

PUBLIC HEARING**Professional Conduct Committee
Initial Hearing****28 September to 7 October 2026****Name:** BLAKE, Adrian**Registration number:** 158398**Case number:** CAS-209915

General Dental Council: Tom Stevens of Counsel
Instructed by Natasha Savovic of Kingsley Napley**Registrant:** Not present
Unrepresented

Fitness to practise: Impaired by reason of misconduct**Outcome:** Suspension (with a review)**Duration:** 12 months**Immediate order:** Immediate suspension order

Committee members: Marnie Hayward (DCP) (Chair)
Melissa Oura (Dentist)
Rachel Onikosi (Lay)**Legal adviser:** Graeme Dalglish**Committee Secretary:** Paul Carson

The Charge

That being a registered dentist,

You practised as a dentist at the dental practice referred to in Schedule 1 below (“the Practice”) and treated the patients listed below (and referred to in Schedule 1 below).

Patient 1

1. You failed to provide an adequate standard of care to Patient 1 from 29 April 2016 to 25 July 2017, in that:
 - a. during an appointment on 29 April 2016, you provided a poor standard of restoration at Patient 1’s LL7, in that:
 - i. it had a distal overhang;
 - ii. you completed the restoration without first sufficiently removing caries present in that tooth.
 - b. during an appointment on 25 July 2017 you:
 - i. prescribed antibiotics without adequate clinical justification;
 - ii. failed to offer Patient 1 the option of draining their infection through the pulp of their LL7;

- c. during an appointment on 27 February 2019 you did not report on and/or sufficiently investigate, radiolucency suggestive of caries found around Patient 1's filling at their LR6.
- 2. You failed to maintain an adequate standard of record keeping in respect of Patient 1's appointment from the 25 July 2017 to 27 February 2019, in that you did not record:
 - a. the justification for providing antibiotics, on 25 July 2017;
 - b. offering Patient 1 the option of local drainage for an infection at their LL7, on 25 July 2017;
 - c. any plan to manage their LR6, on 27 February 2017

Patient 2

- 3. You failed to provide an adequate standard of care to Patient 2 on 7 February 2018, in that:
 - a. you did not diagnose and/or treat caries found at Patient 2's:
 - i. LR7;
 - ii. LL5;
 - iii. UL6;
 - b. you did not sufficiently investigate the crown margin at Patient 2's LL6 and/or offer Patient 2 the option of replacing this crown.
- 4. You failed to maintain an adequate standard of record keeping in respect of Patient 2's appointment on 7 February 2018, in that you did not record:
 - a. the presence of caries, found at Patient 2's LR7 and/or LL5 and/or LL6 and/or UL6;
 - b. informing Patient 2 of the presence of caries

Patient 3

- 5. You failed to provide an adequate standard of care to Patient 3 from 1 August 2017 to 3 May 2018, in that:
 - a. during an appointment on 1 August 2017, you did not diagnose and/or treat caries found at Patient 3's:

- i. UL3;
 - ii. UL4;
 - iii. UL7;
 - iv. UR3;
 - v. LR6;
 - vi. LR5.
 - b. during an appointment on 3 January 2018, you did not diagnose and/or treat caries found at Patient 3's UL7;
 - c. during an appointment on 4 January 2018, you did not treat caries found at Patient 3's:
 - i. LR6;
 - ii. LR5;
 - d. during an appointment on 5 April 2018, you did not diagnose and/or offer to treat caries found at Patient 3's LR4;
 - e. during an appointment on 3 May 2018, you did not diagnose and/or offer to treat caries found at Patient 3's LR4;
6. You failed to maintain an adequate standard of record keeping in respect of Patient 3's appointment from 1 August 2017 to 3 May 2018, in that you did not record:
- a. the presence of caries, found at Patient 3's UL7 and/or UR3 and/or LR6 and/or LR5 on 1 August 2017;
 - b. the options for management of caries, found at Patient 3's UL7; and/or UL4 and/or UL3 and/or UR2 and/or UR3 and/or LR5 and/or LR6 on 1 August 2017;
 - c. the presence of caries, found at Patient 3's LR6 and/or LR5, and/or the option for the management of these teeth on 4 January 2018;
 - d. the presence of caries found at Patient 3's LR4 and/or the options for the management of this tooth on:
 - i. 5 April 2018;
 - ii. 3 May 2018.

Patient 4

7. You failed to provide an adequate standard of care to Patient 4 on 3 April 2017, in that you provided a poor standard of crown treatment at Patient 4's UL5, as its margins were deficient.
8. You failed to maintain an adequate standard of record keeping in respect of Patient 4's appointment from 7 December 2017 to 21 March 2019, in that you did not record informing Patient 4 of the risks of not replacing the crown found at their UL5.

Patient 5

9. You failed to provide an adequate standard of care to Patient 5 from 24 August 2016 until 3 October 2018, in that you did not diagnose and/or treat caries found at Patient 5's UR6 over this period.
10. You failed to maintain an adequate standard of record keeping in respect of Patient 5's appointments from 24 August 2016 until 3 October 2018, in that you did not record the presence of caries found at Patient 5's UR6.

Patient 6

11. You failed to maintain an adequate standard of record keeping in respect of Patient 6's appointments between 11 April 2018 and 11 March 2019, in that you did not record the presence of caries found at Patient 6's LL5.

Patient 7

12. You failed to provide an adequate standard of care to Patient 7 from 6 June 2016 to 22 March 2018, in that you did not diagnose and/or treat caries found at Patient 7's UR5 over this period.
13. You failed to maintain an adequate standard of record keeping in respect of Patient 7's appointments from 6 June 2016 to 22 March 2018, in that you did not record the presence of caries found at Patient 7's UR5.

Patient 8

14. You failed to provide an adequate standard of care to Patient 8 on 24 October 2017 in that you did not diagnose and/or treat caries found at Patient 8's UL6.
15. You failed to maintain an adequate standard of record keeping in respect of Patient 8's appointment on 24 October 2017, in that you did not record the presence of caries found at Patient 8's UL6.

Patient 9

16. You failed to provide an adequate standard of care to Patient 9 from 31 August 2016 to 18 February 2019, in that:
 - a. you did not diagnose and/or treat caries found at the distal margin of Patient 9's LL5 over this period;
 - b. you did not take any bitewing radiographs during an appointment on 31 August 2016 or 20 March 2017.
17. You failed to maintain an adequate standard of record keeping in respect of Patient 9's appointments from 31 August 2016 to 18 February 2019, in that you did not:
 - a. record the presence of caries found at Patient 9's LL5 over this period;
 - b. adequately report on bitewing radiographs taken on 7 December 2017.

Patient 10

18. You failed to provide an adequate standard of care to Patient 10 from 24 October 2016 to 13 December 2018, in that:
 - a. during an appointment on 24 October 2016, you provided a poor standard of restoration at Patient 10's LL6, in that it had a distal ledge;
 - b. you did not diagnose a distal ledge and/or caries found at Patient 10's LL6 on 13 December 2018;

- c. you did not replace / offer to replace, the restoration at Patient 10's LL6 on 13 December 2018.

19. You failed to maintain an adequate standard of record keeping in respect of Patient 10's appointment on 13 December 2018, in that you did not record the presence of a distal ledge and/or caries found at Patient 10's LL6.

Patient 11

20. You failed to provide an adequate standard of care to Patient 11 from 20 October 2016 to 18 April 2018, in that:

- a. you did not diagnose and/or treat caries found at Patient 11's LL7 on 20 October 2016;
- b. you did not diagnose and/or treat caries found at Patient 11's LR7 on 18 April 2018.

21. You failed to maintain an adequate standard of record keeping in respect of Patient 11's appointments from 20 October 2016 to 18 April 2018, in that you did not record:

- a. the presence of caries, found at Patient 11's LL7 on 20 October 2016 and/or 3 November 2016;
- b. the presence of caries, found at Patient 11's LR7 on 18 April 2018.

Patient 12

22. You failed to provide an adequate standard of care to Patient 12 on 25 January 2016, in that you did not diagnose and/or treat caries found at Patient 12's LL5.

23. You failed to maintain an adequate standard of record keeping in respect of Patient 12's appointment on 25 January 2016, in that you did not record the presence of caries found at Patient 12's LL5.

Patient 13

24. You failed to provide an adequate standard of care to Patient 13 from 6 December 2016 to 7 February 2018, in that:

- a. you did not diagnose and/or treat caries found at Patient 13's LR5 from 6 December 2016 until 7 February 2018;
- b. during an appointment on 7 February 2018, you inappropriately restored Patient 13's LR5 with glass ionomer cement.

