Dental Professionals Hearings Service

HEARING PARTLY HEARD IN PRIVATE*

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

HANSON, Leslie Lucas Alfred

Registration No: 54448

PROFESSIONAL CONDUCT COMMITTEE

JANUARY 2023 - FEBRUARY 2023

Outcome: Erased with Immediate Suspension

HANSON, Leslie Lucas Alfred, a dentist, BDS University of Edinburgh 1980, was summoned to appear before the Professional Conduct Committee on 30 January for an inquiry into the following charge:

Charge (as amended on 30 January 2023)

"That, being a registered dentist:

1. In your capacity as principal dentist at the dental practice (identified in Schedule 1 below) ("the Surgery") at a planned inspection on 3 September 2020, you failed to demonstrate knowledge and/or understanding of, and/or adherence to, laws, regulations, standards and policies (including but not limited to the ones identified in Schedule 2) in respect of:

   (a) Cross infection control and/or decontamination including[1][2]:-

      i. not carrying out a six-monthly decontamination audit;

      ii. not having a practice cross-infection policy;

      iii. your practice being unclean including furniture and cabinetry which were damaged;

      iv. not using appropriately treated water within dental systems;

      v. not correctly storing sterilized instruments;

      vi. not using appropriate disinfectants to clean surfaces;

   (b) Radiography [3]

   (c) Equipment and/or medicines [4]including:-

      i. the steriliser/autoclave not being certified;

Schedule 1 is a private document that cannot be disclosed.
[2]See Schedule 2.
[3]See Schedule 2.
[4]See Schedule 2.

ii. the Automated External Defibrillator ('AED') not being certified;

iii. the pads of the AED having expired in 2017;

iv. intubation masks and bags in the Medical Emergency Box not being sealed.

(d) Covid-19 risk prevention and control[5].

(e) Medical emergencies[6], including that:-

i. **WITHDRAWN**;

ii. You had no basic life support training.

2) Your actions at charge 1 above put patient safety and staff safety at risk.

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

Mr Hanson was not present and was not represented. On 30 January 2023, the Chairman made statements regarding the preliminary applications. On 6 February 2023, the Chairman announced the findings of fact to the Counsel for the GDC:

"This is a Professional Conduct Committee (PCC) hearing in respect of a case brought by the General Dental Council (GDC) against Mr Hanson. The hearing is being conducted remotely by Microsoft Teams video-link.

Mr Hanson is not present at the hearing, and he is not represented in his absence. The Case Presenter for the GDC is Ms Louise Culleton, Counsel.

PRELIMINARY MATTERS

At the outset of the proceedings, Ms Culleton made an application under Rule 54 of the *GDC (Fitness to Practise) Rules Order of Council 2006* ('the Rules'), to proceed with the hearing notwithstanding Mr Hanson's absence. The Committee took account of Ms Culleton's submissions in respect of the application, and it considered the supporting documentation provided. The Committee accepted the advice of the Legal Adviser in relation to service and proceeding in the absence of Mr Hanson.

Decision on service

The Committee first considered whether notice of the hearing had been served on Mr Hanson in accordance with Rules 13 and 65. It had sight of the Notice of Hearing dated 8 December 2022 ('the notice'), which was sent to Mr Hanson's registered address by Special Delivery and by First Class post. The Committee took into account that there is no requirement within the Rules for the GDC to prove delivery of the notice, only that it was sent. However, it had regard to the Royal Mail 'Track

[5]See Schedule 2.
[6]See Schedule 2

and Trace' receipt, which confirmed that the copy of the notice sent by Special Delivery was signed for and collected from the relevant Royal Mail customer service office on 19 December 2022.

In addition, the Committee noted that in an email to the GDC dated 19 December 2022, an Advocate at M&P Legal confirmed on Mr Hanson's behalf that the notice for this hearing had been received. In considering this email, the Committee took into account that there is no evidence to indicate that M&P Legal are formally instructed by Mr Hanson as his representatives in this case. The Committee noted, however, that M&P Legal have been assisting Mr Hanson with his communications with the GDC in this matter.

The Committee was satisfied that the notice of 8 December 2022, which was sent to Mr Hanson, complied with the 28-day notice period required by the Rules. It was also satisfied that the notice contained all the required particulars, including the date and time of the hearing, confirmation that it would be held remotely by video-link on Microsoft Teams, and that the Committee had the power to proceed with the hearing in Mr Hanson's absence.

On the basis of all the information before it, the Committee was satisfied that notice of the hearing had been served on Mr Hanson in accordance with the Rules.

Decision on whether to proceed with the hearing in the absence of the registrant

The Committee next considered whether to exercise its discretion under Rule 54 to proceed with the hearing in the absence of Mr Hanson. It approached this issue with the utmost care and caution. The Committee took into account the factors to be considered in reaching its decision, as set out in the case of *R v Jones* [2003] 1 AC 1HL, and as affirmed in the regulatory cases of *General Medical Council v Adeogba* and *General Medical Council v Visvardis* [2016] EWCA Civ 162. The Committee remained mindful that fairness to Mr Hanson was an important consideration, however, it also bore in mind the need to be fair to the GDC. The Committee took into account the public interest in the expeditious disposal of the allegations in this case.

The Committee had regard to the email communications which were sent to the GDC on Mr Hanson's behalf by M&P Legal, over the period 19 December 2022 to 23 January 2023. It noted that in the first of these emails, dated 19 December 2022, it was stated that Mr Hanson would be attending this hearing, and that he would be representing himself.

However, in an email dated 13 January 2023, the GDC was informed of the possibility that Mr Hanson might not be able to attend the hearing due to an issue with his health. It was stated in the email that, [**IN PRIVATE**] *In such circumstances he may ask that the hearing be re-scheduled, or if that is not possible that the hearing be heard on the papers"*. The GDC's solicitor responded by email on 16 January 2023, asking that Mr Hanson let the Council know as soon as possible if he

wished to apply for an adjournment. Mr Hanson was referred to the case of *GMC v Hayat* [2018] EQCA Civ 2796, which sets out the type of medical evidence required to support an application to adjourn a hearing.

The GDC subsequently received some medical evidence in respect of Mr Hanson. [**IN PRIVATE**]. Following the provision of this medical evidence, it was confirmed in a further email, sent on Mr Hanson's behalf on 23 January 2023, that he would not be able to attend this hearing due to his ongoing health issue. It was stated that **[IN PRIVATE**]. *Mr Hanson will not be able to attend the scheduled hearing, but he is content for it to proceed in his absence as he believes his witness statement and submissions put forward everything that he wishes to say in his defence. He also wants to ensure that there is no more inconvenience caused to the Tribunal and the witnesses than is necessary and he is concerned that re-arranging the hearing date will do so".* [**IN PRIVATE**].

[**IN PRIVATE**]. The Committee was not satisfied that there is sufficient medical evidence before it to support the adjournment of the hearing.

The Committee took into account that Mr Hanson did not apply for an adjournment in any event. It considered that it was made clear in the email of 23 January 2023 that he was content for the hearing to go ahead in his absence, having provided written evidence and submissions in his defence. In the light of this, the Committee considered that an adjournment would serve no meaningful purpose. It took into account that it received no information to suggest that deferring the hearing would secure Mr Hanson's attendance on a future date. [**IN PRIVATE**].

In all the circumstances, the Committee determined that it was fair, reasonable and in the public interest to proceed with the hearing in the absence of Mr Hanson.

Having decided to proceed with the hearing in Mr Hanson's absence, the Committee took into account and accepted the further advice given by the Legal Adviser regarding its duty to ensure that the proceedings are as fair as circumstances permit. The Committee was reminded that this should include considering any matters on the available evidence which may be favourable to Mr Hanson.

Decision on application to amend the charge

Ms Culleton made a further application, pursuant to Rule 18 of the Rules, to amend the charge against Mr Hanson. She applied to withdraw the sub-particular at head of charge 1(e)(i), which was set out in the Notice of Hearing as follows:

***e**. Medical emergencies, including that:-*

***i.** You had had no training in how to use adrenaline and emergency drugs;*

Ms Culleton told the Committee that, in light of evidence since provided by Mr Hanson to the GDC, the GDC's expert witness in this case, Mr David Ward, had withdrawn his criticism which formed the basis for head of charge 1(e)(i). Ms Culleton

stated that the evidence provided by Mr Hanson included relevant Continuing Professional Development (CPD) certificates.

Having heard from Ms Culleton, and having accepted the advice of the Legal Adviser, the Committee acceded to the GDC's application to withdraw head of charge 1(e)(i). It had regard to the merits of the case and the fairness of the proceedings, and it was satisfied that the allegation could be withdrawn without causing injustice.

FINDINGS OF FACT – 6 February 2023

The matters in this case against Mr Hanson arise out of a referral made to the GDC by the Isle of Man's Department of Health and Social Care (the DHSC). This was following a visit by the DHSC to one of Mr Hanson's dental practices on 3 September 2020. At the material time, Mr Hanson owned two dental practices on the Isle of Man, both of which were private practices.

