General
Dental
Council

**HEARING HEARD IN PUBLIC**

**RYLKO, Michael Daniel**

**Registration No: 102933**

**PROFESSIONAL CONDUCT COMMITTEE**

**MAY 2022**

**Outcome: Erased with Immediate Suspension**

RYLKO, Michael Daniel, a dentist, Registered under s16(2A) of the Dentists Act 1984 2006, was summoned to appear before the Professional Conduct Committee on 9 May 2022 for an inquiry into the following charge:

**Charge**

"That being a registered dentist:

1. Between on or about 3 June 2015 and 23 October 2019 you were practising at Practice 1 as set out in Schedule 1[1] and provided care and treatment to the patients set out in Schedule A.
2. You failed to carry-out sufficient diagnostic assessment and/or maintain adequate records as set out in Schedule B.
3. You failed to maintain adequate records as set out in Schedule C.
4. You failed to undertake sufficient treatment planning and/or investigation as set out in Schedule D.
5. You failed to provide an adequate standard of care and/or treatment as set out in Schedule E.
6. You failed to assess, treat and/or monitor patients as set out in Schedule F
7. You failed to obtain patients' fully informed consent in that you did not discuss the risks, benefits and/or alternative treatments as set out in Schedule G
8. You did not act in your patients' best interests in respect of:
    a. your decision to provide Patient E with Invisalign;
    b. your decision not to suggest alternative treatments to Patient F;
    c. your decision to fit Patient G with eleven crowns;
    d. your recommendation, on 5 June and 3 July 2019, for Patient H to have orthodontic treatment (Invisalign) when this was not required;
    e. your decision to fit a large bridge over Patient I's teeth which had a poor

[1] All Schedules are private documents which cannot be disclosed.

long-term prognosis.

9. Your conduct in respect of 8 was:
   a. misleading; and/or
   b. dishonest in that it was financially motivated.
10. Following a request from the General Dental Council ('the Council') to provide the records of Patients A, B, C and/or D, you altered the contemporaneous patient records and provided amended records to the Council.
11. Your conduct in respect of 10, above, was:
   a. Misleading; and/or
   b. Dishonest, in that you knew that the Council sought to obtain records that were contemporaneous to the appointments, and you amended the records without informing the Council.
12. From at least 22 May 2019 to 22 November 2019, you displayed a sticker in your Practice window which stated 'Dentistry Awards 2016, Best Performing Dentist, Michael Rylko, Winner issued by Butterfly Dental Laboratory' in circumstances whereby:
   a. you had not received such a sticker from the Butterfly Dental Laboratory; and/or
   b. you had not received such an award from the Butterfly Dental Laboratory.
13. Your conduct in respect of 12 was:
   a. Misleading;
   b. Lacking in integrity, as you sought to elevate your professional standing without actually achieving an award;
   c. Dishonest, in that you knew that you had not received such an award from the Butterfly Dental Laboratory.

And that, in consequence of the matters set out above (individually and/or cumulatively), your fitness to practise is impaired by reason of your misconduct."

Mr Rylko was not present and was not represented. On 09 May 2022 the Chairman made a statement regarding the preliminary applications. On 18 May 2022 the Chairman announced the findings of fact to the Counsel for the GDC:

"This is a Professional Conduct Committee hearing of Mr Rylko's case. The hearing is being conducted remotely by Microsoft Teams video-link in line with the current practice of the General Dental Council (GDC).

Mr Rylko is not present at this hearing, and he is not represented in his absence. The Case Presenter for the GDC is Mr Sam Thomas, Counsel.

**PRELIMINARY MATTERS**

On 9 May 2022, at the outset of the hearing, Mr Thomas made an application pursuant to Rule 54 of the *GDC (Fitness to Practise) Rules Order of Council 2006* to proceed with the hearing notwithstanding Mr Rylko's absence. The Committee took account of the submissions made by Mr Thomas in respect of the application, and it had regard to the supporting documentation provided.

The Committee accepted the advice of the Legal Adviser in relation to service and proceeding in the absence of the registrant.

**The Committee's decision on service – 9 May 2022**

The Committee first considered whether notice of the hearing had been served on Mr Rylko in accordance with Rules 13 and 65. It had regard to the Notice of Hearing dated 29 March 2022 ('the notice'), which was sent to Mr Rylko's registered address by Special Delivery. The Committee was provided with a Royal Mail 'Track and Trace' receipt as proof of postage. Whilst the 'Track and Trace' receipt indicated that the notice was *"delivered back to sender"* on 1 April 2022, 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. Notwithstanding this, the Committee noted that the GDC also sent an electronic copy of the notice to Mr Rylko by email; it was sent to an email address previously used by him to correspond with the Council. The Committee noted that there was evidence to indicate that the electronic copy of the notice was delivered to the email server.

The Committee was satisfied that the notice sent to Mr Rylko complied with the 28-day notice period required by the Rules. It was further 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 Microsoft Teams video-link, and that it indicated that the Committee had the power to proceed with the hearing in Mr Rylko's absence.

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

**The Committee's decision on whether to proceed with the hearing in the absence of the registrant – 9 May 2022**

The Committee next considered whether to exercise its discretion under Rule 54 to proceed with the hearing in the absence of Mr Rylko. 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 legal authorities drawn to its attention, namely *R v Jones [2001] EWCA Crim 168, [2001] Q.B. 862; General Medical Council v Adeogba [2016] EWCA Civ 162;* and *Davies v Health And Care Professions Council [2016] EWHC 1593 (Admin).* The Committee remained mindful that fairness to Mr Rylko was an important consideration, but it also took into account the need to be fair to the GDC, and to the public interest in the expeditious disposal of this case.

The Committee was satisfied that all reasonable efforts had been made by the GDC to notify Mr Rylko of this hearing. Whilst it took into account that there had been no response from him to the notice of 29 March 2022, it received evidence showing that he had previously corresponded with the GDC regarding this case, including through former legal representatives. The Committee's attention was drawn to an email from Mr Rylko dated 27 August 2020, in which he stated that he no longer lived in the UK. In a further email from Mr

Rylko, which he sent in response to an email from the GDC, dated 12 January 2021, Mr Rylko stated that he did not wish to engage any further with the GDC's investigation.

The Committee was satisfied that Mr Rylko's absence from this hearing is voluntary. It noted that it received no request for an adjournment, nor did it receive any information to suggest that deferring this hearing might secure Mr Rylko's attendance on a future date. The Committee concluded that adjourning the hearing would serve no meaningful purpose.

In reaching its conclusion, the Committee took into account the potential unfairness and inconvenience to the GDC of any delay. It noted that the expert witness instructed by the GDC was in attendance at the hearing and was prepared to give evidence in the case. The Committee further took into account its duty to act expeditiously in the public interest. In all the circumstances, the Committee was satisfied that it was fair and in the public interest to proceed with the hearing in the absence of Mr Rylko.

**FINDINGS OF FACT – 18 May 2022**

Mr Rylko is a registered dentist. The matters in this case concern allegations relating to the care and treatment that he provided to a number of patients, whilst practising at a dental practice in Shetland ('Practice 1'). There are also allegations relating to Mr Rylko's probity.

The Committee heard by way of background that in May 2019, the GDC received information from the initial complainant in this case, Witness 1. Witness 1 had worked as a dental nurse at Practice 1. She contacted the GDC to raise concerns about patient safety, in particular in relation to Mr Rylko's care and treatment of four patients, Patients A, B, C and D. Subsequently, in July 2019, Witness 1 provided the GDC with copies of the clinical records for these four patients.

Witness 1 also raised a concern regarding Mr Rylko's probity. This concern was in relation to a dentistry award displayed by Mr Rylko at Practice 1, which was alleged to be false.

In response to Witness 1's complaint, the GDC requested from Mr Rylko the clinical records of Patients A, B, C and D, which he provided through his then solicitors. On receipt of the records from Mr Rylko, the GDC noted that there were some discrepancies between the copies provided by him, and the copies of the records previously received from Witness 1. The GDC considered that the identified discrepancies indicated that Mr Rylko had made amendments to the copies of the records he provided. The GDC considered that this raised additional concerns about Mr Rylko's honesty and integrity.

The GDC commenced an investigation into Mr Rylko's fitness to practice, which included the gathering of further factual evidence, and the instruction of an expert witness, Dr Lucy Nichols.

During the course of the GDC's investigation concerns arose in respect of Mr Rylko's care and treatment of a further seven patients, Patients E, F, G, H, I, J and K. The concerns included Mr Rylko's alleged undertaking of disproportionate, unnecessary, and overly technical treatment. The allegation being that in providing such dental treatment, Mr Rylko was acting with a financial motive, as opposed to providing dental treatment that was in the best interests of the patients, and dishonest.

It is against this background that the charge against Mr Rylko is brought by the GDC. The charge covers two broad areas of concern; firstly, the clinical aspects relating to the 11 patients in this case, and secondly, the probity matters. The probity matters include Mr Rylko's display of an allegedly false dental award within Practice 1, his alleged amendment

of the patient records he provided to the GDC, and the question of whether some of the dental treatment he provided to patients was financially motivated, not in the patients' best interests, and dishonest.

**Evidence**

The evidence received from the GDC was largely documentary. The Committee received clinical records in relation to the 11 patients involved in this case. It also received the written evidence of nine factual witnesses. The Committee was given the opportunity to hear oral evidence from the nine witnesses by telephone, but it was satisfied that it did not have any questions to ask of them that would assist beyond their written evidence. Accordingly, the Committee received the witness statements (along with associated exhibits) of the nine factual witness, which were as follows:

- The witness statement of Witness 1 dated 30 April 2020.
- The witness statement of Witness 2 dated 10 June 2021. Witness 2, a Paralegal with the GDC, conducted the comparison of the clinical records provided by Witness 1 and Mr Rylko.
- The witness statement of Witness 3 dated 11 July 2020. Witness 3 is a dentist who worked with Mr Rylko at Practice 1.
- The witness statement of Witness 4 dated 30 August 2020. Witness 4 is a dentist who worked with Mr Rylko at Practice 1.
- The witness statement of Witness 5 dated 4 November 2021. Witness 5 is a Consultant Orthodontist, who subsequently saw one of Mr Rylko's patients, Patient H.
- The witness statement of Witness 6 dated 18 March 2020. Witness 6 is the owner of Butterfly Dental Laboratory.
- The witness statement of Witness 7 dated 29 June 2020. Witness 7 is Editorial Director at FMC, a UK dental publisher. Witness 7 is responsible for issuing awards on behalf of FMC.
- The witness statement of Patient C dated 17 October 2020.
- The witness statement of Patient D dated 18 May 2020

In addition to the factual evidence, the Committee received an expert report prepared by Dr Lucy Nichols, dated 6 May 2022. Dr Nichols also gave oral evidence at the hearing.

**The Committee's findings**

The Committee considered all the evidence presented to it. It took account of the submissions made by Mr Thomas on behalf of the GDC. The Committee accepted the advice of the Legal Adviser.

In approaching its findings on the alleged facts, the Committee considered each of the allegations against Mr Rylko separately, save where it considered it appropriate and fair to admit evidence relating to another charge. This applied to any charges of dishonesty in respect of occasions later than where dishonesty was first found proved. When initially considering dishonesty, the Committee had regard to the good character direction given by the Legal Adviser.

In this regard, the Committee noted that the ambit of heads of charge 12 and 13 which allege that Mr Rylko dishonestly displayed a sticker in the window of Practice 1, extended for a period from at least 22 May 2019. The Committee determined to consider heads of charge 12 and 13 at the outset of its deliberations since the evidence of Witness 1 in her witness statement was that the sticker had been displayed, as aforesaid, for some two years before she reported it to the GDC in July 2019. The Committee considered that if it determined that Mr Rylko had behaved dishonestly in relation to the displaying of the sticker from about July 2017, that could materially affect the Committee's approach to dishonesty allegations later than that date.

The Committee further noted that, as part of the evidence, it received two sets of clinical records in relation to four of the patients in this case, Patients A, B, C and D. The unchallenged evidence of Witness 2 is that the first set of clinical records for these four patients was provided to the GDC by Witness 1 in July 2019. The second set of clinical records for the same four patients was provided to the GDC by Mr Rylko in September 2019, through his then legal representatives, following a request by the Council. It is alleged at heads of charge 10 and 11, that Mr Rylko altered the contemporaneous patient records of Patients A, B, C and D before providing them to the GDC, and that he did so dishonestly.

The Committee noted that the preceding allegations in the charge, at heads of charge 2 to 7, were dependent on its assessment of information within the patient's clinical records. In the circumstances, the Committee considered it necessary to first establish the status of the clinical records provided to the GDC by Mr Rylko in respect of Patients A, B, C and D, and whether it could rely upon any of those records in reaching its decisions at heads of charge 2 to 7. Therefore, the Committee next considered heads of charge 10 and 11, before going on to consider heads of charge 2 to 7, 8 and 9.

The Committee bore 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.

