GENERAL DENTAL COUNCIL

AND

BALCK, John Charles

[Registration number: 74613]

NOTICE OF INQUIRY

SUBSTANTIVE HEARING

Notice that an inquiry will be conducted by a Practice Committee of the General Dental Council, commencing at **10:00am** on **10 November 2025.**

The General Dental Council
37 Wimpole Street
London
W1G 8DQ

Please note that this hearing will be conducted remotely by video conference.

The heads of charge contained within this sheet are current at the date of publication. They are subject to amendments at any time before or during the hearing. For the final charge, findings of fact and determination against the registrant, please visit the Recent Decisions page at https://www.dentalhearings.org/hearings-and-decisions/decisions after this hearing has finished.

Committee members:

Gaon Hart	Lay	Chair
Janhvi Amin	Dentist	
Nosheen Kabal	DCP	

Legal Adviser:

Alain Gogarty

CHARGE

John Charles BLACK, a dentist, BDS Queen's University of Belfast 1998, is summoned to appear before the Professional Conduct Committee on 10 November 2025 for an inquiry into the following charge:

Part A - Individual patient failings

Patient 1

1. You administered advanced sedation as follows:

    1.1. Fentanyl (100mcg) and Midazolam (10mg) on 17th February 2017.

2. You failed to provide an adequate standard of care to Patient 1 at the appointment under 1.1, in that you failed to:

    2.1. Take an updated medical history;

    2.2. Assess whether advanced sedation was the most appropriate method of managing pain or anxiety, as opposed to other methods;

    2.3. Assess their ASA score;

    2.4. Provide pre-sedation information and/or instructions;

    2.5. Conduct a pre-sedation assessment of their suitability for sedation;

    2.6. Monitor their response to sedation including with regards to blood pressure, pulse, and/or oxygen saturation at appropriate intervals before, during and/or after sedation;

    2.7. Monitor clinical parameters (including respiration, skin colour, depth of sedation) at appropriate intervals before, during and/or after sedation; and/or

    2.8. Assess whether they met the criteria for safe discharge.

3. In the alternative to one or more of 2.1 through 2.8, you failed to record those matters, and/or also failed to record:

    3.1. When sedation began and/or ended.

Patient 2

1. You administered sedation and/or advanced sedation as follows:

    1.1. Fentanyl (100mcg) and Midazolam (10mg) on 27th October 2016;

    1.2. Fentanyl (100mcg) and Midazolam (10mg) on 6th August 2018;

2. You failed to provide an adequate standard of care to Patient 2 at one or more of the appointments under 1.1 and/or 1.2, in that you failed to:

    2.1. Take an updated medical history;

    2.2. Assess whether sedation and/or advanced sedation was the most appropriate method of managing pain or anxiety, as opposed to other methods;

    2.3. Assess their ASA score;

    2.4. Provide pre-sedation information and/or instructions;

2.5. Conduct a pre-sedation assessment of their suitability for sedation;

2.6. Monitor their response to sedation including with regards to blood pressure, pulse, and/or oxygen saturation at appropriate intervals before, during and/or after sedation;

2.7. Monitor clinical parameters (including respiration, skin colour, depth of sedation) at appropriate intervals before, during and/or after sedation; and/or

2.8. Assess whether they met the criteria for safe discharge.

3. In the alternative to one or more of 2.1 through 2.8, you failed to record those matters, and/or also failed to record:

3.1. When sedation began and/or ended.

Patient 3

1. You administered advanced sedation as follows:

1.1. Fentanyl (100mcg) and Midazolam (5mg) on 6th October 2017.

2. You failed to stimulate breathing and/or give oxygen when oxygen saturation fell to 94% at the appointment under 1.1.

3. Your conduct under 2 endangered the health of Patient 3, in that it risked hypoxia.

4. You failed to provide an adequate standard of care to Patient 3 at the appointment under 1.1, in that you failed to:

4.1. Take an updated medical history;

4.2. Assess whether advanced sedation was the most appropriate method of managing pain or anxiety, as opposed to other methods;

4.3. Assess their ASA score;

4.4. Provide pre-sedation information and/or instructions;

4.5. Conduct a pre-sedation assessment of their suitability for advanced sedation; and/or

4.6. Assess whether they met the criteria for safe discharge.

5. In the alternative to one or more of 4.1 through 4.6, you failed to record those matters.

Patient 4

1. You administered advanced sedation as follows:

1.1. Fentanyl (100mcg) and Midazolam (5mg) on 15 January 2019.

2. You failed to provide an adequate standard of care to Patient 4 at the appointment at 1.1 above, in that you failed to:

2.1. Take an updated medical history;

2.2. Assess whether sedation and/or advanced sedation was the most appropriate method of managing pain or anxiety, as opposed to other methods;

2.3. Assess their ASA score;

2.4. Provide pre-sedation information and/or instructions;

2.5. Conduct a pre-sedation assessment of their suitability for sedation;

2.6. Monitor their response to sedation including with regards to blood pressure, pulse, and/or oxygen saturation at appropriate intervals before, during and/or after sedation;

2.7. Monitor clinical parameters (including respiration, skin colour, depth of sedation) at appropriate intervals before, during and/or after sedation; and/or

2.8. Assess whether they met the criteria for safe discharge.

3. In the alternative to one or more of 2.1 through 2.8, you failed to record those matters, and/or also failed to record:

3.1. When sedation began and/or ended.

Patient 5

1. You administered advanced sedation as follows:

1.1. Fentanyl (100mcg) and Midazolam (10mg) on 23rd March 2016;

1.2. Fentanyl (100mcg) and Midazolam (12mg) on 9th November 2018.

2. You failed to stop treatment, stimulate breathing and/or give oxygen when oxygen saturation fell to 92% at the appointment under 1.1.