Background and summary of the charge

By way of background, the Committee heard that in March 2020, in the context of the Covid-19 pandemic, emergency legislation came into force on the Isle Man which required all dental practices, both NHS and private, to close. It was decided, when it was possible for dental practices to re-open in June 2020, that inspectors acting on behalf of the DHSC would visit all dental practices on the Isle of Man to assess whether they were compliant with Covid-19 infection control measures before re-opening to patients. This was the purpose of the DHSC's visit to Mr Hanson's private dental practice (referred to in this determination as 'the Practice') on 3 September 2020. The visit was undertaken by a Primary Care Team of three inspectors, all of whom are witnesses called by the GDC in this case.

The DHSC report from the visit to the Practice referred to concerns across a number of areas including in relation to Covid-19 infection control, general infection control, radiography, medical equipment, and concerns in respect of medical emergencies. In light of the identified concerns, the DHSC was unable to sign off on the re-opening of the Practice. Further, it was decided that, due to the extent of the problems identified, a referral should be made to the GDC.

The evidence received by the GDC from the DHSC regarding the concerns about the Practice was reviewed by the Council's expert witness Mr Ward, who produced a report including his opinions on the matters.

It is on the basis of the factual and expert evidence obtained by the GDC, that Mr Hanson faces the charge that, in his capacity as principal dentist at the Practice, at a planned inspection on 3 September 2020, he failed to demonstrate knowledge and/or understanding of, and/or adherence to, laws, regulations, standards and policies in relation to cross infection control, radiography, equipment and/or medicines, Covid-19 risk prevention and control, and medical emergencies. It is alleged that on account of his actions Mr Hanson put patient and staff safety at risk.

Partial admission to head of charge 1(b) – 'Radiography'

Mr Hanson has provided a witness statement for the purpose of these proceedings, dated 20 December 2022. The Committee noted that in his witness statement, Mr Hanson stated under the heading 'Ionising Radiation', *"I accept that I wasn't registered with DEFA as I was supposed to be…".*

The Committee considered this comment by Mr Hanson to be a partial admission to the allegation at head of charge 1(b), which relates to 'Radiography'. However, given that he is not in attendance and not legally represented at these proceedings, the Committee decided to defer its finding in relation to this matter until after all the evidence had been adduced.

Mr Hanson did not make any further admissions in his witness statement.

Evidence

The factual evidence received by the Committee from the GDC comprised of the following:

- a signed witness statement dated 30 May 2022 with exhibits, from Witness 1, a General Manager at Manx Care, an organisation commissioned by the DHSC. Included in the exhibits provided by Witness 1 is a copy of the Practice inspection report, dated 10 September 2020;
- a main witness statement signed and dated 19 May 2022 with exhibits, from Witness 2, a dentist and Dental Clinical Lead for a health service on the Isle of Man. Witness 2 was one of the three members of the Primary Care Team that visited the Practice on 3 September 2020. Witness 2 also provided two supplemental witness statements signed and dated 6 July 2022 and 21 July 2022;
- a signed witness statement dated 22 July 2022 with exhibits, from Witness 3, a Manager at Manx Care. Witness 3 was also a member of the Primary Care Team that visited the Practice on 3 September 2020;
- a signed witness statement dated 21 June 2022 with exhibits, from Witness 4, who was employed by Manx Care as an Infection Prevention and Control Nurse. Witness 4 was the third member of the Primary Care Team that visited the Practice on 3 September 2020.

In addition, the Committee heard oral evidence from all of the above witnesses.

By way of expert evidence, the Committee received Mr Ward's main expert report signed and dated 2 August 2022 with appendices and an addendum expert report dated 11 January 2023. Mr Ward also gave oral evidence at the hearing.

In Mr Hanson's defence, the Committee received his witness statement signed and dated 20 December 2022 together with a number of exhibits relied upon by him.

Key issues

Prior to reaching its findings on the alleged facts, the Committee considered a number of key issues raised during the course of this case, which it deemed necessary to determine before making any decisions on the allegations against Mr Hanson. These key issues were as follows:

- Jurisdiction

  The GDC's jurisdiction over the matters referred to it by the DHSC has been questioned on a number of occasions by Mr Hanson, including in his witness statement provided for this hearing.

  The Committee noted that a Preliminary Meeting of the PCC (conducted before a different Committee) was held on 8 December 2022 to deal with Mr Hanson's challenge to the GDC's jurisdiction. The decision at that Preliminary Meeting was that the GDC does have jurisdiction in this case. It was a requirement that all dentists practising on the Isle of Man must be registered with the GDC. It was determined that, as a GDC registrant, Mr Hanson is bound by the GDC's *'Standards for the Dental Team (Effective from September 2013)'* ('the GDC Standards'). As a result, the GDC is entitled to hold him to account in relation to allegations that he failed to adhere to the GDC Standards. The Dentists Act 1984 gives the GDC the authority and the responsibility to regulate dentists and dental care professionals who are registered with it regardless of where those registrants live. The GDC has powers under section 27(3) of the Dentists Act to investigate matters outside the UK, as supported by the approach taken in the case of *Sastry v General Medical Council* [2019] EWHC 390 (Admin). In that case the court further stated that, *"in short, a registrant's behaviour is to be judged by reference to UK standards but taking into account local conditions and practices"*.

  The Committee did not consider that there was any reason to depart from the preliminary decision made by the PCC in December 2022. It was satisfied that the GDC has jurisdiction to investigate concerns regarding a GDC registrant, regardless of where they live and/or practice. In accepting this position, the Committee remained aware of its duty to take into account any evidence regarding local conditions and practices. It received evidence in this case from Witness 2, a dentist on the Isle of Man, as well as evidence from Mr Hanson.

- The laws, regulations, standards, and policies set out in Schedule 2 to the charge

  In view of the wording in the charge against Mr Hanson, namely that he failed to demonstrate knowledge and/or understanding of, and/or adherence to, laws, regulations, standards, and policies in respect of a number of areas, the Committee considered the applicability to the Isle of Man of the laws, regulations, standards, and policies referred to in Schedule 2 to the charge. It

took into account that Mr Hanson, in his witness statement provided for this hearing, and previously in correspondence with the DHSC and the GDC, has refused to accept that certain regulations and guidance applied to him and the Practice.

Schedule 2 includes reference to the following:

- *The HTM 01-05 Technical Memorandum ('HTM 01-05') and relevant GDC Standards:*

  The evidence before the Committee indicates that HTM 01-05 is not legislation, but was guidance on decontamination that was in general use in the UK and on the Isle Man at the material time. The Committee heard from Witness 2 that both he and fellow practitioners followed HTM 01-05. Further, the information received from the DHSC was that HTM 01-05 was used in a number of areas of healthcare on the Isle of Man, including in dentistry.

  The Committee also took into account the expert opinion of Mr Ward that, if a practitioner was not applying the HTM 01-05 guidance, there was a requirement to follow equivalent decontamination guidance, in order to be compliant with infection control processed and procedures.

  The Committee had regard to the relevant GDC standards in Schedule 2, which make clear that registrants have a duty to find out about and follow the laws, regulations, current evidence, and best practice relating to their work and premises. It was the Committee's conclusion that it would regard HTM 01-05 as applicable guidance in this case, in the absence of any evidence suggesting that equivalent guidance was used.

- *The Ionising Radiation Regulations 2017 ('IRR') and The Ionising Radiation (Medical Exposure) Regulations 2019 (IRMER) and relevant GDC Standards:*

  The Committee noted that both the IRR and IRMER were formally adopted into Manx law. Further, that the relevant GDC Standards require all registrants to find out about and follow the laws and regulations governing their practice.

- *The SARS phase 4 Standard Operating Procedure ("SOP") and GDC Standard 1.9:*

  The Committee noted from the evidence that this SOP was a document produced by the Isle of Man Dental Association in response to the circumstances surrounding the Covid-19 pandemic. The Committee received evidence that this version of the SOP was in operation from 29 June 2020 to 31 January 2021. The evidence of Witness 2 was that he operated under the SOP, as did fellow practitioners.

  The Committee was satisfied that the SOP was applicable and highly relevant on the Isle of Man at the material time. Whilst it noted that the SOP was guidance and not law, it was satisfied from the GDC Standards that there was

an obligation on registrants to operate in accordance with the SOP, particularly given its purpose. Standard 1.9 of the GDC Standards states that *"You must find out about laws and regulations that affect your work and follow them".*

- *The Resuscitation Council (UK) Quality Standards: Primary Dental Care November 2013, and/or British National Formulary (BNF) and relevant GDC Standards:*

The Committee was satisfied by virtue of the relevant GDC Standards that The Resuscitation Council (UK) Quality Standards are applicable in this case, and were to be followed by GDC registrants practising on the Isle of Man. The Committee noted that Standard 1.5.3 specifically states that *"You must follow the guidance on medical emergencies and training updates issued by the Resuscitation Council (UK)".*

- Whether the inspection of the Practice was a planned inspection

The Committee noted the evidence of Mr Hanson that the DHSC's visit to the Practice on 3 September 2020 was not a 'planned inspection' as alleged. He stated in his witness statement for this hearing that he was never told that the visit was considered to be an inspection, or that the Practice should have been in a condition ready for treating patients. Mr Hanson maintains that he was told that it was a *"supportive visit"*. He stated that at the time of the visit, the Practice was *"effectively a work site"*, and that he had been working there on renovations for three days prior to 3 September 2020.

