Hearing heard in public
Professional Conduct Committee
Initial Hearing
17- 20 March 2025

Name:	HAMILTON, Malcom
Registration number:	64770
Case number:	CAS-202067

General Dental Council:	John Greany, counsel Instructed by Sarah Atkinson, Kingsley Napley LLP.
Registrant:	Not Present Unrepresented

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

Committee members:	Rhona Stevens (Chair, Dentist member) Tanya Viehoff(Dental Care Professional member) Tara Wilmott(Lay member)
Legal adviser:	Tanveer Rakhim
Committee Secretary:	Jamie Barge

The amended allegations are as follows:

"*That being registered as a dentist, Malcom Hamilton's fitness to practise is impaired by reason of misconduct in that he:*

Patient 2

1. *Failed to provide an adequate standard of care to Patient 2 on 8 April 2022 by failing to make a clinical diagnosis of caries at UL2*

Patient 3

2. *Failed to provide an adequate standard of care to Patient 3 on 18 April 2022, including by:*
   a) *Failing to use a rubber dam when providing root canal treatment.*
   b) *Failing to use any appropriate method (e.g. an apex locator or working-length film) to determine working length.*

Patient 6

3. *Failed to provide an adequate standard of care to Patient 6 by failing to use a rubber dam during root-canal treatment at appointments on:*
   a) *17 March 2022;*
   b) *28 March 2022.*

Patient 12

4. *Failed to provide an adequate standard of care to Patient 12 between 15 October 2021 and 14 July 2022 by:*
   a) *Failing to adequately assess the working length film exposed on 1 November 2021;*
   b) *Failing to adequately obturate the UL4 tooth to within 2mm of the radiographic apex*

Patient 13

5. *Failed to provide an adequate standard of care to Patient 13 on 2 May 2022 by failing to adequately remove caries at LL3.*

Patient 14

6. *Failed to provide an adequate standard of care to Patient 14 on 6 July 2022 by:*

   a) *As amended - Failing to identify extensive buccal caries at LR8 and/or failed to reasonably record that on a radiographic report.*
   b) *As amended - Failing to make a clinical diagnosis of that caries at LR8 on examination of the patient.*

Patient 15

7. *Failed to provide an adequate standard of care to Patient 15 by failing to adequately remove caries at UR7 on 19 July 2022 and/or alternatively failing to diagnose the buccal caries clinically.*

Patient 17

8. *Failed to provide an adequate standard of care to Patient 17 from 8 April 2022 to 7 July 2022 by failing to adequately remove decay when placing a filling at LR6 on 25 April 2022.*

Patient 20

9. *Failed to maintain an adequate standard of record keeping in respect of Patient 20's appointment on 22 June 2022*

Patient 24

10. *Failed to provide an adequate standard of care to Patient 24 from 23 November 2021 to 9 May 2022 by:*
    a) *As amended - Failing to adequately analyse the radiographs of 2 December 2021 in respect of caries at UL4 and LL5;*
    b) *Failing to adequately diagnose caries at UL4 and/or LL4 and/or LL5*"

1. This is an initial hearing before the Professional Conduct Committee, pursuant to section 27B of the Dentists Act 1984 (as amended) ('the Act').

2. The hearing is being conducted remotely by Microsoft Teams video-link.

3. Mr Hamilton is not present nor represented at these proceedings. Mr John Greany, Counsel, appears on behalf of the General Dental Council (GDC).

Preliminary Matters

4. The Committee first considered the issues of service and proceeding in the absence of Mr Hamilton. In so doing, it had regard to the GDC's hearing bundle as well as the submissions made by Mr Greany on behalf of the GDC. It accepted the advice of the Legal Adviser on these matters.

Decision on service

5. The Committee first considered whether notice of the hearing had been served on Mr Hamilton in accordance with Rules 13 and 65 of the GDC (Fitness to Practise) Rules Order of Council 2006 ('the Rules'), and section 50A of the Act.

6. The Committee had regard to the Notice of Hearing ('the notice') dated 28 January 2025, which was sent to Mr Hamilton's registered address by international post. The Committee noted that the address shown on the notice is the same address as that shown on the printout of the GDC's entry of Mr Hamilton's contact details. Presented is an International signed envelope, confirming that the notice was sent via international delivery to Mr Hamilton's registered overseas address. The Committee also noted that a copy of the notice was emailed to Mr Hamilton's registered email address on 28 January 2025.

7. The Committee was satisfied that the notice sent to Mr Hamilton 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, time and duration of the hearing, confirmation that it would be held remotely by Microsoft Teams, and that the Committee had the power to proceed with the hearing in the absence of Mr Hamilton.

8. Accordingly, the Committee was satisfied that notice of the hearing had been served on Mr Hamilton in accordance with the Rules and the Act.

