General
Dental
Council

HEARING HEARD IN PUBLIC

WIENZEK, Udo

Registration No: 105226

PROFESSIONAL CONDUCT COMMITTEE

OCTOBER 2020

Outcome: Erased with Immediate Suspension

Udo WIENZEK, a dentist, Zahnarzt Mainz 1975, was summoned to appear before the Professional Conduct Committee on 5 October 2020 for an inquiry into the following charge:

Charge

"That, being a registered dentist:

1. You practised at the dental practice identified in Schedule 1[1] below between June 2016 and April 2018, and treated the patients identified in Schedule 2 below.
2. You failed to provide an adequate standard of care between 24 June 2016 and 14 December 2017 by not carrying out appropriate periodontal assessments on Patient 2 on:
   (a) 24 June 2016;
   (b) 6 February 2017.
3. You failed to provide an adequate standard of care by providing a poor standard of radiographic practice between 24 June 2016 and 13 February 2018 in respect of the patients and dates in Schedule A.
4. You failed to provide an adequate standard of care by prescribing antibiotics without adequate clinical justification between 24 June 2016 and 28 March 2018 in respect of the patients and dates in Schedule B.
5. You failed to maintain an adequate standard of record keeping between 24 June 2016 and 3 April 2018 in respect of the patients and dates in Schedule C.
6. You failed to provide an adequate standard of care to Patient 4 by advising him on 18 October 2017 to stop taking aspirin for five days before his appointment for a scale and polish.
7. You failed to provide an adequate standard of care to Patient 6 by failing to attempt drainage of the infection at the UR6 on:
   (a) 14 December 2017;
   (b) 19 December 2017;
   (c) 4 January 2018.

[1] All schedules are private documents and are not disclosed to the public

8. You failed to co-operate with an investigation into your clinical practice conducted by NHS England between 23 May 2018 and 9 October 2018.

9. You failed to co-operate with an investigation by the General Dental Council (GDC) between 29 October 2018 and 26 April 2019 by failing to provide the GDC with your employment details and your professional indemnity insurance details.

And that, by reason of the facts alleged, your fitness to practice is impaired by reason of your misconduct."

Mr Wienzek was not present and was not represented. On 7 October 2020 the Chairman announced the findings of fact to the Counsel for the GDC:

"This is a Professional Conduct Committee hearing. The members of the Committee, as well as the Legal Adviser and the Committee Secretary, conducted the hearing remotely via Microsoft Teams in line with current GDC practice. Mr Wienzek was neither present nor represented in this hearing. Ms Tahta, Case Presenter for the General Dental Council (GDC) also attended via Microsoft Teams.

Background

Mr Wienzek was employed at 'MyDentist' between June 2016 and April 2018. At the beginning of 2017 dental practitioners who also worked at MyDentist raised concerns about Mr Wienzek's practice to the practice manager after they had treated Mr Wienzek's patients in emergency appointments. As a result of those concerns being raised, the Regional Clinical Director of MyDentist met with Mr Wienzek in January 2017 and discussed with him various clinical concerns that had arisen. Following that meeting Mr Wienzek received a support plan which was designed to help him to improve in those areas of clinical concerns. Mr Wienzek resigned at the practice on 27 April 2018. Shortly after Mr Wienzek's resignation at the practice, MyDentist referred the concerns into his performance to NHS England in April 2018. The matter was then referred to the GDC in October 2018.

The allegations before the Committee concern Mr Wienzek's alleged failings in relation to his clinical practice in that he failed to provide an adequate standard of care in relation to 7 patients. There are also allegations in relation to Mr Wienzek's alleged failure to co-operate with an investigation into his clinical practice conducted by NHS England and failed to co-operate with an investigation by the GDC.

Decision on service of notification of hearing

Ms Tahta made an application under Rule 54 of the General Dental Council (Fitness to Practise) Rules 2006 ("the Rules") that the hearing should proceed in Mr Wienzek's absence. She submitted that the notification of hearing had been served on Mr Wienzek in accordance with Rules 13 and 65 and that the committee could exercise its discretion to proceed with the hearing.