In the light of Mr Hanson's evidence, and given the wording of the charge which alleges that there was a *"planned inspection"*, the Committee considered the evidence it received relating to the visit to the Practice.

The Committee noted that in a letter dated 18 July 2022, which was exhibited by Witness 3, Mr Hanson was asked to contact the DHSC to arrange a date for an inspection. Mr Hanson was informed that the context of the DHSC's inspections was to assist dental practices in being able to open safely. He was asked to make contact as soon as possible so that *"I can update you with the Standard Operating Procedure the dentists (both NHS and private) are working to, and quality assurance measures that need to be in place. I would also like to arrange fit testing and a date to inspect your practice".*

The evidence is that following receipt of this letter Mr Hanson contacted the DHSC to arrange a visit. Witness 1 told the Committee that she had followed up his request with a telephone call to explain the inspection process and who would be there. Witness 1 provided with her witness statement a list of documents that she said she sent to Mr Hanson prior to the inspection. The Committee noted that Witness 1 could not definitively say whether Mr Hanson received all of the documents. However, there was some evidence that he had received some of the documentation that she said she had provided to him, as he produced some of the required practice documentation at the inspection.

The information sent to Mr Hanson included a document entitled *'Guidance to Dentists on the Isle of Man – 29th June 2020*', which had within it a list of questions to ask patients about any possible exposure to Covid-19.

The Committee also noted the contents of a letter sent to Mr Hanson after the inspection of the Practice, dated 10 September 2020, which was exhibited by Witness 1. The letter states that *"Following your telephone communication indicating that you were ready for a visit, the visit took place on Thursday, 3 September 2020".* The letter also refers to Mr Hanson having another dental practice, which had not yet been inspected, as he had advised the DHSC that the other practice was under renovation.

Having taken account of the evidence, the Committee considered that Mr Hanson should have been aware of what the DHSC's visit to the Practice on 3 September 2020 would entail. The Committee acknowledged that in the correspondence sent to him by the DHSC, the words 'inspection' and 'visit' were used interchangeably, including a reference to a *"supportive visit".* The Committee did not consider that this distinction was material: the witnesses of the DHSC accepted that the DHSC did not have the power following the visit to require that Mr Hanson's practice, being a private practice, should not re-open as a result of the concerns they had identified. The action they took was to refer the concerns to the GDC.

The Committee was satisfied that the visit to the Practice on 3 September 2020 was a planned inspection as alleged in head of charge 1.

- <u>Health matters</u>

  The Committee also considered the issues raised by Mr Hanson regarding his health in his witness statement of 20 December 2022. [**IN PRIVATE**]. The Committee was not persuaded that there was evidence that Mr Hanson's responses were significantly impacted by health matters at that time.

The Committee's findings

In reaching its findings on the alleged facts, the Committee took into account its conclusions on the above key issues. It considered all the evidence presented to it, both oral and documentary, including Mr Hanson's witness statement of 20 December 2022.

The Committee took account of the closing submissions made by Ms Culleton on behalf of the GDC. She referred to a Schedule of Evidence that she prepared in respect of this case and submitted that the Committee could be satisfied that Mr Hanson had failed in the ways alleged.

The Committee accepted the advice of the Legal Adviser. It considered each allegation separately, bearing in mind that the burden of proof rests with the GDC,

and that the standard of proof is the civil standard, that is, whether the alleged matters are proved on the balance of probabilities.

In relation to the evidence of Mr Ward, the GDC's expert witness, the Committee accepted his opinions. No expert evidence has been submitted on behalf of Mr Hanson. The Committee noted that Mr Ward stated that he is not an expert in laws and regulations relating to dental care provision on the Isle of Man. The Committee found that Mr Ward's evidence in relation to the standards expected of GDC registered general dental practitioners was coherent and comprehensive.

The Committee made the following findings:

1.	*In your capacity as principal dentist at the dental practice (identified in Schedule 1 below) ("the Surgery") at a planned inspection on 3 September 2020, you failed to demonstrate knowledge and/or understanding of, and/or adherence to, laws, regulations, standards and policies (including but not limited to the ones identified in Schedule 2) in respect of:*
1.a)	*Cross infection control and/or decontamination including:-*
1.a) i.	*not carrying out a six-monthly decontamination audit;* **Found proved.** The Committee considered the evidence of Witness 4. She exhibited with her witness statement two documents, one of which is the *'Dental Infection Prevention and Control Audit Tool (HTM01-05)*'. The Committee noted that in accordance with HTM 01-05, dental practices are required to audit their decontamination processes every six months using the audit tool. The second document exhibited by Witness 4 is a written summary of her concerns, which she compiled following the inspection of the Practice on 3 September 2020. In her summary, Witness 4 wrote that, *"I asked if I could see his HTM 01 05 audit whilst we were waiting but Lesley had never heard of this guidance and advised me that in the IOM this kind of audit isn't needed".* Mr Hanson acknowledged in his witness statement that he was *"questioned on HTM01-05 and relevant audits"*. He stated that, *"It was my view that this was an English requirement and that remains the case. The regulations referred to in HTM01-05 are UK regulations and are not applicable on the Isle of Man…In any event, I always ensured my surgery was cleaned before seeing a patient. The fact is that on average I only saw one patient a week there [at the Practice] so there was no need to clean the surgery daily".* The relevant GDC Standards, as set out in Schedule 2 to the charge, make clear that Mr Hanson had a duty to find out about and follow the laws, regulations, current evidence, and best practice affecting his work,

premises, and equipment. Standard 1.5. states that *"You must treat patients in a hygienic and safe environment"* and Standard 1.5.1 makes clear that all registrants *"must find out about the laws and regulations which apply to your clinical practice, your premises and your obligations as an employer and you must follow them at all times. This will include (but is not limited to) legislation relating to:*

- *the disposal of clinical and other hazardous waste*
- *radiography*
- *health and safety*
- *decontamination*
- *medical devices.*

Further, Standard 7.1.1 states that "*You must find out about current evidence and best practice which affect your work, premises, equipment and business and follow them"* and Standard 7.1.2 states that "*If you deviate from established practice and guidance, you should record the reasons why and be able to justify your decision".*

The Committee took into account that HTM 01-05 is guidance, and not law. Therefore, it is not mandatory that providers of dental services follow its procedures. However, it is clearly necessary and expected that providers of dental services must follow decontamination procedures for hygiene and safety reasons. The Committee had regard to the expert opinion of Mr Ward who stated in his report that *"A registered provider may be able to demonstrate that it meets the regulations in a different way (equivalent or better) from that described in the document. This implies that any practice not complying with the code and HTM01-05 must have in place a clear justification demonstrating why their systems are at least the equivalent of compliance with HTM01-05".* The Committee also took into account the evidence of Witness 2, who told the Committee that he adheres to the guidance in HTM 01-05, and that as far as he was aware, so did all his dental colleagues on the Isle of Man.

Taking all the evidence into account, the Committee considered that Mr Hanson should have been following HTM 01-05 or equivalent guidance. It noted that he did not mention in his witness statement that he was adhering to any equivalent guidance at the time the Practice was inspected. Whilst the Committee took into account what he said about ensuring that he cleaned the Practice prior to seeing patients, it considered that this fell far short of the requirements listed in the *'Dental Infection Prevention and Control Audit Tool (HTM01-05)*'.

