Dental Professionals Hearings Service

PUBLIC DETERMINATION

PUBLIC HEARING

Professional Conduct Committee
Initial Hearing

31 August 2022 - 7 November 2023

Name: GUPTA, Rahul

Registration number: 254692

Case number: CAS-188206

General Dental Council: Miss Lydia Barnfather, Counsel
Instructed by Capsticks Solicitors

Registrant: Present
Represented by Miss Julia Furley, Counsel

Fitness to practise: Impaired by reason of misconduct

Outcome: Erased

Immediate order: Immediate Suspension order

Committee members: Nora Nanayakkara
Gill Jones
Louise Fletcher

Legal adviser: Gerard Coll

Committee Secretary: Andrew Keeling

Mr Gupta,

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

General Dental Council's (GDC) case. The hearing took place at Wimpole Street.

2. Your case was considered on a joint basis at this hearing with another registrant (Registrant 2). Registrant 2 attended the hearing and was represented by Mr Andrew Kennedy KC.

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

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

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

5. Mr Kennedy, on Registrant 2's behalf, submitted that he was neutral on the issue.

The Committee's Decision (31 August 2022)

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

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

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

GDC Submissions

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

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

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

Your Submissions

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

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

14. Mr Kennedy made no submissions on behalf of Registrant 2.

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

15. The Committee took into account the submissions made by both parties and accepted the advice of the Legal Adviser. The Committee had regard to the interests of justice and remained mindful of the principle of fairness. It balanced the interests of the GDC with your and Registrant 2's interests.

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

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

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

17. In making its decision, the Committee noted that the witness statement was relevant to heads of charge 12 and 13 against you and was contested. With regard to fairness, the Committee then considered whether reasonable steps had been taken by the GDC to secure the witness's attendance. The Committee noted that, although reasonable steps had been taken by the GDC, a witness summons had not been issued to Witness 2. The Committee also considered the medical evidence provided by Witness 2 as a reason for her non-attendance. It noted that the GP letter provided did not explain in sufficient detail why her health condition would prevent her from attending either in person or remotely. The Committee also had sight of Witness 2's emails to the GDC in August 2022 and the note of her telephone call on 25 August 2022. Furthermore, it noted that it appeared that Witness 2 had

continued to work in the role of CQC inspector as described at head of charge 12.

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

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

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

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

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

22. Mr Kennedy, on Registrant 2's behalf, submitted that he was neutral on the issue.

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

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

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

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

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

27. With regard to Registrant 2's case, Miss Barnfather submitted that head of charge 13(c) and the reference to 13(c) in the stem of head of charge 14 should be deleted.

28. You and Registrant 2 accepted the amendment as it was a deletion of a charge.

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

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

Preliminary Matters - Decision on Adjournment (17 October 2021)

Application for Adjournment

31. Miss Furley, on behalf of Mr Gupta, made an application to adjourn the hearing. She submitted that Mr Gupta was currently unwell and was not fit

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

32. Mr Kennedy, on Registrant 2's behalf, submitted that he was neutral on the application if Witness 3, who was due to give evidence today, was available tomorrow instead.

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

Decision

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

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

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

"**Postponement and adjournments**

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

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

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

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

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

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

(c) fairness to the respondent."

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

<u>Application under Rule 57 to adduce evidence (7 February 2023)</u>

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

38. Miss Furley informed the Committee that exhibit MIA 9 is a record made by one of Witness 2's assistants (Person 1) on the day of the inspection on 23 June 2017. She submitted that this document had always been exhibited by Witness 2 and had been agreed hearsay evidence. No objections had been raised by Miss Barnfather or by Mr Kennedy, on behalf of Registrant 2, that it would be adduced as part of Witness 2's evidence rather than by Person 1 herself. With regard to the telephone note, Miss Furley submitted that this was a note of a conversation between a GDC caseworker and Person 1 on 25 November 2019. The conversation was in relation to Person 1's recollection of

the CQC's inspection on 23 June 2017. Miss Furley submitted that the note was relevant to charge 8(c) which alleges that you falsified the signature of Patient A on a treatment plan dated 19 December 2019. She submitted that the telephone note states that Person 1 confirmed that she had seen the patient's written consent forms, which had been signed by him.

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

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

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

42. Mr Kennedy, on Registrant 2's behalf, made no submissions on the application.

The Committee's Decision

43. The Committee took into account the submissions made by all parties and accepted the advice of the Legal Adviser. The Committee had regard to the interests of justice and remained mindful of the principle of fairness. It balanced the interests of the GDC with yours and Registrant 2's interests.

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

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

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

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

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

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

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

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

50. Mr Kennedy, on Registrant 2's behalf, made no submissions on the application.

The Committee's Decision

51. The Committee took into account the submissions made by all parties and accepted the advice of the Legal Adviser. The Committee had regard to the interests of justice and remained mindful of the principle of fairness. It balanced the interests of the GDC with yours and Registrant 2's interests.

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

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

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

<u>Decision on Recusal of Committee Member (17 March 2023)</u>

54. At the beginning of today's session, the Chair of the Committee made a disclosure to parties that, having made applications to a number of Chambers, she had yesterday been invited for a first round interview for a Barrister's pupillage (a training position). That is the Chambers where Mr Andrew Kennedy KC, who is representing Registrant 2 at this hearing, is currently a member. The Committee was not sitting yesterday so today was the first opportunity to bring this matter to the attention of the parties. The Chair stated that she was due to be interviewed by members of Chambers who are not involved in this hearing. This was confirmed by Mr Kennedy.

55. As a result of the Chair's disclosure, Mr Kennedy, on Registrant 2's behalf, made an application for the Chair to recuse herself from this hearing. He submitted that the application is made on the grounds that there was a risk that a fair-minded and informed observer would conclude that there was a real possibility of bias. He submitted that he does not make an allegation of actual bias. He referred the Committee to the cases of *Haliburton Co v Bermuda Insurance Ltd [2021] UKSC 48* and *Ameyaw v McGoldrick and Others [2020] EWHC 1787 (QB)*.

56. Mr Kennedy submitted that it is relevant that the allegations against you and Registrant 2 are serious, which include allegations at the higher end of dishonesty. Furthermore, he submitted that both you and Registrant 2 are running "cut-throat" defences as you are both blaming the other in relation to some of the allegations and this was relevant to the perception of bias.

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

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

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

prohibition would be inconceivable as it would be unnecessary and disproportionate. She therefore invited the Committee to reject Mr Kennedy's application.

Committee's Decision

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

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

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

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

63. Accordingly, the Committee rejected Registrant 2's application for the Chair to recuse herself.

FINDINGS OF FACT – 28 June 2023

Admissions

64. At the start of the hearing, Miss Julia Furley, on your behalf, stated that you admit to the following heads of charge: 1, 2, 3 (in respect of recording but not planning), 4(a), 6(a), 6(c), 6(d), 6(g), 7(a) (but not in respect of 6(b)), 7(b) (but not in respect of 6(b)), 10(a), 10(c), 10(d), 10(e) and 11(d).

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

Background

66. Your case is being heard on a joint basis with Registrant 2, who was your Principal.

67. The matters at this hearing concern the care and treatment you provided to Patient A during the period between October 2016 and June 2017. During this time, you were in general dental practice as an associate at practices owned by Registrant 2. On 21 June 2017, Patient A attended one of these practices, Practice 1, for the extraction of several of his teeth under private contract. It is alleged that you extracted or assisted Registrant 2 in the extraction of UL7, UR8, UR7, LL7, LL6 and/or LL1. It is alleged that you also attempted or assisted in the attempted extraction of LR8. The attempts at the extraction of LR8 were unsuccessful and Patient A had the tooth subsequently extracted in hospital under a general anaesthetic. During the appointment on 21 June 2017, it is alleged, and Registrant 2 has admitted, that Registrant 2 provided conscious sedation to Patient A. However, there is a dispute between you and Registrant 2 as to the exact roles each of you played during this appointment. You denied that you extracted any of Patient A's teeth, having referred the case in its entirety to Registrant 2, whereas it is Registrant 2's case that he was only there to provide sedation services but ended up assisting you with the extractions once it became clear that you were in difficulty.

68. This was presented to the Committee by Registrant 2's Counsel as what is known as "a cut-throat defence" in that you attribute the alleged failings on 21 June 2017 largely to Registrant 2 and he in turn, attributes the alleged failings largely to you.

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

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

71. You face allegations in respect of the aftercare you provided to Patient A on that appointment of 24 June 2017.

72. The further allegations you face regarding your treatment of Patient A relate to treatment planning and record keeping. In particular, it is alleged that you provided misleading and dishonest information in the retrospective manuscript record of the appointment on 21 June 2017. Furthermore, it is alleged that you were misleading and dishonest when you allegedly provided the GDC with documentation containing the falsified signature of Patient A.

73. On 23 June 2017, the Care Quality Commission (CQC) carried out a planned inspection of Practice 1. It is alleged that you behaved in a verbally and physically intimidating manner towards Witness 3 (the receptionist at the practice) during the inspection in that you instructed her to deny to the CQC that conscious sedation was provided at the practice. It is also alleged that your actions in this regard were misleading and dishonest.

Evidence Received

74. By way of factual evidence from the GDC, the Committee was provided with the following signed witness statements:
    - Patient A, dated 16 December 2019;
    - Witness 1 (Patient A's partner), dated 15 October 2019;
    - Witness 3 (the receptionist), dated 18 December 2019;

- A Casework Manager in the Fitness to Practise department of the GDC, dated 5 October 2020.