The Committee had before it a copy of the notification of hearing letter dated 24 August 2020 which was sent by international delivery to Mr Wienzek's registered address in Germany as it appears in the Dentists Register. It was satisfied that the letter contained all the components necessary such as the date, time and venue (via Skype/Microsoft Teams) in accordance with Rule 13. The Committee noted the international track and trace report showed that the letter had been delivered to Mr Wienzek. An attempt was also made to

deliver the notice letter by email, to an email address Mr Wienzek had used in the past. However, by August 2020 it appeared that email address was no longer in use.

Having accepted the advice of the Legal Adviser, the Committee was satisfied that the notification of hearing had been served in accordance with Rules 13 and 65.

Decision on proceeding in Mr Wienzek's absence

Ms Tahta then made an application under Rule 54 that the hearing should proceed in Mr Wienzek's absence. The Committee bore in mind that its discretion to proceed with a hearing in these circumstances should be exercised with the utmost care and caution. It took account of Ms Tahta's submissions and it accepted the advice of the Legal Adviser.

Ms Tahta informed the Committee that that several attempts have been made by the GDC to contact Mr Wienzek via post and email. Correspondence was sent to Mr Wienzek's email address by the GDC in December 2019 and by Capsticks (Solicitors for the GDC) continuously between December 2019 and September 2020. On each occasion the email would return undelivered. However, correspondence that was posted to Mr Wienzek's registered address in Germany were all successfully delivered and signed for. The Committee found all reasonable efforts had been made to send notification of the hearing to Mr Wienzek. There was no request from Mr Wienzek for an adjournment of the hearing. In considering the exercise of its discretion to proceed in his absence the Committee had regard, amongst other things, to the public interest in the expeditious disposal of this case, the potential inconvenience to the witnesses called to attend this hearing and fairness to Mr Wienzek. The Committee was of the view that adjournment was unlikely to secure Mr Wienzek's attendance at a future hearing given that he has not engaged with these proceedings and was satisfied there was no good reason to inconvenience witnesses. For all these reasons the Committee determined to proceed with the hearing in Mr Wienzek's absence. In reaching this decision the Committee had full regard to all the principles set out in the case of GMC v Adeogba [2016] EWHC Civ 162 relevant to the exercise of its discretion under Rule 54.

Preliminary amendments to the charge

At the outset of the hearing, Ms Tahta made an application to amend the charge under Rule 18 of the *GDC (Fitness to Practise) Rules 2006* (the Rules). She applied to remove the words *'of treatment plans'* in Schedule C of the Charge. The Committee accepted the advice of the Legal Adviser. It acceded to Ms Tahta's Rule 18 application. In granting the application, the Committee was satisfied that the minor amendment could be made without causing any injustice to Mr Wienzek.

Evidence

In relation to the alleged matters, the GDC provided the Committee with documentary evidence, including

- A witness statement from the Clinical Support Manager at MyDentist.
- A witness statement from the NHS Programme Manager.
- A witness statement from the Casework Manager at the GDC

The Committee also received a report dated 17 December 2019 from Mr Canty, expert witness for the GDC. His written report and oral evidence were clear. The Committee accepted his evidence and considered that he provided a careful and thorough analysis of

the available evidence and presented fair and balanced opinions including the questions posed to him by the Committee.

The Committee also sought clarification from Witness 1 as to what was stated in his witness statement in relation to the dates of Mr Wienzek's employment.

The Committee took account of all the oral and documentary evidence presented in this hearing. It considered the submissions made by Ms Tahta. The Committee drew no adverse inferences from Mr Wienzek's absence.

The Committee accepted the advice of the Legal Adviser. In accordance with that advice it considered each charge separately.

The burden of proving the facts alleged is on the GDC and the standard of proof is the civil standard which is on the balance of probabilities. Mr Wienzek is not required to prove anything.