Accordingly, the Committee was satisfied on the balance of probabilities

	that Mr Hanson did not carry out six-monthly decontamination audits at the Practice in line with the guidance in HTM 01-05 or any equivalent guidance. The Committee considered that as a registered dentist, Mr Hanson should have been aware of this duty to find out about and follow a suitable decontamination audit procedure at the Practice. The Committee considered that had he done so, he would have been aware that HTM 01-05 was being followed by dentists on the Isle of Man, and although he was not bound to do so, he was required to follow guidance of an equivalent standard. The Committee was satisfied, having considered all the evidence that by not carrying out a six-monthly decontamination audit at the Practice, Mr Hanson failed to demonstrate knowledge, understanding of, and adherence to, laws, regulations, standards, and policies in respect of cross infection control.
1.a) ii.	*not having a practice cross-infection policy;* **Found proved.** The Committee noted that the HTM 01-05 audit tool requires, among other things, confirmation of a policy/procedure that includes all appropriate aspects of decontamination within the practice e.g., cleaning, disinfection, inspection, packaging, disposal, sterilization, transport, and storage of re-usable and single use instruments. The Committee had regard to Witness 4's witness statement in which she stated that, *"We asked the Registrant if we could see his cleaning schedules but he said that he did not have any. There was no evidence that the Registrant was cleaning after every patient that he saw. He said that cleaning was done on an ad hoc basis and that he did the cleaning around once a week. The Registrant said that he did not know that cleaning products needed to be left on surfaces for certain periods of time for them to be effective.* Witness 4 also stated that she noted the presence of out-of-date cleaning wipes at the Practice, which she recalled as being *"the incorrect type of wipes"* in any event, as they were not the type that would disinfect, as you would expect in dentistry. Further, in her written summary of concerns, Witness 4 stated regarding Mr Hanson *"He had no decontamination awareness...."* She also highlighted the absence of any polices at the Practice. The Committee was satisfied on the basis of Witness 4's evidence that it was more likely than not that Mr Hanson did not have a cross infection control policy in place at the Practice. In accepting her evidence, the Committee took into account that Mr Hanson made no reference in his

	witness statement to having a formal cross-infection control policy. It also had regard to the fact that Witness 4's evidence has been tested at this hearing through questioning, including questions from the Committee. It found her to be a credible witness with a good recollection of the events. Having considered the evidence, the Committee was satisfied that this head of charge is proved. Further, it was satisfied that by not having a cross-infection policy, Mr Hanson failed to demonstrate knowledge, understanding of, and adherence to, laws, regulations, standards, and policies in respect of cross infection control.
1.a) iii.	*your practice being unclean including furniture and cabinetry which were damaged;* **Found proved.** The Committee had regard to the evidence of Witness 2, Witness 3, and Witness 4, both written and oral, about the uncleanliness and the general poor condition in which they said they found the Practice on 3 September 2020. The Committee noted that in his main witness statement, Witness 2 stated that *"It was evident that there were several issues regarding sanitation at the Practice. The chair covering for the patient's chair was aged and ripped, and the surgery wooden cabinetry was very old with drawers difficult to open and close. This meant that the chair and cabinets were more likely to have a higher source of bacterial load and that they are more difficult to clean. The chairside suction unit piping, was intermittently split which likewise meant a cross infection risk due to likely inadequate cleaning potential…"* In an email dated 3 September 2020, which Witness 3 sent to Witness 1 and another individual following the inspection, Witness 3 stated that *"He has no knowledge of HTMO105, the practice is filthy, the equipment is old 1982, there's corrosion on the foot pedal and chair…"* Witness 4 stated in her witness statement that her first impression of the Practice was that it was not clean. She stated that "…*there was dirty equipment, cobwebs, and rusted and breached equipment. The chair which the patients were supposed to sit on for their treatment was ripped which meant that it could not be cleaned properly. This was also the case for the tube which was kept next to the chair".* The Committee found the oral evidence of all three witnesses remained consistent with their written statements. All the witnesses commented on the Practice environment, highlighting the presence of rust, cobwebs, and a general state of dilapidation. The Committee also had regard to Mr Hanson's witness statement. It

	noted his explanation that renovation work was ongoing at the Practice at the time of the inspection on 3 September 2020. He stated that the chips identified on the cabinetry were marks from where he had sanded them down because the doors were sticking. He stated that he was going to seal any chips as part of the renovation. With regard to the dental chair, he denied that this was ripped, but stated *"the fabric had come away from the underside of the arm…it wasn't difficult to fix as I was able [to] simply re-bond the loose fabric to the chair. Similarly, there was no rust at the bottom of the chair, there was some debris from the refurbishment work which I wiped away following the inspection".* The Committee had sight of two invoices allegedly relating to repair works carried out at the Practice. These have not been formally produced by any witness and the Committee could not confirm their authenticity or relevance to the charges. The Committee gave no weight to these documents. In preferring the evidence of the three inspectors, Witness 2, Witness 3 and Witness 4, the Committee took into account that their evidence had been tested at this hearing through questioning, including questions from the Committee. Their evidence was clear, consistent, and in the Committee's view, credible. The Committee noted that when questioned the witnesses were confident in their recollections that there was no evidence of any renovation taking place at the Practice at the time, and that Mr Hanson did not mention that he was renovating the Practice. The Committee also noted that there is no reference to renovation works in the report of the inspection. The Committee took into account that Mr Hanson's witness statement has not been tested during these proceedings. It further noted that the first time that he apparently mentions the subject of renovation works is in his witness statement prepared for this hearing, which is dated 20 December 2022. There is nothing to indicate that Mr Hanson provided such an explanation before this date. In all the circumstances, the Committee found this head of charge proved. It was satisfied on the evidence that, at the time of the inspection on 3 September 2020, the Practice was unclean including that furniture and cabinetry which were damaged. The Committee noted the evidence regarding the infection control risks associated with the poor state of the Practice environment, including the opinion of Mr Ward. He stated in his report that *"There is a clear obligation within HTM01-05 to keep premises clean …. Equipment such as dental chairs and associated cabinetry must be maintained to allow easy and efficient cleaning. Tears to fabric and chipped cabinetry as described by*

	the inspectors makes cleaning less efficient". In view of this evidence, the Committee was satisfied that Mr Hanson failed to demonstrate knowledge, understanding of, and adherence to, laws, regulations, standards, and policies in respect of cross infection control.
1.a) iv.	*not using appropriately treated water within dental systems;* **Found proved.** The Committee had regard to the expert evidence of Mr Ward, who stated in his report that *"HTM01-05 on page 40 states 'self-contained water supplies used with dental care systems should be distilled or RO water'. Dental care systems include the water used within high-speed unit. The 'high speed unit' is the drill typically used by dentists to drill teeth during fillings. In my opinion it is widely accepted that distilled water should be used within such drills rather than tap water as it typically has much lower levels of contaminants and the water will enter patients' mouths during treatment".* The Committee noted the evidence of Witness 4 that Mr Hanson was using tap water in the Practice instead of distilled water. She stated that Mr Hanson was very open about this, and that he did not seem to realise that using tap water was an issue. The concern about Mr Hanson using tap water within dental systems was also noted by Witness 2. He explained in his witness statement that *"To protect the water supply and prevent cross infection, dentists use a bottle of distilled water or reverse osmosis (RO) water attached to the drill unit for tooth cooling/cleansing purposes. This protocol was introduced over twenty years ago and detailed within HTM01-05 in 2009 and was updated in 2013. [Witness 4] noted that the Registrant was not using distilled or RO water in the water bottle and was instead using tap water in this bottle. I advised the Registrant that tap water was no longer suitable as the regulations had been updated. The Registrant did not know about this advice and said he was not aware of HTM01-05".* Mr Hanson stated in his witness statement that he always used de-ionised water from the garage near his other dental practice for the high-speed delivery unit and autoclave. He stated that the only reason that tap water was in the high-speed delivery unit on the day of the inspection was that he had run out of de-ionised water when trying install the unit. He said that he did not think that there would be an issue using tap water whilst installing the unit, provided that it was flushed out before use in a clinical setting. In finding this allegation proved, the Committee preferred the tested evidence of Witness 4 and Witness 2. It was satisfied on the basis of their

	evidence, and its findings regarding Mr Hanson's failings in other aspects of infection control, that it was more likely than not that he was using tap water within the dental systems at the Practice. The Committee also took into account that Mr Hanson's explanation does not appear in the inspection report, and Witness 4 and Witness 2 did not recall such an explanation being given at the time. The Committee accepted Mr Ward's expert opinion and was satisfied that the use of tap water in dental systems is inappropriate. Accordingly, it was satisfied that by not using appropriately treated water within dental systems, Mr Hanson failed to demonstrate knowledge, understanding of, and adherence to, laws, regulations, standards, and policies in respect of cross infection control.
1.a) v.	*not correctly storing sterilized instruments;* **Found proved.** In his witness statement, Witness 2 stated that *"The Registrant did not have his dental instruments in bags and the drawers were very old and did not easily open. The Registrant was therefore storing the un-bagged instruments on trays in a layered perspex tray holder".* According to Witness 2, Mr Hanson said that he did not know about the need for instruments to be bagged and dated, and that he did not know that instruments not in a bag needed to be used within a day. These details noted by Witness 2 appear in the report on the inspection, dated 3 September 2020. Having noted from the inspection report how the surgical instruments were said to be stored, Mr Ward commented in his report that *"It would be inappropriate and against HTM01-05 to store instruments this way unless they were to be re-sterilized prior to usage."* In response to this allegation, Mr Hanson stated in his witness statement that he usually kept his surgical instruments at his other dental practice. He stated that "*Similarly, it was also more economical to stop using the autoclave in [the Practice] and instead sterilise my instruments in [the other practice] the evening before an appointment and transport them in bags to [the Practice] the morning of the appointment".* The Committee accepted the tested evidence of Witness 2. Whilst it noted Mr Hanson's evidence regarding where he kept his surgical instruments, this explanation does not appear in the inspection report. Also, Witness 2 did not recall such an explanation being given by Mr Hanson on the day. The Committee was satisfied on the balance of probabilities that Mr Hanson did not correctly store sterilised instruments at the Practice. Therefore, he failed to demonstrate knowledge, understanding of, and

