Dental Professionals Hearings Service

HEARING PARTLY HEARD IN PRIVATE*

The Committee has made a determination in this case that includes some private information. That information has been omitted from the text.

STARKEY, Ian John

Registration No: 64934

HEALTH COMMITTEE

OCTOBER 2022

Outcome: Erased with Immediate Suspension

Ian John STARKEY, a dentist, BDS University of Birmingham 1989, was summoned to appear before the Professional Conduct Committee on 3 October 2022 for an inquiry into the following charge:

CHARGE (as AMENDED and READ on 3 October 2022 and as further AMENDED on 5 October 2022)

"That, being a registered dentist:

1. Between April 2014 and July 2016 you were in general dental practice at Practice 1.
2. You provided care and treatment to the patients set out in Schedule A[1].

Patient 1

Clinical

3. In March 2015 you failed to adequately assess the suitability of LR6 and/or LR4 to support a bridge at LR6-LR4 in that:
   (a) you did not undertake appropriate radiographic assessment;
   (b) you did not carry out a periodontal assessment.
4. You did not adequately discuss, or adequately record discussion, with Patient 1 regarding the risks, benefits and alternatives to the proposed bridge at LR6-LR4.
5. In March 2016 you failed to adequately assess the suitability of UL2 for a proposed post and crown to be incorporated as part of a bridge at UL2-UL4 in that:

[1] Schedule A is a private document which cannot be disclosed.

(a) you did not undertake appropriate radiographic assessment;

(b) you did not carry out a periodontal assessment.

6. The UL2 was not suitable for a post and crown as indicated by a Consultant in Restorative Dentistry on 19 December 2011.

7. On 31 March 2016 you inappropriately prepared the UL2 for a post and crown and thereafter incorporated it as part of a bridge at UL2-UL4.

8. You did not adequately discuss, or adequately record discussion, with Patient 1 regarding the risks, benefits and alternatives to the proposed bridge at UL2-UL4.

Claiming

9. You caused or permitted a claim [68119] to be submitted for a Band 3 course of treatment incorporating UL2 with a date of completion of 31 March 2016 when the treatment was not completed until after that date.

10. You thereby obtained 12 UDAs to which you were not entitled for the UDA year 2015/2016.

11. You caused or permitted a claim [67995] to be submitted for a Band 1 course of treatment which ought to have formed part of a single course of treatment and one Band 3 claim.

12. You thereby obtained 1 additional UDA to which you were not entitled.

13. You caused or permitted a claim [68765] to be submitted for a Band 2 course of treatment which ought to have formed part of a single course of treatment and one Band 3 claim.

14. You thereby obtained 3 additional UDAs to which you were not entitled.

15. Your conduct as set out above at 10, 12 and/or 14 was:

(a) misleading;

(b) lacking in integrity, in that you failed to ensure your claims complied with the relevant regulations.

Patient 2

Clinical

16. On 26 February 2016 you failed to:

(a) carry out or record a BPE;

(b) report on bitewing radiographs.

17. On 15 March 2016 you failed to adequately assess a probable periodontal abscess at UL7 in that:

(a) you did not undertake appropriate radiographic assessment;

(b) you did not carry out a periodontal assessment.

18. On 15 March 2016 you inappropriately prescribed antibiotics.

19. On 12 May 2016 you provided a crown at UL5 and failed to carry out root canal treatment.

Patient 3

Clinical

20. On 15 December 2015 you failed to:

(a) report on bitewing and/or periapical radiographs;

(b) adequately record your clinical findings and/or diagnoses.

21. You failed to identify and/or appropriately treat caries visible on bitewing radiographs dated 15 December 2015 at:

(a) LR6;

(b) UL4;

(c) UL5;

(d) UL6;

(e) UL7;

(f) LL6.

22. On 28 January 2016 you failed to adequately record an examination and oral health review.

Claiming

23. You caused or permitted two separate claims [68273 & 68496] to be submitted as Band 3 courses of treatment in respect of the same treatment provided incorporating a crown at UR1.

24. You thereby obtained an additional 12 UDAs to which you were not entitled.

25. Your conduct as set out above at 24 was:

(a) misleading;

(b) lacking in integrity, in that you failed to ensure your claims complied with the relevant regulations.

Patient 4

Clinical

26. On 3 October 2014 you provided a substandard restoration at LR6.

27. Between 18 December 2014 and about 5 June 2015:
    (a) you failed to adequately investigate and/or formulate a treatment plan for LR6 which you noted as having an abscess;
    (b) you proceeded with cosmetic treatment without having adequately investigated and treated the LR6.
28. You failed to adequately review or report on bitewings dated 2 April 2015.
29. You failed to treat caries visible on bitewing radiographs dated 2 April 2015 at:
    (a) LR6;
    (b) UR5;
    (c) UR4;
    (d) UL7.
30. You failed to keep complete and accurate records on 8 May 2015 in that:
    (a) you did not adequately record which teeth were prepared for a bridge in the Upper Left Quadrant ('ULQ');
    (b) you did not record the refusal or use of Local Anaesthetic.
31. You did not adequately discuss, or adequately record discussion, with Patient 4 regarding the risks, benefits or alternative treatments to the proposed bridge at UL3-UL6.
32. You failed to obtain informed consent to the bridge at UL3-UL6.
33. In May 2015 you failed to adequately assess the suitability of UL3 and/or UL6 as support for a bridge in that:
    (a) you did not undertake appropriate radiographic assessment;
    (b) you did not carry out a periodontal assessment.
34. On 15 May 2015 you failed to adequately assess the suitability of the UR1 and/or UR2 for crowns in that you did not undertake appropriate radiographic assessment.
35. On 11 January 2016 you failed to adequately assess the suitability of the LL2, LR1 and/or LR2 as support for a replacement bridge in that:
    (a) you did not undertake appropriate radiographic assessment;
    (b) you did not carry out a periodontal assessment.
36. You did not adequately discuss, or adequately record discussion, with Patient 4 regarding risks, benefits or alternative treatments to the proposed bridge at LL2-LR2.
37. You failed to obtain informed consent to the bridge at LL2-LR2.

Claiming

38. You caused or permitted a claim [63537] to be submitted for a Band 1 course of treatment which ought to have formed part of a single course of treatment and one Band 3 claim [64014].

39. You thereby obtained an additional 1 UDA to which you were not entitled.

40. Your conduct set out above at 39 was:

    (a) misleading;

    (b) lacking in integrity, in that you failed to ensure your claims complied with the relevant regulations.

Patient 5

Clinical

41. You failed to report on bitewing radiographs dated 2 February 2015.

42. Prior to 2 July 2015 you failed to adequately assess the suitability of UR2 and/or UL1 to support a proposed bridge at UR2-UL1 in that:

    (a) you did not undertake appropriate radiographic assessment;

    (b) you did not carry out a periodontal assessment.

43. You did not adequately discuss, or adequately record discussion, with Patient 5 regarding the risks, benefits and alternatives to the proposed bridge at UR2-UL1.

44. You failed to obtain informed consent to the bridge at UR2-UL1.

45. Prior to 21 April 2016 you failed to adequately assess the suitability of UR3 and/or UR5 to support a proposed bridge at UR3-UR5 in that:

    (a) you did not undertake appropriate radiographic assessment;

    (b) you did not carry out a periodontal assessment.

46. Between 11 April 2016 and 21 April 2016 you did not adequately discuss, or adequately record discussion, with Patient 5 regarding the risks, benefits and alternatives to the proposed bridge UR3-UR5.

47. You failed to obtain informed consent to the bridge at UR3-UR5.

Patient 6

Clinical

48. On 10 June 2014 you failed to take bitewing radiographs.

Patient 7

Clinical

49. You failed to take bitewing radiographs on:

    (a) 21 August 2014;

    (b) 11 June 2015.

50. On 26 February 2016 you failed to adequately record a treatment plan in respect of a bridge at LR1-LR2.

51. On 26 February 2016 and/or 14 March 2016 you failed to adequately assess the suitability of LR2 as support for a bridge at LR1-LR2 in that:

    (a) you did not undertake appropriate radiographic assessment;

    (b) you did not carry out a periodontal assessment.

52. You failed to adequately review or adequately report on bitewing radiographs dated 15 March 2016.

53. You failed to identify and/or treat caries visible on bitewing radiographs dated 15 March 2016 at:

    (a) UR4;

    (b) UL3;

Claiming

54. You caused or permitted a claim [67743] to be submitted for a Band 2 course of treatment which ought to have formed part of a single course of treatment and one Band 3 claim [68131].

55. You thereby obtained an additional 3 UDAs to which you were not entitled.

56. Your conduct as set out above at 55 was:

    (a) misleading;

    (b) lacking in integrity, in that you failed to ensure your claims complied with the relevant regulations.

Patient 8

Clinical

57. In April 2016:

    (a) you failed to use, or record the use, of rubber dam;

    (b) you provided substandard root canal care and treatment at UL5 in that:

        (i) you failed to take a pre-operative radiograph;

(ii) you used local anaesthetic as the canal irrigant;

(iii) you failed to take a post-operative radiograph.

Patient 9

Clinical

58. On 23 September 2014, or prior to the provision of a bridge at UR2-UL2 and/or veneers at UL3 to UR3, you failed to undertake adequate radiographic assessment in that:

    (a) you failed to take sufficient periapical radiographs;

    (b) you failed to take bitewing radiographs.

59. You failed to adequately treat caries identified at UL8.

60. You proposed an inappropriate bridge design at UR2-UL2 in that UR1 was not suitable for use to support the bridge due to a failing root filling as visible on a radiograph dated 23 September 2014.

61. On 12 August 2015 Patient 9 attended in connection with a probable abscess at LR4 and:

    (a) you failed to take a periapical radiograph;

    (b) you inappropriately prescribed antibiotics;

    (c) you inappropriately continued treatment at UR1 to UL3.

62. On 1 February 2016 you provided an apicectomy at UR1 and thereafter failed to allow an appropriate period to elapse before reassessing the UR1 and resuming the provision of bridge at UR2-UL2.

Patient 10

Clinical

63. [withdrawn].

Indemnity

64. Between 1 January 2015 and about 4 July 2016 you treated patients without holding adequate indemnity cover.

65. You knew, or ought to have known, you did not have adequate indemnity cover and your conduct in continuing to practise was:

    (a) misleading;

    (b) dishonest in that you knew you did not have adequate indemnity insurance and should not be practising.

Declaration to MyDentist

66. You provided MyDentist with an indemnity certificate for the period 1 January 2015 to 1 January 2016.

67. You knew, or ought to have known, that the indemnity certificate you had supplied MyDentist was not valid and your conduct in failing to notify MyDentist it was not, or no longer, valid was:

    (a) misleading;

    (b) dishonest in that you knew MyDentist understood you to have adequate indemnity cover when you did not.

Non co-operation with the GDC

68. You failed to co-operate with the GDC in that you did not respond promptly, or at all, to requests to produce your indemnity insurance made in communications dated:

    (a) 21 July 2016;

    (b) 14 December 2016;

    (c) 12 January 2017;

    (d) 6 March 2017.

Patient 11

69. Between 29 May 2019 and 24 March 2020, you were in general dental practice at Practice 2 and treated Patient 11.

70. On 19 November 2019:

    (a) you failed to report on a periapical radiograph;

    (b) you did not adequately discuss with Patient 11 the risks, benefits and alternatives to the proposed immediate post-extraction fit of a two-unit cantilever bridge at UL2.

71. On 11 December 2019:

    (a) you inappropriately amended the treatment plan to include a pontic at UL4 when the UL3 was not suitable to support two pontics at UL2 and UL4;

    (b) you did not adequately discuss with Patient 11 the risks, benefits, and alternatives to the proposed three-unit cantilever bridge at UL2-UL4.

72. On 20 December 2019:

    (a) you extracted the UL2 and fitted an inappropriate three-unit cantilever bridge at UL2-UL4;

(b) you failed to obtain informed consent to the three-unit cantilever bridge at UL2-UL4;

(c) you failed to record any investigations and/or treatment at UR6.

Non-co-operation in respect to Patient 11's complaint

73. You failed to co-operate with the GDC in that you did not respond promptly, or at all, to requests to produce details of your employment and/or indemnity insurance made in communications dated:

(a) 1 June 2020;

(b) 18 June 2020;

(c) 24 June 2020.