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

9. The Committee next considered whether to exercise its discretion under Rule 54 to proceed with the hearing in the absence of Mr Hamilton. It had regard to the factors to be considered in reaching its decision, as set out in the case of R v Jones [2003] 1 AC 1HL, and as affirmed in the joined regulatory cases of General Medical Council v Adeogba and General Medical Council v Visvardis [2016] EWCA Civ 162. The Committee also took into account the need to be fair to both Mr Hamilton and the GDC, as well as the public interest in the expeditious disposal of this case.

10. The Committee bore in mind that the Notice of Hearing letter dated 28 January 2025 to Mr Hamilton advised him that the Committee had the power to proceed in his absence. He was invited to inform the GDC by 11 February 2025 of confirmation of his attendance, but no response was received by the GDC. It was informed that the GDC contacted the Registrant on or around October 2022, where he responded that no longer wished to be contacted by the GDC.

11. Having regard to all the information before it, the Committee was satisfied that Mr Hamilton has voluntarily absented himself from it. Mr Hamilton has not applied for an adjournment. In the Committee's judgement, there is no information to suggest that an adjournment would secure his attendance on a future date. Accordingly, the Committee decided that in the absence of any good reason not to proceed, it was fair and in the public interest to proceed with the hearing in the absence of Mr Hamilton.

Application to amend the charge

12. Mr Greany made another application under Rule 18 to amend head of charge 6 to add the words "LR8" before the words caries at 6(a) and 6(b). It should read as follows:

> *6. Failed to provide an adequate standard of care to Patient 14 on 6 July 2022 by:*
>
> *a) Failing to identify extensive buccal caries at LR8 and/or failed to reasonably record that on a radiographic report.*
> *b) Failing to make a clinical diagnosis of that caries at LR8 on examination of the patient.*

13. Mr Greany also applied to correct a typographical error within allegation 10 which refers to 3 December when the expert indicates that the appointment was on 2 December 2021 in respect of Patient 24. It should read as follows:

> 10) *Failed to provide an adequate standard of care to Patient 24 from 23 November 2021 to 9 May 2022 by:*
>
> *a) As amended - Failing to adequately analyse the radiographs of 2 December 2021 in respect of caries at UL4 and LL5;*
> *b) Failing to adequately diagnose caries at UL4 and/or LL4 and/or LL5*"

14. Mr Greany submitted that the proposed changes are uncontroversial and could be made without injustice to Mr Hamilton since they did not change the meaning or the way in which the GDC put its case.

15. The Committee had regard to the submissions made by Mr Greany. It accepted the advice of the Legal Adviser.

16. The Committee was satisfied that the proposed amendments as set out at 6 and 10 above could be made without injustice. Accordingly, the Committee acceded to the GDC's application.

Summary of the case

17. Malcolm Hamilton ("the Registrant") had been employed as a Senior Dental Officer at 'The Hospital' in the Falkland Islands. The dental clinic is the sole provider of dental care on the Falkland Islands that is available to the islands' civilians, and it is here that the Registrant was working at the relevant time. The Registrant was responsible for the entire Dental Department at this hospital in his capacity as Senior Dental Officer.

18. This case concerns Mr Hamilton's conduct arising from a referral to the GDC on 10 August 2022 by the Director of Health and Social Services for the Falklands Island Government. He had been alerted to concerns about Mr Hamilton's clinical work by two dental professionals, Witness 1 and Witness 2, who worked at the hospital.

19. Witness 1 was a dental officer working with the Registrant. She knew the Registrant in his capacity as the hospital's Senior Dental Officer. She was the subsequent treating dentist in relation to a number of patients who had been examined by the Registrant. In her witness statement that she raised concerns about Mr Hamilton with the Director of Health and Social Services. Witness 2 is a Dental Officer at the Hospital, and subsequent treating dentist for a number of patients, after the Registrant had departed.

20. The Director in his referral provided examples of patients treated by Mr Hamilton where concerns had been raised. He explained that there were several more examples where there appeared to be misdiagnoses, or poor treatment leaving patients in some pain and with a distrust in the Dental Service. As a result of these concerns, Mr Hamilton was suspended from his position in the Falkland Islands.

Findings of Fact

21. The Committee had regard to a number of documents, including the GDC hearing bundle, referred to as Exhibit 1. This bundle included but was not limited to a number of witness statements with associated exhibits, namely:

- Witness 1's written statement dated 30 July 2024;
- Witness 2's written statement dated 31 July 2024;
- Witness 3's written statement dated 13 August 2024 and associated patient records;
- GDC expert witness report dated 22 August 2024;

22. The Committee also heard oral evidence from the following witnesses:

- Witness 1;
- Witness 2; and
- GDC expert witness.

23. The Committee considered all the evidence presented to it, both documentary and oral. It took account of the submissions on the alleged facts made by Mr Greany on behalf of the GDC.

24. The Committee notes that the Registrant has not provided any representations to the heads of charge against him.

25. The Committee considered the factual allegations separately, bearing in mind that the burden of proof rests with the GDC and that the standard of proof is the civil standard, that is, whether the alleged matters are proved on the balance of probabilities.