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

1.	You practised at the dental practice identified in Schedule 1 below between June 2016 and April 2018, and treated the patients identified in Schedule 2 below **Found Proved** The Committee found this proved as a matter of fact. It also had regard to Witness 1's statement which confirmed this.
2.	You failed to provide an adequate standard of care between 24 June 2016 and 14 December 2017 by not carrying out appropriate periodontal assessments on Patient 2 on: (a) 24 June 2016; (b) 6 February 2017. **Found Proved** The Committee had regard to Mr Canty's evidence who having looked at the clinical records noted that there is evidence of a basic periodontal examination (BPE) taken by Mr Wienzek on 24 June 2016. Mr Canty stated however, that the coding of '3s' would indicate as per the British Society of Periodontology guidelines that a more detailed assessment of the gums was required, indicating the need for a six point pocket chart which was not carried out by Mr Wienzek. Furthermore, no explanation was provided by Mr Wienzek within the records confirming whether he intended to carry out a detailed assessment at a later appointment. In Mr Canty's view Mr Wienzek failed to carry out an appropriate periodontal assessment. In relation to the appointment on 6 February 2017, Mr Canty could see no evidence of a BPE carried out at all by Mr Wienzek. He stated that there was no picture of the patient's periodontal condition within the records and was of the view that it was more likely than not that Mr Wienzek failed to carry it out rather than not carrying it out and not

	recording given that it was a brief procedure to do. The Committee was satisfied there was a clear duty for Mr Wienzek to appropriately carry out periodontal assessments on Patient 2 at both appointments and that he failed to do so. It accepted the evidence before it. Accordingly, on the balance of probabilities, it finds this charge proved.
3.	You failed to provide an adequate standard of care by providing a poor standard of radiographic practice between 24 June 2016 and 13 February 2018 in respect of the patients and dates in Schedule A **Found Proved** The Committee had regard to Mr Canty's evidence who having looked at the clinical records noted that Mr Wienziek failed to record or adequately record the findings of bitewing radiographs taken on 24 June 2016, an OPT on 26 January 2017, periapical radiographs on 31 March 2017, 13 February 2018. Additionally, Mr Wienzek failed to retake the right bitewing of 24 June 2016. Mr Canty explained the importance of accurately recording the findings in the clinical record so that should the radiographs become separated from the records, the information is easily accessible, if required. An accurate report ensures that the radiographs have been reviewed, evaluated and provides insights of the observations of the dentist. He stated that failure to adequately record the findings can result in extra radiographs being taken and a patient being exposed needlessly to further ionizing radiation. A periapical radiograph for this patient was highlighted to the Committee. Within the clinical notes for this date there is no report for this radiograph. Mr Canty details what should have been included in this report including the restorations present, bone loss and widening periapically of the lamina. The Committee had sight of the records and noted that in relation to Patient 8's appointment on 1 November 2018, it could see evidence that a radiograph was taken and an entry made within the notes stating a small radiograph taken on 1 November 2017. However, there was no evidence that Mr Wienzek had graded or reported on the radiograph as was his statutory duty. The Committee was satisfied there was a clear duty for Mr Wienzek to provide an adequate standard of radiographic practice in accordance with the Ionising Radiation Medical Exposure Regulations (IRMER) and that he failed to do so. It accepted the evidence before it. Accordingly, on the balance of probabilities, it finds this charge proved.
4.	You failed to provide an adequate standard of care by prescribing antibiotics without adequate clinical justification between 24 June 2016 and 28 March 2018 in respect of the patients and dates in Schedule B **Found Proved**

	The Committee had regard to Mr Canty's evidence who having looked at the clinical records noted the following: **Patient 1** There was no clinical justification for the prescription of Amoxicillin for the treatment of gingivitis on 12 October 2017 or for the prescription of Metronidazole 500 mg on 19 October 2017 for a child of 6 years of age. **Patient 2** There was no rationale recorded to indicate the prescriptions for antibiotics were justified on 24 June 2016, 15 March 2018, 28 March 2018 and 10 April 2018. The full details of the antibiotic prescribed on 10 April 2018 were not recorded. **Patient 5** There was no record of a diagnosis, rationale for prescribing Amoxicillin 500mg or for any follow up that might be necessary. There was nothing recorded to indicate whether any infection was present and, if so, its position and whether it could have been treated by local measures such as drainage either by extraction or through the root canal. **Patient 6** Patient 6 had been prescribed four courses of antibiotics in a three week period. Three of these were prescribed by Mr Wienzek. There was no record explaining the rationale for prescribing multiple courses of antibiotics or for the repeat prescription of the same antibiotic within a 3 week period when metronidazole was prescribed on 19 December 2017 and 04 January 2018. There was nothing to explain the rationale for prescribing an antibiotic on 04 January 2018 when the patient reported her symptoms had resolved. **Patient 8** The notes lacked detail about the patient's presenting symptoms, and there was nothing recorded to indicate the presence of a systemic or spreading infection that would indicate the need for antibiotics. **Patient 9** There was nothing recorded to indicate why the patient could not have been treated by local measures such as extraction or removal of the fractured portion of the tooth. Repeated dosages of the same antibiotic Metronidazole were unlikely to have any therapeutic effect in this situation and were likely to increase the risk of bacterial resistance. In each case Mr Canty was of the view that Mr Wienzek performed far below the standard expected of a reasonably competent dentist. The Committee accepted the evidence before it and finds this charge proved.
5.	You failed to maintain an adequate standard of record keeping between 24 June 2016 and 3 April 2018 in respect of the patients and dates in