25. You failed to maintain an adequate standard of record keeping in respect of Patient 13's appointments from 6 December 2016 to 7 February 2018, in that you did not record the presence of caries found at Patient 13's LR5.

Patient 14

26. You failed to maintain an adequate standard of record keeping in respect of Patient 14's appointments on 24 May 2018, in that you did not record discussing the risks of leaving Patient 14's UR7 untreated.

Patient 15

27. You failed to maintain an adequate standard of record keeping in respect of Patient 15's appointments from 14 June 2018 to 3 September 2018, in that you did not record:

- a. the reason Patient 15's UR6 required a filling on 14 June 2018;
- b. the presence of mesial radiolucency at Patient 15's UR6 on 3 September 2018.

AND that by reason of the matters alleged above your fitness to practise is impaired by reasons of deficient professional performance and/or misconduct

FINDINGS OF FACT– 5 October 2026

1. This is a hearing before the Professional Conduct Committee (the “Committee”) to consider allegations (subject to joinder and amendment) against Mr Blake, a dentist, in relation to his care and treatment of 15 patients between 2016 and 2019.
2. The General Dental Council (GDC) alleges clinical failings relating to the diagnosis and/or treatment of caries, restorative and crown treatment, antibiotic prescribing, radiography and record keeping. The GDC alleges that these failings amount to misconduct and/or deficient professional performance.

Service and absence

3. Mr Blake was neither present nor represented at the hearing, which was conducted remotely. Mr Stevens, on behalf of the GDC, submitted, that notice of this hearing had been served on Mr Blake in accordance with the requirements of the General Dental Council (Fitness to Practise) Rules 2006 (the “Rules”) and that the hearing should proceed in his absence.
4. The Committee accepted the advice of the Legal Adviser on the requirements of service and proceeding in absence.
5. There has been no response or engagement from Mr Blake regarding his attendance or otherwise. The notice of hearing was sent to him at his registered address in France on 28 August 2026 by both first-class post and special delivery (“International tracked and signed”). The GDC had attempted to trace Mr Blake’s current whereabouts and the enquiries it made through a tracing agent indicate that he continues to reside at the registered address held for him. Royal Mail tracking information records that the notice was delivered to that address on 4 September 2026.
6. The Committee was satisfied that the notice contained the information prescribed under Rule 13 of the Rules, including the time, date and (remote) venue of this hearing; and that it had been served on him in accordance with the requirements of Rule 65 by virtue of its being posted to his registered address.
7. The next consideration for the committee was whether to proceed with the hearing in Mr Blake's absence. This is a discretion which must be exercised with great care and caution, having regard to fairness to both Mr Blake and to the public interest in the fair and expeditious disposal of proceedings. The Committee had regard to Mr Blake's history of engagement. He had previously been legally represented but his former representatives had themselves reported to the GDC difficulty contacting him. They ultimately came off the record for him in December 2025. Thereafter, the GDC attempted to correspond directly with Mr Blake at his registered address but its attempts had elicited no response from him. There was evidence that the correspondence had been delivered but no response has been received.
8. The Committee was satisfied that the GDC had made all reasonable efforts to send notice of this hearing to Mr Blake.
9. There was no information before the Committee indicating that Mr Blake wishes to participate in the hearing or that an adjournment would make his attendance any more likely at a future date. Given his history of non-engagement, including with his own

legal representatives, and the repeated unsuccessful attempts the GDC has made to communicate with him, the Committee determined that an adjournment is unlikely to serve any useful purpose and would only result in further delay in these already prolonged proceedings. Having regard to Mr Blake's interests and to the need for the expeditious disposal of proceedings, the Committee determined that it would be fair and in the public interest to proceed notwithstanding his absence.

Joinder

10. Mr Stephens applied under Rule 25 of the Rules to join five further allegations to those which had already been referred by the Case Examiners. These further allegations were set out as charges 7, 14, 18, 20 and 22 of a consolidated Charge sheet provided by the GDC.
11. The Committee accepted the advice of the Legal Adviser on the question of joinder.
12. The existing allegations had been referred to the Committee but had not yet been heard. The Committee was satisfied that the additional allegations were of a similar kind or founded on the same alleged facts. They concern the same underlying clinical subject matter, including restorative treatment and alleged failures to diagnose and/or treat caries. They also arise from the same body of obtained clinical records, radiographs and expert opinion evidence.
13. The underlying evidence on which the GDC seeks to rely in support of the further allegations had been provided to Mr Blake's then legal representatives much earlier in the proceedings. The formal Rule 25 application notice was also sent to him directly on 28 August 2026 in accordance with the notice requirements under the Rules. Mr Blake had therefore been put on notice of the GDC's intention to apply for further allegations to be joined and he had been given an opportunity to respond.
14. During its consideration of the joinder application, the Committee identified, of its own motion, that the proposed allegation concerning Patient 4 referred to crown treatment on 20 March 2017. However, the clinical records record that the crown was fitted on 3 April 2017. In response, Mr Stevens amended the joinder application so that the correct date would be pleaded if the joinder were to be granted.
15. Whilst Mr Blake had not been notified of that corrected date, the Committee was satisfied that the substance of the allegation remained unchanged. That is to say, the only change is to the date on which the crown treatment was provided. The crown, the corresponding tooth and the treatment itself remain the same as does the underlying expert opinion on which the GDC seeks to rely. In those circumstances, the Committee was satisfied that correcting the date from that which had been notified to Mr Blake would cause no unfairness or prejudice to him.
16. Having regard to all the circumstances, the Committee determined that it would be fair and proportionate for the additional allegations to be joined to the existing Charge so that they are considered and decided together at this same hearing. The Committee therefore granted the joinder application and proceeded on the basis of the consolidated Charge sheet.

Amendment to the Charge

17. Mr Stevens then applied under Rule 18 of the Rules for a number of amendments to be made to the consolidated Charge to correct typographical or other drafting errors. The Committee also later identified two further errors during its consideration of the case and invited representations on them from Mr Stevens.
18. The Committee accepted the advice of the Legal Adviser on its power to amend the Charge.
19. The Committee was satisfied that the proposed amendments would merely correct typographical or drafting errors and that they would not alter the substance or seriousness of what is alleged. The Committee was satisfied that these amendments accurately reflected the evidence which had already been disclosed to Mr Blake and that no injustice would be caused to him in amending the Charge to correct what are no more than typographical or drafting errors. Accordingly, the Committee amended the Charge as follows:
 - Charge 2(b) was amended so that the letters “LL” would now also include the tooth number “7” so as to read “LL7”.
 - Charge 6(b) did not specify the date of the appointment to which the alleged failings relate. The charge was therefore amended by adding the words “on 1 August 2017” at the end.
 - Charge 6(c) incorrectly pleaded 3 January 2018 when it should have been 4 January 2018 and so the Committee corrected the date accordingly.
 - Charge 11 originally pleaded “between 11 and 11 March 2019”. The Committee corrected this obvious error by inserting “April 2018” so that the relevant period reads as “between 11 April 2018 and 11 March 2019”.
 - Charge 12 originally pleaded “16 June 2016 to 22 March 2018” when the relevant period commenced on 6 June 2016 and so the Committee amended the charge accordingly.
 - Charge 13 contained the same date error as charge 12 and was amended in the same way.
 - The stem of charge 1 originally alleged “failed to provide an adequate standard of care to Patient 1 from 29 April 2016 to 25 July 2017”. As charge 1(c) referred to an appointment on 27 February 2019, the Committee corrected the end date in the stem from 25 July 2017 to 27 February 2019, so that charge 1(c) was contained within the period particularised at its stem.
 - Charge 2(c) incorrectly referred to the appointment in question having taken place on 27 February 2017 rather than 2019. The Committee therefore corrected the charge by changing the year from 2017 to 2019.

The factual inquiry

20. No factual witnesses were called to give evidence to the Committee. The GDC instead relied upon the patients’ clinical records and radiographs which it had obtained and upon the expert opinion of Dr Abhijit Kumar Pal.

21. The Committee heard oral evidence from Dr Pal. In his oral evidence, he adopted the terms of his draft report dated 31 July 2025, subject to some minor corrections relating to dates.
22. The Committee questioned Dr Pal extensively. It tested the factual basis of his opinion by reference to the clinical records and radiographs. In response to the Committee's questioning, Dr Pal conceded, clarified or corrected a number of matters although his substantive criticisms remained the same.
23. The Committee considered Dr Pal to be an experienced and independent expert. It considered that he generally approached the evidence fairly and recognised the limitations of the clinical records and radiographs. The Committee considered his opinion alongside the clinical records and radiographs for each patient. Where the Committee was not satisfied that the contemporaneous evidence supported an inference made by Dr Pal, it did not find the allegation proved simply because he was an expert witness who had expressed a critical opinion which was unchallenged by any defence case.
24. The Committee had regard to the submissions made by Mr Stevens on behalf of the GDC.
25. The Committee accepted the advice of the Legal Adviser.
26. The burden is on the GDC to prove each allegation on the balance of probabilities.