26. The Committee made the following findings:

1	***Patient 2*** *Failed to provide an adequate standard of care to Patient 2 on 8 April 2022 by failing to make a clinical diagnosis of caries at UL2.* ***Found proved*** In its consideration of charge 1, the Committee had regard to the written and oral evidence of Witness 2 as well as the findings of the expert report. Witness 2's evidence was that Mr Hamilton failed to make an adequate diagnosis of caries of Patient 2's UL2. In her written statement she stated "*This patient had previously seen the Registrant and when I inspected the mouth, I saw that there was a very deep decay and the caries were getting close to the nerve. Fortunately, because the patient had noticed the problem, we could clean and repair it with a filling. This was the sort of decay which was quite obvious visually and the patient could feel it with her tongue. Given the patient had been examined by the Registrant a few months before, it would be hard to imagine that that very large decay would not have been visible during that examination*." The Committee also had regard to the GDC expert report. Mr Bateman reviewed the records and stated: "*On the evidence of Witness 2 then in my view there was an on-balance failure of the Registrant to have diagnosed and treat decay at the UR21 [sic] on the basis of his clinical examination on 08/04/22. That was a failure of basic care and put the patient at risk of decay progressing and infection and tooth loss. That fell far below a reasonable standard in my view*." Witness 2 in oral evidence stated that when she subsequently examined the patient, she confirmed that the patient had significant caries. The Committee notes the previous appointment was 5 months prior to Witness 2 examining the patient.

	The Committee found Witness 2's evidence to be credible on this point and to be consistent with the documentary evidence contained in the GDC's hearing bundle. The Committee notes the patient's computer records had a watch symbol placed on it. However, no witness was able to confirm who had done this. Even so, regardless of who put the watch on against the patient's records, the Registrant had failed to act upon this either by treating the caries or providing preventative advice or therapy, and did not make a record of this. The Committee is satisfied that when the Registrant examined Patient 2, he had a duty to diagnose and treat any signs of caries. Taking all of this into account, the Committee is satisfied the caries was significant at that material time, that the Registrant failed in his duty to make a clinical diagnosis of caries at UL2. Accordingly, it finds this head of charge proved.
2	***Patient 3*** *Failed to provide an adequate standard of care to Patient 3 on 18 April 2022, including by:*
2a	*Failing to use a rubber dam when providing root canal treatment.* ***Found proved*** In reaching its decision, the Committee had regard to the GDC expert report. Mr Bateman reviewed the records and stated: *"There is no evidence that rubber dam was used here in the records or on any of the available radiographs. Any reasonable dentist would use rubber dam for endodontics as a matter of course."* The expert stated in oral evidence that when using a rubber dam particularly on back teeth, clamps are used to hold it onto the back teeth. These clamps would be visible on radiographs. He stated there are no radiographs to confirm this. He also stated in oral evidence "*that it is the basic standard to use a rubber dam when providing root canal treatment*. The Committee is satisfied that there are no radiographs which indicate that clamps were present. Witness 1 and 2 confirmed in oral evidence that rubber dams and clamps are used at the practice and are readily available. The Committee accepts that it is common practice for dentists to use rubber dams to protect patients when undertaking root canal treatment. Records before this Committee indicate that the Registrant noted the use of rubber dams occasionally for root canal treatment. The Committee accepts the

	evidence of the expert witness that the Registrant failed to his duty to use a rubber dam on this occasion. The Committee also accepts the evidence of both witnesses 1 and 2, that rubber dams were available for the Registrant to use at the material time. Both Witness 1 and 2 expressed the view that the trainee dental nurses who worked with the Registrant were also unfamiliar with the rubber dam technique until they subsequently worked with other treating dentists. The Committee considered that this demonstrated little use of rubber dams by the Registrant. Taking all of this into account, the Committee is satisfied that on the balance of probabilities, the Registrant failed in his duty to use a rubber dam during root canal treatment for Patient 3 on 18 April 2022. Accordingly, it finds this allegation proved.
2b	*Failing to use any appropriate method (e.g. an apex locator or working-length film) to determine working length.* ***Found not proved*** In reaching its decision, the Committee had regard to the conclusions of the expert written report. In particular he notes that*: "There was no working length film present or reflected in the records."* The Committee noted in the patient records that three radiographs were taken. Also, he made a record stating "*PAs for RCT correct patient Grade A pre-op single canal WLPA 18mm, short Post op, no canal visible apical to GP*". The Committee is satisfied that the Registrant having made a note as above, despite not having had sight of this periapical radiograph, implies that he undertook methods to determine the patients working length. The Committee takes the initials WLPA to mean working length periapical radiograph. The Committee notes the Registrant had made previous record entries of using working-lengths films to determine working lengths. The Committee is satisfied that it would have been his usual practice to do this. It also noted the oral evidence from Witness 1 and 2 that the radiographs were kept on a separate system from that of the patient record system. The Committee therefore considers that on balance of probabilities it is likely that the Registrant would have taken a working length radiograph, based on the notes he made above. Accordingly, it finds this allegation not proved.

