Dental Professionals Hearings Service

PUBLIC HEARING

Professional Conduct Committee
Initial Hearing

Hearing Dates: 6 to 17 March 2023; 2 May 2023; 2 June 2023; and 11 to 12 September 2023

Name:	CIMPEAN, Razvan
Registration number:	114685
Case number:	CAS-197686-J2S5N0

General Dental Council:	Natasha Tahta, Counsel Instructed by Clare Hastie, Kingsley Napley
Registrant:	Present – Unrepresented in September 2023 Previously represented by Valerie Charbit, Counsel (March to June 2023) Instructed by Evan Wright, JMW Solicitors (March to June 2023)

Fitness to practise:	Impaired by reason of misconduct
Outcome:	Erased with Immediate Suspension
Duration:	N/A
Immediate order:	Immediate suspension order

Committee members:	Diane Meikle (Chair) (Lay) Alison Mayell (Dentist) Joanne Whitehouse (DCP)
Legal adviser:	Mark Sullivan
Committee Secretary:	Lola Bird

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Mr Cimpean,

1. This is a Professional Conduct Committee hearing in respect of a charge brought against you by the General Dental Council (GDC).

2. You are represented by Ms Valerie Charbit, Counsel. The Case Presenter for the GDC is Ms Natasha Tahta, Counsel.

3. The hearing has been conducted in a 'hybrid' format, with the majority of the factual inquiry held in-person at the offices of the Dental Professionals Hearings Service in London. The hearing is currently proceeding remotely by Microsoft Teams video-link.

4. The hearing first commenced on 6 March 2023 and adjourned part-heard on 17 March 2023. It resumed from 2 to 4 May 2023, with the majority of that session used for the Committee's deliberations on the alleged facts. The hearing has resumed today, 2 June 2023, for the handing down of the Committee's findings of fact.

5. Firstly, the Committee has set out in this document the preliminary matters dealt with at the hearing in March 2023, as well as its decision on the application made by the GDC to hear Patient 6's oral evidence by telephone, also made in March 2023.

PRELIMINARY MATTERS

Decision on application to amend the charge – 6 March 2023

6. At the outset of the hearing Ms Tahta made an application to amend the charge, pursuant to Rule 18 of the *GDC (Fitness to Practise) Rules Order of Council 2006* ('the Rules'). Her application was to withdraw heads of charge: 3a, 7c, 12cii, 13c, 15b, 16c and 16d.

7. Ms Tahta told the Committee that, shortly before the start of the hearing, information had been received by the GDC as part of the disclosure of your case. She explained that some of that information prompted further considerations of the charge by the GDC, along with its expert witness, Mr Geoffrey Bateman. Ms Tahta stated that, as a consequence of those further considerations, Mr Bateman was no longer critical of certain matters, hence the basis for her seeking to withdraw heads of charge 3a, 7c, 12cii, and 15b.

8. In relation to head of charge 13c, Ms Tahta submitted that this was an allegation that had been included in the charge in error.

9. With regard to heads of charge 16c and 16d, which were charged in respect of Patient 7, Ms Tahta told the Committee that the GDC sought to withdraw those allegations, as it had come to light that the orthopantomograph ('OPG'), which formed the basis of the criticisms, was in fact an OPG taken of a different patient and not Patient 7.

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10. It was Ms Tahta's submission that the proposed withdrawals were in your interests and that they fairly reflected the evidence.

11. Ms Charbit raised no objection to the GDC's application to amend the charge.

12. Having heard from both parties, and having accepted the advice of the Legal Adviser, the Committee acceded to the application to amend the charge. It had regard to the merits of the case and the fairness of the proceedings, and it was satisfied that the proposed withdrawals could be made without causing injustice. The charge was amended accordingly.

Admissions to the amended charge – 6 March 2023

13. You made a number of admissions to the amended charge. You admitted heads of charge: 4a, 4b, 6, 8a, 8b, 10a, 10b, 10c, 10d, 12a, 12ci, 13b, 16a and 16b. These allegations relate to alleged failings in the standard of your record keeping in respect of a number of the patients concerned.

The Committee's findings in respect of your admissions – 6 March 2023

14. The Committee accepted your admissions and heads of charge 4a, 4b, 6, 8a, 8b, 10a, 10b, 10c, 10d, 12a, 12ci, 13b, 16a and 16b were announced as admitted and found proved.

DECISION ON APPLICATION TO HEAR PATIENT 6's ORAL EVIDENCE BY TELEPHONE – 7 March 2023

15. On 7 March 2023, the Committee determined an application made by Ms Tahta to hear Patient 6's oral evidence by telephone. The original position had been that Patient 6 would appear by video-link on Microsoft Teams.

16. Ms Tahta stated that her application was made on the basis of the GDC's understanding that Patient 6 would be unable to access Microsoft Teams from her location at the time she was due to give evidence. Ms Tahta confirmed that the patient would have access to her emails, and therefore could be taken to relevant documents during her questioning.

17. Ms Tahta submitted that the Committee could receive evidence in any way it wished. She maintained that there would be no inherent unfairness in receiving Patient 6's oral evidence by telephone compared to on a video-link.

18. Ms Charbit opposed the application. She told the Committee that she had not been forewarned of the situation regarding Patient 6's oral evidence. She stated that your anticipation was that Patient 6 would give evidence via Microsoft Teams, where she could be seen and heard. It was Ms Charbit's submission that, given the subject that Patient 6 would be called to deal with, namely the issue of her informed consent for treatment, the credibility of this patient would be a matter that the Committee would need to consider in due course. Ms Charbit also asked the Committee to take into account that the content of Patient 6's evidence was in dispute.

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19. Ms Charbit submitted that Patient 6 was a determinative witness on the matters in question, and she stated that the Committee's assessment of the patient's oral evidence would be decisive. Ms Charbit contended that, in the circumstances, hearing Patient 6's oral evidence by telephone would be unfair.

The Committee's decision on the application

20. The Committee took account of the submissions made by both parties. It accepted the advice of the Legal Adviser.

21. The Committee noted that there is no provision in the Rules which requires evidence to be given in a certain form. However, it also took into account that the usual position, unless otherwise agreed, is for witnesses to give their oral evidence in person or by a video-link, so that they can be seen, as well as heard, although telephone evidence is not uncommon.

22. The Committee considered whether, in the circumstances of this case, it would be unfair to hear Patient 6's oral evidence by telephone. In doing so, it had regard to the submissions made by Ms Charbit regarding the issue of credibility. The Committee acknowledged that it would not be able to see Patient 6 if she gave evidence by telephone, which was not ideal. However, it did not consider that this amounted to such prejudice that Patient 6's evidence should not be heard by telephone.

23. The Committee took into account that it would be able to assess the quality of Patient 6's oral evidence when making its decision on the relevant facts, and attribute what weight it saw fit to her account.

24. Accordingly, the Committee determined to accede to the application to hear Patient 6's oral evidence by telephone.

FINDINGS OF FACT – 2 June 2023

Background and summary of the charge

25. At the material time, you held a self-employed associate contract with the company, MyDentist. The disputed charges against you include an allegation of dishonesty, as well as a number of clinical allegations.

26. With regard to the alleged dishonesty, it is asserted by the GDC that you failed to make complete records on the R4 software system at the MyDentist Practice at which you worked ('the Practice'), in respect of treatment you provided to five patients. It is alleged that this was to conceal from MyDentist that you were taking payment directly from the patients, contrary to your associate contract. The five patients in question are referred to anonymously in Schedule 1 to the amended charge, namely Patients 1, 2 3 4 and 5. Also included in Schedule 1 in relation to each patient are the dates of treatment, the type of treatment provided, and the cost charged.

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27. In opening the case for the GDC, Ms Tahta outlined the relevant provisions of your associate contract with MyDentist, as set out in the evidence. She stated that the contractual arrangement between you and MyDentist was that all payments for the work you carried out were taken by the Practice. The patients paid the Practice, a record was made in the Practice's computer system, and then, at the end of each month, you were entitled to be paid for the work that you had undertaken.

28. It was said that under your associate contract, you were generally entitled to receive 50% of all your private work, and 50% of all your NHS work. It was also said that laboratory costs were generally shared on a 50/50 basis between you and My Dentist. These contractual provisions, including the system of payment for work at the end of each month, were said to be normal for associate dentists. As you had been working under contract for MyDentist since 2013, the GDC maintained that you would have been well aware that all the treatment you provided to patients at the Practice, whether NHS or private, fell under this payment system.

29. Another detail highlighted in relation to your associate contract, which the GDC considered to be relevant to this case, was that you were not permitted to treat patients at the Practice out of hours. It was said, for example, that the Practice was not meant to be used at weekends. It was highlighted that within your contract there was a specific requirement that, although dental associates could have access to the Practice premises outside of normal working hours for any dental related work, that access was not for the treatment of patients.

30. In the context of this background, Ms Tahta summarised the evidence relied upon by the GDC in relation to the dishonesty allegation. This evidence included reference to the circumstances in which you provided treatment to Patients 1 to 5 and received payment from them, as well as evidence in relation to how you made computer records on the R4 software system in respect of their treatment. It is contended by the GDC that there is a difference in the way you entered the treatment of the five patients into the system, when compared with the way you entered information for patients who paid for their treatment the usual way through the Practice.

31. The other allegations in this case, namely the clinical allegations, arise out of your treatment of Patients 1 to 5, as well as two further patients, Patients 6 and 7. The clinical records for these seven patients were reviewed by Mr Bateman, the expert witness instructed by the GDC. Mr Bateman's expert evidence forms the basis of the alleged clinical matters, which in summary relate to the standard of care provided, informed consent and record keeping.

Evidence

32. The factual evidence adduced by the GDC included the clinical records for Patients 1 to 7. Also provided by the Council were the following witness statements along with associated exhibits:

- The witness statement of Patient 1 dated 20 June 2022.
- A witness statement from the son of Patient 2 dated 20 May 2022.
- The witness statement of Patient 6 dated 21 August 2022.

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- The witness statement of Witness A, Area Manager for MyDentist, dated 21 July 2022.
- The witness statement of Witness B, Patient Liaison Manager for MyDentist, dated 8 July 2022.
- The witness statement of Witness C, Self-employed Associate Dentist and Clinical Support Manager for MyDentist, dated 13 July 2022.

33. The Committee also heard oral evidence from Patient 1 and from Patient 6, both of whom gave their oral evidence by telephone. Witness A and Witness C attended the hearing in person to give their oral evidence.

34. The evidence of the remaining GDC witnesses, namely that of Patient 2's son and Witness B, was evidence that was agreed by both parties, and the Committee was content to proceed on the basis of their witness statements alone.