The Committee's findings are as follows:

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| 1. | *Between on or about 3 June 2015 and 23 October 2019 you were practising at Practice 1 as set out in Schedule 1 and provided care and treatment to the patients set out in Schedule A.*<br><br>**Found proved.**<br><br>The Committee received the clinical records of Mr Rylko for all the patients in question. The clinical records cover the dates in this head of charge, and they confirm that Mr Rylko was practising as a dentist at Practice 1 at the material time. The Committee also took into account the evidence of Witness 1, who confirmed that she had worked with Mr Rylko at Practice 1 for part of the period concerned.<br><br>Further, the Committee noted that Mr Rylko did engage with the GDC in the early stages of its investigation into the matters in this case, and there was no suggestion from him, or those that were representing him, that he did not work at Practice 1 and/or that he did not treat any of the patients referred to in Schedule A over the period in this charge. |

| **Heads of charge 12 and 13:** | |
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| 12. | *From at least 22 May 2019 to 22 November 2019, you displayed a sticker in your Practice window which stated 'Dentistry Awards 2016, Best Performing Dentist, Michael Rylko, Winner issued by Butterfly Dental Laboratory' in circumstances whereby:* |
| 12(a). | *you had not received such a sticker from the Butterfly Dental Laboratory; and/or*<br><br>**Found proved.** |
| 12(b). | *you had not received such an award from the Butterfly Dental Laboratory.*<br><br>**Found proved.**<br><br>In considering heads of charge 12(a) and 12(b), the Committee was mindful of legal advice given by the Legal Adviser that it could be appropriate for it to consider a period which did not extend fully to 22 November 2019. The rationale for this advice was that the period in the stem at head of charge 12 would embrace a lesser period. The Legal Adviser relied upon the case of *Gangar v General Medical Council [2003] UKPC 28*. The Committee accepted this legal advice.<br><br>The Committee accepted the evidence of Witness 1 that the sticker was displayed in the window of Practice 1. She provided photographs of the sticker to the GDC, which she said were taken in mid-July 2019, and she noted that the sticker had been on display at Practice 1 for about two years by that time. Copies of the photographs were exhibited to Witness 1's witness statement.<br><br>Also in support of the allegations, the Committee received witness statements from Witness 6 and Witness 7.<br><br>Witness 6 stated that whilst he knew Mr Rylko from Practice 1, and that Mr Rylko was a customer of Butterfly Dental Laboratory, he had never met him personally. Witness 6 stated in his witness statement "*I have been asked by the GDC whether Butterfly Dental Laboratory has ever given dentistry or non-dentistry awards to either dental practices or dental practitioners. I can confirm that we have never given dentistry or non-dentistry awards to dental practices or dental practitioners.* Witness 6 further stated, *"I have also been asked by the GDC whether Butterfly Dental Laboratory has ever given a dentistry or non-dentistry award to Mr Rylko. I can confirm that we have never given Mr Rylko a dentistry or non-dentistry award."*<br><br>The Committee noted that Witness 6 was provided with copies of the photographs of Mr Rylko's 'Best Performing Dentist' award, purportedly issued by Butterfly Dental Laboratory. Whilst Witness 6 saw that it was complemented by Butterfly Dental Laboratory's logo, he reiterated that Butterfly Dental Laboratory had never issued awards of that nature.<br><br>In his witness statement, Witness 7 stated, "*FMC has given many awards to both dental practices and individual dentists…I have been asked by the* |

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| | *GDC whether FMC has ever given an award to [Practice 1] or Mr Rylko. I can confirm that since FMC started doing award schemes, we have never given an award to [Practice 1] or Mr Rylko.* Witness 7 also confirmed having seen photographs of the sticker displayed by Mr Rylko at Practice 1, and he stated that FMC had never issued any award like to any practice or dentist. |
| 13. | *Your conduct in respect of 12 was:* |
| 13(a). | *Misleading;*<br><br>**Found proved.**<br><br>The Committee was satisfied that the displayed sticker would have misled members of the public into believing that Mr Rylko had won such an award, when in fact he had not. |
| 13(b). | *Lacking in integrity, as you sought to elevate your professional standing*<br><br>*without actually achieving an award;*<br><br>**Found proved.**<br><br>The Committee had drawn to its attention the case of *Wingate v SRA [2018] EWCA Civ 366*. It is stated in that judgement that, *"In professional codes of conduct, the term 'integrity' is a useful shorthand to express the higher standards which society expects from professional persons and which the professions expect from their own members…Integrity connotes adherence to the ethical standards of one's own profession. That involves more than mere honesty".*<br><br>The Committee was satisfied that Mr Rylko's conduct in displaying a sticker in the window of Practice 1 which was fabricated, and which gave the impression that he was better or more qualified than he was, was conduct that lacked integrity. The Committee had regard to Standard 1.3 of the GDC Standards, which requires all registrants to *"act with integrity".* In all the circumstances, the Committee considered that Mr Rylko's behaviour failed to meet the higher standard expected of him as a registered dentist. Accordingly, this head of charge is proved. |
| 13(c). | *Dishonest, in that you knew that you had not received such an award from the Butterfly Dental Laboratory.*<br><br>**Found proved.**<br><br>The Committee was satisfied that Mr Rylko must have known that he had not received such a sticker and/or award from Butterfly Dental Laboratory and, that being the case, he was not entitled to display a sticker and/or award purporting to be from Butterfly Dental Laboratory. The Committee noted the evidence that no such award exists, and therefore there could be no question of error, confusion, or innocent explanation. The Committee considered that even if Mr Rylko did not place the sticker in the window of Practice 1 himself, he must have known that it was there, and what it was purporting to do.<br><br>The Committee was satisfied that ordinary decent people would regard Mr |

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| | Rylko's conduct in displaying a false award stating that he had been judged the 'Best Performing Dentist' in 2016 as dishonest. |
| **Heads of charge 10 and 11:** | |
| 10. | *Following a request from the General Dental Council ('the Council') to provide the records of Patients A, B, C and/or D, you altered the contemporaneous patient records and provided amended records to the Council.*<br><br>**Found proved.**<br><br>In reaching its decision, the Committee accepted the unchallenged evidence of Witness 2, who undertook a comparison of the sets of records provided by Witness 1 and Mr Rylko. Witness 2 outlined the following in her witness statement:<br><br>*a. Some entries in the records that [Witness 1] provided are different from the entries in the Registrant's records;*<br><br>*b. Some entries or documents are present in the records that the Registrant provided but are not present in the records that [Witness 1] provided; and*<br><br>*c. Some entries or documents are present in the records that [Witness 1] provided but are not present in the records that the Registrant provided.*<br><br>The Committee considered the sets of records in question and was satisfied that Witness 2's comparison was accurate. Of particular note to the Committee were the number of instances in the clinical records provided by Mr Rylko for Patients A, B, C and D, in which it found that significant amounts of information had been added to the patient notes. In some cases, the Committee noted the addition of multiple pages of handwriting, setting out information that is not present in the copy of the clinical records provided by Witness 1. The Committee also noted that the sets of clinical records provided by Mr Rylko have handwritten numbers in the top right hand corner of the pages, whereas the copies provided by Witness 1 are not paginated.<br><br>By way of an example, the Committee noted the clinical records relating to Mr Rylko's consultation with Patient A on 28 January 2019. The Committee saw that the clinical records supplied by Witness 1 for this consultation included minimal information covering half a page of the notes in total. However, the clinical records subsequently provided by Mr Rylko in relation to the same consultation were significantly more extensive, including more than two pages of additional information. The Committee noted that Mr Rylko's version of the notes included a lot more information about Patient A's denture, the proposed bridgework to replace the denture, and the alternative treatment options that were said to have been discussed with the patient. The Committee noted that much of this information was not in the clinical records provided by Witness 1.<br><br>In relation to Patient B, the Committee noted the clinical records in relation |

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| | to an appointment with Mr Rylko on 18 January 2018. The Committee found that, when comparing the information provided by Witness 1 and Mr Rylko in relation to this appointment, the notes provided to the GDC by Mr Rylko appeared entirely different. The Committee noted a considerable difference in the detail contained in the sets of clinical records.<br><br>The Committee considered the clinical records provided by Witness 1 and Mr Rylko in relation to Patient C. In particular, the Committee noted the brief nature of the clinical records provided by Witness 1 in respect of an appointment that took place on 9 April 2019. The Committee saw from the notes provided by Witness 1 that only basic information was provided in respect of the proposed bridgework for the patient. However, in the version of the notes provided by Mr Rylko in respect of the same appointment, full information about the patient's history with their lower denture is included, as well as a more extensive explanation justifying the proposed bridgework. This was information that was not included in the clinical records provided by Witness 1. It was the opinion of the Committee that the clinical records provided by Witness 1 are vastly different to the clinical records subsequently provided by Mr Rylko.<br><br>The Committee noted that at the beginning of the clinical records provided in relation to Patient D, the dental chart featured in the material provided by Witness 1 has not been completed. However, the same chart features in the notes provided by Mr Rylko, and it is completed. The Committee also noted that in respect of an appointment with Patient D on 4 January 2018, the set of notes provided by Mr Rylko includes significant differences, including the addition of a reference to the benefits of the proposed bridgework, which is absent from the notes provided by Witness 1 of the same appointment.<br><br>Having considered all the evidence, the Committee was satisfied on the balance of probabilities that the clinical records provided by Witness 1 were the contemporaneous records of Patients A, B C and D. It was satisfied that Mr Rylko altered those contemporaneous records, and that he provided amended records to the GDC. Accordingly, the Committee found this head of charge proved. |
| 11. | *Your conduct in respect of 10, above, was:* |
| 11(a). | *Misleading; and/or*<br><br>**Found proved.**<br><br>The Committee found that the clinical records provided to the GDC by Mr Rylko in respect of Patients A, B, C and D included extensive additions and, in some places, omissions. The Committee found nothing in the clinical records provided by Mr Rylko in respect of these four patients to indicate that they were not made contemporaneously. The evidence is that he sent the clinical records to the GDC purporting them to be contemporaneous, and the Committee was satisfied that anyone reading them would be misled into thinking that they were contemporaneous and accurate. This head of charge is therefore proved. |

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| 11(b). | *Dishonest, in that you knew that the Council sought to obtain records that were contemporaneous to the appointments, and you amended the*<br><br>*records without informing the Council.*<br><br>**Found proved.**<br><br>The Committee was satisfied that, even if not explicitly stated by the GDC in its request for the records of Patients A, B, C and D, Mr Rylko would have known that the Council was seeking contemporaneous clinical records. The Committee had regard to Standard 4.1 of the '*GDC Standards for the Dental Team (September 2013)'* ('the GDC Standards') which states, *"You must: Make and keep contemporaneous, complete and accurate patient records".*<br><br>The Committee also took into account the evidence of Dr Nichols, who told the Committee that the requirement for contemporaneous clinical records was to ensure that the events of an appointment were fresh in the mind of the clinician, and that an accurate reflection of what had happened could be recorded. Whilst Dr Nichols acknowledged that there may be instances when a dentist could not record notes for an appointment on the same day, it was her opinion that records should be made no later than a day after an appointment.<br><br>The Committee noted that the alterations made by Mr Rylko to the records of Patients A, B, C and D were made after Witness 1 had already copied them in or around June 2019 to provide to the GDC. The Committee noted that June 2019 was significantly later than many of the patient appointments concerned. Further, in a number of instances seen by the Committee, the level of the alterations made by Mr Rylko were significant, to the extent that he altered the entire narrative of some of the consultations.<br><br>In the absence of any explanation from Mr Rylko as to his actual state of knowledge or belief as to the facts, the Committee considered whether there could be an innocent explanation for his amending of the clinical records in the manner seen. However, it could find no logical explanation, other than it had been Mr Rylko's intention to make it appear to the GDC as if he had originally recorded full accounts of his appointments with the patients, including discussions about their treatment, treatment planning, treatment options and risk and benefits. In reaching its conclusion, the Committee considered that the additions and amendments made by Mr Rylko would have taken some time and care to produce. It also noted that many of the changes he made directly addressed issues that were relevant to the GDC's investigation. The Committee further took into account Mr Rylko's handwritten pagination of the clinical records, which it regarded as a method of obscuring their lack of contemporaneity.<br><br>Having established what it considered to be Mr Rylko's knowledge or belief as to the facts, the Committee next considered whether his conduct would be regarded as dishonest by ordinary decent people. The Committee was satisfied that such people would regard Mr Rylko's actions as dishonest. The evidence is that he deliberately and knowingly provided altered patient |

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| | records to his regulatory body during its investigation of his fitness to practice.<br><br>In all the circumstances, the Committee was satisfied on the balance of probabilities that this head of charge is proved. |
| **Heads of charge 2 to 7:** | |
| In view of its decisions at heads of charge 10 and 11 above, the Committee did not rely on any of the clinical records provided to the GDC by Mr Rylko in respect of Patients A, B, C and D. The Committee relied on what it was satisfied to be the contemporaneous clinical records for the four patients, as provided to the GDC by Witness 1. | |
| 2. | *You failed to carry-out sufficient diagnostic assessment and/or maintain adequate records as set out in Schedule B.*<br><br>**Found proved.**<br><br>**The Committee found proved that there was a failure to carry out sufficient diagnostic assessment of all the patients referred to in Schedule B.**<br><br>**<u>Patient A</u>**<br><br>Schedule B refers to Patient A's appointment with Mr Rylko on 9 November 2016. The Committee had regard to the opinion of Dr Nichols that as Patient A had not had a routine examination undertaken for over a year, and as the appointment on 9 November 2016 was the start of a new course of treatment, namely denture treatment, Mr Rylko should have carried out sufficient diagnostic assessment prior to starting the treatment.<br><br>In her report, Dr Nichols stated that such an assessment should have included consideration of Patient A's **"***presenting complaint, history of presenting complaint, medical history and social history, extraoral oral examination, TMJ examination, soft tissues examination, BPE (Basic Periodontal Examination), teeth examination, and routine radiography as required".*<br><br>The Committee accepted Dr Nichols' opinion. It was satisfied that Mr Rylko had a duty to carry out sufficient diagnostic assessment of Patient A at the appointment on 9 November 2016, prior to starting any treatment. The Committee considered the contemporaneous clinical records for Patient A. It found no record of any details of assessment, as referred to by Dr Nichols, and as set out in Schedule B. There was also no indication that any radiographs had been taken by Mr Rylko prior to his starting Patient A's treatment. In the absence of relevant records, and any radiographs, the Committee was satisfied on the balance of probabilities, that Mr Rylko did not carry out sufficient diagnostic assessment of Patient A on 9 November 2016. The Committee noted the oral evidence of Dr Nichols that this represented a significant deviation on Mr Rylko's part from acceptable clinical practice.<br><br>**<u>Patient B</u>**<br><br>Schedule B refers to Patient B's appointments with Mr Rylko between 4 |

December 2017 and 18 January 2018 and also, in some instances, an appointment which took place on 20 August 2018. The Committee noted from the contemporaneous clinical records that the specific treatment that Mr Rylko provided to Patient B over this period in question, was crown treatment to the LL5.