	adherence to, laws, regulations, standards, and policies in respect of cross infection control.
1.a) vi.	*not using appropriate disinfectants to clean surfaces;* **Found proved**. The Committee had regard to Witness 3's evidence about the lack of any cleaning schedules at the Practice, and the presence of a pack of out-of-date wipes, which she noted were the wrong type, not capable of disinfecting surfaces. Witness 3 told the Committee in her oral evidence that the Practice did not smell like a clinical environment. She described the premises as old, dirty with a mouldy smell. Mr Hanson's evidence is that when he was asked about what cleaning products he had used to clean the dental chair, he had assumed he was being asked about what he had used on that day. His evidence was that he had only wiped things down with water to remove some of the dust from the refurbishment. Mr Hanson further stated that the out-of-date disinfectant wipes were used to clean up paint or other stains as they were still useful. Having noted the absence of any evidence regarding refurbishment at the Practice at the time of the inspection on 3 September 2020, including in the inspection report itself, the Committee did not find Mr Hanson's explanations credible. It considered, on the basis of Witness 3's evidence, and the evidence of the other inspectors about the uncleanliness of the Practice, that Mr Hanson did not use appropriate disinfectants to clean surfaces. The Committee accepted the expert opinion of Mr Ward that *"Water only as a cleaning fluid, as noted within the DHSC report, is not acceptable for cleaning clinical surfaces. The exact requirements of the cleaning products used within surgeries depends on the materials being cleaned and their potential exposure to potentially infective agents. I would expect practice management to seek guidance and use the appropriate agents".* The Committee noted the evidence that Mr Hanson had attended training with Witness 3 prior to the inspection. He stated, however, that he could not remember what products she had advised. In all the circumstances, the Committee was satisfied that by not using appropriate disinfectants to clean surfaces, Mr Hanson had failed to demonstrate knowledge, understanding of, and adherence to, laws, regulations, standards, and policies in respect of cross infection control.
1.b)	*Radiography* **Found proved**.

	In reaching its finding on this head of charge, the Committee took into account Mr Hanson's partial admission that, at the time of the inspection, he was not registered with the Isle of Man Government for Ionising Radiation. He stated that when he received the report regarding the inspection of the Practice on 3 September 2020, he was advised of the registration requirement and immediately contacted the Department of Environment, Food and Agriculture (DEFA) for the relevant forms. However, the Committee considered that the evidence relating to the inspection indicated that the identified deficiencies in Mr Hanson's practice in Radiography were more extensive. In this regard, the Committee took into account the information included in the inspection report, as well as the evidence of Witness 2. Witness 2 stated that Mr Hanson's x-ray processes at the Practice were a concern. In particular, it was noted by Witness 2 that *"On checking the Registrant's wall mounted X-ray unit, I noticed that he did not have any local rules printed out by the unit. These would include aspects for the safe use of x-rays, exposure levels, contingency plans and named responsible individuals. The Ionising Radiation Regulations 2017 (IRR) require local rules to be displayed by the X-ray unit. I asked the Registrant what the procedures were for taking an X-ray and the Registrant said that he did not have any local rules. The Registrant said that he thought that all was required was the National Radiation Board booklet. This is a booklet that provides advice on dental radiography and was published by the National Radiological Board in the early 1990s. As far as I can recall, from the time I qualified, this was the document to follow for safe radiography practice. This was a problem and made me realise that the Registrant was not aware of the up to date regulations as the IRR were initially instituted in 1999. He also said he was likewise not aware of the Ionising Radiation (Medical Exposures) Regulations 2019 or its year 2000 predecessor".* It was noted that Mr Hanson reported to the inspectors that he had had the x-ray unit at the Practice serviced by a local engineer. However, Witness 3 stated in her witness statement that she found no evidence to certify that the unit had been serviced. As already noted by the Committee, *The Ionising Radiation Regulations 2017* and *The Ionising Radiation (Medical Exposure) Regulations 2019* have been incorporated into Manx law. Therefore, it was incumbent on Mr Hanson to follow the requirements of these Regulations. It is made clear in the relevant GDC Standards that Mr Hanson had a duty to find out about the laws and regulations governing his work as a dentist and the Practice premises.

	The Committee had regard to the expert report of Mr Ward who explained that the Regulations in question "*deal with the safe and effective use of ionising radiation for dental x-rays"*. Mr Ward also referred to the various clinical requirements under the Regulations including justifying and reporting on radiographs, and the need for regular audits of radiography quality. He also highlighted the need for compliance with regular certification, maintenance, and provision *"of what are known as 'local rules'. These are the instructions for use of each individual x-ray machine which need to be available adjacent to each x-ray machine".* The Committee was satisfied, on all the evidence, that Mr Hanson was not complying with the requirements of the relevant Regulations on Radiography, and indeed the GDC Standards. Accordingly, it was satisfied that Mr Hanson failed to demonstrate knowledge, understanding of, and adherence to, laws, regulations, standards, and policies in respect of Radiography. This allegation is proved.
1.c)	*Equipment and/or medicines including:-*
1.c) i.	*the steriliser/autoclave not being certified;* **Found proved**. It was the evidence of Witness 3, as contained in her witness statement, that the autoclave did not have a certificate on it, and that she could not find any other certificates to confirm servicing of the autoclave. She stated that Mr Hanson had said that the autoclave had been looked at, but she found no record of this. Witness 3 stated that she explained to Mr Hanson the importance of having this equipment serviced and that it should not be topped up with tap water. In his witness statement, Mr Hanson maintained that much of the official paperwork requested by the inspectors was held at his other dental practice, such as insurance certificates, CPD certificates and service certificates. However, the Committee took into account that there is no indication in the inspection report that he provided such an explanation to the inspectors at the time. Further, none of the relevant witnesses recalled being told by Mr Hanson that certificates, including for the autoclave were at his other dental practice, and there is no suggestion that Mr Hanson subsequently sought to provide them to the DHSC. Further, the Committee took into account the inconsistency between Mr Hanson explanation regarding the whereabouts of the certificates with his evidence on where he sterilised his surgical instruments. In his witness statement, Mr Hanson stated that *"…it was also more economical to stop using the autoclave at [the Practice] and instead sterilise my instruments in [the other dental practice] the evening before an appointment and*

	transport them in bags to [the Practice] the morning of the appointment. This meant I only needed to keep [the other dental practice] autoclave serviced". The Committee found that the evidence provided by Mr Hanson in relation to the certification of the autoclave at the Practice lacked credibility. It preferred and accepted the evidence of Witness 3. The Committee was satisfied on the balance of probabilities that the autoclave at the Practice was not certified. It took into account the expert evidence of Mr Ward indicating that certification of a steriliser is mandatory under HTM 01-05 for decontamination compliance. The Committee was satisfied in all the circumstances, that Mr Hanson failed to demonstrate knowledge, understanding of, and adherence to, laws, regulations, standards, and policies in respect equipment.
1.c) ii.	*the Automated External Defibrillator ('AED') not being certified;* **Found proved**.
1.c) iii.	*the pads of the AED having expired in 2017;* **Found proved**. The Committee considered heads of charge 1(c)(ii) and 1(c)(iii). It found each of the allegations proved having noted the evidence it received from the inspectors regarding their concerns about the Automated External Defibrillator (AED). Witness 3 stated in her witness statement that she checked the AED machine, and although Mr Hanson advised her that it had been serviced recently, she could find no date of service on the machine. She also noticed that the pads for the machine had expired in 2017. Similarly, Witness 4 referred in her evidence to the AED machine and to Mr Hanson retaining of out-of-date resuscitation equipment. She stated in her witness statement that *"…In addition, the expiry date on the AED had passed, although I do not recall the extent to which this was out of date".* Mr Hanson's evidence suggested that he only kept a certified AED along with in date AED pads at his other dental practice. He stated in his witness statement that *"As my business slowed down it was more economical to keep one emergency medical kit, one set of resuscitation equipment and one AED fully serviced and in date and to simply take these items to [the Practice] when I had appointments there".* The Committee noted, however, that there was no reference in the inspection report to Mr Hanson having given such an explanation. Further, that none of the inspectors recall him having given this explanation at the time, nor is there any evidence to suggest that Mr Hanson was able to

