fitness to Practise) Rules 2006 (the Rules) provides:

    "**Postponement and adjournments**

    (2) A Committee, may, of their own motion or upon the application of a party, adjourn the proceedings at any stage, provided that –

        (a) No injustice is caused to the parties; and

        (b) The decision is made after hearing representations from the parties (where present) and taking advice from the legal adviser.

(4) In considering whether or not to grant a request for postponement or adjournment, a Committee shall, amongst other matters, have regard to—

(a) the public interest in the expeditious disposal of the case;

(b) the potential inconvenience caused to a party or any witness to be called by that party; and

(c) fairness to the respondent."

36. In making its decision, the Committee noted the doctor's letter and although it stated that Registrant 1 was not well enough to attend the hearing, it did not state that he was unfit to participate in the hearing. The Committee noted that although this is an in-person hearing, Registrant 1 would be available to attend via video-link with his camera and microphone turned off. It further noted that Registrant 1 was appropriately represented by Counsel, who was also able to receive instructions from him. With regard to Witness 3, the Committee bore in mind that she has already been inconvenienced as she has been on oath since 6 September 2022 when it was not possible to accommodate all of her evidence due to delays caused by preliminary applications being heard and decided. Witness 3 had agreed to return today to assist the Committee. It noted Witness 3's assertion that it would be of extreme inconvenience to both her and the person assisting her, if she were required to give evidence again tomorrow. The Committee was mindful that Miss Furley's cross-examination of Witness 3, on behalf of Registrant 1, had actually concluded on 6 September 2022. Mr Kennedy's cross-examination today would be touching only on one limited area regarding Registrant 1's case, which had already been advised to him and Miss Furley in advance. For these reasons, the Committee refused the application for adjournment and directed that the hearing should proceed today in the absence of Registrant 1.

Application under Rule 57 to adduce evidence (7 February 2023)

37. At the conclusion of the GDC's case, Miss Furley, on Registrant 1's behalf, made an application pursuant to Rule 57 of the GDC (Fitness to Practise) Rules Order of Council 2006 (the Rules). She submitted that she would like to apply for exhibit MIA 9 of Witness 2's statement and a telephone note between the GDC and a CQC inspector to be admitted into evidence.

38. Miss Furley informed the Committee that exhibit MIA 9 is a record made by one of Witness 2's assistants (Person 1) on the day of the inspection on 23 June 2017. She submitted that this document had always been exhibited by

Witness 2 and had been agreed hearsay evidence. No objections had been raised by Miss Barnfather or by Mr Kennedy, on your behalf, that it would be adduced as part of Witness 2's evidence rather than by Person 1 herself. With regard to the telephone note, Miss Furley submitted that this was a note of a conversation between a GDC caseworker and Person 1 on 25 November 2019. The conversation was in relation to Person 1's recollection of the CQC's inspection on 23 June 2017. Miss Furley submitted that the note was relevant to charge 8(c) which alleges that Registrant 1 falsified the signature of Patient A on a treatment plan dated 19 December 2019. She submitted that the telephone note states that Person 1 confirmed that she had seen the patient's written consent forms, which had been signed by him.

39. Miss Furley submitted that following the Committee's previous decision not to admit Witness 2's statement into evidence, it was assumed that exhibit MIA 9 could be admitted as agreed evidence. However, she submitted that the GDC no longer takes that position. Furthermore, she does not have access to Person 1 herself as she was not her witness. Therefore, she submitted that she wishes to make the application to admit exhibit MIA 9 into evidence, along with the telephone note, which appears to be the most contemporaneous record of the communications between the GDC and Person 1 regarding the notes she took of the CQC inspection.

40. Miss Barnfather, on behalf of the GDC, submitted that Witness 2's statement had already been ruled as inadmissible by the Committee and these included her contemporaneous documents about the inspection. She submitted that Miss Furley is therefore trying to cherry pick one set of contemporaneous records over another. She submitted that if Miss Furley was seeking to rely on Person 1's contemporaneous records, then both sets of contemporaneous records should be made available to the Committee. She submitted that it would be unfair for one set of documents to be taken in isolation and in circumstances when Witness 2 would not be available to give evidence about the overall CQC inspection.

41. With regard to the telephone note, Miss Barnfather submitted that the Committee should be mindful that the telephone note documents a brief conversation, which took place more than two years after the CQC inspection. Further, she submitted that we do not know whether the notetaker is a GDC caseworker as Miss Furley suggested, and there is no verification as to the accuracy of the notetaker. Therefore, she submitted that it is difficult to know how safely one can rely on the documents. She also submitted that there was nothing prohibiting Miss Furley approaching Person 1 and obtaining a witness statement. She submitted that the GDC opposes the telephone note being admitted into evidence.

42. Mr Kennedy, on your behalf, made no submissions on the application.

The Committee's Decision

43. The Committee took into account the submissions made by all parties and accepted the advice of the Legal Adviser. The Committee had regard to the interests of justice and remained mindful of the principle of fairness. It balanced the interests of the GDC with yours and Registrant 1's interests.

44. The Committee noted its powers under Rules 57(1) and 57(2), which are as follows:

> *(1) A Practice Committee may in the course of the proceedings receive oral, documentary or other evidence that is admissible in civil proceedings in the appropriate court in that part of the United Kingdom in which the hearing takes place.*
>
> *(2) A Practice Committee may also, at their discretion, treat other evidence as admissible if, after consultation with the legal adviser, they consider that it would be helpful to the Practice Committee, and in the interests of justice, for that evidence to be heard.*

45. In making its decision, the Committee considered the transcripts when the hearing took place in August and September 2022. It noted Miss Furley's submissions and the nature and extent of her challenge to Miss Barnfather's application for Witness 2's statement being admitted into evidence. This included that Witness 2 would not be available to be cross-examined. However, the Committee noted that Miss Furley is now seeking to adduce a part of this evidence, which the Committee has already determined as being inadmissible, under Rule 57. The Committee did not share Miss Furley's understanding that it was assumed that exhibit MIA 9 could be admitted as agreed evidence. The Committee considered that this exhibit to Witness 2's evidence has the same characteristics as the rest of her evidence, which Miss Furley had objected to, including that Witness 2 is not available to be cross-examined and that the evidence is contested. The Committee noted that it is agreed between parties that it does not constitute a business record.

46. In conclusion, the Committee was not satisfied, based on the submissions it has heard today, that it would be fair or relevant to admit either exhibit MIA 9 or the telephone note dated 25 November 2019 as evidence under Rule 57 having already made a decision on the entirety of Witness 2's evidence. Accordingly, the Committee refused Miss Furley's application.

Application under Rule 57 to adduce evidence (14 March 2023)

47. Miss Furley, on Registrant 1's behalf, made an application pursuant to Rule 57 of the GDC (Fitness to Practise) Rules Order of Council 2006 (the Rules) for Person 1's witness statement to be admitted into evidence.

48. Miss Furley submitted that she had originally intended to apply for a witness summons in order that Person 1 could attend the hearing. Miss Furley informed the Committee that she had spoken to Person 1 by phone and Person 1 had informed her that she could not attend the hearing today due to a pre-existing work commitment, but would be willing to sign the witness statement that had been sent to her. This witness statement confirms that Person 1 is the author of exhibit MIA 9 of Witness 2's statement. This MIA 9 exhibit is now exhibited as part of Person 1's witness statement. She submitted that the witness statement is significant and relevant evidence for Registrant 1's case as it deals specifically with what was present on Patient A's records at the time of the CQC inspection. Furthermore, she submitted that it would be in the interests of justice for the witness statement to be admitted into evidence.

49. Miss Barnfather, on behalf of the GDC, submitted that she opposed the application. She submitted that the Committee had already determined in February that exhibit MIA 9 should not be admitted into evidence as it would not be fair or relevant, and the Committee should have regard to her submissions made at the time. She submitted that Miss Furley's application is effectively a renewed and repeated application to admit hearsay evidence that the Committee had already ruled on. She informed the Committee that if Person 1 attends the hearing, it would be the GDC's intention to ask her questions relating to matters that go beyond her witness statement. In addition to her original submissions in February, Miss Barnfather submitted that the Committee now has Registrant 1's evidence about the records and whether the signatures are genuine or not. She further submitted that the Committee has already ruled the evidence of Witness 2 as inadmissible and that it would not be fair or relevant for Person 1's witness statement to be admitted into evidence.

50. Mr Kennedy, on your behalf, made no submissions on the application.

The Committee's Decision

51. The Committee took into account the submissions made by all parties and accepted the advice of the Legal Adviser. The Committee had regard to the

interests of justice and remained mindful of the principle of fairness. It balanced the interests of the GDC with yours and Registrant 1's interests.

52. The Committee noted its powers under Rules 57(1) and 57(2), which are as follows:

> *(1) A Practice Committee may in the course of the proceedings receive oral, documentary or other evidence that is admissible in civil proceedings in the appropriate court in that part of the United Kingdom in which the hearing takes place.*
>
> *(2) A Practice Committee may also, at their discretion, treat other evidence as admissible if, after consultation with the legal adviser, they consider that it would be helpful to the Practice Committee, and in the interests of justice, for that evidence to be heard.*

53. In making this decision, the Committee bore in mind its previous decision not to admit Witness 2's statement into evidence. The Committee determined that it would be inconsistent, unfair and not in the interests of justice to now agree to the admission of a fragment of the material already refused. The Committee is not satisfied, based on Miss Furley's application, that Person 1's witness statement has any more than uncertain evidential value as a statement of attribution. The Committee also noted Registrant 1's oral evidence that the author was potentially not furnished with Patient A's records at all or just a partial set of records from one practice. The Committee further considered the progress of this case, which has already been much delayed. Accordingly, the Committee refused Miss Furley's application to admit Person 1's witness statement into evidence.

Decision on Recusal of Committee Member (17 March 2023)

54. At the beginning of today's session, the Chair of the Committee made a disclosure to parties that, having made applications to a number of Chambers, she had yesterday been invited for a first round interview for a Barrister's pupillage (a training position). That is the Chambers where Mr Andrew Kennedy KC, who is representing you at this hearing, is currently a member. The Committee was not sitting yesterday so today was the first opportunity to bring this matter to the attention of the parties. The Chair stated that she was due to be interviewed by members of Chambers who are not involved in this hearing. This was confirmed by Mr Kennedy.

55. As a result of the Chair's disclosure, Mr Kennedy, on your behalf, made an application for the Chair to recuse herself from this hearing. He submitted that the application is made on the grounds that there was a risk that a fair-minded and informed observer would conclude that there was a real possibility of bias. He submitted that he does not make an allegation of actual bias. He referred the Committee to the cases of *Haliburton Co v Bermuda Insurance Ltd [2021] UKSC 48* and *Ameyaw v McGoldrick and Others [2020] EWHC 1787 (QB)*.