In reaching its decisions in relation to Patient B, the Committee noted and accepted the opinion of Dr Nichols. It was satisfied on the basis of her evidence that, in all the circumstances of Patient B's treatment, Mr Rylko had a duty to carry out sufficient diagnostic assessment prior to commencing treatment over the period in question.

In her report, Dr Nichols highlighted that prior to 4 December 2017, Patient B was last seen by Mr Rylko in March 2017. Dr Nichols noted that at an appointment on 27 March 2017 *"Severe bone loss was noted and a deep periodontal pocket at LR6. There is a BPE for this date which is Upper 333 Lower 433. A diagnosis of mild chronic periodontal disease was made and a scale and polish was carried out".* Dr Nichols outlined the elements that she considered were necessary as part of a diagnostic assessment of Patient B, when the patient was later seen by Mr Rylko between 4 December 2017 and 18 January 2018 and also on 20 August 2018. These elements being, a discussion of the patient's presenting complaint or history of the presenting complaint, obtaining the patient's medical and social history, carrying out extra oral, TMJ, soft tissues and teeth examinations, carrying out a BPE, and undertaking a vitality test or taking a periapical radiograph of LL5 prior to providing a crown.

The Committee considered the contemporaneous clinical records for Patient B. It found that in relation to the appointment on 4 December 2017, there was some evidence in the notes that Mr Rylko had discussed with the patient their presenting complaint. The Committee noted reference to the patient having lost a filling at LL5. However, the Committee considered this to be insufficient information in the absence of any other notes about the history of the complaint, including when the filling was lost. Further, having considered the records in relation to all the other appointments between 4 December 2017 and 18 January 2018, and the appointment on 20 August 2018, which was specifically an examination appointment, the Committee found no details of assessment covering all of the aspects outlined by Dr Nichols and as set out in Schedule B. It also found no indication that a periapical radiograph had been taken of LL5. In view of this, the Committee was satisfied on the balance of probabilities, that Mr Rylko did not carry out sufficient diagnostic assessment of Patient B over the period in question, including where relevant on 20 August 2018.

**Patient C**

Schedule B refers to Patient C's appointment with Mr Rylko on 12 April 2019. As highlighted by Dr Nichols, the contemporaneous clinical records for this date show that occlusal decay was removed from LL7 and a filling placed, that a screw retained core was built up for LL5, that a 9 unit bridge preparation was carried out, and a temporary bridge fitted. The Committee was satisfied from the evidence of Dr Nichols that in the circumstances of

Patient C's treatment, which was extensive treatment, Mr Rylko should have carried out sufficient diagnostic assessment on 12 April 2019 prior to commencing.

Having had regard to the contemporaneous clinical records, the Committee accepted the evidence of Dr Nichols that "*There is no evidence that an adequate assessment was made prior to preparing teeth for a bridge".* The Committee noted from her evidence that such an assessment should have included *"vitality testing the teeth, taking pre-operative radiographs, assessing the periodontal condition and the occlusion."* In the absence of any indication in the clinical records that Mr Rylko undertook these clinical steps, which included the lack of any radiographs, the Committee was satisfied that he did not carry out sufficient diagnostic assessment of Patient C on 12 April 2019.

**Patient D**

Schedule B refers to a number of dates and periods of time during which Patient D attended appointments with Mr Rylko. The Committee noted from the contemporaneous clinical records, and as referred to by Dr Nichols, that Patient D first attended Mr Rylko on 17 June 2015 for a consultation to discuss the cost of replacing missing teeth. The patient returned on 18 June 2015 and impressions were taken for a denture. On 3 July 2015 a bite registration was carried out and on 13 July 2015 an upper denture was fitted. Treatment was then noted to be complete.

The Committee accepted the opinion of Dr Nichols that there was a duty on Mr Rylko to sufficiently examine Patient D before providing the patient with the denture. The Committee noted her evidence that sufficient diagnostic assessment in Patient D's case should have included reference to the patient's presenting complaint, a history of presenting complaint, extraoral examination, TMJ examination, soft tissues examination, BPE, teeth examination, and routine radiography as required. The Committee considered the contemporaneous clinical records for Patient D, and found no evidence to indicate that Mr Rylko had undertaken any of these aspects of assessment prior to fitting Patient D's upper denture in July 2015. It also found no evidence of any radiographs having been taken prior to the treatment.

The Committee further noted and accepted Dr Nichols opinion in relation to assessments that should have been carried out at later stages, when issues arose with the upper denture provided by Mr Rylko in July 2015. The Committee saw from the contemporaneous clinical records that Patient D returned to see Mr Rylko on 4 January 2019. The notes for that date indicate that the upper denture had fractured due to a deep bite and that there was no way to offer a new denture, that the teeth were heavily worn, and therefore an upper 8 unit bridge was necessary and that with this, the bite would be opened by 2 to 3mm.

Patient D attended various appointments with Mr Rylko between 4 January 2019 and 14 February 2019 for the purpose of being provided with the upper 8 unit bridge, and also crown treatment. Dr Nichols' opinion was that

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| | further assessments were required over the course of this period, such as vitality testing the teeth, assessment of the occlusion and/or bite, and periapical radiographs prior to providing the bridgework. The Committee found no evidence in the contemporaneous clinical records to suggest that Mr Rylko had carried out an adequate assessment in accordance with Dr Nichols' opinion, which the Committee accepted.<br><br>In all the circumstances, the Committee was satisfied on the balance of probabilities, that Mr Rylko did not carry out sufficient diagnostic assessment of Patient D, in all the instances alleged in Schedule B of the charge.<br><br>**Patient F**<br><br>Schedule B refers to Patient F's appointments with Mr Rylko between 20 April 2017 and 23 October 2019. The Committee took into account the evidence of Dr Nichols that between these dates Mr Rylko provided a considerable amount of treatment to Patient F. This included bridgework, crown treatment, root canal treatment and the provision of fillings. A letter from Mr Rylko to Patient F, dated 16 October 2017 refers to a *"the dental makeover plans"* they had discussed. The Committee accepted Dr Nichols' opinion that it would have been fundamental for Mr Rylko to have carried out sufficient diagnostic assessment of the patient before undertaking the extensive treatment in question. Dr Nichols sets out in her report that extraoral, TMJ, soft tissues and teeth examinations should have been undertaken by Mr Rylko, as well as a BPE and screen radiographs.<br><br>It was Dr Nichols' evidence that none of the relevant aspects of assessment were indicated in the clinical records as having been carried out in respect of Patient F over the period in question. The Committee having considered the clinical records, accepted Dr Nichols' evidence.<br><br>In the absence of any records to indicate sufficient diagnostic assessment, the Committee was satisfied on the balance of probabilities, that Mr Rylko did not carry out sufficient diagnostic assessment of Patient F, as alleged in Schedule B to the charge.<br><br>**Patient G**<br><br>Schedule B refers to Patient G's appointments with Mr Rylko between 27 July 2017 and 17 March 2020, as well as an appointment on or just before 12 February 2018.<br><br>The clinical records for Patient G indicate that from 27 July 2017 to 12 October 2017, Mr Rylko replaced a fractured composite filling at UL3,<br><br>replaced a lost filling at UL1, took impressions and fitted a nightguard, and placed fillings at UL1 and UL2.<br><br>On 24 November 2017, Patient G saw another dentist at Practice 1, Witness 3, for repair of a filling at UR3. However, the notes for that appointment also indicate that the patient was due to see Mr Rylko for the provision of 10 crowns. It is noted that Witness 3 provided Patient G with a consent form to read and sign. The patient is recorded to have stated that |

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| | they wished to discuss the cost of the crown treatment before signing the consent form. The patient was said to be *"otherwise happy".*<br><br>The Committee had regard to the clinical records for Patient G's next appointment, which was on 12 February 2018, and which is under a heading in the notes which reads: *"Huge Treatment Day".* The Committee noted that, at this appointment, 11 of the patient's teeth were prepared for crowns.<br><br>Dr Nichols highlighted in her report that in his clinical notes relating to the period in question, Mr Rylko did not record the periodontal health of Patient G, the vitality of the teeth, an assessment of the bite, or carry out a radiographic review of the teeth to be crowned. She noted that photos were taken but that these have not been provided as part of this case.<br><br>The Committee was satisfied on the basis of Dr Nichols' evidence that Mr Rylko had a duty to carry out sufficient diagnostic assessment in respect of Patient G. In accepting her opinion, the Committee considered the information regarding Patient G's treatment over the period concerned, which included the provision of a large number of crowns. It had regard to his clinical notes for all of the appointments in question, and whilst it found details of the treatment he provided, it found nothing to indicate that he had carried out any of the aspects of assessment detailed by Dr Nichols. This included the absence of any evidence to indicate that Mr Rylko had undertaken adequate pre-operative assessment of the teeth to be crowned.<br><br>In all the circumstances, the Committee was satisfied on the balance of probabilities, that Mr Rylko did not carry out sufficient diagnostic assessment of Patient G, as alleged in Schedule B of the charge.<br><br>**Patient I**<br><br>Schedule B refers to Patient I's appointments with Mr Rylko between 23 November 2015 and 15 April 2019, as well as an appointment on 1 March 2018.<br><br>The Committee noted Dr Nichols' criticism regarding the lack of any evidence that an adequate BPE examination had been undertaken in respect of Patient I between 23 November 2015 and 15 April 2019. She stated in her report that she considered it clear from the evidence, including radiographic evidence, that *"this patient had already suffered significant periodontal disease and bone loss".*<br><br>The Committee accepted Dr Nichol's opinion, and was satisfied that, in the circumstances, there was a duty on Mr Rylko to carry out an adequate BPE examination in relation to Patient I over the period in question. The Committee had regard to the clinical records for the patient. Whilst it noted that BPE scores were recorded on an 'Intra Oral exam' sheet, dated 23 November 2015, the scores which were '2s' and '1s', did not appear to accord with the radiographic findings Mr Rylko also recorded on the sheet. His noted report on bitewing radiographs subsequently taken on 24 May 2017 was *" - severe bone loss - posterior molars leaned forward and not supported by bone".* The Committee noted Dr Nichols' opinion that Patient |

I's bone loss would have been evident from 2015. The Committee found no record of BPE scores for any of the patient's subsequent appointments with Mr Rylko.

In the absence of any or any adequate records, the Committee was satisfied on the balance of probabilities that Mr Rylko did not undertake an adequate BPE of Patient I between 23 November 2015 and 15 April 2019.

In relation to Patient I's appointment on 1 March 2018, the relevant notes record *"Top 8 unit bridge prep"*, that three teeth were prepared, and that the treatment would be continued the next week. The notes further indicate that local anaesthetic was given and that a temporary bridge was fitted. The Committee found no evidence in the clinical records to indicate that any pre-operative radiographs were taken, and it was satisfied on the balance of probabilities that Mr Rylko did not take any. The Committee noted the criticism of Dr Nichols in her report that in the absence of any prior radiographic review, *"The Registrant would therefore not have known if he was placing the bridge over teeth that were chronically infected with failing root canal treatments for example."*

Having considered all the evidence, the Committee was satisfied on the balance of probabilities, that Mr Rylko did not carry out sufficient diagnostic assessment of Patient I, as alleged in Schedule B to the charge.

**Patient J**

Schedule B refers to Patient J's appointments with Mr Rylko on a number of occasions, namely on or before June 2018 in respect of a bridge, on or before 16 February 2017 in respect of a crown, and on or before 19 July 2019 in respect of a bridge.

The Committee noted that in relation to each occasion, Dr Nichols was critical of the absence of any pre-operative or periapical radiographs. It accepted her opinion that such radiographs would have been necessary in all the circumstances of Patient J's treatment. The Committee found no indication in the clinical records that radiographs, as referred to by Dr Nichols, had been taken, and it was not provided with any radiographs. The Committee was satisfied on the balance of probabilities that Mr Rylko did not take the radiographs, and accordingly, he did not carry out sufficient diagnostic assessment of Patient J, as alleged in Schedule B to the charge.