Health

74. You have adverse health conditions as particularised in Schedule B[2].

And that, by reason of the facts alleged, your fitness to practise is impaired by reason of your misconduct and in respect of charge 74, adverse health".

Mr Starkey was not present and was not represented. On 3 October 2022, the Chairman made a statement regarding the preliminary application. On 11 October 2022, the Chairman announced the findings of fact to the Counsel for the GDC:

Decisions on Service, Proceeding in absence and Preliminary matters – 3 October 2022

"This is a hearing of the Health Committee (HC). Mr Starkey is not present and is not represented in his absence. Ms Lydia Barnfather of Counsel, instructed by the General Dental Council's (GDC's) In-House Legal Presentation Service, appears for the GDC. The hearing 31T32Tis being held remotely using Microsoft Teams in line with the GDC's current practice.

Preliminary matters

Ms Barnfather on behalf of the GDC invited the Committee to hear part of the case in private, given that there would be some references to Mr Starkey's health during the course of the hearing. The application was made pursuant to Rule 53 of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules'). The Committee acceded to the application.

[2] Schedule B is a private document which cannot be disclosed.

Service of notice

Ms Barnfather submitted that service of notice of this hearing has been properly effected in accordance with Rules 13 and 65 of the Rules. The Committee noted that on 23 August 2022 a notice of hearing was sent to the address that Mr Starkey has registered with the GDC, setting out the date and time of this hearing, as well as its remote nature, and all other prescribed information. The notice was sent using the Royal Mail's Special Delivery postal service. The Royal Mail's Track and Trace service records that the notice was delivered on the afternoon of 24 August 2022. A copy of the notice was also sent to Mr Starkey by email.

The Committee accepted the advice of the Legal Adviser. The Committee was satisfied that service had been properly effected in accordance with the Rules.

Proceeding in absence

The Committee then went on to consider whether to exercise its discretion to proceed in the absence of Mr Starkey in accordance with Rule 54 of the Rules. Ms Barnfather invited the Committee to proceed in Mr Starkey's absence on the basis that Mr Starkey has waived his right to attend, and that it is his expectation that the hearing shall proceed without him.

The Committee accepted the advice provided by the Legal Adviser. The Committee was mindful that its discretion to conduct a hearing in the absence of a registrant should be exercised with the utmost care and caution. After careful consideration the Committee determined that it would be fair and appropriate for the hearing to proceed in Mr Starkey's absence. The Committee considers that the GDC has made every effort to inform Mr Starkey of this hearing and that he has voluntarily absented himself. The Committee considers that an adjournment, which has not been requested, would be unlikely to secure Mr Starkey's attendance in circumstances where it appears to be Mr Starkey's settled intention not to participate in these proceedings. The Committee was also mindful of the public interest in the expeditious consideration of these matters and of the potential inconvenience to the GDC and its witnesses were it not to proceed.

Further preliminary matters

Ms Barnfather applied to amend a number of heads of charge in accordance with Rule 18 of the Rules. The heads of charge are, namely, 9, 60, 61 and 74. Having accepted the advice of the Legal Adviser, the Committee determined that the minor amendments sought could be made without injustice. The schedule of charge was duly amended.

Decision on further amendments to the charge – 3 October 2022

Additional amendments to the charge

On 5 October 2022, at the conclusion of the GDC's factual case, Ms Barnfather applied to withdraw a head of charge, namely head of charge 63, and to amend one

of the dates that appears at head of charge 27. The Committee, having accepted the advice of the Legal Adviser, was content to accede to the application on the basis that the amendment and withdrawal could be made without injustice. The schedule of charge was amended once more.

Findings of fact – 11 October 2022

Background to the case and summary of allegations

The allegations giving rise to this hearing relate to the standard of care and treatment that Mr Starkey provided to 11 patients, as well as to his units of dental activity (UDA) claiming practices relating to some of those patients. 10 of the 11 patients, who are referred to for the purposes of these proceedings as Patient 1 to Patient 10, were treated at a dental practice in the overall period of April 2014 to July 2016, and the eleventh patient, who is referred to as Patient 11, was treated at another dental practice in the later period of May 2019 to March 2020.

Mr Starkey also faces allegations that he acted in a misleading and dishonest manner in treating patients without adequate indemnity cover for an 18-month period and in providing, or relying on, incorrect information about his indemnity insurance arrangements to his then practice. It is further alleged that Mr Starkey failed to co-operate with a GDC investigation in relation to his indemnity insurance. The GDC also contends that Mr Starkey has adverse health conditions.

The allegations that Mr Starkey faces are set out in full below.

Evidence

The Committee has been provided with documentary material in relation to the heads of charge that Mr Starkey faces, including the witness statements and documentary exhibits of: an employee of the Medical Defence Union (MDU) with knowledge of Mr Starkey's membership of the Dental Defence Union (DDU), who is referred to for the purposes of these proceedings as Witness A; a representative of the company which engaged Mr Starkey's services, who is referred to as Witness B; three patients to whom Mr Starkey provided care and treatment, who are referred to as Patient 4, Patient 5 and Patient 11; a member of staff with the NHS Business Services Authority (NHS BSA), who is referred to as Witness C; a paralegal in the GDC's In-House Legal Presentation Service with knowledge of the GDC's investigation, who is referred to as Witness D; and a former colleague of Mr Starkey, who was the site manager at Mr Starkey's former practice and who is referred to as Witness E. The Committee has also been provided with the reports of the GDC's expert witness, namely Dr David Igoe, who gives evidence about the non-health allegations. The Committee has also received the records relating to the 11 patients in this case.

[PRIVATE]

IN PUBLIC

The Committee heard oral evidence from Patient 4, Patient 5, Patient 11 and Dr Igoe. By a preliminary ruling made on 10 September 2021 the witness statements of the other witnesses of fact were directed to stand as their evidence-in-chief unless otherwise directed. Having considered those witness statements the Committee decided that no contrary direction was necessary and therefore those witnesses did not give oral evidence.

[PRIVATE]

IN PUBLIC

Committee's findings of fact

The Committee has taken into account all the evidence presented to it. It has considered the submissions made by Ms Barnfather on behalf of the GDC.

The Committee has accepted the advice of the Legal Adviser. The Committee is mindful that the burden of proof lies with the GDC, and has considered the heads of charge against the civil standard of proof, that is to say, the balance of probabilities. In applying that standard to the allegations of dishonesty and lack of integrity, the Committee has followed the guidance set out in *Bank St. Petersburg PJSC v Arkhangelsky* at paragraphs [117] to [119] of the judgment of Lord Justice Males referring to passages from *In re B* [2009] AC 11. The Committee has considered each head of charge separately, although some of its findings will be announced together.

A Medical Adviser was in attendance on the first day of the hearing, and not thereafter, in the event that Mr Starkey attended the hearing. As Mr Starkey did not attend the hearing, the Medical Adviser did not attend the hearing after its first day. The Committee received no advice from the Medical Adviser.

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

1.	*Between April 2014 and July 2016 you were in general dental practice at Practice 1.* **Proved**
	The Committee finds the facts set out at head of charge 1 proved. These anodyne facts are set out by way of background to the allegations that Mr Starkey faces, and the Committee finds that the documentary evidence provided to it supports these facts.
2.	*You provided care and treatment to the patients set out in Schedule A.* **Proved**
	The Committee finds the facts set out at head of charge 2 proved. These anodyne facts are set out by way of background to the allegations that Mr Starkey faces, and the Committee finds that the

	documentary evidence provided to it supports these facts.
Patient 1	
Clinical	
3.	*In March 2015 you failed to adequately assess the suitability of LR6 and/or LR4 to support a bridge at LR6-LR4 in that:*
3. a)	*you did not undertake appropriate radiographic assessment;* **Proved**
	The Committee finds the facts alleged at head of charge 3 (a) proved. In reaching this finding the Committee notes the expert evidence of Dr Igoe that Mr Starkey was under a duty to adequately assess the suitability of the patient's LR6 and LR4 to support a bridge spanning those teeth by way of undertaking appropriate radiographic assessment. The Committee notes that no such radiographs, and in particular periapical radiographs, appear in the patient's records, and it infers that no such radiographs were taken as required. The Committee finds that this omission amounts to a failure to adequately assess the suitability of LR6 and LR4.
3. b)	*you did not carry out a periodontal assessment.* **Proved**
	The Committee finds the facts alleged at head of charge 3 (b) proved. The Committee has had regard to the expert evidence of Dr Igoe, who states that as a minimum a basic periodontal examination (BPE) should have been conducted and recorded. The Committee infers from the absence of a record of such an examination that no such examination, or any other periodontal assessment, was undertaken. The Committee considers that this amounts to a failure to adequately assess the suitability of LR6 and LR4 to support a bridge spanning those teeth.
4.	*You did not adequately discuss, or adequately record discussion, with Patient 1 regarding the risks, benefits and alternatives to the proposed bridge at LR6-LR4.* **Proved**
	The Committee finds the facts alleged at head of charge 4 proved. The Committee notes that there is no record of any discussion with Patient 1 about the risks, benefits and alternatives to the proposed bridge at LR6 to LR4. The Committee infers from the absence of any recorded discussions that no such required discussions took place. The Committee accepts the expert evidence of Dr Igoe that such

	discussions should have taken place.
5.	*In March 2016 you failed to adequately assess the suitability of UL2 for a proposed post and crown to be incorporated as part of a bridge at UL2-UL4 in that:*
5. a)	*you did not undertake appropriate radiographic assessment;* **Proved**
	The Committee finds the facts alleged at head of charge 5 (a) proved. In reaching this finding the Committee notes the expert evidence of Dr Igoe that Mr Starkey was under a duty to adequately assess the suitability of the patient's UL2 for a proposed post and crown to be incorporated as part of a bridge at UL2 to UL4 by way of undertaking appropriate radiographic assessment. The Committee notes that no such radiographs appear in the patient's records, and it infers that no such radiographs were taken as required. The Committee finds that this omission amounts to a failure to adequately assess the suitability of UL2 for the purposes referred to at this head of charge.
5. b)	*you did not carry out a periodontal assessment.* **Proved**
	The Committee finds the facts alleged at head of charge 5 (b) proved. The Committee has again had regard to the expert evidence of Dr Igoe, who states that as a minimum a BPE should have been conducted and recorded. The Committee infers from the absence of a record of such an examination that no such examination, or any other periodontal assessment, was undertaken. The Committee considers that this amounts to a failure to adequately assess the suitability of UL2 for the purposes referred to at this head of charge.
6.	*The UL2 was not suitable for a post and crown as indicated by a Consultant in Restorative Dentistry on 19 December 2011.* **Proved**
	The Committee finds the facts alleged at head of charge 6 proved. The Committee accepts the expert evidence of Dr Igoe that Patient 1's UL2 was not suitable for a post and crown in view of the opinion given by a Consultant in Restorative Dentistry on 19 December 2011.
7.	*On 31 March 2016 you inappropriately prepared the UL2 for a post and crown and thereafter incorporated it as part of a bridge at UL2-UL4.* **Proved**

