HEARING HEARD IN PUBLIC

CRAIG, John Geater

Registration No: 157838

PROFESSIONAL CONDUCT COMMITTEE

NOVEMBER 2016 - NOVEMBER 2018

Most recent outcome: conditions extended for 12 months (with a review) *

*See page 29 for the latest determination

John Geater CRAIG, a clinical dental technician, Dip Clin Dent Tech RCPS Eng 2011, Qual-Diploma in Dental Technology SCOTVEC 1988, was summoned to appear before the Professional Conduct Committee on 21 November 2016 for an inquiry into the following charge:

Charge (as amended on 21 November 2016)

"That, being a registered dental care professional,

1. On dates between 3 March 2013 and 31 August 2013 you provided a course of treatment to Patient 1 (as named in Schedule A[1]).
2. On 3 March 2013, you did not provide an adequate standard of care to Patient 1 as you failed to:
   a) Carry out sufficient pre-treatment assessment of:
      (i) the presenting dental condition; and/or
      (ii) the dental and denture history; and/or
      (iii) the medical history; and/or
      (iv) soft tissues, through an examination as part of an oral cancer screening; and/or
   b) Provide Patient 1 with an estimate of the cost of treatment;
3. On or after 27 March 2013, you did not provide an adequate standard of care to Patient 1 as you failed to advise Patient 1 of a recall interval for an oral cancer screening assessment to be carried out by a dentist.
4. On or after 15 May 2013 you failed to provide Patient 1 with the set of dentures which had been purchased.
5. On 3 March 2013, you did not maintain an adequate standard of record keeping in respect of Patient 1, as you failed to record:
   a) Sufficient pre-treatment assessment of:
      (i) the presenting dental condition; and/or
      (ii) the dental and denture history; and/or

[1] The Schedule is a private document and is not disclosed to the public.

(iii) the medical history; and/or

(iv) soft tissues through an examination as part of an oral cancer screening; and/or

b) An estimate of the cost of treatment; and/or

c) The medical history in the dental records; and/or

d) In the alternative, failed to record that a medical history had been taken at all and was stored elsewhere.

6. You did not maintain an adequate standard of record keeping in respect of Patient 1, in that between 15 May 2013 and 31 August 2013 you failed to record details of appointments which took place.

7. On dates between 3 March 2013 and 30 April 2014 you did not adequately respond to Patient 1's or their representatives' communication regarding the provision of Patient 1's dentures,

a) In that you failed to respond at all to:

(i) A letter sent by Airdrie Citizens Advice Bureau on 28 November 2013; and/or

(ii) A letter sent by Airdrie Citizens Advice Bureau on 17 February 2014; and/or

b) In that you failed to attend appointments arranged with Patient 1 by text message on the following dates:

(i) 26 August 2013; and/or

(ii) 27 August 2013; and/or

(iii) 12 September 2013; and/or

(iv) 13 September 2013; and/or

(v) 26 September 2013; and/or

(vi) 4 October 2013; and/or

(vii) 10 October 2013; and/or

(viii) 29 October 2013; and/or

c) In that you failed to respond at all to text messages from Patient 1 asking if you were attending on the following dates:

(i) 20 September 2013; and/or

(ii) 7 October 2013; and/or

(iii) 11 October 2013; and/or

(iv) 31 October 2013; and/or

d) In that you failed to respond at all to text messages from Patient 1 asking about collecting the dentures on the following dates:

(i) 4 November 2013; and/or

(ii) 7 November 2013; and/or

(iii) 14 November 2013; and/or

e) In that during a telephone conversation with a representative from Airdrie Citizens Advice Bureau on 18 November 2013 you agreed that you would deliver Patient 1's dentures on Wednesday 20 November 2013, which you subsequently failed to do.

8. Your conduct in relation to charges 7a - 7e was individually and/or collectively:

a) Misleading; and/or

b) Dishonest; and/or

c) Unprofessional.

9. Following the closure of your clinic in or around June 2013 you did not refer Patient 1 for treatment with another dental professional as you were unable to complete the treatment.

10. From 08 March 2013 to 22 July 2013:

a) you failed to have indemnity insurance

b) you have provided dental services while you failed to hold adequate indemnity insurance

11. From 30 June 2015 to at least 9 September 2015 you failed to cooperate with an investigation conducted by the GDC.

12. You submitted non-contemporaneous records in respect of Patient 1's appointments for a period of time including:

a) from 03 March 2013 to 02 April 2013 in respect of the hand written records on the GP25 card;

b) from 06 April to 15 May for a year unknown in respect of the hand written records on plain paper;

13. Your conduct in relation to 12 above was:

a) Misleading

b) Dishonest

And that by reason of the facts alleged your fitness to practise as a dental care professional is impaired by reason of your misconduct."

Mr CRAIG was not present and was not represented. On 22 November 2016 the Chairman announced the findings of fact to the Counsel for the GDC:

"Mr Craig is not present at this hearing of the Professional Conduct Committee (PCC) and is not represented in his absence. Mr Kevin Dent of Counsel appears for the General Dental Council (GDC).

Service of notice

On behalf of the GDC Mr Dent submitted that service of notice of this hearing has been properly effected in accordance with the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules'). On 21 October 2016 a notice of hearing was sent to the address that Mr Craig has registered with the GDC, setting out the date, time and location of this hearing. The notice was sent to Mr Craig's registered address using the Royal Mail's Special Delivery postal service. The Royal Mail's Track and Trace Service records that the item was delivered on the morning of the following day, namely 22 October 2016. A copy of the notice was sent by email to Mr Craig's known email address on 21 October 2016.

The Committee accepted the advice of the Legal Adviser. Having regard to the evidence put before it the Committee was satisfied that service has been properly effected in accordance with the Rules and that all reasonable efforts have been made to inform Mr Craig of this hearing.

Proceeding in absence

The Committee then went on to consider whether to exercise its discretion to proceed in the absence of Mr Craig in accordance with Rule 54 of the Rules. Mr Dent invited the Committee to do so on the basis that the GDC had made all reasonable efforts to notify the registrant of this hearing and that it would be appropriate to proceed in his absence.

The Committee accepted the advice provided by the Legal Adviser. The Committee is mindful that its discretion to conduct a hearing in the absence of a registrant should be exercised with the utmost care and caution. After careful consideration the Committee was satisfied that it would be appropriate and fair to proceed in Mr Craig's absence. The Committee notes that in his email to the GDC of 3 November 2016 Mr Craig stated that he would not be in attendance at this hearing. It also notes that Mr Craig has been informed of the possibility of participating by other means, such as via Skype link, but has not requested any such alternative arrangements. Mr Craig has also not requested a postponement. In the circumstances the Committee considered that Mr Craig has voluntarily absented himself from this hearing and that an adjournment would serve no purpose as it would be unlikely to secure his attendance. The Committee also considered that there is a clear public interest in proceeding with today's hearing for the purposes of securing an expeditious disposal of this matter.

Preliminary matters

Mr Dent made an application to amend heads of charge 4, 5 and 7 for the purposes of correcting typographical errors, pursuant to Rule 18 of the Rules. A further amendment was subsequently sought in relation to head of charge 12 for the purposes of clarity.

The Committee, having received advice from the Legal Adviser, considered that the proposed changes could be made with no injustice to either party and that it was fair for the minor amendments to be made. The schedule of charge was duly amended.

Background to the case and summary of allegations

The allegations that Mr Craig faces arise out of the standard of care and treatment that he provided as a clinical dental technician (CDT) to a patient, referred to for the purposes of these proceedings as Patient 1.

Patient 1 first attended an appointment with Mr Craig on 3 March 2013 for the purposes of obtaining a new set of upper and lower dentures. A number of appointments then took place

in the period to 31 August 2013, by which date Mr Craig is alleged to have failed to provide a satisfactory new set of dentures for which Patient 1 had made payment.

It is specifically alleged that, at the initial appointment on 3 March 2013, Mr Craig did not provide an adequate standard of care to Patient 1 on account of his alleged failure to carry out sufficient pre-treatment assessments of the patient's presenting dental condition, soft tissues and the patient's dental, denture and medical history, as well as his failure to provide an estimate of the cost of treatment. It is also alleged that at the appointment that the patient attended on 27 March 2013 when he supplied the new set of dentures, Mr Craig again did not provide an adequate standard of care, as he failed to advise the patient of a recall interval for an oral cancer screening assessment to be carried out by a dentist. The GDC also alleges that, on or after 15 May 2013, Mr Craig failed to provide Patient 1 with a satisfactory set of dentures which the patient had purchased. The GDC also alleges that, following the closure of Mr Craig's clinic in or around June 2013, Mr Craig did not refer Patient 1 for treatment with another dental professional.

The GDC has raised a number of record-keeping failures in respect of Mr Craig's care and treatment of Patient 1. It is contended that, at the initial session on 3 March 2013, Mr Craig failed to record the pre-treatment assessments described above, as well as an estimate of the cost of treatment. The GDC alleges that these failures meant that Mr Craig did not maintain an adequate standard of record-keeping on that date. The GDC also contends that thereafter, more particularly in the period 15 May to 31 August 2013, Mr Craig's alleged failure to record details of appointments which took place meant that Mr Craig did not maintain an adequate standard of record-keeping in this further respect. The GDC also contends that Mr Craig submitted non-contemporaneous records in respect of his appointments with Patient 1 when the relevant records were requested by the GDC, and that such conduct was misleading and dishonest.

It is further alleged that Mr Craig did not adequately respond to the attempts that Patient 1, and those acting on his behalf, made to communicate with him in relation to the provision of the patient's dentures. It is alleged in particular that Mr Craig failed to respond to two letters sent to him by the Citizen's Advice Bureau, from whom Patient 1 had sought help and guidance, and in particular that he failed to attend a number of appointments in the period August to October 2013 which Patient 1 had arranged by text message. The GDC contends that, in respect of a number of planned meetings, Mr Craig did not respond to Patient 1's requests for clarification as to whether he would be attending. It is also alleged that Mr Craig agreed to deliver Patient 1's dentures on 20 November 2013 but then failed to do so. The GDC alleges that this conduct was misleading, unprofessional and dishonest.