35. By way of expert evidence from the GDC, the Committee received the main report of Mr Bateman, dated 12 July 2022, as well as his supplementary report dated 15 March 2023. The Committee also heard oral evidence from him over a number of days in relation to the clinical aspects of this case. The majority of Mr Bateman's oral evidence was given in person.

36. The evidence received by the Committee in respect of your case at the fact-finding stage included your written responses to the allegations. You also provided a copy of your CV, an 'Inspection Report Summary' in relation to an inspection undertaken by Healthcare Inspectorate Wales at the practice, jointly owned by you, on 13 September 2022, a statement of your alleged financial losses over the period 2013 to 2019, and some client feedback forms. A number of character references were also submitted on your behalf.

37. Additionally, you gave oral evidence to the Committee over a number of days, the majority of which was heard in person. During your oral evidence you referred extensively to video evidence that you provided in respect of the CT scans you took of Patients 3 and 5. These videos were also referred to by Mr Bateman during his oral evidence.

Further admissions to the charge – 2 May 2023

38. In her closing submissions on the alleged facts, Ms Charbit acknowledged that the record keeping allegations at heads of charge 12(b), 12(c)(iii) and 13(a), which you denied at the outset of the hearing, had been "*made plain during the hearing"*. She stated that it was clear from the evidence that you had not properly reported on the CT scans and OPG radiograph, as alleged. Therefore, you no longer sought to advance a defence in relation to those three allegations.

The Committee findings

39. In reaching its findings on the outstanding allegations, the Committee considered all the evidence presented to it. It took account of the closing submissions, both written and oral, made by Ms Tahta on behalf of the GDC, and by Ms Charbit on your behalf.

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40. The Committee accepted the advice of the Legal Adviser. It considered each of the outstanding heads of charge separately, bearing in mind that the burden of proof rests with the GDC, and that the standard of proof is the civil standard, that is, whether the alleged matters are proved on the balance of probabilities.

41. The Committee findings in relation to all the alleged facts are as follows:

1.	*[You] Failed to make complete records on the R4 computer system in respect of treatment you provided to the patients listed in schedule 1, in order to conceal from MyDentist that you were taking payment directly from these patients.* **Found proved in respect of all the patients listed in Schedule 1, namely Patients 1 to 5.** It was not disputed that there is a duty on all GDC registrants to make complete and accurate patient records. Standard 4.1 of the GDC's *'Standards for the Dental Team (Effective from September 2013)'* makes clear that *"You must make and keep contemporaneous, complete and accurate patient records".* You admitted that you did not make complete records on the R4 computer system in respect of the five patients listed in Schedule 1. You accepted that in relation to the treatment provided to those patients, you had only completed what is known as a *"baseline"* record which simply records the condition of the patient's teeth upon initial examination. You accepted that the normal procedure was to make a complete record of the treatment provided which would, inter alia, form the basis for the calculation for what the patient was to be charged for the treatment. You accepted that by doing so, the R4 system did not allocate any charge to the patient and that MyDentist would therefore not be aware that a charge was due. You denied however, that this was to conceal from MyDentist that you were taking payment directly from the patients. In relation to Patients 2 to 5 in particular, it was your evidence that you believed you were entitled to the payments they made to you. You stated that you were recovering funds which MyDentist had wrongfully withheld from you. You maintained in relation to the payment you received from Patient 1 that it had been your intention to inform MyDentist of the matter and to pay the company what it was owed. In all cases, you stated that there was no deliberate attempt on your part to conceal what you were doing. The Committee was satisfied on the basis of the evidence, and your own admission, that you failed in your duty to make and keep contemporaneous, complete, and accurate R4 computer records in respect of Patients 1 to 5. The outstanding issue for the Committee was whether you failed to make complete computer records in order to conceal from MyDentist that you were taking payment directly from the five patients.

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	In reaching its decision, the Committee had regard to the reasons that you gave in your oral evidence for the incomplete computer records. In respect of Patient 1, you stated that you had no access to the computer system to complete her records. In relation to Patients 2 to 5, you stated that you did not have sufficient time to complete their records. However, having considered all the evidence, the Committee concluded that your explanations lacked credibility. The Committee noted that you provided extensive dental treatment to Patient 1, which involved the provision of 16 crowns and a five-unit bridge. One of the appointments that Patient 1 attended with you was out of Practice hours on the evening of Sunday, 22 September 2019. Whilst the Committee had regard to your account that this was an emergency appointment, it found that this was not supported by the other evidence before it. The handwritten notes that you made of that appointment indicate that it was a *"crown and bridges fit appointment*". Patient 1 also recalled in her witness statement that the appointment was for the *"fitting of prepared crowns".* It was at this out of hours appointment that you also took payment for treatment from Patient 1, using a personal PDQ machine. The total cost of her treatment was £14,000, which was put through on the PDQ machine as two separate payments of £5,500 and one payment of £3,000. You told the Committee that this was because Patient 1's initial attempt to pay the full £14,000 in one transaction was declined. Patient 1's appointment on 22 September 2019 was not recorded in the patient's R4 computer records with the Practice. Nor was the fact that the patient had paid you £14,000. The Committee accepted that you may not have had access to the computer system on that Sunday evening, when the Practice was effectively closed. It noted, however, that at no point subsequently did you update the patient's computer records to show that the appointment had taken place. Overall, you recorded very little in Patient 1's computer records, despite the extensive nature of her treatment. The evidence shows that there were a number of other appointments that Patient 1 attended with you, both before and after the evening of 22 September 2019. Those other appointments were during the Practice's opening hours, when you would ordinarily have had access to the R4 computer system. However, the extent of your computer records for Patient 1 was the charting of the patient's existing teeth, which you entered onto the system at the patient's first appointment on 3 May 2019, followed by a brief entry made on 15 August 2019, in which you recorded that the patient would like to go ahead with the treatment previously discussed. In respect of the appointment on 15 August 2019, the Committee considered it significant that you did not generate a treatment plan for Patient 1 on the computer system, despite having noted on the system that the patient had agreed to go ahead with treatment. You clearly had access to the R4 computer system at the time. The Committee took into account the evidence of Witness B, who states in his witness statement that, "*All payments are to be handled by the Practice's reception team. No dentist should be paid directly by patients in any of our*

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	practices. The standard process is that the dentist creates a treatment plan and explains to the patient what the treatment entails, the cost of the treatment if the patient is private paying, and the length of time it will take to complete. Any treatment a patient undergoes has to be logged within the clinical record by the treating dentist using our R4 computer system. This system shows the history of all payments made by patients. In order to provide a treatment plan, the details for the payment have to be entered into the R4 system. This then alerts reception that there is a charge on a patient's account. The dentist then provides the treatment plan to the patient, who attends reception and pays for the treatment". Similarly, Witness C states in his witness statement that *"…When a dentist is building a treatment plan for a patient they will use the plan tab and then select the relevant tooth and what treatment the patient will be receiving. If they select a crown, for example, the system will automatically generate a charge for that patient which they will then need to pay at the reception desk after the appointment".* Taking all the evidence into account, the Committee rejected your explanation that it was a lack of access to the R4 computer system that prevented you from making complete computer records in respect of your treatment of Patient 1. The Committee considered that you had opportunities to ensure that Patient 1's computer records were completed and up to date, including with a treatment plan which, as described by Witnesses B and C, would have alerted the Practice reception of the need to take payment from Patient 1. The Committee noted that the large majority of the records you made in relation to Patient 1's treatment were handwritten. It was satisfied on the evidence that it was more likely than not that you failed in your duty to make complete records on the R4 system in order to conceal from MyDentist that you were taking payment directly from Patient 1. In finding this allegation proved in relation to Patient 1, the Committee also took into account the evidence that it was not through your own admission that MyDentist became aware of the matter. The issue only came to light when Patient 1 contacted the Practice to request a receipt for the £14,000 she paid you. The Committee did not accept your evidence that you had been distracted from mentioning Patient 1's payment to MyDentist by your personal circumstances, the details of which were heard in private. The Committee noted the evidence indicating that those personal circumstances did not arise until about mid-October 2019. It considered that you had ample opportunity prior to that time to raise the issue with MyDentist and pay its share of the money, as you said you had intended. The Committee noted that two meetings were held in respect of the issue involving Patient 1, one on 22 October 2019 and the other on 21 November 2019, and subsequently you were required to pay MyDentist its share of the £14,000 minus half the laboratory fees which you had paid in full. The manner in which the issue was disclosed to MyDentist further persuaded the Committee that it was more likely that you failed to make complete R4 computer

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	records in respect of Patient 1's treatment in order to conceal that you were taking payment directly from the patient. The Committee also noted that this was the only occasion on which you had paid the laboratory fee personally, contrary to the usual process of the Practice paying the fee. The Committee considered that you paid this fee personally to conceal that you had used the laboratory for Patient 1. In respect of Patients 2 to 5, the Committee noted that for each of these patients you recorded the details of the treatment that you proposed to provide to them in the baseline charting on the R4 computer system. This was instead of using the computer-generated treatment plan which, the Committee noted from the evidence of Witnesses B and C, was the standard process for logging proposed treatment, and which would have alerted the Practice reception of charges on the patients' accounts. The Committee noted that in relation to your treatment of the two other patients in this case, Patients 6 and 7 (not included in Schedule 1), you did make a record of their treatment using the computer-generated treatment plan. Patients 6 and 7 did not pay you directly. The Committee noted the written evidence of Witness C *that "the baseline tab in the charting section of the records.. is used when a dentist first sees a patient in order to chart the treatment the patient has already had…As this is a record of pre-existing treatment, a charge will not be generated from the inputting of this information"*. In your written response to the allegations, you acknowledged the effect of using the baseline charting to make records. You also acknowledged that doing so was not your usual practice. You stated that *"…there were occasions when I recorded the treatment differently on R4. The way I completed the relevant records against the baseline on R4 meant that a payment instruction was not automatically raised for the receptionist's attention. In my frustration, I did this in the belief that I was treating one of my own patients, but I recognize the dispute with MyDentist in that respect".* The Committee took into account the conflict between your written response, in which you reference your frustration over your dispute with MyDentist, and your explanation given in oral evidence that you had insufficient time to make complete R4 computer records for Patients 2 to 5. It was the conclusion of the Committee that it was more likely than not that your written response indicates the true position. The Committee found that you were consistent in your evidence that you believed MyDentist owed you money. The Committee considered that you consciously completed the records for Patients 2 to 5 against the baseline on R4 in order to avoid the computer system generating charges that would be noticed by the Practice reception. In rejecting your explanation about a lack of time to make complete records, the Committee took into account that you had sufficient time to input the relevant information into the baseline charting. It also took into account your acknowledgment that this was not your usual practice. You accepted that you had recorded "*treatment differently on R4".*