	produce subsequently evidence of certification of the AED. The Committee was satisfied, on the basis of the evidence, that Mr Hanson failed to demonstrate knowledge, understanding of, and adherence to, laws, regulations, standards, and policies in respect equipment on account of the identified issues concerning the AED at the Practice.
1.c) iv.	*intubation masks and bags in the Medical Emergency Box not being sealed.* **Found proved**. Witness 2 stated in his witness statement that *"There were no issues with the Registrant's practice oxygen cylinders. However, the patient face masks – used for the delivery of emergency oxygen to the nose and mouth of an ill patient were not in sealed packages. The masks and attached reservoir bags should be kept in a sealed bag so that they cannot be reused on different patients".* Witness 3 also noted in her witness statement that *"Some intubation masks and bags were unsealed which means that they could be cross-contaminated."* In accepting the evidence of both witnesses, the Committee took into account that there is nothing to indicate that Mr Hanson's explanation about only keeping one medical emergency kit at his other dental practice was raised with the inspectors at the time of the inspection. It appeared to the Committee that his first mention of this matter, and a number of the other explanations given, was in his witness statement of December 2022. Accordingly, the Committee was satisfied that this head of charge is proved. It was satisfied on the evidence that Mr Hanson failed to demonstrate knowledge, understanding of, and adherence to, laws, regulations, standards, and policies in respect equipment in light of the intubation masks and bags in the Medical Emergency Box not being sealed.
1.d)	*Covid-19 risk prevention and control.* **Found proved**. The Committee had regard to Witness 2's witness statement in which he stated that *"A standard operating procedure was distributed online by the DHSC prior to September 2020 providing guidance on the re-opening of dental practices post-pandemic. [Witness 3] noted that she had sent this to the Registrant in the post as he did not have access to a computer. However, when we asked the Registrant he said he was not aware of the standard operating procedure. The Registrant did have a thermal*

	temperature to check the temperature of patients arriving and said that he would ask them whether they had tested positive for Covid-19". Witness 2's evidence was supported by that of Witness 3, who stated in her witness statement that *"The Registrant did say that he had a list of Covid-19 questions to ask patients prior to attending the Practice, but he said that he was unaware of the SOP and protocol".* In his witness statement, Mr Hanson highlighted that he has repeatedly questioned the GDC and DHSC as to the status of many of the regulations and guidance referred to in this case including the '*SARS phase 4 Standard Operating Procedure'* (SOP). The Committee considered that this evidence from Mr Hanson clearly demonstrated a lack of knowledge, understanding and adherence on his part, given that the SOP was a document produced by the Isle of Man's Dental Association for the purpose of returning dental practices to safe practice in the context of the Covid-19 pandemic. The Committee noted the evidence that the SOP was circulated to all dentists on the Isle of Man. It also took into account the oral evidence of Witness 2 that he was operating under the SOP, as were other practitioners that he knew. The Committee noted that Mr Hanson had complied with the requirements for a thermal temperature check. It also noted that reference was made in the inspection report about Mr Hanson having a folder to "*remind him of Covid questions to ask patients prior to booking appointments and to remind him of donning and doffing of PPE".* This suggested to the Committee that Mr Hanson did have access to some of the relevant paperwork relevant to the SOP. However, the Committee noted from the evidence of the inspectors, which it accepted, that when questioned about how he was applying the SOP at the Practice, Mr Hanson did not seem fully cognisant of all the requirements. The evidence indicates that Mr Hanson could not show that he fully understood the polices and procedures for dealing with the Covid-19 risk at the time. In all the circumstances, the Committee was satisfied that Mr Hanson failed to demonstrate knowledge, understanding of, and adherence to, laws, regulations, standards, and policies in relation to Covid-19 risk prevention and control. In reaching its decision, the Committee took into account the SOP was not law on the Isle of Man. However, it was appropriate and relevant guidance, which the Committee was satisfied that Mr Hanson should have been following by virtue of the duties imposed on him by the GDC Standards.
1.e)	*Medical emergencies, including that*
1.e) i.	**WITHDRAWN**.

1.e) ii.	*You had no basic life support training.* **Found proved**. It was the evidence of Witness 3 that as at the time of the inspection, Mr Hanson had not had Basic Life Support training. She stated in her witness statement that she remembered that Mr Hanson had told them "*little anecdotal stories about this".* Witness 3 stated that *"It seemed that the Registrant did not realise the seriousness of the questions we were asking" He did not try to hide anything and was very open about not being aware of the need for training".* The Committee had regard to Mr Hanson's witness statement in which he stated that he has tried to provide as much documentation as possible in his defence, however, due to certain circumstances not all documents are available. The Committee noted that Mr Hanson provided a letter dated 18 November 2022, apparently from a dental nurse previously employed by him. The letter states that the dental nurse regularly attended training with Mr Hanson for several years up until 2020 including resuscitation training with the use of an AED, as well as training in medical emergencies including the use of an EpiPen. In accepting the evidence of Witness 3, the Committee took into account the lack of satisfactory objective evidence to indicate that Mr Hanson had undertaken any appropriate Basic Life Support training. In noting this, the Committee remained mindful that the letter provided by a former dental nurse who worked with Mr Hanson has not been tested in evidence. It therefore decided that it could attach little weight to the letter. The Committee also took into account the absence of any appropriate certificate on Basic Life support training. In all the circumstances, the Committee was satisfied on the balance of probabilities that Mr Hanson did not have training in Basic Life Support. Accordingly, he failed to demonstrate knowledge, understanding of, and adherence to, laws, regulations, standards, and policies in relation medical emergencies. In this regard, the Committee took into account that Standard 1.5.3 of the GDC Standards specifically states that *"You must follow the guidance on medical emergencies and training updates issued by the Resuscitation Council (UK)".* The Committee had before it a copy of the relevant guidance which was appended to Mr Ward's expert report. It noted the requirement for training in Basic Life Support.
2.	*Your actions at charge 1 above put patient safety and staff safety at risk.* **Found proved**. In finding this allegation proved, the Committee had regard to the evidence of the DHSC witnesses and the expert evidence of Mr Ward.

	Mr Ward stated in relation to the failings in cross infection control, including in relation to Covid-19 prevention and control that, *"Inadequacy of cross infection procedures can lead to potential infection spread for both staff and patients alike. This was even more important than usual during the COVID pandemic when a new pathogen was spreading in the community".* Mr Ward also highlighted the cross infection control risks associated with an uncertified autoclave and intubation masks and bags in the Medical Emergency Box not being sealed. In relation to radiography, Mr Ward stated that *"Failure to certify the x-ray machine, provide local rules and have a clear system of quality assurance through a radiation protection file would be a clear failure of one of the basic skills of a general dental practitioner and could contribute to serious harm to both staff and patients".* With regard to the identified concerns regarding the AED at Practice, it was Mr Ward's opinion that, "*Failure to formally inspect and certify that the AED was in full working order could lead to the AED not functioning when required and therefore reduced survival rates for victims of cardiac arrest for both staff, patients and the local community…Failure to replace out of date pads would also lead to potentially inferior performance of this potentially life-saving equipment…"* Mr Ward also addressed the issue of training related to the management of medical emergencies stating that, "*Competent provision of medical emergency treatment is a basic skill requirement of general dental practice as it can prevent serious patient/staff injury and/or save lives".* The Committee accepted Mr Ward's expert opinions in relation to the risks posed to both patients and staff from Mr Hanson's lack of knowledge, understanding and adherence to the relevant laws, regulations, standards, and policies featured in this case. The Committee was satisfied that Mr Hanson's actions as found proved at charge 1 put patients' safety and staff safety at risk.

We move to Stage Two."

On 7 February 2023, the Chairman announced the determination as follows:

"This is a Professional Conduct Committee hearing in respect of a case brought by the General Dental Council (GDC) against Mr Hanson. The hearing is being conducted remotely by Microsoft Teams video-link.

Mr Hanson is neither present nor represented at the hearing. The Case Presenter for the GDC is Ms Louise Culleton, Counsel.

Summary of the facts found proved

The facts found proved in this case are that, at a planned inspection of his dental practice on the Isle of Man on 3 September 2020, by the Isle of Man's Department of Health and Social Care (DHSC), Mr Hanson, in his capacity as the principal dentist, failed to demonstrate knowledge, understanding of, and adherence to, relevant laws, regulations, standards and policies in respect of:

- Cross infection control and decontamination.
- Radiography.
- Equipment and/or medicines.
- Covid-19 risk prevention and control.
- Medical emergencies.

The Committee found proved that, through his actions in respect of the above matters, Mr Hanson put patient safety and staff safety at risk.

This second stage of the hearing

The Committee's tasks at this second stage of the hearing have been to consider whether the facts found proved amount to misconduct, and if so, whether Mr Hanson's fitness to practise is currently impaired by reason of that misconduct. The Committee noted that if it found current impairment, it would need to consider the issue of sanction.

The Committee considered all the evidence presented to it, both at the fact-finding stage and this stage. The evidence received by the Committee at this stage included a copy of a handwritten letter dated 14 September 2020, from Mr Hanson to the GDC, in which he requested to be voluntarily removed from the Dentists Register. Also provided to the Committee was a copy of the GDC's letter in response, dated 2 December 2020, refusing Mr Hanson's application for voluntary removal on account of these ongoing fitness to practise proceedings.

The Committee took account of the submissions made by Ms Culleton in relation to misconduct, impairment, and sanction, including the legal authorities she cited: *Roylance v General Medical Council (No 2)* [2001] 1 AC 311; *Nandi v General Medical Council* [2004] All ER (D) 25; *Cohen v General Medical Council* [2008] EWCH 581 (Admin) and *Council for Healthcare Regulatory Excellence v Nursing Midwifery Council and Grant* [2011] EWHC 927 (Admin).