Findings

Patient 1

1. You failed to provide an adequate standard of care to Patient 1 from 29 April 2016 to 27 February 2019, in that:

a. during an appointment on 29 April 2016, you provided a poor standard of restoration at Patient 1's LL7, in that:

i. it had a distal overhang.

Charge 1(a)(i): PROVED

27. The clinical records show that Mr Blake placed a restoration at the LL7 on 29 April 2016.
28. The Committee was satisfied from the radiograph taken on 25 July 2017 that the distal overhang to that restoration was present. There was no evidence to indicate that the overhang was the result of any subsequent alteration to the restoration. The Committee was satisfied that the distal overhang had formed part of the restoration itself. The Committee accepted Dr Pal's opinion that the restoration was therefore of a poor standard and Mr Blake had therefore failed to provide an adequate standard of care.
29. Accordingly, the Committee found charge 1(a)(i) proved.

ii. you completed the restoration without first sufficiently removing caries present in that tooth.

Charge 1(a)(ii): NOT PROVED

30. Dr Pal's criticism was based on caries being visible beneath the restoration on the radiograph taken on 25 July 2017. He concluded that this shows that the caries had not been sufficiently removed prior to that restoration being placed.
31. The Committee questioned Dr Pal in relation to whether the distal overhang could itself have contributed to the subsequent development of caries. Dr Pal conceded that this was clinically possible but maintained his original criticism having compared the position of the caries on an earlier radiograph. He explained that, in his view, the radiographic evidence shows that it was more likely than not that caries had been left behind when the restoration was placed.
32. The Committee had regard to the contemporaneous clinical records in which Mr Blake had recorded that caries had been removed when the restoration was placed. No post-operative radiograph had been taken and so there is no contemporaneous radiographic evidence demonstrating whether caries remained present immediately following the treatment.
33. The Committee therefore considered there to be two plausible explanations for the presence of the caries on the July 2017 radiograph. The first is that the existing caries had been insufficiently removed when the restoration was placed in April 2016. The second is that the caries had subsequently developed or progressed, potentially as a result of the distal overhang.
34. The Committee was not satisfied that the available clinical records demonstrate that one explanation was more likely than the other. On the face of the clinical records, the caries had been removed as that is what was recorded in the notes. There is no contemporaneous clinical evidence to contradict this record. In those circumstances, the Committee was not satisfied that the GDC had discharged the burden of proof.
35. Accordingly, the Committee found charge 1(a)(ii) not proved.

b. during an appointment on 25 July 2017 you:

i. prescribed antibiotics without adequate clinical justification.

Charge 1(b)(i): PROVED

36. The clinical records confirm that Mr Blake prescribed Amoxicillin in relation to Patient 1's LL7. He recorded "acute dental pain" as part of the patient's clinical presentation.
37. The Committee accepted Dr Pal's opinion that antibiotics would be clinically justified where there were signs of spreading infection or swelling. His opinion was that acute dental pain alone would not be sufficient to justify the prescribing of antibiotic treatment.
38. As the clinical records contain no direct or indirect reference to swelling, systemic involvement or spreading infection, the Committee determined that no such symptoms

were present and that the prescribing of antibiotic treatment was therefore not justified. The Committee did not consider this to be merely a record keeping failing, as Mr Blake had specifically recorded acute dental pain as a reason for the prescription. The Committee concluded that the recorded justification was more likely than not to have been the clinical justification. Had Mr Blake assessed the patient as presenting with the symptoms of swelling, systemic involvement or spreading infection, then it is more likely than not that he would have also recorded these as part of the clinical justification but did not do so. Mr Blake had therefore failed to provide an adequate standard of care.

39. Accordingly, the Committee found 1(b)(i) proved.

ii. failed to offer Patient 1 the option of draining their infection through the pulp of their LL7.

Charge 1(b)(ii): PROVED

40. The Committee accepted Dr Pal's opinion that local draining was an indicated treatment option which should have been offered in circumstances where Patient 1 was in acute pain and was not going to have the tooth extracted at that appointment.
41. In the clinical records, Mr Blake documented Patient 1's pain. He also documented the proposed extraction of the LL7 at a future appointment and the antibiotic prescription in the intervening period. There was no reference in the clinical notes to local drainage having been discussed or offered as a treatment option and no evidence that it was otherwise undertaken.
42. In the Committee's view, this was an important clinical option and so it is more likely than not that it would have been recorded had it been offered. Mr Blake had therefore failed to provide an adequate standard of care.
43. The Committee therefore found charge 1(b)(ii) proved.

c. during an appointment on 27 February 2019 you did not report on and/or sufficiently investigate radiolucency suggestive of caries found around Patient 1's filling at their LR6.

Charge 1(c): PROVED

44. Bitewing radiographs were taken on 27 February 2019. Having examined that radiograph for itself, the Committee accepted Dr Pal's opinion that a radiolucency around the LR6 restoration was suggestive of caries and that the radiolucency therefore required further clinical investigation.
45. The clinical records confirm that Patient 1 attended for an examination that day but there is no report of the LR6 radiolucency. There is also no record of any clinical investigation and no record of any management plan for the tooth.
46. There was therefore no evidence that the radiographic finding was reported or investigated. Mr Blake had therefore failed to provide an adequate standard of care.
47. Accordingly, the Committee found charge 1(c) proved.

2. You failed to maintain an adequate standard of record keeping in respect of Patient 1's appointments from 25 July 2017 to 27 February 2019, in that you did not record:

a. the justification for providing antibiotics, on 25 July 2017.

Charge 2(a): NOT PROVED

48. This record keeping charge was pleaded in the alternative to charge 1(b)(i). As the Committee found that charge proved, this record keeping charge falls away. The Committee found that Mr Blake had prescribed the antibiotics without justification and so there is not also a corresponding record keeping failure to have recorded the justification.
49. Charge 2(a) is therefore not proved and falls away.

b. offering Patient 1 the option of local drainage for an infection at their LL7, on 25 July 2017.

Charge 2(b): NOT PROVED

50. The Committee found the substantive charge proved and this alternative record keeping charge therefore falls away.
51. Charge 2(b) is therefore not proved and falls away.

c. any plan to manage their LR6, on 27 February 2019.

52. Charge 2(c): NOT PROVED

53. The Committee found the substantive charge proved and this alternative record keeping charge therefore falls away.
54. Accordingly, the Committee found Charge 2(c) not proved and so it falls away.

Patient 2

3. You failed to provide an adequate standard of care to Patient 2 on 7 February 2018, in that:

55. **a. you did not diagnose and/or treat caries found at Patient 2's:**
 - i. LR7;
 - ii. LL5;
 - iii. UL6.

Charges 3(a)(i)-(iii): PROVED

56. Bitewing radiographs were taken on 7 February 2018. Having examined the radiographs for itself, the Committee accepted Dr Pal's opinion that radiolucencies at

the LR7, LL5 and UL6 were present and that these were indicative of caries requiring diagnosis and treatment.

57. The clinical records referred mainly to periodontal bone loss but did not identify that caries was present at any of these three teeth. The Committee determined that it was more likely than not that there would be at least some clinical record made of the caries had Mr Blake diagnosed and/or treated these. Mr Blake had therefore failed to provide an adequate standard of care.
58. The Committee therefore found charges 3(a)(i), 3(a)(ii) and 3(a)(iii) proved.

b. you did not sufficiently investigate the crown margin at Patient 2's LL6 and/or offer Patient 2 the option of replacing this crown.

Charge 3(b): PROVED

59. The radiograph of 7 February 2018 demonstrated a radiolucency beneath the distal margin of the LL6 crown. Dr Pal's evidence was that this required further clinical investigation. His opinion was that replacement of the crown was a likely treatment option.
60. The clinical records contain no identification of the deficient crown margin. They also contain no record of any further investigation and no evidence that replacing the crown was discussed.
61. The Committee considered that, had these matters been investigated and discussed, some record of this would reasonably be expected to appear in the clinical record. Mr Blake had therefore failed to provide an adequate standard of care.
62. Accordingly, the Committee found Charge 3(b) proved.