75. The Committee also heard oral evidence from Patient A, Witness 1 and Witness 3. The Casework Manager's witness statement was received into evidence by agreement without the need for him to attend the hearing.

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

77. From you, the Committee received your witness statements, dated 16 October 2020 and 22 April 2022. It also heard oral evidence from you. A witness statement, dated 8 October 2020, from Mr David Hartoch, a Dento-Legal Adviser at Dental Protection, was received. The Committee also received three letters sent by RadcliffesLeBrasseur, on your behalf, to the GDC dated 21 September 2017, 15 August 2018 and 7 February 2019.

78. Registrant 2 provided two witness statements; the first dated 1 October 2020 and the second dated 21 April 2022. He also gave oral evidence.

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

80. The Committee also received an expert report from Dr Christopher Holden, dated 22 September 2020, who was instructed on behalf of Registrant 2. Dr Holden also gave oral evidence at this hearing.

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

Agreed Facts

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

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

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

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

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

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

84. In respect of this examination the expert concluded:

    "A clinical audit log is recorded automatically by the R4 software of all events pertaining to each patient and cannot be amended at an Administrator level. On review of the live analysis of the Carestream database and data from the forensic image copy, I have no reason to believe that the 'Clinical Audit Log' has been edited or amended in any way."

Discussion of Evidential Issues

85. The Committee has considered all the evidence presented to it, both oral and documentary. It took account of the submissions made by Miss Barnfather, on behalf of the GDC, by Miss Furley, on your behalf, and by Mr Kennedy, on Registrant 2's behalf. The Committee heard and accepted the advice of the Legal Adviser. In accordance with that advice, it has considered each head of charge separately, bearing in mind that the burden of proof rests with the GDC and that the standard of proof is the civil standard, that is, whether the alleged matters are found proved on the balance of probabilities.

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

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

Extractions/Attempted Extractions

87. The Committee, having heard all of the evidence, considers that you share responsibility for the extraction/attempted extraction of teeth on 21 June 2017 while Registrant 2 admits extracting teeth.

88. Each of you made conscious efforts to obscure and/or minimise your individual roles on 21 June 2017. Both of you deviated substantially in your oral evidence on key points from your earlier written representations. Registrant 2's evidence evolved in an unsatisfactory way and some of it appears to have emerged only at the prompting of his solicitors. For example, in your representations of August 2018, you assert that Registrant 2 specifically requested that you be present in the Treatment Room. However, in oral evidence you asserted that you were only at the appointment due to "bad fortune" despite the appointment having been booked in your name for 45 minutes, with your nurse, in your diary, using your Treatment Room. You say in your oral evidence you did not speak with Patient A at all on 21 June 2017, but in your representations of August 2018 said that you verbally confirmed the medical history and gave post-operative instructions.

89. You were both qualified, registered dental professionals with associated professional obligations and duties in respect of your treatment and care of Patient A on 21 June 2017 and both of you were in the Treatment Room. Due to the way in which you have both given evidence and the shortcomings in record keeping, the Committee is unable to reliably distinguish between the exact roles each of you played at any one time during this appointment, with the exception of the administration of the sedation. It is open to the Committee to consider both of you responsible for the relevant identified failings in your shared treatment of Patient A. Registrant 2 admits extracting four to five teeth and you maintain that you did not extract any teeth although Registrant 2's evidence is that you did in fact do so or attempt to do so before he was asked to step in. Patient A is unable to assist on this point and Witness 1 was in the waiting room. No evidence was called from the nurse who is said to have

been present. The Committee finds that Registrant 2 extracted teeth and you assisted in the extraction of the teeth.

90. Due to the misleading and retrospective handwritten note drawn up by you, which you claim was done at Registrant 2's behest (something he refutes) and the paucity of information recorded on Registrant 2's conscious sedation record, which Registrant 2 is adamant was produced during or immediately after the procedure on 21 June 2017 despite appearances to the contrary, it is not possible to decipher which teeth were actually extracted at the appointment, how much anaesthetic was injected, to what parts of the mouth and critically, neither is it possible to identify who monitored the patient throughout.

91. Having heard Registrant 2's and your oral evidence, the Committee is of the view that both your accounts of your shared treatment of Patient A on 21 June 2017 were almost entirely inconsistent and at times, both strained the bounds of credulity in your efforts to explain why you behaved as you did with little care for the safety of a clinically vulnerable patient who had entrusted you with his dental treatment.

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

93. The Committee did not accept your assertion that you were newly qualified (you were not) as a valid reason for neither extracting nor assisting in the extraction of teeth. At the material time, you had been qualified for eight years, had undertaken a Masters qualification and had passed the Overseas Registration Examination (ORE) to be allowed onto the GDC register.

94. Nonetheless, it was apparently accepted by all parties that you were historically reluctant to perform extractions and would usually only undertake what you considered "simple" extractions, preferring instead to refer extractions to Registrant 2 or other clinicians. Patient A's planned extractions spanned a range of complexity from what you would describe as "simple", to one (LR8) which the experts agreed might be complicated and perceived as difficult for a General Dental Practitioner who lacked confidence in undertaking extractions. Indeed, it was Patient A's evidence that he had previously asked you repeatedly to extract teeth under local anaesthetic that were causing him pain, but you did not and offered instead to arrange to have them all extracted together. In the interim, Patient A had one of the teeth planned for extraction extracted at another dental practice due to the ongoing pain it was causing him. It was your advice to arrange for the extractions to be done altogether under sedation that ultimately led to the appointment on 21

June 2017. This was documented in the clinical notes on 20 October 2016 and in the Treatment Plan, purportedly signed by Patient A on 19 December 2016, as opting variously for options 2 and 3, which are described as "*under principal care (IV sedation), told he charges £90 per IV sedation +Private £100 per tooth for extraction* ".

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

96. Your chaotic and inconsistent records, Registrant 2's sparsely populated conscious sedation record and both of your conflicting accounts were set before the Committee, whose task was to reconcile this material. The Committee considers both of your accounts to lack reliability and credibility with respect to the matter of extractions, but with the benefit of documents produced at or near the material time, has assessed each head of charge individually to determine findings to the civil standard, which are set below in the findings of fact.

Referrals

97. Registrant 2's account is that it was his standard practice at the time to accept informal, verbal referrals from colleagues within the practice. It is his case that you informally referred the patient to him for sedation services only. Registrant 2's evidence is that he was reluctant as he did not generally perform sedations at Practice 1, despite there being a sign in the window that sedation services were offered. Registrant 2's evidence was that you managed to persuade him to perform sedation services as the patient had been waiting a long time. In his witness statement, Registrant 2 stated:

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

98. Your case is that you made an informal referral to Registrant 2 for both sedation and extractions.

   (1) Your evidence in your written representations of 15 August 2018 is that you made an appointment to see Registrant 2, provided him with the

Treatment Plan and discussed the case with him several days in advance of 21 June 2017. Your evidence is that the radiographs were available to Registrant 2 and you stated in your witness statement of 16 October 2020 that, "*you were aware that Registrant 2 had reviewed the patient's treatment plan and the radiographs before he verbally confirmed to me that he could accept the referral and carry out the extractions*".

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

100. The Treatment Plan, purportedly signed on 19 December 2016 by Patient A, details "*three under principal care (IV sedation), told he charges £90 per IV sedation + private £100 per tooth for extraction*" in respect of UR7 and UR8, "*mobile teeth LL1 LR7 (stump) not sure if it is LR8 opted to under principal care (IV sedation)*", in respect of LL7 and LL6, "*opted 3 under principal care (IV sedation)*". The clinical notes, poor as they are, bear this out as set out above. The inclusion in the notes of pricing per sedation and per tooth for extraction supports your case that you had intended Registrant 2 to carry out both sedation and extractions.

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

102. For his part, Registrant 2's evidence is that he attended Practice 1 on the appointed day with a bag of equipment and sedated the patient without sight of the relevant consent forms, treatment plan, radiographs or medical history. He stated in oral evidence that you began extracting teeth, despite your well-known aversion to doing so, but Registrant 2 could not see which ones as he was "*busy*". Registrant 2's evidence evolved but it ranged from you stepping back with your hands held aloft in a wordless gesture of surrender, which he interpreted as a sign you needed assistance, to you saying, "*please help me*". It was Registrant 2's evidence that he then stepped in to extract "4 or 5" of the 6 teeth estimated to have been extracted. He stated, "*once you get committed to assisting and then if you are - and they*

say one needs to come out "can you do that for me?" I had to go along with that." Registrant 2's evidence was that he only knew which teeth to extract as you pointed to them, "*I don't know how many teeth were supposed to come out. He pointed at teeth and I took them out*".

103. Registrant 2's evidence is that he did not touch the LR8 despite the fact that at the time, he would have been under the impression it was a LR7 due to your failings in identifying and recording teeth correctly. In oral evidence, despite saying that you had pointed to each tooth for extraction and that he had not seen the Treatment Plan or radiographs, he asserted, "*I saw the radiograph on the screen - it was impacted, very, very difficult and a big surgical job*". This contrasts sharply with his earlier evidence in which he stated that he had not seen any records at all.

104. Your evidence with respect to LR8, is that Registrant 2 did attempt to extract it. In your oral evidence, you told the Committee that he, "*tried to extract tooth by gripping tooth and doing some movements but it was not possible*".