3. Your conduct under 2 endangered the health of Patient 5, in that it risked hypoxia.

4. You failed to provide an adequate standard of care to Patient 5 at one or more of the appointments under 1.1 and/or 1.2 in that you failed to:

4.1. Take an updated medical history;

4.2. Assess whether sedation and/or advanced sedation was the most appropriate method of managing pain or anxiety, as opposed to other methods;

4.3. Assess their ASA score;

4.4. Provide pre-sedation information and/or instructions;

4.5. Conduct a pre-sedation assessment of their suitability for sedation;

4.6. Monitor their response to sedation including with regards to blood pressure, pulse, and/or oxygen saturation at appropriate intervals before, during and/or after sedation; (save for the appointment under 1.1);

4.7. Monitor clinical parameters (including respiration, skin colour, depth of sedation) at appropriate intervals before, during and/or after sedation; and/or

4.8. Assess whether they met the criteria for safe discharge.

5. In the alternative to one or more of 4.1 through 4.8, you failed to record those matters, and/or also failed to record:

5.1. When sedation ended at the appointment under 1.3.

Patient 6

1. You administered sedation and/or advanced sedation as follows:

    1.1. Fentanyl (100mcg) and Midazolam (10mg) on 1st November 2016;

    1.2. Fentanyl (100mcg) and Midazolam (10mg) on 30th November 2018.

2. You failed to provide an adequate standard of care to Patient 6 at one or more of the appointments under 1.1 and/or 1.2, in that you failed to:

    2.1. Take an updated medical history;

    2.2. Assess whether sedation and/or advanced sedation was the most appropriate method of managing pain or anxiety, as opposed to other methods;

    2.3. Assess their ASA score;

    2.4. Provide pre-sedation information and/or instructions;

    2.5. Conduct a pre-sedation assessment of their suitability for sedation;

    2.6. Monitor their response to sedation including with regards to blood pressure, pulse, and/or oxygen saturation at appropriate intervals before, during and/or after sedation;

    2.7. Monitor clinical parameters (including respiration, skin colour, depth of sedation) at appropriate intervals before, during and/or after sedation; and/or

    2.8. Assess whether they met the criteria for safe discharge.

3. In the alternative to one or more of 3.1 through 3.8, you failed to record those matters, and/or also failed to record:

    3.1. When sedation began and/or ended (save for the appointment under 1.2 where start and end times were recorded).

Patient 7

1. You administered sedation and/or advanced sedation as follows:

    1.1. Fentanyl (100mcg) and Midazolam (10mg) on 24th October 2017;

    1.2. Fentanyl (100mcg) and Midazolam (15mg) on 17th September 2018.

2. You failed to provide an adequate standard of care to Patient 7 at one or more of the appointments under 1.1 through 1.2, in that you failed to:

    2.1. Take an updated medical history;

    2.2. Assess whether sedation and/or advanced sedation was the most appropriate method of managing pain or anxiety, as opposed to other methods;

    2.3. Assess their ASA score;

2.4. Provide pre-sedation information and/or instructions;

2.5. Conduct a pre-sedation assessment of their suitability for sedation;

2.6. Monitor their response to sedation including with regards to blood pressure, pulse, and/or oxygen saturation at appropriate intervals before, during and/or after sedation;

2.7. Monitor clinical parameters (including respiration, skin colour, depth of sedation) at appropriate intervals before, during and/or after sedation; and/or

2.8. Assess whether they met the criteria for safe discharge.

3. In the alternative to one or more of 2.1 through 2.8, you failed to record those matters, and/or also failed to record:

3.1. When sedation began and/or ended.

4. You failed to provide an adequate standard of care at the appointments under 1.1 and/or 1.2, in that you failed to:

4.1. Review, or record your review of, the patient's suitability for advanced sedation given their complex medical history; and/or

4.2. Consult with their GMP to assess their suitability for advanced sedation in primary care.

Patient 8

1. You administered advanced sedation as follows:

1.1. Fentanyl (100mcg) and Midazolam (10mg) on 19th January 2018.

2. You failed to provide an adequate standard of care to Patient 8 at the appointment at 1.1 above, in that you failed to:

2.1. Take an updated medical history;

2.2. Assess whether sedation and/or advanced sedation was the most appropriate method of managing pain or anxiety, as opposed to other methods;

2.3. Assess their ASA score;

2.4. Provide pre-sedation information and/or instructions;

2.5. Conduct a pre-sedation assessment of their suitability for sedation;

2.6. Monitor their response to sedation including with regards to blood pressure, pulse, and/or oxygen saturation at appropriate intervals before, during and/or after sedation;

2.7. Monitor clinical parameters (including respiration, skin colour, depth of sedation) at appropriate intervals before, during and/or after sedation; and/or

2.8. Assess whether they met the criteria for safe discharge.

3. In the alternative to one or more of 2.1 through 2.8, you failed to record those matters, and/or also failed to record:

3.1. When sedation began and/or ended.

Patient 9

1. You administered sedation and/or advanced sedation as follows:

    1.1. Fentanyl (100mcg) and Midazolam (5mg) on 29th June 2016;

    1.2. Fentanyl (100mcg) and Midazolam (10mg) on 15th August 2018.

4. You failed to obtain any, or any adequate, written consent to advanced sedation at one or more of the appointments under 1.1 through 1.2.