56. Mr Kennedy submitted that it is relevant that the allegations against you and Registrant 1 are serious, which include allegations at the higher end of dishonesty. Furthermore, he submitted that both you and Registrant 1 are running "cut-throat" defences as you are both blaming the other in relation to some of the allegations and this was relevant to the perception of bias.

57. Mr Kennedy submitted that although there are no concerns raised about the Chair making pupillage applications, a question may arise whether it was prudent for the Chair to have made any such application whilst this case is part-heard. Looking forward, he submitted that there may be a risk that the outcome of the interview might influence the Chair's decision in this case. He submitted that the timing of this was unfortunate as the Chair could receive the outcome of the interview whilst deciding on the facts of this case at Stage 1, and this would be a particularly acute factor.

58. Miss Julia Furley, on behalf of Registrant 1, submitted that she remained neutral on the application but highlighted that it would be a grave concern to Registrant 1 if the hearing did not proceed.

59. Miss Lydia Barnfather, on behalf of the GDC, submitted that she opposed the application and that the Committee could confidently reject it. She invited the Committee to conclude that a fair-minded and informed observer would not conclude that there was a real possibility of bias and that there would be no proper grounds for the Chair to recuse herself. With reference to the same cases, she submitted that the suggestion that the Chair's decision-making in this case might be affected by the outcome of her application for pupillage was speculative, fanciful and unlikely. She submitted that it is Day 15 of the hearing and the Chair has shown objectivity and a lack of bias throughout with a "commendable even-handedness". She further submitted that there was nothing unique to this case that would enhance the perception of bias. She also submitted that there was no prohibition on any Committee member making applications to join a Chambers. She submitted that any such prohibition would be inconceivable as it would be unnecessary and

disproportionate. She therefore invited the Committee to reject Mr Kennedy's application.

Committee's Decision

60. The Committee carefully considered the submissions made and accepted the advice of the Legal Adviser. In addition to the cases cited above, the Committee also had sight of the guidance contained in the case of *Porter v Magill [2002] 2 AC 357* namely, whether the fair-minded and informed observer, having considered the facts, would conclude there was a real possibility that the Chair was biased.

61. The Committee noted that the Chair is appointed as an independent contractor to a Panel of three members, who are all equal decision-makers. The Committee has the benefit of independent legal advice. The Committee was not satisfied that there was anything particular about this case which heightened any objective perception of bias and that it would be able to hear the case fairly. The Committee determined that the fair-minded and informed observer would not consider that there would be a real possibility that the Chair would be biased in this case. As Lord Hodge said in paragraph 52 of *Haliburton*:

"Then there is the attribute that the observer is 'informed'. It makes the point that, before she takes a balanced approach to any information she is given, she will take the trouble to inform herself on all matters that are relevant. She is the sort of person who takes the trouble to read the text of an article as well as the headlines. She is able to put whatever she has read or seen into its social, political or geographic context. She is fair-minded, so she will appreciate that the context forms an important part of the material which she must consider before passing judgment".

62. The Committee considered that the fair-minded and informed observer would consider the context in which this matter arises; namely in relation to an annual competition for pupillage in a profession that is guided by the principle of independence. This is an experienced Committee. All Committee members are bound by the Seven Principles of Public Life which include those of integrity and objectivity in carrying out their quasi-judicial function. The Committee therefore concluded that the *Porter and Magill* test had not been satisfied and that there are no real grounds for doubt.

63. Accordingly, the Committee rejected your application for the Chair to recuse herself.

FINDINGS OF FACT – 28 June 2023

Admissions

64. At the start of the hearing, Mr Kennedy KC, on your behalf, stated that you admit to the following heads of charge: 1, 2(a), 4(a), 4(c) (admitted in respect of weight but not BMI), 4(d), 5, 6, 12(a), 12(b) and 12(c) (admitted in respect of the name, but not role).

65. On 5 September 2022, following Miss Barnfather's application to delete head of charge 13(c), Mr Kennedy also submitted that you admit to heads of charge 13(a) and 13(b).

66. The Committee decided to defer making a finding on your admissions until all the evidence had been adduced.

Background

67. Your case is being heard on a joint basis with Registrant 1, who was one of your Associates.

68. The matters at this hearing concern the treatment you provided to Patient A on 21 June 2017. At this time, you were the owner and Practice Principal of PS Photay & Associates dental practices. On 21 June 2017, Patient A attended one of these practices, Practice 1, for the extraction of several of his teeth under private contract. It is alleged that you extracted or assisted Registrant 1 in the extraction of UL7, UR8, UR7, LL7, LL6 and/or LL1. It is alleged that you also attempted or assisted in the attempted extraction of LR8. The attempts at the extraction of LR8 were unsuccessful and Patient A had the tooth subsequently extracted in hospital under a general anaesthetic. During the appointment on 21 June 2017, it is alleged, and you have admitted, that you provided conscious sedation to Patient A. However, there is a dispute between you and Registrant 1 as to the exact roles each of you played during this appointment. Registrant 1 denied that he extracted any of Patient A's teeth, having referred the case in its entirety to you, whereas it is your case that you were only there to provide sedation services but ended up assisting him with the extractions once it became clear that he was in difficulty.

69. This was presented to the Committee by your Counsel as what is known as "a cut-throat defence" in that you attribute the alleged failings on 21 June 2017

largely to Registrant 1 and he in turn, attributes the alleged failings largely to you.

70. There are some agreed facts, which the Committee will set out below. The GDC's case is that either one of you is responsible for the alleged failings or, in the alternative, that you share responsibility for the alleged failings in the treatment of Patient A at the appointment of 21 June 2017. You both face additional individual allegations in respect of matters distinct from the treatment of Patient A on 21 June 2017.

71. Patient A returned to see Registrant 1 on 24 June 2017 in severe pain following the extractions on 21 June 2017. He presented with a limited mouth opening which prevented Registrant 1 from examining him appropriately. Registrant 1 provided him with an inadequate prescription for amoxicillin tablets, which Patient A and Witness 1 maintain was pre-written. Patient A was ultimately unable to swallow the tablets and later that day he was taken by ambulance to hospital as he was "*unable to swallow and open mouth fully*". He was intubated and placed in an induced coma and was subject to a critical transfer to another hospital for specialist care. He was not discharged until 10 July 2017 after an admission to the intensive care unit and treatment for a life-threatening neck space infection.

72. With regard to the conscious sedation provided to Patient A on 21 June 2017, it is alleged that this was inappropriate in a general dental practice setting as it was contraindicated. It is alleged that you failed to assess Patient A adequately prior to sedation, failed to record an adequate pre-sedation assessment and failed to obtain his informed consent to conscious sedation. It is also alleged that you failed to ensure Patient A was monitored adequately during conscious sedation in that there was not an appropriately trained team member present to whom you could delegate the monitoring of sedation whilst you undertook or assisted with the extractions.

73. You face further allegations regarding your treatment of Patient A relating to treatment planning of the LR8 and record keeping in respect of the care and treatment provided on 21 June 2017.

74. It is alleged that your conduct was misleading and dishonest in that you allegedly failed to document that you had acted as both sedationist and dental surgeon (operator) and you caused or permitted an inadequate and/or inaccurate record to be made of your involvement during the procedure. Furthermore, it is alleged that you failed to provide Patient A's records to the GDC when requested to do so on 2 October 2018 and that you failed to maintain adequate records of the conscious sedation provided.

75. On 23 June 2017, the Care Quality Commission (CQC) carried out a planned inspection of Practice 1. It is alleged that your conduct was misleading and dishonest in that you failed to correct an 'Information request template' in which you indicated that the services provided did not include conscious sedation and in that you failed to inform the CQC that conscious sedation had been provided at the practice on 21 June 2017.

Evidence Received

76. By way of factual evidence from the GDC, the Committee was provided with the following signed witness statements:
    - Patient A, dated 16 December 2019;
    - Witness 1 (Patient A's partner), dated 15 October 2019;
    - Witness 3 (the receptionist), dated 18 December 2019;
    - A Casework Manager in the Fitness to Practise department of the GDC, dated 5 October 2020.
77. The Committee also heard oral evidence from Patient A, Witness 1 and Witness 3. The Casework Manager's witness statement was received into evidence by agreement without the need for him to attend the hearing.

78. The Committee was also provided with dental and hospital records for Patient A along with a letter from Patient A's GP.

79. From you, the Committee received two witness statements; the first dated 1 October 2020 and the second dated 21 April 2022. It also heard oral evidence from you.

80. Registrant 1 provided two witness statements, dated 16 October 2020 and 22 April 2022. He also gave oral evidence and produced a witness statement from Dr David Hartoch, a Dento-Legal Adviser at Dental Protection, dated 8 October 2020. The Committee also received three letters sent by RadcliffesLeBrasseur, on Registrant 1's behalf, to the GDC dated 21 September 2017, 15 August 2018 and 7 February 2019.

81. The Committee received an expert report dated 27 November 2019, and an addendum report, dated 3 October 2020, from Professor Ian Brook. Professor Brook also gave oral evidence at the hearing.

82. The Committee received an expert report from Dr Christopher Holden, dated 22 September 2020, who was instructed on your behalf. Dr Holden also gave oral evidence at this hearing.

83. A joint expert report by Professor Brook and Dr Holden, dated by the experts respectively on 15 and 17 May 2022, was also made available to the Committee.

Agreed Facts

84. The relevant Agreed Facts as set out in a document provided to the Committee are as follows:

    a. *"Witness 3 made an allegation to the police of assault by Registrant 1. Registrant 1 attended a voluntary interview in July 2017. No charges were brought against Registrant 1 by the police.*

    b. *Witness 3 – the only emails provided to Capsticks Solicitors by the GDC from Witness 3 are exhibited at CG2 and CG3.*

    c. *The GDC instructed a handwriting expert to determine whether or not Patient A signed either of the two medical history forms and the treatment plan dated 19 December 2016. In a report dated 18 November 2018 the expert's summary of findings was, "Based on the available documents, the evidence as to whether or not Patient A signed any of the documents in question was essentially inconclusive".*

    The following scale was used as a basis on which to express the strength of the expert's conclusion:
    "Conclusive evidence to support one of the stated propositions
    Very strong evidence to support one of the stated propositions
    Strong evidence to support one of the stated propositions
    Weak evidence to support one of the stated propositions
    Inconclusive"

85. The GDC instructed a forensic computing expert to carry out a live examination and make a copy of the 'Carestream' CS R4 Software Database for further analysis. Examine the Carestream Database specifically for any records pertaining to the Patient A. To examine whether there is an electronic record of the treatment conducted on 21 June 2017 and whether the record has been altered in any way deleted.