The Committee accepted the advice of the Legal Adviser. It noted that there is no burden or standard of proof at this stage of the proceedings, and that its decisions were for its independent judgement.

Summary of the GDC's submissions

Ms Culleton confirmed that Mr Hanson has no fitness to practise history before the GDC.

Ms Culleton submitted that the question for the Committee, in reaching its decision on the issue of misconduct in this case, is whether there has been a falling short of the standards expected, that is serious, and which would be regarded by fellow dental practitioners as deplorable in terms of the seriousness. She stated that in answering this question, the Committee may wish to consider the evidence of the GDC's expert witness, Mr David Ward, as well as the GDC's *'Standards for the Dental Team (Effective from September 2013)'* ('the GDC Standards').

Ms Culleton highlighted that Mr Ward made clear in his main expert report of 2 August 2022, that each of the matters found proved against Mr Hanson fell far below the standard expected of a reasonably competent dentist. She drew the Committee's attention to paragraph 6.5 of his main report, in which he states that "*My overall impression of the standards within LH's practice as described by the DHSC inspectors was that it was lacking in many basic standards of general dental practice, such as cross infection control and radiography. LH's admittance of no knowledge of IRMER regulations, HTM01-05 and COVID SOPs in addition to a failure to maintain adequate emergency equipment, medicines and training demonstrates an alarming failure to maintain adequate standards".*

Ms Culleton submitted that Mr Hanson's failings were in basic and fundamental aspects of dental practice and included his failure to follow a Standard Operating Procedure (SOP) specifically designed by the Isle of Man in the context of the Covid-19 pandemic. She stated that around the material time, the DHSC was engaged in finding a safe way to re-open dental practices for the protection of patients and the protection of staff working in the dental clinics.

In regard to Mr Hanson's failings, Ms Culleton invited the Committee to consider the relevance of GDC Standards 1.5, 1.5.1, 1.5.3, 7, 7.2 and 7.3. It was her submission that these key GDC Standards had not been complied with by Mr Hanson, and that the facts found proved against him amount to misconduct.

In addressing the Committee on current impairment, Ms Culleton submitted that there is no evidence of remediation before the Committee. She highlighted that the information provided by Mr Hanson in his witness statement dated 20 December 2022, provided at the facts stage, was found by the Committee to lack credibility. Ms Culleton submitted that it might even be said that Mr Hanson's written responses to the issues in this case are disingenuous, in light of the evidence given by the DHSC witnesses and given that his first mention of

many of the matters he put forward in his defence was in late December 2022, more than two years after the inspection of his practice.

Ms Culleton also asked the Committee to take into account that all of the Continuing Professional Development (CPD) certificates exhibited by Mr Hanson with his witness statement pre-date the inspection of his practice in September 2020. She stated that there is no evidence of any CPD undertaken by Mr Hanson since then.

It was Ms Culleton's submission that the matters found proved in this case have not been remedied, and that it is highly likely that they will be repeated. She stated that in the circumstances, the Committee may conclude that Mr Hanson's fitness to practise is currently impaired.

In relation to sanction, Ms Culleton submitted that, given the findings made by the Committee, which the GDC considers to be serious and deplorable matters amounting to misconduct, with no evidence of remediation, the Committee should consider a sanction at the top end of the spectrum. Ms Culleton submitted that this should be no less than suspension. She stated that the Committee may also wish to take into account Mr Hanson's position in having sought voluntary removal from the GDC Register.

Decision on misconduct

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

1.5 You must treat patients in a hygienic and safe environment.

1.5.1 You must find out about the laws and regulations which apply to your clinical practice, your premises and your obligations as an employer and you must follow them at all times. This will include (but is not limited to) legislation relating to:

- …
- radiography
- health and safety
- decontamination
- medical devices.

…

1.5.3 You must follow the guidance on medical emergencies and training updates issued by the Resuscitation Council (UK).

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

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

7.3 Update and develop your professional knowledge and skills throughout your working life.

In its findings the Committee identified a broad range of serious failings in fundamental aspects of Mr Hanson's practice. These included significant shortcomings in basic hygiene, general cross-infection control, Covid-19 prevention and control, medical emergencies, radiography, and certification of dental equipment. It was important that Mr Hanson had knowledge of, understood and adhered to the relevant laws, regulations, standards, and policies in all of these areas of practice. In particular, adherence to guidance on infection control was especially important during the pandemic because of the heightened risk posed to patients and staff from Covid-19. The Committee took into account the opinion of Mr Ward that Mr Hanson's practice in relation to each of the matters found proved fell far below the standard expected of a reasonably competent dentist.

The GDC Standards have been in place for a long time, and as a GDC registrant Mr Hanson has always been obliged to follow them. Whilst the Committee noted that the inspection of Mr Hanson's dental practice took place on one day, the evidence relating to the concerns suggest that Mr Hanson's failings had persisted over a longer period of time. It noted for instance, the evidence regarding Mr Hanson's reference to and reliance upon the National Radiological Board booklet, which Witness 2 told the Committee was a book used in practice in the 1990s. The Committee considered that this, and many of Mr Hanson's other responses to the issues identified by the DHSC, which included his refusal to accept the applicability of important guidance, demonstrated a pattern of wilful or ignorant non-adherence to legislation, guidelines, and standards. Such behaviour brings the dental profession into disrepute.

The Committee was satisfied on all the evidence that Mr Hanson actions, as highlighted in this case, represented serious breaches of the GDC Standards set out above, all of which were crucial to his work as a practising dentist. These were serious failings which pose a real risk to patients and staff, and the Committee was satisfied that the facts found proved amount to misconduct.

Decision on impairment

The Committee next considered whether Mr Hanson's fitness to practise is currently impaired by reason of his misconduct.

In reaching its decision, the Committee bore in mind the over-arching objective of the GDC, which is: the protection, promotion and maintenance of the health, safety, and well-being of the public; the promotion and maintenance of public confidence in the dental profession; and the promotion and maintenance of proper professional standards and conduct for the members of the dental profession.

The Committee had regard to the evidence in this case and it considered that, looking back to the material time, there was no evidence to suggest that Mr Hanson had sufficient insight into the concerns that were pointed out to him or that he took sufficient steps to rectify them. It appears that the only action that he took was to contact the Department of Environment, Food and Agriculture (DEFA) regarding registration for Ionising Radiation. In view of this, the Committee was satisfied that his fitness to practise was impaired around the time of the DHSC inspection.

In assessing whether Mr Hanson's fitness to practise is impaired as of today, the Committee considered whether the identified failings are remediable, whether they have been remedied, and whether they are highly likely to be repeated.

It was the view of the Committee that the failings identified in this case are remediable. It considered that any qualified dentist could remedy the behaviour found proved by demonstrating knowledge, understanding and compliance with the relevant laws, regulations and standards.

However, the Committee considered that there is no evidence of Mr Hanson's insight before it, other than his partial admission in respect of not being registered with the DEFA and the action he took in that one regard. Further, there is no evidence of any remorse, or any remediation undertaken by Mr Hanson in the intervening period since September 2020. Nothing has been provided in relation to testimonial evidence, and there is no evidence of any CPD since the time of his referral to the GDC.

The Committee took into account that Mr Hanson has continued to engage with the GDC in respect of his case, and that he has engaged with the hearing to the extent that he has provided a witness statement dated 20 December 2022 with supporting documentation. However, throughout his witness statement Mr Hanson has continued to deny his failings. He has provided late rationales of his behaviour which lack credibility. Furthermore, there has been no way of testing a number of the documents that he has sought to rely on. The Committee considered that the manner of Mr Hanson's responses put forward at this hearing have demonstrated the absence of any understanding by him of

what a reasonable level of remediation might be in his case. It was the view of the Committee that it received little or no evidence that Mr Hanson has changed his behaviour or attitude since the DHSC's inspection.

In considering the issue of risk of repetition, the Committee also took into account the application made by Mr Hanson for voluntary removal from the Dentists Register in his letter of 14 September 2020. The Committee noted that in that letter he stated that he had decided not to return to practice after the national lockdown, and that he was retiring from dentistry. The Committee also noted the information before it, indicating that Mr Hanson has since vacated the Practice and he has converted the surgery at his other practice to residential use. In considering the relevance of these matters in the context of Mr Hanson's current fitness to practise, the Committee had regard to paragraph 19 of the '*Guidance for the Practice Committees including Indicative Sanctions Guidance (Effective from October 2016; last revised in December 2020)'* ('the Guidance'). Paragraph 19 states that:

"Where a registrant is intending to continue to practise, the likelihood of repetition is relevant to the issue of impairment. Where the likelihood of repetition is improbable only because the Registrant has retired, or has indicated that he or she will soon be retiring, that cannot be regarded as indicative that the Registrant is fit to practise. If anything, cessation of practice may point in the opposite direction, since a registrant's skills may deteriorate through lack of use; in addition, the fact that a registrant has not undertaken CPD may also be taken into account".