	The Committee finds the facts alleged at head of charge 7 proved. The Committee accepts the expert evidence of Dr Igoe that Mr Starkey's preparation of the patient's UL2 for a post and crown, and the subsequent incorporation of it as part of a bridge spanning UL2 to UL4, was inappropriate.
8.	*You did not adequately discuss, or adequately record discussion, with Patient 1 regarding the risks, benefits and alternatives to the proposed bridge at UL2-UL4.* **Proved**
	The Committee finds the facts alleged at head of charge 8 proved. The Committee notes that there is no record of any discussion with Patient 1 about the risks, benefits and alternatives to the proposed bridge at UL2 to UL4. The Committee accepts the expert evidence of Dr Igoe that such discussions should have taken place. The Committee infers from the absence of a recording of such discussions that no such required discussions took place.
<u>Claiming</u>	
9.	*You caused or permitted a claim [68119] to be submitted for a Band 3 course of treatment incorporating UL2 with a date of completion of 31 March 2016 when the treatment was not completed until after that date.* **Proved**
	The Committee finds the facts alleged at head of charge 9 proved. The Committee notes from the patient's notes that Mr Starkey made an entry on 31 March 2016 that the patient would return in a fortnight for the fitting of a bridge. The patient's records record that the bridge was not fitted until 20 April 2016. This demonstrates that the treatment being claimed for, namely the provision of a crown at the patient's UL2, was not completed until after the claim date of 31 March 2016. The crown at UL2 was part of the bridge which spanned UL2 to UL4. In finding this head of charge proved, and when finding other claiming heads of charge proved, the Committee finds the facts alleged proved on the basis that Mr Starkey caused claims to be submitted as opposed to permitted claims.
10.	*You thereby obtained 12 UDAs to which you were not entitled for the UDA year 2015/2016.* **Proved**
	The Committee finds the facts alleged at head of charge 10 proved. The Committee accepts the expert evidence of Dr Igoe that, having

	submitted a claim for 12 UDAs in the financial year of 1 April 2015 to 31 March 2016, Mr Starkey obtained UDAs to which he was not entitled for that year.
11.	*You caused or permitted a claim [67995] to be submitted for a Band 1 course of treatment which ought to have formed part of a single course of treatment and one Band 3 claim.* **Proved**
	The Committee finds the facts alleged at head of charge 11 proved. The Committee notes from Patient 1's records that on 15 March 2016 Mr Starkey submitted a claim for a Band '1' course of treatment. Dr Igoe's expert evidence is that the claim should not have been submitted as a separate claim and instead should have formed part of a single course of Band '3' treatment.
12.	*You thereby obtained 1 additional UDA to which you were not entitled.* **Proved**
	The Committee finds the facts alleged at head of charge 12 proved. The Committee accepts the expert evidence of Dr Igoe that, having submitted a claim for one Band '1' UDA instead of incorporating that treatment as part of a single course of Band '3' treatment as he should have done, Mr Starkey obtained an additional UDA to which he was not entitled.
13.	*You caused or permitted a claim [68765] to be submitted for a Band 2 course of treatment which ought to have formed part of a single course of treatment and one Band 3 claim.* **Proved**
	The Committee finds the facts alleged at head of charge 13 proved. The Committee notes from Patient 1's records that on 13 May 2016 Mr Starkey submitted a claim for three UDAs as a Band '2' course of treatment. Dr Igoe's expert evidence is that the claim should not have been submitted as a separate claim and instead should have formed part of a single course of Band '3' treatment.
14.	*You thereby obtained 3 additional UDAs to which you were not entitled.* **Proved**
	The Committee finds the facts alleged at head of charge 14 proved. The Committee accepts the expert evidence of Dr Igoe that, having submitted a claim for three UDAs as a separate Band '2' treatment

	instead of incorporating that treatment as part of a single course of Band '3' treatment as he should have done, Mr Starkey obtained three additional UDAs to which he was not entitled.
15.	*Your conduct as set out above at 10, 12 and/or 14 was:*
15. a)	*misleading;* **Proved**
	The Committee finds the facts alleged at head of charge 15 (a) proved in respect of heads of charge 10, 12 and 14. The Committee considers that the claims that Mr Starkey submitted were false and attracted UDAs to which he was not entitled, and that they were therefore misleading. The reader of those claims would have been entitled to expect that the information contained in the claims was true and accurate. As the forms were not in fact true and accurate in the ways set out above at heads of charge 10, 12 and 14, the claims were misleading.
15. b)	*lacking in integrity, in that you failed to ensure your claims complied with the relevant regulations.* **Proved**
	The Committee finds the facts alleged at head of charge 15 (b) proved in respect of heads of charge 10, 12 and 14. In approaching this and the other heads of charge relating to lack of integrity, the Committee has had regard to *Wingate & Evans v SRA; SRA v Malins* [2018] EWCA Civ 366 at paragraphs [66], [83] to [89] and [95] to [103] of the judgment of Lord Justice Rupert Jackson. At paragraph [100] he states, *'integrity connotes adherence to the ethical standards of one's own profession […] to take one example, a solicitor conducting negotiations or a barrister making submissions to a judge or arbitrator will take particular care not to mislead. Such a professional person is expected to be even more scrupulous about accuracy than a member of the public in daily discourse'.* The Committee considers that this standard applies to Mr Starkey as a trusted member of the dental profession. The Committee finds that, in submitting the false claims set out at heads of charge 10, 12 and 14, Mr Starkey lacked integrity because he failed to ensure that his UDA claims, which form the basis of remuneration for NHS dental work and were required by the NHS to record completed courses of treatment, were true and accurate.
Patient 2	
<u>Clinical</u>	

16.	*On 26 February 2016 you failed to:*
16. a)	*carry out or record a BPE;* **Proved**
	The Committee finds the facts alleged at head of charge 16 (a) proved in respect of a failure to record a BPE. The Committee has again had regard to the expert evidence of Dr Igoe, who states that a BPE score should have been undertaken and recorded. The Committee notes that Mr Starkey makes reference in the patient's records to a BPE having been conducted, but it notes that the resulting score was not recorded. The Committee considers that the GDC has not demonstrated to the standard required that a BPE was not carried out, but the Committee finds that a BPE was not recorded.
16. b)	*report on bitewing radiographs.* **Not proved**
	The Committee finds the facts alleged at head of charge 16 (b) not proved. The Committee notes that on 26 February 2016 bitewing radiographs were prescribed by Mr Starkey, to be taken by another practitioner, with the radiographs being taken by that other practitioner on 2 March 2016. As there were no radiographs capable of being reported on on the alleged date of 26 February 2016, the Committee finds that there was no failing on the part of Mr Starkey. Accordingly the Committee finds the facts alleged at this head of charge not proved.
17.	*On 15 March 2016 you failed to adequately assess a probable periodontal abscess at UL7 in that:*
17. a)	*you did not undertake appropriate radiographic assessment;* **Proved**
	The Committee finds the facts alleged at head of charge 17 (a) proved. Mr Starkey refers in the patient's notes to a probable periodontal abscess at the patient's UL7. The Committee notes that no radiographs or references to radiographs, having been taken, appear in the patient's records on 15 March 2016. The Committee infers that no such radiographs were taken. The Committee accepts the expert evidence of Dr Igoe that this amounts to a failure to adequately assess a probable periodontal abscess at Patient 2's UL7.
17. b)	*you did not carry out a periodontal assessment.* **Proved**

	The Committee finds the facts alleged at head of charge 17 (b) proved. The Committee accepts the expert evidence of Dr Igoe that Mr Starkey was under a duty to carry out a periodontal assessment in light of his identification of a probable periodontal abscess. The Committee notes that there is no entry in the patient's notes to suggest that Mr Starkey conducted a periodontal assessment, and it infers that he did not carry out such an assessment. The Committee accepts the expert evidence of Dr Igoe that this amounts to a failure to adequately assess a probable periodontal abscess at Patient 2's UL7.
18.	*On 15 March 2016 you inappropriately prescribed antibiotics.* **Proved**
	The Committee finds the facts alleged at head of charge 18 proved. The Committee notes from Mr Starkey's entry in the patient's notes on 15 March 2016 that Mr Starkey prescribed antibiotics to Patient 2. The Committee accepts Dr Igoe's expert evidence that antibiotics should be an adjunct to treatment and should not constitute treatment itself. The Committee notes Dr Igoe's evidence that, no other treatment took place, and that there was also an apparent lack of a definitive diagnosis and proper investigations, such as percussion and vitality tests, of the probable periodontal abscess.
19.	*On 12 May 2016 you provided a crown at UL5 and failed to carry out root canal treatment.* **Proved**
	The Committee finds the facts alleged at head of charge 19 proved. The Committee notes from Mr Starkey's entries in Patient 2's notes that on 12 May 2016 Mr Starkey provided a crown at the patient's UL5. Mr Starkey recorded in the notes on 11 April 2016 that there was a longstanding periapical infection around the UL5, but that the tooth was asymptomatic. The Committee notes that on 11 April 2016 a periapical radiograph taken by Mr Starkey revealed a large area of infection around the UL5. The Committee accepts the expert evidence of Dr Igoe that root canal treatment (RCT) was required before the possible crowning of the tooth in light of the presence of a large area of infection around the UL5.
Patient 3	
Clinical	
20.	*On 15 December 2015 you failed to:*

20. a)	*report on bitewing and/or periapical radiographs;* **Proved**
	The Committee finds the facts alleged at head of charge 20 (a) proved. The Committee notes that on 15 December 2015 Mr Starkey took bitewing and periapical radiographs. The Committee accepts the expert evidence of Dr Igoe that Mr Starkey was under a duty to report on those radiographs under the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). The Committee infers from the absence of a report on those radiographs that he did not make such a report.
20. b)	*adequately record your clinical findings and/or diagnoses.* **Proved**
	The Committee finds the facts alleged at head of charge 20 (b) proved. The Committee notes that Mr Starkey made some entries in the patient's notes about clinical findings and diagnoses, such as an abscess as reported to him by the patient and that a crown was required. The Committee accepts the expert evidence of Dr Igoe that there were clinical findings and diagnoses that Mr Starkey failed to record in light of the radiographs that he took. As there is no adequate record of clinical findings and diagnoses, Mr Starkey failed in this duty.
21.	*You failed to identify and/or appropriately treat caries visible on bitewing radiographs dated 15 December 2015 at:*
21. a)	*LR6;* **Proved**
21. b)	*UL4:* **Proved**
21. c)	*UL5;* **Proved**
21. d)	*UL6;* **Proved**
21. e)	*UL7;* **Proved**
21. f)	*LL6.* **Proved**

	The Committee finds the facts alleged at heads of charge 21 (a), 21 (b), 21 (c), 21 (d), 21 (e) and 21 (f) proved. The Committee has had sight of bitewing radiographs taken on 15 December 2015. Dr Igoe's evidence is that those radiographs demonstrate that caries was present at LR6, UL4, UL5, UL6, UL7 and LL6. The Committee accepts Dr Igoe's evidence in this regard. The Committee notes that Mr Starkey made no entries in the patient's records on 15 December 2015 and thereafter to suggest that he identified and treated caries at these teeth, and it infers that he failed to identify and treat caries as required.
22.	*On 28 January 2016 you failed to adequately record an examination and oral health review.* **Proved**
	The Committee finds the facts alleged at head of charge 22 proved. The Committee notes from the patient's records that on 28 January 2016 Mr Starkey recorded that an examination and oral health review took place. The Committee accepts the expert evidence of Dr Igoe that this was not an adequate record of the examination and oral health review of Patient 3, and that Mr Starkey was under a duty to make such an adequate record of those matters.
<u>Claiming</u>	
23.	*You caused or permitted two separate claims [68273 & 68496] to be submitted as Band 3 courses of treatment in respect of the same treatment provided incorporating a crown at UR1.* **Proved**
	The Committee finds the facts alleged at head of charge 23 proved. The Committee notes that Mr Starkey made two separate Band '3' claims within a short period of time in respect of the same course of treatment incorporating a crown at Patient 3's UR1. The first claim related to the preparation of the crown and the second claim related to the fitting of the crown. The Committee accepts the expert evidence of Dr Igoe that this amounts to causing two claims for one course of treatment.
24.	*You thereby obtained an additional 12 UDAs to which you were not entitled.* **Proved**
	The Committee finds the facts alleged at head of charge 24 proved. The Committee accepts the expert evidence of Dr Igoe that, in having submitted two claims for the same course of treatment, Mr Starkey

	obtained 12 additional UDAs to which he was not entitled.
25.	*Your conduct as set out above at 24 was:*
25. a)	*misleading;* **Proved**
	The Committee finds the facts alleged at head of charge 25 (a) proved. The Committee considers that the claims that Mr Starkey submitted were false and attracted UDAs to which he was not entitled, and that they were therefore misleading. The reader of those claims would have been entitled to expect that the information contained in the claims was true and accurate. As the forms were not in fact true and accurate in the ways set out above at head of charge 24, the claims were misleading.
25. b)	*lacking in integrity, in that you failed to ensure your claims complied with the relevant regulations.* **Proved**
	The Committee finds the facts alleged at head of charge 25 (b) proved in respect of head of charge 24. The Committee finds that, in submitting the false claims set out at head of charge 24, Mr Starkey lacked integrity because he failed to ensure that his claims were true and accurate.
Patient 4	
<u>Clinical</u>	
26.	*On 3 October 2014 you provided a substandard restoration at LR6.* **Proved**
	The Committee finds the facts alleged at head of charge 26 proved. The Committee notes that on 3 October 2014 Mr Starkey provided a restoration at Patient 4's LR6. The Committee notes the expert evidence of Dr Igoe that the restoration was substandard and that Mr Starkey should have provided RCT because of the presence of caries. The Committee accepts the expert evidence of Dr Igoe that RCT was required to provide for an adequate restoration, and as Mr Starkey did not proceed in this manner it follows that the restoration that he provided was substandard.
27.	*Between 18 December 2014 and about 5 June 2015:*
27. a)	*you failed to adequately investigate and/or formulate a treatment plan*