105. It is your evidence that Registrant 2 extracted five teeth but ultimately was unable to extract the LR8, which you had identified to him as the LR7 or LR7 "stump" and was referred to as LR7 in the treatment plan. The Committee considers it more likely than not that it only became apparent to you both that this was in fact, the LR8, after the attempted extraction proved unsuccessful. It comes to this conclusion on the balance of the evidence, including what you said to Patient A after you escorted him to the waiting area. Evidence on the outcome of the attempted extraction of LR7/LR8 was given as follows:

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

106. Patient A's evidence is that after the treatment he was taken to the waiting room where Witness 1's evidence was that you went in and out of the

surgery confirming with Registrant 2 what you should say in answer to questions. “POIG” is recorded in your handwritten retrospective note, although Witness 1 asserts that you did not give advice about presenting symptoms that would indicate a deterioration requiring prompt medical attention.

107. Your oral evidence is that it was only after being asked to create the retrospective note that you realised Registrant 2 was trying to "*put the blame*" on you for the failings on 21 June 2017 and you felt "*mentally raped*" by the pressure that Registrant 2 put you under.

108. Your supplementary witness statement of October 2020 stated that Registrant 2 put a lot of pressure on you to support his account and to say you had undertaken the extractions alone. Registrant 2 denies this and highlights that there is no reference to the dictation you say you were subjected to in your original witness statement.

109. Registrant 2 maintains the retrospective handwritten note was your own work, it was not done under his direction, his role was confined to sedation and assisting with extractions and that he had no need to apply any pressure to you in this regard. His evidence was that Patient A was your patient and therefore your responsibility.

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

Monitoring of Patient A

111. Registrant 2’s evidence is that monitoring equipment was used. Your evidence is that there was no monitoring equipment such as a pulse oximeter or BP cuff in place, which is also the evidence of Patient A and Witness 1.

112. Registrant 2 says that he assumed you were monitoring the patient while he was the operator but there is no record of this and you deny it. In any event, no record of any monitoring was made by you. In oral evidence, Registrant 2 accepted that because of the complexities of Patient A he would want someone “*very significantly trained in sedation*”. The Committee has had sight of your CV and that offers no evidence that you had anything approaching this level of training or experience. Registrant 2 described the expected standard of monitoring in oral evidence as, “*he had to just stand there and tell me if there was a problem, if the patient goes blue or there is a bleep or there is an obstruction*”.

Records

i. Conscious Sedation Record

113. Registrant 2's evidence was that he completed the conscious sedation record during or after the treatment on 21 June 2017 but it was not kept with the patient's clinical notes, nor was it sent by you in the first bundle of records you sent to your solicitors on 9 August 2017. It was produced for the first time at some point between 9 August 2017 and 8 September 2017 when you sent it in a second bundle of documents to your indemnity organisation. Several of the recordings were incompatible with life and the consistent oxygen saturation recordings seemed unlikely. The conscious sedation record was silent on Registrant 2's role as operator. The Committee has doubts about when this record was produced.

ii. Computer Entries

114. There are two entries on the computer system that indicate Registrant 2 phoned Patient A in the weeks subsequent to 21 June 2017, which are attributed to his log-in at Practice 1 on 17 July 2017 and 26 July 2017. There is no record of you contacting the patient after 21 June 2017.

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

iii. Retrospective and Handwritten Records

116. Registrant 2's evidence is that in his role as your VT-equivalent trainer, he had "just signed you off" in respect of your record keeping, which was demonstrated during the course of this hearing to be far from reliable.

117. Your evidence is that following the events of 21 June 2017 (and on receipt of Patient A's letter of claim) Registrant 2 dictated text to you to handwrite and enter into Patient A's clinical notes in such a way that edited out his role in the treatment. Your written representations of September 2017 and August 2018 make no mention of dictation but reflect that Registrant 2 instructed you to make a retrospective entry so as to appear contemporaneous with the treatment. Registrant 2 denies dictating or instructing him to make any note.

118. You added the retrospective note to Patient A's clinical records and noted that it was handwritten due to "software issues". As outlined above, this was something that you also did for other handwritten entries in the clinical records of Patient A, which you attributed to repeated and unfortunate technical issues. The Committee considered this coincidence remarkable and further noted that the majority of the original patient records in this case have never been provided; either by you or Registrant 2. Registrant 2 did ultimately provide a very limited set of original documents in March 2019, which he claimed had been recovered by a staff member conducting an in depth search following the GDC's request almost two years earlier in September 2017.

Nomenclature

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

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

The Committee's Findings of Fact

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

1.	Between October 2016 and June 2017 you were in general dental practice as an associate at **[REDACTED]** providing care and treatment from the dental practices as set out in **Schedule 1**. **Admitted and Found Proved**
2.	Between 18 October 2016 and 24 June 2017 you provided care and treatment to Patient A. **Admitted and Found Proved**
Treatment Planning	
3.	You failed to plan adequately or record adequately a plan to treat caries at LL8. **Admitted (Failure to record)** **Found Proved (Failure to plan and record)**

	You admitted that you failed to record your plan to treat caries at LL8. The Committee accepted your admission and found this aspect of the charge proved. With regard to the allegation that you failed to plan adequately to treat caries at LL8, you stated that you had intended to review the LL8 once the LL7 had been extracted. In your witness statement, you stated that this "*would allow better access to the LL8 to investigate any cavity and excavate any caries if necessary".* The Committee noted Professor Brook's expert report in which he agreed with you that the LL8 could be treated more easily once the LL7 had been extracted. However, he went on to state that, "*there is no record to indicate this was the plan*". The Committee had sight of Patient A's records. It noted that there was no record of a diagnosis of caries at LL8. It also noted that there were at least two entries in the notes in which you recorded the LL8 as "*missing*". The Committee considered that this significantly undermined your assertion that you had intended to treat caries at LL8 at a later date. The Committee also noted that there was no mention of your intended treatment for LL8 on the treatment plan or costs form. Furthermore, there was no radiographic report to support your assertion that you had diagnosed caries at LL8 from the radiograph taken. Patient A also stated in evidence that he was unaware of any proposed treatment to the LL8. Therefore, in all the circumstances, the Committee determined that it was more likely than not that you had failed to plan adequately to treat caries at LL8. Accordingly, the Committee found this head of charge proved in its entirety.
4.	You failed to plan adequately the extraction of LR8 prior to surgery in that:

4 (a)	you did not carry out adequate radiographic investigation; **Admitted and Found Proved**
4(b)	you did not determine adequately what surgical approach was the most appropriate; **Found Proved** When considering this head of charge, the Committee accepted that it was the agreed position between parties that you had mistakenly recorded the LR8 as the LR7 in the records. The Committee next sought to determine whether it accepted your assertion that you had referred Patient A to Registrant 2 to undertake the extractions. You stated it was Registrant 2's responsibility, and not yours, to determine what surgical approach was the most appropriate as you had made an informal verbal referral. Registrant 2's account is that any referral made was solely for sedation. The Committee accepted Professor Brook's oral evidence that once a referral is made, then this is "*effectively hitting a reset button*". The Committee also accepted Professor Brook's oral evidence that a written referral would be required in order for that to be the case. In this case, no written referral was made and the Committee also noted the following: • There are several references in the records to you proposing extraction under sedation by principal; • A treatment plan authored by you which refers to, "*Principal care (IV sedation), told he charges £90 per IV sedation + Private £100 per tooth for extraction"*; • An appointment for 45 minutes was booked under your name although the notes of that appointment have been deleted. The Committee does not accept your oral evidence that your role during the appointment was merely to hold a light; • Your regular nurse, and not Registrant 2's nurse, was present during the appointment; • Patient A stated in evidence that he understood that you would be performing the surgery;

	• In oral evidence, Registrant 2 stated that he understood that he would only be doing the sedation, but recognised that he might be required to assist you if you encountered any difficulties with the extractions; • The Committee also noted that you had been reluctant in the past to undertake extractions and that you had previously referred extractions to Registrant 2; • You assisted Patient A after the surgery and gave him post-operative instructions in the presence of Witness 1. For these reasons, the Committee determined that it was more likely than not that you and Registrant 2 each played a role in and therefore shared a responsibility for the treatment of Patient A on 21 June 2017. The Committee then went on to consider whose responsibility it was to determine the most appropriate surgical approach in those circumstances. You did not make a valid referral such that responsibility was "reset" in the way that Professor Brook described. As such, you remained responsible to determine the surgical approach and you both shared responsibility for your respective roles in the treatment of Patient A on 21 June 2017. In any event, the radiographs that you had taken were inadequate to determine the most appropriate surgical approach as agreed by Professor Brook, whose evidence on this issue the Committee preferred. Furthermore, the Committee noted that you had mistaken the LR8 for the LR7, which had previously been extracted. For all of these reasons, the Committee concluded that you had not determined adequately the most appropriate surgical approach. Accordingly, the Committee found this head of charge proved.
4(c)	you did not assess appropriately whether the extraction was within your competence and abilities.