	Schedule C. **Found Proved** **Patient 1 – Inadequate record of justification for prescribing antimicrobials**. The Committee finds in charge 4 above that Mr Wienzek failed to provide an adequate record of justification for antimicrobials prescribed to Patient 1. Amoxicillin was prescribed on 12 October 2017 contrary to guidance provided by Faculty of General Dental Practice 2016 (FGDP) and the Metronidazole prescribed on 17 October 2017 was far in excess of the recommended dose. No explanation was found in the records to justify these significant departures from the relevant guidance. **Patient 2 - Inadequate recording** Mr Canty in his evidence stated that there were multiple recording errors which cumulatively fall far below the standard. **Patient 4 - Inadequate record of discussions regarding rationale for stopping anti-platelet medication** The Committee took into account that it had found charge 6 below proved insofar as Mr Wienzek had failed to provide an adequate standard of care to Patient 4 by advising him to stop taking aspirin. Mr Canty in his evidence stated that if a practitioner deviates from standard practice they need to explain the thought processes that led to this rationale and the discussions with the patient, none of which appear in the patient records.
6.	You failed to provide an adequate standard of care to Patient 4 by advising him on 18 October 2017 to stop taking aspirin for five days before his appointment for a scale and polish. **Found Proved** The Committee had regard to Mr Canty's evidence who having looked at the clinical records noted that Mr Wienziek advised Patient 4 to stop taking their prescribed dose of aspirin. No accompanying note was included in the patient records explaining Mr Wienzek's rationale for this clinical decision. Mr Canty was of the view that to have stopped Patient 4's anti-platelet therapy for the purposes of dental scaling would have potentially placed the patient at risk of harm. The Committee accepted Mr Canty's evidence and on the balance of probabilities, it finds this charge proved.
7.	You failed to provide an adequate standard of care to Patient 6 by failing to attempt drainage of the infection at the UR6 on: (a) 14 December 2017; (b) 19 December 2017;

	(c) 4 January 2018. **Found Proved** The Committee had regard to Mr Canty's evidence who having looked at the clinical records noted that Mr Wienzek prescribed antibiotics on a number of occasions. Apart from at the appointment of 21 December 2017, there is no record that drainage of the infection UR6 was attempted as recommended by the FGDP(UK) guidance. The Committee accepted the evidence before it and finds this charge proved.
8.	You failed to co-operate with an investigation into your clinical practice conducted by NHS England between 23 May 2018 and 9 October 2018. **Found Proved** In accordance with Standard 9.4.2 the Committee was satisfied that, as a registrant, Mr Wienzek had a duty to co-operate with an investigation conducted by NHS England into his fitness to practise. It received and accepted the clear evidence from the NHS Programme Manager of Mr Wienzek's non-engagement with NHS England between the dates specified in the charge. Mr Wienzek was on the NHS England Performers List, it therefore, commenced an investigation into the clinical concerns that had been raised by MyDentist. NHS England attempted to contact Mr Wienzek between 23 May 2018 and 9 October 2018 but received no response despite sending numerous emails to him. On 4 June 2018, NHS England sent a registered letter to Mr Wienzek's address but there was no response. Eventually matters were referred by NHS England to the North Yorkshire and Humber Dental Advisory group who convened a Performers List decision panel to consider Mr Wienzek's case on 9 October 2018. Throughout the period of investigation, Mr Wienzek failed to co-operate by failing to respond to NHS England in any way.
9.	You failed to co-operate with an investigation by the General Dental Council (GDC) between 29 October 2018 and 26 April 2019 by failing to provide the GDC with your employment details and your professional indemnity insurance details. **Found Proved** In accordance with Standard 9.4.1 the Committee was satisfied that, as a registrant, Mr Wienzek had a duty to cooperate with the GDC's investigation into his fitness to practise. It received and accepted the clear evidence from the GDC Casework Manager of Mr Wienzek's non-engagement with the GDC between the dates specified in the charge. On 22 October 2018, NHS England referred Mr Wienzek's case to the GDC. The GDC's Casework Manager's statement set out the attempts made by the GDC to contact Mr Wienzek. An email was sent to Mr