**Patient K**

Schedule B refers to Patient K's appointment with Mr Rylko on 3 June 2019. The clinical records for this date indicate that there was a preparation for a 3 unit bridge on the lower right. Dr Nichols stated in her report that *"the exact teeth are not recorded but it appears that the LR3,4 were to support a pontic at LR5".*

The Committee accepted the opinion of Dr Nichols that there was a duty on Mr Rylko to undertake adequate pre-operative assessment of the LR3,4, which should have included vitality testing and radiographic review. The Committee found no indication in the clinical notes for 3 June 2019 that vitality testing was carried out by Mr Rylko, nor was there any evidence of

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| | radiographs having been taken.<br><br>In all the circumstances, the Committee was satisfied on the balance of probabilities, that Mr Rylko did not carry out sufficient diagnostic assessment of Patient K, as alleged in Schedule B of the charge. |
| 3. | *You failed to maintain adequate records as set out in Schedule C.*<br><br>**Found proved.**<br><br>**The Committee found proved that there was a failure to maintain adequate records for all the patients referred to in Schedule C.**<br><br>**Patient A**<br><br>The relevant appointment dates for Patient A as set out in Schedule C are 5 February 2018 and 12 February 2018.<br><br>In relation to 5 February 2018, the Committee noted from the contemporaneous clinical records for Patient A the presence of a medical history form which indicates that the patient attended an appointment with Mr Rylko on this date. Given the presence of the medical history form, the Committee was satisfied on the balance of probabilities that there was an appointment with Patient A on 5 February 2018. However, it found no notes for this date in the patient's contemporaneous clinical records.<br><br>In relation to Patient A's appointment on 12 February 2018, the Committee took into account the evidence of Dr Nichols, who highlighted that three periapical radiographs were taken on this date, but there is no record of Mr Rylko having reported on the radiographs. The Committee was satisfied on the basis of Dr Nichols' evidence that Mr Rylko should have reported on the radiographs in accordance with the Ionising Radiation Medical Exposure Regulations 2000 ('the IRMER 2000 Regulations'). It considered the contemporaneous clinical records for Patient A and found no record of a report by Mr Rylko.<br><br>In all the circumstances, the Committee was satisfied that Mr Rylko failed to maintain adequate records for Patient A in respect of the appointments on 5 February 2018 and 12 February 2018.<br><br>**Patient B**<br><br>It is alleged in Schedule C that between 30 January 2018 and 22 October 2018, Mr Rylko did not write any or any sufficient notes in relation to the crowns fitted to Patient B's UR2 and UL2. The Committee noted that the basis for this allegation was the evidence of Witness 1, who stated in an email to the GDC in July 2019 that Patient B's crowns at UR2 and UL2 *"came off several times"*. Witness 1 stated that *"According to the notes they came off twice each, but Michael R. has not recorded every time, because they came off many more times, and the patient started to be quite annoyed about it."*<br><br>The Committee accepted Witness 1's unchallenged evidence about the crown coming off several times. It had regard to the contemporaneous clinical records, and noted that in accordance with Witness 1's account, Mr |

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| | Rylko only noted four occasions when the crowns were lost. Accordingly, the Committee was satisfied that his notes in relation to the crowns at the patients UR2 and UL2 were not sufficient in all the circumstances.<br><br>**Patient K**<br><br>It is alleged in Schedule C that between 15 May 2018 and 12 July 2019, Mr Rylko did not maintain adequate records in respect of Patient K, as it is difficult to ascertain which teeth were treated on specific dates.<br><br>The Committee had regard to the clinical records for Patient K. It saw that the patient received treatment on several occasions over the relevant period. However, it found no mention in the notes of which of the patient's teeth were being treated at the material appointments. The Committee also took account of the evidence of Dr Nichols that *"the exact teeth are not recorded".*<br><br>Having considered the evidence, the Committee was satisfied that Mr Rylko did not maintain adequate records for Patient K, as alleged in Schedule C. |
| 4. | *You failed to undertake sufficient treatment planning and/or investigation as set out in Schedule D.*<br><br>**Found proved.**<br><br>**The Committee found proved that there was a failure to undertake treatment planning and/or investigation for all the patients referred to in Schedule D.**<br><br>**Patient A**<br><br>The allegations relating to Patient A in Schedule D include that Mr Rylko did not record a BPE for Patient A on 5 February 2018, and that he did not take radiographs on this date. The Committee found at head of charge 3 above, that Mr Rylko did not record any clinical notes for Patient A in respect of the appointment that took place on 5 February 2018.<br><br>In the absence of any information to indicate that a BPE was carried out in respect of Patient A on 5 February 2018, the Committee was satisfied that Mr Rylko did not undertake one. In finding that he had a duty to carry out a BPE, the Committee accepted the evidence of Dr Nichols, who assumed on the basis of the information available, that 5 February 2018 was an examination appointment. Dr Nichols referred in her report to the guidelines on 'Clinical Examination and Record Keeping: Faculty of General Dental Practitioners (May 2016)'. The Committee noted that the taking of a BPE during a full examination was a basic requirement.<br><br>The Committee also noted and accepted Dr Nichols' opinion that Mr Rylko should have taken a periapical radiograph of Patient A, either at the examination appointment on 5 February 2018 or at the subsequent appointment on 14 February 2018, when crown preparation was undertaken on the patient's UL5. In the absence of any clinical records for 5 February 2018, the Committee was satisfied on the balance of |

probabilities that Mr Rylko did not take a radiograph on this date.

The Committee was satisfied on the evidence that Mr Rylko failed to undertake the treatment planning and/or investigation in respect of Patient A on 5 February 2018.

The Committee reached the same conclusion in respect of the crown treatment provided to Patient A between 5 February 2018 and 7 March 2018, which is also alleged in Schedule D. The Committee accepted the evidence of Dr Nichols that as part of the treatment planning and investigation process, it would have been important for Mr Rylko "*to check the vitality of the UL5 and take a periapical radiograph to ensure the periapical health of the tooth".* The Committee found no evidence in the contemporaneous clinical records for Patient A to suggest that Mr Rylko undertook either of these actions.

In all the circumstances, the Committee found all the matters relating to Patient A in Schedule D proved.

**Patient C**

The allegation in Schedule D in relation to Patient C is that, on or before 8 April 2019, Mr Rylko did not provide a treatment plan in respect of a bridge. The Committee noted the evidence that Patient C first saw Mr Rylko on 8 April 2019, when a number of the patient's teeth were extracted. A plan was also noted for the patient to return for a 9-unit bridge. At the time the patient wore dentures.

The Committee had regard to Patient C's witness statement in which the patient stated, *"At my first appointment with Mr Rylko, he looked over the two dentures and told me that he did not think that a lower denture was a good idea. He said that he would have made a bridge for my bottom teeth rather than a denture."* Patient C further stated, *"…I do not think that Mr Rylko gave me any documents and I did not sign any documents. I have reviewed my dental records…and note that there is a document titled 'Treatment Plan and Estimate'. I can confirm that I have never seen this document before".*

The Committee took into account the evidence of Dr Nichols, who highlighted in her report Patient C's evidence about not having seen the 'Treatment Plan and Estimate' document. Dr Nichols stated that, if Patient C's account was found by the Committee to be accurate, there would have been a breach on Mr Rylko's part of Standard 2.3.6 of the GDC Standards, which states that, *"You must give patients a written treatment plan, or plan, before their treatment starts and you should retain a copy in their notes. You should also ask patients to sign the treatment plan."*

The Committee accepted Patient C's evidence and accordingly was satisfied that there had been a failure by Mr Rylko in relation to treatment planning, in that he failed in his obligation to provide the patient with a treatment plan in respect of their bridge treatment. In finding this matter proved, the Committee noted that the document to which Patient C referred, namely the 'Treatment Plan and Estimate', is a document that

appears in the altered clinical notes provided to the GDC by Mr Rylko. The document is not included in the contemporaneous clinical records provided by Witness 1. The Committee also noted that the document in question is unsigned.

**Patient E**

It is alleged in Schedule D that on 22 November 2018, Mr Rylko did not carry out adequate orthodontic assessment of Patient E.

The Committee noted the evidence that at the appointment on 22 November 2018, photographs were taken of Patient E as part of treatment planning for Invisalign Treatment. The Committee heard from Dr Nichols in evidence that Invisalign Treatment involves the provision of clear, removable orthodontic aligners, which are used to straighten the teeth. She told the Committee that the clear aligners are provided to the patient at various stages over the course of the treatment. Dr Nichols stated that Invisalign Treatment is an elective procedure and that it is not available on the NHS. She told the Committee that she is a provider of Invisalign Treatment herself.

Specifically in relation to the treatment of Patient E, Dr Nichols noted from the information included in the clinical records, that the patient had a history of *"unstable periodontal disease"*, and that there was no indication that the periodontal disease had been treated or stabilised prior to the Invisalign Treatment provided by Mr Rylko. Dr Nichol's opinion was that it was *"unacceptable"* to carry out Invisalign Treatment in the presence of unstable periodontal disease. She told the Committee that orthodontic forces on unstable teeth further increased the risk of tooth loss. Dr Nichols stated in her report that, *"In addition there is no evidence of an orthodontic assessment which would include facial profile details, overbite and overjet measurement, incisor relationship, molar relationship, rotations, degree of spacing or crowding, discussion of treatment aims and objectives, discussions of treatment options including the option of fixed braces and specialist treatment. In this case it would also have been necessary to have taken radiographs of any teeth affected by periodontal bone loss".*

The Committee accepted the evidence of Dr Nichols and was satisfied that there was a duty on Mr Rylko to carry out an orthodontic assessment, as she outlined, prior to the provision of the Invisalign Treatment. The Committee had regard to the clinical records for Patient E on 22 November 2018, and found no evidence of such an assessment. It was therefore satisfied that Mr Rylko failed to undertake treatment planning and/or investigation for Patient E.

**Patient F**

It is alleged in Schedule D that between 16 October 2017 and 7 November 2017, Mr Rylko undertook treatment planning with regard to a five-unit-bridge, but that he did not consider the suitability of the bridge based upon the weakest tooth. Patient F was the patient with which Mr Rylko had discussed a *"dental makeover".* The proposed treatment was for a bridge at UR3, UR4, UR5, UR6, and UR7, and crowns at UR1 and UR2, and UL1,

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| | UL2 and UL3.<br><br>The evidence before the Committee suggests that the weakest tooth, as far as the five-unit bridge was concerned, was the patient's UR4. The Committee noted the references made by Dr Nichols in her report to information about this tooth in the clinical notes, which indicated that the UR4 had been previously root treated and crowned. Dr Nichols highlighted that it was noted by Mr Rylko at an appointment on 29 September 2017, that the tooth was chipped, and that Mr Rylko prepared the tooth for a new crown. The clinical records for 7 November 2017 indicate that Mr Rylko had prepared the five teeth, including the UR4, for the 5-unit bridge and that five teeth were prepared for crowns. On 11 December 2017, the bridge and crowns were cemented by Mr Rylko.<br><br>The Committee was satisfied that Mr Rylko had a duty to consider the suitability of the five-unit bridge in light of the issues with Patient F's UR4. It noted the evidence of Dr Nichols that given the questionable prognosis of the UR4, there was a likelihood of rapid loss of such a large bridge. Indeed, the Committee noted that the bridge was subsequently lost with the core of the UR4 retained in it. Dr Nichols noted in her report that, some 10 months later on 31 October 2018, Patient F attended Practice 1 because the five-unit bridge placed by Mr Rylko had come out. Patient F was seen by Witness 3 on that occasion. Dr Nichols highlighted from the clinical records that *"The core of the UR4 was inside the bridge and [Witness 3] suggested a new bridge may be required…".*<br><br>The Committee had regard to Mr Rylko's clinical records for Patient F between 16 October 2017 and 7 November 2017, which is the period over which he had planned the proposed bridgework. The Committee found no evidence to indicate that he had given consideration to the suitability of the bridge based upon UR4, which was the weakest tooth.<br><br>In the absence of any records to indicate that Mr Rylko fulfilled this duty to consider this matter, the Committee was satisfied that there was a failure on his part to undertake treatment planning and/or investigation in respect of Patient F's bridge. |
| 5. | *You failed to provide an adequate standard of care and/or treatment as set out in Schedule E.*<br><br>**Found proved.**<br><br>**The Committee found proved that there was a failure to provide an adequate standard of care and/or treatment for all the patients referred to in Schedule E.**<br><br>**<u>Patient A</u>**<br><br>It is alleged in Schedule E that Mr Rylko did not discuss with Patient A on 19 March 2019 the risks associated with the proposed bridge treatment.<br><br>The contemporaneous clinical records indicate that Patient A was taking alendronic acid for osteoporosis. Dr Nichols' evidence was that alendronic acid slows bone turnover. She stated in her report that *"Patients taking this* |

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| | *drugs are at risk of necrosis of the jaw bone following tooth extraction. Preparing the teeth for a bridge would have increased the risk of future tooth loss and the subsequent risk of jaw necrosis".*<br><br>On the basis of Dr Nichols' opinion, the Committee was satisfied that Mr Rylko should have discussed the associated risks of the bridge treatment on 19 March 2019, prior to preparing the bridge on this date. The Committee had regard to the contemporaneous clinical records for Patient A and found no reference in the notes to there having been a discussion with Patient A about the relevant risks, as outlined in Schedule E of the charge, namely hypersensitivity, pulpal necrosis, root canal treatment, temporary bridge discomfort, necrosis of the jaw as a consequence of taking alendronic acid.<br><br>The Committee also had regard to the evidence of Witness 1, who stated in her witness statement that it was at an appointment on 12 February 2019 that Patient A mentioned that she took Alendronic Acid for osteoporosis. Witness 1 stated that "*I was aware that she could not have any extractions when taking this medication or even a long time after finishing taking this medication. I discussed this with her in front of Mr Rylko to make him think twice about whether a 11-unit bridge was an appropriate treatment for this patient. Despite this though, Mr Rylko did not say anything; he just wrote 'osteoporosis' near her name in her notes."* The Committee saw this reference in the contemporaneous clinical notes.<br><br>It is also alleged in respect of Patient A in Schedule E that on 25 April 2019, Mr Rylko cemented a permanent bridge, when the patient was unsure whether she was happy with the shape of the temporary bridge. The Committee saw that Mr Rylko recorded in the contemporaneous clinical records *"pat unsure cemented"*. The Committee considered it clear from this evidence that Patient A had been unsure, but that Mr Rylko had cemented the bridge anyway.<br><br>Having considered all the evidence, the Committee was satisfied on the balance of probabilities that Mr Rylko failed to provide an adequate standard of care and/or treatment to Patient A, as alleged in Schedule E.<br><br>**Patient B**<br><br>It is alleged in Schedule E that between 18 January 2018 and 19 February 2018, with respect to the provision of Invisalign Treatment, Mr Rylko did not communicate the Orthopantomogram ('OPG') findings to the Patient B, and that he did not report on the OPG in accordance with the IRMER 2000 Regulations.<br><br>The Committee took into account the evidence of Dr Nichols, who noted that there are findings in relation to the OPG recorded in the clinical records provided by Mr Rylko in respect of Patient B. These included findings of moderate to severe bone loss, decay at UR5, UR7, and a retained root at LR8. Dr Nichols noted that the conclusion from these findings was that the Patient B was not suitable for Invisalign Treatment. Dr Nichols' opinion was that it would have been a failure on Mr Rylko's part if these findings were |

not discussed with Patient B.