	Found Proved The Committee noted that you had already admitted the inadequacy of your radiographic investigation and noted in "*hindsight that you should have been more pro-active in ensuring that radiographs were available*". The Committee also noted the expert reports and preferred the opinion of Professor Brook, who stated that radiographs would have assisted in determining whether the extractions were within your competence and abilities. In addition, you had mistaken the LR8 for the LR7 on several occasions and, as such, the Committee considers you were incapable of making an appropriate assessment. Accordingly, the Committee found this head of charge proved.
Treatment on 21 June 2017	
5.	On 21 June 2017 under conscious sedation at Practice 1:
5(a)	you extracted or assisted in the extraction of UL7, UR8, UR7, LL7, LL6 and/or LL1; **Found Proved** The Committee finds that the responsibility for the extractions was shared; commissioned by you and carried out by Registrant 2 with your assistance throughout the procedure. Patient A was a patient who had agreed to a great deal of private work and as such it is likely that you would have been keen to maintain this relationship. Witness 3 highlighted that you "*wanted to make a fuss of patient as he was having a lot of work done*". The Committee determines therefore that contrary to your oral evidence it was unlikely to have been mere "*bad fortune*" that you were there that day, and more likely than not that it was planned, as evidenced by the booking being made under your name, in your diary, in your surgery and with your nurse.

	The Committee determines that you worked together to arrange, carry out and complete this treatment. It was agreed that sedation services had been referred to Registrant 2. You claim that the extractions had also been referred to Registrant 2, something that he denies. Nonetheless, his evidence is that he did extract the majority of the teeth that day, although he says this was only because you began the extractions but could not complete them. The Committee finds this unlikely and instead considers it more likely than not that there was always a common understanding that Registrant 2 would carry out the extractions. The Committee finds this more likely than not due to: a) the documentary evidence in the patient's clinical notes/treatment plan that record discussions about the principal carrying out both the sedation and the extraction of Patient A's teeth including prices for principal led extractions. b) although the Committee has misgivings about the integrity of the Treatment Plan document of 19 December 2016 provided by you, appearing as it does, to have been constructed by overlaying and copying selected information from several distinct documents, it does corroborate the clinical notes in recording that Patient A opted for principal care. c) the common evidence of Witness 3 and Registrant 2 that you were known to be averse to extracting teeth. d) the common evidence of Witness 3 and Registrant 2 that he often carried out sedation and extraction, which he clarified in his oral evidence as being something he offered with his brother at other practices. e) Registrant 2's acceptance that he did in fact carry out 4-5 extractions on 21 June 2017. The Committee finds it is more likely than not that he extracted all of the teeth which were removed on that day. The Committee considers it inherently unlikely that you, with your aversion to extracting teeth, would have extracted a single tooth in the lower anterior part of the mouth before handing over to Registrant 2 to remove further teeth. f) Your CV refers to undertaking simple and complex extractions independently. In oral evidence, it emerged under Committee questioning that this was an admitted lie and you

had not in fact performed extractions or, indeed, IV sedation independently at all.

g) The notes from a call between you and your indemnifier on 2 August 2017 indicate that at that time, you were plainly under the impression that Patient A's complaints about his treatment on 21 June 2017 were directed at Registrant 2 as principal for the extractions under sedation that he performed. Your view on your vulnerability, at that stage, was that it was confined to "*perio and rct etc*" as listed in Patient A's letter before claim. The Committee considered this to be significant.

The Committee determined therefore that "*assisted in the extraction of*" would include a dental nurse's function but also considered that it included your function on 21 June 2017 at Practice 1. This included, greeting and escorting the patient to the surgery, negotiating an alternative extraction in the place of a tooth which had already been extracted in the interim, potentially administering local anaesthetic, indicating which extractions were to be performed, escorting the patient to the waiting area and providing post-operative instructions.

While there is no evidence in the records that Registrant 2 had acted as the operator, the balance of the evidence suggests that this absence of evidence was intentional. It is more likely than not that the purpose of your retrospective note, whether under Registrant 2's instruction or dictation, and Registrant 2's sparsely completed conscious sedation record, which materialised for the first time on a date between August and September 2017, was to deflect attention away from his role. The Committee was mindful that none of the original documents dealing with the treatment Patient A received on 21 June 2017 have ever been produced and the computer entry for the same date has been deleted, which neither you nor Registrant 2 could explain.

Taking all of this into consideration, the Committee determined that it was more likely than not that you and Registrant 2 shared responsibility for the treatment of Patient A on 21 June 2017. Registrant 2 has accepted extracting teeth and the Committee has concluded, on the balance of the evidence, that you assisted in the extraction of UL7, UR8, UR7, LL7, LL6 and/or LL1.

	Accordingly, the Committee found this head of charge proved.
5(b)	you attempted or assisted in the attempted extraction of LR8. **Found Proved** The Committee accepted that it was the agreed position between parties that you had mistakenly recorded the presence of the LR8 alternately as: *15.10.16 (previous treating dentist note)* — *LR7 extracted Plumstead – apices intact post extraction* *20.10.16* — *LR7 stump infected* *LR7 1) do nothing* *LR7 2) extraction* *2.11.16* — *LR7 defective - broken* *LR7 retained root* *LR8 missing* *LR7 or LR8 not sure stump – paper notes* *Broken -apical periodontitis LR7* *6 teeth needs extracting, so for now I am charging for LR7 and rest I will ask principal* *5.11.16* — *LR8 pericoronitis inflamed* *LR8 1) do nothing* *LR8 2) CHX etc* *19.12 16* — *LR7 (stump) not sure if it is LR8 – paper notes* *21.6.17* — *XLA – LL6, LL7, LL1 ,UR7, UR8, LR7- paper notes*

	Additionally, the Committee noted the retrospective handwritten entry in Patient A's records for 21 June 2017 which stated, "*LR7 could not be extracted as difficult, patient and his wife informed and told referral to specialist needed NHS/Private*". You told Patient A post-operatively, "*nothing but problems with wisdom tooth on bottom right*". The Committee was of the view that this implied that an attempt to extract the LR8 had been made. The Committee also noted that although this entry was revealed to be written retrospectively, it is nonetheless the most contemporaneous account of the appointment. The Committee determined, therefore, that it was more likely than not that Registrant 2 had attempted to extract Patient A's LR8. The Committee's rationale is that on 21 June 2017 Registrant 2 would not have known that it was in fact a partially erupted, impacted wisdom tooth requiring a surgical approach as he claimed he had not seen the treatment plan or radiographs and you were operating under the assumption that it was a LR7 "*stump*". It was Registrant 2's evidence that you pointed at the teeth to be extracted. The LR7 was planned for extraction. Registrant 2's evidence was that he wanted to do you a favour and provide a good service to Patient A, who had opted for conscious sedation in order that all the planned extractions could take place at one appointment having waited several months. In all the circumstances therefore, the Committee determined that it was more likely than not that Registrant 2 had attempted the extraction of LR7/LR8 and you had assisted in that attempted extraction. Accordingly, the Committee found this head of charge proved.
Record Keeping	
6.	You retrospectively created a manuscript record of the appointment which took place on 21 June 2017 and:

6 (a)	you failed to indicate that the record was not contemporaneous; **Admitted and Found Proved**
6 (b)	you detailed a consent process which had not in fact been carried out on the day of surgery; **Found Proved** The Committee had sight of your representations, dated 15 August 2018, from RadcliffesLeBrasseur to the GDC. The Committee noted the following from the letter: "*Mr Gupta proceeded to retrospectively complete the note in the patient's records. The note was silent on who performed the extractions however Mr Gupta acknowledges he dated it 21 June 2017 and that it detailed a consent procedure which had not been carried out prior to the surgery on the patient, to the extent that the note contains the phrase, "consent given".* It is clear from this letter that you admit to this head of charge and the Committee accepts this. Accordingly, the Committee found this head of charge proved.
6. (c)	you failed to record who else was present and their respective roles; **Admitted and Found Proved**
6 (d)	you wrote the record in such a way so as to permit the inference that you alone had carried out the extractions; **Admitted and Found Proved**
6 (e)	you failed to record the teeth extracted; **Found Proved**

	You denied this allegation as you stated that the record does note the teeth that were extracted. The Committee noted from the retrospective manuscript clinical note that you had recorded: "*XLA - LL6, LL7, LL1, UR7, UR8, LR7*". There is no accurate record of the teeth that were actually extracted. The UL7 was in fact extracted but had not been treatment planned as you agreed to substitute it for the UR6 on the day of treatment. The UL7 is absent from your record. Further, the tooth noted as LR7 had in fact already been extracted in October 2016 (records indicate tooth had been successfully extracted "apices intact") and was therefore not extracted on 21 June 2017. The Committee reviewed the records in relation to each of the teeth that were recorded as to be extracted and noted the following: LL6, LL7 & LL1 – included on the Treatment Plan of 19 December 2016 and extracted on 21 June 2017. UR7 – included on Treatment Plan for extraction (19 December 2016) but had been recorded in the records as missing on 2 November 2016. UR8 – charted on 2 November 2016 as being partially erupted but not included on Treatment Plan in December 2016 for extraction. LR7 – included on Treatment Plan in December 2016 for extraction in June 2017, but had already been extracted on 15 October 2016. The Committee determined, therefore, that you had failed to record the teeth extracted. Accordingly, the Committee found this head of charge proved.
6 (f)	you failed to record adequately why the LR8 was not extracted;