	Wienzek from the GDC on 25 October 2018 to which they received no reply. On 29 October 2018 a notice of complaint letter was sent to his registered address in Germany by special delivery which was signed for. This letter requested that he contact the GDC and provide details of his current employers, details of his previous employers and proof that he had indemnity insurance during the period of treatment. The GDC Casework Manager was clear in their evidence that there was no response from Mr Wienzek. A further letter was sent to Mr Wienzek at the same address on 14 January 2019 from the GDC. In this letter he was reminded that he needed to provide evidence of his employment and indemnity information and that if he failed to do so, this could be considered as an allegation that his fitness to practise is impaired. No response was received. Mr Wienzek's case was transferred to the Case Examiners on 26 April 2019. The Committee concluded that as a registered dental professional, Mr Wienzek was under a duty to cooperate fully with the GDC's investigations into his fitness to practise.

We move to Stage Two."

On 8 October 2020 the Chairman announced the determination as follows:

"The Committee took account of the submissions made by Ms Tahta on behalf of the General Dental Council (GDC). It accepted the advice of the Legal Adviser.

Ms Tahta referred the Committee to the relevant cases and outlined the specific GDC standards which, in her submission, have been breached by Mr Wienzek. She invited the Committee to consider whether the various breaches amount to misconduct.

Ms Tahta then addressed the Committee on the factors that it must consider in respect of current impairment, including Mr Wienzek's level of insight and any remediation. She also addressed the Committee on the need to have regard to the protection of the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the GDC as a regulatory body. Ms Tahta submitted that Mr Wienzek's fitness to practise is currently impaired by reason of misconduct.

Ms Tahta then addressed the Committee on the matter of sanction and submitted that an order of erasure would be appropriate in this case.

Decision on whether the facts found proved amount to misconduct:

When determining whether the facts found proved amount to misconduct the Committee had regard to the terms of the relevant professional standards in force at the time of the incidents. The Committee, in reaching its decision, had regard to the public interest and reminded itself that misconduct was a matter for its judgment.

The Committee has concluded that Mr Wienzek's conduct was in breach of the following *Standards for the Dental Team* (2013). It was satisfied that Mr Wienzek's failings included a breach of the following standards:

4.1 Make and keep contemporaneous, complete and accurate patient records

4.1.1 You must make and keep complete and accurate patient records, including an up-to-date medical history, each time that you treat patients. Radiographs, consent forms, photographs, models, audio or visual recordings of consultations, laboratory prescriptions, statements of conformity and referral letters all form part of patients records where they are available.

7.1 Provide good quality care based on current evidence and authoritative guidance.

7.1.1 You must find out about current evidence and best practice which affect your work, premises, equipment and business and follow them.

7.1.2 If you deviate from established practice and guidance, you should record the reasons why and be able to justify your decision.

7.2 You must work within your knowledge, skills, professional competence and abilities

8.1 Always put patients' safety first.

9.1 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.

9.4.1 If you receive a letter from the GDC in connection with concerns about your fitness to practise, you must respond fully within the time specified in the letter. You should also seek advice from your indemnity provider or professional association.

9.4.2 You must co-operate with: • commissioners of health; • other healthcare regulators; • hospital trusts carrying out any investigation; • the Coroner or Procurator Fiscal acting to investigate a death; • any other regulatory body; • the Health and Safety Executive; and • any solicitor, barrister or advocate representing patients or colleagues.