The GDC further contends that Mr Craig failed to have indemnity insurance for a period in excess of four months in 2013, and that he provided dental services during that time. It is also contended that Mr Craig failed to co-operate with a GDC investigation into the matters referred to above for a period of around two months from 30 June to 9 September 2015.

Evidence

The Committee heard oral evidence from the expert witness for the GDC, namely Mr Nigel Entwistle.

The Committee has been provided with documentary material in relation to the heads of charge that Mr Craig faces, including a number of witness statements and exhibits which Mr Craig has accepted and agreed. These statements have been provided by the patient in this case, namely Patient 1; a small claims adviser with the Citizens' Advice Bureau (CAB),

referred to for the purposes of these proceedings as Witness A; an adviser with CAB, referred to as Witness B; and the Head of Business Services with APS Group Scotland, which supplies stationery used in NHS clinical record-keeping, namely Witness C.

The Committee has also been provided with correspondence between the GDC and Mr Craig, including Mr Craig's written responses to the allegations that he faces and exchanges in relation to his indemnity insurance arrangements. The Committee has also received the reports of Mr Entwistle.

Committee's findings of fact

The Committee has taken into account all the evidence presented to it, both written and oral, and has considered the submissions made by Mr Dent on behalf of the GDC. It has accepted the advice of the Legal Adviser.

The Committee has applied the civil standard of proof, namely the balance of probabilities, and has been reminded that the burden of proof lies with the GDC. The Committee has considered each head of charge separately, although in respect of heads of charge 2 (a) (i), 2 (a) (ii), 2 (a) (iii) and 2 (a) (iv); 5 (a) (i), 5 (a) (ii), 5 (a) (iii) and 5 (a) (iv); 7 (b) (i), 7 (b), (ii), 7 (b) (iii), 7 (b) (iv), 7 (b) (v), 7 (b) (vi), 7 (b) (vii) and 7 (b) (viii); 7 (c) (i), 7 (c) (ii), 7 (c) (iii) and 7 (c) (iv); and 7 (d) (ii) and 7 (d) (iii) its findings will be announced collectively.

The Committee notes that Mr Craig has stated in correspondence that he accepts that the allegations against him are 'basically true'. The Committee has not treated this as a formal admission and has considered all of the available evidence presented to it in coming to its decisions.

I will now announce the Committee's findings in relation to each head of charge:

1.	Proved
	The Committee finds the facts alleged at head of charge 1 proved. The clinical records that have been provided to the Committee, as well as the witness statement of Patient 1 and the correspondence of Mr Craig, make it clear that Mr Craig provided a course of treatment to Patient 1 between 3 March and 31 August 2013.
2. a) (i)	Proved
2. a) (ii)	Proved
2. a) (iii)	Proved
2. a) (iv)	Proved
	The Committee finds the facts alleged at heads of charge 2 (a) (i), 2 (a) (ii), 2 (a) (iii) and 2 (a) (iv) proved. The Committee considers that the entry that Mr Craig made in the patient's clinical records of his assessment of Patient 1 on 3 March 2013 suggests that the assessment that he made was insufficient. His entry records that he examined the patient's upper and lower ridges. The paucity of this entry leads the Committee to conclude that Mr Craig did not make a sufficient assessment of the patient's presenting dental condition, dental and denture history, medical history and soft

	tissues. The Committee also relies on the written evidence of Patient 1 in relation to the specific issue of the inadequate assessment of the patient's medical history, and notes that the patient stated that he has no recollection of any such history being taken at this or at any subsequent appointment. Although Mr Craig stated in his letter to the GDC dated 4 March 2015 that he did take a medical history at this appointment on 3 March 2013 but that the record of the patient's medical history could not be retrieved due to flood damage, the Committee was able to place greater reliance on the evidence of Patient 1 that no such history was in fact taken. The Committee considered that Patient 1 would be more likely than Mr Craig to recall whether such a history was taken, and the Committee also considers that Mr Craig's explanation is not credible, given that Mr Craig later stated that in fact all of the patient's records had instead been soiled by rats rather than damaged by a flood. The Committee is therefore satisfied that, as a matter of fact, Mr Craig did not carry out a sufficient pre-treatment assessment of Patient 1 on 3 March 2013 in the respects alleged at these heads of charge. It further accepts the expert evidence of Mr Entwistle that having not done so Mr Craig did not provide an adequate standard of care to Patient 1. It also accepts Mr Entwistle's evidence that this was a culpable failure on the part of Mr Craig. Accordingly, the Committee finds the facts alleged at heads of charge 2 (a) (i), 2 (a) (ii), 2 (a) (iii) and 2 (a) (iv) proved.
2. b)	Proved
	The Committee finds the facts alleged at heads of charge 2 (b) proved. The Committee has received written evidence from Patient 1 in relation to this head of charge. In his witness statement Patient 1 stated that Mr Craig did not provide an estimate of the cost of treatment at the first appointment on 3 March 2013, and that the estimate of £240.00 was only provided at the second appointment that he had with Mr Craig three days later on 6 March 2013. Patient 1's account is corroborated by Mr Craig's own clinical records, which make no mention of a cost estimate being provided on 3 March 2013 but such an estimate being given at the second session on 6 March 2013, albeit for a slightly different sum, namely £250.00. The Committee accepts the expert evidence of Mr Entwistle that Mr Craig should have provided a cost estimate to the patient on 3 March 2013, given that treatment commenced on that date with the taking of impressions of the patient's mouth. The Committee considers that Mr Craig failed in this regard to provide an adequate standard of care to Patient 1. It therefore finds the facts alleged at head of charge 2 (b) proved.

3.	Proved
	The Committee finds the facts alleged at head of charge 3 proved. It notes that Mr Craig made no entry in Patient 1's clinical records of him having advised the patient of a recall interval for an oral cancer screening assessment to be carried out by a dentist and also notes that Patient 1 has not made any reference in his evidence to Mr Craig having provided such advice. The Committee accepts the expert evidence of Mr Entwistle that Mr Craig should have provided such advice to Patient 1, and that by not having done so Mr Craig failed in his duty to the patient. The Committee considers that Mr Craig should have provided this advice to the patient on 27 March 2013, as it is reasonable to conclude that the recorded provision of the dentures on that date suggested that treatment had been completed. The Committee therefore finds the facts alleged at head of charge 3 proved.
4.	Proved
	The Committee finds the facts alleged at head of charge 4 proved. The Committee notes that there is no disagreement between Patient 1 and Mr Craig that the final set of dentures, with the necessary modifications, were not provided to Patient 1. It is also satisfied that, particularly as Patient 1 had paid in advance for the provision of dentures on 6 March 2013 as evidenced in his witness statement, Mr Craig was under a duty to provide the patient with that set of dentures. The Committee considers that Mr Craig failed in this duty, and it therefore finds the facts alleged at head of charge 4 proved.
5. a) (i)	Proved
5. a) (ii)	Proved
5. a) (iii)	Proved
5. a) (iv)	Proved
	The Committee finds the facts alleged at head of charge 5 (a) (i), 5 (a) (ii), 5 (a) (iii) and 5 (a) (iv) proved. The only records in evidence are those provided by Mr Craig in the form of handwritten entries on a GP25 form and two pages of handwritten notes. The Committee considers that Mr Craig did not record that a sufficient pre-treatment assessment had been undertaken of the patient's presenting condition, dental and denture history, medical history and soft tissues in the patient's clinical records. It accepts the expert evidence of Mr Entwistle as to the inadequacy of Mr Craig's record-keeping in these respects, and also accepts his evidence that this represents a culpable failure on the part of the registrant. Accordingly, the Committee finds the facts alleged at each of these heads of charge proved.
5. b)	Proved

	The Committee finds the facts alleged at head of charge 5 (b) proved. It notes that Mr Craig made no entry in the patient's records of the anticipated cost of treatment until the patient returned for the second appointment on 6 March 2013 and is further satisfied that this represents a culpable failure on Mr Craig's part to maintain an adequate standard of record-keeping.
5. c)	Proved
	The Committee finds the facts alleged at head of charge 5 (c) proved. It again notes that Mr Craig made no reference to an assessment of Patient 1's medical history in the clinical records. The Committee is mindful that, as set out in respect of its findings at head of charge 2 (a) (iii), Mr Craig stated in his letter to the GDC dated 4 March 2015 that he did take a medical history but that the record of the patient's medical history could not be retrieved due to flood damage. However, the Committee again places greater reliance on the evidence of Patient 1 that no such history was in fact taken and considers that Mr Craig's explanation is not credible, given that he subsequently stated that in fact all of the patient's records had instead been damaged by rats rather than by a flood. The Committee considers that the absence of a record of sufficient pre-treatment assessment of Patient 1's medical history constitutes a culpable failure on the part of Mr Craig to maintain an adequate standard of record-keeping. Accordingly, the Committee finds the facts alleged at head of charge 5 (c) proved.
5. d)	Proved
	The Committee finds the facts alleged at head of charge 5 (d) proved. As set out above, in his letter to the GDC dated 4 March 2015 Mr Craig stated that a medical history had been taken but had been destroyed in a flood, implying that the medical history had been stored elsewhere and away from the main clinical records. The Committee notes that Mr Craig made no reference to this arrangement in the main clinical records and it accepts the expert evidence of Mr Entwistle that Mr Craig should have made an entry in the clinical records to this effect. The Committee accepts Mr Entwistle's evidence that this represents a culpable failure on Mr Craig's part to maintain an adequate standard of record-keeping. The Committee therefore finds the facts alleged at head of charge 5 (d) proved.
6.	Proved
	The Committee finds the facts alleged at head of charge 6 proved. The Committee notes that Mr Craig and Patient 1 agree that a number of appointments took place in the period 15 May to 31 August 2013. The Committee also notes that Mr Craig made no entries in the patient's clinical records in respect of any of these appointments. The Committee again accepts the expert evidence