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	Taking all the evidence into account, it was the finding of the Committee that you failed to make complete R4 computer records in respect of your treatment of Patients 2 to 5 in order to conceal that you were taking payment directly from them. In finding head of charge 1 proved in respect of all the patients concerned, the Committee was satisfied that there was no facility in your contract with MyDentist which allowed you to engage your own patients privately, as alluded to in your written response. The Committee had a copy of the contract before it and found no such provision. It also took into account the evidence of Witness A that no such provision existed in your contract. Further, the Committee noted that no mention was made by you of your belief of a 'private patient facility' at the meetings you attended with MyDentist in October and November 2019 in respect of Patient 1, at which time you had completed the treatments of the other patients. In all the circumstances, the Committee was satisfied on the balance of probabilities that head of charge 1 is proved in its entirety.
2.	*Your conduct at 1 above was:*
2. a.	*misleading;* **Found proved.** You accepted in your evidence that your failure to make complete R4 computer records for Patients 1 to 5 could have misled MyDentist, but that it was not your intention to mislead. The Committee took into account that an allegation of 'misleading' conduct in this context is judged objectively. Therefore, your evidence that you did not intend to mislead is irrelevant. The Committee found that you failed to make complete computer records in respect of each of the patients in question in order to conceal from MyDentist that you were taking payments directly from the patients. The effect of this was that MyDentist was unaware of the charges relating to your treatment of Patients 1 to 5. In this regard, the Committee noted the evidence of Witness C, who stated in his witness statement that *"By not charting the treatment or using the baseline option in the chart, Mr Cimpean was bypassing the system so that the patients did not have to make a payment to MyDentist for their treatment".* The Committee was satisfied on the balance of probabilities that your conduct as found proved at 1 above, gave MyDentist the wrong impression in terms what money was owed to the company. Accordingly, this head of charge is proved.
2. b.	*dishonest.* **Found proved.**

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	The Committee found proved that you failed to make complete records on the R4 computer system in respect of Patients 1 to 5 in order to conceal from MyDentist that you were taking payment directly from these patients. In determining whether your conduct in this regard was dishonest, the Committee applied the test for dishonesty, as set out in the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67.* The Committee first ascertained the actual state of your knowledge or belief as to the facts. It took into account that it is not a requirement that your belief must be reasonable; the question is whether your belief was genuinely held. The crux of your evidence was that you did what you did because you believed that MyDentist owed you money. Your position, in light of your belief, was that you did not act dishonestly, and that honest and decent people would regard your conduct as legitimate. The Committee noted the closing submissions made on your behalf regarding a 'claim of right' under section 2(1) of the *Theft Act 1968*. You were not charged with theft, but by analogy, it was submitted on your behalf that if you believed you had the right to take payment directly from the patients, you could not be regarded as dishonest. In accordance with the legal advice that the Committee was given, it did not accept that the cited provision of the *Theft Act 1968* applies in the circumstances of this case. You have not been charged with theft. Accordingly, the Committee did not take into account section 2(1) of the *Theft Act 1968* in reaching its decision on the issue of dishonesty. The Committee also had regard to the case of *Birhan v The Commissioners for Her Majesty's Revenue and Customs* [2022] UKFTT 00270 (TC). This case was drawn to the Committee's attention in the closing submissions made on your behalf. In the Committee's view, the judgement in *Birhan* did not take the matters in this case any further forward. The Tribunal Judge in *Birhan* applied the dishonesty test in *Ivey* and came to his conclusion. This Committee applied the same test and came to its own conclusion on the evidence before it. The Committee considered what you said about MyDentist owing you money. However, the evidence of Witness A was that there were no outstanding funds due to you from MyDentist. The Committee was referred to email correspondence between Witness A and a MyDentist Dental Payments Supervisor on 16 May 2022, in which it was stated *"No we don't have anything retained for Razvan"*. Whilst the Committee had regard to the statement of financial losses that you provided in support of your case, there was no other evidence to support any promises of payment to you from MyDentist. The Committee noted that some of the items you listed on your financial statement were settled by MyDentist, and you recorded those items as recovered. In relation to the amounts that you said were outstanding, a total of over £100,000, you listed in your financial statement items such as *"Opportunity loss", "Marketing fees"* and *"Loss of income through false claims…".* However, there was no evidence before the Committee to suggest that you formally relayed these itemised claims to MyDentist, nor was

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	there any information to show that they were established debts. The Committee also noted the reference in your financial statement to unpaid *"Third party fees…",* which it understood to be fees in respect of a mentor that you had engaged. The Committee noted that there was some correspondence between you and Witness A regarding this matter. You provided a copy of an email you sent to Witness A dated 13 February 2017. The Committee noted, however, that in that email you asked the following regarding your mentoring fees *"Do you think we can discuss so the company considers the mentor's fee just another expenditure that we share?".* The Committee considered from your question that you knew that the company was not contractually obliged to pay your mentor's fees. Further, there was no evidence before the Committee to indicate that any agreement was reached regarding your proposal to share that expenditure. The Committee acknowledged the evidence you put forward regarding previous payment disputes and heard that you had previously commenced legal proceedings against MyDentist for the repayment of established debts in October 2013. In light of this history, the Committee considered that if you had genuinely believed that you were owed over £100,000 by MyDentist, you would have formally put this to the company and/or pursued the matter legally as you had done before. It was the view of the Committee, having considered all the evidence, that whilst you may have been dissatisfied and frustrated with your relationship with MyDentist, you did not genuinely believe that you had a right to the money you retained. It considered that you had a sense of grievance about your financial situation whilst contracted with the company because you wanted to be paid more. The Committee noted that you had previously complained that the company had advertised for a new dentist at a higher UDA remuneration rate than you. You had also sent communications to MyDentist suggesting that you had not been properly remunerated by the company for marketing that you said you had undertaken. In the Committee's judgement it was your sense of grievance, and not a genuine belief that MyDentist owed you money, that prompted your failure to make complete records to conceal the payments you took from Patients 1 to 5. Having ascertained your knowledge and belief as to the facts, the Committee next considered whether your conduct would be considered dishonest by ordinary decent people. The Committee was satisfied that ordinary decent people would regard your failure to make complete records in order to take and keep money that you knew you were not entitled to as dishonest. The Committee considered that, even if it had concluded that you genuinely believed that you were entitled to the money, taking the law into your own hands by concealing the direct payments would still be regarded as dishonest. The Committee took into account that, whilst you do have a fitness to practise history, you have not previously been accused of dishonesty. It was however, satisfied on the basis of the evidence that you were dishonest on this occasion.

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	The Committee also noted the written character references that were provided to it on your behalf, although it found these to be of limited value given that three of the four references were from family members. The Committee's finding is that this head of charge is proved.
Patient 1	
3.	*Failed to provide an adequate standard of care to Patient 1 before providing extensive crown and bridgework, between 15 August 2019 and 22 September 2019, in that you failed to:*
3. a.	**WITHDRAWN.**
3. b.	*obtain study models;* **Found proved.** In considering this and any other charges alleging a failure to do something, the Committee recognised that it first had to be satisfied that you were under an obligation to take the relevant action, and secondly that you did not do so. The Committee noted the clear difference in opinion between you and Mr Bateman on the requirement for obtaining study models. You did not obtain study models in respect of Patient 1. It was your evidence that study models were not necessary for your treatment of the patient. In your written response to this allegation, you stated *"In this case, study models were not needed as they would have been just a copy of the existing veneers and bridges and would not have given any information with regards to the natural teeth's condition, shape, volume or position".* You expanded on your opinion in your oral evidence, stating that many of Patient 1's teeth were covered by crowns, and that you would only use study models where lots of natural teeth were present. You stated that study models would not have provided the necessary information, and that you took photographs of the patient instead. The Committee was shown the photographs that you took from three different perspectives: one of the frontal view of the patient's teeth, one photograph of the left profile of her teeth, and one photograph of the right profile of her teeth. You stated that the photographs showed the patient smiling in a natural way, and that this had helped you to assess and plan her treatment. You stated that you could see from the photographs how the patient's teeth were biting together, and how many of her teeth were visible with a natural smile. Mr Bateman's opinion was that study models were required in the circumstances of Patient 1's treatment which, he noted, involved complex restorative dental care in both the upper and lower arches. In his main report, Mr Bateman stated that *"With simpler treatment such as a single crown it is reasonable not to have study models but with multiple units planned, in my view it is unsafe to rely on merely a visual examination of how the teeth meet together and how that may*

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	change with such treatment,. A dentist needs to plan how much tooth tissue should be removed and where; study models are the accepted standard for doing that.". The Committee noted that at the time of writing his main report, Mr Bateman had been unaware of the photographs that you took of Patient 1's teeth. However, in his oral evidence he maintained his opinion that obtaining study models was a basic standard in the care of this patient. Mr Bateman told the Committee that the purpose of obtaining study models was not to capture a patient's natural teeth, but to provide a permanent 3D record of a patient's mouth at the outset, including the position of the teeth at the time, whether restored or not. Mr Bateman stated that study models were very useful for initial planning purposes, including for the dental laboratory to be able to see the patient's existing occlusion and to decide how the restorations should look. Mr Bateman also stated that study models provided important information for the treating dentist, and any subsequent treating dentist. He explained that if anything went wrong with a patient's treatment, study models would provide a baseline to refer back to. Mr Bateman did not consider the taking of photographs to be adequate in Patient 1's case. In finding this allegation proved, the Committee acknowledged that you are a dentist with many years' experience, and that you are entitled to hold your own opinions. In coming to a conclusion on this and all the other clinical charges, the Committee bore in mind that the GDC is required to prove that the standard of care provided was such that no reasonable dentist would have done or failed to do what is alleged in the charge and it is not simply whether others would have acted differently. However, having considered the nature and extent of the proposed treatment for Patient 1, the Committee accepted the evidence of Mr Bateman in relation to the obtaining study models. It found that he was clear and consistent in explaining the relevance of study models in the context of extensive dental work. The Committee accepted Mr Bateman's conclusion as set in his main report that, *"In the circumstances, no reasonable dentist would have failed to obtain pre-treatment study models and a failure to do the same put the patient at risk of failure or significant problems with crown and bridgework".* Accordingly, the Committee was satisfied that you failed to provide an adequate standard of care to Patient 1 before providing extensive crown and bridgework between the dates in question by not obtaining study models.
3. c.	*obtain periapical radiographs of the heavily restored teeth that you prepared for crown and bridgework, namely:*
3. c. i.	*UR4* **Found proved.**
3. c. ii.	*UL1*