86. In respect of this examination the expert concluded:

    "A clinical audit log is recorded automatically by the R4 software of all events pertaining to each patient and cannot be amended at an Administrator level. On review of the live analysis of the Carestream database and data from the

forensic image copy, I have no reason to believe that the 'Clinical Audit Log' has been edited or amended in any way."

Discussion of Evidential Issues

87. The Committee has considered all the evidence presented to it, both oral and documentary. It took account of the submissions made by Miss Barnfather, on behalf of the GDC, by Miss Furley, on Registrant 1's behalf, and by Mr Kennedy, on your behalf. The Committee heard and accepted the advice of the Legal Adviser. In accordance with that advice, it has considered each head of charge separately, bearing in mind that the burden of proof rests with the GDC and that the standard of proof is the civil standard, that is, whether the alleged matters are found proved on the balance of probabilities.

88. The circumstances of this case have necessitated the Committee setting out its conclusions on a number of evidential issues before making its findings of fact:

- Extractions/Attempted Extractions;
- Referrals;
- Monitoring of Patient A;
- Records;
- Nomenclature.

Extractions/Attempted Extractions

89. The Committee, having heard all of the evidence, considers that Registrant 1 shares responsibility for the extraction/attempted extraction of teeth on 21 June 2017 while you admit to extracting teeth.

90. Each of you made conscious efforts to obscure and/or minimise your individual roles on 21 June 2017. Both of you deviated substantially in your oral evidence on key points from your earlier written representations. Your evidence evolved in an unsatisfactory way and some of it appears to have emerged only at the prompting of you solicitors. For example, in your second witness statement of 2022 it was brought to your attention by those you instruct that the paper trail demonstrated that some of your earlier witness statement was inaccurate.

91. You were both qualified, registered dental professionals with associated professional obligations and duties in respect of your treatment and care of Patient A on 21 June 2017 and both of you were in the Treatment Room. Due to the way in which you have both given evidence and the shortcomings in

record keeping, the Committee is unable to reliably distinguish between the exact roles each of you played at any one time during this appointment, with the exception of the administration of the sedation. It is open to the Committee to consider both of you responsible for the relevant identified failings in your shared treatment of Patient A. You admit extracting four to five teeth and Registrant 1 maintains that he did not extract any teeth although your evidence is that he did in fact do so or attempt to do so before you were asked to step in. Patient A is unable to assist on this point and Witness 1 was in the waiting room. No evidence was called from the nurse who is said to have been present. The Committee finds that you extracted teeth and Registrant 1 assisted in the extraction of the teeth.

92. Due to the misleading and retrospective handwritten note drawn up by Registrant 1, which he claims was done at your behest (something you refute) and the paucity of information recorded on your conscious sedation record, which you are adamant was produced during or immediately after the procedure on 21 June 2017 despite appearances to the contrary, it is not possible to decipher which teeth were actually extracted at the appointment, how much anaesthetic was injected, to what parts of the mouth and critically, neither is it possible to identify who monitored the patient throughout.

93. Having heard Registrant 1's and your oral evidence, the Committee is of the view that both your accounts of your shared treatment of Patient A on 21 June 2017 were almost entirely inconsistent and at times, both strained the bounds of credulity in your efforts to explain why you behaved as you did with little care for the safety of a clinically vulnerable patient who had entrusted you with his dental treatment.

94. The clinical notes on 18 October 2016 detail, "*LR 7 2) extraction followed by do nothing, denture, bridges, implants. Opted 2 Offered NHS, private specialist or principal not aspecialist* [sic] *but exp for 20 years*".

95. It was apparently accepted by all parties that Registrant 1 was historically reluctant to perform extractions and would usually only undertake what he considered "simple" extractions, preferring instead to refer extractions to you or other clinicians. Patient A's planned extractions spanned a range of complexity from what Registrant 1 would describe as "simple", to one (LR8) which the experts agreed might be complicated and perceived as difficult for a General Dental Practitioner who lacked confidence in undertaking extractions. Indeed, it was Patient A's evidence that he had previously asked Registrant 1 repeatedly to extract teeth under local anaesthetic that were causing him pain, but he did not and offered instead to arrange to have them all extracted together. In the interim, Patient A had one of the teeth planned for extraction extracted at another dental practice due to the ongoing pain it

was causing him. It was Registrant 1's advice to arrange for the extractions to be done altogether under sedation that ultimately led to the appointment on 21 June 2017. This was documented in the clinical notes on 20 October 2016 and in the Treatment Plan, purportedly signed by Patient A on 19 December 2016, as opting variously for options 2 and 3, which are described as "*under principal care (IV sedation), told he charges £90 per IV sedation +Private £100 per tooth for extraction* ".

96. The clinical notes of the appointment of 10 May 2017 state, "*tolf* [sic] *will give a call for extraction under IV after talking to [you]*" and on 2 November 2016 states, "*finalising treatment plan" "opted 3 under IV sedation*".

97. Registrant 1's chaotic and inconsistent records, your sparsely populated conscious sedation record and both of your conflicting accounts were set before the Committee, whose task was to reconcile this material. The Committee considers both of your accounts to lack reliability and credibility with respect to the matter of extractions, but with the benefit of documents produced at or near the material time, has assessed each head of charge individually to determine findings to the civil standard, which are set below in the findings of fact.

Referrals

98. Your account is that it was your standard practice at the time to accept informal, verbal referrals from colleagues within the practice. It is your case that Registrant 1 informally referred the patient to you for sedation services only. Your evidence is that you were reluctant as you did not generally perform sedations at Practice 1, despite there being a sign in the window that sedation services were offered. Your evidence was that Registrant 1 managed to persuade you to perform sedation services as the patient had been waiting a long time. In his witness statement, you stated:

"*…[Registrant 1] was persistent, and wanted the extractions and sedation done there He told me that [Practice 1] suited Patient A better. He told me it was a favour to Patient A, as it were. In addition, [Registrant 1] told me that Patient A was overweight, so [Registrant 1] felt [Practice 1] would be more suitable for Patient A given its location ([Practice 1] is on a level street, and Patient A lived nearby. Upper Belvedere is on a steep hill). I was not informed that he had limited mobility. [Registrant 1] told me that it was easier and more convenient for Patient A to attend [Practice 1]".*

99. Registrant 1's case is that he made an informal referral to you for both sedation and extractions.

100. Registrant 1's evidence in his written representations of 15 August 2018 is that he made an appointment to see you, provided you with the Treatment Plan and discussed the case with you several days in advance of 21 June 2017. Registrant 1's evidence is that the radiographs were available to you and he stated in his witness statement of 16 October 2020 that, "*[he was] aware that [you] had reviewed the patient's treatment plan and the radiographs before [you] verbally confirmed to [him] that [you] could accept the referral and carry out the extractions*".

101. The Committee noted the agreed position that Registrant 1 was averse to extracting teeth and therefore considered it more likely than not, given the discussions recorded in the clinical notes with Patient A about pricing for the principal to sedate and extract, that he had in fact never intended to perform the extractions himself.

102. The Treatment Plan, purportedly signed on 19 December 2016 by Patient A, details "*three under principal care (IV sedation), told he charges £90 per IV sedation + private £100 per tooth for extraction*" in respect of UR7 and UR8, "*mobile teeth LL1 LR7 (stump) not sure if it is LR8 opted to under principal care (IV sedation)*", in respect of LL7 and LL6, "*opted 3 under principal care (IV sedation)*". The clinical notes, poor as they are, bear this out as set out above. The inclusion in the notes of pricing per sedation and per tooth for extraction supports Registrant 1's case that he had intended you to carry out both sedation and extractions.

103. While Registrant 1 may never have intended to perform the extractions himself, it is clear to the Committee that any informal, verbal referral he may have made, was, in light of expert evidence to the Committee ineffective to hit the "reset button", as Professor Brook described it, with regard to your responsibility for the shared treatment of Patient A on 21 June 2017. You were both registered, experienced dental practitioners and both participated in the treatment that day.

104. For your part, your evidence is that you attended Practice 1 on the appointed day with a bag of equipment and sedated the patient without sight of the relevant consent forms, treatment plan, radiographs or medical history. You stated in oral evidence that Registrant 1 began extracting teeth, despite his well-known aversion to doing so, but you could not see which ones as you were "*busy*". Your evidence evolved but it ranged from Registrant 1 stepping back with his hands held aloft in a wordless gesture of surrender, which you interpreted as a sign he needed assistance, to him saying, "*please help me*". It was your evidence that you then stepped in to extract "4 or 5" of the 6 teeth estimated to have been extracted. You stated, "*once you get committed to assisting and then if you are - and they say one needs to come*

out "can you do that for me?" I had to go along with that." Your evidence was that you only knew which teeth to extract as Registrant 1 pointed to them, "*I don't know how many teeth were supposed to come out. He pointed at teeth and I took them out*".

105. Your evidence is that you did not touch the LR8 despite the fact that at the time, you would have been under the impression it was a LR7 due to Registrant 1's failings in identifying and recording teeth correctly. In oral evidence, despite saying that Registrant 1 had pointed to each tooth for extraction and that you had not seen the Treatment Plan or radiographs, you asserted, "*I saw the radiograph on the screen - it was impacted, very, very difficult and a big surgical job*". This contrasts sharply with your earlier evidence in which you stated that you had not seen any records at all.

106. Registrant 1's evidence with respect to LR8, is that you did attempt to extract it. In his oral evidence, he told the Committee that you, "*tried to extract tooth by gripping tooth and doing some movements but it was not possible*".

107. It is Registrant 1's evidence that you extracted five teeth but ultimately were unable to extract the LR8, which he had identified to you as the LR7 or LR7 "stump" and was referred to as LR7 in the treatment plan. The Committee considers it more likely than not that it only became apparent to you both that this was in fact, the LR8, after the attempted extraction proved unsuccessful. It comes to this conclusion on the balance of the evidence, including what Registrant 1 said to Patient A after he escorted him to the waiting area. Evidence on the outcome of the attempted extraction of LR7/LR8 was given as follows:

- The retrospective handwritten note records, "*very difficult extractions, LR7 could not be extracted as difficult*";
- Patient A's original complaint to the GDC of 29 July 2017 records Witness1 being told on 21 June 2017 there had been, "*nothing but problems with the wisdom tooth on the bottom right";*
- Witness 1's witness statement of October 2019 records, "*they had trouble extracting the lower right wisdom tooth…we'll deal with it at a later date*".
- Patient A's witness statement dated 16 December 2019 records, "*there was one failed extraction which was very problematic which was LR third molar*";

108. Patient A's evidence is that after the treatment he was taken to the waiting room where Witness 1's evidence was that Registrant 1 went in and out of the surgery confirming with you what he should say in answer to

questions. “POIG” is recorded in Registrant 1’s handwritten retrospective note, although Witness 1 asserts that he did not give advice about presenting symptoms that would indicate a deterioration requiring prompt medical attention.