	of Mr Entwistle that this represents a culpable failure on the part of Mr Craig to maintain an adequate standard of record-keeping. The Committee therefore finds the facts alleged at head of charge 6 proved.
7. a) (i)	Proved
	The Committee finds the facts alleged at head of charge 7 (a) (i) proved. The Committee has had regard to the witness statement of Witness B, who states that she wrote to Mr Craig on 28 November 2013 in relation to his failure to provide Patient 1 with the dentures. The Committee has also been provided with a copy of the same letter as part of the evidential bundle presented by the GDC and agreed by Mr Craig. Witness B's evidence is that neither she nor Patient 1 received any response to that letter. The Committee accepts the expert evidence of Mr Entwistle that Mr Craig was under a duty to respond to this letter and that by not having done so Mr Craig failed in his duty towards Patient 1. Accordingly the Committee finds the facts alleged at head of charge 7 (a) (i) proved.
7. a) (ii)	Proved
	The Committee finds the facts alleged at head of charge 7 (a) (ii) proved. The Committee has had regard to the witness statement of Witness A, who states that she wrote to Mr Craig on 17 February 2014 in relation to his failure to provide Patient 1 with the dentures. The Committee has again been provided with a copy of the same letter as part of the evidential bundle presented by the GDC and agreed by Mr Craig. Witness A confirms that neither she nor Patient 1 received any response to that letter.The Committee again accepts the expert evidence of Mr Entwistle that Mr Craig was under a duty to respond to this letter and that by not having done so Mr Craig failed in his duty towards Patient 1. Accordingly the Committee finds the facts alleged at head of charge 7 (a) (ii) proved.
7. b) (i)	Proved
7. b) (ii)	Proved
7. b) (iii)	Proved
7. b) (iv)	Proved
7. b) (v)	Proved
7. b) (vi)	Proved
7. b) (vii)	Proved
7. b) (viii)	Proved
	The Committee finds the facts alleged at heads of charge 7 (b) (i), 7 (b) (ii), 7 (b) (iii), 7 (b) (iv), 7 (b) (v), 7 (b) (vi), 7 (b) (vii) and 7 (b)

	(viii) proved. The Committee has been provided with screenshots of the mobile phone text messages that Patient 1 exchanged with Mr Craig in the relevant period and considers that these demonstrate that Mr Craig agreed appointments with Patient 1 on the dates alleged but did not attend those appointments. The Committee considers that Mr Craig was under a duty to do so, and it therefore finds the facts alleged at these heads of charge proved.
7. c) (i)	Proved
7. c) (ii)	Proved
7. c) (iii)	Proved
7. c) (iv)	Proved
	The Committee finds the facts alleged at heads of charge 7 (c) (i), 7 (c) (ii), 7 (c) (iii) and 7 (c) (iv) proved. The Committee has again had regard to the screenshots of the mobile phone text messages that Patient 1 sent to Mr Craig in the relevant period, and it considers that these demonstrate that Patient 1 sent text messages on the alleged dates to Mr Craig, but that Mr Craig did not respond. The Committee once more considers that Mr Craig ought to have done so, and having failed in this duty the Committee finds the facts alleged at these heads of charge proved.
7. d) (i)	Not proved
	The Committee finds the facts alleged at head of charge 7 (d) (i) not proved. The Committee notes that Patient 1 sent a text message to Mr Craig on 4 November 2013, but considers that the message in question related to an enquiry about whether Mr Craig would call at his address with the dentures rather than a request for Patient 1 to collect the dentures. The Committee therefore considers that the GDC has not discharged its burden of proof to the required standard and accordingly the facts alleged at head of charge 7 (d) (i) are not proved.
7. d) (ii)	Proved
7. d) (iii)	Proved
	The Committee finds the facts alleged at heads of charge 7 (d) (ii) and 7 (d) (iii) proved. The Committee has again had regard to the screenshots of the mobile phone text messages that Patient 1 sent to Mr Craig in the relevant period, and it considers that these demonstrate that Patient 1 sent text messages on the alleged dates to Mr Craig about collecting the dentures, but that Mr Craig did not respond. The Committee once more considers that Mr Craig ought to have responded, and having failed in this duty the Committee finds the facts alleged at these heads of charge

	proved.
7. e)	Proved
	The Committee finds the facts alleged at head of charge 7 (e) proved. The Committee has been provided with a witness statement from Witness B, who states that she had a telephone conversation with Mr Craig on 18 November 2013, during which he agreed to deliver the patient's dentures to him on 20 November 2013. The Committee also notes the evidence contained in the witness statement provided by Patient 1, namely that Mr Craig did not attend that appointment and the dentures were not provided. The Committee considers that Mr Craig was under a duty to provide the dentures at this appointment and that he failed to meet this duty. Accordingly the Committee finds the facts alleged at this head of charge proved.
8. a)	Proved in respect of heads of charge 7 (b) and 7 (e)
	The Committee finds the facts alleged at head of charge 8 (a) proved in relation to heads of charge 7 (b) and 7 (e). It finds that the effect of Mr Craig's proven conduct at heads of charge 7 (b) and 7 (e) was that Patient 1 was misled into believing that the dentures for which he had paid would be provided on one of the dates specified. The dentures were not provided, and indeed Mr Craig did not attend on any of the dates in question. The Committee is in no doubt that Mr Craig's failure to attend appointments, contrary to his prior agreement to attend, had the effect of misleading Patient 1. The Committee therefore finds the facts alleged at this head of charge proved.
8. b)	Proved in respect of heads of charge 7 (b) and 7 (e)
	The Committee finds the facts alleged at head of charge 8 (b) proved in relation to heads of charge 7 (b) and 7 (e). Mr Craig failed to keep appointments with Patient 1 on eight separate occasions. The Committee has found above that such conduct was misleading. The Committee considers that Mr Craig's actions were, furthermore, dishonest. Mr Craig made false promises and failed on a number of occasions to provide Patient 1 with the dentures for which the patient had made full payment in advance. He knowingly led Patient 1 to believe that he would provide the dentures when it appears that he was either unable or unwilling to do so. The Committee considers that the reasonable and honest dental practitioner would regard Mr Craig's conduct as dishonest. It also considers that Mr Craig would have known that his actions would be perceived as being dishonest by those standards. For these reasons, the Committee considers that Mr Craig's conduct amounts to dishonesty, and it therefore finds the facts alleged at head of charge 8 (b) proved.

8. c)	Proved in respect of heads of charge 7 (a), 7 (b), 7 (c), 7 (d) and 7 (e)
	The Committee finds the facts alleged at head of charge 8 (a) proved in relation to heads of charge 7 (a), 7 (b), 7 (c), 7 (d) and 7 (e). The Committee is in no doubt that Mr Craig's failure to attend appointments and respond to messages sent by and on behalf of Patient 1 represents conduct that was inconsistent with Mr Craig's trusted and privileged position particularly given the Committee's findings above that such conduct was misleading and dishonest. The Committee accordingly finds the facts alleged at this head of charge proved.
9.	Proved
	The Committee finds the facts alleged at head of charge 9 proved. It notes that Mr Craig did not, as a matter of fact, refer Patient 1 to another dental professional for the continuation and conclusion of treatment, as evidenced in particular by Patient 1's witness statement.
10. a)	Proved
	The Committee finds the facts alleged at head of charge 10 (a) proved. It notes that Mr Craig admits that he did not have indemnity insurance between the dates specified, and the Committee also notes from the registrant's indemnity records that he lacked appropriate insurance in the relevant period. The Committee accepts the expert evidence of Mr Entwistle that Mr Craig was under a duty to hold such cover, and that he therefore failed in this duty.
10. b)	Proved
	The Committee finds the facts alleged at head of charge 10 (b) proved. The Committee has found at head of charge 10 (a) above that Mr Craig did not have indemnity insurance between the dates specified. The Committee notes that the clinical records for Patient 1 demonstrate that he provided dental services during that period, and accordingly the Committee finds the facts alleged at head of charge 10 (b) proved.
11.	Proved
	The Committee finds the facts alleged at head of charge 11 proved. It has had regard to the evidence of the lawyer with conduct of the GDC's investigation, namely Mr Christopher Evans, that a number of letters were sent to Mr Craig in relation to his indemnity arrangements, to which responses were not received. The Committee is satisfied that Mr Craig was under a duty to co-operate with his regulator's investigation and that it was a relatively straightforward matter for him to supply the basic information that was being requested. The Committee therefore

	finds the facts alleged at head of charge 11 proved.
12. a)	Proved
	The Committee finds the facts alleged at head of charge 12 (a) proved. It has had particular regard to the evidence provided by Witness C that the stationery used by Mr Craig to record his care and treatment of Patient 1 in the specified period was manufactured and published after the events that the record purports to describe. The Committee also notes that in his written response to the allegations of 14 November 2016 Mr Craig accepts that he copied in longhand the clinical records on to that stationery quite some time after the events described, and more particularly when requested to submit the clinical records as part of the GDC's investigation. The Committee is further satisfied that these retrospective records were submitted to the GDC with no note to explain what he had done, and accordingly it finds the facts alleged at head of charge 12 (a) proved.
12. b)	Proved
	The Committee finds the facts alleged at head of charge 12 (b) proved. As set out above, in his written response to the allegations of 14 November 2016 Mr Craig accepts that he subsequently wrote out in longhand a copy of the entries that he made at the time, and submitted that non-contemporaneous record to the GDC when asked for the patient's clinical records with no explanatory note. The Committee therefore finds the facts alleged at head of charge 12 (b) proved.
13. a)	Proved
	The Committee finds the facts alleged at head of charge 13 (a) proved. The Committee considers that the effect of Mr Craig's conduct as set out above was to mislead the GDC into believing that the records that Mr Craig had provided were contemporaneous, when in fact that was not the case. The Committee considers that this conduct was misleading, and accordingly it finds the facts alleged at head of charge 13 (a) proved.
13. b)	Proved
	The Committee finds the facts alleged at head of charge 13 (b) proved. Mr Craig passed off as contemporaneous records which were retrospective. At the time of submitting the records to the GDC he made no mention that they were not contemporaneous and, upon being challenged about their provenance, Mr Craig has given a number of inconsistent explanations. Having found that Mr Craig's conduct was misleading, the Committee considers that the reasonable and honest dental professional would regard that action as dishonest. The Committee is also satisfied that Mr Craig knew that his actions would be considered to be dishonest.