3	***Patient 6*** *Failed to provide an adequate standard of care to Patient 6 by failing to use a rubber dam during root-canal treatment at appointments on:*
3.(a)	*17 March 2022;* ***Found proved*** The Committee has had regard to the written expert report, and in particular: *"The Registrant carried out root canal treatment at UR5 on 17/03/22. No rubber dam clamp was visible and there was no mention of the use of rubber dam. On that I am critical of an on-balance failure to have used rubber dam for root canal treatment…. The Registrant attempted to find the canal at UL2 on 28/03/22 but was unable to because that tooth was naturally difficult. I am not critical of that failure. There was no record that rubber dam was used for root canal treatment at UL2 on 28/03/22."* The expert notes that, based on the available records, during RCT on both these dates no rubber dam appears to have been used by the Registrant. The Committee having examined the patient records, is satisfied that no record has been made of any rubber dams being used on these dates. The Committee accepts the evidence of the expert witness that he had a duty to put a rubber dam on in this case prior to providing root canal treatment. It is satisfied on the balance of probabilities that the Registrant had failed to use a rubber dam on 17 March 2022 and 28 March 2022. Accordingly, it finds this head of charge proved.
3.(b)	*28 March 2022.* *Proved for reasons as given above for head of charge 3(a).*
4	***Patient 12*** *Failed to provide an adequate standard of care to Patient 12 between 15 October 2021 and 14 July 2022 by:*
4.(a)	*Failing to adequately assess the working length film exposed on 1 November 2021;* ***Found proved*** The Committee has had regard to the written expert report, and in particular: *…He completes root canal treatment on 29/11/21. The root canal filling was placed at the same length as the evidently short diagnostic film on 29/11/21. The Registrant notes that at being short of the apex. In my view it was significantly short of the apex by around 4-5mm and that was wholly avoidable with reasonable consideration of the working length xray exposed on 29/11/21. The acceptable standard is to obturated to*

	within 2mm of the radiographic apex or closer. In my view, the Registrant failed to have adequately assessed the working length film exposed on 01/11/21 and diagnosed that working length was too short. The Registrant avoidably placed a significantly short root canal filling at the UL4 per the post op radiograph dated 01/12/21. In my view the second failure was linked to the first but there was a duty in respect of both. That was basic care and left the patient at significant risk of root canal infection and premature failure of the tooth. For that reason, I say that the endodontic care fell far below a reasonable standard here… The Committee carefully considered the patient notes for this date and cannot find any record of the Registrant assessing the working length or making adjustments in the light of the radiograph exposed on 1 November 2021. It notes that it is the duty of a Registrant to check and take appropriate action and is satisfied that he failed to do so. The Committee is satisfied on the balance of probabilities that the Registrant failed to adequately assess the working length film exposed on 1 November 2021. Accordingly, it finds this head of charge proved.
4.(b)	*Failing to adequately obturate the UL4 tooth to within 2mm of the radiographic apex.* *Found proved.* The Committee examined the patient records and the radiographs. It noted the relevant radiograph clearly shows a unfilled patent canal apical to the root filling material in Patient 12's UL4. The Committee accepted the evidence of the expert witness that there is a duty for the Registrant to fill the tooth to within 2mm of the apex, and that in this case he stated in his report "*The Registrant avoidably placed a significantly short root canal filling at the UL4 per the post op radiograph dated 01/12/21". The expert also stated "In my view it was significantly short of the apex by around 4-5mm and that was wholly avoidable with reasonable consideration of the working length xray exposed on 29/11/21."* Having assessed the patient records and associated radiographs, the Committee considered there is no evidence that he had adequately obturated Patient 12's UL4. The Committee therefore finds this head of charge proved.
5.	***Patient 13*** *Failed to provide an adequate standard of care to Patient 13 on 2 May 2022 by failing to adequately remove caries at LL3.* ***Found proved.*** The Committee has had regard to the written expert report, and in particular:

	"The patient returned a mere 3 months later on 27/07/22 with pain at the LL4…The same caries was imaged radiographically on that date. Given its extensive size it appears very likely that the Registrant failed to adequately remove caries at LL3. That fell far below a reasonable standard given that was very basic care and put the patient at significant risk of caries progression and later tooth loss." The Committee took into account that on the appointment on 19 April 2022, radiographs were available for the Registrant, to examine the extent of the caries that was present. He undertook a composite filling on LL3 on 2 May 2022. Witness 1 the subsequent treating dentist a mere three later, confirmed in her oral evidence, that when she examined Patient 13, there was gross decay, and she had to root fill the tooth. The Committee accepts the evidence of the expert witness and Witness 1. The Committee determined the Registrant failed to identify and adequately remove all of the caries at LL3 regarding Patient 13 on 2 May 2022. The Committee therefore find this head of charge proved.
6.	***Patient 14*** *Failed to provide an adequate standard of care to Patient 14 on 6 July 2022 by:*
6.(a).	*As amended - Failing to identify extensive buccal caries at LR8 and/or failed to reasonably record that on a radiographic report.* ***Found proved in respect of failure to identify only.*** The Committee has had regard to the written expert report, and in particular: *…Extensive buccal caries was imaged at LR8 on 06/07/22. The registrant failed to apprehend that on the right bitewing and/or failed to reasonably record that on a radiographic report…Without prejudice to the x-ray failings, in my view the Registrant failed to have made a clinical diagnosis of that caries on his own examination.* The Committee had regard to the patient notes and associated radiographs. It also took into account the patient notes made by Witness 2, the subsequent treating dentist who recorded at that time "*large buccal caries cavity*". The Committee is satisfied that at the time of examination by the Registrant, it would have been more than likely that on 6 July 2022 he failed to identify the extensive buccal caries on the radiograph. Therefore, he failed in his duty to make a clinical diagnosis. As he has failed to identify the caries, the Committee is satisfied that he would not have been able to make a record of this.

	The Committee therefore finds this head of charge proved only in respect of failing to identify .
6.(b).	*As amended - Failing to make a clinical diagnosis of that caries at LR8 on examination of the patient.* ***Found proved for reasons as given above in head of charge 6(a).***
7.	***Patient 15*** *Failed to provide an adequate standard of care to Patient 15 by failing to adequately remove caries at UR7 on 19 July 2022 and/or alternatively failing to diagnose the buccal caries clinically.* ***Found proved.*** The Committee has had regard to the written expert report, and in particular: *"…Fillings were placed by the Registrant at UR7 LR5 on 19/07/22. The patient returned a mere week later on 28/07/22 with pain at the UR7. A note was made that a large buccal carious lesion was present, and a filling was placed. Given its large size and location it appears very likely that the Registrant either failed to adequately remove caries at that tooth on 19/07/22 or alternatively failed to diagnose that buccal caries clinically. That a buccal cavity was untreated at that tooth is supported by the factual evidence of [Witness 1] at her Witness Statement (12). That fell far below a reasonable standard given that was very basic care and put the patient at significant risk of caries progression and later tooth loss."* The Committee took into account the patient records and associated radiograph dated 6 July 2022. The Committee notes from the Registrant's records that he diagnosed caries on the distal and occlusal surface 6 July 2022 and treated this by only placing an occlusal composite filling on 9 July 2022. Witness 1 confirmed that when she subsequently treated the patient 9 days later, she identified the presence of a large amount of decay on the buccal aspect of the tooth. In her witness statement she stated: "*Patient 15 attended the dental practice to see me on 28 July 2022, nine days after receiving a filling in the UR7 tooth, placed by the Registrant. Patient 15 was experiencing ongoing pain and sensitivity from the tooth since the filling. Very extensive decay was found on the buccal wall of the tooth. The restoration that had been placed by the Registrant was a small filling on the occlusal (biting) surface of the tooth, not at all consistent with the very large sized cavity identifiable on the radiographs taken by the Registrant on 6 July 2022. Of note, the Registrant records this as distal caries in his notes on the 6 July 2022, also not consistent with the filling he placed on 19 July 2022. It appears that the Registrant had not noticed the decay*

	on the buccal wall, as there had been no attempt to clear the decay or restore this surface, and the restoration did not match the radiographic findings, which should have indicated a large filling was needed." The Committee accepts the evidence of the expert witness and also Witness 1 and is satisfied on the balance of probabilities that the Registrant failed to adequately diagnose and remove caries at UR7 on 19 July 2022. In addition, the Committee is satisfied that the Registrant also failed to diagnose the buccal caries clinically. The Committee finds this head of charge proved in its entirety.
8.	***Patient 17*** *Failed to provide an adequate standard of care to Patient 17 from 8 April 2022 to 7 July 2022 by failing to adequately remove decay when placing a filling at LR6 on 25 April 2022.* ***Found proved.*** The Committee has had regard to the written expert report, and in particular: *"…On 24/08/22 the filling is replaced at LR6 with a note made that buccal caries was present at a deep fissure and internally at the cavity left by the Registrant. On all the evidence then the Registrant failed to adequately remove decay when placing the filling at LR6 on 25/04/22. That fell far below a reasonable standard given that was very basic care and put the patient at significant risk of caries progression and later tooth loss…"* The Committee accepted the evidence of the expert witness. It also accepted the written and oral evidence of Witness 1, the subsequent treating dentist, who recorded in her notes that that she had spotted decay at Patient 17's LR6 on 24 August 2022. She stated in oral evidence that the buccal caries should have been identified and removed at the previous appointment. The Committee is satisfied that the Registrant had failed in his duty of care to adequately remove decay when placing a filling at LR6 on 25 April 2022. The Committee therefore finds this head of charge proved.
9.	***Patient 20*** *Failed to maintain an adequate standard of record keeping in respect of Patient 20's appointment on 22 June 2022.* ***Found proved.*** The Committee has had regard to the written expert report, which states:

	"*The Registrant it seems saw the patient on one occasion only 22/06/22. Bitewings were taken and it was reasonable to have done so. There are no records whatsoever in respect of this attendance. I am unclear for the reason for that. If the Registrant failed to make any records, then that fell far below a reasonable standard of record keeping. If he did make records but they are lost or missing through no fault of his own, then he met a reasonable standard. The committee will need to resolve the factual construction here. If it will assist, this seems to be relatively unusual in respect of the Registrant's overall record keeping*." Witness 1 in her oral evidence stated that both she and the Registrant were working in the practice at that time. She could not be sure who the patient had seen. Witness 2 in her oral evidence confirmed that she had taken over the treatment list from the Registrant whilst he was on leave. Finding there were no clinical records, she checked who the patient had seen previously by looking at the administration section of the computer system. She also consulted the dental nurse listed as being present on 22 June 2022. She also asked the patient who they had been treated by. The patient confirmed it was the Registrant. From this she was confident that it was the Registrant that the patient had seen and not Witness 1. Both witness 1 and 2 confirmed that the clinicians were responsible for entering notes for patient appointments. The Committee accepts the evidence of both Witness 2 and the expert witness. Despite the Committee not having seen these administrative notes, it is clear that Witness 2 had conducted her own checks. The Committee is satisfied on the balance of probabilities that the Registrant had seen Patient 20 on 22 June 2022 and that he failed in his duty to make any records for this date. It therefore finds this head of charge proved.
10.	***Patient 24*** *Failed to provide an adequate standard of care to Patient 24 from 23 November 2021 to 9 May 2022 by:*
10 (a).	*As amended - Failing to adequately analyse the radiographs of 2 December 2021 in respect of caries at UL4 and LL5;* ***Found proved.*** The Committee has had regard to the written expert report, and in particular: *Cervical caries was imaged at LL5 and distal caries at UL4 on 02/12/21. The registrant failed to apprehend that on the left bitewing and/or failed to reasonably record that on a radiographic report.*

	Without prejudice to the x-ray failings, in my view the Registrant failed to have made a clinical diagnosis of that caries on his own examination. *In my view analysing the bitewing film or adequately reporting the same; and further failing to clinically diagnose a buccal carious cavity at LL5 is basic care and that failure puts the patient at risk of caries progressing and tooth loss. That fell far below a reasonable standard in my view….* In his oral evidence and questions from the Committee the expert witness stated that it is his opinion that caries was present at that material time. The Committee having examined the patient notes, is satisfied that there is no evidence to demonstrate that the Registrant had analysed the radiographs of 2 December 2021 in respect of caries at UL4 and LL5. The Registrant's notes make no mention of caries on these teeth. The Committee is satisfied that radiographs provided show that caries was present at that material time. However, there is no record that he had analysed the relevant radiographs. The Committee is satisfied that the Registrant only made a clinical diagnosis at a later appointment on 9 May 2022 when the patient attended with a broken tooth at UL4. The Committee is satisfied on the balance of probabilities that the Registrant has failed in his duty of care to adequately analyse the radiographs. It finds this head of charge proved.
10(b).	*Failing to adequately diagnose caries at UL4 and/or LL4 and/or LL5.* ***Found proved.*** The Committee examined the patient records and is satisfied that the only time the Registrant had diagnosed the UL4 with caries was on 9 May 2022 following the tooth breaking. However, on all previous appointments on this period, he failed to diagnose caries regarding Patient 24. The Committee notes in the expert report, he stated: "*Caries was also noted at LL4 on 25/07/22 and I critical of the Registrant as falling far below a reasonable standard in failing to diagnose that caries clinically from 02/12/21."* The Committee is satisfied that the Registrant had a duty of care to diagnose caries at UL4, LL4 and LL5, but had failed to do so. It therefore finds this head of charge proved.

28. The hearing moves to Stage Two.

29. Having announced its decision on the facts, in accordance with Rule 20, the Committee heard submissions from Mr Greany in relation to the matters of misconduct, impairment and sanction.

30. Mr Greany first addressed the Committee on the matter of misconduct. He submitted that there have been found proved a substantial number of serious matters that plainly amount to misconduct. Moreover, it occurred over a protracted period of time and breached a position of trust in an isolated setting. He submitted that some of his failings resulted in patient harm. The findings amount to a departure from the GDC's Standards, and a finding of misconduct should be made.

31. In relation to the matter of impairment, Mr Greany submitted that the facts found proved demonstrate repeated and sustained conduct. The GDC's position is that Mr Hamilton has not provided any evidence of insight or any steps towards remediation. Nor has he demonstrated remorse or engaged in this hearing.

32. Mr Greany submitted that a finding of current impairment is necessary for the protection of patients as well as upholding professional standards and confidence in the profession.

33. Lastly, Mr Greany addressed the Committee on the matter of sanction. The GDC's position is that given the seriousness of the clinical concerns found proved, the absence of any insight or remediation and complete lack of engagement by Mr Hamilton, the appropriate and proportionate sanction is a 12 month suspension order with a review.