109. Registrant 1’s oral evidence is that it was only after being asked to create the retrospective note that he realised you were trying to "*put the blame*" on him for the failings on 21 June 2017 and he felt "*mentally raped*" by the pressure that you put him under.

110. Registrant 1’s supplementary witness statement of October 2020 stated that you put a lot of pressure on him to support your account and to say he had undertaken the extractions alone. You deny this and highlight that there is no reference to the dictation Registrant 1 says he was subjected to in his original witness statement.

111. You maintain the retrospective handwritten note was Registrant 1’s own work, it was not done under your direction, your role was confined to sedation and assisting with extractions and that you had no need to apply any pressure to him in this regard. Your evidence was that Patient A was Registrant 1’s patient and therefore his responsibility.

112. The Committee’s findings of fact with respect to the extractions are set out below.

Monitoring of Patient A

113. Your evidence is that monitoring equipment was used. Registrant 1’s evidence is that there was no monitoring equipment such as a pulse oximeter or BP cuff in place, which is also the evidence of Patient A and Witness 1.

114. You say that you assumed Registrant 1 was monitoring the patient while you were the operator but there is no record of this and Registrant 1 denies it. In any event, no record of any monitoring was made by Registrant 1. In oral evidence, you accepted that because of the complexities of Patient A you would want someone “*very significantly trained in sedation*”. The Committee has had sight of Registrant 1’s CV and that offers no evidence that he had anything approaching this level of training or experience. You described the expected standard of monitoring in oral evidence as, “*he had to just stand there and tell me if there was a problem, if the patient goes blue or there is a bleep or there is an obstruction*”.

Records

i. Conscious Sedation Record

115. Your evidence was that you completed the conscious sedation record during or after the treatment on 21 June 2017 but it was not kept with the patient's clinical notes, nor was it sent by Registrant 1 in the first bundle of records he sent to his solicitors on 9 August 2017. It was produced for the first time at some point between 9 August 2017 and 8 September 2017 when Registrant 1 sent it in a second bundle of documents to his indemnity organisation. Several of the recordings were incompatible with life and the consistent oxygen saturation recordings seemed unlikely. The conscious sedation record was silent on your role as operator. The Committee has doubts about when this record was produced.

ii. Computer Entries

116. There are two entries on the computer system that indicate you phoned Patient A in the weeks subsequent to 21 June 2017, which are attributed to your log-in at Practice 1 on 17 July 2017 and 26 July 2017. There is no record of Registrant 1 contacting the patient after 21 June 2017.

117. The computer entry in Patient A's records for the 21 June 2017 has been deleted. Registrant 1 told the Committee he encountered repeated difficulties with the computerised record system at the practice in response to which he handwrote entries in the patient’s records. The Committee noted that these difficulties arose most frequently on dates which are material to this case.

iii. Retrospective and Handwritten Records

118. Your evidence is that in your role as Registrant 1’s VT-equivalent trainer, you had “just signed [him] off” in respect of his record keeping, which was demonstrated during the course of this hearing to be far from reliable.

119. Registrant 1’s evidence is that following the events of 21 June 2017 (and on receipt of Patient A's letter of claim) you dictated text to him to handwrite and enter into Patient A's clinical notes in such a way that edited out your role in the treatment. Registrant 1’s written representations of September 2017 and August 2018 make no mention of dictation but reflect that you instructed him to make a retrospective entry so as to appear contemporaneous with the treatment. You deny dictating or instructing him to make any note.

120. Registrant 1 added the retrospective note to Patient A's clinical records and noted that it was handwritten due to "software issues". As outlined above, this was something that he also did for other handwritten entries in the clinical records of Patient A, which he attributed to repeated and unfortunate technical issues. The Committee considered this coincidence remarkable and further noted that the majority of the original patient records in this case have never been provided; either by you or Registrant 1. You did ultimately provide a very limited set of original documents in March 2019, which you claimed had been recovered by a staff member conducting an in depth search following the GDC's request almost two years earlier in September 2017.

Nomenclature

121. Any reference in this determination to sedationist and dental surgeon is equivalent to sedationist and operator.

122. Any reference to LR8 includes LR7, a "stump", "third right molar" and "missing tooth", due to inconsistencies in your record-keeping.

The Committee's Findings of Fact

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

1.	Between October 2016 and June 2017 you were the owner and Practice Principal of PS Photay & Associates dental practices as set out in Schedule 1. **Admitted and Found Proved**
2.	On 21 June 2017 at Practice 1 in respect of Patient A:
2 (a)	you provided conscious sedation; **Admitted and Found Proved**
2 (b)	you extracted or assisted in the extraction of:
2 (b)(i)	UL7, UR8, UR7, LL7, LL6, and/or LL1; **Found Proved**

	The Committee finds that the responsibility for the extractions was shared; commissioned by Registrant 1 and carried out by you with Registrant 1's assistance throughout the procedure. Patient A was a patient who had agreed to a great deal of private work and as such it is likely that Registrant 1 would have been keen to maintain this relationship. Witness 3 highlighted that he "*wanted to make a fuss of patient as he was having a lot of work done*". The Committee determines therefore that contrary to Registrant 1's oral evidence it was unlikely to have been mere "*bad fortune*" that he was there that day, and more likely than not that it was planned, as evidenced by the booking being made under his name, in his diary, in his surgery and with his nurse. The Committee determines that you worked together to arrange, carry out and complete this treatment. It was agreed that sedation services had been referred to you. Registrant 1 claimed that the extractions had also been referred to you, something that you denied. Nonetheless, your evidence is that you did extract the majority of the teeth that day, although you say this was only because Registrant 1 began the extractions but could not complete them. The Committee finds this unlikely and instead considers it more likely than not that there was always a common understanding that you would carry out the extractions. The Committee finds this more likely than not due to: a) the documentary evidence in the patient's clinical notes/treatment plan that record discussions about the principal carrying out both the sedation and the extraction of Patient A's teeth including prices for principal led extractions. b) although the Committee has misgivings about the integrity of the Treatment Plan document of 19 December 2016 provided by Registrant 1, appearing as it does, to have been constructed by overlaying and copying selected information from several distinct documents, it does corroborate the clinical notes in recording that Patient A opted for principal care.

	c) the common evidence of Witness 3 and you that Registrant 1 was known to be averse to extracting teeth. d) the common evidence of Witness 3 and Registrant 1 that you often carried out sedation and extraction, which you clarified in your oral evidence as being something you offered with your brother at other practices. e) Your acceptance that you did in fact carry out 4-5 extractions on 21 June 2017. The Committee finds it is more likely than not that you extracted all of the teeth which were removed on that day. The Committee considers it inherently unlikely that Registrant 1, with his aversion to extracting teeth, would have extracted a single tooth in the lower anterior part of the mouth before handing over to you to remove further teeth. f) Registrant 1's CV refers to undertaking simple and complex extractions independently. In oral evidence, it emerged under Committee questioning that this was an admitted lie and he had not in fact performed extractions or, indeed, IV sedation independently at all. g) The notes from a call between Registrant 1 and his indemnifier on 2 August 2017 indicate that at that time, he was plainly under the impression that Patient A's complaints about his treatment on 21 June 2017 were directed at you as principal for the extractions under sedation that you performed. Registrant 1's view on his vulnerability, at that stage, was that it was confined to "*perio and rct etc*" as listed in Patient A's letter before claim. The Committee considered this to be significant. The Committee determined therefore that "*assisted in the extraction of*" would include a dental nurse's function but also considered that it included Registrant 1's function on 21 June 2017 at Practice 1. This included, greeting and escorting the patient to the surgery, negotiating an alternative extraction in the place of a tooth which had already been extracted in the interim, potentially administering local anaesthetic, indicating which extractions were to be performed, escorting the patient to the waiting area and providing post-operative instructions. While there is no evidence in the records that you had acted as the operator, the balance of the evidence suggests that this absence of evidence was intentional. It is more likely than

	not that the purpose of Registrant 1's retrospective note, whether under your instruction or dictation, and your sparsely completed conscious sedation record, which materialised for the first time on a date between August and September 2017, was to deflect attention away from your role. The Committee was mindful that none of the original documents dealing with the treatment Patient A received on 21 June 2017 have ever been produced and the computer entry for the same date has been deleted, which neither you nor Registrant 1 could explain. Taking all of this into consideration, the Committee determined that it was more likely than not that you and Registrant 1 shared responsibility for the treatment of Patient A on 21 June 2017. You have accepted extracting teeth and the Committee has concluded, on the balance of the evidence, that Registrant 1 assisted in the extraction of UL7, UR8, UR7, LL7, LL6 and/or LL1. Accordingly, the Committee found this charge proved.
2 (b)(ii)	the attempted extraction of LR8. **Found Proved** The Committee accepted that it was the agreed position between parties that Registrant 1 had mistakenly recorded the presence of the LR8 alternately as: *15.10.16 (previous treating dentist note)* — *LR7 extracted Plumstead – apices intact post extraction* *20.10.16* — *LR7 stump infected* *LR7 1) do nothing* *LR7 2) extraction* *2.11.16* — *LR7 defective - broken* *LR7 retained root* *LR8 missing*

		LR7 or LR8 not sure stump – paper notes
		Broken -apical periodontitis LR7
		6 teeth needs extracting, so for now I am charging for LR7 and rest I will ask principal
	5.11.16	*LR8 pericoronitis inflamed*
		LR8 1) do nothing
		LR8 2) CHX etc
	19.12 16	*LR7 (stump) not sure if it is LR8 – paper notes*
	21.6.17	*XLA – LL6, LL7, LL1 ,UR7, UR8, LR7- paper notes*

Additionally, the Committee noted the retrospective handwritten entry in Patient A's records for 21 June 2017 which stated, "*LR7 could not be extracted as difficult, patient and his wife informed and told referral to specialist needed NHS/Private*". Registrant 1 told Patient A post-operatively, "*nothing but problems with wisdom tooth on bottom right*". The Committee was of the view that this implied that an attempt to extract the LR8 had been made. The Committee also noted that although this entry was revealed to be written retrospectively, it is nonetheless the most contemporaneous account of the appointment.