The Committee appreciated that the above breaches do not automatically result in a finding of misconduct. However, it was of the view that the failings in this case are serious and wide ranging and the Committee concluded that Mr Wienzek's conduct was a significant departure from the standards expected of a registered dental professional. In considering the gravity of Mr Wienzek's departures from the GDC's Standards, the Committee took into account the opinion of the expert witness in this case, Mr Canty for the GDC.

The Committee considered Mr Wienzek's clinical failures. It had regard to Mr Canty's expert report and oral evidence in which he opined that the clinical failures amounted to care that is far below the standard expected. Particularly, in relation to Patient 1, a 6 year old child who was prescribed Amoxicillin for the treatment of gingivitis on 12 Oct 2017 and Metronidazole 500 mg on 19 Oct 2017. Mr Canty stated that *"the dosage of 500 mg is in excess of the recommended dose for a child and has the potential to cause harm to the patient"*. Furthermore, in relation to Patient 4 who was advised to stop taking his aspirin, Mr Canty was of the opinion that, "*to have stopped the patient's anti-platelet therapy for the purposes of dental scaling or RSD would have potentially placed the patient at serious risk".*

The Committee noted that the factual findings in this case included numerous clinical failings (27 separate occasions) by Mr Wienzek in relation to seven patients over a long period of time. It considered that these failings concern fundamental aspects of dentistry and directly impacted upon the overarching issue of patient safety.

The Committee was satisfied that the clinical failings were wide ranging repeated and serious. The failures concern basic and fundamental obligations of a competent dentist. In the Committee's view the findings amount to misconduct.

In relation to the non-clinical matters the Committee was satisfied from the above Standards that Mr Wienzek had an unequivocal duty to co-operate with the investigation being conducted by NHS England and the GDC and that he clearly failed to do so over a prolonged period of time. Mr Wienzek has failed to respond to communications from NHS England and his regulatory body and those of the solicitors instructed by it. The Committee considered that his conduct has frustrated the GDC investigation into concerns relating to his fitness to practise and undermined the effectiveness of the GDC's role in professional regulation. The Committee had no doubt that this would be seen as deplorable conduct by fellow registrants and the public. In the Committee's view, Mr Wienzek has breached a fundamental duty of his registration. It was satisfied that such a breach is serious and that it amounts to misconduct.

The Committee therefore concluded that overall Mr Wienzek's conduct fell far below the standards expected of a registered dental professional and amounted to misconduct.

Impairment

The Committee then went on to consider whether Mr Wienzek's fitness to practise is currently impaired by reason of his misconduct. In doing so, the Committee has again exercised its independent judgement.

The Committee was of the view that Mr Wienzek's clinical failures are capable of being remedied. It had regard to Witness A's statement, which details that MyDentist employers provided Mr Wienzek with a detailed support plan followed by an action plan which pointed to the current evidence and guidance as to the clinical care which appears Mr Wienzek did not put into practice between 2017 and 2018. Witness A met with Mr Wienzek to try and help him improve his practice. He states *"when I first spoke to the Registrant previously, he appeared attentive and happy to improve his clinical performance. However, it seemed to me during my further meetings with the Registrant that he did not want to improve his clinical practise."* Witness A further stated that on the 20 February 2018 (a year since Mr Wienzek was first provided the opportunity to follow a support plan) he met with Mr Wienzek and was *"disappointed to note that there was little to no improvement"* in Mr Wienzek's clinical practice. By April 2018 Witness A found Mr Wienzek's record keeping *"slightly improved"* but considered it to be an *"insignificant improvement"*. At that point Witness A felt it was necessary to refer Mr Wienzek to a contract review meeting which Mr Wienzek did not attend and resigned on the day of that meeting.

The Committee was of the view that Mr Wienzek is a practitioner who is unwilling to be guided and improve his clinical practice which demonstrated a lack of insight into his actions.