	for LR6 which you noted as having an abscess; **Proved**
	The Committee finds the facts alleged at head of charge 27 (a) proved. On 18 December 2014 Mr Starkey noted an abscess and swelling at the patient's LR6. At that appointment Mr Starkey recorded that he took a radiograph, that he prescribed antibiotics, and that the patient would come again after the tooth had settled for a possible RCT or extraction. The Committee considers that this was an adequate investigation and treatment plan at this appointment. However, the patient returned to Mr Starkey on subsequent occasions, and Dr Igoe is critical of Mr Starkey's failure to address the problems at LR6 at those later appointments. The Committee accepts this expert evidence and finds that, taking the period of time as a whole after 18 December 2014, Mr Starkey failed to adequately investigate and formulate a treatment plan for the patient's LR6.
27. b)	*you proceeded with cosmetic treatment without having adequately investigated and treated the LR6.* **Proved**
	The Committee finds the facts alleged at head of charge 27 (b) proved. As set out above in respect of head of charge 27 (a), Mr Starkey failed to adequately investigate and treat the patient's LR6. Mr Starkey nonetheless proceeded to provide cosmetic treatment, including teeth whitening, and the Committee therefore finds the facts alleged at this head of charge proved.
28.	*You failed to adequately review or report on bitewings dated 2 April 2015.* **Proved**
	The Committee finds the facts alleged at head of charge 28 proved. The Committee notes from the evidence presented to it on 2 April 2015 Mr Starkey recorded that he took bitewing radiographs. The Committee notes that there is no entry to suggest that Mr Starkey either reviewed or reported on those radiographs on 2 April 2015 or thereafter. The Committee infers from this that Mr Starkey did not do so. The Committee accepts the expert evidence of Dr Igoe that Mr Starkey was under a duty to review and report on the radiographs, and the Committee finds that Mr Starkey failed in this duty.
29.	*You failed to treat caries visible on bitewing radiographs dated 2 April 2015 at:*
29. a)	*LR6;*

	Proved
29. b)	*UR5;* **Proved**
29. c)	*UR4;* **Proved**
29. d)	*UL7.* **Proved**
	The Committee finds the facts alleged at heads of charge 29 (a), 29 (b), 29 (c) and 29 (d) proved. The Committee has had sight of bitewing radiographs dated 2 April 2015 which demonstrate the presence of caries at the patient's LR6, UR5, UR4 and UL7. Dr Igoe's evidence is that those radiographs demonstrate that caries was present at these teeth. The Committee accepts Dr Igoe's evidence in this regard. The Committee notes that Mr Starkey made no entries in the patient's records on 2 April 2015 and thereafter to suggest that he identified and treated caries at these teeth, and it infers from this that he failed to identify and treat caries as required.
30.	*You failed to keep complete and accurate records on 8 May 2015 in that:*
30. a)	*you did not adequately record which teeth were prepared for a bridge in the Upper Left Quadrant ('ULQ');* **Proved**
	The Committee finds the facts alleged at head of charge 30 (a) proved. The Committee has had regard to Mr Starkey's notes for the patient on 8 May 2015 regarding a bridge for the upper left quadrant. Mr Starkey's entry did not identify which teeth were being prepared for that bridge. The Committee accepts the expert of Dr Igoe that this was an inadequate record, and the Committee finds that this amounts to a failure to keep complete and accurate records on 8 May 2015.
30. b)	*you did not record the refusal or use of Local Anaesthetic.* **Not proved**
	The Committee finds the facts alleged at head of charge 30 (b) not proved. The Committee notes from Mr Starkey's entry on 8 May 2015 that there are no references to local anaesthetic. The expert evidence of Dr Igoe is that one would 'normally see' either the use or non-use of local anaesthetic, and that it is likely that it was not used. The Committee has no information about whether local anaesthetic was

	used. As it may have been the case that local anaesthetic was simply not used, rather than being specifically refused, the Committee considers that the GDC has not demonstrated to the standard required that local anaesthetic was used or refused.
31.	*You did not adequately discuss, or adequately record discussion, with Patient 4 regarding the risks, benefits or alternative treatments to the proposed bridge at UL3-UL6.* **Proved**
	The Committee finds the facts alleged at head of charge 31 proved. The Committee notes from the entries that Mr Starkey provided for Patient 4 that he made no entries about discussions with Patient 4 about the risks, benefits and alternative treatment options for the proposed bridge at UL3 to UL6. The Committee infers from this that such discussions did not take place. In reaching this finding the Committee has also had regard to the evidence of Patient 4 that Mr Starkey did not adequately discuss with her the risks, benefits or alternative treatment options concerning the bridge that was proposed at UL3 to UL6, save for a brief discussion about the design of the bridge.
32.	*You failed to obtain informed consent to the bridge at UL3-UL6.* **Proved**
	The Committee finds the facts alleged at head of charge 32 proved. As Mr Starkey did not adequately discuss the risks, benefits and treatment options with Patient 4 in relation to the bridge at UL3 to UL6, it follows that Mr Starkey failed in his duty to obtain informed consent for that treatment.
33.	*In May 2015 you failed to adequately assess the suitability of UL3 and/or UL6 as support for a bridge in that:*
33. a)	*you did not undertake appropriate radiographic assessment;* **Proved**
	The Committee finds the facts alleged at head of charge 33 (a) proved. The Committee notes that Patient 4 attended Mr Starkey at appointments in May 2015 for a bridge. The Committee notes from the records that preparations were done on UL3 and UL6, but that there are no records to suggest that Mr Starkey assessed the suitability of those teeth as supports for the bridge that was being planned by way of radiographic assessment. The Committee infers from this that Mr Starkey did not undertake appropriate radiographic assessment. The Committee accepts the criticisms of Dr Igoe that Mr

	Starkey should have taken periapical radiographs. As Mr Starkey did not undertake appropriate radiographic assessment, the Committee finds that Mr Starkey failed to adequately assess the suitability of UL3 and UL6.
33. b)	*you did not carry out a periodontal assessment.* **Proved**
	The Committee finds the facts alleged at head of charge 33 (b) proved. The Committee again notes from the records that preparations were done on UL3 and UL6, but that there are no references to suggest that Mr Starkey assessed the suitability of those teeth as supports for the bridge that was being planned by way of a periodontal assessment. The Committee infers from this that Mr Starkey did not carry out a periodontal assessment. The Committee once more accepts the criticisms of Dr Igoe that Mr Starkey should have carried out a periodontal assessment. As Mr Starkey did not do so, the Committee finds that Mr Starkey failed to adequately assess the suitability of UL3 and UL6.
34.	*On 15 May 2015 you failed to adequately assess the suitability of the UR1 and/or UR2 for crowns in that you did not undertake appropriate radiographic assessment.* **Proved**
	The Committee finds the facts alleged at head of charge 34 proved. The Committee notes that Patient 4 attended for an appointment with Mr Starkey on 15 May 2015 for the purposes of the preparation of crowns at UR1 and UR2. The Committee notes that there are no records to suggest that Mr Starkey assessed the suitability of those teeth for crowns by way of radiographic assessment. The Committee infers from this that Mr Starkey did not carry out appropriate radiographic assessment. The Committee accepts the criticisms of Dr Igoe that Mr Starkey should have undertaken such radiographic assessment. As Mr Starkey did not undertake appropriate radiographic assessment, the Committee finds that Mr Starkey failed to adequately assess the suitability of the UR1 and UR2.
35.	*On 11 January 2016 you failed to adequately assess the suitability of the LL2, LR1 and/or LR2 as support for a replacement bridge in that:*
35. a)	*you did not undertake appropriate radiographic assessment;* **Proved**
	The Committee finds the facts alleged at head of charge 35 (a) proved. The Committee notes that Patient 4 attended for an

	appointment with Mr Starkey in connection with preparation for a replacement bridge on 11 January 2016. Dr Igoe's evidence is that LL2, LR1 and LR2 would have been used as support for a replacement bridge. The Committee notes that there are no records to suggest that Mr Starkey assessed the suitability of those teeth by way of radiographic assessment. The Committee infers from this that Mr Starkey did not carry out appropriate radiographic assessment. The Committee accepts the criticisms of Dr Igoe that Mr Starkey should have undertaken such radiographic assessment. As Mr Starkey did not undertake appropriate radiographic assessment, the Committee finds that Mr Starkey failed to adequately assess the suitability of the UR1 and UR2.
35. b)	*you did not carry out a periodontal assessment.* **Proved**
	The Committee finds the facts alleged at head of charge 35 (b) proved. The Committee notes from the records that there are no references to suggest that Mr Starkey assessed the suitability of those teeth as supports for the bridge that was being planned by way of a periodontal assessment. The Committee infers from this that Mr Starkey did not carry out a periodontal assessment. The Committee once more accepts the criticisms of Dr Igoe that Mr Starkey should have carried out a periodontal assessment. As Mr Starkey did not do so, the Committee finds that Mr Starkey failed to adequately assess the suitability of LL2, LR1 and LR2.
36.	*You did not adequately discuss, or adequately record discussion, with Patient 4 regarding risks, benefits or alternative treatments to the proposed bridge at LL2-LR2.* **Proved**
	The Committee finds the facts alleged at head of charge 36 proved. The Committee notes from the entries that Mr Starkey provided for Patient 4 that he made no entries about discussions with Patient 4 regarding the risks, benefits and alternative treatment options for the proposed bridge at LL2 to LR2. The Committee infers from this that such discussions did not take place. In reaching this finding the Committee has also had regard to the evidence of Patient 4 that Mr Starkey did not adequately discuss with her the risks, benefits or alternative treatment options concerning the bridge that was proposed at LL2 to LR2.
37.	*You failed to obtain informed consent to the bridge at LL2-LR2.*

	Proved
	The Committee finds the facts alleged at head of charge 37 proved. As Mr Starkey did not adequately discuss the risks, benefits and treatment options with Patient 4 in relation to the bridge at LL2 to LR2, it follows that Mr Starkey failed in his duty to obtain informed consent for that treatment.
Claiming	
38.	*You caused or permitted a claim [63537] to be submitted for a Band 1 course of treatment which ought to have formed part of a single course of treatment and one Band 3 claim [64014].* **Proved**
	The Committee finds the facts alleged at head of charge 38 proved. The Committee notes from Patient 4's records that on 16 April 2015 Mr Starkey submitted a claim for a Band '1' course of treatment which had commenced one month previously on 17 March 2015. Dr Igoe's expert evidence is that the claim should not have been submitted as a separate claim and instead should have formed part of the single course of Band '3' treatment which Mr Starkey subsequently claimed. The Committee is satisfied that these two claims relate to the same course of treatment.
39.	*You thereby obtained an additional 1 UDA to which you were not entitled.* **Proved**
	The Committee finds the facts alleged at head of charge 39 proved. The Committee accepts the expert evidence of Dr Igoe that, having submitted a claim for one Band '1' UDA instead of incorporating that treatment into the single course of Band '3' treatment for which he claimed, Mr Starkey obtained an additional UDA to which he was not entitled.
40.	*Your conduct set out above at 39 was:*
40. a)	*misleading;* **Proved**
	The Committee finds the facts alleged at head of charge 40 (a) proved. The Committee considers that the claim that Mr Starkey submitted was false and attracted a UDA to which he was not entitled, and that it was therefore misleading. The reader of the claim would have been entitled to expect that the information contained in the claim was true and accurate. As the claim was not in fact true and

	accurate in the ways found in respect of head of charge 39, the claim was misleading.
40. b)	*lacking in integrity, in that you failed to ensure your claims complied with the relevant regulations.* **Proved**
	The Committee finds the facts alleged at head of charge 40 (b) proved. The Committee finds that, in submitting the false claim set out at head of charge 39, Mr Starkey lacked integrity because he failed to ensure that his claim was true and accurate.
Patient 5	
Clinical	
41.	*You failed to report on bitewing radiographs dated 2 February 2015.* **Proved**
	The Committee finds the facts alleged at head of charge 41 proved. The Committee notes that Mr Starkey took bitewing radiographs for Patient 5 on 2 February 2015. The Committee notes that there is no report in the patient's records on those radiographs on or after that date. The Committee accepts the expert evidence of Dr Igoe that Mr Starkey was under a duty to report on the radiographs. As Mr Starkey failed to do so the Committee finds the facts alleged at head of charge 41 proved.
42.	*Prior to 2 July 2015 you failed to adequately assess the suitability of UR2 and/or UL1 to support a proposed bridge at UR2-UL1 in that:*
42. a)	*you did not undertake appropriate radiographic assessment;* **Proved**
	The Committee finds the facts alleged at head of charge 42 (a) proved. The Committee notes that a bridge was proposed at UR2 to UL1, with the bridge being fitted on 2 July 2015. The Committee accepts the expert evidence of Dr Igoe that the suitability of UR2 and UL1 would have had to be assessed. The Committee notes that there are no records to suggest that Mr Starkey assessed the suitability of those teeth by way of radiographic assessment. The Committee infers from this that Mr Starkey did not carry out appropriate radiographic assessment. The Committee accepts the criticisms of Dr Igoe that Mr Starkey should have undertaken such radiographic assessment. As Mr Starkey did not undertake appropriate radiographic assessment, the Committee finds that Mr Starkey failed to adequately assess the suitability of the UR2 and UL1.