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	Found proved.
3. c. iii.	*UL3/4* **Found proved.**
3. c. iv.	*LR5/4* **Found proved.** The Committee considered heads of charge 3.c.i to 3.c.iv separately but reached the same finding in relation to each allegation. You assessed radiographically the teeth referred to at 3.c.i to 3.c.iv above using OPG radiographs. The evidence of Mr Bateman was that OPG radiographs were insufficient to adequately assess the status of these teeth, and that periapical radiographs should have been taken. He stated in his main report regarding OPG radiographs, *"That x-ray type has poor resolution of any disease at the tip of the root of the tooth, that may have been present but hidden on that film".* Mr Bateman stated that the OPG radiographs taken in relation to the above teeth suggested that there may have been apical infection at the tips of the root of UL1 and LR5, but that he was unable to say definitively from those films. He told the Committee that periapical radiographs would have provided a view of the apices of the teeth, and therefore would have shown more information than the OPG radiographs. Mr Bateman noted that all the teeth in question were heavily restored, and that it was not unusual for such teeth to have nerve problems. He stated in his oral evidence that sometimes root canal infections are "*quiet"* and will only show upon x-ray. It was his opinion that any reasonable dentist would have exposed periapical films of the UR4, UL1, UL3/4 and LR5/4. He stated that periapical radiographs are the standard view for assessing endodontic pathology, and he regarded it a failure not to have obtained periapical radiographs of these teeth, which you had prepared for crown and bridgework. You admitted that you should have taken periapical radiographs of the teeth in question. You stated however, that the intra-oral x-ray machine at the Practice was not working at the time, so you took OPG radiographs instead. You told the Committee that the intra-oral x-ray machine at the Practice had not worked for four years. It was on this basis that you denied that there had been any failure on your part. The Committee was satisfied from Mr Bateman's evidence that you should have taken periapical radiographs of the teeth listed at 3.c.i to 3.c.iv above. It also took into account your acceptance that you should have taken periapical radiographs. In finding that there was a failure on your part to obtain periapical radiographs, the Committee rejected your evidence regarding the faulty intra-oral x-ray

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	machine. Witness C was asked questions about this matter, and he told the Committee that he had been unaware that the x-ray machine had not been working. Furthermore, the Committee considered that if it was the case that the intra-oral x-ray machine had not been working for a number of years, as you maintained, there would have been more extensive communication about the issue. The Committee had regard to the email dated 17 March 2015, which was drawn to its attention as evidence that you mentioned the intra-oral x-ray machine with Witness A. In that email you stated that "*the x-ray machine sometime and the sensor some other times didn't work for ages" [sic]* The Committee considered that your non-specific complaint about the machine not working 'sometimes' is a complete contradiction to your evidence that the machine had not been working for four years. The Committee also took into account the evidence of Witness C who stated that the Practice had x-ray arms in two of the surgeries. Witness C also stated that if the x-ray machine had not been working the fault would have been reported and it would have been logged as a faulty item. The Committee was satisfied on the balance of probabilities that you did have adequate access to a working intra-oral x-ray machine at the Practice, and that your failure to take periapical radiographs of the teeth in question was not attributable to the non-availability of the necessary equipment. In all the circumstances, the Committee was satisfied that heads of charge 3.c.i to 3.c.iv are proved, and that as a result you failed to provide an adequate standard of care to Patient 1 before providing extensive crown and bridgework between the dates in question.
3. d.	*provide a written treatment plan to Patient 1.* **Found proved.** It was your evidence that, although no treatment plan could be found at the Practice, you believed that you did provide a written treatment plan to Patient 1. You stated in your written response to this allegation that *"I rely on the fact that in respect of the 6 out of 7 patients where the treatment plan was initially not found, it was eventually located. I believe the treatment plan exists, but simply cannot be found".* The Committee did not have sight of a written treatment plan for Patient 1. It took into account that written treatment plans in respect of the other patients in this case, which were initially deemed missing from their records, were eventually found, and produced by you, hence the withdrawal of a number of allegations at the outset of the hearing. However, the Committee also took into account the complete lack of computer records as far as Patient 1's treatment is concerned. In addition, it had regard to Patient 1's oral evidence that she did not recall receiving a written treatment plan in respect of her treatment with you.

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	In considering Patient 1's evidence, the Committee noted her acknowledgement that her memory was not as good as it was. However, it found that she was clear when she stated in her oral evidence that she was someone who generally kept paperwork that was given to her. She also stated that the treatment she received had been more extensive than she was expecting. This indicated to the Committee that it was more likely than not that she had not received a written treatment plan of the treatment proposed. Having considered the absence of a written treatment plan in Patient 1's records, the general standard of your record keeping in relation her treatment, and the patient's oral evidence, the Committee concluded that it more likely than not that you did not provide the patient with a written treatment plan. The Committee was satisfied that this amounted to a failure on your part to provide an adequate standard of care to Patient 1 before providing extensive crown and bridgework between the dates in question. In this regard, it took into account Mr Bateman's evidence in his main report that the provision of a written treatment plan "… *is a standard mandated by the General Dental Council in Standards for the Dental Team at 2.3.6; 2.3.7 and 2.3.8".* Accordingly, the Committee found this allegation at 3.d. proved.
4.	*Failed to maintain an adequate standard of record keeping in that you failed to:*
4. a.	*adequately report on the orthopantomograph ("OPG") of Patient 1, taken on 15 August 2019;* **Admitted and found proved.**
4. b.	*make an adequate contemporaneous record of patient 1's appointment on 15 August 2019.* **Admitted and found proved.**
5.	*You failed to obtain informed consent from Patient 1 before providing extensive crown and bridgework, between 15 August 2019 and 22 September 2019.* **Found proved.** In considering this and other allegations of a failure to obtain informed consent, the Committee had regard to the nature and extent of what is required of a practitioner as set out in *Montgomery v Lanarkshire Health Board* [2015] AC 1430. The Committee noted Mr Bateman's evidence in respect of your treatment of Patient 1 that, *"To have gain[ed] consent for care, the Registrant would need to have discussed the justification for his treatment proposed; the cost of the same; alternative treatment options and the risks and benefits of care".* His opinion was that *"The failure to have exposed periapical radiographs of the teeth UR4 UL134*

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	LR54, with particular reference to disease at UL1 and LR5, meant that patient and the Registrant were not in a position to have understood the risks of care and alternative treatment options. In this respect the Registrant could not have gained an adequate consent for care". The Committee accepted Mr Bateman's opinion. In its view, you could not have adequately discussed the risks and benefits of the proposed treatment with Patient 1 without having taken periapical radiographs to assess the status of the UR4, UL1, UL3/4 and LR5/4. In the absence of such radiographs, you were not in a position to know fully what lay beneath these teeth which had previously been extensively restored. Also, in considering the issue of informed consent, the Committee took into account its finding that you did not provide Patient 1 with a written treatment plan. It noted her oral evidence indicating that she had not appreciated beforehand the extensive nature of the proposed treatment. This suggested to the Committee that she had not been fully prepared for what was carried out. Having taken all the evidence into account, the Committee was satisfied that this head of charge is proved on the balance of probabilities. It was satisfied that there was sufficient evidence to determine that you failed to obtain informed consent from Patient 1 before providing extensive crown and bridgework between the dates in question.
Patient 2	
6.	*Failed to maintain an adequate standard of record keeping between 17 June 2019 and 25 July 2019 in that you failed to record the appointment at which you assessed Patient 2's suitability for implant placement at the UR1 and UL1.* **Admitted and found proved.**
Patient 3	
7.	*Failed to provide an adequate standard of care to Patient 3 between 15 February 2019 and 18 March 2019, in that you failed to:*
7. a.	*make an adequate periodontal assessment of Patient 3;* **Found proved.** The treatment that you provided to Patient 3 involved the placement of implants and the provision of a bridge in the patient's upper arch. Mr Bateman stated in his main report that he was critical "*of an apparent failure to have carried out any or any adequate periodontal assessment*" in respect of Patient 3. In his oral evidence, Mr Bateman told the Committee that, although the proposed treatment was for the upper arch, he had been concerned by the evidence of the periodontal status of the patient's teeth in the lower arch. In particular, that an OPG radiograph of 2 July 2019 revealed severe bone loss and

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	pathology at LL1. Mr Bateman's opinion was that the whole of Patient 3's mouth should have been periodontally assessed prior to the provision of treatment, and that the patient should have been made aware of the potentially imminent loss of the LL1, before embarking on complex and expensive implant care in the upper arch. He stated that Patient 3 may well have opted for a different treatment plan in the circumstances. You denied that you had a duty to make a periodontal assessment in respect of Patient 3 in the context of the care that you were providing. In your written response to this allegation, you stated *"I was called in as "the implant dentist". I was the specialist dentist called for an opinion and primary assessment of the maxillary anterior area after the patient requested implant treatment for the prosthetic restoration of this area…I was not dealing in full mouth rehabilitation in this case. All prosthetic options were explained, and the patient chose to go ahead with the implants".* The Committee accepted the opinion of Mr Bateman on this issue. Whilst it took into account that Patient 3 had been referred to you for implant treatment, it also took into account Mr Bateman's oral evidence that patients with periodontal disease are at risk of implant failure. Given the potential impact of any periodontal disease on the treatment that you proposed to provide, the Committee was satisfied that you should have carried out a periodontal assessment of the patient prior to starting implant treatment. Furthermore, the Committee was satisfied that the periodontal assessment should have been of the patient's whole mouth. It took into account that the LL1, in which significant periodontal disease had been identified, was a tooth directly opposing the implants proposed for the upper arch. The Committee accepted the opinion of Mr Bateman that "*periodontal infection at a hopeless disease tooth put the implant care at risk and further would have been relevant to the patients consent for care in the upper arch in the event that a lower front tooth was about to be lost imminently".* The Committee was satisfied on the evidence that this head of charge is proved. It was also satisfied that you failed to provide Patient 3 with an adequate standard of care between the date in question by not carrying out an adequate periodontal assessment before starting the treatment, given the evidence indicating the potential imminent loss of the LL1, and the general risk of implant failure from periodontal disease.
7. b.	*diagnose periodontal disease at the LL1;* **Found proved.** The Committee considered it clear from your evidence that you knew that there was periodontal disease at LL1. You stated, however, that you did not diagnose it because it had already been diagnosed previously by Patient 3's treating dentist. In this regard, you highlighted from the patient's clinical records that