4. You failed to maintain an adequate standard of record keeping in respect of Patient 2's appointment on 7 February 2018, in that you did not record:

a. the presence of caries found at Patient 2's LR7 and/or LL5 and/or LL6 and/or UL6;

b. informing Patient 2 of the presence of caries.

Charge 4(a)-(b): NOT PROVED

63. These allegations were pleaded in the alternative to the clinical allegations under charge 3.
64. As the Committee found the substantive clinical matters proved under charge 3, the issue is not one of a failure in record keeping and these alternative charges therefore fall away. Mr Blake could not have been under a clinical duty to record matters which he had not diagnosed or identified.
65. Charge 4 therefore falls away and so is not proved.

5. You failed to provide an adequate standard of care to Patient 3 from 1 August 2017 to 3 May 2018, in that:

a. during an appointment on 1 August 2017, you did not diagnose and/or treat caries found at Patient 3's:

- i. UL3;**
- ii. UL4;**
- iii. UL7;**
- iv. UR3;**
- v. LR6;**
- vi. LR5.**

Charges 5(a)(i)-(vi): PROVED

- 66. Dr Pal identified caries on the radiographs of 1 August 2017 at each of the six teeth particularised under this charge. The Committee accepted his clinical interpretation of the radiographs.
- 67. The clinical records contain reference to a radiolucency at UL3 and a need to “watch” the UL4. However, Dr Pal’s evidence, which the Committee accepted, was that the lesions visible on the radiograph would have required active management and that simply monitoring UL4 was inadequate.
- 68. In respect of the UL7, UR3, LR6 and LR5, the clinical records contain no diagnosis of the caries identified by Dr Pal and no corresponding treatment plan.
- 69. Accordingly, the Committee found this charge proved in respect of each of the particularised teeth in that Mr Blake had failed to diagnose and/or treat the caries which were present on the radiographs of those teeth. Mr Blake had therefore failed to provide an adequate standard of care.
- 70. Charges 5(a)(i)-(vi) are therefore proved.

b. during an appointment on 3 January 2018, you did not diagnose and/or treat caries found at Patient 3's UL7.

Charge 5(b): NOT PROVED

- 71. Dr Pal’s opinion was that caries at UL7 was visible on the radiograph of 3 January 2018 and that it had not been diagnosed or treated. The Committee did not agree with Dr Pal’s interpretation of this radiograph. Unlike some of the clearer radiographic lesions referred to elsewhere in his report, the Committee was not satisfied from its own examination of the radiograph of 3 January 2018 that caries was visible at UL7. The radiographic image was not sufficiently clear for the Committee to find that it is more likely than not that the radiograph showed the presence of caries.
- 72. Accordingly, the Committee found charge 5(b) not proved.
- 73. **c. during an appointment on 4 January 2018, you did not treat caries found at Patient 3's:**

- i. LR6;
- ii. LR5.

Charges 5(c)(i)-(ii): NOT PROVED

- 74. The Committee has already found more generally that caries at LR6 and LR5 had not been adequately diagnosed or treated. The allegation under this charge 5(c) is more specific, as it is confined to failing to treat those teeth at the appointment on 4 January 2018.
- 75. The clinical records show that Patient 3 attended on 4 January for extraction of the LL6. Given the clinical priority and importance of extracting that tooth, the Committee was not satisfied that a failure to have also treated LR6 and LR5 at that same appointment itself amounted to a failure to provide an adequate standard of care.
- 76. The Committee therefore found charges 5(c)(i) and 5(c)(ii) not proved.

d. during an appointment on 5 April 2018, you did not diagnose and/or offer to treat caries found at Patient 3's LR4.**Charge 5(d): PROVED**

- 77. A periapical radiograph was taken on 5 April 2018. Dr Pal's opinion was that the radiograph shows a radiolucency at LR4 which he considered to be caries.
- 78. The clinical records state in respect of LR4 that nothing abnormal was detected ("NAD"). Accordingly, the clinical records contain no diagnosis of the lesion and no evidence that any corresponding treatment was offered.
- 79. The Committee was satisfied that the radiographic evidence on this occasion was sufficiently clear. It accepted Dr Pal's opinion that the radiograph shows a radiolucency at LR4 which he considered to be undiagnosed caries which required treatment. There is no record in the clinical records showing that Mr Blake diagnosed the caries far less that he offered to treat it. He instead recorded "NAD". Mr Blake had therefore failed to provide an adequate standard of care.
- 80. The Committee therefore found Charge 5(d) proved.

e. during an appointment on 3 May 2018, you did not diagnose and/or offer to treat caries found at Patient 3's LR4.**Charge 5(e): NOT PROVED**

- 81. The clinical records for 3 May 2018 stated "caries charted" and "treat caries". Any associated dental chart was not available to the Committee.
- 82. Whilst the available clinical records did not specifically refer to LR4, they are contemporaneous evidence that caries had been identified and that the treatment of those caries formed part of the patient's planned treatment.

83. In the absence of the dental chart, which also was not available to Dr Pal, the Committee could not reasonably identify one way or the other whether the LR4 was among the teeth which had been charted as being carious.
84. The Committee was therefore not satisfied that the GDC had discharged the burden of proof of showing that it is more likely than not that Mr Blake had failed to diagnose or offer to treat the LR4 on 3 May 2018. The available clinical records suggest that he may have done so.
85. The Committee therefore found charge 5(e) not proved.

6. You failed to maintain an adequate standard of record keeping in respect of Patient 3's appointments from 1 August 2017 to 3 May 2018, in that you did not record:

a. the presence of caries found at Patient 3's UL7 and/or UR3 and/or LR6 and/or LR5 on 1 August 2017;

b. the options for management of caries found at Patient 3's UL7 and/or UL4 and/or UL3 and/or UR2 and/or UR3 and/or LR5 and/or LR6 on 1 August 2017;

c. the presence of caries found at Patient 3's LR6 and/or LR5, and/or the option for the management of these teeth on 4 January 2018;

d. the presence of caries found at Patient 3's LR4 and/or the options for the management of this tooth on:

i. 5 April 2018;

ii. 3 May 2018.

Charge 6(a)-(d): NOT PROVED

86. These record keeping allegations were pleaded in the alternative to the corresponding clinical allegations.
87. As the Committee either found the substantive clinical matters proved or that the presence of caries had not been proved, the remaining issue is not one of a failure in record keeping. These alternative charges therefore fall away.
88. Accordingly, charge 6 is not proved and therefore falls away.

Patient 4

7. You failed to provide an adequate standard of care to Patient 4 on 3 April 2017, in that you provided a poor standard of crown treatment at Patient 4's UL5, as its margins were deficient.

Charge 7: NOT PROVED

89. The clinical records show that the crown was due to be fitted on 20 March 2017. However, at that appointment, Mr Blake recorded that he considered the occlusion to be too high and so returned the crown to the laboratory so that it could be adjusted.
90. The crown was subsequently fitted on 3 April 2017.
91. The clinical records for that appointment record that the occlusion had been checked and that the crown was cemented. They go on to record that the margins were cleaned and checked. They also record that the patient was “happy”.
92. A subsequent radiograph taken on 7 December 2017 shows that the distal crown margins were deficient. Dr Pal’s opinion was that the deficient distal margins visible on this radiograph would have been present from the outset.
93. The Committee gave careful consideration to Dr Pal’s opinion but could not rely upon it to find this charge proved. The radiograph had been taken some eight months after the crown was fitted with no other relevant radiographic evidence available to the Committee in the intervening period. The Committee could not be satisfied from this radiograph alone that it reflected the position of the distal margins at the time the crown was fitted. The contemporaneous clinical evidence records that the crown had already been returned to the laboratory once because Mr Blake was dissatisfied with its fit. When the adjusted crown was fitted at the later appointment on 3 April 2017, Mr Blake recorded in the clinical records that the margins had been checked.
94. There was therefore a conflict between the contemporaneous clinical records and the apparent care with which the crown had been adjusted and placed, and what could properly be inferred from a radiograph alone taken some eight months later.
95. The Committee was not satisfied that the GDC had discharged its burden of proof and found charge 7 not proved.

8. You failed to maintain an adequate standard of record keeping in respect of Patient 4’s appointments from 7 December 2017 to 21 March 2019, in that you did not record informing Patient 4 of the risks of not replacing the crown found at their UL5.