The Committee determined, therefore, that it was more likely than not that you had attempted to extract Patient A's LR8. The Committee's rationale is that on 21 June 2017 you would not have known that it was in fact a partially erupted, impacted wisdom tooth requiring a surgical approach as you claimed you had not seen the treatment plan or radiographs and Registrant 1 was operating under the assumption that it was a LR7 "*stump*". It was your evidence that Registrant 1 pointed at the teeth to be extracted. The LR7 was planned for extraction. Your evidence was that you wanted to do Registrant 1 a favour and provide a good service to Patient A, who had opted for conscious sedation in order that all the planned extractions could take place at one appointment having waited several months.

	In all the circumstances therefore, the Committee determined that it was more likely than not that you had attempted the extraction of LR7/LR8 and Registrant 1 had assisted in that attempted extraction. Accordingly, the Committee found this head of charge proved.
Treatment Planning	
3.	You failed to plan adequately or ensure that adequate planning for the extraction of LR8 had been undertaken prior to surgery in that: 1. you did not ensure that there had been adequate radiographic investigation of LR8; 2. you did not ensure that the most suitable surgical approach had been determined; 3. you did not assess appropriately whether the extraction was within your competence and abilities. **Found Proved (in its entirety)** The Committee has previously found proved that you had attempted the extraction of LR8 (see charge 2(b)(ii) above). The Committee determined that before attempting the extraction, you had a duty to ensure that there had been adequate radiographic investigation and planning in order to assess whether the extraction was in your competence and abilities. The Committee found no evidence that you had ensured that any such planning had taken place. It was your oral evidence that you had not seen the radiographs until the extractions were underway and claimed to have seen them on the screen. Your witness statement of 1 October 2020 asserts that you were not responsible as all the radiographs are initialled "*RG*", which you interpret as Registrant 1 reviewing them. In any event, the radiograph available was inadequate as the root morphology could not be assessed.

	There is no evidence that you ensured that the most suitable surgical approach had been determined, nor whether the extraction was within your competence and abilities. In your witness statement of October 2020, you deny responsibility. In your oral evidence when asked about your approach to the surgery and your assessment of whether the extraction was within your competence, you replied, "*Well, they are there in the mouth*". The Committee concluded it was more likely than not that that was the extent of your planning. Therefore, the Committee determined that without appropriate radiographic investigation you were not in a position to ensure that the most suitable surgical approach had been undertaken or whether the extraction was within your competence and capabilities. Accordingly, the Committee found charges 3(a), 3(b) and 3(c) proved in its entirety.
Treatment 21 June 2017	
4.	You failed to assess adequately Patient A prior to sedation in that:
4 (a)	you did not assess adequately his medical history which included a cardiac condition, recent chest infection and obstructive sleep apnoea; **Admitted and Found Proved**
4 (b)	you did not obtain adequately his drug history; **Found Proved** The Committee noted that in your oral evidence, you admitted that you did not obtain adequately Patient A's drug history. Accordingly, the Committee found this charge proved.
4 (c)	you did not obtain adequate information in respect of his weight and/or BMI;

	Admitted (in respect of weight) **Found Proved (in respect of weight and BMI)** You admitted that you did not obtain adequate information in respect of Patient A's weight and that you would have "*guessed*" his weight. You recorded his weight as "*obese*". However, you stated that you were not under an obligation to obtain information about the patient's BMI. In your oral evidence, you initially said that BMI was obsolete, but then went on to say that a high BMI was irrelevant in any event. You further stated that: *"I was not subjecting the patient to a higher risk. I felt that the experience I had and all the thigs* [sic] *I took into account that I was going to deliver a great service to the patient."* The Committee noted that Patient A's BMI was recorded at the hospital as being between 60 – 70, and his weight as 177kg. The Committee noted the evidence of both the experts. Professor Brook referred to the guidance in SAAD (The Society for the Advancement of Anaesthesia in Dentistry) and stated that BMI information was required prior to sedation. He stated that your failure to determine Patient A's weight and BMI fell far below the standard. Dr Holden disagreed and was not critical of your failure to determine weight and BMI as conscious sedation given intravenously is titrated to effect. Both experts, however, agreed that Patient A should not have been provided with conscious sedation in a general dental practice because of his co-morbidities. You noted that Patient A was obese, which you acknowledged with hindsight was not sufficient. Either way, you admitted that Patient A was overweight and should not have been sedated in a general dental practice. You now accept that you should have referred Patient A to a hospital setting. The Committee preferred Professor Brook's evidence that Patient A's BMI information was required to inform the ASA

	grade, which was subsequently recorded by the hospital as ASA grade 3 to 4 plus. You have admitted that you incorrectly classified Patient A's ASA grade. In this particular case, Patient A was at significant risk of an untoward medical event. Both experts commented that it was fortunate that this did not occur. Therefore, adequate information about his weight and BMI should have been taken and recorded alongside a detailed medical history to ensure the safety of the patient. Accordingly, it found this charge proved.
4 (d)	you incorrectly classified his ASA grade as ASA 1-2 when it was at least ASA 3. **Admitted and Found Proved**
5.	You failed to record an adequate pre-sedation assessment. **Admitted and Found Proved**
6.	You inappropriately provided Patient A with conscious sedation in a general dental practice setting when it was contraindicated. **Admitted and Found Proved**
7.	You failed to obtain informed consent to conscious sedation in that you failed to ensure Patient A:
7 (a) 7(b)	had been informed and understood his pain and anxiety management options; had been informed and understood the risks and benefits of conscious sedation. **Found Proved in its entirety** It was your evidence that you had delegated all obligations with respect to obtaining informed consent, including informing the patient of his pain and anxiety management options to Registrant 1. It was clear from your evidence that

	you failed to ensure that Patient A had been informed of or understood these options. With respect to head of charge 7(b), you initially admitted you had not spoken to Patient A at the appointment, but then contradicted that when you stated that you had verbally checked his medical history with him. In any event, you accepted that you had a duty to check that Patient A had given informed consent. Your evidence was that you asked Registrant 1 if Patient A had consented to the procedure and he had said 'yes', while flashing a white wallet at you. You said that your mistake had been that you placed too much reliance on Registrant 1 and had been "*too trusting*". In oral evidence, when you were asked what you did wrong on 21 June 2017 you said you were not subjecting the patient to a higher risk and felt that the experience you had was going to deliver a great service to the patient. You admitted with the benefit of hindsight that if you had referred the patient, you would have "*saved the hassle of this hearing*". The Committee noted that you had not assessed Patient A's presentation and co-morbidities accurately so you could not possibly have assessed the risks of conscious sedation that Patient A could have been exposed to nor discussed those risks with him. Registrant 1 stated in his witness statement that written consent for conscious sedation had not been obtained from Patient A. Both Patient A and Witness 1 stated that Patient A had not provided informed consent for conscious sedation. The Committee noted Professor Brook's expert evidence that you had failed to discharge your duty to check or assure yourself that appropriate informed consent had been obtained from Patient A. Dr Holden agreed with Professor Brook's evidence. The Committee therefore determined that it was more likely than not that you failed to obtain informed consent to conscious sedation from Patient A Accordingly, the Committee found this head of charge proved in its entirety.
8.	You failed to ensure Patient A was monitored adequately during conscious sedation in that whilst assisting with surgical

	treatment you did not have an appropriately trained team member present to whom you could delegate monitoring of sedation. **Found Proved** Patient A and Witness 1's evidence was consistent in that they both stated that neither a blood pressure cuff nor a pulse oximeter was in place during the procedure. You denied this stating that monitoring devices were used and cited the entries recorded in your conscious sedation record as evidence of this. The Committee noted that the blood pressure recordings were incompatible with life (90/30, 80/110, 90/30) and therefore did not accept this evidence. In the circumstances, the Committee determined that having an appropriately trained team member present to whom you could delegate monitoring of sedation was even more important than otherwise. The circumstances include Patient A being a clinically vulnerable patient. These vulnerabilities were referred to in subsequent hospital entries as an ASA grade of 3 - 4 plus, obesity with pre-existing health conditions and evidence suggestive of a cardiac condition. Your evidence was that while you extracted teeth you "expected" Registrant 1 to monitor the patient. Registrant 1 denies being asked to monitor the patient and stated in his evidence that he was, "*holding a light in place to illuminate the patient's mouth*". The Committee found deeply troubling your oral evidence in which you described your expected standard of monitoring in oral evidence as, "*he had to just stand there and tell me if there was a problem, if the patient goes blue or there is a bleep or there is an obstruction*". Also deeply troubling was your evidence about the purpose of taking baseline measurements of blood pressure readings. You could not assure the Committee that baseline readings had been taken prior to the initial introduction of the sedative agent. The Committee also noted that there were three

	incorrect blood pressure readings in the conscious sedation record, which was otherwise unamended apart from three identical oxygen saturation readings and an assessment that the patient was obese. The Committee concluded that even for a healthy low-risk patient, this would have been a wholly inadequate and dangerous approach to the monitoring of sedation in a primary care general dental practice setting and this was agreed by both experts. Accordingly, the Committee found this head of charge proved.
Record Keeping	
9.	In respect of a record of the care and treatment provided on 21 June 2017:
9 (a)	you failed to document that you had acted as both sedationist and dental surgeon; **Found Proved** In the Conscious Sedation Record you failed to document you had acted as both sedationist and dental surgeon (operator). The Committee also noted that this was not documented in the retrospective clinical note of the appointment written by Registrant 1, which he claimed you dictated to him; something you deny. Nonetheless, you accept that by extracting some teeth you acted as both sedationist and dental surgeon (operator) and that you failed to record this in the conscious sedation record. Accordingly, the Committee found this head of charge proved.
9 (b)	you permitted or caused there to be an inadequate and/or inaccurate record made of your involvement as both sedationist and dental surgeon. **Found Proved**

	The Committee concluded that the Conscious Sedation Record which materialised for the first time at some point between August and September 2017 and the retrospective clinical note of this appointment produced by Registrant 1 were both inadequate and inaccurate as neither recorded the fact that you acted as both sedationist and dental surgeon (operator). The Committee also concluded that, although the retrospective clinical note was not written by you, you were aware of it and had known it was being sent to the GDC. You had not sought to clarify the nature of that note to the GDC in advance of this hearing. Accordingly, the Committee found this head of charge proved.
10.	You conduct as set out above at 9(a) and/or 9(b):
10 (a)	was misleading; **Found Proved** The Committee concluded that both the Conscious Sedation Record and the retrospective note would have misled the reader into thinking that you had not acted as both dental surgeon and sedationist during the procedure on 21 June 2017. The Committee also determined that the retrospective note would have misled the reader into thinking that it was an accurate and contemporaneous record of the appointment when this was not the case. Accordingly, it found this head of charge proved.
10 (b)	was dishonest in that you intended to mislead as to your role as both sedationist and dental surgeon. **Found Proved** When considering this head of charge, the Committee referred to the test set out in the case of *Ivey v Genting Casinos (UK) Ltd. t/a Crockfords* [2017] *UKSC 67*. It first

	considered the actual state of your knowledge or belief as to the facts at the time. The Committee then considered whether your conduct would be viewed as dishonest by the objective standards of ordinary and decent people. The Committee determined that you would have been aware of your duty at the time to accurately reflect in the clinical notes the roles you performed during the procedure. The Committee has determined you were aware that an inaccurate record was handwritten and backdated by Registrant 1, which also misled as to your role. The Committee concluded that you intended to deflect attention away from any enquiry into the adequacy and accuracy of the monitoring of Patient A. The Committee determined that ordinary and decent people would view your actions as dishonest. Accordingly, the Committee found this head of charge proved.
11.	You failed to provide Patient A's records when requested to do so by the GDC on 2 October 2018. **Found Proved** You denied this head of charge and stated that as Patient A was Registrant 1's patient, it was Registrant 1's responsibility to provide the records to the GDC. The GDC originally requested a copy of Patient A's records from you on 1 September 2017. You informed the GDC, in a letter received by them on 7 September 2017, that: *"Please note all records are held by [Registrant 1] for this case, including my RECORDS OF treatment for this patient. He will send to you direct as you have already requested same from him."* The GDC subsequently contacted you again by email on 2 October 2018 and requested the original records. You replied by email on the same date stating, "*what record do you want. All original patient records (Patient A) was held by [Registrant 1]. Pl [sic] contact him*".