However, having disregarded the clinical records provided by Mr Rylko in respect of Patient B, because of the extensive alterations, the Committee relied only the contemporaneous clinical records for Patient B, as provided by Witness 1. The Committee found that there was no report on OPG. The findings included in Mr Rylko's altered version of the notes were not recorded in the contemporaneous clinical records. In the absence of such records, the Committee was satisfied that Mr Rylko did not report on the OPG. It was also satisfied on the balance of probabilities that Mr Rylko failed to communicate any findings in relation to the OPG to Patient B.

The Committee also found proved that on 19 February 2018, Mr Rylko provided Patient B with crowns at UL2 and UR2, which was not the optimal clinical choice. The Committee accepted the evidence of Dr Nichols, who stated in her report that "*The OPG shows that the UL2 and UR2 appeared unrestored with some possible mesial decay in UL2. There is spacing around these teeth and other teeth. This is not a functional problem which requires treatment but could be treated if it was a cosmetic problem for the patient. In my opinion this could have been treated with composite bonding without any tooth preparation, or with porcelain veneers with minimal tooth preparation. The heavy preparations required to crown these teeth was not an optimal clinical choice".*

Having considered all the evidence, the Committee was satisfied on the balance of probabilities that Mr Rylko failed to provide an adequate standard of care and/or treatment to Patient B, as alleged in Schedule E.

**Patient C**

The allegation in relation to Patient C in Schedule E relates to the nine-unit bridge proposed for the patient at the appointment on 8 April 2019.

The Committee found proved all of the criticisms listed in Schedule E regarding the bridge treatment. In reaching its findings, the Committee accepted the evidence of Dr Nichols, who covers all of the alleged matters in her report stating that, *"In my opinion, there was no clinical justification to include the LR4, LL4, LL5 in the bridge design as a canine to canine bridge from LR3 to LL3 is a common successful bridge design. The inclusion of the sound LR4 and LL4 was unnecessarily destructive. The LL5 which was a retained root had a questionable long term prognosis and therefore should not have been included in the bridge. The linking together of crowns as part of the bridge would have led difficulty with oral hygiene and increased risk of decay in the roots between the teeth. This bridge design was not necessary and posed avoidable risks of further decay, periodontal disease and tooth loss".*

The Committee was satisfied on the basis of the expert evidence that Mr Rylko failed to provide an adequate standard of care and/or treatment to Patient C, as alleged in Schedule E.

**Patient D**

It is alleged in schedule E that Mr Rylko did not inform Patient D, prior to 30 January 2019, that by opening the bite with the upper bridge, further expensive treatment would be required on the lower teeth in order to provide a satisfactory bite.

The Committee noted from the clinical records that 30 January 2019 was the date on which the upper bridge was fitted. The Committee was satisfied on the evidence of Dr Nichols that Patient E should have been informed about the need for further treatment on the lower teeth before 30 January 2019.

It appeared to the Committee, from its reading of the clinical records, that the first time Patient D was informed that extra work would need to be done on the lower teeth was at the appointment on 30 January 2019, after Mr Rylko had already fitted the upper bridge. The notes indicate that "*Pat was told we need a bridge on his LR as teeth descluding there".* Dr Nichols explained in her report that this meant that the patient's teeth were *"kept apart on biting".*

In all the circumstances, the Committee was satisfied that Mr Rylko failed to provide an adequate standard of care and/or treatment to Patient D, as alleged in Schedule E.

**Patient E**

It is alleged in Schedule E that on or after 12 January 2019, Mr Rylko undertook orthodontic treatment on Patient E, namely Invisalign Treatment, which was inappropriate when unstable periodontal disease was present.

Dr Nichols noted from the information included in the clinical records, that Patient E had a history of *"unstable periodontal disease"*, and that there was no indication that the periodontal disease had been treated or stabilised prior to the Invisalign Treatment provided by Mr Rylko.

The Committee had regard to the clinical records for Patient E and noted the references to the patient having periodontal disease. In particular, it saw that in relation to an appointment on 24 December 2018, Witness 3 saw Patient E on an emergency appointment and noted in the records *"severe periodontitis".* It was then less than a month later on 12 January 2019 that the Invisalign Treatment was started.

In finding that Mr Rylko failed to provide an adequate standard of care and/or treatment to Patient E, as alleged in Schedule E, the Committee accepted Dr Nichol's opinion that it was *"unacceptable"* to carry out Invisalign Treatment in the presence of unstable periodontal disease, as orthodontic forces on unstable teeth would further increase the risk of tooth loss.

**Patient F**

In relation to Patient F, the allegations in Schedule E concern appointments that the patient attended with Mr Rylko on 12 December 2015, 27 April 2017, and 16 September 2018. In finding the alleged matters in respect of

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| | these three appointments proved, the Committee noted that the allegations were supported by the expert evidence of Dr Nichols, which it accepted, as well as Mr Rylko's own clinical records of what occurred at the appointments.<br><br>The Committee noted that, with regard to the appointment on 12 December 2015, Dr Nichols highlighted that Mr Rylko took a radiograph of Patient F's UR5 and carried out crown preparation on that tooth. Dr Nichols noted that a later radiograph showed a *"grossly poor angulation of the root post causing a root perforation such that the tooth required extraction".* The Committee noted that, in the clinical records for a subsequent appointment on 16 January 2016, Mr Rylko noted that *"UR5 crown came out yesterday along with the post/core build up!"* Mr Rylko further noted that *"After reassessing everything I've come to the conclusion that the root was very short and narrow…so that the screw I've used was not sufficiently bend [sic] – and ultimately came out".* Further, Mr Rylko noted taking a periapical radiograph at a further appointment on 20 January 2016, from which he noted that the post had not been placed *"in a parallel way"*. Mr Rylko noted that the UR5 was extracted.<br><br>In relation to the appointment on 27 April 2017, the Committee noted from Mr Rylko's clinical records for Patient F that he noted the UL6 was *"severely compromised"* and that *"we cannot do anything, T/C [treatment complete]".* The Committee took into account the evidence of Dr Nichols that to inform the patient that nothing could be done for the tender tooth with severe bone loss was inappropriate. It was her opinion that the appropriate treatment to prevent further pain and infection was to extract the tooth.<br><br>Dr Nichols noted that at the appointment on 16 September 2018, Mr Rylko continued re-root canal treatment at UL6 (mis-noted in the clinical records as UL7). Dr Nichols stated that "*The root canal filling could not be removed from two of the canals so only the palatal canal was treated. A post was placed in the palatal canal. A crown preparation was planned….*The Committee had regard to the clinical records made by Mr Rylko in relation to the appointment on 16 September 2018, in which he noted *"No proper root treatment was performed as apical old root filling is still there".* The Committee took into account and accepted the opinion of Dr Nichols that "…*Without removing all the old root canal filling material, and disinfecting the root canal system, the re-root canal treatment was likely to fail and to lead to further infection. In addition, the limited remaining tooth structure as shown below means that the prognosis for the crown is extremely poor."*<br><br>Having considered all the evidence, the Committee was satisfied on the balance of probabilities that Mr Rylko failed to provide an adequate standard of care and/or treatment to Patient F at the three appointments in question.<br><br>**Patient G**<br><br>It is alleged in Schedule E that between 13 March 2018 and 17 July 2020, Mr Rylko failed to provide Patient G crowns of an adequate standard in that |

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| | they frequently debonded.<br><br>This allegation relates to 11 crowns that Mr Rylko provided to Patient G. The Committee noted from the clinical records that the crowns were fitted on 13 March 2018, and that in the notes Mr Rylko had recorded that the top central incisors were cemented *"in a bit distorted way"* but that the patient was shown this, and the occlusion was immediately adjusted. The Committee saw from subsequent notes made in respect of Patient F that it was indicated on various dates that crowns had come off. Accordingly, the Committee was satisfied that what is alleged in Schedule E is what happened in Patient F's case.<br><br>The Committee noted and accepted the evidence of Dr Nichols that *"The frequent debonding of the crowns suggests that this treatment was performed far below the expected standard".* It was therefore satisfied on the balance of probabilities that Mr Rylko failed to provide an adequate standard of care and/or treatment to Patient G in respect of the crowns.<br><br>**Patient I**<br><br>Schedule E alleges in respect of Patient I that, on 1 March 2018, Mr Rylko inappropriately fitted a large bridge, at Patient I's UR4 to UL4, on heavily restored anterior teeth with reduced bone support.<br><br>The expert stated in her report that she considered it clear from the evidence, including radiographic evidence, that *"this patient had already suffered significant periodontal disease and bone loss."* The committee accepted that this was the case.<br><br>In addition, the committee noted evidence from Witness 4 who treated Patient I on 8 October 2020 which stated: Patient I had had an 8-unit upper bridge from UR4 to UL4 fitted by Mr Rylko even though the patient had *"progressed periodontitis"* Witness 4 stated that he knew this because when he saw the patient in October 2020, she had progressed gum disease and she had never had a periodontal assessment.<br><br>Although the Committee was unable to find specific evidence that the anterior teeth were heavily restored, having considered all the evidence, the committee was satisfied that on the balance of probabilities Mr Rylko had failed to provide an adequate standard of care/treatment to Patient I as alleged in Schedule E.<br><br>**Patient J**<br><br>The matters set out in Schedule E in relation to Patient J concern an appointment that the patient attended with Mr Rylko on 26 June 2018. In particular, it is alleged that Mr Rylko failed to extract the root for Patient J's UR3, instead recording a 'semi-extraction', which is a clinically unknown procedure. It is further alleged that Mr Rylko placed a bridge at Patient J's UR1, UR2, UR3 and UR4 when there was not enough tooth structure at UR4 to support the bridge.<br><br>In finding this matter proved, the Committee had regard to the relevant clinical records, in which Mr Rylko noted *"UR3 semi extraction Temporary* |

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| | *bridge construction".* The Committee accepted the opinion of Dr Nichols that *"there is no such procedure as semi-extraction".* It was Dr Nichol's assessment that "*it appears that the Registrant was unable to extract the tooth himself and rather than refer to an oral surgeon to complete the extraction he just left the root in place as can be seen on the x-ray taken…"*<br><br>The Committee also took into account Dr Nichols' evidence regarding Patient J's bridge treatment. She noted from radiographic evidence, including a periapical radiograph taken of the UR3 on 22 June 2018, shortly before the bridge treatment was commenced, that some of the teeth involved were chronically infected or unsuitable to support a bridge. In particular, Dr Nichols noted that UR4 did not have enough remaining structure to support a bridge.<br><br>Having considered all the evidence, the Committee was satisfied on the balance of probabilities that Mr Rylko failed to provide an adequate standard of care and/or treatment to Patient J on 26 June 2018.<br><br>**Patient K**<br><br>In relation to Patient K, the allegations in Schedule E concern appointments that the patient attended with Mr Rylko on 12 July 2019 and 30 September 2019.<br><br>The appointment on 12 July 2019 involved the fitting of a lower bridge for Patient K. The Committee noted and accepted the evidence of Dr Nichols that *"later radiographs show that this bridge was mechanically unsound with a distal cantilever pontic biting against an over-erupted upper tooth. This would have caused unfavourable loading on the LR4".* Copies of the radiographs in question were before the Committee.<br><br>With regard to Patient K's appointment on 30 September 2019, Dr Nichols noted that root canal treatment to the LR4 was undertaken. She highlighted that *"a final radiograph was taken and the root canal filling noted to be 3mm short."* The Committee accepted Dr Nichols' opinion that the root canal filling was *"grossly short"* and represented a failing far below the expected standard.<br><br>Having considered all the evidence, the Committee was satisfied on the balance of probabilities that Mr Rylko failed to provide an adequate standard of care and/or treatment to Patient K, as alleged in Schedule E. |
| 6. | *You failed to assess, treat and/or monitor patients as set out in Schedule F*<br><br>**Found proved in relation to all the patients referred to in Schedule F.**<br><br>**Patient E**<br><br>The Committee found proved both the allegations in Schedule F relating to Patient E. In particular that, between 19 February 2018 and 4 December 2019, Mr Rylko failed to assess, treat and/or monitor the patient's periodontal disease. Also that between 8 November 2018 and<br><br>2 April 2020, Mr Rylko failed to assess and monitor Patient E's orthodontic treatment. |

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| | The Committee noted the evidence from the clinical notes that Patient E had a history of untreated periodontal disease. In respect of the appointment that the patient had with Mr Rylko on 19 February 2018, Dr Nichols stated in her report that *"A diagnosis of periodontal disease was made and advice given to the patient. However, there was a failure to carry out detailed 6 point periodontal charting in line with BPE Guidelines, a failure to radiographically assess the upper anterior teeth which had a BPE score of 4 indicating advanced periodontal disease, and a failure to plan root surface debridement under local anaesthetic".*<br><br>The Committee accepted the evidence of Dr Nichols in terms of the type of assessment and treatment that was required to address Patient E's periodontal disease. The Committee had regard to the clinical records for Patient E over the period in question, and noted that various issues were recorded regarding the patient's periodontal disease, but it found no indication of any assessment or planned treatment to address Patient E's periodontal problems, or any evidence of monitoring. The Committee noted that Mr Rylko planned Invisalign Treatment for this patient, which Dr Nichols stated was unacceptable in the presence of unstable periodontal disease because of the increased risk of tooth loss.<br><br>In relation to Patient E's orthodontic treatment, namely the Invisalign Treatment, the Committee found proved at head of 4 above that Mr Rylko did not carry out any assessment in relation to the treatment. In relation to monitoring the Invisalign Treatment, the Committee accepted Dr Nichols' opinion that *"Orthodontic treatment should be closely monitored. Invisalign patients are typically reviewed every 4-8 weeks".* Dr Nichols highlighted to the Committee that contrary to this, Patient E was given all the Invisalign aligners for the treatment, and was asked to return in several months. The Committee was satisfied on the basis of the evidence that Mr Rylko failed to assess and monitor Patient E's orthodontic treatment.<br><br>**Patient G**<br><br>It is alleged in Schedule F that on 12 February 2018, Mr Rylko failed to assess, treat and/or monitor Patient G's periodontal health.<br><br>As previously noted, Patient G's appointment on 12 February 2018 is in the clinical records under the heading *"Huge Treatment Day".* At this appointment, 11 of the patient's teeth were prepared for crowns. The Committee had regard to the clinical records for Patient G, and it found no evidence of any assessment of the patient's periodontal health either before 12 February 2018 or in relation to that appointment.<br><br>The Committee noted the comment made by Dr Nichols in relation to 12 February 2018 in relation to the absence of any record regarding Patient G's periodontal health. Dr Nichols considered that such a record should have formed part of an adequate pre-operative assessment. The Committee also had regard to the general concerns raised by Witness 3 in his witness statement about the large scale treatment that Mr Rylko provided to patients. Witness 3 raised concerns about Mr Rylko's planning, including the lack of periodontal analysis. |