42. b)	*you did not carry out a periodontal assessment.* **Proved**
	The Committee finds the facts alleged at head of charge 42 (b) proved. The Committee notes from the records that there are no references to suggest that Mr Starkey assessed the suitability of the UR2 and UL1 as supports for the bridge that was being planned by way of a periodontal assessment. The Committee infers from this that Mr Starkey did not carry out a periodontal assessment. The Committee once more accepts the criticisms of Dr Igoe that Mr Starkey should have carried out a periodontal assessment. As Mr Starkey did not do so, the Committee finds that Mr Starkey failed to adequately assess the suitability of UR2 and UL1.
43.	*You did not adequately discuss, or adequately record discussion, with Patient 5 regarding the risks, benefits and alternatives to the proposed bridge at UR2-UL1.* **Proved**
	The Committee finds the facts alleged at head of charge 43 proved. The Committee notes from the entries that Mr Starkey provided for Patient 5 that he made no entries about discussions with Patient 5 about the risks, benefits and alternative treatment options for the proposed bridge at UR2 to UL1. The Committee infers from this that such discussions did not take place. In reaching this finding the Committee has also had regard to the evidence of Patient 5 that Mr Starkey did not adequately discuss with her the risks, benefits or alternative treatment options concerning the bridge that was proposed at UR2 to UL1.
44.	*You failed to obtain informed consent to the bridge at UR2-UL1.* **Proved**
	The Committee finds the facts alleged at head of charge 44 proved. As Mr Starkey did not adequately discuss the risks, benefits and treatment options with Patient 5 in relation to the bridge at UR2 to UL1, it follows that Mr Starkey failed in his duty to obtain informed consent for that treatment.
45.	*Prior to 21 April 2016 you failed to adequately assess the suitability of UR3 and/or UR5 to support a proposed bridge at UR3-UR5 in that:*
45. a)	*you did not undertake appropriate radiographic assessment;* **Proved**
	The Committee finds the facts alleged at head of charge 45 (a)

	proved. The Committee notes that a bridge was proposed at UR3 to UR5, with the bridge being fitted on 21 April 2016. The Committee accepts the expert evidence of Dr Igoe that the suitability of UR3 and UR5 would have had to be assessed. The Committee notes that there are no records to suggest that Mr Starkey assessed the suitability of those teeth by way of radiographic assessment. The Committee infers from this that Mr Starkey did not carry out appropriate radiographic assessment. The Committee accepts the criticisms of Dr Igoe that Mr Starkey should have undertaken such radiographic assessment. As Mr Starkey did not undertake appropriate radiographic assessment, the Committee finds that Mr Starkey failed to adequately assess the suitability of the UR3 and UR5.
45. b)	*you did not carry out a periodontal assessment.* **Not proved**
	The Committee finds the facts alleged at head of charge 45 (b) not proved. The Committee notes from the records that the only reference to a BPE having been undertaken was on 11 April 2016. The resulting BPE scores are not recorded. Although the record that Mr Starkey made was, as Dr Igoe opines, poor, the record that was made does suggest that a periodontal assessment was in fact carried out. The Committee therefore finds the facts alleged at head of charge 45 (b) not proved.
46.	*Between 11 April 2016 and 21 April 2016 you did not adequately discuss, or adequately record discussion, with Patient 5 regarding the risks, benefits and alternatives to the proposed bridge UR3-UR5.* **Proved**
	The Committee finds the facts alleged at head of charge 46 proved. The Committee notes from the entries that Mr Starkey provided for Patient 5 that he made no entries about discussions with Patient 5 about the risks, benefits and alternative treatment options for the proposed bridge at UR3 to UR5. The Committee infers from this that such discussions did not take place. The Committee accepts the expert evidence of Dr Igoe that such discussions were required. The Committee also accepted the evidence of Patient 5 that Mr Starkey did not adequately discuss with her the risks, benefits or alternative treatment options concerning the bridge that was proposed at UR3 to UR5.
47.	*You failed to obtain informed consent to the bridge at UR3-UR5.*

	Proved
	The Committee finds the facts alleged at head of charge 47 proved. As Mr Starkey did not adequately discuss the risks, benefits and treatment options with Patient 5 in relation to the bridge at UR3 to UR5, it follows that Mr Starkey failed in his duty to obtain informed consent for that treatment.
Patient 6	
Clinical	
48.	*On 10 June 2014 you failed to take bitewing radiographs.* **Proved**
	The Committee finds the facts alleged at head of charge 48 proved. The Committee notes from the records that Mr Starkey made for Patient 6 that the patient attended for an examination appointment with him on 10 June 2014. The Committee notes that there are no records to suggest that bitewing radiographs were taken. The expert evidence of Dr Igoe is that bitewing radiographs should have been taken as they had not been taken previously. Dr Igoe's evidence is that bitewing radiographs should have been taken every two years for Patient 6. The Committee finds that Mr Starkey was under a duty to take bitewing radiographs at the appointment in question, and that as he failed in this duty the Committee finds the facts alleged at this head of charge proved.
Patient 7	
Clinical	
49.	*You failed to take bitewing radiographs on:*
49. a)	*21 August 2014;* **Proved**
	The Committee finds the facts alleged at head of charge 49 (a) proved. The Committee notes that Patient 7 attended an appointment with Mr Starkey on 21 August 2014. Mr Starkey recorded in the patient's notes that bitewings were not needed at that appointment. The Committee accepts the expert evidence of Dr Igoe that Mr Starkey was in fact under a duty to take bitewing radiographs at that appointment given that it had been some years since such radiographs had been taken. Radiographs were further required in light of the presentation of a broken filling at LL4. Dr Igoe's evidence is also that there was undetected caries at UR4 and UL3 which were subsequently identified on radiographic examination, which further

	demonstrates that radiographs should have been taken. The Committee also accepts this evidence. For these reasons Mr Starkey failed in his duty to take radiographs.
49. b)	*11 June 2015.* **Proved**
	The Committee finds the facts alleged at head of charge 49 (b) proved. The Committee notes that the patient saw Mr Starkey on 11 June 2015. Mr Starkey recorded in the patient's notes that bitewings were not needed at that appointment. The Committee accepts the expert evidence of Dr Igoe that Mr Starkey was in fact under a duty to take bitewing radiographs at that appointment given that, as set out at head of charge 49 (a), it had been some years since such radiographs had been taken and radiographs had not been taken at the appointment on 21 August 2014. Radiographs were further required in light of the presentation of a lost filling at UL5. Dr Igoe's evidence is also that there were undetected caries at UR4 and UL3 which were subsequently identified on radiographic examination, which further demonstrates that radiographs should have been taken. For these reasons Mr Starkey failed in his duty to take radiographs.
50.	*On 26 February 2016 you failed to adequately record a treatment plan in respect of a bridge at LR1-LR2.* **Not proved**
	The Committee finds the facts alleged at head of charge 50 not proved. The Committee notes that Mr Starkey recorded that he provided a treatment plan. The purpose of the appointment appears to have been an examination. At the next appointment on 14 March 2016 the patient attended for the taking of impressions for a bridge. This leads to the Committee to conclude that at the appointment on 26 February 2016 a bridge was being envisaged, and the treatment plan to which Mr Starkey briefly referred in the patient's clinical notes was in connection with that bridge. However, the Committee notes that in addressing this head of charge Dr Igoe stated in his written evidence that he would not be critical if a treatment plan had been provided to the patient but not retained. As set out above the Committee considers that it appears that a treatment plan was provided. Having found that Mr Starkey did provide a treatment plan, the Committee is not satisfied that the GDC has demonstrated that Mr Starkey was under a duty to adequately record a treatment plan. Accordingly the Committee finds the facts alleged at this head of charge not proved.

51.	*On 26 February 2016 and/or 14 March 2016 you failed to adequately assess the suitability of LR2 as support for a bridge at LR1-LR2 in that:*
51. a)	*you did not undertake appropriate radiographic assessment;* **Proved**
	The Committee finds the facts alleged at head of charge 51 (a) proved. The Committee notes that Mr Starkey recorded at the appointment on 26 February 2016 that bitewing radiographs should be taken at the next appointment. The Committee notes that at the next appointment on 14 March 2016 Mr Starkey made no record of having taken such bitewing radiographs, and it infers from this that he did not take such radiographs. Although Mr Starkey recorded on 26 February 2016 that two bitewing radiographs were taken, the Committee concludes that radiographs were not in fact taken by Mr Starkey either at that appointment or at the subsequent appointment on 14 March 2016. Instead bitewing radiographs were taken by another practitioner on 15 March 2016. In any event, even if bitewing radiographs had been taken, the Committee considers that this would not have amounted to appropriate radiographic assessment, as periapical radiographs were also required. The Committee accepts the expert evidence of Dr Igoe that Mr Starkey was under a duty to undertake appropriate radiographic assessment of the patient's LR2 in order to determine its suitability as a support for a bridge at LR1 to LR2. As Mr Starkey did not take appropriate radiographs at either appointment, he failed in his duty to adequately assess the suitability of LR2.
51. b)	*you did not carry out a periodontal assessment.* **Not proved**
	The Committee finds the facts alleged at head of charge 51 (b) not proved. The Committee notes that on 26 February 2016 Mr Starkey recorded that he had undertaken a BPE. Although this is an inadequate record, the Committee considers that the record, such as it is, suggests that a periodontal assessment was in fact conducted. The Committee finds that Mr Starkey was not under a recurring duty to carry out a periodontal assessment at the next appointment which took place on 14 March 2016 in light of him apparently having conducted a periodontal assessment at the earlier appointment on 26 February 2016. The Committee notes that Dr Igoe is critical of a record-keeping failure in respect of a periodontal assessment, but in finding this head of charge not proved the Committee is mindful that

	the allegation relates to a carrying out of a periodontal assessment, rather than a recording of the same.
52.	*You failed to adequately review or adequately report on bitewing radiographs dated 15 March 2016.* **Proved**
	The Committee finds the facts alleged at head of charge 52 proved. As noted above bitewing radiographs were taken by another practitioner, who is a dental therapist, on 15 March 2016. The Committee accepts the expert evidence of Dr Igoe that Mr Starkey was under a duty to review and report on those radiographs. The Committee infers from the absence of a record of a review or report on the radiographs that no such review or report was done by Mr Starkey. As Mr Starkey did not conduct such a review or report, he failed in his duty to do so.
53.	*You failed to identify and/or treat caries visible on bitewing radiographs dated 15 March 2016 at:*
53. a)	*UR4;* **Proved**
53. b)	*UL3;* **Proved**
	The Committee finds the facts alleged at heads of charge 53 (a) and 53 (b) proved. The Committee accepts the expert evidence of Dr Igoe that caries was visible at the patient's UR4 and UL3 on the bitewing radiographs taken on 15 March 2016. The Committee found above at head of charge 52 that Mr Starkey did not review or report on the radiographs, and there is no other evidence to indicate that Mr Starkey identified and treated those caries. The Committee infers from the absence of a record of Mr Starkey's identification and treatment of caries at these two teeth that he did not identify and treat caries. The Committee accepts the expert evidence of Dr Igoe that Mr Starkey was under a duty to do so, and because the Committee finds that Mr Starkey did not identify and treat caries it follows that he failed in his duty to do so.
<u>Claiming</u>	
54.	*You caused or permitted a claim [67743] to be submitted for a Band 2 course of treatment which ought to have formed part of a single course of treatment and one Band 3 claim [68131].* **Proved**