	The email of 2 October 2018 to you from the GDC asked you to provide original records for this case "*at the latest by 9 October 2018*". The Committee noted that almost six months later in March 2019 you instructed a staff member to conduct an in-depth search for the records and finally provided a limited set of original records to the GDC, stating they had been mis-filed. You are under a duty to respond fully within the time specified in any letter from the GDC in connection with concerns about your fitness to practise. The Committee determined, therefore, that you had failed to provide the GDC with Patient A's records when requested to do so by the GDC on 2 October 2018. It further noted that the majority of the original records have never been recovered. Accordingly, it found this head of charge proved.
12.	You failed to maintain adequate records of the conscious sedation provided in that:
12 (a)	you did not record time sedation was administered; **Admitted and Found Proved**
12 (b)	you did not record the site of IV access; **Admitted and Found Proved**
12 (c)	you did not record the name and role of the Dental Nurse; **Admitted and Found Proved (did not record name)** **Found Not Proved (did not record role)** The Committee accepted your admission and found proved that you did not record the name of the Dental Nurse. The Committee had sight of the Conscious Sedation Record and noted that the section to record the Dental Nurse was left blank.

	In your oral evidence, you stated that the dental nurse's role at the appointment was not to monitor sedation but to perform dental nursing duties. The Committee accepted your evidence on this point and determined that you were not under a duty to record the role of the Dental Nurse. Accordingly, the Committee found this head of charge in respect of your failure to record the role of the Dental Nurse not proved.
12 (d)	you did not record adequately oxygen saturation and/or blood pressure throughout the procedure. **Found Proved** The Committee noted that a working estimate of 45 minutes for this procedure was given by you and Registrant 1. The basis for this estimate was unclear as neither you nor Registrant 1 accurately recorded the length of the procedure and the computer record has been deleted. The appointment was, however, booked for 45 minutes so the Committee proceeded on the basis that the procedure lasted 40 – 45 minutes. The sole evidence that any oxygen saturation or blood pressure monitoring devices were used is yours. The only records of blood pressure and oxygen saturation are at minute zero and minute three. A post-operative recording is also present and all of the blood pressure recordings are incompatible with life. The evidence of the experts differed on this point. Professor Brook found your monitoring "*far below standard"* and *"of concern"*. Dr Holden's evidence was that your practice met the contemporaneous guidance for sedation and that guidance does not constitute mandatory requirements. The relevant guidance reads, "*as a minimum…monitoring pre-operatively, at appropriate intervals during the procedure and post-operatively*".

	The Committee was unable to reconcile Dr Holden's evidence with the overriding objective of patient safety, particularly for an individual with multiple co-morbidities. The Committee preferred Professor Brook's evidence on this point. In any event, the Committee was unable to find that three inaccurate recordings of Patient A's blood pressure constituted an adequate record for a procedure of 40 – 45 minutes on a patient such as Patient A. The same could be said for the oxygen saturation measurements that you recorded. The Committee found it more likely than not that you did not adequately record oxygen saturation and/or blood pressure throughout the procedure. Accordingly, it found this head of charge proved.
CQC – Conscious sedation	
13.	In respect of the provision of conscious sedation at Practice 1:
13 (a)	you failed to correct an 'Information request template' on or about 8 June 2017 which indicated the services provided at Practice 1 did not include sedation; **Admitted and Found Proved**
13 (b)	you failed to inform CQC that conscious sedation had been provided at Practice 1 on 21 June 2017; **Admitted and Found Proved**
13 (c)	Deleted.
14.	Your conduct as set out above at 13(a) and/or 13(b):
14 (a)	was misleading; **Found Proved** The Committee determined that your actions, as found proved at heads of charge 13(a) and (b), would have misled the CQC into thinking that conscious sedation was not provided at Practice 1 when this was not the case.

	Accordingly, the Committee found this head of charge proved.
14 (b)	was dishonest in that you intended to mislead as to the provision of sedation at Practice 1. **Found Proved** When determining whether your conduct amounts to dishonesty, the Committee applied the test set out in the case of *Ivey v Genting Casinos (UK) Ltd. t/a Crockfords* [2017] *UKSC 67*. The Committee had sight of the 'Information request template' and noted that 'NO SEDATION' was stated in the box titled, 'Services provided'. Your evidence is that you wrote 'no sedation' as at the time you completed the form, sedation was not being carried out at Practice 1 and you were also no longer intending to carry out any more sedation services there. You also stated that the CQC would have been aware that sedation was not being carried out at the practice. However, the Committee could see no evidence that would support that claim. You explained that you had delayed returning the 'Information request template' to the CQC as you were not sure of the full names of your own employees. In the meantime, you stated that you had performed sedation on Patient A on 21 June 2017. However, the Committee noted that this was inconsistent with the evidence that the form was received by the CQC in advance of the inspection. The Committee considered your evidence on this point to be inconsistent and unreliable. It determined that it was more likely than not that you were aware at the time of completing the template you would be providing sedation services for Patient A's appointment on 21 June 2017. You failed to inform the CQC of this. The Committee does not accept that you were unable to remember the names of your two employees, one of which is Registrant 1 whose case is being heard jointly with yours. You failed at any point to correct the information you had provided to the CQC on the Information request template and did not attend on the day of inspection. The Committee determined that your conduct would be

	viewed as dishonest by the objective standards of ordinary and decent people. Accordingly, the Committee found this head of charge proved.

123. The Committee resumed consideration of your case between 29 September 2023 and 6 October 2023, and from 6 to 7 November 2023. You attended the hearing and were represented by Mr Andrew Kennedy KC. Miss Lydia Barnfather of Counsel presented the General Dental Council's (GDC) case. Your case was heard on a joint basis with Registrant 1. All parties attended remotely on Microsoft Teams.

Summary of the Committee's Findings

124. The matters at this hearing concern the treatment you and Registrant 1 provided to Patient A on 21 June 2017. On this date, Patient A, a clinically vulnerable patient attended Practice 1, for the extraction of several of his teeth under private contract. It was found proved, following your admission, that you provided conscious sedation to Patient A for the treatment. The Committee found proved that this was inappropriate in a general dental practice setting as it was contraindicated. You failed to assess Patient A adequately prior to sedation, failed to record an adequate pre-sedation assessment and failed to obtain his informed consent to conscious sedation. You also failed to ensure Patient A was monitored adequately during conscious sedation in that there was not an appropriately trained team member present to whom you could delegate the monitoring of sedation whilst you undertook the extractions.

125. The Committee has found proved that on 21 June 2017 you extracted the UL7, UR8, UR7, LL7, LL6 and/or LL1. It found that the responsibility for the extractions was shared; commissioned by Registrant 1 and carried out by you with Registrant 1's assistance throughout the procedure. It was also found proved that you attempted the extraction of LR8 (incorrectly recorded in the records as LR7) with the assistance of Registrant 1. The attempts at the extraction of LR8 were unsuccessful and Patient A had the tooth subsequently extracted in hospital under a general anaesthetic.

126. The Committee also found proved allegations in respect of your treatment planning for the extraction of LR8. The Committee determined that as you had undertaken the extraction, you had a duty to ensure that there had been adequate radiographic investigation and planning in order to assess whether the most suitable surgical approach had been determined and whether the extraction was within your competence and abilities. The

Committee found no evidence that you had ensured that any such planning had taken place.

127. In respect of your record keeping of the care and treatment provided on 21 June 2017, the Committee found that you failed to document that you had acted as both sedationist and dental surgeon (operator) and you caused or permitted an inadequate and inaccurate record to be made of your involvement during the procedure. Your dual role had deliberately not been recorded either in the retrospective clinical note of this appointment produced by Registrant 1 or in the Conscious Sedation Record. The Committee found your conduct to be misleading and dishonest in that you intended to deflect attention away from any enquiry into the adequacy and accuracy of the monitoring of Patient A.

128. As part of its investigation, the GDC requested a copy of Patient A's records on 1 September 2017. However, you failed to provide them with a copy. The GDC then contacted you on 2 October 2018 and requested the original records by 9 October 2018. You ultimately provided a limited set of the original records to the GDC in March 2019 stating that they had been mis-filed. The majority of the original records have never been recovered. The Committee further found proved that you failed to maintain adequate records of the conscious sedation provided.

129. On 23 June 2017, the Care Quality Commission (CQC) carried out a planned inspection of Practice 1. You failed to correct an 'Information request template' in which you had indicated that the services provided did not include conscious sedation. You failed to inform the CQC that conscious sedation had been provided at the practice on 21 June 2017. The Committee found that your conduct was misleading and dishonest.

Documents and Oral Evidence

130. The Committee had regard to your Stage 2 remediation bundle, which included workplace supervision reports, dated from 12 August 2021 to 1 July 2023, testimonials and four Continuing Professional Development (CPD) certificates all dated 22 September 2020. The Committee also had regard to your letter, which you read out as part of your oral evidence at this stage. The Committee was further provided with a bundle from the GDC containing information about your previous fitness to practice history.

Submissions

131. In accordance with Rule 20 of the General Dental Council (Fitness to Practise) Rules 2006 (the Rules), the Committee then heard submissions

from Miss Barnfather, on behalf of the GDC, and submissions from Mr Kennedy, on your behalf, in relation to the matters of misconduct, impairment and sanction.