34. The Committee reminded itself that its decisions on misconduct, impairment and sanction are matters for its own independent judgement. There is no burden or standard of proof at this stage of the proceedings. It had regard to its duty to protect the public, declare and uphold proper standards of conduct and competence and maintain public confidence in the profession.

35. The Committee took into consideration the GDC's Standards for the Dental Team (September 2013) (updated June 2019) ('the Standards') and the Guidance for the Practice Committees, including Indicative Sanctions Guidance, (October 2016, revised December 2020) ('the Guidance'). The Committee also had regard to relevant case law.

36. The Committee accepted the advice of the Legal Adviser.

Decision on misconduct

37. The Committee first considered whether the facts found proved against Mr Hamilton amount to misconduct. The Committee has found that Mr Hamilton failed on six occasions over a number of patients to adequately diagnose and/or remove patients' caries. He also failed on three occasions to use rubber dams during root canal treatment. On one of those occasions failed to assess the working length, make the necessary alterations to that and proceeded to inadequately complete the root filling. Mr Hamilton also failed to analyse radiographs and maintain an adequate standard of record keeping.

38. Mr Hamilton's actions were compounded in that some of his failings resulted in patients suffering from pain. The subsequent treating dentist was required to remove and treat caries for various patient, and complete root canal treatment where caries was very advanced. One patient required implants, where their teeth were damaged beyond repair.

39. The Committee considers that Mr Hamilton has breached the following GDC's Standards:

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.

7.1 You must provide good quality care based on current evidence and authoritative guidance.

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

7.2 You must work within your knowledge, skills, professional competence and abilities.

40. The Committee also noted that the Registrant's conduct also fell below the basic care standards quoted in the Faculty of General Dental Practice (FGDP) UK guidelines, more particularly in consultation and diagnosis, restorations and endodontics.

41. The Committee noted the GDC expert report which stated that the clinical and record keeping failures fell far below the standards expected of a reasonably competent dentist. His failings relate to basic fundamental tenets of dentistry, including repeated failures to diagnose and treat patients' caries. Some of which resulted in patient harm. In the Committee's view, there appears to be a pattern of conduct by Mr Hamilton over a protracted period of time, relating to a number of patients. The Committee is satisfied that the identified clinical failings presented real safety issues for patients. The Committee considered that Mr Hamilton's acts and omissions as particularised in the heads of charge, constituted a disregard for the Standards set out above. His failures to adhere to regulations, standards and guidance in respect of diagnosis and treatment of caries and use of rubber dams, were a pattern of practice which the Committee found had put patients' safety at risk.

42. The Committee considers that patients had placed their trust in Mr Hamilton's competence and integrity as a dental professional. He was at the time in a position of trust as the Senior Dental Officer in a remote location where patients had little choice with regard to their dental provision. The Committee considered Mr Hamilton's actions and omissions in this situation could seriously undermine public trust and confidence in the dental profession. The Committee is satisfied Mr Hamilton's cumulative clinical failings over a period of time fell far below the conduct expected of a registered dental professional and would bring the profession into disrepute.

43. Taking all these factors into account, the Committee is satisfied that the findings cumulatively are serious and amount to misconduct.

Decision on impairment

44. The Committee then considered whether Mr Hamilton's fitness to practise is currently impaired by reason of his misconduct.

45. The Committee was mindful of its role to protect patients from risk of harm and to uphold the public interest, which includes the need to declare and maintain proper standards of conduct and performance.

46. The Committee considered that Mr Hamilton's misconduct was serious and was not an isolated incident. His misconduct was repeated over several months. The Committee note that some of his clinical failings resulted in actual patient harm. In the Committee's view, Mr Hamilton has acted so as to put patients at unwarranted risk of harm and could bring the dental profession into disrepute.

47. The Committee next considered whether the misconduct found proved is remediable. It considers that his clinical failings are capable of being remedied.

48. The Committee went on to consider whether Mr Hamilton has in fact remedied his failings. It has been provided with no evidence to suggest that he has developed any meaningful insight into his misconduct, or that he has taken steps to remedy his failings. The Committee has not drawn any inference from Mr Hamilton's absence at this hearing. At the same time, Mr Hamilton's lack of participation means that the Committee has not been provided with any meaningful evidence from him as to his acceptance of the heads of charge, any reflection or any remediation of the serious misconduct that has been found. For instance, the Committee has not been provided with any reflection or expression of remorse, or any information setting out any learning that he has undertaken, or intends to undertake, in order to address and overcome the misconduct that the Committee has found. The Committee noted there has been no contact from Mr Hamilton for over two years.

49. It noted that Mr Hamilton has not provided any evidence of his understanding of the importance for Registrants to follow the GDC's standards. The Committee's findings suggest a pattern of behaviour, the lessons of which Mr Hamilton has not begun to acknowledge and address.