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	periodontal disease on the lower incisors was first diagnosed on 16 January 2017, when BPE scores of 4 were recorded for this area. Further, that at an emergency appointment on 2 March 2017, the patient was diagnosed with and informed about a periodontal abscess at LL1. You maintained that you were only seeing Patient 3 as a specialist dentist, specifically for the provision of the implants in the upper arch. However, the Committee accepted the opinion of Mr Bateman that you had a duty to diagnose the periodontal disease that was radiographically evident at LL1. The Committee considered that this was your responsibility, while providing treatment to Patient 3, in light of the risk periodontal disease poses to the success of implant treatment. In the Committee's view, the fact that Patient 3 had been made aware previously of the presence of periodontal disease at LL1 was irrelevant. The Committee accepted Mr Bateman's opinion that you had a duty to refresh that periodontal assessment and make a diagnosis in respect of LL1. He told the Committee that a periodontal assessment was a necessary part of planning implant treatment. The Committee had regard to Mr Bateman's considerable experience in implantology, which has included planning thousands of implants. The Committee noted and accepted his opinion that the available CT scan of Patient 3's upper jaw was not sufficient to amount to an assessment of the patient's entire mouth. You should have but did not carry out a periodontal assessment of Patient 3's upper and lower arches and therefore did not make a fresh diagnosis of the periodontal disease at LL1. The Committee was satisfied that this was a failure on your part, which also amounted to a failure to provide Patient 3 with an adequate standard of care between the dates in question.
7. c.	**WITHDRAWN.**
8.	*Failed to maintain an adequate standard of record keeping between 15 February 2019 and 18 March 2019 in that you failed to:*
8. a.	*adequately report on the computed tomography ("CT") scan of Patient 3, taken on 15 February 2019;* **Admitted and found proved.**
8. b.	*record the appointment at which you assessed Patient 3's suitability for implants.* **Admitted and found proved.**
9.	*Failed to obtain informed consent from Patient 3 to place upper implants between 15 February 2019 and 18 March 2019 in that you failed to inform Patient 3:*
9. a.	*of the risk of infection at the LL1;* **Found proved.**

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	The Committee accepted the evidence of Mr Bateman that there was a risk of infection at the LL1. It was further satisfied that you did not inform Patient 1 of this risk, given your evidence that you were only called upon as a specialist to deal with implant treatment to the Patient 3's upper arch. The Committee noted and accepted the evidence of Mr Bateman that in respect of the LL1 *"…the patient could not have understood the risk of the loss of that tooth in the near future and whether that would influence her decision to have implant treatment at her upper teeth"*. The Committee considered that the risk of loss of the LL1 represented a material risk involved in the implant treatment that you proposed for Patient 3. As such, she should have been informed of that risk in course of the consent process, as part of any discussion on alternative treatment options and the risks and benefits of the proposed treatment. Given the Committee's conclusion that you did not inform Patient 3 of the risk of infection at the LL1, it was satisfied on the balance of probabilities that you failed to obtain inform consent for treatment from the patient.
9. b.	*that the UR3 was viable and did not need to be removed for implant care.* **Found proved.** It was agreed by both parties that UR3 was a viable tooth. The difference of professional opinion between you and Mr Bateman was whether the UR3 needed to be removed for implant care. The Committee heard extensive evidence from both you and Mr Bateman on this issue. This included considerable reference by both parties to the video evidence that you provided in respect of the CT scans you took of Patient 3. It was your opinion, on your assessment of the CT Scans and video evidence, that there was insufficient bone in the UR2 area for the placement of an implant. You maintained that no implant could have been placed in this area without the need for bone augmentation prior to implant treatment. This was one option. In your view, there was also a second option, this being the removal of the viable UR3 and using the "*good bone volume"* on that site for the placement of the implant. As you stated in your written response to this allegation, you considered this second option *"was more straightforward, less traumatic and helped the patient to regain a fixed dentition in the minimum time at a lower cost".* You also said in your evidence that you had explained to Patient 3 that proceeding without extracting UR3 would require bone augmentation at UR2 and that she opted for the extraction. Mr Bateman's opinion was that there was sufficient bone in the UR2 area, and so in his view, there was no good justification for extracting the viable UR3. Mr Bateman did not consider your assessment of the CT scans to be accurate. The first time that Mr Bateman had seen the video evidence of the CT scans was

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	during his cross-examination on the matter. However, he maintained his original opinion and provided the Committee with his supplementary report in which he stated *"I was able to download this software as freeware in the evening, following the conclusion of Razvan Cimpean's evidence. I was further able to analyse raw CT data for Patient 3 with this same software. I planned an implant with this software at the UR2 site. On the basis of this planning, I formed the view that any reasonable dentist would have considered that an implant was possible at that site. That was consistent with my analysis of the original CT data."* Having considered all the evidence, the Committee accepted the professional opinion of Mr Bateman. In doing so, it took into account his background and experience as a specialist in restorative dentistry and his considerable experience in implantology. The Committee found that Mr Bateman remained clear and consistent in his opinion, even after carrying out an assessment using the same software that you used. The Committee was satisfied on the evidence of Mr Bateman that there was enough bone in the UR2 for the placement of an implant, and therefore there was no adequate justification for the removal of the viable UR3. Accordingly, the Committee considered that your opinion was incorrect. It was satisfied, having heard Mr Bateman's clear and detailed assessment, that no reasonable dentist would have supported the removal of the healthy UR3. Having accepted Mr Bateman's evidence, the Committee considered whether there had been a failure on your part to obtain informed consent from Patient 3 to place upper implants, as alleged in the stem of this allegation. The Committee considered that as your discussion with Patient 3 about removing the viable UR3 was based on your incorrect and unreasonable opinion that there was insufficient bone in the UR2 area, she could not have given her informed consent for the upper implant treatment. In the Committee's view, Patient 3's decision to proceed with the treatment was based on wrong information. The Committee was therefore satisfied that this head of charge is proved.
Patient 4	
10.	*Failed to maintain an adequate standard of record keeping between 1 August 2018 and 24 August 2018, in that you failed to:*
10. a.	*adequately report on the CT scan of Patient 4, taken on 1 August 2018;* **Admitted and found proved.**
10. b.	*adequately report on the OPG of Patient 4, taken on 24 August 2018;* **Admitted and found proved.**
10. c.	*record the appointment at which you assessed Patient 4's suitability for implants;* **Admitted and found proved.**

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10. d.	*record the appointment at which you placed Patient 4's implants.* **Admitted and found proved.**
Patient 5	
11.	*Failed to provide an adequate standard of care to Patient 5 between 12 September 2018 and 3 July 2019, in that you:*
11. a.	*failed to diagnose caries visible radiographically on the OPG taken between 14 September 2018 and 8 October 2018, at the:*
11. a. i.	*UL6;* **Found proved.**
11. a. ii.	*UL7;* **Found proved.** The Committee considered heads of charge 11.a.i and 11.a.ii separately but reached the same finding in relation to each allegation. It was the evidence of Mr Bateman, having viewed the OPG radiograph in question, that there was a high index of suspicion of caries at the UL6 and UL7. He told the Committee that caries does not always show up well on OPG radiographs, and that bitewing radiographs are usually used to diagnose caries. He stated that if caries can be seen on an OPG radiograph, that would indicate that the caries would be more extensive clinically. You disagreed that the OPG radiographs showed the presence of caries on the UL6 and UL7. You stated in your written response to the allegation that the OPG radiograph in question *"shows a large area of translucency which at the first sight can be mistaken for a large carious cavity".* It was your opinion that this large translucent area was either a dental lining or previous drilling that had been filled. You provided the Committee with two articles on this topic. In reaching its decision, the Committee took into account that Mr Bateman's conclusion was a high index of *"suspicion"* of caries on these teeth. However, it also took into account his evidence that, whilst OPG radiographs are not the best radiographs for diagnosing caries, *"barn door"* caries, that is caries that is obvious, can be seen on OPG radiographs. The Committee was satisfied, having noted the irregular cavities under the fillings drawn to its attention by Mr Bateman, that it was more likely than not that it is caries that can be seen on the OPG radiograph in question. The Committee accepted his opinion that dental liners are less radio-opaque than fillings, but more radio-opaque than cavities. The articles provided by you did not change Mr Bateman's opinion in this regard. In all the circumstances, the Committee was satisfied on the balance of

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	probabilities that caries is visible on the OPG radiograph taken between 14 September 2018 and 8 October 2018. It was further satisfied that any reasonable dentist would have diagnosed the caries, but that you failed to do so. The Committee was satisfied that this amounted to a failure to provide Patient 5 with an adequate standard of care between the dates in question.
11. b.	*failed to treat caries between 14 September 2018 and 3 July 2019 at the:*
11. b. i.	*UL6;* **Found proved.**
11. b. ii.	*UL7;* **Found proved.** The Committee considered heads of charge 11.b.i and 11.b.ii separately but reached the same finding in relation to each allegation. The Committee accepted the evidence of Mr Bateman that you could have dealt with the caries present on these teeth by referring Patient 5 back to their treating dentist. Mr Bateman stated that it was not mandatory that you treated the caries yourself in the circumstances. You failed to diagnose the caries at UL6 and UL7 and accordingly failed to treat it. The Committee noted that on your own admission you did not even investigate the possibility of caries. The Committee was satisfied that this was a failure on your part, and accordingly it found heads of charge 11.b.i to 11.b.ii proved. It was also satisfied that, as a result of your failure to treat the caries, you failed to provide Patient 5 with an adequate standard of care between the dates in question.
11. c.	*provided a poor standard of implant at the UL5 on an unknown date between 14 September 2018 and 8 October 2018;* **Found proved.** You denied that the implant you provided at the UL5 was of a poor standard. You told the Committee that Patient 5 is now a patient at your new practice and remains satisfied with the work you undertook. The evidence of Mr Bateman was that the implant you placed at UL5 is at significant risk of being lost. He stated in his main report that *"There were exposed threads above the level of bone of around 2-3mm and that appeared to be a bone level implant. On all the evidence that implant was placed too superficially".* During his oral evidence, Mr Bateman referred the Committee to the relevant radiographic evidence. He referred to three OPG radiographs showing the implant placed at UL5, and he highlighted that on the last of those