Charge 8: PROVED

96. The clinical records confirm that Mr Blake had identified the deficient crown margin on 7 December 2017 and discussed with Patient 4 the options of replacing the crown or of monitoring the tooth. The clinical records record that Patient 4 opted to monitor the tooth.
97. These treatment options were also recorded again in the clinical records on a subsequent occasion. The Committee noted that there is therefore evidence that ongoing clinical review and discussion had taken place in respect of the treatment options for the crown.
98. However, this charge 8 pleads the adequacy of the clinical records. In this regard, the clinical records contain no entry identifying the risks associated with retaining a crown with deficient margins. Dr Pal gave evidence to the Committee that such risks would

include the development of caries beneath the crown and therefore a poor prognosis of the tooth.

99. While such discussions may have taken place, they were not recorded in the clinical records. The Committee accepted Dr Pal's opinion that these were important matters which should have been documented. The Committee was therefore satisfied that Mr Blake had failed to maintain an adequate standard of record keeping.
100. Accordingly, charge 8 is proved.

Patient 5

9. You failed to provide an adequate standard of care to Patient 5 from 24 August 2016 until 3 October 2018, in that you did not diagnose and/or treat caries found at Patient 5's UR6 over this period.

Charge 9: PROVED

101. A bitewing radiograph taken on 24 August 2016 shows a mesial radiolucency at UR6 beneath a crown which had previously been placed at that tooth. In Dr Pal's opinion, this radiolucency showed the presence of caries.
102. The clinical records contain no record of any diagnosis or treatment of caries at UR6 on 24 August 2016 or at the subsequent appointments Patient 5 attended for examinations in March 2017, October 2017 and March 2018.
103. On 3 October 2018, the clinical records then refer to "gross mesial caries" at UR6 and the tooth was subsequently extracted.
104. The Committee accepted Dr Pal's opinion that the radiographic evidence showed that lesion was present at UR6 from 24 August 2016 and that it had remained undiagnosed and untreated until 3 October 2018. Mr Blake had therefore failed to provide an adequate standard of care.
105. Accordingly, the Committee found charge 9 proved.

10. You failed to maintain an adequate standard of record keeping in respect of Patient 5's appointments from 24 August 2016 until 3 October 2018, in that you did not record the presence of caries found at Patient 5's UR6.

Charge 10: NOT PROVED

106. This allegation was advanced as the record keeping alternative to charge 9.
107. Having found that Mr Blake had not diagnosed the UR6 caries during the relevant period, it follows that he could not have failed in a corresponding record keeping duty. There would be no clinical duty on him to record a diagnosis which he had not reached. The criticism found proved against him in relation to this tooth is the failure to diagnose and not merely a failure to record.
108. Accordingly, the Committee found charge 10 not proved and it therefore falls away.

Patient 6

11. You failed to maintain an adequate standard of record keeping in respect of Patient 6's appointments between 11 April 2018 and 11 March 2019, in that you did not record the presence of caries found at Patient 6's LL5.

Charge 11: NOT PROVED

109. In his report, Dr Pal's stated that the radiograph taken on 11 April 2018 showed caries at LL5 and that this was also apparent on an accompanying clinical photograph. However, during his oral evidence, the Committee questioned Dr Pal in detail on the two images. Upon reconsidering the clinical photograph, he accepted that it was unlikely to depict the same tooth as the radiograph. This was because the type of crown which was visible in photograph was inconsistent with what appeared on the radiograph.
110. Accordingly, the Committee could not rely on the clinical photograph as supporting evidence. In terms of the radiograph itself, the image was unclear and there was some confusion in Dr Pal's evidence between an older radiograph and that which relates to the relevant charged period.
111. In those circumstances, the Committee was not satisfied that the GDC had provided evidence from which it could properly be concluded that it is more likely than not that caries was present at LL5 during the period pleaded in this charge.
112. The Committee therefore found charge 11 not proved.

Patient 7

12. You failed to provide an adequate standard of care to Patient 7 from 6 June 2016 to 22 March 2018, in that you did not diagnose and/or treat caries found at Patient 7's UR5 over this period.

Charge 12: NOT PROVED

113. Dr Pal's opinion was that a bitewing radiograph taken on 6 June 2016 showed caries beneath a restoration at UR5. The clinical records identified the radiolucency to which Dr Pal referred but attributed this to the composite restoration rather than to the presence of caries. In those clinical records, Mr Blake also recorded that there was no outward clinical evidence of caries.
114. The clinical records later record that treatment was provided to UR5 on 8 March 2018. That treatment included the excavation of caries and the placement of a glass ionomer filling. The period pleaded within this charge is 6 June 2016 to 22 March 2018.
115. Accordingly, there is evidence that Mr Blake had diagnosed and treated the caries within the charged period. Read literally, the charge is therefore not proved. However, the Committee recognised that, in context, the evidence suggests that Mr Blake had failed to diagnose and treat that caries from at least 6 June 2016 until March 2018. This would reflect a substantial delay in diagnosis and/or treatment. The Committee therefore considered whether to exercise its power to amend the charge of its own

motion, so as to shorten the charged period by ending it not later than 7 March 2018. This would allow the charge to then be proved on the clinical evidence.

116. However, the Committee did not consider it appropriate to exercise its power to amend the charge in this way, given the multiple amendments which the Committee had already agreed on the GDC's application. The need for those amendments appears to have resulted from a failure on the part of the GDC to have taken sufficient care to accurately formulate and proofread the charges it had drafted and which it brings against this unrepresented and absent registrant. Whilst the latest error appears to be purely typographical or clerical, the Committee had already retired in camera on the facts. Whilst the power to amend remained open to it even at this stage, the Committee was not satisfied that it would be fair and in the interests of justice to amend a charge during its deliberative process so as to then find it proved. Only where the circumstances plainly justify it, such as where the failure to amend would result in a significant under prosecution of the case, or would otherwise risk public safety, would the Committee allow a charge to be reformulated for the purposes of proving it.
117. Accordingly, the Committee found charge 12 not proved as Mr Blake had diagnosed and treated the caries on 8 March 2018 which was before the charged period ended on 22 March 2018.

13. You failed to maintain an adequate standard of record keeping in respect of Patient 7's appointments from 6 June 2016 to 22 March 2018, in that you did not record the presence of caries found at Patient 7's UR5.

Charge 13: NOT PROVED

118. This was a record keeping allegation pleaded in the alternative to charge 12 above.
119. Whilst the Committee did not find charge 12 proved, this was because of the wording of the charge. When the caries were diagnosed and treated by Mr Blake on 8 March 2018 he made an adequate record of this.
120. Accordingly, charge 13 is not proved and falls away.

Patient 8

14. You failed to provide an adequate standard of care to Patient 8 on 24 October 2017 in that you did not diagnose and/or treat caries found at Patient 8's UL6.

Charge 14: PROVED

121. Bitewing radiographs were taken on 24 October 2017. In Dr Pal's opinion, a distal radiolucency visible at UL6 represented caries.
122. The clinical notes for 24 October 2017 contain "chart only" entries. These referred to an amalgam restoration, the preparation of a cavity and the excavation of caries. In his oral evidence, Dr Pal initially regarded these entries as relating to treatment on the occlusal and palatal surfaces. He maintained that the distal lesion remained untreated.
123. The Committee treated this aspect of Dr Pal's evidence with caution. His opinion appeared to be predicated on an assumption that the way in which the clinical record

keeping software presented the information meant that it was referring to treatment actually performed that day. The Committee had a different interpretation of the way in which the clinical information was presented by the software. The Committee also had regard to the subsequent clinical records, which contained much more information about when the UL6 was clinically assessed and later restored. The Committee did not accept Dr Pal's interpretation of these clinical records.

124. However, the Committee accepted Dr Pal's opinion in relation to the distal radiolucency which was visible on the 24 October radiograph. The Committee accepted that this appeared to show the presence of caries. The clinical records contain no specific diagnosis of that distal lesion and there is no evidence to suggest that it was treated on that date.
125. Having regard to the entirety of the relevant clinical records and the radiograph, the Committee was satisfied that it is more likely than not that the distal caries had not been diagnosed or treated. Mr Blake had therefore failed to provide an adequate standard of care.
126. Accordingly, the Committee found Charge 14 proved.

15. You failed to maintain an adequate standard of record keeping in respect of Patient 8's appointment on 24 October 2017, in that you did not record the presence of caries found at Patient 8's UL6.

Charge 15: NOT PROVED

127. This record keeping allegation was pleaded in the alternative to charge 14 above and falls away in light of that charge being found proved.
128. The Committee therefore found charge 15 not proved and it falls away.

Patient 9

16. You failed to provide an adequate standard of care to Patient 9 from 31 August 2016 to 18 February 2019, in that:

a. you did not diagnose and/or treat caries found at the distal margin of Patient 9's LL5 over this period.