	The Committee finds the facts alleged at head of charge 54 proved. The Committee notes from Patient 1's records that on 26 February 2016 Mr Starkey submitted a claim for three UDAs as a Band '2' course of treatment. Dr Igoe's expert evidence is that the claim should not have been submitted as a separate claim and instead should have formed part of the single course of Band '3' treatment for which Mr Starkey claimed on 31 March 2016.
55.	*You thereby obtained an additional 3 UDAs to which you were not entitled.* **Proved**
	The Committee finds the facts alleged at head of charge 55 proved. The Committee accepts the expert evidence of Dr Igoe that, having submitted a claim for three UDAs as a separate Band '2' treatment instead of incorporating that treatment as part of a single course of Band '3' treatment as he should have done, Mr Starkey obtained three additional UDAs to which he was not entitled.
56.	*Your conduct as set out above at 55 was:*
56. a)	*misleading;* **Proved**
	The Committee finds the facts alleged at head of charge 56 (a) proved. The Committee considers that the claim that Mr Starkey submitted was false and attracted UDAs to which he was not entitled, and that it was therefore misleading. The reader of the claim would have been entitled to expect that the information contained in the claim was true and accurate. As the claim was not in fact true and accurate in the ways set out above, the claim was misleading.
56. b)	*lacking in integrity, in that you failed to ensure your claims complied with the relevant regulations.* **Proved**
	The Committee finds the facts alleged at head of charge 56 (b) proved. The Committee finds that, in submitting the false claim referred to at head of charge 55, Mr Starkey lacked integrity because he failed to ensure that his claim was true and accurate.
Patient 8	
<u>Clinical</u>	
57.	*In April 2016:*
57. a)	*you failed to use, or record the use, of rubber dam;*

	Proved
	The Committee finds the facts alleged at head of charge 57 (a) proved. The Committee notes from the records that Mr Starkey made for Patient 8 that there is no entry to suggest that rubber dam was used. Dr Igoe's evidence is that, as local anaesthetic was used for irrigation of the canal, it would be highly unlikely that Mr Starkey used rubber dam as the two are incompatible. Dr Igoe is critical of Mr Starkey's use of local anaesthetic as an irrigant and states that Mr Starkey should have used a sodium hypochlorite bleach solution as an irrigant, with rubber dam to protect the airway. The Committee accepts this evidence, and also infers from the absence of a record of Mr Starkey using rubber dam that rubber dam was not used. The Committee accepts Dr Igoe's expert evidence that Mr Starkey should have used rubber dam, and that as he did not do so Mr Starkey failed in his duty.
57. b)	*you provided substandard root canal care and treatment at UL5 in that:*
57. b) i	*you failed to take a pre-operative radiograph;* **Proved**
	The Committee finds the facts alleged at head of charge 57 (b) (i) proved. The Committee notes from the patient's records that there are no, and no references to, preoperative radiographs. The Committee infers that such a radiograph was not taken. There is reference to bitewing radiographs having been taken previously in February 2016, but even if taken these would not have been sufficient for preoperative radiographic examination. The Committee accepts the expert evidence of Dr Igoe that Mr Starkey was under a duty to take a preoperative radiograph prior to embarking upon RCT. As he failed to do so, the Committee considers that this amounts to substandard root canal care and treatment of the patient's UL5.
57. b) ii	*you used local anaesthetic as the canal irrigant;* **Proved**
	The Committee finds the facts alleged at head of charge 57 (b) (ii) proved. As noted above, local anaesthetic was used for irrigation of the canal. Dr Igoe is critical of Mr Starkey's use of local anaesthetic as an irrigant, as it has no antibacterial properties, and instead states that Mr Starkey should have used a sodium hypochlorite bleach solution as an irrigant, with rubber dam to protect the airway. The Committee considers that Mr Starkey's use of local anaesthetic amounted to substandard root canal care and treatment of the

	patient's UL5.
57. b) iii	*you failed to take a post-operative radiograph.* **Not proved**
	The Committee finds the facts alleged at head of charge 57 (b) (iii) not proved. The Committee notes that Mr Starkey took a postoperative periapical radiograph on 12 April 2016, which was the date on which RCT was undertaken. Mr Starkey recorded his grading of that radiograph. Dr Igoe stated in evidence that such a radiograph was not available to him. The Committee considers that, as there is evidence to suggest that a postoperative radiograph was taken, the facts alleged at this head of charge are not proved.
Patient 9	
Clinical	
58.	*On 23 September 2014, or prior to the provision of a bridge at UR2-UL2 and/or veneers at UL3 to UR3, you failed to undertake adequate radiographic assessment in that:*
58. a)	*you failed to take sufficient periapical radiographs;* **Proved**
	The Committee finds the facts alleged at head of charge 58 (a) proved. Dr Igoe's evidence is that the periapical radiographs that Mr Starkey took, were insufficient as they would not have shown all of the teeth that were to be treated. Dr Igoe referred in particular to the absence of radiographic exposure of the UL2 and UL3. The Committee has reviewed the radiographs and associated records and accepts Dr Igoe's evidence. The Committee accepts the expert evidence of Dr Igoe that Mr Starkey was under a duty to take sufficient periapical radiographs prior to the provision of a bridge at UR2 to UL2 and veneers at UL3 to UR3, and that as he did not do so Mr Starkey failed in his duty to undertake an adequate radiographic assessment.
58. b)	*you failed to take bitewing radiographs.* **Proved**
	The Committee finds the facts alleged at head of charge 58 (b) proved. The Committee notes that on 23 September 2014 Mr Starkey recorded that bitewings were not needed. The Committee infers from this that bitewing radiographs were not taken, and it also notes that there is no other evidence to suggest or demonstrate that bitewing radiographs were taken. The Committee accepts the expert evidence

	of Dr Igoe that Mr Starkey was under a duty to take bitewing radiographs prior to the provision of a bridge at UR2 to UL2 and veneers at UL3 to UR3, and that as he did not do so Mr Starkey failed in his duty to undertake an adequate radiographic assessment.
59.	*You failed to adequately treat caries identified at UL8.* **Proved**
	The Committee finds the facts alleged at head of charge 59 proved. On 23 September 2014 Mr Starkey recorded that UL8 should be watched, although there was no diagnosis of caries, with advice given about a later extraction. Dr Igoe's evidence is that it was likely that Mr Starkey had recognised caries, but that he did not then treat caries. A subsequent treating dentist saw Patient 9, who was complaining of pain, on 5 February 2015 and recorded UL8 as 'badly decayed'. The Committee accepts Dr Igoe's evidence that Mr Starkey was under a duty to adequately treat caries at UL8, and that as he did not do so he failed in this duty.
60.	*You proposed an inappropriate bridge design at UR2-UL2 in that UR1 was not suitable for use to support the bridge due to a failing root filling as visible on a radiograph dated 23 September 2014.* **Proved**
	The Committee finds the facts alleged at head of charge 60 proved. The Committee accepts the expert evidence of Dr Igoe that the UR1 was not a suitable support for a bridge spanning UR2 to UL2, as it had a failing root filling. The Committee accepts the evidence of Dr Igoe that the bridge was likely to fail as a result of insufficient support. The bridge was therefore of inappropriate design.
61.	*On 12 August 2015 Patient 9 attended in connection with a probable abscess at LR4 and:*
61. a)	*you failed to take a periapical radiograph;* **Proved**
	The Committee finds the facts alleged at head of charge 61 (a) proved. The Committee notes that there is no evidence in the notes to suggest that Mr Starkey took a periapical radiograph, and the Committee infers that he did not do so. The Committee accepts the expert evidence of Dr Igoe that Mr Starkey should have taken a periapical radiograph as a relevant investigation into the patient's complaint of pain, and that as he did not do so he failed in this duty.
61. b)	*you inappropriately prescribed antibiotics;*

	Proved
	The Committee finds the facts alleged at head of charge 61 (b) proved. The Committee accepts Dr Igoe's expert evidence that antibiotics should be an adjunct to treatment and should not constitute treatment itself. The Committee notes an apparent lack of a definitive diagnosis and proper investigations, such as percussion and vitality tests, and a lack of substantive treatment. It therefore finds that Mr Starkey's prescription of antibiotics was inappropriate.
61. c)	*you inappropriately continued treatment at UR1 to UL3.* **Not proved**
	The Committee finds the facts alleged at head of charge 61 (c) not proved. Having considered the evidence presented to it, with particular regard to the patient's records, the Committee considers that the GDC has not demonstrated that treatment was continued at UR1 to UL3 on the date alleged, namely 12 August 2015.
62.	*On 1 February 2016 you provided an apicectomy at UR1 and thereafter failed to allow an appropriate period to elapse before reassessing the UR1 and resuming the provision of bridge at UR2-UL2.* **Proved**
	The Committee finds the facts alleged at head of charge 62 proved. The Committee notes that on 1 February 2016 Mr Starkey provided an apicectomy at the patient's UR1. Subsequently on 10 March 2016 bridge and veneer preparation treatment was provided, which initiated the provision of a bridge at UR2 to UL2. The Committee accepts the expert evidence of Dr Igoe that Mr Starkey should have allowed at least six months to pass before further treatment was provided involving the UR1. The Committee therefore finds that Mr Starkey failed in his duty to allow an appropriate period of time to elapse before reassessing the UR1 and resuming his bridge treatment.
Patient 10	
Clinical	
63.	***[withdrawn]***
Indemnity	
64.	*Between 1 January 2015 and about 4 July 2016 you treated patients without holding adequate indemnity cover.*

	Proved
	The Committee finds the facts alleged at head of charge 64 proved with regard to the period of 16 April 2015 to about 4 July 2016. The Committee notes from the evidence presented to it that Mr Starkey treated patients in the period of 1 January 2015 to about 4 July 2016. The Committee has had particular regard to the written evidence of Witness B in this regard. The Committee has also had regard to the witness statement of Witness A. Witness A's evidence is that Mr Starkey 'held no form of membership' with his indemnifiers, namely the DDU, over the period in question. Witness A does however state that, having defaulted on his direct debit subscription payments, the DDU commenced correspondence with Mr Starkey in an effort to obtain the necessary payments for his indemnity insurance arrangements. On 16 April 2015 Mr Starkey was informed of the DDU's erasing of his indemnity insurance membership, with the erasure retrospective as of 1 January 2015. In July 2016 the GDC contacted Mr Starkey about his indemnity insurance arrangements, leading him to stepping back from treating patients and attempting to obtain indemnity insurance, including retrospective indemnity insurance. As Mr Starkey did at the time have indemnity insurance in place until 16 April 2015, albeit that that cover was retrospectively withdrawn, the Committee finds the facts alleged at this head of charge proved with regard to the approximate period of 16 April 2015 to 4 July 2016.
65.	*You knew, or ought to have known, you did not have adequate indemnity cover and your conduct in continuing to practise was:*
65. a)	*misleading;* **Proved**
	The Committee finds the facts alleged at head of charge 65 (a) proved. In approaching this head of charge, the Committee has considered whether the conduct found proved at head of charge 64 means that such conduct was misleading. The Committee considers that Mr Starkey's conduct in continuing to practise was likely to mislead patients into believing that he had indemnity insurance arrangements in place when he did not.
65. b)	*dishonest in that you knew you did not have adequate indemnity insurance and should not be practising.* **Proved**