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	radiographs, the issue with the implant appeared to be worsening. This contradicted your explanation that you had carried out a bone graft which was in the process of consolidating. The Committee accepted Mr Bateman's explanation on this point. The Committee accepted the evidence of Mr Bateman in relation to this allegation. In its view, visually, the implant at UL5 looked like it was half in and half out of the bone. It considered the radiographic evidence to be consistent with Mr Bateman's opinion that the implant was placed too superficially. The Committee also took into account Mr Bateman's evidence that failing implants can be *"quiet",* which would explain the absence of any complaint from the patient. The Committee had regard to Mr Bateman's considerable experience in implantology and his opinion that the placement of the implant was such that no reasonable dentist would consider it satisfactory. The Committee was satisfied from the evidence he drew to its attention, that you provided a poor standard of implant at the UL5 on an unknown date between 14 September 2018 and 8 October 2018. The Committee was satisfied that, as a result, you failed to provide an adequate standard of care to Patient 5 between the dates in question.
11. d.	*failed to take any bitewing radiographs between 12 September 2018 and 3 July 2019;* **Found proved.** You admitted that you did not take any bitewing radiographs over this period. You denied, however, that this amounted to a failure, as you did not consider that bitewing radiographs were required. You stated that Patient 5 did not attend the Practice for general dentistry but was a regular attender elsewhere. Mr Bateman's evidence was that even if the patient was referred to you from another practice, it was unsafe to proceed with implant care in the presence of caries. His evidence, which the Committee accepted at head of charge 11(a) above, was that the OPG radiograph taken of Patient 5 between 14 September 2018 and 8 October 2018 showed a high index of suspicion of caries on the UL6 and UL7. Mr Bateman's opinion was that, in the circumstances, a reasonable dentist would have either take their own bitewing radiographs for further investigation or referred the patient back to their own treating dentist for the taking of bitewings. The Committee accepted the evidence of Mr Bateman. It accepted his conclusion, as set out in this main report that *"It was unreasonable to have not exposed bitewing radiographs at any stage particularly in light of the heavily restored dentition and the caries apparent at UL6 UL7 on the radiographs exposed. That was a basic standard of care and the omission put the patient at risk of caries progressing."* The Committee considered on the basis of the expert evidence that it was a

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	failure on your part not to have taken bitewings or referred Patient 5 to their treating dentist for the taking of bitewing prior to commencing implant treatment. The Committee was satisfied that this omission amounted to a failure to provide the patient with an adequate standard of care between the dates in question. Accordingly, the head of charge is proved.
12.	*Failed to maintain an adequate standard of record keeping between 14 September 2018 and 3 July 2019 in that you failed to:*
12. a.	*record the appointment at which you placed Patient 5's implants;* **Admitted and found proved.**
12. b.	*report on the CT scan taken on 12 September 2018;* **Admitted and found proved.**
12. c.	*report on OPG radiographs taken:*
12. c. i.	*between 14 September 2018 and 8 October 2018;* **Admitted and found proved.**
12. c. ii.	**WITHDRAWN.**
12. c. iii.	on 3 July 2019. **Admitted and found proved.**
Patient 6	
13.	*Failed to maintain an adequate standard of record keeping between 18 September 2019 and 12 November 2019, in that you failed to:*
13. a.	*report on the CT scan of Patient 6 taken on 18 September 2019;* **Admitted and found proved.**
13. b.	*make a record of the emergency appointment of 7 November 2019;* **Admitted and found proved.**
13. c.	**WITHDRAWN.**
14.	*Failed to obtain informed consent for the implants fitted in September 2019 in that you failed to ensure that Patient 6 understood all the risks of implant treatment.* **Found not proved.** Patient 6 told the Committee in her oral evidence that she had not received a treatment plan until she requested one. She further stated that she had not fully

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	understood the discussion you had with her about her treatment, which she described as having been rushed, and that she had not had time to consider her treatment plan before the commencement of her treatment. In her written evidence, Patient 6 stated that you "*almost breezed through the explanation"*, she also stated that she was given no information about the risks of her treatment. However, she does mention that you discussed three treatment options with her. The Committee considered that a discussion including a number of treatment options was inconsistent with Patient 6's assertion that you had breezed through your explanation. The Committee also had regard to the clinical records for Patient 6, which indicate that you did discuss the risks and complications of the treatment with her on 24 September 2019. A further record made on 25 September 2019 stated that *"Pt brought the signed paperwork including the consent form."* The Committee noted the presence of the signed treatment plan in the patient's records. Having taken all the evidence into account, the Committee was not satisfied that this allegation is proved. On balance, it considered it more likely that you did ensure that Patient 6 understood all the risks of the implant treatment and that she did give her informed consent for treatment.
Patient 7	
15.	*Failed to provide an adequate standard of care to Patient 7 between 9 January 2018 and 26 January 2018, in that you:*
15. a.	*provided a poor standard of implant at the UR2 on 26 January 2018;* **Found proved.** It was Mr Bateman's evidence that the implant you provided at Patient 7's UR2 was out of the bone by almost 2 millimetres. In support of his evidence, Mr Bateman produced three screenshots that he had taken of the CT scans of the patient showing the axial and sagittal views. It was Mr Bateman's opinion that there was very little buccal bone at the site of the implant, and that it should have been placed more palatally. In your written response to this allegation, you stated that "*The CBCT Scan that Mr Bateman takes as reference in making these allegations shows a large area of scatter around the UR2 implant making [it] impossible to identify the real contour of the buccal plate of the alveolar bone".* You produced an article in support of your contention, which was considered by Mr Bateman. The Committee noted that Mr Bateman maintained his opinion that the UR2 implant had been placed insufficiently into bone. He acknowledged the presence of artifacts on the images that he was relying on, but he did not consider that the artifacts affected the parts of the images that were relevant. The Committee accepted the opinion of Mr Bateman on this issue. It found that

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	he was detailed and consistent in explaining the reasons for his conclusion, and it found the CT Scan screenshots he produced to be compelling evidence. In reaching its decision, the Committee took into account your evidence that you had seen Patient 7 several times subsequently and the implant at UR2 remains in place. However, it took into account Mr Bateman's expert opinion that failing implants can be *"quiet".* The Committee accepted his opinion that no reasonable dentist would have placed the implant in the position shown in the radiographs. The Committee was satisfied on the balance of probabilities that you provided a poor standard of implant at UR2, as it was not sufficiently placed in bone. The Committee was further satisfied that, as a result of the poor standard of implant, you did not provide an adequate standard of care to Patient 7 between the dates in question.
15. b.	**WITHDRAWN.**
16.	*Failed to maintain an adequate standard of record keeping in that you failed to:*
16. a.	*report on the CT scan of Patient 7 taken on 9 January 2018;* **Admitted and found proved.**
16. b.	*report on the CT scan of Patient 7 taken on 12 April 2018;* **Admitted and found proved.**
16. c.	**WITHDRAWN.**
16. d.	**WITHDRAWN.**

42. We move to Stage Two.

Stage Two of the hearing – 11 to 12 September 2023

Mr Cimpean,

43. This Professional Conduct Committee (PCC) hearing in respect of your case resumed today, following the last adjournment in June 2023. Prior to adjourning on the last occasion, the Committee handed down its findings on the facts which concluded Stage One. The hearing is now at the second stage.

44. You are representing yourself at this stage of the proceedings. The Case Presenter for the General Dental Council (GDC) is Ms Natasha Tahta, Counsel.

45. The Committee's task at this second stage has been to consider whether the facts found proved against you amount to misconduct, and if so, whether your fitness to practise is currently impaired by reason of that misconduct. The Committee noted that if it found current impairment, it would need to consider the issue of sanction.

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46. The Committee considered all the evidence presented to it, both at the fact-finding stage and at this stage. The evidence received by the Committee at this stage was a bundle of documents submitted by you, which comprised a number of testimonials and three Continuing Professional Development (CPD) certificates confirming your completion of courses on Probity and Ethics on 4 September 2023.

47. The Committee took account of the submissions made by Ms Tahta in relation to misconduct, impairment, and sanction, as well as your submissions.

48. The Committee accepted the advice of the Legal Adviser. It reminded itself that its decisions were for its independent judgement. There is no burden or standard of proof at this stage of the proceedings.

Summary of the facts found proved

49. The matters in this case involve seven patients. At the material time, you held a self-employed associate contract with the company, MyDentist. The facts found proved by the Committee concern your dishonesty in your financial dealings with the company, relating to the treatment of five of the patients (Patients 1 to 5). Separately, the Committee found proved that there were a number of clinical failings arising from the treatment that you provided to all seven patients.

50. The fact of your dishonesty is that you failed to make complete records on the R4 computer system in respect of treatment you provided to Patients 1 to 5, in order to conceal from MyDentist that you were taking payment directly from these patients.

51. In finding dishonesty proved in this case, the Committee acknowledged the evidence you put forward regarding previous payment disputes with the company, and your explanation that you believed that you were entitled to take the money. However, it was the view of the Committee, having considered all the evidence, that whilst you may have been dissatisfied and frustrated with your relationship with MyDentist, you did not genuinely believe that you had a right to the money you retained. It considered that you had a sense of grievance about your financial situation whilst contracted with the company because you wanted to be paid more.

52. The Committee considered that, even if it had concluded that you genuinely believed that you were entitled to the money, taking the law into your own hands by concealing the direct payments would still be regarded as dishonest.

53. In relation to the clinical aspect of this case, namely the treatment you provided to all seven of the patients, the Committee found that there were multiple failings on your part, including:

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- a failure to obtain study models before providing extensive crown and bridgework to one of the patients;
- failings in relation to the planning and execution of complex implant surgery;
- failings in assessment and diagnosis;
- failings in radiography;
- failings in reporting on CT scans;
- failings in providing written treatment plans;
- failings in obtaining informed consent for treatment; and
- failings in record keeping.

Summary of the submissions made by the parties

54. The Committee first heard submissions from Ms Tahta on behalf of the GDC.

55. As required by Rule 20(1)(a) of the 'GDC Fitness to Practise Rules 2006 Order of Council', Ms Tahta addressed the Committee on your fitness to practise history with the GDC. She reminded the Committee that the fact of this history was introduced at the first stage of these proceedings by way of an admission made by you.

56. Ms Tahta told the Committee that at a previous hearing before the PCC in April 2019, you admitted to failing to cooperate with an investigation conducted by the GDC in 2017, as well as to working without indemnity insurance during three separate periods between 2011 and 2017. Whilst the PCC in April 2019 made a finding of misconduct against you, it determined that your fitness to practise was not impaired. Accordingly, that hearing was concluded with no restriction imposed on your registration.

57. In relation to this current case, Ms Tahta referred the Committee to the relevant case law regarding misconduct. She highlighted from the legal principles that misconduct is often described as involving an act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed, which in this case are the professional standards of the GDC. Ms Tahta also highlighted that for a finding of misconduct to be made in regulatory proceedings, the conduct concerned must be sufficiently serious.