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| | In all the circumstances, having considered the evidence, the Committee was satisfied on the balance of probabilities that Mr Rylko did not assess, treat, or monitor Patient G's periodontal health on 12 February 2018, and that this was a failure on his part.<br><br>**Patient I**<br><br>It is alleged in Schedule F that on 24 November 2019, Mr Rylko failed to assess, treat and/or monitor Patient I's periodontal disease.<br><br>The Committee had regard to the witness statement of Witness 4, another dentist who worked at Practice 1, who subsequently treated Patient I. It was his evidence that he saw Patient I on 8 October 2020. Witness 4 stated in his witness statement that on 26 April 2018, Patient I had had an 8-unit upper bridge from UR4 to UL4 fitted by Mr Rylko, even though the patient had *"progressed periodontitis".* Witness 4 stated that he knew this because when he saw the patient in October 2020, she had progressed gum disease, and she had never had a periodontal assessment. It was Witness 4's evidence that Mr Rylko had fitted the 8-unit upper bridge without carrying out a periodontal assessment.<br><br>The Committee accepted Witness 4's evidence, and was satisfied that it was more likely than not that Patient I had periodontal disease at the time Mr Rylko saw her on 24 November 2019. In addition to the evidence of Witness 4, the Committee noted Dr Nichols' evidence that Mr Rylko's clinical records for 24 November 2019 indicated *"lower bleeding on probing, furcation involvement, 4-6mm periodontal pocketing, 3mm of alveolar bone loss, 6+ teeth lost, high periodontal risk…".* The Committee considered that this recorded information showed that there was a periodontal issue. However, having had regard to the clinical notes itself, the Committee could not find any evidence to indicate that the patient was informed or that anything was done in relation to the periodontal disease that was evident.<br><br>In all the circumstances, the Committee was satisfied that Mr Rylko failed to assess, treat and/or monitor Patient I's periodontal disease, as alleged in Schedule F. |
| 7. | *You failed to obtain patients' fully informed consent in that you did not discuss the risks, benefits and/or alternative treatments as set out in Schedule G.*<br><br>**Found proved in relation to all the patients referred to in Schedule G.**<br><br>**Patient A**<br><br>Schedule G refers to a number of appointments attended by Patient A on and between various dates. The treatment provided to the patient at the material times was the provision of a denture, the provision of a crown at UL5, and the provision of a bridge. It is alleged that Mr Rylko did not discuss with Patient A the risks and benefits and/alternative treatment options in respect of the treatments.<br><br>The Committee had regard to the contemporaneous clinical records in |

relation to the periods of time concerned. It found no notes to suggest that Mr Rylko did discuss the risks and benefits and/alternative treatment options with Patient A in relation to the relevant treatment. In relation to the provision of the bridge in particular, the Committee had regard to its finding at head of charge 5 above, that Mr Rylko's failed to discuss with Patient A the specific risks associated with taking Alendronic Acid.

In the absence of any records to indicate any discussions, the Committee was satisfied on the balance of probabilities that Mr Rylko did not have the necessary discussions with Patient A. The Committee accepted the evidence of Dr Nichols that a failure to have such discussions is a breach of the GDC Standards. In particular, Standard 2.2.2.1 which states *"… Before treatment starts you must: explain the options (including those of delaying treatment or doing nothing) with the risks and benefits of each…".* Dr Nichols also refers to Standard 3.1 which states, *"Obtain valid consent before starting treatment, explaining all the relevant options and the possible costs".* The Committee was satisfied on the evidence that Mr Rylko failed in his obligation to obtain informed consent from Patient A in relation to the treatments in question.

**Patient C**

The allegation in relation to Patient C, as set out in Schedule G, is that on 8 April 2019, Mr Rylko failed to discuss with the patient the risks and/or benefits and/or alternative treatment options in respect of the provision of a bridge.

The Committee had regard to the contemporaneous clinical records in for the appointment on 8 April 2019. It found no notes to suggest that Mr Rylko did discuss the risks and/or benefits and/or alternative treatment options with Patient C. The Committee also had regard to the witness statement of the patient, in which it is stated *"I have been asked by the GDC whether Mr Rylko discussed any alternatives to a lower bridge. I can confirm that he did not discuss any alternatives; he only suggested a bridge. I have been asked by the GDC whether Mr Rylko mentioned the risks or benefits of having a lower bridge and I can confirm that he did not mention any risks or benefits."*

Having taken all the evidence into account, including the observation of Dr Nichols that "*There is no evidence from the records that the risks,*

*benefits and alternatives were properly discussed*", the Committee was satisfied that Mr Rylko failed to obtain Patient C's fully informed consent for the bridge treatment.

**Patient D**

Schedule G refers to appointments attended by Patient D between various dates. The treatment provided to the patient at the material times was the provision of an upper plate, and the provision of an upper bridge. It is alleged that Mr Rylko did not discuss with Patient D the risks and/or benefits and/or alternative treatment options in respect of the treatment in question.

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| | The Committee had regard to the witness statement of Patient D in which it is stated that *"I have been asked by the GDC whether Mr Rylko mentioned any alternatives to having the plate. I can confirm that he did not discuss any alternatives. I have been asked by the GDC whether Mr Rylko discussed the risks and benefits of the plate. I can confirm that Mr Rylko did not discuss the risks and benefits of the plate.* The Committee noted that Patient D stated the same in relation to any discussion regarding the risks, benefits, and alternative treatment options in respect of the bridge. The patient confirmed that none of these matters were discussed with Mr Rylko in relation to the proposed bridge.<br><br>In addition to the evidence of Patient D, the Committee had regard to the contemporaneous clinical records for the patient. If found no notes to suggest that there had been any discussion in relation to the risks, benefits and alternative treatment options in relation to the plate or bridge. Whilst the Committee took into account that Dr Nichols identified the presence of a consent form in relation to the bridge treatment, the Committee noted that the form only appears in those clinical records provided by Mr Rylko. The form does not appear in the contemporaneous clinical records provided by Witness 1.<br><br>Having taken all of the evidence into account, the Committee was satisfied on the balance of probabilities that Mr Rylko failed to obtain Patient D's fully informed consent for the plate and bridge treatment.<br><br>**Patient E**<br><br>The allegation in relation to Patient E, as set out in Schedule G, is that on 22 November 2018, Mr Rylko failed to discuss with the patient the risks and/or benefits and/or alternative treatment options in relation to the provision of orthodontic treatment. There is also an alternative allegation that Mr Rylko failed to assess and/or diagnose periodontal disease.<br><br>The Committee had regard to its previous findings that no assessment or treatment planning was undertaken by Mr Rylko prior to the provision of Patient E's Invisalign Treatment. The Committee accepted the opinion of Dr Nichols that Patient E was provided the orthodontic treatment in the presence of unstable periodontal disease. The Committee found no evidence in the clinical records to indicate that the matter of the periodontal disease was drawn to Patient E's attention, and it was satisfied on the balance of probabilities that Mr Rylko did not do so. The Committee was satisfied that Patient E was not privy to information about the consequences of having Invisalign Treatment with unstable periodontal disease, and therefore could not have made an informed decision about having the treatment.<br><br>The Committee found that it was more likely than not that Mr Rylko did not discuss with Patient E the risks, benefits and alternative treatment options in relation to the Invisalign Treatment. Whilst the Committee noted the presence of a signed consent form for Patient E, it was not satisfied that all in the circumstances, that fully informed consent was obtained.<br><br>Having reached this finding, the Committee did not consider the alternative |

allegation in respect of Patient E in Schedule G.

**Patient F**

It is alleged in Schedule G that on 16 October 2017, Mr Rylko did not discuss with Patient F the alternative treatment options including whitening and composite bonding, composite veneers, or porcelain veneers. The Committee accepted the opinion of Dr Nichols that these alternative treatment options should have been discussed with Patient F.

The evidence indicates that the only option offered by Mr Rylko was crowns "*to match a new A2 shade of your new bridges since we agreed to brighten all your teeth",* as part of Patient F's *"dental makeover".* The Committee noted the indication that a consent form was provided to Patient F by way of an attachment to a letter dated 16 October 2017. However, that consent form was in relation to proposed bridgework. The Committee found, as Dr Nichols noted, that there was no consent form in relation to the crowns and any alternatives to brighten the front teeth, such as whitening or veneers.

In all the circumstances, the Committee was satisfied on the balance of probabilities that Mr Rylko did not obtain fully informed consent from Patient F in relation to the use of crowns to brighten the teeth.

**Patient G**

Schedule G refers to the provision of posterior crowns in Patient G's case, specifically that between 24 November 2017 and 17 March 2020 Mr Rylko did not discuss the risks and/or benefits and/or alternative treatment options.

Patient G's treatment involved the provision of 11 crowns, and that Mr Rylko had noted in the clinical records on 12 February 2018 that it was a "*Huge Treatment Day"* for the patient. The Committee had regard to the opinion of Dr Nichols regarding the treatment, as set out in her report. She stated that, "*An open bite was created between the posterior teeth and it was only once the front crowns had been fitted that consideration was given to crowning the posterior teeth later. There is no evidence that the patient was consented for the need for posterior crowns at the outset.*

In accepting Dr Nichols' opinion, the Committee had regard to the consent form provided to the patient, as contained within the clinical records. It noted that the form only related to the provision of anterior crowns, with no mention of further posterior crowns being needed. The Committee also noted that the risks outlined on the form were generalised risks that did not appear to be specific to Patient G's crown treatment.

Having considered the evidence, the Committee was satisfied on the balance of probabilities that, in all the circumstances, Mr Rylko could not have obtained fully informed consent form Patient G in respect of the crown treatment provided.

**Patient I**

It is alleged in Schedule G that on 1 March 2018, in relation to the provision of a bridge, Mr Rylko did not discuss with Patient I the risks and/or benefits

and/or alternative treatment options.

The Committee had regard to the clinical records of Mr Rylko for 1 March 2018, which is when the preparation for Patient I's 8-unit bridge was undertaken. The Committee found the notes to be brief, with no reference to any discussion with the patient about risks, benefits, or alternative treatment options. The only references were to the treatment provided. In the absence of any records to suggest a discussion, the Committee was satisfied on the balance of probabilities that Mr Rylko did not discuss with Patient I the risks, benefits and alternative treatment options.

The Committee also noted the evidence of Witness 4, which it accepted, regarding his subsequent treatment of Patient I, and his observations that Mr Rylko had fitted the bridge without carrying out any periodontal assessment and without taking radiographs. In the circumstances, the Committee considered that Mr Rylko could not have discussed any risks of the treatment with the patient, as he did not have available all the clinical information about the patient's dental health.

The Committee accepted the evidence of Dr Nichols that *"There were breaches by way of proceeding with a large bridge with no discussion of the risks involved and explain all alternative options such that fully informed consent could not be obtained. The significant risk to discuss would have been the guarded prognosis of the planned bridge due to the poor restorative state and compromised bone support or the supporting teeth".*

The Committee was satisfied on the balance of probabilities that, in all the circumstances, Mr Rylko could not have obtained fully informed consent form Patient I in respect of the provision of the bridge.

**Patient J**

Schedule G refers to an appointment attended by Patient J with Mr Rylko on 26 June 2018. It is alleged that Mr Rylko did not discuss with Patient J the risks and/or benefits and/or alternative treatment options in the provision of a bridge at UR1, UR2, UR3 and UR4, and also in relation to the provision of a bridge at LR4, LR5, LR6 and LR7.

The Committee had regard to the clinical records for Patient J. Whilst it noted that there had been a discussion with the patient at a previous appointment, when an estimate for the bridge was given, the Committee found nothing in the records to indicate that Mr Rylko had discussed the risks, benefits and alternative treatment options with Patient J either before or on 26 June 2018, which is when the bridge treatment was commenced. The Committee also noted the absence of a consent form in the clinical records.