	Found Proved You denied this head of charge, as you recorded the reason that it was not extracted was because it was "*difficult*". The Committee considers that difficult is an adjective and not an adequate recording of the efforts made to extract the tooth and why it was that it ultimately could not be extracted. The Committee further noted that you had recorded that a referral was needed to a specialist. However, there is no evidence that any such referral was made. Accordingly, the Committee found this head of charge proved.
6 (g)	you failed to record accurately the amount of local anaesthetic agent used. **Admitted and Found Proved**
7.	Your conduct set out above at 6(a), 6(b), 6(c) and/or 6(d):
7.a	was misleading; **Admitted – 6(a), (c) and (d)** **Found Proved in its entirety** The Committee accepted your admission that your conduct was misleading in relation to heads of charge 6(a), 6(c) and 6(d). With regard to head of charge 6(b), the Committee determined that your actions would have misled any subsequent treating dentist to believe that you had obtained fully informed consent from Patient A for the procedure on 21 June 2017 when this had not been the case. Accordingly, the Committee found this head of charge proved in its entirety.
7.b	was dishonest in that you intended the record to mislead. **Admitted - 6(a), (c) and (d)** **Found Proved in its entirety**

	The Committee accepted your admission that your conduct was dishonest in relation to heads of charge 6(a), 6(c) and 6(d). When determining whether your conduct amounted to dishonesty in relation to head of charge 6(b), the Committee applied the test set out in the case of *Ivey v Genting Casinos (UK) Ltd. t/a Crockfords* [2017] *UKSC 67*. It noted it should first consider the actual state of your knowledge or belief as to the facts at the time. It should then go on to consider whether your conduct would be viewed as dishonest by the objective standards of ordinary and decent people. When writing the retrospective record for 21 June 2017, you were aware that you had not obtained fully informed consent from Patient A. That would be viewed as dishonest by the objective standards of ordinary and decent people. The Committee concluded that an honest person would not have created a retrospective record of an appointment and record that it had been necessary due to software issues when that was not in fact the case. Accordingly, the Committee found this head of charge proved in its entirety.
8.	In September 2017 you provided the GDC with the following documentation which bore the falsified signatures of Patient A:
8 (a)	a Medical History Form dated 18 October 2016 and annotated as updated on 24 June 2017; **Found Not Proved** The Committee noted that it was agreed that a handwriting expert could not conclusively say, one way or the other, whether the signature had been falsified. Patient A and Witness 1's evidence was that they did not recognise the handwriting on the form. Your evidence is that the signature was not falsified.

	Given the handwriting expert's conclusion, the Committee found that the GDC had not provided sufficient evidence for this head of charge to be proved on the balance of probabilities. Accordingly, the Committee found this head of charge not proved.
8 (b)	a Medical History Form dated 5 November 2016 and dated 21 June 2017; **Found Not Proved** Given the handwriting expert's conclusion, the Committee found that the GDC had not provided sufficient evidence for this head of charge to be proved on the balance of probabilities. Accordingly, the Committee found this head of charge not proved.
8 (c)	a Risks of Recommended Treatment form dated 19 December 2016. **Found Not Proved** The Committee has reservations about the integrity of the document, but there is insufficient evidence to prove that Patient A's signature has been falsified. The Committee concluded, therefore, that the GDC has failed to discharge its burden of proof in relation to this head of charge. Accordingly, the Committee found this head of charge not proved.
9. 9 (a) 9 (b)	Your conduct set out above at 8(a), 8(b) and/or 8(c): was misleading; was dishonest in that you intended the documents to mislead.

	As the Committee has found heads of charge 8(a), 8(b) and 8(c) not proved, these heads of charge fall away and it did not go on to consider them.
After Care	
10.	On 24 June 2017 Patient A attended for an emergency appointment experiencing:
10 (a)	breathing difficulties; **Admitted and Found Proved** You admitted this head of charge to the extent that Patient A always had breathing difficulties. You stated that at the time of the appointment, neither Patient A nor Witness 1 raised any concerns about breathing difficulties. Given the wording of the heads of charge 10(a) to 10 (e), the Committee gave greater weight to Patient A's evidence about what he was experiencing and where relevant, Witness 1's evidence, as they were likely to be the more accurate historians in this respect. The Committee noted that in Patient A's complaint letter to the GDC, dated 29 July 2017, he stated that, "*I was having breathing difficulties*". The Committee accepted Patient A's evidence as reliable as it was the most contemporaneous account of his symptoms at the time. Accordingly, the Committee found this head of charge proved.
10 (b)	increasing difficulty swallowing; **Found Proved** The Committee noted that in his complaint letter dated 29 July 2017, Patient A stated that he had phoned the NHS 111 medical helpline on 22 and 23 June 2017 and stated that he

	was having "*difficulty swallowing*". Witness 1 also stated in evidence that Patient A could only swallow water at the time. Following the appointment on 24 June 2017, Patient A states that he continued to experience difficulty in swallowing and an emergency ambulance was called to take him to hospital where he was intubated, transferred to a specialist department in another hospital where he underwent emergency surgery to protect his airway. The Committee concluded that it was more likely than not from Patient A's evidence and the fact that he was suffering from other symptoms such as breathing difficulties, limited mouth opening, pain and facial swelling, that he had been experiencing increasing difficulty in swallowing at the time of the appointment on 24 June 2017. Accordingly, the Committee found this head of charge proved.
10 (c)	limited mouth opening; **Admitted and Found Proved**
10 (d)	pain; **Admitted and Found Proved**
10 (e)	facial swelling. **Admitted and Found Proved**
11.	At the emergency appointment on 24 June 2017 with Patient A:
11 (a)	you failed to obtain a full history; **Found Proved** The Committee noted that although the medical history form in the records was signed and dated by you, it was not signed by Patient A.

	You denied this head of charge. In Miss Furley's closing submissions, she states that, "*the documentary evidence discloses that [you] checked the MH form and updated it (he signed and dated it to indicate this)*". However, the Committee noted that this was inconsistent with your oral evidence in which you stated that you did not have enough time to take a full history as it was an emergency appointment. The Committee considered that your account in oral evidence was more likely and was supported by Patient A and Witness 1's evidence that they had felt rushed. The Committee determined that you had an obligation to take a full history of Patient A's presenting complaint and that it was more likely than not that you had failed to do so. Accordingly, it found this head of charge proved.
11 (b)	you failed to record adequately his symptoms; **Found Proved** The Committee noted from the records that you had recorded Patient A's symptoms as 'normal' by manually entering this on a pro-forma list. This was clearly not the case as Patient A had stated that he was suffering from breathing difficulties, limited mouth opening, increased difficulty in swallowing, pain and facial swelling. Accordingly, the Committee found this head of charge proved.
11 (c)	you failed to examine adequately; **Found Proved** Your evidence that you undertook an examination and recorded it in the records to the best of your abilities was undermined by your oral evidence that the patient's limited mouth opening had hampered your efforts to examine him. In the clinical notes of 24 June 2017, you record that you were unable to take radiographs or conduct investigations "*as limited mouth opening*". In the circumstances, the Committee

	found it more likely than not that you failed to examine Patient A adequately. Accordingly, the Committee found this head of charge proved.
11 (d)	you failed to refer for prompt medical attention or advise him to seek prompt medication attention [sic] in the event of any deterioration. **Admitted (failure to refer)** **Found Proved in its entirety** The Committee accepted your admission that you failed to refer Patient A for prompt medical attention. With regard to advising him to seek prompt medical attention, you stated that you gave Patient A verbal advice to seek medical attention if his symptoms worsened as was your common practice. Advice about an adverse reaction to amoxycillin is recorded in the notes. However, the notes refer only to you giving Patient A oral hygiene instruction and advising warm saline rinses. There is no reference to advice to seek prompt medical attention in the event of deterioration. Both Patient A and Witness 1 stated that you failed to advise him to seek prompt medical attention. In fact, they were not aware of the presenting symptoms, which would signify a deterioration such that it should be acted upon. It was only when Patient A's relative reacted to his difficulty in swallowing tablets by summoning the emergency services that medical attention was sought. Given the Committee's findings in respect of your conduct at that appointment and the deficiencies in your record keeping, it has concluded that it was more likely than not that you did fail to advise him to seek prompt medication attention in the event of any deterioration. Accordingly, the Committee found this head of charge proved.
CQC – Conscious sedation	

12.	In respect of the provision of conscious sedation at Practice 1:
12 (a)	in advance of a CQC inspect [sic] on 23 June 2017 you instructed the receptionist words to the effect that she should deny to CQC that conscious sedation was provided at Practice 1; **Found Proved** By way of background, Registrant 2 did not attend the planned CQC inspection which took place on 23 June 2017. You say that Registrant 2 told you to attend and you were surprised that he was not present, as was Witness 3. You both showed the CQC inspectors around. Witness 3 complained to Registrant 2 in an email of 26 June 2017 about the way that you had behaved towards her on the day of the CQC inspection. Registrant 2 replied later that day and offered to speak to her about moving to another practice if she wanted. She did not return to work at any of Registrant 2's practices after 24th June 2017 and on 30 June 2017 made a police complaint followed by a GDC complaint on 24 July 2017. In his oral evidence, Registrant 2 described the interaction between you and the receptionist (Witness 3) on that day as an "ugly situation". You denied this head of charge. You stated that you had no reason to instruct Witness 3 to deny that conscious sedation was taking place at Practice 1. The Committee noted that in advance of the CQC inspection, the CQC had been advised that conscious sedation was not provided at Practice 1. The Committee was of the view that this was a reason for you to instruct Witness 3 to deny conscious sedation was taking place at Practice 1. Witness 3's evidence in her witness statement, dated 18 December 2019, was, *"Dr Gupta also told me to deny that sedations happened at [Practice 1] and to say that [Registrant 2]*

	never performed sedations… Dr Gupta then firmly told me not to speak or do anything during the inspection.” Registrant 2, for his part, had absented himself from the practice on the day of the inspection and had informed you and Witness 3 to show the inspectors around. You were therefore the most senior practitioner present on the day of the inspection. Therefore, the Committee determined that it was more likely than not that you had instructed Witness 3 to deny to the CQC that conscious sedation was taking place at the practice. Accordingly, the Committee found this head of charge proved.
12 (b)	Deleted.
13.	You conduct as set out above at 12(a):
13 (a)	was misleading; **Found Proved** The Committee determined that your conduct misled the CQC into believing that conscious sedation did not take place at the practice when this was not the case. Accordingly, the Committee found this head of charge proved.
13 (b)	was dishonest in that you intended to mislead as to the provision of sedation at Practice 1. **Found Proved** When determining whether your conduct amounts to dishonesty, the Committee applied the test set out in the case of *Ivey v Genting Casinos (UK) Ltd. t/a Crockfords* [2017] *UKSC 67*.