5. You failed to provide an adequate standard of care to Patient 9 at one or more of the appointments under 1.1 through 1.2, in that you failed to:

    5.1. Take an updated medical history;

    5.2. Assess whether sedation and/or advanced sedation was the most appropriate method of managing pain or anxiety, as opposed to other methods;

    5.3. Assess their ASA score;

    5.4. Provide pre-sedation information and/or instructions;

    5.5. Conduct a pre-sedation assessment of their suitability for sedation;

    5.6. Monitor their response to sedation including with regards to blood pressure, pulse, and/or oxygen saturation at appropriate intervals before, during and/or after sedation;

    5.7. Monitor clinical parameters (including respiration, skin colour, depth of sedation) at appropriate intervals before, during and/or after sedation; and/or

    5.8. Assess whether they met the criteria for safe discharge.

6. In the alternative to one or more of 5.1 through 5.8, you failed to record those matters, and/or also failed to record:

    6.1. When sedation began and/or ended (save for the start time at the appointment under 1.2).

Patient 11

1. You administered advanced sedation as follows:

    1.1. Fentanyl (100mcg) and Midazolam (10mg) on 21st June 2016;

    1.2. Fentanyl (100mcg) and Midazolam (10mg) on 30th January 2017;

    1.3. Fentanyl (100mcg) and Midazolam (10mg) on 27th October 2017.

2. You failed to provide an adequate standard of care to Patient 11 at one or more of the appointments under 1.1 through 1.3, in that you failed to:

    2.1. Take an updated medical history;

    2.2. Assess whether advanced sedation was the most appropriate method of managing pain or anxiety, as opposed to other methods;

2.3. Assess their ASA score;

2.4. Provide pre-sedation information and/or instructions;

2.5. Conduct a pre-sedation assessment of their suitability for sedation;

2.6. Monitor their response to sedation including with regards to blood pressure, pulse, and/or oxygen saturation at appropriate intervals before, during and/or after sedation;

2.7. Monitor clinical parameters (including respiration, skin colour, depth of sedation) at appropriate intervals before, during and/or after sedation; and/or

2.8. Assess whether they met the criteria for safe discharge.

3. In the alternative to one or more of 2.1 through 2.8, you failed to record those matters, and/or also failed to record:

3.1. When sedation began and/or ended.

Patient 12

1. You administered sedation and/or advanced sedation as follows:

1.1. Fentanyl (100mcg) and Midazolam (10mg) on 21st September 2018;

1.2. Fentanyl (100mcg) and Midazolam (10mg) on 1st October 2018;

1.3. Fentanyl (100mcg) and Midazolam (5mg) on 19th December 2018.

2. You failed to provide an adequate standard of care to Patient 12 at one or more of the appointments under 1.1 through 1.3, in that you failed to:

2.1. Take an updated medical history;

2.2. Assess whether sedation and/or advanced sedation was the most appropriate method of managing pain or anxiety, as opposed to other methods;

2.3. Assess their ASA score;

2.4. Provide pre-sedation information and/or instructions;

2.5. Conduct a pre-sedation assessment of their suitability for sedation;

2.6. Monitor their response to sedation including with regards to blood pressure, pulse, and/or oxygen saturation at appropriate intervals before, during and/or after sedation;

2.7. Monitor clinical parameters (including respiration, skin colour, depth of sedation) at appropriate intervals before, during and/or after sedation; and/or

2.8. Assess whether they met the criteria for safe discharge.

3. In the alternative to one or more of 2.1 through 2.8, you failed to record those matters, and/or also failed to record:

3.1. When sedation began and/or ended.

Patient 13

1. You administered sedation and/or advanced sedation as follows:

    1.1. Fentanyl (100mcg) and Midazolam (10mg) on 23rd October 2018;

2. You failed to provide an adequate standard of care at the appointment at 1.1 above, in that you failed to:

    2.1. Take an updated medical history;

    2.2. Assess whether sedation and/or advanced sedation was the most appropriate method of managing pain or anxiety, as opposed to other methods;

    2.3. Assess their ASA score;

    2.4. Provide pre-sedation information and/or instructions;

    2.5. Conduct a pre-sedation assessment of their suitability for sedation;

    2.6. Monitor their response to sedation including with regards to blood pressure, pulse, and/or oxygen saturation at appropriate intervals before, during and/or after sedation;

    2.7. Your monitoring of clinical parameters (including respiration, skin colour, depth of sedation) at appropriate intervals before, during and/or after sedation; and/or

    2.8. Assess whether they met the criteria for safe discharge.

3. In the alternative to one or more of 2.1 through 2.8, you failed to record those matters, and/or also failed to record:

    3.1. When sedation began and/or ended.

Patient 13

1. You administered sedation and/or advanced sedation as follows:

    1.1. Fentanyl (100mcg) and Midazolam (10mg) on 23rd October 2018;

2. You failed to provide an adequate standard of care at the appointment at 1.1 above, in that you failed to:

    2.1. Take an updated medical history;

    2.2. Assess whether sedation and/or advanced sedation was the most appropriate method of managing pain or anxiety, as opposed to other methods;