Charge 16(a): PROVED

129. A radiograph taken by another practitioner in March 2014 shows the presence of distal caries at LL5. When Mr Blake examined Patient 9 on 31 August 2016, he recorded a defective composite margin at that tooth. On 20 September 2016 he restored the mesial-buccal aspect of LL5 and recorded that caries had been removed. The Committee concluded that this related to a different surface from the distal lesion alleged in this charge.
130. Bitewing radiographs taken on 7 December 2017 continued to show that the distal lesion remained present. However, Mr Blake recorded "NAD" in the corresponding radiographic report. The clinical records contained no evidence that the distal caries was subsequently diagnosed or treated during the period referred to in this charge.

131. Even if Mr Blake had not reviewed the 2014 radiographs when first treating the tooth, the lesion was still apparent on the later 2017 radiograph taken whilst the patient was under Mr Blake's own care. The Committee was satisfied that Mr Blake was under a duty to have diagnosed and treated the caries during the period referred to in the charge and that he had failed to do so. Mr Blake had therefore failed to provide an adequate standard of care.

132. The Committee therefore found charge 16(a) proved.

b. you did not take any bitewing radiographs during an appointment on 31 August 2016 or 20 March 2017.

Charge 16(b): PROVED

133. No bitewing radiographs were taken at either of those appointments.

134. The Committee accepted Dr Pal's opinion that the frequency of bitewings should be determined by caries risk. The Committee noted that Patient 9 had a heavily restored dentition and a history of dental disease and that the previous bitewings were already more than two years old by August 2016.

135. Dr Pal's opinion, which the Committee accepted, was that, even with a degree of latitude, new bitewing radiographs should have been taken by at least one of the appointments in August 2016 or March 2017. Mr Blake had therefore failed to provide an adequate standard of care.

136. Accordingly, the Committee found charge 16(b) proved.

17. You failed to maintain an adequate standard of record keeping in respect of Patient 9's appointments from 31 August 2016 to 18 February 2019, in that you did not:

a. record the presence of caries found at Patient 9's LL5 over this period.

Charge 17(a): NOT PROVED

137. This record keeping charge was pleaded in the alternative to charge 16(a) above. Having found that substantive charge proved, the record keeping failing allegation falls away.

138. Accordingly, the Committee found charge 17(a) not proved and so it falls away.

b. adequately report on bitewing radiographs taken on 7 December 2017.

Charge 17(b): PROVED

139. Bitewing radiographs taken on 7 December 2017 show the distal abnormality at LL5. However, Mr Blake merely recorded in the clinical records "NAD" when reporting on the radiographs.

140. In his written report, Dr Pal referred both to February 2017 and December 2017 when discussing these radiographs. However, it is clear from the clinical records and the radiographs themselves that the relevant bitewings were in fact taken in December 2017 and so the Committee proceeded on that basis.
141. The Committee was satisfied that the presence of the distal abnormality in the radiographs meant that a report of “NAD” was an inadequate standard of record keeping.
142. Accordingly, the Committee found charge 17(b) proved.

Patient 10

18. You failed to provide an adequate standard of care to Patient 10 from 24 October 2016 to 13 December 2018, in that:

a. during an appointment on 24 October 2016, you provided a poor standard of restoration at Patient 10’s LL6, in that it had a distal ledge.

Charge 18(a): PROVED

143. The clinical records show that Mr Blake placed an amalgam restoration at LL6 on 24 October 2016. A distal ledge to that restoration is visible in a bitewing radiograph taken on 13 December 2018. Whilst the version of that radiographic image in the hearing bundle was inverted and its date had been obscured by the patient identifier, Dr Pal checked the original material available to him when preparing his report and confirmed in evidence that it was dated 13 December 2018.
144. The Committee was satisfied that the distal ledge identified by Dr Pal was visible on the radiograph and that it is more likely than not that this was present from the outset. The Committee was therefore satisfied that Mr Blake had provided a poor standard of restoration at the LL6 on 24 October 2016. Mr Blake had therefore failed to provide an adequate standard of care.
145. Accordingly, the Committee found charge 18(a) proved.

b. you did not diagnose a distal ledge and/or caries found at Patient 10’s LL6 on 13 December 2018.

Charge 18(b): PROVED in relation to the distal ledge; NOT PROVED in relation to caries

146. The clinical records make reference to a distal radiolucency and record that the tooth had been checked clinically with “NAD” found. The clinical records did not go so far as to identify the distal ledge visible on the radiograph.
147. The Committee was therefore satisfied from the contemporaneous clinical records made by Mr Blake that he had failed to diagnose the distal ledge and therefore found this charge proved to that extent.
148. In respect of caries, Dr Pal stated in his report that the gap visible between the restoration and the tooth could be either a deficiency in the filling or caries. In his oral

evidence, he referred to the “possibility” of caries. He later stated more definitively that his conclusion was that caries had not been diagnosed.

149. The Committee also noted that Mr Blake had recorded that the radiolucency had been checked clinically and that nothing abnormal was detected.
150. The Committee was not satisfied that this part of the charge referring to caries was proved, as the GDC had not produced sufficiently clear evidence that it was more likely than not that the radiolucency showed caries.
151. The Committee therefore found charge 18(b) proved only so far as it alleged that Mr Blake failed to diagnose the distal ledge.

c. you did not replace / offer to replace, the restoration at Patient 10’s LL6 on 13 December 2018.

Charge 18(c): PROVED

152. There was no evidence in the clinical records that Mr Blake had replaced, or offered to replace, the restoration at LL6.
153. Accordingly, the Committee found charge 18(c) proved.

19. You failed to maintain an adequate standard of record keeping in respect of Patient 10’s appointment on 13 December 2018, in that you did not record the presence of a distal ledge and/or caries found at Patient 10’s LL6.

Charge 19: NOT PROVED

154. This alternative record keeping allegation fell away in light of the Committee’s finding that Mr Blake had not diagnosed the distal ledge and the Committee’s inconclusive finding as to whether caries was present.
155. Accordingly, the Committee found charge 19 not proved.

Patient 11

20. You failed to provide an adequate standard of care to Patient 11 from 20 October 2016 to 18 April 2018, in that:

a. you did not diagnose and/or treat caries found at Patient 11’s LL7 on 20 October 2016.

Charge 20(a): NOT PROVED

156. In Dr Pal’s opinion a periapical radiograph taken on 20 October 2016 demonstrated mesial caries at LL7.
157. The Committee examined the radiograph image carefully. This image was less clear than many of the other radiographic images referred to in Dr Pal’s report. The Committee also noted that the available radiographic image in respect of this tooth

does not appear to show the degree of progression which might clinically be expected to have occurred had there been caries present which remained untreated.

158. Accordingly, the Committee was not satisfied that the GDC had proved on the balance of probabilities that caries was present at LL7 on 20 October 2016.
159. The Committee therefore found charge 20(a) not proved.

b. you did not diagnose and/or treat caries found at Patient 11's LR7 on 18 April 2018.

Charge 20(b): NOT PROVED

160. A distal radiolucency at LR7 is visible on a radiograph taken on 18 April 2018. Mr Blake did identify and record that radiolucency in the clinical records. He had also examined the tooth clinically and recorded no apical pathology.
161. The subsequent clinical records make reference to a distal overhang at LR7 which was removed. In Dr Pal's opinion the radiolucency showed the presence of caries. However, the Committee was not satisfied from the clinical records that this was more likely than not to be the case. The combination of the clinical assessment and the subsequent identification of an overhang meant that another plausible explanation for the radiolucency was the restoration itself rather than the presence of caries.
162. Accordingly, the Committee found charge 20(b) not proved, as more than one explanation for the radiolucency can be inferred from the clinical records and therefore the charge is not proved on the balance of probabilities.

21. You failed to maintain an adequate standard of record keeping in respect of Patient 11's appointments from 20 October 2016 to 18 April 2018, in that you did not record:

a. the presence of caries found at Patient 11's LL7 on 20 October 2016 and/or 3 November 2016;

b. the presence of caries found at Patient 11's LR7 on 18 April 2018.

Charges 21(a)-(b): NOT PROVED

163. These record keeping allegations fell away as the presence of the alleged caries has not been established for the reasons given at charge 20 above.
164. Accordingly, the Committee found charges 21(a) and 21(b) not proved.

Patient 12

22. You failed to provide an adequate standard of care to Patient 12 on 25 January 2016, in that you did not diagnose and/or treat caries found at Patient 12's LL5.