	Although the Committee has no reason to doubt that Mr Craig's transcription of the damaged original records was accurate, and has not been presented with any evidence to the contrary, it considers that the submission of records on this false basis was a dishonest act. The Committee therefore concludes that the facts alleged at head of charge 13 (b) are proved.

We move to stage two."

On 23 November 2016 the Chairman announced the determination as follows:

"The Committee has considered all the evidence presented to it, both written and oral. It has also taken into account the submissions made by Mr Dent on behalf of the General Dental Council (GDC).

The Committee has accepted the advice of the Legal Adviser. In its deliberations the Committee has had regard to the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (1 October 2016).

Fitness to practise history

On behalf of the GDC Mr Dent confirmed that Mr Craig has no fitness to practise history.

Misconduct

The Committee first considered whether the facts that it has found proved constitute misconduct. In considering this matter the Committee exercised its own independent judgement.

The Committee has had regard to the following paragraphs of the GDC's *Standards for Dental Professionals* (May 2005) in place at the time of earlier matters that have given rise to the facts that this Committee has found proved. These paragraphs state that as a dental care professional you must:

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

1.2 Follow these principles when handling questions and complaints from patients and in all other aspects of non-clinical professional service.

1.4 Make and keep accurate and complete patient records, including a medical history, at the time you treat them. Make sure that patients have easy access to their records.

1.5 Give patients who make a complaint about the care or treatment they have received a helpful response at the appropriate time. Respect the patient's right to complain. Make sure that there is an effective complaints procedure where you work and follow it at all times. Co-operate with any formal inquiry into the treatment of a patient.

1.6 Make sure your patients are able to claim any compensation they may be entitled to by making sure you are protected against claims at all times, including past periods of practice.

2.4 Listen to patients and give them the information they need, in a way they can use, so that they can make decisions. This will include:

- Communicating effectively with patients;
- Explaining options (including risks and benefits); and
- Giving full information on proposed treatment and possible costs.

6.1 Justify the trust that your patients, the public and your colleagues have in you by always acting honestly and fairly.

The Committee has also had regard to the following paragraphs of the GDC's *Standards for the Dental Team* (September 2013) in place at the time of the later incidents that have given rise to the facts that this Committee has found proved. These paragraphs state that as a dental care professional:

1.3.1 You must justify the trust that patients, the public and your colleagues place in you by always acting honestly and fairly in your dealings with them. This applies to any business or education activities in which you are involved as well as to your professional dealings.

1.3.2 You must make sure you do not bring the profession into disrepute.

1.7.1 You must always put your patients' interests before any financial, personal or other gain.

1.8.1 You must have appropriate insurance or indemnity in place to make sure your patients can claim any compensation to which they may be entitled.

2.4 [You must] give patients clear information about costs.

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

5.3 [You must] give patients who complain a prompt and constructive response.

The Committee has concluded that the facts that it has found proved constitute misconduct. Mr Craig's acts and omissions were serious, and the Committee consider that his fellow professionals would consider his conduct to be deplorable. Although Mr Craig's conduct relates to the care and treatment of a single patient, his failings were evident over a protracted period of time and across a number of significant and fundamental aspects of his practice. Mr Craig's conduct fell far short of the standards reasonably expected of a registered dental care professional.

Mr Craig's conduct relates to failings in basic aspects of clinical care, more particularly patient assessment, the provision of a dental appliance, appropriate record-keeping and communication with patients. Mr Craig also repeatedly breached a fundamental tenet of the profession in respect of his contact with the patient in question, with those acting on the patient's behalf, and with the GDC, namely the need to act in an honest and trustworthy manner. The Committee considers that Mr Craig's dishonest conduct put the standing and reputation of the profession at risk of being brought into disrepute and jeopardised the trust and confidence that the public places in the profession. The Committee has also found that, for a period of over four months, Mr Craig failed to have in place any indemnity cover whilst providing dental services. The absence of such arrangements placed the public at the risk of harm.

Accordingly, the Committee concludes that the facts that it has found proved amount to misconduct.

Impairment

The Committee then went on to consider whether Mr Craig's fitness to practise is currently impaired because of the misconduct that it has found. In doing so, the Committee has again exercised its independent judgement. Throughout its deliberations, it has borne in mind that its primary duty is to address the public interest, which includes the protection of patients, the maintenance of public confidence in the profession and in the regulatory process, and the declaring and upholding of proper standards of conduct and behaviour.

The Committee has determined that Mr Craig's fitness to practise is currently impaired by reason of his misconduct.

The Committee considers that some of the facts which it has found amount to misconduct are, in theory, capable of being remediated. It finds that Mr Craig's proven failure to provide an adequate standard of care to Patient 1 and to maintain an adequate standard of record-keeping are basic and fundamental clinical matters which could be addressed and remedied. However, the Committee is mindful that Mr Craig's proven dishonesty may connote an attitudinal or behavioural shortcoming which might be more difficult to remedy.

In any event, the Committee finds that there is insufficient evidence of Mr Craig having addressed and remediated any of the misconduct, both clinical and non-clinical, that it has identified. Mr Craig's insight into the conduct that has precipitated these proceedings is only very limited. He has not participated in any substantive way in this hearing, and the written submissions that he has sent suggest a fundamental lack of recognition of, and a sense of responsibility for, the serious acts and omissions which have caused financial harm to one patient and potential harm to other patients. In his correspondence Mr Craig expressed no apology or remorse for the effect that his actions had on Patient 1. The Committee also considers that Mr Craig has not demonstrated any acknowledgement of the damage that his conduct, and particularly his dishonest actions, may have caused to the reputation of the profession to which he belongs, or to the public's trust and confidence in that profession. It has also not been provided with information about any practical steps that Mr Craig may have taken to address and rectify the shortcomings that have been identified, for instance the formulation of a personal development plan (PDP) or any continuing professional development (CPD).

Mr Craig's actions are highly damaging to his fitness to practise. However, the Committee has not been provided with evidence sufficient for it to conclude that Mr Craig understands the damage that may have arisen from his misconduct, or that he has taken any steps to address and remedy the significant acts and omissions evident in this case. The Committee therefore considers that the absence of both insight and remediation means that there is a real risk of such conduct being repeated. This risk of repetition means that there is a real prospect of harm being caused to patients. In concluding that Mr Craig's fitness to practise is currently impaired, the Committee also considers that a finding of impairment is undoubtedly required to maintain public confidence in the profession and in the regulatory process, and to declare and uphold proper professional standards. It considers that trust and confidence in the profession, and in the GDC as the regulator would be seriously undermined, if a finding of impairment was not made.

Sanction

The Committee then determined what sanction, if any, would be appropriate in light of the findings of facts, misconduct and impairment that it has made. The Committee recognises that the purpose of a sanction is not to be punitive, although it may have that effect, but is instead imposed in order to protect patients and safeguard the wider public interest referred to above.

In reaching its decision the Committee has again taken into account the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (1 October 2016). The Committee has applied the principle of proportionality, balancing the public interest with Mr Craig's own interests.

The Committee has had regard to the mitigating and aggravating factors in this case. In terms of mitigation, the Committee accepts that Mr Craig's professional and financial circumstances were difficult at the time of the events giving rise to these proceedings. It also notes that he is otherwise of good character, having had no previous regulatory findings recorded against him. The Committee also notes that there have been no further incidents of a similar or different nature following the matters that have resulted in this Committee's findings, and that some three years have passed since the events in question took place.

However, the Committee is mindful that there are a considerable number of aggravating factors in this case. Mr Craig's actions caused actual harm to a patient, primarily because of the financial loss arising from Mr Craig's failure to provide dentures for which full payment had been made. The Committee also considers that the continued absence of the dentures which the patient had expected to receive denied a patient of the benefits that he would otherwise have derived from using those dentures. Mr Craig's failure to hold appropriate indemnity insurance also placed other patients at the risk of harm, as it would have frustrated any claims for financial recompense that patients who had received care and treatment may have sought to make. The Committee has also found that Mr Craig acted in a dishonest manner in two different and distinct respects, and that his actions involved a breach of trust. His misconduct was sustained and repeated over a protracted period of time, and as stated above the Committee considers that Mr Craig has not demonstrated any meaningful insight into his acts and omissions. The Committee has also made findings which amount to a disregard of the regulatory systems to which Mr Craig's registration is subject, more particularly his failure to hold appropriate indemnity insurance, his failure to co-operate with the GDC, and his lack of candour with the GDC when asked to provide Patient 1's records.

The Committee has considered the range of sanctions available to it, starting with the least serious. In the light of the findings made against Mr Craig, the Committee has determined that it would be wholly inappropriate to conclude this case with no action or with a reprimand. The serious nature of the unremediated conduct that it has identified, raising as it does the prospect of a harmful repetition of such behaviour, leads the Committee to conclude that no action, or the sanction of a reprimand, would be insufficient. It also considers that its findings, particularly in relation to dishonesty, are such that no sanction, or a reprimand, would undermine public confidence and trust in the profession and in the regulatory process.

The Committee next considered whether a period of conditional registration would be appropriate. A number of the failings that the Committee has identified are clinical in nature and could in theory be appropriately addressed with conditions. The Committee is not able, however, even if it were so minded, to formulate conditions which would be workable in

circumstances where Mr Craig is not engaging in any substantive way with these proceedings and where there is a lack of information as to his current circumstances and ability to comply with conditions. The attitudinal deficiencies connoted by Mr Craig's dishonesty would not be capable of being adequately addressed with conditions and, in any event, the Committee again considers that the imposition of a period of conditional registration would not sufficiently protect patients, declare and uphold proper professional standards or maintain trust and confidence in the profession.