	The Committee finds the facts alleged at head of charge 65 (b) proved. In approaching this head of charge, the Committee has considered whether the conduct found proved at head of charge 64 means that such conduct was dishonest. In approaching this head of charge, and the other heads of charge which allege dishonest conduct, the Committee applied the test set out in *Ivey v Genting Casinos (UK) Ltd. t/a Crockfords* [2017] UKSC 67. The test is that the Committee must decide subjectively the actual state of Mr Starkey's knowledge or belief as to the facts, and must then apply the objective standards of ordinary and decent people to determine whether Mr Starkey's conduct was dishonest by those standards. The Committee considers that Mr Starkey was aware that his indemnity insurance arrangements would cease in light of him not paying the necessary subscription payments. The Committee has taken account of an internal email from the DDU dated 11 February 2015 which refers to a telephone call from Mr Starkey in which he requested an amendment to be made to his preferred correspondence address. The Committee notes that the letters that the DDU sent to him after that date reminding him of his outstanding payments and the implications for his membership were sent to that updated address. The Committee is satisfied on the balance of probabilities that Mr Starkey was made well aware of his impending loss of membership and, as of 16 April 2015, the fact that he no longer held adequate indemnity insurance. The Committee considers that Mr Starkey could have been in no doubt about his lack of adequate indemnity insurance as of 16 April 2015, and notes that he continued to treat patients despite not having adequate indemnity insurance in place. The Committee also considers that Mr Starkey's conduct in continuing to treat patients after his receipt of the DDU's letter dated 16 April 2015 would be seen as dishonest by reference to the objective standards of ordinary and decent people.
Declaration to MyDentist	
66.	*You provided MyDentist with an indemnity certificate for the period 1 January 2015 to 1 January 2016.* **Proved**
	The Committee finds the facts alleged at head of charge 66 proved.

	The Committee has had regard to the written evidence of Witness B. It notes that the company which engaged Mr Starkey's services at the practice was provided with a copy of an indemnity insurance certificate dated 10 February 2015 which stated that Mr Starkey was indemnified for the period of 1 January 2015 to 1 January 2016. The Committee concludes on the balance of probabilities that, as the company which engaged Mr Starkey's services at the practice held that certificate, it was Mr Starkey who provided the certificate to them.
67.	*You knew, or ought to have known, that the indemnity certificate you had supplied MyDentist was not valid and your conduct in failing to notify MyDentist it was not, or no longer, valid was:*
67. a)	*misleading;* **Proved**
	The Committee finds the facts alleged at head of charge 67 (a) proved. In approaching this head of charge the Committee has considered whether the conduct found proved at head of charge 66 means that such conduct was misleading. The Committee considers that, even if Mr Starkey was in fact indemnified at the time at which he provided the certificate, that is to say in the period of 10 February 2015 to 16 April 2015, he was then under a duty to inform the company that his indemnity insurance was withdrawn by the DDU on 16 April 2015. The Committee considers that the certificate was misleading after that date, as it indicated to MyDentist that Mr Starkey had adequate indemnity insurance in place for the period of 1 January 2015 to 1 January 2016 when that was not in fact the case.
67. b)	*dishonest in that you knew MyDentist understood you to have adequate indemnity cover when you did not.* **Proved**
	The Committee finds the facts alleged at head of charge 67 (b) proved. In approaching this head of charge the Committee has considered whether the conduct found proved at head of charge 66 means that such conduct was dishonest. As set out at head of charge 65 (b) above, in assessing Mr Starkey's actual state of knowledge and belief the Committee considers that Mr Starkey knew as of his receipt of the letter dated 16 April 2015 that he did not in fact hold adequate indemnity insurance. Mr Starkey was

	also aware that he had provided information to the company which engaged his services about his indemnity insurance which he had not corrected in light of his indemnifiers' withdrawal of cover. The Committee considers that Mr Starkey's conduct would be seen as dishonest by reference to the objective standards of ordinary and decent people.
Non co-operation with the GDC	
68.	*You failed to co-operate with the GDC in that you did not respond promptly, or at all, to requests to produce your indemnity insurance made in communications dated:*
68. a)	*21 July 2016;* **Proved in relation to no response at all**
68. b)	*14 December 2016;* **Not proved**
68. c)	*12 January 2017;* **Proved in relation to no response at all**
68. d)	*6 March 2017.* **Proved in relation to no prompt response**
	The Committee finds the facts alleged at heads of charge 68 (a) and 68 (c) on the basis that Mr Starkey did not respond at all, and head of charge 68 (d) proved on the basis that Mr Starkey did not reply promptly. The Committee finds that he was under a duty to do so. It finds the facts alleged at head of charge 68 (b) not proved. The Committee has had regard to the written evidence of Witness D who provides evidence of the communications referred to at these heads of charge being sent to Mr Starkey. It finds that this evidence demonstrates that Mr Starkey did not respond at all to the GDC's communications of 21 July 2016 and 12 January 2017. The Committee finds that he was under a duty to do so. Mr Starkey made a holding response in respect of the GDC's request of 14 December 2016 that same day. Although brief, his email constitutes a response. The Committee therefore finds the facts alleged at head of charge 68 (b) not proved. In respect of head of charge 68 (d) relating to the communication of 6

	March 2017, Mr Starkey did not reply until 3 May 2017. The Committee considers that Mr Starkey therefore did not reply promptly, rather than not at all.
Patient 11	
69.	*Between 29 May 2019 and 24 March 2020, you were in general dental practice at Practice 2 and treated Patient 11.* **Proved**
	The Committee finds the facts alleged at head of charge 69 proved. These anodyne facts are set out by way of background to the allegations that Mr Starkey faces, and the Committee finds that the documentary evidence provided to it, and particularly the written evidence of Witness E, supports that Patient 11 received care and treatment from Mr Starkey in the period specified.
70.	*On 19 November 2019:*
70. a)	*you failed to report on a periapical radiograph;* **Proved**
	The Committee finds the facts alleged at head of charge 70 (a) proved. The Committee notes that on 19 November 2019 Mr Starkey took a periapical radiograph. The Committee notes that there is no report in the patient's records. The Committee accepts the expert evidence of Dr Igoe that Mr Starkey was under a duty to report on the periapical radiograph that he took, and that as Mr Starkey failed to do so the Committee finds the facts alleged at this head of charge proved.
70. b)	*you did not adequately discuss with Patient 11 the risks, benefits and alternatives to the proposed immediate post-extraction fit of a two-unit cantilever bridge at UL2.* **Proved**
	The Committee finds the facts alleged at head of charge 70 (b) proved. The Committee has had regard to the evidence of Patient 11. Patient 11's evidence is that there may have been some discussion about the risks and benefits of, and alternatives to, treatment. In Mr Starkey's patient notes he set out that he discussed the options for treatment with Patient 11 at the time. The Committee considers that there would have been likely to have been bone loss around the proposed extraction site which as Dr Igoe opined would have required discussion about treatment options. As this is not noted in the patient's records, the Committee infers that this was not

	discussed, which means that the discussion was not adequate.
71.	*On 11 December 2019:*
71. a)	*you inappropriately amended the treatment plan to include a pontic at UL4 when the UL3 was not suitable to support two pontics at UL2 and UL4;* **Proved**
	The Committee finds the facts alleged at head of charge 71 (a) proved. The Committee notes from Patient 11's records that Mr Starkey made an amendment to the treatment plan by including the provision of a pontic at UL4 as alleged at this head of charge. The Committee accepts the expert evidence of Dr Igoe that such an amendment was not appropriate, as there was insufficient root surface on the UL3 to support two pontics, that is to say the bridge.
71. b)	*you did not adequately discuss with Patient 11 the risks, benefits, and alternatives to the proposed three-unit cantilever bridge at UL2-UL4.* **Proved**
	The Committee finds the facts alleged at head of charge 71 (b) proved. The Committee notes that there are some entries in the patient's notes to suggest that a discussion took place about the risks and benefits of, and alternatives to, the proposed treatment. However, the records do not suggest that an adequate discussion took place, and the Committee infers that no adequate discussion occurred about these aspects of treatment. Patient 11's evidence is that there was no discussion about, for instance, any stresses or strains on the proposed bridge, or its risks and life expectancy. The Committee accepts the expert evidence of Dr Igoe, who is critical of the apparent shortcomings in the discussion with the patient.
72.	*On 20 December 2019:*
72. a)	*you extracted the UL2 and fitted an inappropriate three-unit cantilever bridge at UL2-UL4;* **Proved**
	The Committee finds the facts alleged at head of charge 72 (a) proved. The Committee notes that there is sufficient evidence for Mr Starkey's extraction of the patient's UL2 and the fitting of a three-unit cantilever bridge at UL2 to UL4. The Committee accepts the expert evidence of Dr Igoe that such treatment was inappropriate as it was likely to fail as there was insufficient root surface on the UL3 to support two pontics, that is to say the bridge.

72. b)	*you failed to obtain informed consent to the three-unit cantilever bridge at UL2-UL4;* **Proved**
	The Committee finds the facts alleged at head of charge 72 (b) proved. The Committee has found at head of charge 71 (b) above that Mr Starkey did not adequately discuss the treatment with Patient 11, and particularly the increased risk of failure of the amended design of the bridge at UL2 to UL4. It follows that Mr Starkey did not obtain informed consent for the treatment, and as he did not do so he failed in his duty.
72. c)	*you failed to record any investigations and/or treatment at UR6.* **Proved**
	The Committee finds the facts alleged at head of charge 72 (c) proved in relation to treatment. The Committee notes from Patient 11's records that there are no entries of any investigations or treatment of UR6 on the date in question. The evidence of Patient 11 is that some treatment was carried out at her UR6 on that day, namely a filling. The Committee accepts this evidence, as well as the expert evidence of Dr Igoe that Mr Starkey was under a duty to, and did not, record the treatment that he provided. The Committee does not find that the GDC has adduced sufficient evidence for it to find that Mr Starkey conducted investigations which could then have been recorded.
Non-co-operation in respect to Patient 11's complaint	
73.	*You failed to co-operate with the GDC in that you did not respond promptly, or at all, to requests to produce details of your employment and/or indemnity insurance made in communications dated:*
73. a)	*1 June 2020;* **Proved**
73. b)	*18 June 2020;* **Proved**

73. c)	*24 June 2020.* **Proved**
	The Committee finds the facts alleged at heads of charge 73 (a), 73 (b) and 73 (c) on the basis that Mr Starkey did not respond at all to the GDC's requests for details of his employment and indemnity insurance. The Committee has had regard to the written evidence of Witness D who provides evidence of the communications referred to at these heads of charge being sent to Mr Starkey. It finds that this evidence demonstrates that Mr Starkey did not respond at all to the GDC's communications of 1 June 2020, 18 June 2020 and 24 June 2020. The Committee finds that he was under a duty to do so, and that having failed to do so the Committee finds the facts alleged at these heads of charge proved.
Health	
74.	*You have adverse health conditions as particularised in Schedule B.* **Proved**
	The Committee finds the facts alleged at head of charge 74 proved. **[PRIVATE]**

IN PUBLIC

We move to stage two."

On 12 October 2022, the Chairman announced the determination as follows:

"Proceedings at stage two

The Committee has considered all the evidence presented to it, both written and oral. It has taken into account the submissions made by Ms Barnfather on behalf of the General Dental Council (GDC)

In its deliberations the Committee has had regard to the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016, updated December 2020). The Committee has accepted the advice of the Legal Adviser.

The Committee has not been provided with any further documentary or oral evidence following the handing down of its findings of facts.

Fitness to practise history

Ms Barnfather addressed the Committee in accordance with Rule 20 (1) (a) of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules'). She confirmed

that in 2010 a finding of impairment on the grounds of adverse health was made by the Health Committee and a period of conditional registration was imposed. The conditions were revoked in 2012.

Misconduct

The Committee first considered whether the facts that it has found proved constitute misconduct. Ms Barnfather submits that those facts amount to misconduct. In considering this matter, the Committee has exercised its own independent judgement.

In its deliberations the Committee has had regard to the following paragraphs of the GDC's *Standards for the Dental Team* (September 2013) in place at the time of the facts that it has found proved. These paragraphs state that as a dentist:

1.3 [You must] be honest and act with integrity.