    2.3. Assess their ASA score;

    2.4. Provide pre-sedation information and/or instructions;

    2.5. Conduct a pre-sedation assessment of their suitability for sedation;

    2.6. Monitor their response to sedation including with regards to blood pressure, pulse, and/or oxygen saturation at appropriate intervals before, during and/or after sedation;

    2.7. Your monitoring of clinical parameters (including respiration, skin colour, depth of sedation) at

appropriate intervals before, during and/or after sedation; and/or

2.8. Assess whether they met the criteria for safe discharge.

3. In the alternative to one or more of 2.1 through 2.8, you failed to record those matters, and/or also failed to record:

3.1. When sedation began and/or ended.

Patient 15

1. You administered advanced sedation as follows:

1.1. Fentanyl (100mcg) and Midazolam (15mg) on 2nd August 2016;

1.2. Fentanyl (100mcg) and Midazolam (10mg) on 31st March 2017;

1.3. Fentanyl (100mcg) and Midazolam (10mg) on 7th July 2017;

1.4. Fentanyl (100mcg) and Midazolam (10mg) on 30th November 2017;

1.5. Fentanyl (100mcg) and Midazolam (15mg) on 16th November 2018;

1.6. Fentanyl (100mcg) and Midazolam (15mg) on 25th January 2019.

2. You failed to provide an adequate standard of care at one or more of the appointments under 1.1 through 1.6, in that you failed to:

2.1. Take an updated medical history;

2.2. Assess whether advanced sedation and/or sedation was the most appropriate method of managing pain or anxiety, as opposed to other methods;

2.3. Assess their ASA score;

2.4. Provide pre-sedation information and/or instructions;

2.5. Conduct a pre-sedation assessment of their suitability for sedation;

2.6. Monitor their response to sedation including with regards to blood pressure, pulse, and/or oxygen saturation at appropriate intervals before, during and/or after sedation;

2.7. Your monitoring of clinical parameters (including respiration, skin colour, depth of sedation) at appropriate intervals before, during and/or after sedation; and/or

2.8. Assess whether they met the criteria for safe discharge.

3. In the alternative to one or more of 2.1 through 2.8, you failed to record those matters, and/or also failed to record:

3.1. When sedation began and/or ended.

Part B - All patients

1. You failed to provide an adequate standard of care to Patients 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 15, in that you administered advanced sedation:

1.1. Without sufficient training, in that you had not completed any relevant CPD or training between

your initial training in or around 1999 or 2000 and 22nd September 2018;

1.2. Without appropriate support, in the form of one nurse to care for the sedated patient and a second nurse to assist with the dental care provided (save for appointments at which you only administered minimal intervention, as set out by Schedule A).[1]

2. Your conduct under 1.1 endangered the health of one or more of the patients, in that you lacked the training required to administer advanced sedation safely.

3. Your conduct under 1.2 endangered the health of one or more of the patients, in that you lacked the support required to administer advanced sedation safely.

4. In the alternative to 1.2 and 3, you failed to record the names and/or roles of the sedation team working with you.

PART C : "CLINICAL" FAILINGS

Patient A

1. You failed to provide an adequate standard of care between 3rd June 2013 and 16th November 2015, in that you did not:

1.1. Obtain a history of the current condition, needs, and aspirations of the patient;

1.2. Obtain the dental history of the patient;

1.3. Obtain a medical and social history of the patient;

1.4. Evaluate the hard and soft tissues of the face and jaws, including a basic cancer screen; and/or

1.5. Evaluate the periodontal status and oral hygiene of the patient.

Patient B

1. You failed to provide an adequate standard of care between 18th October 2007 and 10th October 2014, in that you did not:

1.1. Obtain a history of the patient's current condition, needs, and aspirations;

1.2. Obtain the dental history of the patient;

1.3. Obtain a medical and social history of the patient;

1.4. Evaluate the hard and soft tissues of the face and jaws, including a basic cancer screen;

1.5. Evaluate the periodontal status and oral hygiene of the patient;

1.6. Provide advice regarding preventive care; and/or

1.7. Take appropriate radiographs to diagnose caries.

Patient F

1. You failed to provide an adequate standard of care between 20th May 2013 and 18th November 2014, in that you did not:

1.1. Obtain a history of the patient's current condition, needs, and aspirations;

1.2. Obtain the dental history of the patient;

1.3. Obtain a medical and social history of the patient;

1.4. Evaluate the hard and soft tissues of the face and jaws, including a basic cancer screen; and/or

1.5. Evaluate the periodontal status and oral hygiene of the patient.

Patient G

1. You failed to maintain an adequate standard of care between 7th May 2013 and 10th November 2016, in that you did not:

1.1. Obtain a history of the patient's current condition, needs, and aspirations;

1.2. Obtain the dental history of the patient;

1.3. Obtain a medical and social history of the patient;

1.4. Evaluate the hard and soft tissues of the face and jaws, including a basic cancer screen; and/or

1.5. Evaluate the periodontal status and oral hygiene of the patient.

Patient H

1. You failed to provide an adequate standard of care between 19th September 2008 and 27th October 2015, in that you did not:

1.1. Obtain a history of the patient's current condition, needs, and aspirations;

1.2. Obtain the dental history of the patient;

1.3. Obtain a medical and social history of the patient;

1.4. Evaluate the hard and soft tissues of the face and jaws, including a basic cancer screen; and/or

1.5. Evaluate the periodontal status and oral hygiene of the patient.

Patient I

1. You administered sedation as follows:

1.1. Midazolam (10mg) on 26th June 2014;

1.2. Midazolam (10mg) on 30th July 2014;

1.3. Midazolam (7mg) 7th January 2015;

1.4. Midazolam (10mg) 2nd August 2016.

2. You failed to provide an adequate standard of sedation at one or more of the appointments under 1.1 through 1.4, in that you failed to:

2.1. Obtain written consent, either adequately or at all, for sedation;

2.2. Take, or record having taken, an updated medical history;

2.3. Assess, or record your assessment of, whether sedation was the most appropriate method of managing pain or anxiety, as opposed to other methods;

2.4. Assess, or record your assessment of, their ASA score;

2.5. Provide, or record your provision of, pre-sedation information and/or instructions;

2.6. Conduct, or record your conduct of, a pre-sedation assessment of the patient for their suitability for sedation;

2.7. Record the beginning and/or end times of sedation;

2.8. Provide, or record your provision of, post-sedation information and/or instructions;

2.9. Adequately monitor, or record your monitoring of, their response to sedation including with regards to blood pressure, pulse, and/or oxygen saturation at appropriate intervals before, during and/or after sedation;

2.10. Adequately monitor, or record your monitoring of, clinical parameters (including respiration, skin colour, depth of sedation) at appropriate intervals before, during and/or after sedation;

2.11. Assess, or record your assessment of, whether they met the discharge criteria;

2.12. Ensure, or record having ensured, that they were accompanied by a responsible escort at the point of discharge; and/or

2.13. Record the name and/or role of the staff acting as your sedation team, if any.

3. You failed to administer sedation with appropriate support, in the form of one nurse to care for the sedated patient and a second nurse to assist with the dental care provided at the appointments under 1.1, 1.2 and/or 1.4.

4. Your conduct under 3 endangered the health of Patient I, in that you lacked the support required to administer sedation safely.

5. You conducted root canal treatment at the appointments under 1.1 and/or 1.2 without use of a rubber dam.

6. Your conduct under 5 endangered the health of Patient I, in that it created a risk of the patient aspirating small instruments while sedated.

7. You failed to report, either adequately or at all, on the radiograph taken on 29th April 2015.

Patient J

1. You administered sedation and/or advanced sedation as follows:

1.1. Fentanyl (100mcg) and Midazolam (20mg) on 21st January 2015;

1.2. Fentanyl (100mcg) and Midazolam (unspecified) on 2nd February 2015;

2. You failed to provide an adequate standard of care between 21 January 2015 and 02 February 2015 in that you did not:

2.1. Obtain a history of the patient's current condition, needs, and aspirations;

2.2. Obtain the dental history of the patient;

2.3. Obtain a medical and social history of the patient;

2.4. Evaluate the hard and soft tissues of the face and jaws, including a basic cancer screen; and/or

2.5. Evaluate the periodontal status and oral hygiene of the patient.

3. You administered advanced sedation without appropriate support, in the form of one nurse to care for the sedated patient and a second nurse to assist with the dental care provided, at the appointments under 1.1 and/or 1.2

4. Your conduct under 3 endangered the health of Patient J, in that you lacked the support required to administer advanced sedation safely.

5. You failed to provide an adequate standard of sedation at the appointments under 1.1 and/or 1.2 in that you failed to:

5.1. Take, or record having taken, an updated medical history;

5.2. Assess, or record having assessed, whether sedation and/or advanced sedation was the most appropriate method of managing pain or anxiety, as opposed to other methods;

5.3. Assess, or record your assessment of, their ASA score;

5.4. Provide, or record your provision of, pre-sedation information and/or instructions;

5.5. Conduct, or record your conduct of, a pre-sedation assessment of the patient for their suitability for sedation and/or advanced sedation;

5.6. Record the beginning and/or end times of sedation;

5.7. Provide, or record your provision of, post-sedation information and/or instructions;

5.8. Adequately monitor, or record your monitoring of, their response to sedation including with regards to blood pressure, pulse, and/or oxygen saturation at appropriate intervals before, during and/or after sedation;

5.9. Adequately monitor, or record your monitoring of, clinical parameters (including respiration, skin colour, depth of sedation) at appropriate intervals before, during and/or after sedation;

5.10. Assess, or record your assessment of, whether they met the discharge criteria;

5.11. Ensure, or record having ensured, that they were accompanied by a responsible escort at the point of discharge; and/or

5.12. Record the name and/or role of the staff acting as your sedation team, if any.

Patient K

1. You failed to provide an adequate standard of care between 5th July 2013 and 8th December 2016, in that you did not:

1.1. Obtain a history of the patient's current condition, needs, and aspirations;

1.2. Obtain the dental history of the patient;

1.3. Obtain a medical and social history of the patient;

1.4. Evaluate the hard and soft tissues of the face and jaws, including a basic cancer screen; and/or

1.5. Evaluate the periodontal status and oral hygiene of the patient.

2. You failed to report, either adequately or at all, on the radiographs taken on 22nd June 2015 and/or 3rd November 2016.