	The Committee noted that only two days before instructing Witness 3 to deny to the CQC that conscious sedation was taking place at the practice, you had engaged in a procedure involving multiple extractions on a clinically vulnerable patient under conscious sedation. The Committee concluded, therefore, that you would have been aware that you were instructing Witness 3 to provide the CQC with untruthful information. The Committee was of the view that you had acted in this way in order to prevent any further CQC enquiries that may have lead to concerns about patient safety at the practice. The Committee determined that your conduct would be viewed as dishonest by the objective standards of ordinary and decent people. Accordingly, the Committee found this head of charge proved.
14.	You behaved towards the receptionist during the CQC inspection on 23 June 2017 in a way that was:
14 (a) 14 (b)	verbally intimidating; physically intimidating. **Found Proved in its entirety** The Committee noted the following from Witness 3's witness statement of 18 December 2019: *"Dr Gupta had come up from behind me and grabbed me just above the left wrist with his right hand and pushed my back against the wall on the right hand side by the kitchen to face him. Dr Gupta's grasp was tight and he was very forceful. As Dr Gupta is much taller than I am, Dr Gupta bent down and put his face right in front of my face and had his right hand on my left hand holding it across my body and rested his left hand (with which he was holding some documents) up against the wall"***.** … "*Dr Gupta said the words to the effect of "get out! [Registrant 2] agreed you are sacked, why are you still here". Dr Gupta kept repeating "get out" and told me that I was finished and that he would ruin my life. Dr Gupta said he would make sure I never worked in another dentist practice again. He was not*

	whispering but he was not shouting either. As Dr Gupta was very close to me, I could feel him spitting on my face". The Committee had sight of Witness 3's complaint letter to the practice, dated 26 June 2017, and her letter to the GDC, dated 24 July 2017. These are contemporaneous accounts of the alleged way you behaved towards her and are consistent that your behaviour was intimidating. The Committee noted that Witness 3 stopped working at the practice shortly after this incident and had also made a police complaint. There was no evidence of any reason for her to make up these allegations against you. You denied these allegations and referred to the fact the police investigated the incident but took no further action. The Committee noted, however, that there is a different standard of proof required in regulatory proceedings compared to criminal proceedings. The Committee considered that there would have been a power imbalance in your relationship with Witness 3, who was not professionally qualified. The Committee also considered that you were the most senior practitioner present on the day and so had responsibility to ensure that the CQC inspection went well. Registrant 2 had also phoned you several times during the inspection. The Committee determined, therefore, that it was more likely than not that you were under pressure that day and that you had acted in a verbally and physically intimidating way towards Witness 3. Accordingly, it found this head of charge proved.

121. The Committee resumed consideration of your case between 29 September 2023 and 6 October 2023, and from 6 to 7 November 2023. You attended the hearing and were represented by Miss Julia Furley, Counsel. Miss Lydia Barnfather of Counsel presented the General Dental Council's (GDC) case. Your case was heard on a joint basis with Registrant 2. All parties attended remotely on Microsoft Teams.

Summary of the Committee's Findings

122. The matters at this hearing concern the treatment you and Registrant 2 provided to Patient A on 21 June 2017. On this date, Patient A, a clinically

vulnerable patient, attended Practice 1 for the extraction of several of his teeth under private contract.

123. The Committee has found proved that on 21 June 2017 you assisted Registrant 2 when he extracted the UL7, UR8, UR7, LL7, LL6 and/or LL1. Furthermore, it found that the responsibility for the extractions was shared; commissioned by you and carried out by Registrant 2 with your assistance throughout the procedure. It was also found proved that you assisted Registrant 2 when he attempted the extraction of LR8 (incorrectly recorded by you in the records as LR7). The attempts at the extraction of LR8 were unsuccessful and Patient A had the tooth subsequently extracted in hospital under a general anaesthetic.

124. Patient A returned to see you on 24 June 2017 in severe pain following the extractions on 21 June 2017. Patient A was experiencing breathing difficulties, increased difficulty in swallowing, limited mouth opening, pain and facial swelling. However, you failed to obtain a full history, to record his symptoms adequately or to examine him adequately. Furthermore, you failed to refer him for prompt medical attention or advise him to seek prompt medical attention in the event of any deterioration. You provided him with an inadequate prescription for amoxicillin tablets, which Patient A and Witness 1 maintain was pre-written. Patient A was ultimately unable to swallow the tablets and later that day he was taken by ambulance to hospital as he was "*unable to swallow and open mouth fully*". He was intubated and placed in an induced coma and was subject to a critical transfer to another hospital for specialist care. He was not discharged until 10 July 2017 after an admission to the intensive care unit and treatment for a life-threatening neck space infection.

125. In respect of treatment planning, the Committee found proved that you failed to plan adequately and record adequately a plan to treat Patient A's caries at LL8. The Committee also found proved allegations in respect of your treatment planning for the extraction of LR8. The Committee determined that you and Registrant 2 both shared a responsibility for Patient A's treatment on 21 June 2017. However, the radiographs you had taken of the LR8 were inadequate. Furthermore, the Committee noted that you had mistaken the LR8 for the LR7, which had previously been extracted. For all of these reasons, the Committee concluded that you had not determined adequately the most appropriate surgical approach or assessed appropriately whether the extraction was within your competence and abilities.

126. In respect of your record keeping for the treatment on 21 June 2017, the Committee found proved that you provided misleading and dishonest information in the retrospective manuscript record of the appointment. In

particular, you failed to indicate that the record was not contemporaneous, you detailed a consent process which had not in fact been carried out on the day of surgery, you failed to record who else was present and their respective roles and you wrote the record in such a way so as to permit the inference that you alone had carried out the extractions. In addition, you failed to record the teeth extracted, failed to record adequately why the LR8 was not extracted and failed to record accurately the amount of local anaesthetic agent used.

127. On 23 June 2017, the Care Quality Commission (CQC) carried out a planned inspection of Practice 1. The Committee found proved that in advance of the inspection you instructed Witness 3 (the receptionist at the practice) to deny to the CQC that conscious sedation was provided at the practice and behaved in a verbally and physically intimidating manner towards her during the inspection. It was also found proved that your actions in this regard were misleading and dishonest.

Documents and Oral Evidence

128. The Committee had regard to your Stage 2 remediation bundle, which included the following documents:

- Your updated curriculum vitae;
- Assorted Continuing Professional Development (CPD) certificates;
- A report from Dr Janine Brooks, Consultant Mentor and Coach, dated 31 August 2023;
- IOC Compliance Documents, including workplace supervision reports, case-based discussion documents and audits;
- References;
- Patient Feedback questionnaires; and
- Personal Development Plans.

129. The Committee also had regard to your witness statement, dated 25 September 2023, and heard oral evidence from you and Dr Brooks.

Submissions

130. In accordance with Rule 20 of the General Dental Council (Fitness to Practise) Rules 2006 (the Rules), the Committee heard submissions from Miss Barnfather, on behalf of the GDC, and submissions from Miss Furley, on your behalf, in relation to the matters of misconduct, impairment and sanction.

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

132. Miss Barnfather then moved on to the issue of current impairment. She submitted that all aspects of the public interest are relevant in this case. This includes public protection, the maintenance of public confidence in the profession, upholding the reputation of the profession and declaring and upholding proper standards of conduct among dental professionals. She submitted that your clinical and moral failings demonstrated a repeated failure to fulfil basic obligations and to abide by the GDC *Standards for the Dental Team (2013)*, and your conduct would be considered deplorable by other members of the dental profession. She submitted that it was sheer good fortune that Patient A survived the sedation on 21 June 2017 and the neglectful care provided by you three days later. She further submitted that both you and Registrant 1 attempted to conceal the provision of sedation at Practice 1 and were involved in the creation and falsification of records.

133. Miss Barnfather submitted that while you were the more junior practitioner, you were the treating dentist for Patient A's overall care. You were responsible for the referral for sedation and you were present throughout the treatment on 21 June 2017. She submitted that as a qualified dentist, you ought to have known that the patient's sedation required attentive and careful monitoring. She submitted that you failed to adequately and appropriately plan for the extractions and sought to conceal the duality of Registrant 2's role by the creation of a false record. When Patient A returned on 24 June 2017 with red flag symptoms, Miss Barnfather submitted that you failed to appropriately examine him and failed to give appropriate advice, resulting in the patient attending hospital and receiving emergency care. She submitted that you were also dishonest in your dealings with the CQC and sought to conceal the provision of sedation. During the inspection, your behaviour was verbally and physically intimidating to Witness 3. She submitted that this showed your lack of understanding of the appropriate standards of conduct in the workplace and raises questions about your temperament and self-control.