58. Ms Tahta asked the Committee to take into account the opinion of the GDC's expert witness in this case, Mr Geoffrey Bateman, that the treatment failings, as found proved, fell far below the standard expected of a reasonably competent general dental practitioner. Ms Tahta submitted that the care of patients should be a registrant's primary concern, but this Committee has found that you failed to provide an adequate standard of care to four patients, over a period of almost two years from January 2018 to September 2019.

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59. Ms Tahta further submitted that you have made no effective attempt to remedy your clinical failings during the intervening period. She asked the Committee to note that at the beginning of this hearing in March 2023, you did not admit any of the alleged clinical matters, save for your failings in record keeping. Ms Tahta stated that this shows a "*shocking lack of insight*".

60. With regard to the dishonesty found proved against you, Ms Tahta stated that, honesty is a fundamental tenet of the dental profession. She stated that you have been found to have been dishonest in your financial dealings with five patients, and not only this, but that you failed to complete accurate clinical records in order to further your own financial gain. She also contended that you lied to the Committee under oath at this hearing in respect of these matters.

61. Ms Tahta submitted that from August 2018 to December 2019 you dishonestly received £50,000 directly from the five patients in question, and when this hearing began in March 2023 you demonstrated no insight into the concerns. She stated that, the only evidence of any remediation by you to date, are the CPD certificates you have provided in relation to the online CPD courses you completed in Probity and Ethics. She noted that this CPD was undertaken on the same day, less than a week ago.

62. Ms Tahta invited the Committee to have regard to a number of the GDC's professional standards, as set out in its publication *'Standards for the Dental Team (Effective from September 2013'* ('the GDC Standards'). It was her submission that your conduct, as found proved, clearly amounts to multiple, serious breaches of the Standards, and therefore constitutes misconduct.

63. With regard to impairment, Ms Tahta again outlined a number of relevant legal principles. In relation to the judicial approach to considering current fitness to practise, she submitted that the Committee should consider whether your misconduct is remediable, whether it has been remedied and whether it is highly likely to be repeated.

64. In relation to the clinical allegations found proved, Ms Tahta submitted that the issue of whether you have successfully remedied those failings requires evidence. She submitted that you have not provided any such evidence, and therefore the Committee could not be reassured that your clinical shortcomings would not be repeated.

65. In relation to your dishonesty, Ms Tahta submitted that such conduct was not easily remedied, given that dishonesty is a character failing. She stated that, nonetheless, you have not provided any evidence to suggest that you have shown any insight into your dishonesty, nor have you provided sufficient evidence of remediation. It was her submission that the CPD material that you have provided does not come anywhere near what is required in terms of evidence of insight and remediation.

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66. Ms Tahta submitted that, on the evidence before the Committee, a finding of impairment is necessary. She submitted there would be a risk of harm to the public if your fitness to practise was found not to be impaired. She also submitted that public confidence in the dental profession would be seriously undermined in the absence of such a finding.

67. With regard to sanction, Ms Tahta referred the Committee to the GDC's *'Guidance for the Practice Committees including Indicative Sanctions Guidance (Effective from October 2016; last revised in December 2020)*' ('the Guidance'). It was her submission on behalf of the Council that the only appropriate and proportionate sanction in this case, is one of erasure.

68. The Committee next heard submissions from you.

69. You told the Committee that in 24 years of practice you have never had any patient complaints. It was your submission that five of the seven patients involved in this current case refused to cooperate with the GDC's investigation. You stated that Patient 4 had wished to make it known that he considered you to be the best dentist he had ever had.

70. You also stated that you had not caused any harm to any of the patients in question. You noted the submission made by the GDC in relation to Patient 5, and the Committee's finding that you failed to diagnose caries in this patient. You stated, however, that you wished to remind the Committee that you were not Patient 5's treating dentist. You highlighted that Patient 5 had continued visiting her regular dentist at another practice, and you said that you were sure that dentist was able to diagnose and treat any caries.

71. You told the Committee that, on account of the matters in this case, your registration has now been suspended on an interim basis for the last two years. You explained that you were enrolled on an international course in advanced surgical implant procedures but due to your interim suspension, you could not continue that course.

72. You stated that over the past two years, to keep your knowledge and skills up to date, you have attended regular meetings with dental colleagues to discuss new approaches to treatment and new procedures. You also said that you have been using at home, plastic and rubber models designed for the practicing of clinical skills. Further, that you have had at your disposal professional literature.

73. You told the Committee of your past achievements in dentistry, including extensive training in Zurich. You said that you had been responsible for introducing new technology into the UK, based around Artificial Intelligence, which you said has been adopted by one of the largest hospitals in your area.

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74. With regard to your own dental practice, you told the Committee about the introduction of a treatment coordinator role. You explained that the person in this new role is responsible for liaising with every patient after their dental consultations to discuss and provide all the necessary information relating to their treatment, including treatment plans and costs. You therefore stated that the things that you did in this case, which were five years ago now, could not be repeated.

75. In relation to the dishonesty found proved against you, you also highlighted that those matters occurred some five years ago. You stated that nothing like that had ever occurred in 24 years of practice. You emphasised that your fitness to practise history was not because of any patient complaints. You stated that you were a *"collateral"* part of that previous investigation.

76. You reiterated that it was because of the repeated tensions and your frustrations with MyDentist over what you described as repeated financial failings towards you, that you acted as you did. This included, you said, the company's refusal to sell you a dental practice in July 2018, when you were the only potential buyer. You told the Committee that this is when you reached the peak of your frustrations, having felt trapped in the company with no way out. You said that it was in these circumstances that you took the *"impulsive"* and *"bad"* decision to take payments directly from the five patients when they were "offered" to you.

77. You explained that the impact of your actions in taking the payments have been severe and life changing. You told the Committee in detail of the impact of your interim suspension on you personally, for your family and for your business. You stated that you wished to apologise to the Committee and to any person affected by your past actions. You said that you had never before acted like that, and have not done so since, and you told the Committee that you feel self-shame and regret over the matter.

78. You stated that during the past two years you have extensively discussed your actions with other dentists, and also looked at GDC cases of a similar nature, which has increased your understanding of the concerns raised about you in relation to the dishonesty concerns. You highlighted the CPD that you have recently undertaken and submitted that you would not repeat similar mistakes in the future. Whilst you acknowledged the limited nature of your CPD, you told the Committee that courses have been hard to find.

79. You submitted that the public interest would be satisfied in this case by the lessons that you have learned from your past actions including the consequences for you. You stated that mistakes would not be repeated and that none of your actions affected patients. You referred to the GDC Standards which deal with honesty and integrity, and you submitted that your patients do have trust and confidence in you.

80. It was your submission that a period of conditional registration would be an appropriate and proportionate outcome in this case. You submitted that the period you have been away from clinical

practice could be addressed by intensive training, which could be undertaken at your own dental practice where, you said, you would have the support of your colleagues. You stated that your dental practice has strong internal policies and a strong management team, to guard against any further concerns.

Decision on misconduct

81. The Committee considered whether the facts found proved amount to misconduct. It took into account that a finding of misconduct in the regulatory context requires a serious falling short of the professional standards expected of a registered dental professional. The Committee had regard to the GDC Standards and was satisfied that the following are engaged in this case:

1.3 Be honest and act with integrity.

1.4.2 You must provide patients with treatment that is in their best interests, providing appropriate oral health advice and following clinical guidelines relevant to their situation. You may need to balance their oral health needs with their desired outcomes.

1.7.1 You must always put your patients' interests before any financial, personal or other gain.

2.2.1 You must listen to patients and communicate effectively with them at a level they can understand. Before treatment starts you must:

- explain the options (including those of delaying treatment or doing nothing) with the risks and benefits of each; and
- give full information on the treatment you propose and the possible costs.

2.3.6 You must give patients a written treatment plan, or plans, before their treatment starts and you should retain a copy in their notes. You should also ask patients to sign the treatment plan.

2.4 You must give patients clear information about costs.

3.1 Obtain valid consent before starting treatment, explaining all the relevant options and the possible costs.

3.2 Make sure that patients (or their representatives) understand the decisions they are being asked to make.

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3.3 Make sure that the patient's consent remains valid at each stage of investigation or treatment.

4.1 Make and keep contemporaneous, complete and accurate patient records.

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

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.

82. In relation to the clinical matters, the Committee found that, over a period of almost two years, you failed to provide an adequate standard of care to four of the seven patients concerned. This included your failure to obtain study models in the context of complex restorative dental care that you provided to one patient, involving both the upper and lower arches. It was also found that you provided a poor standard of implant care to two other patients. Many other clinical shortcomings were identified by the Committee including your failings in radiography, reporting on CT scans, the provision of written treatment plans, assessment and diagnosis, and obtaining informed consent. There were also failings in the standard of your record keeping in respect of all seven patients.

83. In the Committee's judgement, your failings were serious, both individually and cumulatively, in that they represented significant breaches of the relevant GDC Standards. In reaching its conclusion, the Committee took into account that many of your failings were in basic and fundamental aspects of dentistry and that they occurred in circumstances when you were providing highly invasive dental treatment. The Committee also had regard to the opinion of Mr Bateman that the majority of the identified failings fell far below the standard expected of a reasonably competent general dental practitioner.

84. The Committee next considered the matter of your dishonesty. This being that, whilst you were using the practice premises and equipment of MyDentist, you took payments amounting to approximately £50,000 directly from five patients, which was contrary to your associate agreement. You then failed to make complete computer records in respect of the five patients in order to conceal that you had taken the payments, thereby causing significant potential harm to those patients because there was no or an inadequate record of the treatment that they had received. The Committee was in no doubt that your behaviour was a serious departure from the behaviour expected of a registered dental professional. Honesty and integrity are fundamental tenets of the dental profession. Your dishonesty was directly linked to your practice as a dentist, and in the Committee view, it was dishonesty at the higher end of the spectrum.

85. In all the circumstances, the Committee was satisfied that the facts found proved in this case amount to misconduct.

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Decision on impairment

86. The Committee next considered whether your fitness to practise is currently impaired by reason of your misconduct. It had regard to the over-arching objective of the GDC, which is: the protection, promotion and maintenance of the health, safety, and well-being of the public; the promotion and maintenance of public confidence in the dental profession; and the promotion and maintenance of proper professional standards and conduct for the members of the dental profession.

87. In considering the issue of current impairment, the Committee had regard to the relevant legal principles drawn to its attention. This included the factors outlined by Dame Janet Smith in her Fifth Report from Shipman, as set out in the case of *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council and Paula Grant [2011] EWHC 927 Admin.* The Committee considered whether you:

a. have in the past acted and/or are liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

b. have in the past brought and/or are liable in the future to bring the medical profession into disrepute; and/or

c. have in the past breached and/or are liable in the future to breach one of the fundamental tenets of the medical profession; and/or

d. have in the past acted dishonestly and/or are liable to act dishonestly in the future.