Charge 22: PROVED

165. Bitewing radiographs taken on 25 January 2016 showed a radiolucency beneath the LL5 restoration which Dr Pal considered to be caries. The clinical records contain no record of any diagnosis or treatment of caries at the LL5 in relation to this appointment.
166. A later radiograph in October 2018 shows progression of the lesion. The clinical records show that it was at this appointment that Mr Blake identified the caries with a restoration subsequently placed at the LL5.
167. The Committee accepted Dr Pal's opinion that the radiolucency on the radiograph taken on 25 January 2016 showed caries. This was consistent with the later radiographic images showing progression of that lesion and the corresponding clinical records recording a diagnosis of caries. Mr Blake had therefore failed to provide an adequate standard of care.
168. Accordingly, the Committee found charge 22 proved.

23. You failed to maintain an adequate standard of record keeping in respect of Patient 12's appointment on 25 January 2016, in that you did not record the presence of caries found at Patient 12's LL5.

Charge 23: NOT PROVED

169. This was the record keeping alternative to charge 22 and falls away in light of the Committee having found the substantive allegation proved that Mr Blake had not at this stage diagnosed caries at LL5.
170. Accordingly, the Committee found charge 23 not proved and it falls away.

Patient 13

24. You failed to provide an adequate standard of care to Patient 13 from 6 December 2016 to 7 February 2018, in that:

a. you did not diagnose and/or treat caries found at Patient 13's LR5 from 6 December 2016 until 7 February 2018.

Charge 24(a): PROVED in relation to failure to treat

171. A bitewing radiograph taken on 6 December 2016 showed a mesial radiolucency at LR5. Mr Blake recorded the presence of that radiolucency in clinical records for the appointment but there is no record of any subsequent treatment being provided.
172. The clinical records for an appointment on 21 March 2017 then expressly refer to "decay" at LR5. The Committee accepted Dr Pal's evidence that the terms "decay" and "caries" can be used interchangeably in this clinical record keeping context.
173. The Committee therefore did not find proved that Mr Blake had failed to diagnose the caries during the period referred to in this charge. By March 2017, he had diagnosed it as is expressly recorded in the clinical records.
174. However, the clinical records continued to contain no record of any treatment of the lesion during the charged period ending 7 February 2018.

175. The Committee was satisfied that the second limb of this charge, the pleaded failure to treat the diagnosed caries, was therefore established. Mr Blake had therefore failed to provide an adequate standard of care.
176. Accordingly, charge 24(a) is proved to the extent that it pleads that Mr Blake failed to treat the caries at LR5.

b. during an appointment on 7 February 2018, you inappropriately restored Patient 13's LR5 with glass ionomer cement.

Charge 24(b): NOT PROVED

177. The Committee accepted the substance of Dr Pal's opinion that leaving deep caries behind could be an appropriate treatment strategy. He stated that the tooth would then require a restoration capable of providing a reliable seal and of withstanding the occlusal load. He stated that he considered glass ionomer unsuitable for that purpose.
178. The issue for the Committee was that the clinical records state that the glass ionomer restoration was placed on 21 February 2018 and not on 7 February 2018, as alleged under this charge.
179. Again, the Committee found itself in a position where it needed to consider whether to exercise its power to amend the charge of its own motion having already retired on the facts. The incorrect date here appears to be yet another typographical or clerical error on the part of the GDC when formulating the Charge. The Committee reminded itself that Mr Blake is absent and that it is for the GDC to formulate and prove its case. It is not the role of the Committee to reword the charges as it deliberates on them so as to reconcile them with the evidence on which the GDC relies.
180. Having regard to all the circumstances, for the same reasons given earlier, the Committee did not consider it appropriate to amend the charge again at this stage so as to find the allegation proved. The Committee did not consider that there was a risk to public safety or of under prosecution.
181. As the alleged treatment did not occur on the pleaded date of 7 February 2018, the Committee found charge 24(b) not proved.

25. You failed to maintain an adequate standard of record keeping in respect of Patient 13's appointments from 6 December 2016 to 7 February 2018, in that you did not record the presence of caries found at Patient 13's LR5.

Charge 25: NOT PROVED

182. The Committee has found proved at charge 24(a) above that the caries at LR5 was in fact diagnosed (and recorded) by March 2017 but was not treated. In those circumstances, there was no corresponding alternative record keeping failing and this charge therefore falls away.

Patient 14

26. You failed to maintain an adequate standard of record keeping in respect of Patient 14's appointment on 24 May 2018, in that you did not record discussing the risks of leaving Patient 14's UR7 untreated.

Charge 26: PROVED

183. On 24 May 2018 Mr Blake identified a mesial ledge associated with the UR7 restoration. The clinical record showed that he discussed the condition of the tooth with Patient 14 and advised that it should be monitored.
184. Dr Pal's opinion was that leaving the tooth in that condition carried the risk of further periodontal problems at UR6 and UR7 and the development of caries at UR6.
185. The Committee accepted that some discussion clearly had occurred, as is recorded in the records. However, the risks of leaving the tooth untreated were not recorded, albeit they were probably discussed to some extent.
186. The Committee accepted the opinion of Dr Pal that the risks should have been recorded as part of an adequate standard of record keeping.
187. Accordingly, the Committee found charge 26 proved.

Patient 15

27. You failed to maintain an adequate standard of record keeping in respect of Patient 15's appointments from 14 June 2018 to 3 September 2018, in that you did not record:

a. the reason Patient 15's UR6 required a filling on 14 June 2018.

Charge 27(a): PROVED

188. The clinical records show that a composite restoration was placed at UR6 on 14 June 2018. Discussion about acid damage and tooth wear is recorded. The clinical records also state that an existing amalgam restoration and caries were removed prior to the placement of the composite restoration.
189. The Committee considered that these entries were insufficient to identify why the filling was required. Whilst they enabled possible reasons for the treatment to be inferred, they did not clearly record the clinical diagnosis which led to the decision to restore UR6.
190. The Committee accepted Dr Pal's opinion that the reason restorative treatment should be recorded is so that a future practitioner can understand whether treatment was required because of caries, a fracture, tooth wear or some other pathology.
191. The Committee considered that a subsequent treating practitioner should not be in a position where they need to infer the reason for treatment from procedural entries and surrounding discussion. The reason for treatment should be clearly recorded. Mr Blake had therefore failed to maintain an adequate standard of record keeping.
192. The Committee therefore found charge 27(a) proved.

b. the presence of mesial radiolucency at Patient 15's UR6 on 3 September 2018.**Charge 27(b): PROVED**

193. In his written report, Dr Pal initially based his opinion on the understanding that a radiograph showing a mesial radiolucency at UR6 had been taken on 3 September 2018.
194. During his oral evidence, he accepted that closer examination of the image showed that it in fact appeared to be dated 26 July 2018. He also clarified that the radiolucency could represent caries or buccal or palatal tooth surface loss. He stated that clinical examination would be required to distinguish between those possibilities.
195. The Committee examined the chronology of the clinical records. The clinical records for 3 September 2018 record that the patient attended an appointment on this day. The earlier radiographic records were referred to and the notes relating to that earlier period covered by that earlier radiographic record were also retrospectively completed or signed-off on 3 September.
196. The discrepancy in the date upon which the radiograph image was taken does not therefore alter the record keeping failing under this charge. By 3 September 2018, the radiograph was available within the clinical record and the mesial radiolucency at UR6 had not been recorded. Whether or not that radiolucency showed caries (in respect of which the Committee makes no finding) the radiographic appearance itself should have been recorded so that it could be clinically assessed. Mr Blake had therefore failed to maintain an adequate standard of record keeping.
197. The Committee therefore found charge 27(b) proved.
198. We move to Stage Two.

STAGE TWO: 7 October 2026

199. The findings of fact which the Committee has made involve 12 patients over a period of approximately three years. These failings relate primarily to a failure to provide an adequate standard of care by failing to diagnose and treat caries. A poor standard of restorative treatment was also provided. There were also failures to maintain an adequate standard of record keeping and a failure in antibiotic prescribing.
200. At this stage of the proceedings, the Committee shall decide whether the facts found proved, or any of them, give rise to impaired fitness to practise by reason of misconduct and/or deficient professional performance. If current impairment is found, the Committee shall decide on what action, if any, to take in respect of Mr Blake's registration.
201. Mr Blake did not attend this hearing and had ceased engaging in these proceedings. His current circumstances and practising status are unknown, although there is information to suggest from his previous legal representatives that he may have left dentistry and that he currently resides overseas.