134. Miss Barnfather submitted that there was nothing in your evidence that would reassure the Committee as to your insight. On the contrary, she submitted that there remained no real cognisance as to your errors. She submitted that the Committee may wish to closely examine the evidence of your insight, if any. She submitted that you have extremely recently engaged a mentor who acknowledges there is much work for you to do. You have already accepted that you acted dishonestly in 2017 and she submitted that the Committee will note that by then you had already spent a significant

period in the UK. She invited the Committee to conclude that your insight into your conduct was significantly lacking.

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

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

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

138. Miss Furley, on your behalf, submitted that there was no doubt that these were serious incidents and that the Committee will have serious concerns about your conduct. You agreed that this amounts to misconduct.

139. Miss Furley submitted that the incidents took place many years ago and since then you have been going through significant life-changing events. She submitted that you are a very different clinician to the one in 2017. She submitted that at the time of the incidents you had only worked in one dental practice since you came to the UK in 2011 and this was under the supervision of Registrant 2. However, you accept responsibility for everything that took place and clearly you should have made better choices. She submitted that you recognised that there is no excuse for dishonesty, but you were the more junior colleague in that situation and clearly held Registrant 2 in high regard.

140. Miss Furley submitted that you do not accept that you have no insight. She submitted that you understand the impact of your behaviour on the profession. She submitted that you are working very hard to ensure that you will not be in a similar position again and there has been a significant change in your clinical development over the last six years.

141. Miss Furley submitted that you have been subject to an interim order of conditions throughout the investigation. She took the Committee through the reports of your workplace supervisors and submitted that this shows that you have practised safely throughout this time and to the required standard. She submitted that the Committee can be satisfied that your fitness to practise is not impaired by reason of your clinical practice.

142. Miss Furley further submitted that you have focused your professional development on ethical and legal matters, and have worked on improving your communication skills. She referred to the evidence from Dr Brooks, who stated that you are working extremely hard to be a safer clinician and a better man. She submitted that although it may be perceived that you were late in arranging assistance from Dr Brooks, this shows your insight in seeking help and opening yourself up to scrutiny. She submitted that you accept the work with Dr Brooks is a long-term project and that you are capable of being a useful member of the dental profession. You accept that the matters are serious, and it is highly likely that the Committee would find that your fitness to practise is impaired. However, she submitted that you wanted to show that you can get better and are genuinely putting measures in place to ensure there is no repeat of your conduct.

143. In respect of sanction, Miss Furley submitted that you are at a relatively early stage of your career. She submitted that it is open to the Committee to consider a period of suspension in this case with a review hearing. She submitted that you are willing to learn from your mistakes, are well regarded by current colleagues and have had excellent feedback from the patients you currently treat. She submitted that you still have an awful lot to give the profession and that you ask for an opportunity to do that. She submitted that you request that the Committee considers a period of suspension rather than erasure.

Committee's Decision

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

Misconduct

145. The Committee first considered whether the facts found proved against you amounted to misconduct. In doing so it had regard to the GDC publication *Standards for the Dental Team (2013).* It determined that your actions contravened eight out of the nine principles, namely:

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

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

- 1.2 ('*You must treat every patient with dignity and respect at all times*'), 1.2.4;
- 1.3 ('*You must be honest and act with integrity*'), 1.3.1, 1.3.2;
- 1.4 ('*You must take a holistic and preventative approach to patient care which is appropriate to the individual patient*'),1.4.1, 1.4.2;
- 1.7 ('*You must put patients' interests before your own or those of any colleague, business or organisation*') 1.7.1, 1.7.6, 1.7.7;
- 2.3 ('*You must give patients the information they need in a way they can understand so that they can make informed decisions*'), 2.3.1, 2.3.11;
- 3.1 ('*You must obtain valid consent before starting treatment explaining all the relevant options and the possible costs*'), 3.1.1, 3.1.6;
- 4.1 ('*You must make or keep contemporaneous complete and accurate patient records*'), 4.1.1, 4.1.4, 4.1.5, 4.1.6;
- 6.1 ('*You must work effectively with your colleagues and contribute to good teamwork*'), 6.1.2, 6.1.4, 6.1.5;
- 6.3 ('You must delegate and refer appropriately and effectively), 6.3.1;
- 6.5 ('*You must communicate clearly and effectively with other team members and colleagues in the interests of patients*'), 6.5.1;
- 7.1 ('*You must provide good quality care based on current evidence and authoritative guidance*');

- 7.3 (‘*You must update and develop your professional knowledge and skills throughout your working life*’);
- 8.1 (‘*You must always put patients’ safety first*’), 8.1.1;
- 8.2 (‘*You must act promptly if patients or colleagues are at risk and take measures to protect them*’), 8.2.1;
- 9.1 (‘*You must ensure that your conduct, both at work and in your personal life, justifies patients’ trust in you and the public’s trust in the dental profession*’), 9.1.1 and
- 9.4 (‘*You must co-operate with any relevant formal or informal inquiry and give full and truthful information*’).

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

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

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

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

Impairment

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

152. In reaching its decision on impairment, the Committee had regard to the GDC Guidance section on impairment and the relevant case law,

including the cases of *Cohen v General Medical Council [2008] EWCH 581 (Admin)* and *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council and Grant [2011] EWHC 927 (Admin).* In addition, it reviewed the *Fifth Report - Safeguarding Patients: Lessons from the Past - Proposals for the Future 9 December 2004* by Dame Janet Smith which set out the following four potential grounds to consider when determining current impairment:

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

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

154. The Committee took into account that, on your behalf, Miss Furley submitted that you accept that a finding of impairment will be made in light of the Committee's findings. It noted that dishonesty was very difficult to remediate but the clinical failings could be remedied. The Committee considered whether your misconduct was remediable.

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

156. It acknowledged the work you have begun with Dr Brooks. Despite acknowledging aspects of your dishonesty in 2017, you first sought to begin to address your dishonesty after the Committee had made its findings of fact in June this year; something you told the Committee was prompted by your legal team. You have to-date met Dr Brooks remotely on four occasions and have just embarked on addressing professional boundaries; something Dr Brooks described as "*not an easy process*". In her letter to the Committee, Dr Brooks stated that you have made, "*considerable strides in insight and self-awareness*", but in oral evidence qualified that by saying "*it was a work in progress, it takes time and was very early days*". The Committee heard that you have booked to go on a Professional Boundaries course in November 2023. It is clear from Dr Brooks' evidence that your work with her is a long-term project which you have only just begun.

157. Dr Brooks suggested that a possible reason for your failures in this case was your exposure to different ethical systems, having not been born in the UK. She also suggested that there may be cultural differences as regards appropriate boundaries. Her evidence to the Committee was that you had not given as much attention to professional boundaries as is needed. The Committee enquired of Dr Brooks how important evidence of reflection would be in assessing how much insight, if any, a registrant has into boundaries and ethical issues. Dr Brooks' opinion was that depth of reflection is very important in making such an assessment. The Committee accepted that.

158. In respect of Dr Brooks' suggestion about potential cultural influences on your misconduct, the Committee concluded that patient safety depends upon all members of the dental team abiding by and being held accountable to the standards in effect in the UK. In any event, you had been in the UK for several years by the time these events occurred, had achieved a Masters at a UK higher dental education institute and had completed a UK training programme for general dental practice. You ought to have been very clear on the standards, both ethical and clinical, expected of any registered dental professional in the UK. Any failure on your part to inform yourself of your professional obligations is not acceptable.

159. The Committee considered your witness statement, which contained no remorse or apology to Patient A or Witness 3 for your actions. The Committee found your statement to focus predominantly on the impact that the incidents have had on your career and your personal life. For example, you told the Committee you found the determination regarding your behaviour towards Witness 3 very difficult to cope with. Your only recognition of the impact your behaviour has on the profession was in regard to your admitted dishonesty in fabricating Patient A's clinical notes. Your statement inadequately addressed your own conduct. You failed to grasp the fundamental risks to the public and the confidence it places in the profession that your misconduct, both clinical and ethical, raises. In the absence of a demonstrable appreciation for the links between your dishonesty and ethical failings and the harm that was caused to a clinically vulnerable patient, the Committee is not persuaded that the risks to both public safety and the public interest have diminished.

160. You provided the Committee with two PDPs and 27 CPD certificates. None of these certificates contain any evidence of meaningful reflective learning. The only reflective text you have provided is, "*regular training, regular updates, by doing regular courses, by attending conferences*". You did not present any written reflective statement for these proceedings, although in

Dr Brooks' oral evidence she suggested she may have seen a draft version. The absence of appropriate reflection indicates to the Committee that you have not yet fully recognised or accepted the extent of your ethical failings and how these relate to your clinical practice.

161. The Committee has had sight of supervisor reports, notes from case-based discussions with your workplace supervisor and audits. Miss Furley submitted on your behalf that there is no suggestion of anything but compliance with the interim conditions that have been imposed on your registration by the GDC. This was confirmed by your workplace supervisor, with whom you had face-to-face meetings every two weeks.