The Committee went on to consider whether to suspend Mr Craig's registration. It is again mindful that Mr Craig's conduct was sustained and repeated, that he has not shown any significant insight into his misconduct, and that he continues to pose a significant risk to patients because of the prospect of repeating conduct which has not been remediated. However, the Committee is satisfied that, although it has found that Mr Craig's actions were in two distinct respects dishonest, the evidence presented to it does not demonstrate that Mr Craig has a deep-seated personality or professional attitudinal problem which might make erasure the appropriate order.

The Committee has therefore determined that Mr Craig's name should be suspended from the register, and that any lesser sanction would not provide the necessary degree of protection for patients and the wider public interest. The Committee gave careful consideration to whether the higher sanction of erasure was appropriate, but considered that in the particular circumstances of this case the necessary degree of patient protection, confidence and trust can be adequately obtained by the imposition of a period of suspension. An order of erasure would therefore be disproportionate.

The Committee has determined, and hereby directs, that Mr Craig's registration be suspended for a period of 12 months. It considers that this period of time is necessary to mark the Committee's findings of facts, misconduct and impairment. This period is also required to allow Mr Craig to develop and demonstrate insight into, and remediation of, his misconduct. The Committee further directs that this period of suspension be reviewed prior to its expiry.

Although the Committee in no way wishes to bind or fetter the Committee which will review this suspension, it considers that it may well be assisted by evidence of Mr Craig's insight into these matters and evidence of the steps that he decides to take to address and remediate his conduct. This may include, but would not be limited to, a reflective statement, a personal development plan targeted on the specific areas of deficiency, and a log and details of focussed CPD.

Decision on immediate order of suspension

Having directed that Mr Craig's name be suspended from the register, the Committee has considered whether to impose an order for his immediate suspension in accordance with section 36U (1) of the Dentists Act 1984 (as amended) ('the Act').

The Committee has heard the submissions made by Mr Dent on behalf of the GDC as to the necessity of an immediate order of suspension. The Committee has accepted the advice of the Legal Adviser.

The Committee has determined that it is necessary for the protection of the public and is otherwise in the public interest to impose an order for the immediate suspension of Mr Craig's registration. Given the risks of harm that the Committee has identified, it would not be appropriate to allow Mr Craig to practise until the substantive direction of suspension

takes effect. The Committee considers that an immediate order for suspension is proportionate, and is consistent with the concerns that the Committee has set out in its determination.

The effect of the foregoing determination and this immediate order is that Mr Craig's registration will be suspended from the date on which notice of this decision is deemed served upon him. Unless Mr Craig exercises his right of appeal, the substantive direction of suspension will be recorded in the Dental Care Professionals' Register 28 days from the date of deemed service. Should he decide to exercise his right of appeal, this immediate order of suspension will remain in place until the resolution of any such appeal.

That concludes this case."

At a review hearing on 6 December 2017 the Chairman announced the determination as follows:

Service

"Mr Craig is neither present nor represented at the resumed Professional Conduct Committee (PCC) hearing of his case. Mr Middleton is the Case Presenter for the General Dental Council (GDC). In the absence of Mr Craig, the Committee first considered whether the GDC has complied with serving the Notice of Resumed Hearing on Mr Craig in accordance with Rule 28 of the GDC (Fitness to Practise) Rules Order of Council 2006 (the Rules). In so doing, it has had regard to the documents before it as well as the submissions made by Mr Middleton, who represents the GDC. It has accepted the advice of the Legal Adviser.

The Committee has seen a copy of the Notice of Resumed Hearing letter dated 7 November 2011 addressed to Mr Craig's registered address. The letter sets out the date, time and location of today's hearing, as well as the grounds for holding the hearing. Although the date on the letter is shown as being '2011' Mr Middleton advised the Committee that this date was a typographical error and should state '2017', as shown by the Royal Mail receipt which confirms that the letter was collected by Mr Craig on 9 November 2017. The letter was sent more than 28 days in advance of today's hearing, in accordance with Rule 28. It was also signed for in the name of 'Craig'. Notwithstanding the fact that the hearing of Mr Craig's case is taking place at a hearing room at CCT venues - Smithfield (one of the venues used by the GDC for its hearing) and not at Wimpole Street, as stated in the Notice of Resumed Hearing letter, the Committee is satisfied that the Notice of Resumed Hearing letter is compliant with the Rules. Furthermore, the Committee has seen a copy of a GDC Secure File Share email dated 7 November 2017 which confirms that the Notice of Resumed Hearing letter was sent via Secure File to Mr Craig's email address on that day, and Mr Craig acknowledged receipt of that documentation by email dated 15 November 2017. Having regard to all of these documents, the Committee is satisfied that the GDC has served the Notice of Resumed Hearing on Mr Craig in accordance with Rule 28.

Proceeding in absence

The Committee then went on to consider whether to hear this case in the absence of Mr Craig, in accordance with Rule 54. Mr Middleton invited the Committee to do so on the basis that Mr Craig is aware of today's hearing, as confirmed by his email to the GDC dated 15 November 2017 acknowledging receipt of the email to him dated 7 November 2017. Mr Middleton also referred the Committee to a letter from Mr Craig addressed to the "Fitness to Practise Panel" 11 October 2017, in which Mr Craig states that he is unable to attend the

hearing due to financial restrictions and a study commitment. Furthermore, Mr Middleton referred to the GDC's email dated 7 November 2017 to Mr Craig in which the GDC confirmed that it was possible for registrants to participate in hearings via telephone or video-link. The email stated that Mr Craig should contact the GDC if he would like to engage in his hearing via these methods so that steps could be taken to facilitate this process. Mr Craig has not responded to this request and has chosen to absent himself from attending this hearing. Furthermore, Mr Middleton submitted that there is a public interest in reviewing this case today before the current order of suspension lapses on 25 December 2017 and that a failure to do so would mean a loss of jurisdiction of the order and thus place the public at risk.

The Committee has considered the submissions made by Mr Middleton. It has accepted the advice of the Legal Adviser, during the course of which it was reminded of the relevant factors in deciding whether to proceed in the absence of a Registrant. The Committee has borne in mind that the discretion to proceed in the absence of the Registrant must be exercised with the utmost care and caution as well as the statutory objectives of the GDC, which include the protection; promotion and the maintenance of the health, safety and well-being of the public, and the maintenance of the reputation of the profession.

The Committee has had regard to the telephone attendance note dated 21 August 2017 between KE (a GDC member of staff) and Mr Craig regarding information relating to today's review hearing. The telephone note records that KE informed Mr Craig that the PCC hearing was listed to be held on 6 December 2017 and also advised Mr Craig to submit the information recommended by the initial PCC that heard his case. The telephone note also records that Mr Craig had indicated that it would be too hard to attend the hearing, especially as he was booked on to attend a course that day. In his letter to the GDC dated 11 October 2017 Mr Craig cites financial restrictions and a study commitment as his reasons for not attending the hearing. It is clear from telephone and email contact between Mr Craig and the GDC that on more than one occasion the GDC has offered Mr Craig the opportunity of participating at his hearing either by telephone or by video link but that he chose not to participate via this method. There is nothing before the Committee to suggest that Mr Craig would attend on a future occasion, were it not to proceed with the hearing today. The Committee has concluded that Mr Craig is aware of today's resumed hearing and that he has voluntarily absented himself from these proceedings. It has received no compelling reasons as to why it should not proceed with today's hearing and indeed in his letter dated 11 October 2017 addressed to this Committee Mr Craig has not sought a postponement of today's hearing.

Furthermore, the Committee considers that it is in the public interest to review the current order before its expiry at the end of this month (25 December 2017). It is aware that were it not to proceed with the hearing today, there would not be sufficient time for the GDC to serve the Notice of Resumed hearing on Mr Craig and allow him 28 days in advance of the hearing taken place, before the order expiring on 25 December 2017.

Having regard to all these factors, the Committee has decided that it is fair and appropriate to proceed in the absence of Mr Craig in accordance with Rule 54.

Background

This is a resumed hearing of Mr Craig's case, which is being convened pursuant to Section 36Q of the Dentists Act 1984 (as amended). Mr Craig's case was considered by the PCC at a hearing in November 2016. Mr Craig did not attend that hearing and he was not

represented. At that hearing the PCC considered allegations against Mr Craig, a Clinical Dental Technician (CDT), concerning the standard of care and treatment he provided to Patient 1 concerning the provision of a new set of upper and lower dentures in 2013. The PCC found proved the vast majority of the findings against Mr Craig, including the fact that at the initial appointment on 3 March 2013, he did not provide an adequate standard of care to Patient 1 in that he failed to carry out sufficient pre-treatment assessments of the patient's presenting dental condition, soft tissues and the patient's dental, denture and medical history, as well as his failure to provide an estimate of the cost of treatment. Patient 1 attended on 27 March 2013 when Mr Craig supplied the patient with a new set of dentures. On that occasion Mr Craig failed to advise Patient 1 of a recall interval for an oral cancer screening assessment to be carried out by a dentist. Further on or after 15 May 2013, Mr Craig failed to provide Patient 1 with a satisfactory set of dentures which the patient had paid for in advance.

The PCC also reached a number of record-keeping failures in respect of Mr Craig's care and treatment of Patient 1 at various appointments between the period 3 March 2013 and 31 August 2013. It also found that Mr Craig did not adequately respond to the attempts that Patient 1, and those acting on their behalf, made to communicate with them in relation to the provision of the patient's dentures. This included Mr Craig's failure to respond to two letters dated 28 November 2013 and 17 February 2014 sent to him by the Citizen's Advice Bureau (CAB), from whom Patient 1 had sought help and guidance. Mr Craig also failed to attend a number of appointments between August 2013 and October 2013 arranged with Patient 1 by text message. Further, Mr Craig did not respond to Patient 1's text messages enquiring whether Mr Craig would be attending. The PCC found that during the course of a telephone conversation with a representative from the CAB on 18 November 2013 Mr Craig agreed to deliver Patient 1's dentures on 20 November 2013 but then failed to do so. The PCC found that Mr Craig's conduct was misleading, unprofessional and dishonest.