Mr Wienzek chose not to engage with these proceedings and there is nothing before this Committee to demonstrate that any remediation has taken place. The Committee has received no information on Mr Wienzek's current circumstances and importantly no evidence of insight on his part. There is nothing before the Committee to suggest that he has any understanding of his clinical failures, his duty to co-operate with NHS England, nor has he provided any reason for his failure to co-operate with his regulatory body in matters of importance. The evidence before this Committee indicates a pattern of non-engagement on Mr Wienzek's part, including at previous fitness to practise hearings.

In the absence of any evidence of insight or remediation, the Committee considered that there is a likelihood that Mr Wienzek could repeat the misconduct. Given that Mr Wienzek's misconduct is of the kind that could put patients at serious risk of harm and potentially undermine the GDC's ability to effectively regulate the profession. The Committee considered that patient safety concerns do arise from the matters in this case.

Dental professionals occupy a position of privilege and trust in society and must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession. The Committee has borne in mind that its primary function is not only to protect patients but also to take account of the wider public interest, which includes maintaining confidence in the dental profession and the GDC as a regulator and upholding proper standards and behaviour.

Furthermore, members of the public would be concerned by Mr Wienzek's acts and omissions and would expect his regulatory body to declare and uphold the standards expected of all registered practitioners. In the Committee's judgement public confidence in the profession would be significantly undermined were the Committee not to make a finding of current impairment. Having regard to all of this the Committee has concluded that Mr Wienzek's fitness to practise is currently impaired by reason of misconduct.

Decision on Sanction

The Committee next considered what action, if any, to take in relation to Mr Wienzek's registration. The Committee reminded itself that the purpose of a sanction is not to be punitive although it may have that effect. The Committee took into account the GDC's "Guidance for the Practice Committees, including Indicative Sanctions Guidance" (October 2016 revised May 2018). The Committee took account of the principle of proportionality.

The Committee considered the mitigating and aggravating factors in this case. In relation to mitigation, it noted that Mr Wienzek's employer had recognised that his workload was unbalanced. The frequency of inspections meant that he was unable to complete his work routinely and would sometimes have to work weekends to complete treatment plans. Conversely the Committee noted that patients (including a child) could have potentially suffered serious harm from the care and treatment Mr Wienzek provided. Mr Wienzek breached the trust placed in him as a professional by failing to adhere to standards of care which are fundamental to the practice of dentistry. Mr Wienzek's misconduct was sustained and repeated in that he has adverse findings at a previous fitness to practise hearing, which contained similar elements to the findings made in this case. Mr Wienzek has demonstrated a blatant or wilful disregard of the role of the GDC and the regulation of the profession by failing to respond to correspondence and requests from the GDC. Mr Wienzek has also not demonstrated any insight into his actions.

The Committee was provided with previous PCC determinations relating to adverse findings against Mr Wienzek. In August 2019 a PCC convened to consider allegations Mr Wienzek's failure to engage with the GDC and a single patient complaint in relation to his clinical practice. Mr Wienzek failed to engage with the GDC investigation, nor did he attend the hearing. At the conclusion of that hearing Mr Wienzek was made subject to a twelve month suspension order and the Committee set out recommendations for the purposes of the next reviewing Committee:

- *Evidence of Mr Wienzek's co-operation with the GDC following this hearing;*
- *Evidence of Mr Wienzek's reflection on the matters found proved in this case;*

- *Evidence of Mr Wienzek's insight and remediation.*

The review hearing took place in August 2020 and Mr Wienzek continued failing to engage with the GDC. In light of Mr Wienzek's non engagement, lack of insight and the absence of any evidence of remediation, the reviewing Committee determined to extend his order of suspension for a further period of twelve months.

The Committee took the view that Mr Wienzek's persistent non-engagement, his previous fitness to practise history, together with the current findings of misconduct and impairment strongly indicates that he has a professional attitudinal problem which is difficult to remedy.

The Committee considered the available sanctions in ascending order starting with the least restrictive.

The Committee was of the view that to conclude this case with no further action or with a reprimand would be inappropriate because neither outcome would manage the risk Mr Wienzek poses to patients. in addition, neither option would be sufficient to protect the wider public interest.