202. Mr Stevens confirmed to the Committee that Mr Blake has no previous fitness to practise history.
203. Mr Stevens submitted that the facts found proved amount to misconduct. Although deficient professional performance was also pleaded in the Charge, he did not pursue a finding of impairment on that alternative statutory ground.
204. Mr Stevens submitted that Mr Blake's fitness to practise is currently impaired by reason of misconduct on both public protection and wider public interest grounds. He submitted that the clinical failings are capable of remediation, but that there is no evidence before the Committee of any remediation, reflection or insight. He submitted that, whilst conditions of practice might normally be indicated in a clinical case such as this, Mr Blake's lack of engagement means that conditions would be unworkable. He therefore submitted that Mr Blake's registration should be suspended for a period of 12-months with a review.

Decision

205. The Committee accepted the advice of the Legal Adviser.
206. Misconduct connotes a serious departure from the standards reasonably expected of a dental professional. The Committee considered whether the facts found proved amount to misconduct. The Committee has found repeated failures to diagnose and treat caries along with the provision of a poor standard of restorative treatment and the prescribing of antibiotics without adequate clinical justification. There were also record keeping failings.
207. The repeated failures to diagnose and treat caries are particularly serious in the Committee's judgment. Diagnosis and management of caries are basic and fundamental aspects of dentistry. Where caries is not diagnosed and treated, there is an increasing risk that the disease will progress and that the patient will therefore suffer avoidable harm or would otherwise be required to undergo more substantial treatment. In relation to Patient 5, by way of example, caries at UR6 remained undiagnosed by Mr Blake over multiple examination appointments before gross caries was eventually identified and the tooth extracted. The clinical failings which the Committee has found proved were not isolated. They did not relate to a single patient or a single course of treatment but involved a number of patients over a period of years.
208. The Committee had regard to Dr Pal's opinion that the failings to provide an adequate standard of care fell far below the standard expected of a reasonably competent dentist.
209. The Committee also had regard to Standard 7.1 of *Standards for the Dental Team* (September 2013) which requires all registered dental professionals to provide good quality care based on current evidence and authoritative guidance.
210. The Committee was satisfied that the facts found proved represented serious departures from the standards reasonably expected of Mr Blake and that his repeated clinical failings meet the threshold for misconduct.
211. Accordingly, the Committee found that the facts found proved amount to misconduct.

212. Having found misconduct in respect of its findings of fact, the Committee determined that it was unnecessary to separately consider the question of deficient professional performance, it therefore falls away.
213. The Committee next considered whether Mr Blake's fitness to practise as a dentist is currently impaired by reason of misconduct.
214. In assessing the question of impairment, the Committee had regard to whether Mr Blake's misconduct is remediable, whether it had been remedied, and the risk of repetition. The Committee also had regard to the wider public interest, which includes the overarching need to uphold and declare appropriate standards of conduct and behaviour so as to maintain public confidence in the profession and its regulation.
215. The Committee considered that the clinical failings in this case are capable of remediation through reflection, insight, further training, and evidence of embedded improvement in clinical practice. However, there was no evidence before the Committee that any such remediation has taken place. Mr Blake has disengaged from these proceedings and has provided no reflective statement. Neither has he provided any evidence of CPD, remediation or other material demonstrating that he has considered and addressed the clinical failings which have been found proved. By reason of his lack of engagement, there is also no indication that Mr Blake even acknowledges or accepts the Committee's findings.
216. There was also consequently no evidence of any insight into the failings or their potential effect upon patients, including an increased risk of harm or a need for the patient to undergo more extensive treatment for the caries than would otherwise have been needed.
217. The Committee acknowledged that these matters mainly occurred between 2016 and 2019. Mr Blake has no prior fitness to practise history and there is no evidence of similar concerns arising since that relatively historic period. However, the Committee could attach only limited weight to the passage of time and to the absence of further concerns. This is because there is evidence to suggest that Mr Blake may have ceased practising as a dentist. There is therefore no evidence of any subsequent period of unrestricted clinical practice from which the Committee might be able to conclude that Mr Blake had remedied the clinical failings and that they are highly unlikely to be repeated.
218. Although the information suggests that Mr Blake is no longer practising in the UK, he remains registered as a dentist with the GDC and there is therefore nothing which would prevent him from returning to clinical practice if he so wished. The Committee must therefore assess his fitness to practise on that basis. In the absence of any evidence of remediation or insight, and having regard to the repeated nature of the original clinical failings, the Committee could not be satisfied that the clinical failings which have been found proved are highly unlikely to be repeated. Indeed, in the Committee's judgment, there remains a significant risk of repetition and therefore a risk of harm to patients.
219. Accordingly, the Committee determined that Mr Blake's fitness to practise is currently impaired on public protection grounds.

220. The Committee also considered the wider public interest. The Committee considered that members of the public would reasonably expect a registered dentist to diagnose and appropriately manage dental disease, provide restorations to an acceptable standard and prescribe antibiotics only where clinically justified. These are basic aspects of dentistry. In those circumstances, a finding of impairment is also necessary to uphold and declare proper professional standards and to maintain public confidence in the profession.
221. The Committee therefore determined that Mr Blake's fitness to practise is also currently impaired on wider public interest grounds.
222. The purpose of sanction is not to be punitive but to protect the public and the wider public interest. It considered the available sanctions in ascending order of seriousness and applied the principle of proportionality.
223. In mitigation, the Committee took account of the fact that Mr Blake has no previous fitness to practise history.
224. The Committee identified the following aggravating features: (i) a risk of harm to patients; (ii) in some cases, disease had progressed before treatment was provided; (iii) the failings were repeated across a number of patients and occurred over a period of years; (iv) there is no evidence of insight or remediation.
225. To conclude this case with no further action or a reprimand would not sufficiently protect the public and meet the wider public interest. The Committee has found repeated and serious clinical failings involving multiple patients over an extended period. The Committee has identified a continuing risk of repetition, and therefore a continuing risk of harm to patients should Mr Blake be allowed to return to practice without any restriction on his registration. A reprimand would also be wholly insufficient to meet the wider public interest given the seriousness of Mr Blake's misconduct.
226. The Committee next considered whether conditions of practice could be formulated which would be measurable, workable, and proportionate. Whilst conditional registration might ordinarily be an appropriate response to clinical failings such as those which have been found proved here, Mr Blake's disengagement from the proceedings means that the Committee could not be satisfied that he would adhere to any conditions on his registration. He has provided no evidence of insight, reflection or remediation. He has shown no willingness to engage with the GDC and the Committee as part of this regulatory process. In those circumstances, conditions of practice would not be workable, measurable or proportionate. They would not adequately protect the public and would not otherwise meet the wider public interest.
227. The Committee next considered whether to direct that Mr Blake's registration be suspended for a period of up to 12 months, with or without a review. The Committee was satisfied that suspension would provide immediate protection to the public and would also adequately mark the seriousness of the misconduct in order to maintain public confidence in the profession. It would also provide Mr Blake with an opportunity to re-engage with the regulatory process, develop insight and any remediation.
228. The Committee therefore directs that Mr Blake's registration be suspended for a period of 12 months. This maximum period is proportionate given Mr Blake's current lack of engagement and the extent of the remediation which would be required before any

reviewing committee could reasonably conclude that he is safe to return to unrestricted practice.

229. The suspension shall be reviewed prior to its expiry. The reviewing committee may be assisted by evidence of Mr Blake's re-engagement with the GDC and a reflective statement from him addressing the Committee's factual findings. That statement should set out what went wrong, the potential impact upon patients and what he has learned. The reviewing committee might also be assisted by evidence of appropriate remediation, including targeted CPD in the areas of diagnosis and management of caries, restorative dentistry, radiography, record keeping and appropriate antibiotic prescribing.
230. Accordingly, the Committee directs that Mr Blake's registration be suspended for a period of 12 months with a review.
231. The Committee now invites submissions on the question of an immediate order.
-
232. Mr Stevens applied for an immediate suspension order to be made under section 30(1) of the Dentists Act 1984.
233. The Committee accepted the advice of the Legal Adviser on its power to make an immediate order.
234. The Committee determined that it is necessary for the protection of the public and is otherwise in the public interest to make an immediate suspension order. It would be inconsistent with the substantive decision the Committee has made not to make an immediate order. The Committee has found a continuing risk to the public and to the wider public interest should be Mr Blake be allowed to practise unrestricted.
235. The effect of this order is that Mr Blake's registration shall be suspended from when notification of this decision is deemed served on him. Unless he exercises his right of appeal, the substantive 12 month period of suspension shall take effect upon the expiry of the 28-day appeal period.
236. Should he exercise his right of appeal, this immediate order shall remain in force pending the disposal of the appeal.
237. That concludes this determination.