The PCC found that Mr Craig failed to have indemnity insurance for a period in excess of four months in 2013, during which time he provided dental services. Further, between the period from 30 June 2015 up until at least 9 September 2015 Mr Craig failed to co-operate with the GDC investigation into the matters relating to Patient 1. As part of that investigation the GDC requested that Mr Craig provide copies of his records regarding his appointments with Patient 1. Mr Craig submitted non-contemporaneous records, which the PCC found to be misleading and dishonest.

The PCC considered that Mr Craig's acts and omissions were serious, encompassing a number of significant and fundamental aspects of his practice. It was in no doubt that Mr Craig's dishonest conduct in two areas of his professional duties had brought the dental profession into disrepute and jeopardised the trust and confidence that the public places in the profession. Further, the PCC took a serious view of Mr Craig's failure to have in place any indemnity cover whilst providing dental services over a period of four months. The absence of such arrangements placed the public at the risk of harm. The PCC determined that the facts found proved amounted to misconduct.

The PCC took the view that some of the clinical shortcomings identified in this case were capable of being remediated. However, it considered Mr Craig's proven dishonesty might connote an attitudinal or behavioural shortcoming which might be more difficult to remedy. In any event, the PCC had insufficient evidence before it to satisfy it that Mr Craig had addressed and remediated his shortcomings, such as the formulation of a personal development plan (PDP) or any continuing professional development (CPD). The PCC also

had concerns about Mr Craig's limited insight into the conduct that had precipitated the GDC's proceedings against him.

Furthermore, the PCC considered that due to the absence of both insight and remediation, there remained a risk of such conduct being repeated and thus a real prospect of harm being caused to patients. In these circumstances, the PCC judged Mr Craig's fitness to practise to be impaired. It further considered that a finding of impairment was necessary to maintain public confidence in the profession and in the regulatory process, and to declare and uphold proper professional standards.

In arriving at the sanction of suspension the Committee took into account the severity of the findings against Mr Craig. It noted that Mr Craig's misconduct was sustained and repeated over a protracted period. The PCC had made findings which amounted to a disregard of the regulatory systems to which Mr Craig's registration is subject, more particularly his failure to hold appropriate indemnity insurance, his failure to co-operate with the GDC, and his lack of candour with the GDC when asked to provide Patient 1's records. The PCC was also concerned that Mr Craig had not demonstrated significant insight into his misconduct and considered that he continued to pose a significant risk to patients because of the prospect of repeating conduct which has not been remediated.

The PCC directed that Mr Craig's name be suspended from the register for a period of 12 months. It considered that this period of time was necessary to mark the PCC's findings of facts, misconduct and impairment and to allow Mr Craig to develop and demonstrate insight into, and remediation of, his misconduct. In its concluding remarks, the PCC indicated that a future Committee reviewing the order might be assisted by evidence of Mr Craig's insight into these matters and evidence of the steps he had taken to address and remediate his conduct such as a reflective statement, a PDP targeted on the specific areas of deficiency, and a log and details of focussed CPD.

Today's review

At today's hearing this Committee has comprehensively reviewed the current order. In so doing, the Committee has had regard to the GDC prosecution bundle, which contains copies of letters and emails between the period November 2016 and August 2017 from the GDC's Case Review Team to Mr Craig, reminding him several times of the recommendations made by the PCC in November 2016.

The information provided by Mr Craig to the GDC for the purpose of today's hearing amounts to a single letter dated 11 October 2017 in which he states that he now understands why he was suspended from the register. Mr Craig cites the financial failing of his business as a reason for his behaviour. He also states that he accepts that his behaviour was unprofessional and dishonest and assures the Committee that he will never allow this to happen again. He states that he has taken action to address his mistakes by gaining educational qualifications. This is in the form of photograph of a certificate, entitled "National Certificate in Pharmacy Services SCQF Level 6" which was awarded to Mr Craig in June 2017. There is also a detailed record of the areas of study completed by Mr Craig in respect of this certificate. None of this information appears to relate to work of a Clinical Dental Technician and it does not deal with the areas of concern raised by the PCC in 2016. There is no other evidence before the Committee as to Mr Craig's insight into the matters that went before the PCC in November 2016 or any of the other information recommended by that PCC.

Mr Middleton submitted that Mr Craig's fitness to practise remains impaired. He invited the Committee to direct that Mr Craig's registration be suspended for a period of 12 months and submitted that such a direction was necessary and proportionate to the concerns identified by the PCC in November 2016, which have not yet been addressed.

The Committee has considered carefully the submissions made. It has accepted the advice of the Legal Adviser. The Committee considers that the comments set out in Mr Craig's letter dated 11 October 2017 raises significant concerns as to his level of understanding of the seriousness of the matters found proved by the PCC in November 2016. In the Committee's view, Mr Craig appears to have no appreciation of his professional obligations or the impact of his conduct on his patient. The Committee also considers that the evidence of CPD, in the form of one certificate in Pharmacy Services, does not address the concerns identified by the PCC. In summary, the Committee considers that the information provided by Mr Craig is woefully inadequate. In the Committee's view, Mr Craig has provided insufficient evidence to satisfy this Committee that he has addressed the PCC's concerns and that he has developed a full insight into these matters. The Committee considers that Mr Craig remains a risk to the public. Accordingly, the Committee has determined that Mr Craig's fitness to practise is currently impaired.

The Committee next considered what direction to give, bearing in mind its powers in accordance with Section 36Q of the Dentists Act 1984. In so doing, it has had regard to the GDC's "Guidance for the Practice Committees including Indicative Sanctions Guidance" (October 2016).

In the Committee's judgement, Mr Craig has not demonstrated any commitment to remediate his deficiencies or engage properly with the GDC, despite being given ample opportunity to do so. In these circumstances, the Committee has concluded that replacing the current suspension order with one of conditions would not be appropriate or sufficient for the protection of the public.

The Committee therefore directs that the current period of suspension on Mr Craig's registration be extended for a period of 12 months. It is satisfied that extending the order for the maximum period of 12 months is necessary for the protection of the public, given the absence of any remediation and his limited engagement with the GDC.

The order of suspension will be reviewed shortly prior to the end of the 12-month period. That Committee will consider what action it should take in relation to Mr Craig's registration. This Committee echoes the recommendations made by the PCC in November 2016 as to the evidence a Committee reviewing the order might be assisted with. This may include, but would not be limited to, a more detailed reflective statement that convinces a reviewing Committee of his insight, a personal development plan targeted on the specific areas of deficiency, and a log and details of focussed CPD.

That concludes today's case."

At a review hearing on 28 November 2018 the Chairman announced the determination as follows:

"Mr Craig: This is the second review hearing of your case before the Professional Conduct Committee (PCC). You are present via telephone and represent yourself. Mr Grey appears on behalf of the General Dental Council (GDC).

Background

Your case was first considered at an initial PCC hearing in November 2017. That PCC reached findings against you concerning your conduct relating to the care and treatment of a single patient. Your failings were evident over a protracted period of time and across a number of significant and fundamental aspects of your practice. The Committee determined your conduct fell far short of the standards reasonably expected of a registered dental care professional. Your conduct relates to failings in basic aspects of clinical care, more particularly patient assessment, the provision of a dental appliance, appropriate record-keeping and communication with patients and dishonesty. You also repeatedly breached a fundamental tenet of the profession in respect of your contact with the patient in question, with those acting on the patient's behalf, and with the GDC, namely the need to act in an honest and trustworthy manner. The Committee considered that your dishonest conduct put the standing and reputation of the profession at risk of being brought into disrepute and jeopardised the trust and confidence that the public places in the profession. The Committee has also found that, for a period of over four months, you failed to have in place any indemnity cover whilst providing dental services.

The PCC in November 2016 determined that the facts found proved amounted to misconduct. In particular, the PCC found there was insufficient evidence of you having addressed and remediated any of the misconduct, both clinical and non-clinical. It considered your insight into the conduct was very limited and that your written submissions that you sent suggested a fundamental lack of recognition of, and a sense of responsibility for, the serious acts and omissions which have caused financial harm to one patient and potential harm to other patients. It concluded that your fitness to practise was impaired by reason of your misconduct. It directed that your registration should be suspended for a period of twelve months.

The PCC in November 2016 determined that a reviewing Committee might be assisted by receiving the following:

> *"…a reflective statement, a personal development plan targeted on the specific areas of deficiency, and a log and details of focussed CPD."*

The PCC reviewed the order on 6 December 2017. You did not attend that hearing and you were not represented. In your absence, the PCC determined you provided insufficient evidence to satisfy the Committee that you had addressed the concerns identified by the initial Committee and that you had not developed full insight. The PCC concluded that there remained a risk of repetition. It determined that your fitness to practise remained impaired. The PCC directed that your registration be suspended for a further period of twelve months. It concluded that, no lesser sanction than a further period of suspension would be appropriate. It further indicated that a review hearing should take place before the expiry of the order.

The PCC in December 2017 indicated that a Committee reviewing the order may be assisted by the same recommendations made by the initial PCC as set out above, which may also include, but would not be limited to, a more detailed reflective statement that convinces a reviewing Committee of your insight, a personal development plan targeted on the specific areas of deficiency, and a log and details of focussed CPD.

Today's review

Mr Grey submitted that your fitness to practise remains impaired and invited the Committee to consider making a direction that your registration be suspended indefinitely. He referred to the limited evidence of remediation regarding the wide-ranging concerns identified by the PCC in November 2016.

In your oral evidence you referred the Committee to the steps you have taken to address the concerns identified, as set out in the documents provided. You confirmed that you were aware of the nature of the PCC's findings against you. You stated that you fully understand and accept your past failings which you regret. You told the Committee that if you were permitted to return you no longer intend to work as a Clinical Dental Technician but as a Dental Technician under restrictions. You stated this would allow you to be in a better financial position to fund the cost of CPD training.