132. In accordance with Rule 20(1)(a), Miss Barnfather first informed the Committee about your previous fitness to practise history with the GDC. She submitted that at a PCC hearing in October 2007 you had received an admonishment in respect of inappropriate claiming, which she submitted was not wholly dissimilar to the matters in this case as they both involved dishonesty. At a PCC hearing in November 2016, you had conditions with a review imposed on your registration, which were subsequently lifted in May 2017. Lastly, in June 2020, you were issued with a warning by the GDC's case examiners for 12 months for failing to comply with CQC requirements at two of your practices.

133. With regard to misconduct, Miss Barnfather submitted that owing to the seriousness of the facts found proved, the Committee should have little hesitation in finding that they amount to misconduct.

134. Miss Barnfather then moved on to the issue of current impairment. She submitted that all aspects of the public interest are relevant in this case. This includes public protection, the maintenance of public confidence in the profession, upholding the reputation of the profession and declaring and upholding proper standards of conduct among dental professionals. She submitted that your clinical and moral failings demonstrated a repeated failure to fulfil basic obligations and to abide by the GDC's *Standards for the Dental Team (2013)*, and your conduct would be considered deplorable by other members of the dental profession. She submitted that it was sheer good fortune that Patient A survived the sedation and the neglectful care provided three days later by Registrant 1. She further submitted that both you and Registrant 1 attempted to conceal the provision of sedation at Practice 1 and were involved in the creation and falsification of records.

135. Miss Barnfather submitted that you bear the ultimate responsibility for providing sedation for an unsuitable patient, that you carried out surgery with inadequate planning and that you failed to ensure that the patient was appropriately monitored. She submitted that it was hard to imagine a more serious situation in which a dentist risked a patient's life, and that your actions represented a cavalier attitude that ought to have been absent in such a senior and experienced practitioner. She submitted that you failed to obtain Patient A's consent to sedation and created a document that deliberately misled about the duality of your role in an attempted cover-up. You failed to

provide the GDC with Patient A's original records and the records you provided subsequently to the GDC were grossly inadequate.

136. Miss Barnfather submitted that your dishonesty was at the higher end of the scale as it was proactive and not passive dishonesty. She submitted that there was nothing in your evidence regarding your remediation, reflection or insight, either previously or at this stage of the proceedings, that the Committee will find reassuring. She submitted that there was nothing before the Committee that showed you had truly developed any insight in respect of the risks taken or the damage your conduct has caused to the reputation of the profession.

137. Miss Barnfather referred the Committee to the GDC Standards and outlined the Standards which you had breached. She submitted that your failures in clinical care were driven by your failings in values and morals and therefore were less capable of being remedied. She submitted that any remediation you have done remains grossly insufficient and there was a risk of repetition of your behaviour.

138. She invited the Committee to conclude that a finding of impairment should be made in in the public interest. She submitted that the moral and clinical failings in this case are some of the more serious brought before a Committee and that the public interest demands a finding of impairment as the reputation of the profession and the regulator would be tarnished if such a finding was not made.

139. Miss Barnfather next addressed the Committee on the matter of sanction. She submitted that the appropriate and proportionate sanction would be one of erasure. She submitted that the features of this case and your conduct render your continued membership of the dental profession incompatible with the standards expected by the public and the profession.

140. Mr Kennedy, on your behalf, accepted that given the findings in this case your actions amount to misconduct. He further submitted that you acknowledge that the findings are so serious that a finding of impairment will be made.

141. Mr Kennedy took the Committee through your remediation bundle. He informed the Committee that the CPD you have undertaken addresses the consent and record keeping issues. In respect of conscious sedation, he submitted that you have not performed any since Autumn 2020 and you have no intention of doing so. He also took the Committee through the testimonials provided on your behalf.

142. Mr Kennedy submitted that the matter has been going on for a very long time through no fault of your own. He submitted that the incident took place more than six years ago and there has been no repetition of clinical misconduct or dishonesty related to your clinical practice. He submitted that you have been practising for 52 and a half years and that this is a tragic footnote to a lengthy, and in large part, distinguished career. He submitted that you have demonstrated a significant commitment to the profession in providing dental services in Southeast London and North Kent for a number of years. He submitted that the failings identified in this case should not be seen as emblematic of the totality of your practice. He informed the Committee that you have now retired from clinical dentistry and would like to train the next generation of dentists and mentor junior dentists. He submitted that erasure would be disproportionate, and that the Committee should impose a sanction to leave you with some dignity at the end of your career and allow you to contribute to the profession in a controlled manner.

Committee's Decision

143. The Committee has borne in mind that its decisions on misconduct, impairment and sanction are matters for its own independent judgment. There is no burden or standard of proof at this stage of the proceedings. The Committee had regard to the GDC's Guidance for The Practice Committees including Indicative Sanctions Guidance (October 2016, revised December 2020) (the GDC's Guidance). The Committee also received advice from the Legal Adviser which it accepted.

Misconduct

144. The Committee first considered whether the facts found proved against you amounted to misconduct. In doing so it had regard to the GDC Standards. It determined that your actions contravened eight out of the nine principles, namely:

- '*Put patients' interests first*' (Principle One),
- '*Communicate effectively with patients*' (Principle Two),
- '*Obtain valid consent*' (Principle Three),
- '*Maintain and protect patients' information*' (Principle Four),
- '*Work with colleagues in a way that is in patients' best interests*' (Principle Six),
- '*Maintain, develop and work within your professional knowledge and skills*' (Principle Seven),
- '*Raise concerns if patients are at risk*' (Principle Eight) and

- '*Make sure your personal behaviour maintains patients' confidence in you and the dental profession*' (Principle Nine).

145. In particular, the Committee found that your actions were in breach of the following GDC Standards:

- 1.3 ('*You must be honest and act with integrity'*), 1.3.1, 1.3.2;
- 1.4 ('*You must take a holistic and preventative approach to patient care which is appropriate to the individual patient'*),1.4.1, 1.4.2;
- 1.7 ('*You must put patients' interests before your own or those of any colleague, business or organisation'*) 1.7.1;
- 2.3 ('*You must give patients the information they need in a way they can understand so that they can make informed decisions'*), 2.3.1;
- 3.1 ('*You must obtain valid consent before starting treatment explaining all the relevant options and the possible costs'*), 3.1.6;
- 4.1 ('*You must make or keep contemporaneous complete and accurate patient records'*), 4.1.1, 4.1.5;
- 4.5 ('*You must keep patients' information secure at all times, whether your records are held on paper or electronically'*);
- 6.1 ('*You must work effectively with your colleagues and contribute to good teamwork'*), 6.1.2, 6.1.6;
- 6.2 ('*You must be appropriately supported when treating patients'*), 6.2.1;
- 6.4 ('*You must only accept an referral or delegation if you are trained and competent to carry out the treatment and you believe that what you are being asked to do is appropriate for the patient'*), 6.4.1;
- 6.5 ('*You must communicate clearly and effectively with other team members and colleagues in the interests of patients'*);
- 7.1 ('*You must provide good quality care based on current evidence and authoritative guidance'*);
- 7.3 ('*You must update and develop your professional knowledge and skills throughout your working life'*);
- 8.1 ('*You must always put patients' safety first'*) and
- 9.4 ('*You must co-operate with any relevant formal or informal inquiry and give full and truthful information'*).

146. The Committee was satisfied that your actions were a serious and clear breach of the standards of conduct, performance and ethics that govern you as a dental professional. These breaches have brought the profession into disrepute. You have clearly fallen far short of the standards of conduct that are expected of dental professionals.

147. Your conduct involved serious clinical failings, which exposed Patient A, a clinically vulnerable patient, to significant risk of an untoward medical event. Both experts commented that it was fortunate that the outcome was not worse.

148. The Committee turned first to your dishonest conduct. Dental professionals are required to act with honesty and integrity and your conduct constituted a breach of a fundamental tenet of the profession. The Committee considered that your proactive dishonesty in seeking to cover up the provision of conscious sedation in Practice 1 from the CQC and in seeking to deflect attention from your involvement in treating Patient A would be considered shocking and deplorable by fellow professionals and the public alike. You have also accepted that your conduct amounts to misconduct.

149. In conclusion, therefore, the Committee determined that your conduct was serious and amounts to misconduct.

Impairment

150. The Committee then considered whether your fitness to practise is currently impaired by reason of your misconduct.

151. In reaching its decision on impairment, the Committee had regard to the GDC Guidance section on impairment and the relevant case law, including the cases of *Cohen v General Medical Council [2008] EWCH 581 (Admin)* and *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council and Grant [2011] EWHC 927 (Admin).* In addition, it reviewed the Fifth Shipman report by Dame Janet Smith which set out the following four potential grounds to consider when determining current impairment:

1. *He/she has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm;*
2. *He/she has in the past brought and/or is liable in the future to bring the medical profession into disrepute;*
3. *He/she has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession;*
4. *He/she has in the past acted dishonestly and/or is liable to act dishonestly in the future.*

152. The Committee considered that all the grounds were engaged in this case.

153. The Committee took into account that, on your behalf, Mr Kennedy submitted that you accept that a finding of impairment will be made in light of the Committee's findings.

154. The Committee gave careful consideration to all of the evidence you have provided at this stage of the proceedings and considers the following to be of particular assistance in the exercise of its judgement.

155. The Committee first turned to your remediation bundle, your letter and oral evidence, which you provided for this stage of the proceedings. In respect of remediation, the Committee noted the four certificates of CPD amounting to 1.6 hours, all dated 22 September 2020. Mr Kennedy, on your behalf, submitted to the Committee that this was but a selection of what you considered to be the most relevant professional development that you had undertaken. No Personal Development Plan (PDP) and no reflective learning was included. There was no evidence before the Committee of any targeted remediation addressing the failings identified at Stage 1. The Committee considered this to be insufficient.

156. The Committee next considered the six testimonials provided. Two were dated September 2020 and address GDC investigations that were ongoing at that time. Both of these testimonials were provided by individuals who went on to perform the role of your workplace supervisor and describe you as their mentor. Two testimonials were dated August and September 2023 and referred to being aware of investigations or allegations. One was only able to attest to his experience of you as a colleague prior to 2009. Two were provided by longstanding patients in September 2023, both of whom state they are aware of allegations you are facing. None of your referees confirm that they have seen the findings of fact made at Stage 1. In all the circumstances, the Committee considered these to be of limited value.

157. You provided a letter which focused almost exclusively on the impact this case has had on you. You detailed your contributions to the profession, your achievements, your legacy, your thoughts on the demanding nature of dentistry and your desire to keep your registration. There is no mention of Patient A, no evidence of responsibility for the harm you caused, no appreciation for what you might have done differently, no reflection on the impact of your failings on patient safety, the profession and the public's trust and confidence in dentists.