Patient L

1. You administered sedation as follows:

1.1. Midazolam (unspecified) on 21st April 2015;

1.2. Midazolam (10mg) on 5th May 2015;

1.3. Midazolam (10mg) on 10th November 2015;

1.4. Midazolam (10mg) on 1st December 2015.

2. You failed to provide an adequate standard of care between 21st April 2015 and 9th March 2016, in that you did not:

2.1. Obtain a history of the patient's current condition, needs, and aspirations;

2.2. Obtain the dental history of the patient;

2.3. Obtain a medical and social history of the patient;

2.4. Evaluate the hard and soft tissues of the face and jaws, including a basic cancer screen; and/or

2.5. Evaluate the periodontal status and oral hygiene of the patient.

3. You failed to provide an adequate standard of sedation at one or more of the appointments under 1.1 through 1.4 in that you failed to:

3.1. Obtain written consent, either adequately or at all, for sedation;

3.2. Take, or record having taken, an updated medical history;

3.3. Assess, or record your assessment of, whether sedation was the most appropriate method of managing pain or anxiety, as opposed to other methods;

3.4. Assess, or record your assessment of, their ASA score;

3.5. Provide, or record your provision of, pre-sedation information and/or instructions;

3.6. Conduct, or record your conduct of, a pre-sedation assessment of the patient for their suitability sedation;

3.7. Record the beginning and/or end times of sedation

3.8. Provide, or record your provision of, post-sedation information and/or instructions at the appointment under 1.1;

3.9. Adequately monitor, or record your monitoring of, their response to sedation including with regards to blood pressure, pulse and/or oxygen saturation at appropriate intervals before, during, and/or after sedation;

3.10. Adequately monitor, or record your monitoring of, their clinical parameters (including respiration, skin colour and/or depth of sedation) at appropriate intervals before, during, and/or after sedation;

3.11. Assess, or record your assessment of, whether they met the discharge criteria;

3.12. Ensure, or record having ensured, that they were accompanied by a responsible escort at the point of discharge; and/or

3.13. Record the name and/or role of the staff acting as your sedation team, if any.

4. You failed to record the dose of Midazolam given at the appointment under 1.1.

5. You administered sedation without appropriate support, in the form of one nurse to care for the sedated patient and a second nurse to assist with the dental care provided, at one or more of the appointments under 1.1 through 1.4.

6. Your conduct under 5 endangered the health of Patient L, in that you lacked the support required to administer sedation safely.

7. You conducted root canal treatment at the appointments under 1.3 and/or 1.4 without use of a rubber dam.

8. Your conduct under 7 endangered the health of Patient L, in that it created a risk of the patient aspirating small instruments while sedated.

9. You failed to report, either adequately or at all, on the radiograph taken on 21st April 2015

Patient M

1. You administered sedation as follows:

    1.1. Midazolam (5mg) on 27th November 2015;

    1.2. Midazolam (5mg) on 18th March 2016;

    1.3. Midazolam (unspecified) on 6th September 2016.

2. You failed to provide an adequate standard of care between 19th February 2014 and 4th August 2016 in that you did not:

    2.1. Obtain a history of the patient's current condition, needs, and aspirations;

    2.2. Obtain the dental history of the patient;

    2.3. Obtain a medical and social history of the patient; and/or

    2.4. Evaluate the hard and soft tissues of the face and jaws, including a basic cancer screen at appointments on 19th February 2014 and 21st August 2014.

3. You failed to provide an adequate standard of sedation at one or more of the appointments under 1.1 through 1.3, in that you failed to:

    3.1. Take, or record having taken, an updated medical history;

    3.2. Assess, or record your assessment of, whether sedation was the most appropriate method of managing pain or anxiety, as opposed to other methods;

    3.3. Assess, or record your assessment of, their ASA score;

3.4. Provide, or record your provision of, pre-sedation information and/or instructions;

3.5. Conduct, or record your conduct of, a pre-sedation assessment of the patient for their suitability for sedation;

3.6. Record the beginning and/or end times of sedation;

3.7. Adequately monitor, or record your monitoring of, their response to sedation including with regards to blood pressure, pulse and/or oxygen saturation at appropriate intervals before, during, and/or after sedation;

3.8. Adequately monitor, or record your monitoring of, their clinical parameters (including respiration, skin colour and/or depth of sedation) at appropriate intervals before, during, and/or after sedation;

3.9. Assess, or record your assessment of, whether they met the discharge criteria;

3.10. Ensure, or record having ensured, that they were accompanied by a responsible escort at the point of discharge; and/or

3.11. Record the name and/or role of the staff acting as your sedation team, if any.

4. You failed to record the dose of Midazolam given at the appointment under 1.3.

5. You administered sedation without appropriate support, in the form of one nurse to care for the sedated patient and a second nurse to assist with the dental care provided, at the appointments under 1.1 and 1.3.

6. Your conduct under 5 endangered the health of Patient M, in that you lacked the support required to administer sedation safely.

7. You conducted root canal treatment at the appointment under 1.1 without use of a rubber dam.

8. Your conduct under 7 endangered the health of Patient M, in that it created a risk of the patient aspirating small instruments while sedated.