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

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

1.4 [You must] take a holistic and preventative approach to patient care which is appropriate to the individual patient.

1.7 [You must] put patients' interests before your own or those of any colleague, business or organisation.

1.8 [You must] have appropriate arrangements in place for patients to seek compensation if they suffer harm.

1.9 [You must] find out about laws and regulations that affect your work and follow them.

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

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

9.4 [You must] co-operate with any relevant formal or informal inquiry and give full and truthful information.

The Committee's factual findings relate to a number of matters. The Committee has made findings in relation to the standard of care and treatment that Mr Starkey provided to ten patients in the overall periods of 2014 to 2016 and 2019, with particular regard to his proven failings in the areas of radiographic practice, periodontal and other assessments, diagnosis and treatment of caries, record-

keeping, treatment planning, patient discussions, bridge design, restorations, antibiotic prescribing and informed consent.

The Committee has also made findings in relation to Mr Starkey's units of dental activity (UDA) claiming practices relating to some of the ten patients referred to above. The Committee has found that he acted in a manner that was misleading and lacking in integrity in respect of those claims.

The Committee has also found that Mr Starkey acted in a misleading and dishonest manner in treating patients without adequate indemnity cover. The Committee also found that Mr Starkey failed to co-operate with the GDC in relation to its attempts to obtain information about his indemnity insurance arrangements.

The Committee considers that Mr Starkey's conduct fell far short of the standards reasonably expected of a dentist. Mr Starkey's clinical failings related to basic and fundamental aspects of general dental practice, and were repeated over two separate but individually protracted periods of time. Mr Starkey's clinical acts and omissions represent a significant departure from the standards reasonably expected. Mr Starkey placed patients at unwarranted risk of harm, and in the case of at least one patient, namely Patient 9, caused actual harm. The Committee is also mindful that, by working without adequate indemnity insurance for a considerable period of time, Mr Starkey exposed patients to the risk of harm by depriving them of recourse to the usual mechanisms by which they could seek remedial treatment that may have been required.

Mr Starkey's conduct in acting in a manner that was misleading, lacking in integrity and dishonest has brought the standing and reputation of the profession into disrepute, and has undermined public trust and confidence in the profession. In relation to one aspect of such conduct, namely continuing to work without adequate indemnity insurance, Mr Starkey deprived patients of recompense to which they may have been entitled. Mr Starkey has breached a fundamental tenet of the profession, namely the need to be honest and to act with integrity. The Committee finds that Mr Starkey's misconduct was serious, and would be considered by his fellow practitioners to be deplorable. The Committee therefore concludes that all of its findings, save for its findings in relation to Mr Starkey's health, amount to misconduct.

Impairment

The Committee then went on to consider whether Mr Starkey's fitness to practise is currently impaired by reason of his misconduct and/or his adverse health. In doing so, the Committee has again exercised its independent judgement. The Committee has heard from Ms Barnfather that the GDC submits that Mr Starkey's fitness to practise is impaired on the grounds of both misconduct and adverse health. Throughout its deliberations, the Committee has borne in mind that its primary duty is to address the public interest, which includes the protection of patients, the

maintenance of public confidence in the profession and in the regulatory process, and the declaring and upholding of proper standards of conduct and behaviour.

MISCONDUCT

The Committee finds that Mr Starkey's fitness to practise is currently impaired by reason of the misconduct that it has found. The Committee's reasons are as follows.

The Committee considers that the clinical failings that it has identified are capable of being remedied. However, the Committee finds that Mr Starkey has not provided any evidence of insight into, and remediation of, his misconduct. As such, the Committee considers that Mr Starkey is liable to repeat his misconduct if he were to return to practice and is therefore liable to once more put patients at unwarranted risk of harm.

The Committee has found that Mr Starkey acted in a manner that was misleading and lacking in integrity in relation to his claiming practices, that he acted in a misleading and dishonest manner in continuing to practise without holding adequate indemnity insurance, and that he failed to co-operate with the GDC in response to its requests for information about his indemnity insurance. The Committee is mindful that such conduct connotes a professional attitudinal problem which might be more difficult for Mr Starkey to remedy. In any event, the Committee has similarly been provided with no information to suggest that he has developed insight into, and has remedied, such misconduct, or that he is minded to do so in the future.

In light of this lack of insight and remediation the Committee finds that Mr Starkey continues to pose a risk to the public, and that accordingly his fitness to practise is currently impaired.

The Committee finds that a finding of impairment is also, and undoubtedly, required in order to declare and uphold proper standards of conduct and behaviour and to maintain trust and confidence in the profession. The Committee considers that such a finding is particularly required because of the issues of integrity and honesty which have been identified in this case. Mr Starkey's dishonest conduct has breached a fundamental tenet of the profession, and has brought the reputation of the profession into disrepute. Mr Starkey's dishonesty was directly related to his work as a dentist and amounts to a breach of trust, including the trust placed in him by patients and those who contracted his services to provide care and treatment to patients. In the Committee's judgement public trust and confidence in the profession would be significantly undermined if a finding of impairment were not made in the particular circumstances of this case.

HEALTH

The Committee also finds that Mr Starkey's fitness to practise is currently impaired on the grounds of adverse health.

[PRIVATE]

IN PUBLIC

Sanction

The Committee then determined what sanction, if any, would be appropriate in light of the findings of fact, misconduct and impairment that it has made. The Committee recognises that the purpose of a sanction is not punitive, although it may have that effect, but is instead imposed in order to protect patients and safeguard the wider public interests referred to above. The Committee has heard that Ms Barnfather on behalf of the GDC invites the Committee to erase Mr Starkey's name from the register in light of the misconduct that it may find. Ms Barnfather submitted that, if the case were to have related solely to health, a period of suspended registration would have been an appropriate disposal. Ms Barnfather submitted that the ultimate sanction of erasure should be imposed in light of all of the findings that it might make of impairment on the grounds of misconduct and adverse health.

In reaching its decision the Committee has again taken into account the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016, updated December 2020). The Committee has applied the principle of proportionality, balancing the public interest with Mr Starkey's own interests. In considering this matter, the Committee has again exercised its own independent judgement.

The Committee has considered the aggravating and mitigating factors present in this case.

In terms of mitigating factors, the Committee notes that Mr Starkey has no other fitness to practise history relating to misconduct. The Committee notes that Mr Starkey appears to have accepted that he practised without adequate indemnity insurance when responding to the allegations to the GDC's Case Examiners, but the Committee does not consider that this constitutes a mitigating factor, as the Committee does not consider that he accepted that he was at fault or that he appreciated the wider implications. The Committee also does not consider that Mr Starkey's adverse health mitigates the misconduct that he has found, and it accepts the submission of the GDC that there is no association between Mr Starkey's misconduct and adverse health.

In relation to aggravating factors, the Committee considers that Mr Starkey's misconduct placed patients at the risk of harm and, at least in the case of Patient 9, caused actual harm. The Committee has made findings of repeated and protracted dishonesty. The Committee finds that Mr Starkey's claiming practices resulted in his financial gain. The Committee finds that Mr Starkey's conduct amounts to a breach of trust, and that his misconduct was sustained and repeated over two separate and protracted periods of time across two practices. Mr Starkey's failure to co-operate with the GDC, his failure to follow Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) regulations, as well as his claiming practices and practising without adequate indemnity insurance, constitute a blatant and wilful disregard of the GDC

and the systems regulating the profession. The Committee has also found that Mr Starkey lacks insight into his misconduct.

The Committee has considered the range of sanctions available to it, starting with the least restrictive. In the light of its findings, the Committee has determined that it would be inappropriate and insufficient to conclude this case by taking no action or issuing a reprimand. The Committee's findings, in particular its identification of dishonest conduct, mean that taking no action, or issuing a reprimand, would be insufficient to maintain public confidence and trust in the profession and in the regulatory process, and would not declare and uphold proper standards of conduct and behaviour.

The Committee next considered whether a period of conditional registration would be appropriate. Mr Starkey has not engaged with these proceedings, and this would make it very difficult for the Committee to formulate conditions which would be workable and be complied with. Mr Starkey's dishonest conduct could not in the Committee's view be properly addressed with conditions. In any event, the Committee considers that a period of conditional registration would not be sufficient to protect the public and would not declare and uphold proper professional standards of conduct and behaviour or maintain trust and confidence in the profession.

The Committee therefore went on to consider whether to suspend Mr Starkey's registration. The Committee is mindful that Mr Starkey's conduct was repeated, that he has not demonstrated insight into or remediation of his misconduct, and that there is a significant risk of repeating his acts and omissions. Having given the matter careful consideration, the Committee concluded that a period of suspension would not be sufficient to protect patients' interests and public confidence in the profession in light of the serious misconduct that it has found. The Committee is also mindful that there is evidence of a deep-seated professional attitudinal problem which suggests that a period of suspension would not be a sufficient outcome.

In the Committee's judgement the ultimate sanction of erasure is the only sanction which can adequately meet the public interest considerations referred to above which are so directly engaged in this case. Mr Starkey's conduct represents a serious and sustained departure from professional standards, and there is a continuing risk of serious harm to patients' interests and the interests of the public. The Committee finds that Mr Starkey's conduct, with particular regard to his claiming practices and his practising without adequate indemnity insurance, amounts to an abuse of his position of trust. Mr Starkey has also demonstrated a persistent lack of insight into his misconduct, and in particular to his serious dishonesty. In short, Mr Starkey's dishonest conduct is fundamentally incompatible with registration.

The Committee has therefore determined, and hereby directs, that Mr Starkey's name be erased from the register.

The Committee has found above that Mr Starkey's fitness to practise is currently impaired by reason of adverse health as well as misconduct. The Committee has

arrived at its decision to erase Mr Starkey's name from the register in light of its finding that Mr Starkey's fitness to practise is impaired by reason of his misconduct. As noted above the Committee does not consider that Mr Starkey's health provides any mitigation, and it is mindful that the GDC's case on impairment and sanction has been put on the basis that there is no relationship between Mr Starkey's health and misconduct for the purposes of these proceedings. The Committee is satisfied that a direction of erasure is the proportionate and appropriate outcome in the particular circumstances of this case for the reasons set out above, having taken all of the information and submissions presented to it into consideration. Mindful of Sections 27B (6) (a) and (7) of the Dentists Act 1984 (as amended), which stipulates that a Practice Committee cannot erase a registrant's name solely on the grounds of adverse health, the Committee would have imposed a period of suspended registration were its finding of impairment to have been made solely on the grounds of adverse health.

Existing interim order

In accordance with Rule 21 (3) of the General Dental Council (Fitness to Practise) Rules 2006 and section 27B (9) of the Dentists Act 1984 (as amended) the interim order of suspension in place on Mr Starkey's registration is hereby revoked.

Immediate order

Having directed that Mr Starkey's name be erased from the register, the Committee now invites submissions as to whether it should impose an order for his immediate suspension in accordance with section 30 (1) of the Dentists Act 1984 (as amended).

Determination on immediate order – 12 October 2022

Having directed that Mr Starkey's name be erased from the register, the Committee invited submissions as to whether it should impose an order for his immediate suspension in accordance with section 30 (1) of the Dentists Act 1984 (as amended).

The Committee has heard the submissions of Ms Barnfather on behalf of the GDC that an immediate order of suspension is necessary to protect the public and is otherwise in the public interest. The Committee has accepted the advice of the Legal Adviser.

In all the circumstances, the Committee considers that an immediate order of suspension is necessary to protect the public and is otherwise in the public interest. The Committee has decided that, given the risks that it has identified, it would not be appropriate to permit Mr Starkey to practise before the substantive direction of erasure takes effect. An immediate order is needed to protect the public and to maintain trust and confidence in the profession. The Committee considers that an

immediate order of suspension is proportionate, and is consistent with the findings that it has set out in its determination.

The effect of the foregoing determination and this immediate order is that Mr Starkey's registration will be suspended from the date on which notice of this decision is deemed served upon him. Unless Mr Starkey exercises his right of appeal, the substantive direction of erasure will be recorded in the register 28 days from the date of deemed service. Should Mr Starkey so decide to exercise his right of appeal, this immediate order of suspension will remain in place until the resolution of any appeal.

That concludes this case."