158. Instead, your letter characterises this case as "*two men in dispute over betrayal of trust*". In your oral evidence, you describe dentists as "*over-regulated and unrewarded*". You acknowledge that serious shortcomings in

your practice of dentistry have been found but appear to take no responsibility for them. Any remorse you might feel is qualified by an assertion that in your case any errors or mistakes were never a consequence of negligence. You state that you "*will say sorry to some patients*". You claim that you have always put the dental needs of your patients first and have always compelled yourself to reach the highest standard of dental care for your patients, which you describe as your guiding principle.

159. Having evaluated all of the material and evidence that you put before the Committee today, the Committee concluded that any steps you have taken to remedy your clinical failings are wholly inadequate. They do not address the breadth of failings identified in this case. There is an absence of any meaningful reflection or insight into how these failings occurred or into your dishonest conduct, and your remediation is silent on your understanding of the impact of your misconduct on patient safety and the profession.

160. The Committee considers your letter and oral evidence to be the best available evidence on your level of insight. The Committee was reassured by neither and concludes from them that you have deep-seated professional attitudinal problems particularly with regard the value of regulation and the applicability of rules to you and your practice.

161. The Committee acknowledges that you are a dental practitioner with significant experience but weighed that against your fitness to practise history. In light of that history, the Committee considers that you should have had a heightened awareness of your responsibilities as set out in the Standards for the Dental Team. You have demonstrated a lack of regard for the role of regulators in ensuring patient safety and upholding public confidence in the profession. You provided misleading and dishonest information to the CQC, you allowed misleading information to be provided to the GDC and you did not respond promptly to requests by your regulator for documents in support of their investigation of this case. These failures mirror your fitness to practise history, which includes failures to engage appropriately with health regulations. Your evidence to the Committee about the overregulation of the dental profession is evidence of your ongoing failure to understand the vital role of regulation in dentistry in protecting patient safety and maintaining standards. This raises significant concerns about your fitness to practise on both patient safety and public interest grounds.

162. The public interest includes the protection of patients, colleagues and the wider public from the risk of harm, maintaining public confidence in the dental profession, upholding the reputation of the dental professions and

declaring and upholding appropriate standards of conduct and competence among dental professionals.

163. The Committee determined that a finding of impairment for your misconduct was necessary in the wider public interest to maintain public confidence in the profession and the regulator and to uphold proper standards of conduct. The Committee has concluded that a reasonable and informed member of the public, fully aware of the facts of the case, would have their confidence in the profession severely undermined if a finding of impairment were not made in the circumstances of this case.

164. It also concluded that a finding of current impairment is necessary in the interests of public protection because you have demonstrated no insight and your remediation is wholly inadequate such that the Committee finds it is likely that you would repeat your failings and patient safety would be compromised.

165. The Committee therefore determined that your fitness to practise is currently impaired by reason of your misconduct on both grounds.

Sanction

166. The Committee next considered what sanction, if any, to impose on your registration. It recognised that the purpose of a sanction is not to punish you but to protect patients and the wider public from the risk of harm. The Committee applied the principle of proportionality balancing your interest with the public interest. It also took into account the *GDC's Guidance*.

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

168. The two potential mitigations offered by you are the time elapsed since the incident and a submission of good conduct following the incident. As regards the latter, the Committee noted you have been under interim conditions for at least some of the six plus years since the date in question. As regards the former, the Committee considers that the passage of time is less relevant than other factors in the circumstances of this case, given the seriousness of both your clinical and probity failings and the absence of adequate mitigation. In any event, the passage of time does not render your misconduct any less serious.

169. The aggravating factors in this case include:

- Actual harm caused to Patient A;
- Serious dishonesty;
- Premeditated misconduct;
- Breach of trust with Patient A, who trusted you to treat him safely;
- The involvement of a clinically vulnerable patient;
- Misconduct sustained and repeated over a period of time;
- Blatant and wilful disregard of the role of the GDC and the systems regulating the profession;
- Attempts to cover up wrongdoing;
- Previous warning and other adverse findings;
- Lack of insight regarding misconduct.

170. The Committee decided that it would be inappropriate to conclude this case with no further action. It would not satisfy the public interest given the deplorable nature of your misconduct, which was found to be seriously below the appropriate standards expected of a dental professional. Neither would it protect the public.

171. The Committee then considered the available sanctions in ascending order starting with the least serious.

172. The Committee concluded that misconduct of this nature could not be adequately addressed by way of a reprimand. It cannot be said to be at the lower end of the spectrum. Neither the public interest nor the public would be sufficiently protected by the imposition of such a sanction. The Committee therefore determined that a reprimand would be inappropriate and inadequate.

173. The Committee then considered whether a conditions of practice order would be appropriate. It noted that it would be difficult, if not impossible, to formulate conditions to address the issue of your proven dishonesty. You stated that you no longer wished to practise clinical dentistry but wanted to maintain your registration to mentor and train future generations of dentists. In these circumstances, conditions of practice would not be workable. Neither the public interest nor the public would be sufficiently protected by the imposition of such a sanction. The Committee therefore determined that a conditions of practice order would be inappropriate and inadequate.

174. The Committee next considered whether to suspend your registration for a specified period. It questioned whether a suspension would be sufficient in all the circumstances to address the misconduct that it had found. In reaching its decision, the Committee had regard to the factors listed under paragraph 6.28 of the Guidance, which dealt with the sanction of suspension.

However, the Committee bore in mind the serious nature of your clinical and ethical professional failings in this case. Your negligence exposed Patient A, a clinically vulnerable patient, to significant risk of an untoward medical event. You then engaged in misleading and dishonest behaviour by failing to document your true role in the treatment carried out on Patient A on 21 June 2017 and knowingly permitting or causing there to be an inaccurate record made of your involvement sent to the regulator to deflect attention from your role in his treatment. You also concealed the provision of conscious sedation at Practice 1 to the CQC. This was not the first time that you have been before your regulator in respect of dishonesty. Given your fitness to practise history and your continued lack of insight, the risk of repetition remains very high. The Committee noted that the maximum period of suspension that could be imposed was for 12 months. It concludes that a 12-month suspension would be insufficient to protect the public. Neither would it satisfy the public interest and uphold the public's trust and confidence in the profession and its regulator. In all the circumstances, the Committee finds suspension to be insufficient.

175. Paragraph 6.28 of the Guidance also makes clear that a suspension may be appropriate where there is "*no evidence of harmful deep-seated personality or professional attitudinal problems*". The Committee considered that there is evidence that you have a professional attitudinal problem. You have shown no meaningful remorse, your remediation has been wholly insufficient and you appear to have no insight into your clinical and ethical professional failings in this case and the impact these failings have on anyone but yourself.

176. In considering whether the sanction of erasure was proportionate and appropriate, the Committee had regard to paragraph 6.34 of the Guidance, which states:

> *"Erasure will be appropriate when the behaviour is fundamentally incompatible with being a dental professional: any of the following factors, or a combination of them, may point to such a conclusion."*

177. The Committee considered the following factors applied in this case:

- *"serious departure(s) from the relevant professional standards;*
- *where serious harm to patients or other persons has occurred, either deliberately or through incompetence;*
- *where a continuing risk of serious harm to patients or other persons is identified;*

- *the abuse of a position of trust or violation of the rights of patients, particularly if involving vulnerable persons;*
- *serious dishonesty, particularly where persistent or covered up;*
- *a persistent lack of insight into the seriousness of actions or their consequences."*

178. It noted that you have shown a persistent lack of insight into your behaviour and your conduct consisted of serious clinical and ethical professional failings that are a serious departure from the standards expected of dental professionals. The Committee therefore concluded that your behaviour was fundamentally incompatible with being a dental professional.

179. In all the circumstances, the Committee has determined to erase your name from the Dentists' Register. It recognises that this may have an impact on you, but considers that this is far outweighed by the public interest in this case.

180. The Committee will now consider whether an immediate order should be imposed on your registration, pending the taking effect of its determination for erasure.

Decision on Immediate Order – 7 November 2023

59. The Committee has considered whether to make an order for the immediate suspension of your registration in accordance with Section 30 of the Dentists Act 1984 (as amended).

60. Miss Barnfather, on behalf of the GDC, submitted that such an order is necessary for the protection of the public and is otherwise in the public interest. She submitted that an immediate order would be entirely consistent with the Committee's determination in respect of the risk of repetition of your failings. She submitted that it is also necessary in the wider public interest to uphold the reputation of the profession.

61. Mr Kennedy, on your behalf, submitted that you were shocked, disappointed and astonished that the Committee had decided to remove you from the register after almost 53 years. He submitted that you were also disappointed about the quality of the Committee's reasoning in its decision made at Stage 1 of this hearing. Mr Kennedy submitted that an immediate order is not necessary to protect patients as you have retired after over 50 years in clinical practice, and there has been no repetition of the clinical misconduct since the incidents. He further submitted that an Interim Order Committee (IOC)

declined to impose an interim order on your registration when it considered your case after the findings of fact had been handed down.

62. The Committee has considered the submissions made. It has accepted the advice of the Legal Adviser.

63. The Committee noted the submission made by Mr Kennedy that an immediate order was not necessary as you have retired from clinical practice. However, the Committee was not reassured by this assertion given the findings in this case about your dishonesty. It noted that if no immediate order is made and you appeal the decision of erasure, you would still be on the Dentists' Register and could return to practise at any time. Furthermore, the Committee was aware that you had made previous assertions that you intended to retire from practice but had then continued to treat patients.

64. The Committee also considered the submission made that an IOC had determined that it was not necessary to impose an interim order on your registration following the findings of fact. However, the Committee bore in mind that a different test is applied at IOC hearings than at substantive hearings, and this Committee has now made its findings on impairment and sanction.

65. The Committee is satisfied that an immediate order of suspension is necessary for the protection of the public and is otherwise in the public interest. The Committee concluded that given the nature of its findings and its reasons for the substantive order of erasure in your case, it is necessary to direct that an immediate order of suspension be imposed on both of these grounds. The Committee considered that, given its findings, if an immediate order was not made in the circumstances, there would be a risk to public safety and public confidence in the profession would be undermined. Without an immediate order, reputational damage would be suffered by both the profession and the regulator.

66. The effect of this direction is that your registration will be suspended immediately. Unless you exercise your right of appeal, the substantive order of erasure will come into effect 28 days from the date on which notice of this decision is deemed to have been served on you. Should you exercise your right of appeal, this immediate order for suspension will remain in place until the resolution of any appeal.

67. That concludes this hearing.