The Committee has comprehensively reviewed all the information before it, as contained in the GDC's bundle which included the documents provided on your behalf. This includes a single letter in which you state that having been suspended for a period of two years you now realise your behaviour was below that of a Dental Professional. You stated how your order of suspension has affected you financially and as a result you have been unable to pay for CPD, however, you have gained this through your university study which you state is relevant to your professional needs. You apologised for your behaviour and promised the Committee that you will abide by all GDC Regulation and Scope of Practice and will obtain Indemnity Insurance as soon as your suspension is lifted. You also sent a document entitled *'Personal Development Plan in relation to Dentistry'* consisting of two pages. This document set out as stated your short term aims, medium term plan and long-term plan and indicated that you studied a course in National Certificate in Pharmacy Services SCQF Level 6, where you stated it covered the areas of record keeping, medical ethics, cross infection and complaint handling.

The Committee has first considered whether your fitness to practise is currently impaired by reason of the misconduct found proved. In reaching its decision on the issue of impairment, the Committee exercised its own independent judgement. It bore in mind that its duty is to consider the public interest, which includes the protection of patients, the maintenance of public confidence in the profession and the declaring and upholding of proper standards of conduct and behaviour.

The Committee considered the new material that you had placed before it and also had regard to your oral evidence. It considered you have demonstrated insight into your failings and understood why the initial PCC found that you have acted dishonestly. It further found your regret and remorse, in apologising to the profession in the course of your oral evidence to be genuine and compelling. The Committee had regard to your evidence and found that you were open and frank.

In relation to your evidence of remediation the Committee was not satisfied that you have addressed all the concerns identified by the PCC at the initial hearing and at the review hearing. You told the Committee the following:

- That you had completed Non-verifiable CPD hours. However, no evidence was put before the Committee in support of this, nor was there any reflection from you as to what you have learnt from the CPD and how you would embed it in to your practice.

- That you completed a Pharmacy and Accounting course. However, apart from the certificates, there was no evidence from you of any reflective learning and how this learning would prevent you from repeating your misconduct.

The Committee was encouraged by the steps you say you had taken. It noted it was not supported by logs or other supportive evidence. Given the concerns regarding your limited remediation you have undertaken in these proceedings, the Committee considers that the risk of repetition remains. Accordingly, the Committee has concluded that your fitness to practise remains currently impaired.

The Committee next determined what sanction, if any, would be appropriate in light of its finding of current impairment. The Committee recognised that the purpose of a sanction is not punitive, although it may have that effect, but is instead imposed in order to protect patients and safeguard wider public interests. It has applied the principle of proportionality, balancing the public interest with your own interests.

The Committee first considered whether it would be appropriate and proportionate to terminate the current order of suspension. It concluded that given its reasons for finding current impairment, that such a course of action would be inappropriate to protect the public and the wider public interest.

The Committee next considered whether it could formulate conditions which would be workable, measurable, enforceable and which would address the risks that have been identified. It acknowledges that you have made some steps to remedy some of the failings identified since the last review hearing in November 2017 and that you have yet to demonstrate full remediation. It considered that you are now engaged in these proceedings. You are moving in the right direction and the Committee was encouraged by this.

The Committee was satisfied, given your progress towards remediation, albeit at an early stage, and engagement, that conditions of practice are now workable and proportionate. All of the failings in this case are remediable through reflection, learning and embedded improvement in practice. Conditions of practice will serve as a robust framework which will allow you to achieve this whilst protecting patient and maintaining public confidence. Accordingly, the Committee directs that your suspension be terminated and that your registration be made conditional on your compliance with conditions, which will appear against your name in the Register in the following terms:

1. He must forward a copy of his Personal Development Plan to the GDC within 3 months of the date on which these conditions become effective. He must allow the GDC to exchange information about the standard of his professional performance and his progress towards achieving the aims set out in his Personal Development Plan with his employer (or a nominated deputy), and any other person involved in his retraining and supervision.

2. He must notify the GDC promptly of any professional appointment he accepts and provide the contact details of his employer or any organisation for which he is contracted to provide dental services.

3. He must allow the GDC to exchange information with his employer or any organisation for which he is contracted to provide dental services, and any Postgraduate Dental Dean/Director, reporter, workplace supervisor or educational supervisor referred to in these conditions.

4. At any time he is providing dental services, which require him to be registered with the GDC, he must agree to the appointment of a reporter nominated by his employer and approved by the GDC. The reporter shall be a GDC registrant.

5. He must allow the reporter to provide reports to the GDC at intervals of not more than 6 months and the GDC will make these reports available to any Postgraduate Dental Dean/Director, workplace supervisor or educational Supervisor referred to in these conditions.

6. He must inform the GDC of any formal disciplinary proceedings taken against him, from the date of this determination.

7. He must inform the GDC if he applies for dental employment outside the UK.

8. At any time he is employed, or providing dental services, which require him to be registered with the GDC;

   a. As a Clinical Dental Technician he must place himself and remain under the direct supervision of a workplace supervisor nominated by his employer and agreed by the GDC.

   b. As a Dental Technician he must place himself and remain under the close supervision of a workplace supervisor nominated by his employer and agreed by the GDC.

9. He must allow his workplace supervisor to provide reports to the GDC at intervals of not more than 6 months and the GDC will make these reports available to any Postgraduate Dean/Director or Educational Supervisor/workplace supervisor referred to in these conditions.

10. He must keep his professional commitments under review and limit his dental practice in accordance with his workplace supervisor's advice.

11. He must not engage in single-handed dental practice as a GDC Registrant.

12. He must not be responsible for the administration/management (including financial) of any dental practice/dental laboratory.

13. He must not work as a locum or undertake any out-of-hours work or on-call duties without the prior agreement of the GDC.

14. If working as a Clinical Dental Technician:

    a. He shall carry out an audit of record keeping [The audit must be signed by his workplace supervisor.]

    b. He must provide a copy of this audit to the GDC on a 6 monthly basis or, alternatively, confirm that no patients have been treated by him

15. He must inform within 7 days the following parties that his registration is subject to the conditions, listed at (1) to (14), above:

    - Any organisation or person employing or contracting with him to undertake dental work
    - Any locum agency or out-of-hours service he is registered with or applies to be registered with (at the time of application)

- Any prospective employer (at the time of application)

16. He must permit the GDC to disclose the above conditions, (1) to (15), to any person requesting information about his registration status.

The period of conditional registration shall be for 12 months to allow you sufficient time to return to practising and to demonstrate embedded improvement in your practice. The conditions shall be reviewed prior to their expiry.

The Committee now invites submissions on the question of an immediate order.

The Committee is satisfied that it is in the public interest to order that your registration be made conditional forthwith under s 36(U) of the Dentists Act 1984. It would also be in your interests, as your registration would otherwise remain suspended pending the taking effect of the direction for conditional registration.

The effect of this order is that the suspension of your registration is terminated and your registration is now subject to the above conditions. Unless you exercise your right of appeal, the substantive 12-month period of conditional registration will commence in 28 days' time. Should you exercise your right of appeal, this immediate order will remain in force pending the disposal of the appeal. That concludes the hearing."

At a review hearing on 27 November 2019 the Chairman announced the determination as follows:

"This is a resumed hearing pursuant to Section 36Q of the Dentists Act 1984 (as amended) ('the Act') to review the order of conditions for 12 months which was imposed on your registration by the Professional Conduct Committee (PCC) on 28 November 2018. You are present via telephone and represent yourself. Mr Ahmed represents the General Dental Council (GDC).

Background

Your case was first considered at an initial PCC hearing in November 2016. You did not attend that hearing. That PCC reached findings against you concerning your conduct relating to the care and treatment of a single patient. That PCC found proved failings in basic aspects of clinical care, more particularly patient assessment, the provision of a dental appliance, appropriate record-keeping and communication with patients and dishonesty. You also repeatedly breached a fundamental tenet of the profession in respect of your contact with the patient in question, with those acting on the patient's behalf, and with the GDC, namely the need to act in an honest and trustworthy manner. The Committee considered that your dishonest conduct put the standing and reputation of the profession at risk of being brought into disrepute and jeopardised the trust and confidence that the public places in the profession. The Committee also found that, for a period of over four months, you failed to have in place any indemnity cover whilst providing dental services.

The PCC in November 2016 considered that your failings were evident over a protracted period of time and across a number of significant and fundamental aspects of your practice. The Committee determined that your conduct fell far short of the standards reasonably expected of a registered dental care professional. It determined that the facts found proved amounted to misconduct. The PCC found that there was insufficient evidence of you having addressed and remediated any of the misconduct, both clinical and non-clinical. It considered your insight into the conduct was very limited and that your written submissions that you sent suggested a fundamental lack of recognition of, and a sense of responsibility

for, the serious acts and omissions which had caused financial harm to one patient and potential harm to other patients. It concluded that your fitness to practise was impaired by reason of your misconduct. It directed that your registration should be suspended for a period of 12 months. The PCC in November 2016 made recommendations on the types of evidence you could provide that could assist a reviewing Committee. These included the provision of a reflective statement, a personal development plan targeted on the specific areas of deficiency, and a log and details of focussed CPD.

First Review

The PCC reviewed the order on 6 December 2017. You did not attend that hearing and you were not represented. It considered your letter dated 11 October 2017 and evidence of one CPD course which you had provided. In your absence, the PCC determined that you provided insufficient evidence to satisfy it that you had addressed the concerns identified by the initial Committee and that you had not developed full insight. The PCC concluded that there remained a risk of repetition. It determined that your fitness to practise remained impaired. The PCC directed that your registration be suspended for a further period of 12 months. It concluded that, no lesser sanction than a further period of suspension would be appropriate. It further indicated that a review hearing should take place before the expiry of the order and made recommendations as the previous Committee. These were to include, but not limited to a more detailed reflective statement that convinces a reviewing Committee of your insight, a personal development plan targeted on the specific areas of deficiency, and a log and details of focussed CPD.