Having considered the clinical records, the Committee was satisfied on the balance of probabilities that Mr Rylko did not discuss the risks, benefits and alternative treatment options with Patient J. The Committee accepted the evidence of Dr Nichols that there was a "*failure to explain the risks, benefits and alternatives as this is a mandatory requirement in the GDC Standards."* The Committee was satisfied on the basis of all the evidence that Mr Rylko

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| | failed to obtain fully informed consent from Patient J in relation to the provision of the bridge treatment. |
| **Heads of charge 8 and 9:** | |
| 8. | *You did not act in your patients' best interests in respect of:* |
| 8(a). | *your decision to provide Patient E with Invisalign;*<br><br>**Found proved.**<br><br>The Committee accepted the evidence of Dr Nichols that the provision of Invisalign Treatment in the presence of Patient E's unstable periodontal disease was unacceptable. It also noted its finding at Schedule F that Mr Rylko failed to assess, treat, and monitor Patient E's periodontal condition.<br><br>In her oral evidence, in response to a question from the Committee as to whether Invisalign Treatment would ever have been appropriate treatment for Patient E, notwithstanding the periodontal disease, Dr Nichols stated that the provision of Invisalign Treatment was unusual in Patient E's circumstances. Dr Nichols stated that this was because Patient E had a partial denture, and therefore, in her opinion, Invisalign Treatment would have been significantly more complicated to provide.<br><br>The Committee noted however, that Dr Nichols did not suggest that it was inappropriate to provide Invisalign Treatment because of Patient E's partial denture. She was clear that her criticism was that the Invisalign Treatment provided to the patient was inappropriate because Mr Rylko went ahead with the orthodontic treatment without treating the patient's periodontal disease. The Committee noted Dr Nichols' opinion that orthodontic forces on unstable teeth further increased the risk of tooth loss. In view of this risk, the Committee was satisfied on the balance of probabilities that Mr Rylko's decision to provide Patient E with Invisalign Treatment was not in the patient's best interests. |
| 8(b). | *your decision not to suggest alternative treatments to Patient F;*<br><br>**Found proved.**<br><br>In reaching its decision on this head of charge, the Committee took into account a character reference, dated 12 December 2019, which was written by Patient F in respect of Mr Rylko. In that letter, the patient stated that they had been a patient of Mr Rylko for three years, and at that time, they were happy with the treatment he had provided, and they would recommend him as a dentist. Notwithstanding this positive reference from the patient, the Committee noted and accepted the clinical concerns raised by Dr Nichols in relation to the provision of a large 5-unit bridge to Patient F, and multiple crowns.<br><br>The clinical opinion of Dr Nichol was that, given the questionable prognosis of Patient F's UR4, there was a likelihood of rapid loss of such a large bridge. Indeed, the bridge was subsequently lost with the core of the UR4 retained in it. It was Dr Nichol's opinion, which the Committee accepted, that Mr Rylko should have considered the suitability of the 5-unit bridge in all the circumstances. The Committee found no evidence that he suggested |

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| | any alternatives to Patient F.<br><br>The Committee also noted that in addition to the bridge, Mr Rylko suggested and provided multiple crowns to the patient. It was stated by Mr Rylko in correspondence with Patient F that the crowns were *"to match a new A2 shade of your new bridges since we agreed to brighten all your teeth".* It was the evidence of Dr Nichols, which the Committee also accepted, that there were alternative treatment options for brightening the teeth including whitening and composite bonding, composite veneers, or porcelain veneers. The Committee had regard to the clinical records, and was satisfied that there was no indication that Mr Rylko had suggested these alternatives to Patient F.<br><br>Having considered all the evidence, the Committee was satisfied on the balance of probabilities that this head of charge is proved. It considered that Mr Rylko had not acted in the best interests of Patient F by providing the bridge and the crowns, without offering suitable alternative treatments. |
| 8(c). | *your decision to fit Patient G with eleven crowns;*<br><br>**Found proved.**<br><br>The Committee noted from the clinical records for the patient that Mr Rylko recorded the reasons for the crowning as bruxism (grinding), fillings coming off frequently and worn teeth. An aesthetic improvement was planned with a brighter shade.<br><br>In considering Mr Rylko's justifications, the Committee took into account that Patient G was seen by Witness 3 at an appointment on 22 February 2017, a year before the crown treatment was provided by Mr Rylko. There was no indication in the clinical notes for the appointment in 2017 that the patient would need crowns in future.<br><br>In addition, the Committee took into account that Mr Rylko, having decided to provide Patient G with multiple crowns, did so without undertaking sufficient diagnostic assessment, without assessing the patient's periodontal health, and without obtaining fully informed consent. In all the circumstances, the Committee concluded that it could not be said Mr Rylko's decision to fit Patient G with 11 crowns was in the patient's best interests. In reaching its decision, the Committee noted the concern of Dr Nichols, who stated in her report that *"Given my findings with respect to other patients I would be concerned that there was gross overtreatment and that the teeth did not require crowning.* |
| 8(d). | *your recommendation, on 5 June and 3 July 2019, for Patient H to have*<br><br>*orthodontic treatment (Invisalign) when this was not required;*<br><br>**Found proved.**<br><br>The Committee noted from the information in the clinical records that Patient H was a minor at the time of seeing Mr Rylko. The notes also indicate that the patient is autistic. The Committee noted that Patient H had seen Witness 3 prior to seeing Mr Rylko, and that Witness 3 had not indicated in the clinical records any necessity for orthodontic treatment. |

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| | Following an examination of Patient H on 5 June 2019, Mr Rylko recorded that the patient's cusps were wearing down quickly, and that the patient needed orthodontic treatment. Patient H returned for an Invisalign consultation on 3 July 2019.<br><br>Patient H was later referred by another dentist to Witness 5, a Consultant Orthodontist, who saw the patient in August 2019. In Witness 5's witness statement it was stated that Patient H *"had come to see me because when he attended Mr Ryko's [sic] surgery as a new patient, his parents were told by Mr Rylko that he had an anterior open bite and this could be corrected using Invisalign. He was also told that if this was left untreated, then this would result in the wear of his back teeth with permanent long-term damage".* Witness 5 disagreed with Mr Rylko's assessment of Patient H. Witness 5's evidence was that Patient H did not have an anterior open bite, and that the tooth wear was due to dietary issues. The opinion of Witness 5 was that there would be no detrimental effect for Patient H if Invisalign Treatment was not provided.<br><br>The Committee also had regard to the conclusion of Dr Nichols in her report that Mr Rylko had given "*Inappropriate advice for unnecessary orthodontic treatment for a vulnerable patient".* In her oral evidence, Dr Nichols referred to the possibility of Patient H's parents feeling under pressure to agree to the Invisalign Treatment.<br><br>Having considered all the evidence, the Committee was satisfied on the balance of probabilities that Patient H did not require Invisalign Treatment, and that Mr Rylko's recommendation was not in the best interests of the patient. |
| 8(e). | *your decision to fit a large bridge over Patient I's teeth which had a poor*<br><br>*long-term prognosis.*<br><br>**Found proved.**<br><br>The Committee found this head of charge proved, having already accepted Dr Nichols' opinion that there was a "*guarded prognosis of the planned bridge due to the poor restorative state and compromised bone support for the supporting teeth."* The Committee has also noted and accepted the evidence of Witness 4 regarding Patient I's "*progressed periodontitis"*. Witness 4 raised a concern in his witness statement that Mr Rylko had provided Patient I with an 8-unit bridge despite her periodontal issues.<br><br>In light of the expert evidence, and the evidence of Witness 4's observations, the Committee was satisfied on the balance of probabilities that Mr Rylko's decision to fit the bridge was not in Patient I's best interests. |
| 9. | *Your conduct in respect of 8 was:* |
| 9(a). | *misleading; and/or*<br><br>**Found proved.**<br><br>Having found in all the instances at 8(a) to 8(e) that Mr Rylko's decisions were not in the best interests of the patients concerned, the Committee |

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| | considered that it followed logically that the patients were misled. It was the view of the Committee that the patients would have assumed that Mr Rylko's suggestions for treatment would be in their best interests. |
| 9(b). | *dishonest in that it was financially motivated.*<br><br>**Found proved.**<br><br>In reaching its decision, the Committee took into account that Mr Rylko's decisions were not in the best interests of the patients. Whilst the Committee noted that in some instances Mr Rylko recorded rationales for his decision-making, it also took into account that this is a case where he had been found to have falsified and excluded some of the patient's records. In the Committee's view, this raised a concern about the reliability of Mr Rylko's notes overall, in particular his reasons for suggesting certain courses of treatment.<br><br>In addition, the Committee had regard to the concerns raised throughout the evidence by others. In her witness statement, Witness 1 recalled a conversation that she had with Mr Rylko during which he was said to have stated that he "*was hungry for all of [Witness 3's] patients because there were so many crowns, bridges and Invisalign to be made".* The Committee also took into account the evidence of Witness 3, who stated in his witness statement that he *" had various concerns about the treatment that Mr Rylko was providing to patients…Mr Rylko would carry out a lot of crown and bridgework on patients who I do not believe should have received this treatment…"*<br><br>Further, the Committee considered the evidence of Dr Nichols. In her oral evidence, she noted that there was a significant financial benefit to providing private dental treatment involving large bridges and large volumes of crowns. Whilst she did not say that it was impossible, she noted that it was unusual for such treatment to be provided in a general practice. In her experience, patients tended to go to specialist practices for large bridges and multiple crowns. Dr Nichols also noted in relation to Invisalign Treatment that there is an obvious cost to the patient, as the treatment is expensive. The Committee considered that Dr Nichols remained largely objective in her evidence as to Mr Rylko's motivation for making his decisions about treatment. It noted, however, that in relation to the 8-unit bridge provided to Patient I, Dr Nichols did state the following "*Leading a patient to pay a considerable amount of money for a large bridge without explaining this significant risk would have to raise the possibility that the treatment plan was motivated primarily by financial gain on the part of the Registrant."*<br><br>In all the circumstances, the Committee was satisfied on the balance of probabilities that those matters found proved at 8(a) to 8(e) represented a course of conduct by Mr Rylko, which was motivated by financial gain. Given the Committee's findings that none of the treatment he recommended and provided was in the patients' best interests, the only conclusion that it could reach was that Mr Rylko's actions were borne out of a desire to make money. |

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| | The Committee was satisfied on the basis of the evidence that he chose to provide treatment that was financially advantageous compared with other options, and with little or no consideration as to whether the treatment was suitable or appropriate to the patient. The Committee was satisfied that this was Mr Rylko's actual state of mind when he made the decisions that he did at head of charge 8 above. The Committee was also satisfied that ordinary and decent people would regard a dentist providing treatment that was not in the best interest of patients for financial gain as dishonest. |

We move to Stage Two."

On 20 May 2022 the Chairman announced the determination as follows:

"This is a Professional Conduct Committee hearing of Mr Rylko's case. The hearing is being conducted remotely by Microsoft Teams video-link in line with the current practice of the General Dental Council (GDC).

Mr Rylko is not present at this hearing, and he is not represented in his absence. The Case Presenter for the GDC is Mr Sam Thomas, Counsel.

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

The Committee considered all the evidence presented to it at the fact-finding stage. It received no further evidence at this stage. It took account of the submissions made by Mr Thomas in relation to misconduct, impairment and sanction. It accepted the advice of the Legal Adviser. The Committee reminded itself that misconduct, current impairment, and sanction were matters for its independent judgement. There is no burden or standard of proof at this stage of the proceedings.

**Summary of the facts found proved**

Mr Rylko is a registered dentist. The facts found proved relate to the care and treatment that he provided to 11 patients, whilst practising at a dental practice in Shetland ('Practice 1'). Findings were also made in relation to Mr Rylko's probity, which included findings that were a mixture of clinical and probity concerns.

In summary, the findings made by the Committee in respect of Mr Rylko's clinical practice were that, over the relevant time periods set out in the charge, he:

- failed to carry-out sufficient diagnostic assessment in relation to 9 of the patients;
- failed to maintain adequate records in relation to 3 of the patients.
- failed to undertake treatment planning and/or investigation in relation to the treatment of 4 of the patients;
- failed to provide an adequate standard of care and/or treatment to 10 of the patients;
- failed to assess, treat and/or monitor 3 of the patients;

- failed to obtain fully informed consent from 8 of the patients, in that he did not discuss with them the risks and/or benefits and/or alternative treatments.

The mixture of clinical and probity issues found proved by the Committee related to Mr Rylko's conduct in providing and/or recommending to 5 patients treatment that was not in their best interests. The Committee found that in the instances in question, Mr Rylko chose to provide and/or recommend treatment that was financially advantageous, compared with other options, and with little or no consideration as to whether the treatment was suitable or appropriate to the patients. The Committee found that in doing this, Mr Rylko misled the patients concerned, and acted dishonestly, given that his rationale for providing and/or recommending the treatments was financially motivated, as opposed to being in the patients' best interests.

A further probity matter found proved by the Committee related to Mr Rylko's dishonesty in displaying an award sticker in the window of Practice 1, from around July 2017 to July 2019, which stated *'Dentistry Awards 2016, Best Performing Dentist, Michael Rylko, Winner issued by Butterfly Dental Laboratory'*. The Committee received and accepted evidence confirming that Butterfly Dental Laboratory had not issued Mr Rylko with the award, and, in fact, no such award existed. The Committee was satisfied that Mr Rylko's conduct in displaying the false award was misleading, lacking in integrity, and dishonest.

The Committee also found proved that Mr Rylko had acted dishonestly in responding to the GDC regarding the matters in this case. It found that following a request from the Council to provide the clinical records of four of the patients concerned, Mr Rylko altered the contemporaneous records of those patients, and provided the amended records to the Council. The Committee was satisfied on the evidence that, in altering the patient records, it had been Mr Rylko's intention to make it appear to the GDC that he had originally recorded full accounts of his appointments with the four patients, including discussions about their treatment, treatment planning, treatment options and risks and benefits.

In reaching its conclusion that Mr Rylko had been dishonest in altering the clinical records, the Committee accepted evidence indicating that the original and contemporaneous clinical records for the four patients had already been provided to the GDC by Witness 1, the informant in this case. The Committee noted that the records subsequently provided by Mr Rylko for the same four patients contained extensive additions, some significant differences, and a number of omissions. The Committee considered that the additions and amendments made by Mr Rylko would have taken some time and care to produce. It also noted that many of the changes he made directly addressed issues that were relevant to the GDC's investigation into his fitness to practise.

**Summary of the submissions made by the GDC**

Mr Thomas made reference to the relevant case law in relation to misconduct. It was his submission that there is misconduct in this case. He submitted that it was clear that Mr Rylko failed to abide by a number of the GDC's *Standards for the Dental Team (September 2013)* ('the GDC Standards'). Mr Thomas drew the Committee attention to the GDC Standards referred to in the report of Dr Lucy Nichols, the GDC's expert witness in this case. He also noted that the Committee had made reference to relevant GDC Standards in its findings of fact.