The Committee then considered whether an order for conditional registration would be appropriate and sufficient in this case. Mr Wienzek has not engaged with the GDC. The Committee was of the view that conditions require a willingness on the part of a registrant to comply with them and in light of Mr Wienzek's non-engagement the Committee could have no confidence that he would comply even if appropriate and workable conditions could be formulated. Furthermore, the Committee concluded that Mr Wienzek has a professional attitudinal problem. In these circumstances an order for conditional registration would be insufficient in this case to protect patients and maintain public confidence in the profession and declare and uphold appropriate standards of conduct and competence among dental professionals.

The Committee concluded that withdrawal of Mr Wienzek's registration is necessary. It considered whether suspension would be appropriate in this case. It states:

> *"Suspension is appropriate for more serious cases and may be appropriate when all or some of the following factors are present (this list is not exhaustive):*
>
> - *there is evidence of repetition of the behaviour;*
> - *the registrant has not shown insight and/or poses a significant risk of repeating the behaviour;*
> - *patients' interests would be insufficiently protected by a lesser sanction;*
> - *public confidence in the profession would be insufficiently protected by a lesser sanction;*
> - *there is no evidence of harmful deep-seated personality or professional attitudinal problems (which might make erasure the appropriate order)."*

The Committee noted that the factors identified above were present in this case other than the last factor as it had identified evidence of professional attitudinal problems on Mr Wienzek's part. It therefore considered the effect of a suspension order. The Committee considered that a suspension order would protect patients and signal the seriousness of Mr Wienzek's misconduct. However, the Committee noted that Mr Wienzek is currently suspended by the PCC for allegations some of which were similar to those found proved in

this hearing. Mr Wienzek did not engage with the initial hearing in August 2019 or the review hearing in August 2020. The Committee was of the view that this further demonstrated Mr Wienzek's complete lack of insight and professional attitudinal problems. It was also evident to the Committee that another period of suspension would be inappropriate. The Committee concluded that Mr Wienzek was unlikely to engage during another period of suspension.

The Committee then considered the guidance in relation to erasure.

> *"Erasure will be appropriate when the behaviour is fundamentally incompatible with being a dental professional: any of the following factors, or a combination of them, may point to such a conclusion:*
>
> - *serious departure(s) from the relevant professional standards;*
> - *where a continuing risk of serious harm to patients or other persons is identified;*
> - *a persistent lack of insight into the seriousness of actions or their consequences."*

The Committee considered that Mr Wienzek's actions were serious departures from the GDC's standards, his actions placed his patients at a risk of harm, there is no evidence of remediation of the failings found proved in this hearing and the previous hearing and he continues to demonstrate a lack of insight into the seriousness of his actions and a blatant disregard for his regulator. The Committee concluded that for all these reasons including those set out previously, the appropriate order to make is one of erasure.

The Committee therefore determined that, pursuant to section 27B (6)(a) of the Dentists Act 1984, Mr Wienzek's registration in the Dentists' Register be erased.

The Committee now invites submissions as to whether Mr Wienzek's registration should be suspended immediately in terms of S30 and 36U of the Dentists' Act 1984.

Decision on immediate order of suspension

The Committee took account of the submissions made by Ms Tahta on behalf of the GDC that an immediate order should be imposed on Mr Wienzek's registration.

The Committee accepted the advice of the Legal Adviser.

The Committee was of the view that having found that Mr Wienzek put patients at unwarranted risk of harm, breached fundamental tenets of the profession, brought the profession into disrepute and that he has demonstrated a continued lack of insight into his failings and a blatant disregard for his regulator, not to impose an immediate order would be inconsistent with these findings. It concluded that its findings reached the threshold for the imposition of an immediate order for the protection of the public and otherwise in the public interest. The Committee therefore determined that an immediate order of suspension should be imposed on Mr Wienzek's registration, pursuant to Section 30(1) of the Dentists Act 1984, as amended.

The effect of the foregoing direction and this order is that Mr Wienzek's registration will be suspended with immediate effect and unless he exercises his right to appeal, the substantive direction of erasure will take effect 28 days from when notice is deemed served on him. Should Mr Wienzek exercise his right to appeal, this order for immediate suspension will remain in place pending the resolution of any appeal proceedings.

The Committee revokes the interim order of suspension currently on Mr Wienzek's registration in terms if S36P(10) of the Dentists Act 1984.

That concludes the case."