88. The Committee was satisfied that each of the factors at (a) to (d) above apply to the circumstances of your misconduct. Whilst it noted your assertion that you did not cause any harm to any of the patients concerned, it considered that this was not the case. The Committee took into account your failure to diagnose and treat dental disease in some of the patients, as well as the fact that you provided poor implant treatment to two of the patients.

89. In considering whether you were liable to act in the ways described at (a) to (d) above in future, the Committee considered the evidence of the steps you have taken since the events in this case came to light.

90. The Committee considered that your identified clinical failings are potentially remediable. However, the Committee received no evidence to suggest that you have remedied them. It noted that in your submissions at this stage, you largely spoke about your achievements prior to being suspended from practice on an interim basis. Whilst you made reference to keeping your clinical skills and knowledge up to date, you did not provide any objective evidence which the Committee could assess.

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91. The Committee found that there were serious, multiple failings in your clinical practice involving a number of patients. However, you have provided no evidence of any CPD undertaken in the specific areas of clinical concern, namely the obtaining of study models, radiography, reporting on CT scans, the provision of implant treatment, the provision of written treatment plans, assessment and diagnosis, obtaining informed consent and record keeping. A number of your clinical failings occurred in the context of highly invasive treatment, including that you provided implant treatment which was of a poor standard. Yet, from the submissions you made to the Committee, it would appear that you continue to be of the view that you are highly skilled in the provision of implant treatment.

92. The Committee considered that your submissions and the notable absence of any targeted remediation demonstrates a significant lack of insight into the extent and seriousness your clinical failings, a number of which were repeated over the period of time in question. In the circumstances, the Committee concluded that there is a high risk of repetition. It therefore determined that a finding of impairment is necessary on the grounds of public protection.

93. The Committee next considered the wider public interest in the context of your serious clinical failings and your dishonesty.

94. The Committee took into account that dishonesty is an attitudinal failing and therefore is more difficult to remedy, although not impossible. Whilst the Committee acknowledged your apology for your actions, it was not satisfied that you have demonstrated insight into the concerns raised about your dishonesty.

95. The Committee noted that in your submissions made at this stage, you again alluded to your belief that you were claiming back money that you said MyDentist owed to you. However, as clearly stated in the Committee's findings, this was not a position it accepted. It also appeared to the Committee that you were suggesting that the patients had *offered* you payment, and also that your taking of the money was *impulsive*. However, the evidence clearly indicates that your taking of the payments was premediated, including via your use of a personal PDQ machine. The Committee finding was that you willingly and repeated took money directly from a number of patients when you were not permitted to do so, and that you sought to conceal your wrongdoing by failing to make complete and accurate records.

96. The Committee considered that despite your apology, you have failed to demonstrate understanding into the seriousness of your actions, including the impact on the reputation of the dental profession. This is borne out by the limited and recent nature of the CPD you have undertaken. Whilst the Committee acknowledged that you denied the allegation of dishonesty, the Committee's findings on the matter were handed down in June 2023. This included its decision that, even if it had concluded that you genuinely believed that you were entitled to the money, taking the law into your own hands by concealing the direct payments would still be regarded as dishonest.

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97. Having considered all the circumstances of this case, the Committee concluded that a finding of impairment is also required in the wider public interest, both in relation to the clinical matters and the issue of your dishonesty. The evidence before the Committee demonstrates your lack of insight in relation to both aspects of your misconduct, and as a consequence, little or no evidence of remediation. The Committee concluded that public confidence in the dental profession would be seriously undermined if a finding of impairment were not made. It also considered that such a finding is required to declare and uphold proper professional standards.

98. Accordingly, the Committee has determined that your fitness to practise is currently impaired by reason of your misconduct.

Decision on sanction

99. The Committee considered what sanction, if any, to impose on your registration. It noted that the purpose of any sanction is not to be punitive, although it may have that effect, but to protect patients and the wider public interest. In reaching its decision, the Committee had regard to the Guidance. It applied the principle of proportionality, balancing the public interest with your interests.

100. In deciding on the appropriate sanction, the Committee first considered the issue of mitigating and aggravating factors.

101. In mitigation, the Committee took into account your apology in relation to your actions in taking money directly from patients.

102. The Committee identified the following aggravating factors:

- Actual harm or a risk of harm to the patients.
- Dishonesty.
- Premeditated misconduct.
- Financial gain by you.
- Breach of the trust of the company where you were contracted to work.
- Misconduct sustained and repeated over a period of time.
- Attempts to cover up wrongdoing.
- Lack of insight.

103. Although the Committee noted your fitness to practise history, it considered that it was unrelated to the issues in this case.

104. Taking all the above factors into account, the Committee considered the available sanctions, starting with the least restrictive, as it is required to do.

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105. The Committee first considered whether to conclude this case without taking any action in in respect of your registration. It decided, however, that such a course would be wholly inappropriate given the seriousness of its findings and the ongoing risks that have been identified. The Committee decided that taking no action would not protect the public, nor would it satisfy the wider public interest.

106. The Committee reached the same conclusion in relation to issuing a reprimand. It noted from the Guidance that a reprimand is the lowest sanction which can be applied, and it would not impose any restriction on your practice. A reprimand is usually considered to be appropriate where the misconduct is at the lower end of the spectrum and there is no identified risk to patients or the public. This is not such a case. Accordingly, the Committee determined that a reprimand would be inappropriate and insufficient to protect the public and the wider public interest.

107. The Committee next considered whether to impose an order of conditions your registration. Whilst it considered that conditional registration would ordinarily be considered appropriate to address the clinical issues that have been raised, it took into account its ongoing concerns in relation to your lack of insight into your failings. There is little or no evidence before the Committee to suggest that you have taken any relevant steps in addressing the serious shortcomings highlighted in your practice. Furthermore, the Committee took into account that there are no workable or practical conditions to address dishonesty in any event. Dishonesty is an attitudinal failing, not a clinical one. In all the circumstances, the Committee decided that a conditions of practice order would not be appropriate or proportionate to protect the public and the wider public interest.

108. The Committee went on to consider whether suspension would be the appropriate sanction in this case. It had regard to the Guidance at paragraph 6.28, which outlines factors to be considered when deciding whether the sanction of suspension in more serious cases may be appropriate. The Committee considered that the following factors applied in this case, namely that:

- there is evidence of repetition of the behaviour;
- you have not shown sufficient insight and you pose a significant risk of repeating your behaviour;
- patients' interests would be insufficiently protected by a lesser sanction; and
- public confidence in the profession would be insufficiently protected by a lesser sanction.

109. Whilst the Committee noted the presence of the above factors from paragraph 6.28 in the circumstances of this case, it also took into account that this paragraph indicates that a period of suspension may be appropriate where *"there is no evidence of harmful deep-seated personality or professional attitudinal problems (which might make erasure the appropriate order)*. In view of the Committee's ongoing concerns about your insight and your attitude towards the matters that have been found proved against you, it considered that there was evidence before it of a harmful deep-seated problem with your professional attitude.

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110. In the light of this, the Committee had regard to paragraph 6.34 of the Guidance which deals with the sanction of erasure. It noted that almost all of the factors for erasure are present in this case, namely:

- serious departure(s) from the relevant professional standards;
- serious harm to patients has occurred including the unnecessary extraction of a healthy tooth and poor placement of implants;
- there is a continuing risk of serious harm to patients;
- there has been an abuse of a position of trust;
- serious dishonesty, particularly where persistent or covered up; and
- a persistent lack of insight into the seriousness of actions or their consequences.

111. The Committee also took into account the paragraphs relating to dishonesty in Appendix A to the Guidance, in particular paragraph 62, which states that:

> *"It is a matter for the Committee to determine where on the spectrum of seriousness the Registrant's dishonesty lies. However, dishonesty that is persistent and/or covered up, is likely to result in erasure."*

112. It was the judgement of the Committee, having considered the serious nature of your misconduct, and the very limited nature of your understanding of your clinical shortcomings and your wrongdoing in terms of your dishonesty, which appears to have persisted over a number of years, that the suspension of your registration would not be sufficient. The Committee considered that your behaviour is fundamentally incompatible with continued registration, and it decided that a period of suspension would not be sufficient to uphold public interest, particularly public confidence in the dental profession.

113. The Committee has therefore determined that the only appropriate and proportionate sanction in all the circumstances of this case is that of erasure.

114. In reaching its decision, the Committee had regard to the potential consequences for you of the removal of your name from the Register. However, it was satisfied that the need to protect the public interest outweighed your own interests.

115. Unless you exercise your right of appeal, your name will be erased from the Register, 28 days from the date when notice of this Committee's direction is deemed to have been served upon you.

116. The Committee now invites submissions as to whether an immediate order of suspension should be imposed on your registration to cover the 28-day appeal period, pending the taking effect of this substantive determination for erasure.

Decision on an immediate order – 12 September 2023

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117. The Committee has made a substantive direction in this case and therefore the interim order currently in place on your registration is hereby revoked.

118. Accordingly, the Committee has had to make decision on whether to impose an immediate order of suspension on your registration until its substantive direction for erasure takes effect.

119. In reaching its decision, the Committee took account of the submission made by Ms Tahta that such an order should be imposed. You told the Committee that you had no submissions to make in relation to an immediate order of suspension.

120. The Committee accepted the advice of the Legal Adviser, who drew its attention to the statutory test for an immediate order, as set out in Section 30 of the *Dentists Act 1984 (as amended).*

121. The Committee determined that it is necessary for the protection of the public, and is otherwise in the public interest, to impose an immediate order of suspension on your registration. The Committee has identified an ongoing risk to the public on account of the serious failings in your clinical practice, your lack of insight into those failings, and consequently the absence of any relevant remediation. In the circumstances, the Committee considered that it would be inappropriate and inconsistent to allow you the potential opportunity to return to unrestricted practice over the 28-day appeal period, or possibly longer, in the event of an appeal. An immediate order is therefore necessary for the protection of the public.

122. The Committee also considered that the imposition of an immediate order is in the wider public interest. It has determined that your behaviour, as highlighted in this case, is fundamentally incompatible with continued GDC registration. The Committee considered that public confidence in the dental profession and this regulatory process would be seriously undermined in the absence of an order suspending your registration immediately.

123. The effect of the foregoing substantive determination and this order is that your registration will be suspended to cover the appeal period. Unless you exercise your right of appeal, the substantive direction for erasure will take effect 28 days from the date of deemed service.

124. Should you exercise your right of appeal, this immediate order will remain in place until the resolution of the appeal.

That concludes this determination.