Patient N

1. You administered sedation as follows:

1.1. Midazolam (5mg) on 28th August 2014;

1.2. Midazolam (5mg) on 16th November 2015;

1.3. Midazolam (5mg) on 20th October 2016;

1.4. Midazolam (7mg) on 21st November 2016.

2. You failed to provide an adequate standard of sedation at one or more of the appointments under 1.1 through 1.4, in that you failed to:

2.1. Take, or record having taken, an updated medical history;

2.2. Assess, or record your assessment of, whether sedation was the most appropriate method of managing pain or anxiety, as opposed to other methods;

2.3. Assess, or record your assessment of, their ASA score;

2.4. Provide, or record your provision of, pre-sedation information and/or instructions;

2.5. Conduct, or record your conduct of, a pre-sedation assessment of the patient for their suitability for sedation;

2.6. Record the beginning and/or end times of sedation;

2.7. Provide, or record your provision of, post-sedation information and/or instructions;

2.8. Adequately monitor, or record your monitoring of, their response to sedation including with regards to blood pressure, pulse and/or oxygen saturation at appropriate intervals before, during, and/or after sedation;

2.9. Adequately monitor, or record your monitoring of, their clinical parameters (including respiration, skin colour and/or depth of sedation) at appropriate intervals before, during, and/or after sedation;

2.10. Assess, or record your assessment of, whether they met the discharge criteria;

2.11. Ensure, or record having ensured, that they were accompanied by a responsible escort at the point of discharge; and/or

2.12. Record the name and/or role of the staff acting as your sedation team, if any.

3. You failed to administer sedation with appropriate support, in the form of one nurse to care for the sedated patient and a second nurse to assist with the dental care provided at the appointments under 1.2, 1.3 and/or 1.4.

4. Your conduct under 3 endangered the health of Patient N, in that you lacked the support required ot administer sedation safely.

Patient O

1. You failed to provide an adequate standard of care between 11th April 2012 and 26th February 2016, in that you did not:

1.1. Obtain a history of the patient's current condition, needs, and aspirations;

1.2. Obtain the dental history of the patient;

1.3. Obtain a medical and social history of the patient;

1.4. Evaluate the hard and soft tissues of the face and jaws, including a basic cancer screen in appointments before 26th February 2016; and/or

1.5. Evaluate the periodontal status and oral hygiene of the patient.

2. In the alternative to 1.1 through 1.5, you failed to record one or more of those matters.

Patient P

1. You administered sedation as follows:

1.1. Midazolam (7mg) on 5th September 2011;

1.2. Midazolam (10mg) on 12th June 2012;

1.3. Midazolam (9mg) on 23rd June 2016.

2. You failed to provide an adequate standard of care between 5th September 2011 and 23rd June 2016, in that you did not:

    2.1. Obtain a history of the patient's current condition, needs, and aspirations;

    2.2. Obtain the dental history of the patient;

    2.3. Obtain a medical and social history of the patient;

    2.4. Evaluate the hard and soft tissues of the face and jaws, including a basic cancer screen (save for an appointment of 7th January 2016);

    2.5. Evaluate the periodontal status and oral hygiene of the patient; and/or

    2.6. Provide advice regarding preventive care.

3. You failed to provide an adequate standard of sedation at one or more of the appointments under 1.1 through 1.3, in that you failed to:

    3.1. Take, or record having taken, an updated medical history;

    3.2. Assess, or record your assessment of, whether sedation was the most appropriate method of managing pain or anxiety, as opposed to other methods;

    3.3. Assess, or record your assessment of, their ASA score;

    3.4. Provide, or record your provision of, pre-sedation information and/or instructions;

    3.5. Conduct, or record your conduct of, a pre-sedation assessment of the patient for their suitability for sedation;

    3.6. Record the beginning and/or end times of sedation;

    3.7. Provide, or record your provision of, post-sedation information and/or instructions;

    3.8. Adequately monitor, or record your monitoring of, their response to sedation including with regards to blood pressure, pulse and/or oxygen saturation at appropriate intervals before, during, and/or after sedation;

    3.9. Adequately monitor, or record your monitoring of, their clinical parameters (including respiration, skin colour and/or depth of sedation) at appropriate intervals before, during, and/or after sedation;

    3.10. Assess, or record your assessment of, whether they met the discharge criteria;

    3.11. Ensure, or record having ensured, that they were accompanied by a responsible escort at the point of discharge; and/or

    3.12. Record the name and/or role of the staff acting as your sedation team, if any.

4. You failed to administer sedation with appropriate support, in the form of one nurse to care for the sedated patient and a second nurse to assist with the dental care provided, at one or more of the appointments under 1.1 through 1.3.

5. Your conduct under 4 endangered the health of Patient P, in that you lacked the support required to administer sedation safely.