Mr Thomas reminded the Committee that for a finding of misconduct, any identified breaches of the GDC Standards must be serious. It was his submission that Mr Rylko's departures

from the relevant standards were repeated, serious, and involved both clinical and probity concerns.

Mr Thomas submitted that on his calculation, the Committee had found proved in this case, 89 instances where patients had been put at risk of harm. Mr Thomas also highlighted the Committee's findings that Mr Rylko had been dishonest on three separate occasions. Mr Thomas submitted that the Committee's finding that Mr Rylko had acted dishonestly for financial gain in providing certain dental treatment to patients, as opposed to acting in their best interests, was one of the most serious findings that could be made against a registrant. Mr Thomas stated that Mr Rylko's actions in those particular instances demonstrated a complete disregard for the individual patients concerned, as well as for the reputation of the dental profession.

In relation to the issue of impairment, Mr Thomas submitted that the fundamental principles derived from case law, required the Committee to have regard to the impact of Mr Rylko's actions on the safety of the public, as well as to whether his actions could undermine public confidence in the dental profession.

Whilst Mr Thomas acknowledged that some of the clinical concerns in this case could be remedied, he stated that it was more difficult to remedy probity issues. He highlighted, however, that Mr Rylko has not engaged with these proceedings, and therefore, there is no evidence of his insight into any of the concerns, nor is there evidence of any desire to remedy them.

Mr Thomas referred the Committee to the approach for considering impairment of a registrant's fitness to practise, as identified by Dame Janet Smith in her fifth report to the Shipman Inquiry. The approach is referenced at paragraph 76 of the judgment in *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council and Paula Grant [2011] EWHC 927 (Admin)* as follows:

> *"Do our findings of fact in respect of the [dentist's] misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
>
> *a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b. has in the past brought and/or is liable in the future to bring the [dental] profession into disrepute; and/or*
>
> *c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the [dental] profession; and/or*
>
> *d. has in the past acted dishonestly and/or is liable to act dishonestly in the future."*

It was Mr Thomas' submission that all of the factors at (a) to (d) above apply in relation to Mr Rylko's past conduct, as found proved. Further, Mr Thomas stated that, in the absence of any evidence of insight or remediation, Mr Rylko was liable in future to act in the same way. Accordingly, Mr Thomas submitted that Mr Rylko's fitness to practise is currently impaired.

In addressing the Committee on sanction, Mr Thomas submitted that in all the circumstances of this case, the only appropriate and proportionate sanction was one of erasure. He referred the Committee to the factors relevant to erasure, as set out at paragraph 6.34 of the '*Guidance for the Practice Committees including Indicative Sanctions Guidance (Effective from October 2016; last revised December 2020)'* ('the Guidance').

In inviting the Committee to impose the highest available sanction, Mr Thomas stated that, at the outset of this hearing, an email had been sent by the GDC's solicitors to Mr Rylko, advising him that if the allegations of dishonesty were found proved, the Council would be seeking the erasure of his name from the Dentists Register. Mr Thomas told the Committee that there has been no response from Mr Rylko to that email, and consequently, there are no submissions from him.

**The Committee's decision on misconduct**

The Committee considered whether the facts found proved against Mr Rylko 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. It considered the following professional standards to be engaged in this case:

1.2 Treat every patient with dignity and respect at all times.

1.3 Be honest and act with integrity.

1.7 Put patients' interests before your own or those of any colleague, business or organisation.

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

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

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

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

4.1 You must make and keep contemporaneous, complete and accurate patient records.

4.1.1 You must make and keep complete and accurate patient records, including an up-to-date medical history, each time that you treat patients.

The Committee found proved against Mr Rylko a large number of significant and serious allegations. These included multiple and repeated clinical shortcomings in respect of his treatment of the patients, which were in basic and fundamental areas of dentistry. Many of the patients in question were treated by Mr Rylko over lengthy periods of time and were continually put at risk of harm from his failings. The Committee noted that actual harm was caused to some of the patients on account of the deficiencies in Mr Rylko clinical practice.

In addition, the Committee found proved three instances of dishonesty against Mr Rylko, including his doctoring of patient records, and his displaying of a false award in the window of Practice 1. There is also the Committee's finding that Mr Rylko deliberately provided patients with dental treatment that was not in their best interests, including treatment that could or did harm them physically and financially. The Committee found that he did this purely to make money. The Committee considered this particular aspect of its findings to be significantly serious. The Committee considered that the patients concerned, some of whom the Committee regarded as vulnerable patients, would have expected and believed that Mr Rylko, as a registered dentist, was putting their interests before financial gain.

Having taken all of the evidence into account, including the opinion of Dr Nichols, the Committee was satisfied that the matters found proved in this case represented acts and/or omissions that fell far short of the professional standards expected of Mr Rylko as a registered dentist. In a number of instances, Mr Rylko departed from fundamental tenets of the dental profession including by failing to put patients' interests first, by not obtaining fully informed consent for treatment, and by failing to act with honesty and integrity. The Committee took into account the carefully planned and executed nature of some aspects of Mr Rylko's dishonesty, particularly his doctoring of the patient records, and the way in which he took decisions to provide large amounts of treatment to patients for his own financial gain.

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

**The Committee's decision on impairment**

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

Given the enormity of the misconduct found in this case, the Committee was satisfied that Mr Rylko's fitness to practise was impaired at the time of the events in question. In considering whether his fitness to practise is impaired at the time of this hearing, the Committee considered whether there was any evidence before it to demonstrate Mr Rylko's level of insight and/or to indicate that he has attempted to address the serious concerns raised. In its considerations, the Committee acknowledged that some of the clinical matters were capable of being remedied. However, it considered that it would be much more difficult to demonstrate remediation of the probity concerns, particularly taking into account the extent and seriousness of Mr Rylko's dishonesty. Bearing all this in mind, the Committee considered the evidence before it in relation to the current position.

Mr Rylko has not engaged with this hearing. In its decision to proceed with the hearing in his absence made on 9 May 2022, the Committee noted that Mr Rylko had sent emails to the GDC in August 2020 and in early 2021, indicating that he no longer lived in the UK. Mr Rylko also made clear that he did not wish to continue engaging with the GDC's fitness to practise process.

This case involves serious clinical and probity issues. The Committee had regard to the approach to considering impairment, as outlined by Dame Janet Smith in her fifth Shipman Report, and it was satisfied that all of the factors apply in this case.

In view of Mr Rylko's lack of engagement, there is no evidence before the Committee in relation to his insight into the matters in this case, nor is there any evidence of remediation. Accordingly, there has been nothing to reassure the Committee that Mr Rylko would not be liable in the future to act so as to put a patient or patients at unwarranted risk of harm. The Committee was therefore satisfied that a finding of impairment is necessary for the protection of the public.

The Committee also had regard to the wider public interest. It took into account the serious and prolonged nature of Mr Rylko's misconduct, which includes serious dishonesty. His past actions clearly brought the dental profession into disrepute and breached fundamental tenets of the profession and he acted dishonestly. The Committee considered that even if there was evidence in this case of insight and/or remediation, public confidence in the dental profession would be undermined if a finding of impairment were not made in all the circumstances. The Committee considered that such a finding was also required to promote and maintain proper professional standards and conduct within the dental profession.

Accordingly, the Committee determined that Mr Rylko's fitness to practise is currently impaired by reason of his misconduct.

**The Committee's decision on sanction**

The Committee considered what sanction, if any, to impose on Mr Rylko's registration. It noted that the purpose of a 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 Rylko's own interests.

In deciding on the appropriate sanction, the Committee had regard to what it considered to be the mitigating and aggravating factors in this case. The Committee concluded that there was no evidence of any mitigating factors beyond the fact that Mr Rylko was of good character prior to the Committee's earliest finding of dishonesty relating to July 2017. It did, however, identify a considerable number of aggravating factors, which are as follows:

- actual harm or risk of harm to a patient or another;
- dishonesty, which in this case involved instances that were prolonged, as well as high level planning in some respects;
- premeditated misconduct;
- financial gain by Mr Rylko;
- breach of trust, particularly in relation to not acting in the best interests of patients;
- the involvement of a vulnerable patient or other vulnerable individual;
- misconduct sustained or repeated over a period of time;
- blatant or wilful disregard of the role of the GDC and the systems regulating the profession;
- attempts to cover up wrongdoing; and
- lack of insight.

Taking all of these factors into account, the Committee considered the available sanctions, starting with the least restrictive. The Committee noted that it was open to it to conclude this

case without taking any action in respect of Mr Rylko's registration. However, it concluded that taking no action would be wholly inappropriate and disproportionate, given the gravity of its findings and the absence of any evidence of insight or remediation. This means that there is an ongoing risk to the public and the wider public interest.

The Committee reached the same conclusion in respect of a reprimand. It considered that issuing Mr Rylko with a reprimand would be insufficient to protect the public and the wider public interest, and disproportionate in all the circumstances. A reprimand is the lowest sanction which can be applied and is usually considered to be appropriate where the misconduct is at the lower end of the spectrum. This is not such a case.

The Committee next considered whether to impose conditions on Mr Rylko's registration. Whist it took into account that some of the clinical concerns could be remedied, the Committee considered that conditional registration would not be workable, given Mr Rylko's ongoing lack of engagement. In any event, the Committee decided that there are no conditions that would address the serious dishonesty found proved. It therefore decided that the imposition of conditions would neither be appropriate nor proportionate.

The Committee went on to consider whether to suspend Mr Rylko's registration for a specified period. In doing so, it took into account its duty to impose the least restrictive sanction necessary in all the circumstances. It had regard to the Guidance at paragraph 6.28, which sets out the factors to be considered when deciding whether the sanction of suspension would be appropriate. The Committee noted that the majority of those factors are present in this case, including that Mr Rylko has not shown insight and that there remains a risk of repetition. However, it also noted from paragraph 6.28 that a suspension could be considered appropriate in circumstances where *"there is no evidence of harmful deep-seated personality or professional attitudinal problems"*. It was the view of the Committee, that the actions of Mr Rylko, as found proved, do demonstrate attitudinal problems, both professionally and personally. Some of the findings made against him are of the most serious kind, involving serious dishonesty and actual and deliberate harm to patients. Further, there has been no evidence to indicate that he has acknowledged his misconduct and its impact on the patients and the reputation of the dental profession. The Committee took into account that Mr Rylko's response to the GDC's investigation was to seek to cover up his failings by altering patient records. In the Committee's view, the evidence before it shows a registrant capable of being dishonest whenever he considers it to be to his advantage.

Given the Committee's concerns about Mr Rylko's attitude, and the ongoing risk it has identified to the public, and the wider public, particularly in terms of the public's confidence in the dental profession, the Committee went on to consider whether the highest sanction would be more appropriate and proportionate. It had regard to paragraph 6.34 of the Guidance which deals with erasure. That paragraph states that:

> "*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 serious harm to patients or other persons has occurred, either deliberately or through incompetence;*

- *where a continuing risk of serious harm to patients or other persons is identified;*
- *the abuse of a position of trust or violation of the rights of patients, particularly if involving vulnerable persons;*
- *…*
- *serious dishonesty, particularly where persistent or covered up;*
- *a persistent lack of insight into the seriousness of actions or their consequences".*

The Committee noted that all but one of the factors from paragraph 6.34 apply, which in its view indicates the seriousness of the matters found proved against Mr Rylko. Taking this into account, together with its concern that Mr Rylko has harmful deep-seated personality or professional attitudinal problems, the Committee concluded that the only appropriate and proportionate sanction to protect the public is erasure. It further considered that public confidence in the dental profession would be seriously undermined if a lesser sanction were to be imposed. The Committee considered that the wider public interest would not be satisfied by a period of suspension.

In all the circumstances, the Committee determined to erase Mr Rylko's name from the Dentists Register.

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

The Committee now invites submissions from Mr Thomas, as to whether an immediate order of suspension should be imposed on Mr Rylko's registration to cover the appeal period, pending its substantive determination taking effect.

In reaching its decision on whether to impose an immediate order of suspension on Mr Rylko's registration, the Committee took account of Mr Thomas' submission that such an order should be imposed. Mr Thomas highlighted that the Committee's substantive determination for erasure would not come into effect until after the 28-day appeal period, or until any appeal is decided. He submitted that, if Mr Rylko were to appeal the Committee's substantive determination, a decision on the appeal could take a number of months. Mr Thomas stated that in the absence of an immediate order, Mr Rylko could potentially return to unrestricted practice during that time.

The Committee accepted the advice of the Legal Adviser. It noted his references to the relevant paragraphs of the Guidance in relation to immediate orders. The Committee also took into account his advice that under the *Dentists Act 1984 (as amended)* the interim order of suspension currently in place on Mr Rylko's registration is automatically revoked on the reaching of a substantive determination.

**The Committee's decision on an immediate order**

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 Rylko's registration. It has found serious dishonesty in this case, including dishonesty associated with the treatment of patients, as well as a significant number of other serious failings relating to Mr Rylko's clinical practice resulting in significant physical and financial harm to

patients. The Committee received no evidence of insight or remediation, and consequently, it has identified an ongoing risk of harm to the public. 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 has determined that Mr Rylko is not fit to remain on the Dentists Register. The Committee considered that a reasonable and informed member of the public would be dismayed if Mr Rylko's registration was not immediately suspended. In the Committee's view, public confidence in the dental profession and in this regulatory process would be seriously undermined in the absence of an immediate order.

The effect of the foregoing determination and this order is that Mr Rylko's registration will be suspended from the date on which notice is deemed to have been served upon him. Unless he exercises his right of appeal, the substantive direction for erasure, as already announced, will take effect 28 days from the date of deemed service.

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

The interim order currently in place on Mr Rylko's registration is hereby revoked.

That concludes this determination."