Second Review

The PCC reviewed the order on 28 November 2018. You attended that hearing via telephone and you represented yourself. That Committee considered that you had demonstrated insight into your failings and understood why the initial PCC found that you had acted dishonestly. It further found your regret and remorse, in apologising to the profession in the course of your oral evidence to be genuine and compelling. That Committee had regard to your evidence and found that you were open and frank. In relation to your evidence of remediation that Committee was not satisfied that you had addressed all the concerns identified by the PCC at the initial hearing and at the review hearing. It considered that the risk of repetition remained and accordingly, concluded that your fitness to practise remained impaired. The PCC acknowledged that you had made some steps to remedy some of the failings identified since the last review hearing in November 2017, you had engaged in the proceedings and you were moving in the right direction. The PCC was satisfied, given your progress towards remediation, albeit at an early stage, and engagement, that conditions of practice would be workable and proportionate. It directed that the suspension be terminated and that your registration be made conditional on your compliance for a period of 12 months with a review prior to its expiry.

Today's Review

GDC's Submissions

On behalf of the GDC Mr Ahmed submitted that you have breached a number of the conditions on your registration. He submitted that there are substantial concerns as to your engagement with the GDC and your provision of information to the GDC. Mr Ahmed submitted that the Council alleges that you have been working for the last eight to nine months as a dental technician or clinical dental technician without informing the Council, you did not inform your employer of the conditions on your registration and you did not ensure

that a reporter and a workplace supervisor were in place in breach of conditions 1, 2, 3, 4, 5, 8, 9, 10, 14 and 15.

Mr Ahmed submitted that, in the alternative, the Council alleges that you have been working for the last eight to nine months as a lab assistant without informing the Council and you did not inform your employer of the conditions on your registration, in breach of conditions 1, 2 and 15.

He invited the Committee to first determine whether there has been a breach of conditions and specify which conditions have been breached. He referred the Committee to Section 36Q(3) which states that "Where a Practice Committee have given a direction imposing conditions on a person's registration… and the Practice Committee determine that at any time during the period for which that direction or order has effect the person has failed to comply with any condition imposed on his registration, the Practice Committee may direct, in relation to that title, that the person's registration in the dental care professionals register shall be suspended during such period not exceeding twelve months as may be specified in the direction." Mr Ahmed submitted that if the Committee finds that there has been a breach of conditions, it should conclude that your fitness to practise is currently impaired and replace the current order of conditions with one of suspension for a period of 12 months.

In the alternative, Mr Ahmed submitted that if the Committee did not find you in breach of the conditional registration order on your registration, given that you have not been working as a dental technician or a clinical dental technician and as a result you have not remedied the failings found proved in November 2016, your fitness to practise remains impaired.

Your Oral Evidence and Submissions

In your oral evidence you explained that in January 2019 you applied for a job as a laboratory assistant. You said that you informed the owner of the laboratory that although you are a qualified dental technician and clinical dental technician, your registration had been suspended and was recently made subject to conditions. You told the Committee that you were informed by the owner of the laboratory that the conditional registration was not an issue because the job opening was for a laboratory assistant and not a dental technician. You took up the role of laboratory assistant undertaking delivery of laboratory work to dental practices and logging orders in and out of the laboratory and you have been doing this work since January 2019. You explained that you did not consider that working as a laboratory assistant would be in breach of the conditions of your registration as a dental technician such that notification to the GDC was required in line with the conditions on your registration.

You told the Committee that you have made a total of 13 job applications for dental technician positions. You said that although you would receive job offers, once your conditional registration is mentioned, the job offers would be withdrawn. You explained the efforts you had made to secure the support of the Deanery in producing a Personal Development Plan (PDP) as required by the conditions on your registration.

You submitted that you accept and understand that you made mistakes in your practice in the past for which remediation is required. You conceded that the conditions should be continued until you are able secure a role as a dental technician and demonstrate adequate remediation.

Allegation of Breach of Conditions

The Committee first considered whether you have breached the conditions on your registration. In so doing it considered your oral evidence. The Committee found you to be a credible witness who gave clear and truthful answers to questions asked. It accepted your evidence.

The Committee noted that the GDC relied on documentary evidence only in support of its submission that you were working as a dental technician. This includes entries in LinkedIn and a telephone attendance note of a conversation with your employer where it was recorded that he described you as a dental technician. However, it also saw an email from your employer directly who confirmed that you were employed as a laboratory assistant and not a dental technician. The Committee accepted your account as credible that you were not employed as a dental technician but rather as a laboratory assistant. It was supported in this conclusion by the email from your employer. It accepted your explanation for your LinkedIn entry and placed less weight on the Council's documentary evidence.

The Committee considered the documentary evidence presented by the Council in support of the allegations made against you. It also considered the wording of Condition 2 which provides:

> "He must notify the GDC promptly of any professional appointment he accepts and provide contact details of his employer or any organisation for which he is contracted to provide dental services."

The Committee sought clarification from the Council on the scope of the role of a laboratory assistant. Mr Ahmed submitted that the work of a laboratory assistant is supervised and can be carried out by anybody including a registrant whose registration is suspended. The Committee also noted that 'Laboratory Assistant' is not a registered profession. Therefore, the Committee did not accept that working as a laboratory assistant falls within this condition for notification purposes. It concluded that the GDC had not discharged its burden of proving the allegation and you had not breached this condition.

In relation to Condition 1 and the requirement to provide a Personal Development Plan (PDP) within 3 months of the date on which the conditions became effective, the Committee noted from the evidence before it that you were actively seeking the assistance of the Deanery in this regard. You told the Committee in your oral evidence that you waited for a response for a period of 10 months and you only recently secured an appointment. The Committee concluded that you had not breached this condition. The Committee is satisfied that there is no breach of any condition imposed by the previous Committee.

Current Impairment

In considering whether your fitness to practise is currently impaired, the Committee bore in mind that this is a matter for its own independent judgement. It also 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. The Committee was referred to case law including Abraheam v GMC. The Committee accepted the advice of the Legal Adviser.

The Committee first considered whether you have remedied the failings found proved by the PCC in November 2016. You have provided no evidence of remediation to the Committee. You accept that you are yet to address the failings found proved against you. The Committee concluded that in the absence of any evidence of remediation, there remains a risk of repetition. The Committee therefore determined that your fitness to practise remains impaired by reason of your misconduct.

Sanction

The Committee next considered what sanction to impose on your registration under Section 36Q of the Dentists Act, 1984 as amended. It reminded itself that the purpose of any sanction is not to be punitive although it may have that effect. The Committee bore in mind the principle of proportionality.

The Committee first considered whether to terminate the current order of conditions. It was of the view that this course of action would be inappropriate given that you are yet to commence remediation of your failings previously found proved.

The Committee then considered whether to extend the current period of conditions. In light of your engagement with the process and willingness to secure a role that would enable you to start complying with the conditions, the Committee concluded that an order for conditional registration remains appropriate, sufficient and proportionate in this case. The Committee considered that to suspend your registration would be unfair and disproportionate given your engagement with the process.

The Committee has therefore determined to extend the conditions on your registration for a period of 12 months pursuant to section 36Q (2)(b) of the Dentists Act 1984, as amended.

The conditions which will appear against your name in the Register remain in the same terms as before, unvaried:

1. He must forward a copy of his Personal Development Plan to the GDC within 3 months of the date on which these conditions become effective. He must allow the GDC to exchange information about the standard of his professional performance and his progress towards achieving the aims set out in his Personal Development Plan with his employer (or a nominated deputy), and any other person involved in his retraining and supervision.
2. He must notify the GDC promptly of any professional appointment he accepts and provide the contact details of his employer or any organisation for which he is contracted to provide dental services.
3. He must allow the GDC to exchange information with his employer or any organisation for which he is contracted to provide dental services, and any Postgraduate Dental Dean/Director, reporter, workplace supervisor or educational supervisor referred to in these conditions.
4. At any time he is providing dental services, which require him to be registered with the GDC, he must agree to the appointment of a reporter nominated by his employer and approved by the GDC. The reporter shall be a GDC registrant.
5. He must allow the reporter to provide reports to the GDC at intervals of not more than 6 months and the GDC will make these reports available to any Postgraduate Dental Dean/Director, workplace supervisor or educational Supervisor referred to in these conditions.
6. He must inform the GDC of any formal disciplinary proceedings taken against him, from the date of this determination.
7. He must inform the GDC if he applies for dental employment outside the UK.
8. At any time he is employed, or providing dental services, which require him to be registered with the GDC;

a. As a Clinical Dental Technician he must place himself and remain under the direct supervision of a workplace supervisor nominated by his employer and agreed by the GDC.

b. As a Dental Technician he must place himself and remain under the close supervision of a workplace supervisor nominated by his employer and agreed by the GDC.

9. He must allow his workplace supervisor to provide reports to the GDC at intervals of not more than 6 months and the GDC will make these reports available to any Postgraduate Dean/Director or Educational Supervisor/workplace supervisor referred to in these conditions.

10. He must keep his professional commitments under review and limit his dental practice in accordance with his workplace supervisor's advice.

11. He must not engage in single-handed dental practice as a GDC Registrant.

12. He must not be responsible for the administration/management (including financial) of any dental practice/dental laboratory.

13. He must not work as a locum or undertake any out-of-hours work or on-call duties without the prior agreement of the GDC.

14. If working as a Clinical Dental Technician:

    a. He shall carry out an audit of record keeping [The audit must be signed by his workplace supervisor.]

    b. He must provide a copy of this audit to the GDC on a 6 monthly basis or, alternatively, confirm that no patients have been treated by him

15. He must inform within 7 days the following parties that his registration is subject to the conditions, listed at (1) to (14), above:

    - Any organisation or person employing or contracting with him to undertake dental work
    - Any locum agency or out-of-hours service he is registered with or applies to be registered with (at the time of application)
    - Any prospective employer (at the time of application)

16. He must permit the GDC to disclose the above conditions, (1) to (15), to any person requesting information about his registration status.

The period of conditional registration shall be reviewed prior to their expiry.

That concludes the case for today."