Patient Q

1. You failed to provide an adequate standard of care between 10th January 2013 and 5th April 2017, in that you did not:

    1.1. Obtain a history of the patient's current condition, needs, and aspirations;

    1.2. Obtain the dental history of the patient;

    1.3. Obtain a medical and social history of the patient;

    1.4. Evaluate the hard and soft tissues of the face and jaws, including a basic cancer screen in appointments before 10th August 2015;

    1.5. Evaluate the periodontal status and oral hygiene of the patient; and/or

    1.6. Provide advice regarding preventive care.

Patient R

1. You administered sedation as follows:

    1.1. Midazolam (5mg) on 3rd November 2009;

    1.2. Midazolam (10mg) on 10th December 2015;

    1.3. Midazolam (10mg) on 23rd December 2015.

2. You failed to provide an adequate standard of care between 2nd April 2008 and 23rd December 2015, in that you did not:

    2.1. Obtain a history of the patient's current condition, needs, and aspirations;

    2.2. Obtain the dental history of the patient;

    2.3. Obtain a medical and social history of the patient;

    2.4. Evaluate the hard and soft tissues of the face and jaws, including a basic cancer screen (save for an appointment of 27th November 2015);

    2.5. Evaluate the periodontal status and oral hygiene of the patient; and/or

    2.6. Provide advice regarding preventive care.

3. You failed to provide an adequate standard of sedation at one or more of the appointments under 1.1 through 1.3, in that you failed to:

    3.1. Take, or record having taken, an updated medical history;

    3.2. Assess, or record your assessment of, whether sedation was the most appropriate method of managing pain or anxiety, as opposed to other methods;

    3.3. Assess, or record your assessment of, their ASA score;

    3.4. Provide, or record your provision of, pre-sedation information and/or instructions;

    3.5. Conduct, or record your conduct of, a pre-sedation assessment of the patient for their suitability for sedation;

3.6. Record the beginning and/or end times of sedation;

3.7. Provide, or record your provision of, post-sedation information and/or instructions;

3.8. Adequately monitor, or record your monitoring of, their response to sedation including with regards to blood pressure, pulse and/or oxygen saturation at appropriate intervals before, during, and/or after sedation;

3.9. Adequately monitor, or record your monitoring of, their clinical parameters (including respiration, skin colour and/or depth of sedation) at appropriate intervals before, during, and/or after sedation;

3.10. Assess, or record your assessment of, whether they met the discharge criteria;

3.11. Ensure, or record having ensured, that they were accompanied by a responsible escort at the point of discharge; and/or

3.12. Record the name and/or role of the staff acting as your sedation team, if any.

4. You failed to administer sedation with appropriate support, in the form of one nurse to care for the sedated patient and a second nurse to assist with the dental care provided, at one or more of the appointments under 1.1 through 1.3.

5. Your conduct under 4 endangered the health of Patient R, in that you lacked the support required to administer sedation safely.

6. You failed to provide an adequate standard of care, in that you failed to take bitewing radiographs to aid diagnosis between 2nd April 2008 and 23rd December 2015.

Patient S

1. You administered sedation as follows:

1.1. Midazolam (unspecified) on 6th March 2014;

1.2. Midazolam (7mg) on 16th April 2015;

1.3. Midazolam (5mg) on 3rd December 2015;

1.4. Midazolam (6mg) on 16th May 2016;

1.5. Midazolam (7mg) on 27th October 2016.

2. You failed to provide an adequate standard of care between 6th March 2014 and 6th November 2015, in that you did not:

2.1. Obtain a history of the patient's current condition, needs, and aspirations;

2.2. Obtain the dental history of the patient;

2.3. Obtain a medical and social history of the patient;

2.4. Evaluate the hard and soft tissues of the face and jaws, including a basic cancer screen;

2.5. Evaluate the periodontal status and oral hygiene of the patient; and/or

2.6. Provide advice regarding preventive care.

3. You failed to provide an adequate standard of care after taking a radiograph of the UL6 on 6th March 2014, in that you did not:

3.1. Report on the radiograph, either adequately or at all; and/or

3.2. Discuss with the patient the perforation of the distal root that had occurred during root canal treatment.

4. You failed to provide an adequate standard of sedation at one or more of the appointments under 1.1 through 1.5, in that you failed to:

4.1. Provide any, or any adequate, advice on preventive care;

4.2. Take, or record having taken, an updated medical history;

4.3. Assess, or record your assessment of, whether sedation was the most appropriate method of managing pain or anxiety, as opposed to other methods;

4.4. Assess, or record your assessment of, their ASA score;

4.5. Provide, or record your provision of, pre-sedation information and/or instructions;

4.6. Conduct, or record your conduct of, a pre-sedation assessment of the patient for their suitability for sedation;

4.7. Record the beginning and/or end times of sedation;

4.8. Adequately monitor, or record your monitoring of, their response to sedation including with regards to blood pressure, pulse and/or oxygen saturation at appropriate intervals before, during, and/or after sedation;

4.9. Adequately monitor, or record your monitoring of, their clinical parameters (including respiration, skin colour and/or depth of sedation) at appropriate intervals before, during, and/or after sedation;

4.10. Ensure, or record having ensured, that they were accompanied by a responsible escort at the point of discharge; and/or

4.11. Record the name and/or role of the staff acting as your sedation team, if any.

5. You failed to administer sedation with appropriate support, in the form of one nurse to care for the sedated patient and a second nurse to assist with the dental care provided on appointments under 1.1, 1.2, and/or 1.5.

6. Your conduct under 5 endangered the health of Patient S, in that you lacked the support required to administer sedation safely.

Patient T

1. You failed to provide an adequate standard of care, in that you:

1.1. Provided no, or no adequate, advice on preventive care between 3rd October 2014 and 13th October 2016; and/or

1.2. Failed to report on the two radiographs taken on 3rd October 2014 either adequately or at all.

AND that by reason of the matters alleged above your fitness to practise is impaired by reason of misconduct.