50. The Committee considers that the public is at unwarranted risk of significant harm on account of Mr Hamilton's unremediated misconduct. Although the Committee notes that Mr Hamilton has no fitness to practise history, in assessing the risk of him repeating his misconduct, it is satisfied that the conduct is highly likely to reoccur. Such a repetition would in the Committee's judgement place patients at risk of harm. It therefore concluded that a finding of current impairment by reason of Mr Hamilton's misconduct is necessary in the interest of public protection.

51. The Committee further considered that public confidence in the profession and in the GDC as its regulator would be severely undermined if a finding of current impairment in relation to misconduct was not made given the serious nature of the clinical findings in this case. Accordingly, it determined that a finding of impairment by reason of Mr Hamilton's misconduct is in the wider public interest.

Decision and reasons on sanction

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

53. The Committee considered the mitigating and aggravating factors in this case as outlined in paragraphs 5.17 and 5.18 of the Guidance.

54. The mitigating factors in this case include:

- Evidence of previous good conduct, with no previous fitness to practice concerns.

55. The aggravating factors in this case include:

- Lack of engagement;
- Evidence of patient harm;
- The misconduct involved multiple patients, repeated over a period of time;
- Senior role in an isolated practice;
- Lack of insight.

56. The Committee decided that it would be inappropriate to conclude this case with no further action. It would not protect the public or satisfy the public interest, given the serious nature of the misconduct.

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

58. The Committee concluded that misconduct of this nature cannot be adequately addressed by way of a reprimand. It cannot be said to be at the lower end of the spectrum of seriousness. In the Committee's view, the protection of the public and the public interest would not be upheld by the imposition of such a sanction. The Committee therefore determined that a reprimand would be inappropriate and inadequate.

59. The Committee then considered whether a conditions of practice order would be appropriate. The Committee was of the view that although there may be appropriate conditions that could be put in place, the fact that Mr Hamilton has not engaged, meant that they would not be suitable, practical or workable. Further, there is nothing to reassure the Committee that he would comply with conditions, given Mr Hamilton's lack of engagement in these proceedings.

60. The Committee then went on to consider whether a suspension would be appropriate. It takes a serious view of the findings against Mr Hamilton. The Committee is satisfied that the misconduct in this case, although serious, is not fundamentally incompatible with Mr Hamilton remaining on the register. The Committee considered that a period of suspension would be sufficient for the protection of the public and the maintenance of public confidence in the profession. It further considers that this

sanction is sufficient to mark the seriousness of Mr Hamilton's misconduct. The Committee considers that it would be appropriate to give Mr Hamilton an opportunity to reflect on his misconduct and be able to address the issues in this case.

61. The Committee did go on to consider erasure but having regard to the mitigating and aggravating factors in this case, determined that it would be disproportionate. Whilst there was a serious departure from the Standards, the Committee acknowledged that it would be unduly punitive to direct erasure at this time.

62. Balancing all these factors, the Committee directs that Mr Hamilton's registration be suspended for a period of 12 months. The Committee considers that the maximum period of 12 months is necessary to protect patients and to maintain and uphold public confidence in the profession, whilst sending the public and the profession a clear message about the standards of practice required of a dentist.

63. The Committee noted the hardship the suspension may cause Mr Hamilton. However, this is outweighed by the public interest in this regard.

64. The Committee directs that this order be reviewed before its expiry, and Mr Hamilton will be informed of the date and time in writing. It would be advisable for Mr Hamilton to attend the review hearing, should he wish to return to dental practice. The reviewing Committee will consider what action it should take in relation to Mr Hamilton's registration.

65. The reviewing Committee may be assisted to receive:

- *detailed reflective statement demonstrating Mr Hamilton's insight into and understanding of his clinical failings and its impact on patients, the dental profession and public confidence.*

- *Participation in the review hearing.*

66. The Committee now invites submissions from Mr Greany as to whether the suspension should take immediate effect to cover the 28-day appeal period.

Decision and reasons on immediate order

67. Mr Greany made an application for an immediate suspension to be imposed on Mr Hamilton's registration. He invited the Committee to impose an immediate order of suspension on the grounds of public protection and in the wider public interest.

68. The Committee accepted the advice of the Legal Adviser.

69. Due to the risk of repetition, as identified in its earlier findings, the Committee was satisfied that an immediate order is necessary for the protection of the public and the wider public interest. To do otherwise would be incompatible with the Committee's earlier findings.

70. The Committee therefore determined to make an immediate order of suspension.

71. The immediate suspension will remain in place for at least 28 days from the date on which Mr Hamilton is deemed to have been served with the Committee's decision. If an appeal is made, it will remain in place until the appeal has concluded. If no appeal is made, the substantive suspension will replace the immediate suspension after 28 days and will run for the full term of 12 months.

72. The Committee's decision will be confirmed to Mr Hamilton in writing, in accordance with the Act.

73. Any interim order on Mr Hamilton's registration will hereby be revoked.

74. That concludes this determination.