162. It was clear that you had made an effort to engage in remediation, which addresses some of your failings identified in this case. The Committee accepts the evidence of your workplace supervisor and colleagues' testimonials, which attest to improvements in your clinical dentistry, which you have achieved while under supervision at your wife's practice. The Committee was, however, conscious that your remediation in respect of ethical, behavioural, attitudinal and probity matters was far less advanced. The absence of reflection was concerning, as was your focus on the impact this case has had on you in your written evidence, without comparable acknowledgement of the impact that your misconduct has on patients, colleagues and the public interest. Without sufficient insight, remediation is undermined.

163. Taking everything into consideration, in particular your limited insight despite the considerable passage of time since the index incidents, the Committee considered that it is likely that in the future you are liable to repeat the misconduct found. Evidence that you fully and demonstrably understand that ethical standards and clinical standards are inextricably bound together if patients are to be treated safely is absent. The Committee concluded that a finding of current impairment is necessary in the interest of public protection.

164. The Committee was also mindful of its role to protect the public interest, which includes the protection of patients, colleagues and the wider public from the risk of harm, maintaining public confidence in the dental professions, upholding the reputation of the dental professions and declaring and upholding appropriate standards of conduct and competence among dental professionals.

165. The Committee determined that a finding of current impairment for your misconduct is also necessary in the public interest to maintain public confidence in the profession and uphold proper standards of conduct. The

Committee has concluded that a reasonable and informed member of the public, fully aware of the facts of the case, would have their confidence in the profession severely undermined if a finding of impairment were not made in the circumstances of this case. Further, your professional peers would expect misconduct such as yours to result in a finding of current impairment in the public interest.

166. The Committee therefore determined that your fitness to practise is currently impaired by reason of your misconduct.

Sanction

167. The Committee next considered what sanction, if any, to impose on your registration. It recognised that the purpose of a sanction is not to be punitive although it may have that effect. The Committee applied the principle of proportionality balancing your interest with the public interest. It also took into account the *GDC's Guidance*.

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

169. The Committee considered the following mitigating factors to be present in this case:

- Evidence of good clinical conduct following the incident in question – some remedial action in respect of your clinical conduct has been taken;
- Evidence of previous good character (the Committee noted that you have no previous fitness to practise history with the GDC);
- Evidence of steps taken to avoid a repetition – the Committee noted the CPD certificates you have provided and that you have recently begun to work with Dr Brooks on professional boundaries and ethics, although this engagement is at a very early stage.

170. The aggravating factors in this case include:

- Actual harm caused to Patient A;
- Serious dishonesty;
- Premeditated misconduct;
- Breach of the trust Patient A placed in you to treat him safely;
- The involvement of a clinically vulnerable patient;
- Misconduct sustained and repeated over a period of time;

- Blatant and wilful disregard of the role of the GDC and the systems regulating the profession;
- Attempts to cover up wrongdoing;
- Limited insight regarding elements of your misconduct.

171. The Committee decided that it would be inappropriate to conclude this case with no further action. It would not satisfy the public interest nor protect the public given the serious nature of your misconduct.

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

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

174. The Committee then considered whether a conditions of practice order would be appropriate. The Committee noted that you have been working under interim conditions since July 2018 and there is no suggestion you have not complied. However, it would be difficult, if not impossible, to formulate conditions to address the issues of your dishonesty, lack of ethics and unprofessional behaviour towards colleagues. The Committee was also of the view that conditions would neither be sufficient nor appropriate to address the seriousness of the misconduct and safeguard the public interest.

175. The Committee next considered whether to suspend your registration for a specified period. It questioned whether a suspension would be sufficient in all the circumstances regarding the misconduct that it had found. In reaching its decision, the Committee had regard to the factors listed under paragraph 6.28 of the Guidance, which deals with the sanction of suspension, and considered that some of the factors listed applied. However, the Committee bore in mind the serious nature of your clinical and ethical professional failings in this case. You demonstrated such poor clinical judgement on two occasions that Patient A came to serious harm. You then engaged in misleading and dishonest behaviour by creating false records and submitted these to the GDC. Furthermore, you were dishonest in your dealings with the CQC and sought to conceal the provision of sedation in Practice 1. During the inspection, you also engaged in verbally and physically intimidating behaviour towards Witness 3. The Committee considered that your conduct represented serious departures from a wide range of GDC

Standards. It was not reassured, in light of the absence of reflective material, that you have achieved sufficient insight such that you do not continue to pose a risk to the public and the public interest. Your remediation has been inadequate, and in respect of your ethical failings only recently embarked upon at the suggestion of your legal team in advance of this hearing.

176. The Committee further noted that the maximum period of suspension that could be imposed was for 12 months and considered this to be insufficient to mark the severity of your misconduct despite your acknowledgement of some of your dishonesty as early as 2017.

177. In these circumstances, the Committee concluded that the suspension of your registration would not be sufficient or proportionate to protect the public and maintain the public's confidence in the dental profession.

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

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

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

- *"serious departure(s) from the relevant professional standards;*
- *where serious harm to patients or other persons has occurred, either deliberately or through incompetence;*
- *where a continuing risk of serious harm to patients or other persons is identified;*
- *the abuse of a position of trust or violation of the rights of patients, particularly if involving vulnerable persons;*
- *serious dishonesty, particularly where persistent or covered up;*
- *a persistent lack of insight into the seriousness of actions or their consequences."*

180. While this case involves a single patient, this is not a case of an isolated deviation from GDC guidance or a single instance where a treatment did not work despite a practitioner's best efforts. You were, by your own evidence, unaware of the GDC's Standards for the Dental Team until the patient's complaint arose. You told the Committee in oral evidence at Stage 1 that you had been unaware of the role of the CQC at the time of the index

events. It was your professional responsibility to be familiar with the ethical and clinical standards that govern your practice, to demonstrate a proper assessment of risk, to have regard to patient safety and to act in the best interests of the patient. You failed to abide by fundamental duties throughout your treatment of Patient A, from pre-treatment and investigations through to aftercare and recordkeeping. Patient A suffered real harm.

181. You sought in part to place the blame for your failings on your principal dentist and were critical of his practice. Your evidence was that he pressured you to behave as you did and that you had concerns about elements of his practice. All registrants have a responsibility imposed by GDC guidance, as well as a professional duty, to raise concerns. You failed to do so.

182. Your breach of these fundamental duties was compounded by your dishonesty in your proactive efforts to conceal and cover-up your failings by detailing a consent process that had not been carried out and the creation of a false record of the treatment on 21 June 2017. The issue of informed or valid consent is a cornerstone of the public interest. Your early acceptance of your dishonesty in regard to the creation of this false record does not detract from its seriousness.

183. Your intimidating behaviour towards a colleague was unacceptable and your efforts to mislead the CQC in their work to ensure patient safety were further instances where you acted without honesty and integrity in breach of a fundamental tenet of the dental profession.

184. The Committee concluded that your failings in this case represented multiple serious departures across a wide range of categories from the standards expected of dental professionals. Your clinical failings are inextricably bound together with your ethical and probity failings and you have not persuaded the Committee that you understand or accept this. Given the nature and extent of these departures and your limited insight, the Committee concluded that your misconduct is fundamentally incompatible with being a dental professional.

185. In all the circumstances, the Committee has determined to erase your name from the Dentists' Register as there are no other means of protecting the public and maintaining confidence in the profession. It recognises that this may have a significant impact on you, but considers that this is far outweighed by the public interest in this case.

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

Decision on Immediate Order – 7 November 2023

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

188. Miss Barnfather, on behalf of the GDC, submitted that such an order is necessary for the protection of the public and is otherwise in the public interest. She submitted that an immediate order would be entirely consistent with the Committee's determination in respect of the risk of repetition of your failings. She submitted that it is also necessary in the wider public interest as public confidence in the profession would be undermined if you were allowed to continue to practise without restriction in the event of any appeal.

189. Miss Furley, on your behalf, submitted that it was right and proper that you be allowed to continue to practise prior to the imposition of the order of erasure. She submitted that you are the sole breadwinner in the family and that you would like to 'close off' existing treatments and put your affairs in order at the practice at which you work. Furthermore, she submitted that at an Interim Order Committee (IOC) did not feel it was necessary to replace the interim conditions on your registration with a suspension order when it reviewed your case in August 2023 following the findings of fact.

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

191. The Committee is satisfied that an immediate order of suspension is necessary for the protection of the public and is otherwise in the public interest. The Committee concluded that given the nature of its findings and its reasons for the substantive order of erasure in your case, in particular that the risks to both public safety and the public interest have not diminished owing to your limited insight into your conduct, it is necessary to direct that an immediate order of suspension be imposed on both of these grounds.

67. The Committee acknowledged that you may need time to put your affairs in order. However, it considered that this could be done whilst you are not practising and, nonetheless, was outweighed by the necessity for an immediate order to be imposed. In respect of the submissions made about you currently being the 'sole breadwinner', the Committee held in mind that your wife is a practice owner and the public interest outweighs your interests in this regard. It further noted that, although the IOC did not impose an interim suspension order on your registration, a different test is applied at IOC

hearings than at substantive hearings and this Committee has now made its findings on impairment and sanction. The Committee also considered that, given its findings, if an immediate order was not made in the circumstances, there would be a risk to public safety and public confidence in the profession would be undermined. Without an immediate order, reputational damage would be suffered by both the profession and the regulator.

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

193. The Committee also directs that the interim order currently in place on your registration should be revoked.

194. That concludes this hearing.