Having considered this paragraph, the Committee bore in mind that, as Mr Hanson's application for voluntary removal was refused by the GDC is December 2020, he currently remains on the GDC Register. The Committee has no knowledge as to whether Mr Hanson's intentions regarding his future practice as stated in September 2020 may have changed.

The Committee's task remains to decide whether in the light of its findings, Mr Hanson's fitness to practise is currently impaired. In the circumstances, the Committee considered that there is a high risk of repetition. It was its view, based on the evidence, that Mr Hanson has a propensity to act in a way to disregard legislation, regulations and standards. It therefore concluded that there would be a real risk to the safety of patients and members of staff if Mr Hanson were permitted to practise unrestricted. Accordingly, the Committee determined that a finding of impairment is necessary for the protection of the public.

The Committee also determined that a finding of impairment is required in the wider public interest. It considered the seriousness of its findings, the very limited evidence of insight and the absence of any evidence of remorse or remediation. In fact, Mr Hanson continues to deny almost all of his failings. The

Committee concluded that public confidence in the dental profession would be seriously undermined if a finding of impairment were not made in this case. It also considered that such a finding is necessary to promote and maintain proper professional standards.

Decision on sanction

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

In deciding on the appropriate sanction, the Committee first considered the mitigating and aggravating factors of this case. It identified the following in mitigation:

- Evidence of previous good character in that Mr Hanson has no fitness to practise history.
- Mr Hanson partial admission to his failings in radiography in that he admitted that was not registered with the DEFA as required. The Committee also took into account that he took action to contact the DEFA regarding registration.
- Mr Hanson has maintained contact with the GDC in the intervening years and has engaged with the regulatory process up until this hearing.

The aggravating factors that the Committee considered to be present in this case are as follows:

- The identified risk of harm to patients and staff.
- He demonstrated a blatant or wilful disregard of the role of the GDC and the systems regulating the profession.
- He has attempted to explain away his misconduct with a number of implausible explanations more than two years after the events.
- The evidence of his lack of insight and remorse.

Taking all the above factors into account, the Committee considered that the aggravating factors far outweighed those in mitigation. Bearing this in mind, it considered the available sanctions, starting with the least restrictive, as it is required to do.

The Committee first considered whether to conclude this case without taking any action in relation to Mr Hanson's registration. It decided, however, that such an outcome would be entirely inappropriate given the seriousness of its findings

and the identified risk of repetition. Taking no action would not serve to protect the public, nor would it satisfy the wider public interest.

The Committee also concluded that issuing Mr Hanson with a reprimand would not be appropriate or proportionate in all the circumstances. It noted that a reprimand might be appropriate if the circumstances do not pose a risk to patients or the public which requires rehabilitation or restriction of practice. The Committee has determined that Mr Hanson would continue to pose a real risk to the safety of patients and staff is he were permitted to practise unrestricted. Accordingly, a reprimand would not be sufficient to protect the public, nor would this sanction, in the Committee's view, uphold the wider public interest.

The Committee next considered whether to impose conditions on Mr Hanson's registration. It reminded itself that any conditions imposed would need to be workable, measurable, and enforceable. The Committee concluded, however, that conditional registration would not be appropriate in this case given the serious nature of the identified issues, all of which relate to Mr Hanson's failure to adhere to laws, standards, and regulations to which he was already subject. Additionally, there is an absence of any evidence to suggest that Mr Hanson has attempted to remedy his failings. The Committee took into account that his has continued to deny what were significant shortcomings in his dental practice. Also, that he made an application to the GDC for voluntary removal from the Dentists Register not long after the inspection of his practice. The Committee received nothing to suggest that Mr Hanson would comply with conditions even if they could be imposed. In all the circumstances, the Committee was not satisfied that conditional registration would be sufficient to protect the public and the wider public interest.

The Committee went on to consider whether to suspend Mr Hanson's registration for a specified period. In doing so, it had regard to the Guidance at paragraph 6.28, which outlines factors to be considered when deciding whether the sanction of suspension in more serious cases may be appropriate. The Committee noted that there are a number of factors present in this case which are relevant to suspension, including that:

- there is evidence of repetition of the behaviour;
- Mr Hanson has not shown sufficient insight and he poses a significant risk of repeating his behaviour;
- patients' interests would be insufficiently protected by a lesser sanction; and
- public confidence in the profession would be insufficiently protected by a lesser sanction.

However, the Committee considered that there is also evidence in this case of professional attitudinal problems which, as stated in paragraph 6.28, *"might*

make erasure the appropriate order". This is a case in which it has been shown that Mr Hanson did not take his professional obligations seriously, even when they were highlighted to him. He failed to appreciate his duty to actively find out about and follow relevant laws, regulations, standards, and policies affecting his practice as a dentist. Furthermore, he has continued to question his professional obligations for more than two years, providing arguments in support of his failings. The Committee therefore questioned whether the suspension of Mr Hanson's registration, even for the maximum period of 12 months, would be sufficient. Whilst it recognised that a period of suspension would safeguard the public from the risk of repetition, it remained concerned that it has a duty to uphold the wider public interest, which includes the maintenance of public confidence in the dental profession and maintenance of professional standards.

The Committee had regard to paragraph 6.34 of the Guidance which deals with erasure. It noted the relevant parts of this paragraph as follows: *"Erasure will be appropriate when the behaviour is fundamentally incompatible with being a dental professional: any of the following factors, or a combination of them, may point to such a conclusion:*

- *serious departure(s) from the relevant professional standards;*
- *Where a continuing risk of serious harm to patients or other persons is identified; and*
- *a persistent lack of insight into the seriousness of actions or their consequences."*

Given the presence of these factors from paragraph 6.34 and in view of its serious concern about Mr Hanson's professional attitude, the Committee concluded that the sanction of suspension would not be sufficient to promote and maintain public confidence in the dental profession and uphold proper professional standards. There has been no acknowledgement from Mr Hanson of his failings and he has continued to deny the relevance of the laws, regulations and guidance governing the dental profession including the GDC Standards.

In all the circumstances, the Committee determined that the only appropriate and proportionate sanction in this case is that of erasure.

In reaching its decision, the Committee had regard to the potential consequences for Mr Hanson of the removal of his name from the Dentists Register, in that he would no longer be able to work as a dentist. Whilst the Committee noted his stated intention to retire from the profession, it took account of the reputational effect that will be associated with its decision. However, the Committee was satisfied that the need to protect the public interest outweighed Mr Hanson's own interests.

Accordingly, unless Mr Hanson exercises his right of appeal, his name will be erased from the Dentists Register 28 days from the date when notice of this Committee's direction is deemed to have been served upon him.

The Committee now invites submissions from Ms Culleton as to whether an immediate order of suspension should be imposed on Mr Hanson's registration to cover the 28-day appeal period, pending its substantive determination for erasure taking effect.

Decision on immediate order.

The Committee has made a substantive determination in this case and the interim order currently in place on Mr Hanson's registration is hereby revoked.

In reaching its decision on whether to impose an immediate order of suspension on Mr Hanson's registration to cover the appeal period, the Committee took account of the submission made by Ms Culleton that such an order should be imposed. She applied for the imposition of an immediate order for the protection of the public and in the wider public interest. The Committee accepted the advice of the Legal Adviser.

The Committee determined that it is necessary for the protection of the public, and is otherwise in the public interest, to impose an immediate order of suspension on Mr Hanson's registration. In its substantive determination the Committee has identified a real risk to the safety of patients and staff on account of Mr Hanson's failings, his persistent lack of insight and the absence of any evidence of remorse or remediation. Having identified this risk, the Committee considered that it would be inappropriate and inconsistent to allow him the opportunity to remain in unrestricted practise over the 28-day appeal period, or possibly longer, in the event of an appeal. An immediate order is therefore necessary for the protection of the public.

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

The effect of the foregoing substantive determination and this order is that Mr Hanson's registration will be suspended to cover the appeal period. Unless he exercises his right of appeal, the substantive direction for erasure will take effect 28 days from the date of deemed service.

Should Mr Hanson exercise his right of appeal, this immediate order will remain in place until the resolution of the appeal.

That concludes this determination."

Schedule

Schedule 2

1. HTM01-05 Technical Memorandum and GDC standards 1.5.1, 1.9, 7.1.1, 7.1.2, 7.3.2.
2. The Ionising Radiation Regulations 2017 and The Ionising Radiation (Medical Exposure) Regulations 2019 ("IRMER")) and GDC Standards 1.5.1,1.9, 7.1.1, 7.1.2, 7.3.2.
3. HTM 01-05 Technical Memorandum and GDC Standards 1.5.1, 1.9, 7.1.1, 7.1.2.
4. SARS phase 4 Standard Operating Procedure ("SOP") and GDC Standard 1.9.
5. The Resuscitation Council (UK) Quality Standards: Primary Dental Care November 2013, and/or British National Formulary (BNF) and GDC Standards 1.5.3, 1.9, 6.6, 7.1.2, 7.3.2.