HEARING HEARD IN PUBLIC

KADAR, Bence
Registration No: 196077
PROFESSIONAL CONDUCT COMMITTEE
JANUARY - SEPTEMBER 2018

Outcome: Suspended for 12 months with immediate suspension (with a review)

Bence KADAR, a dentist, DMD Semmelweis University 2001 was summoned to appear before the Professional Conduct Committee on 8 January 2018 for an inquiry into the following charge:

Charge

“That being registered as a dentist Bence Kadar's (196077) fitness to practise is impaired by reason of misconduct. In that:

1. You failed to provide an adequate standard of care to Patient A between 12 December 2012 and 12 November 2013 in that:
   a. Prior to the implant treatment which you provided on 9 January 2013 you did not adequately investigate and/or assess:
      i. The history of Patient A's presenting condition;
      ii. Patient A's needs and aspirations;
      iii. Patient A's previous dental history;
      iv. Patient A's periodontal health;
      v. The evaluation of the hard and soft tissues of the face and jaws;
      vi. The evaluation of the dentition;
      vii. The bone height and position of the Inferior Dental Canal (IDC) for the proposed implant at LR6, LL6 and/or LL7;
      viii. The Cone Beam Computer Tomogram (CBCT) scan dated 6 December 2012 provided to you by Patient A;
   b. On 9 January 2013 you:
      i. Inserted implants at incorrect depths at LR6, LL6 and/or LL7;
      ii. Did not carry out an adequate post-surgical assessment of the implant at LL7;
      iii. Did not recognise that the implant you had inserted at LL7 was impinging upon the Inferior Dental Canal (IDC);

1 Please note that this hearing opened on 8 January 2018 and adjourned part heard on 12 January 2018. The hearing resumed on 9 April 2018, was adjourned part-heard and resumed on 3 September 2018.
iv. Did not remove the implant at LL7;

c. You did not obtain informed consent for the implant treatment you provided on 9 January 2013 in that you did not adequately explain to Patient A:
   i. The alternative treatment option of a lower partial denture;
   ii. The high risk of Inferior Alveolar Nerve (IAN) damage when placing implants at LR6, LL6 and/or LL7;
   iii. The use of Xenografts.

d. On 23 January 2013 you:
   i. Did not adequately assess or examine Patient A's IAN injury;
   ii. Did not adequately diagnose Patient A's IAN injury;
   iii. Did not refer Patient A for, or provide her, specialist care in respect of her IAN injury;

e. On 29 October 2013 you:
   i. Removed the implant at LL6 without sufficient clinical justification;
   ii. Did not adequately assess or examine Patient A's IAN injury;
   iii. Did not adequately diagnose Patient A's IAN injury;
   iv. Did not refer Patient A for, or provide her, specialist care in respect of her IAN injury.

2. You failed to maintain an adequate standard of record keeping in respect of Patient A's appointment from 12 December 2012 to 12 November 2013 in that:

a. Prior to the implant treatment which you provided on 9 January 2013 you did not adequately record:
   i. The history of Patient A's presenting condition;
   ii. Patient A's needs and aspirations;
   iii. Patient A's previous dental history;
   iv. Patient A's periodontal health;
   v. The evaluation of the hard and soft tissues of the face and jaws;
   vi. The evaluation of the dentition;
   vii. The bone height and position of the Inferior Dental Canal (IDC) for the proposed implant at LR6, LL6 and/or LL7;
   viii. An evaluation of the height and position of the Inferior Dental Canal (IDC) for the proposed implant at LR6, LL6 and/or LL7;

b. In respect of the implant treatment provided on 9 January 2013 you did not adequately record:
   i. Your post-surgical assessment of the implant at LL7;
   ii. That the implant at LL7 was impinging upon the Inferior Dental Canal (IDC);
c. You did not adequately record discussions of the following matters necessary for Patient A to provide informed consent for the implant treatment you provided on 9 January 2013:
   i. The alternative treatment option of a lower partial denture;
   ii. The high risk of Inferior Alveolar Nerve (IAN) damage when placing implants at LR6, LL6 and/or LL7;
   iii. The use of Xenografts;

d. In respect of the treatment provided on 23 January 2013 you did not adequately record:
   i. Assessment of Patient A's IAN injury;
   ii. Diagnosis of Patient A's IAN injury;

e. In respect of the treatment provided on 29 October 2013 you did not adequately record:
   i. Assessment of Patient A's IAN injury;
   ii. Diagnosis of Patient A's IAN injury.

3. Following a complaint from Patient A in respect of the treatment you provided to her you failed to respond to her adequately or at all.

4. Between 2 June 2016 and 16 January 2017 you failed to adequately cooperate with the GDC's investigation into your fitness to practice in that following a formal request you did not provide:
   a. details of your current employers;
   b. details of any relationships you had with the NHS as a performer or contractor;
   c. details of your indemnity provider and cover arrangements.

On 16 April 2018, the Chairman made the following statement regarding the finding of facts:

“Mr Kadar,

This is a Professional Conduct Committee hearing. You are represented at this hearing by Mr Raj Marwa, a lay representative. You are also being supported during these proceedings by an interpreter. Mr Tom Coke-Smyth, Counsel, is the Case Presenter for the General Dental Council (GDC).

**Background and summary of the alleged facts**

The charge against you relates to the care and treatment you provided to one patient, Patient A, between 12 December 2012 and 12 November 2013. At all material times, you were practising as a dentist at Perfect Profiles in Luton (‘the Practice’).

The Committee heard by way of background that Patient A had, over some years, had a number of her teeth extracted due to decay. The denture that Patient A had had fitted some 20 years ago broke, and she stopped wearing it. Patient A received advice from her regular dentist that she would need dental implants or another denture. As Patient A’s dentist did not
offer dental implants, she searched for a practice which did provide them and found the Practice, where she underwent implant treatment under your care.

In respect of your treatment of Patient A, it is alleged by the GDC that you failed to provide an adequate standard of care to the patient over the period in question on account of a number of clinical failings, coupled with allegations that you did not obtain informed consent before undertaking the treatment. It is also alleged that you failed to maintain an adequate standard of record keeping in respect of Patient A’s appointments during the timeframe in question. Further, there is an allegation that, following a complaint from Patient A in respect of the treatment you provided to her, you failed to respond to her adequately or at all.

In addition to the matters relating to Patient A, you face an allegation that, between 2 June 2016 and 16 January 2017, you failed to adequately cooperate with the GDC’s investigation into your fitness to practise. It is alleged that you did not provide certain information to the Council following a formal request for you to do so.

**Admissions**

At the outset, Mr Marwa told the Committee that the only allegation you admitted was that at head of charge 1e(iv) namely that you did not refer Patient A for, or provide her, specialist care in respect of her IAN injury.

Prior to parties’ closing submissions on the alleged facts, you made further admissions in respect of the following heads of charge: 1b(i), 1b(ii), 1d(i), 1d(ii), 1d(iii), 1e(ii), 1e(iii), 2a(i), 2a(ii), 2a(iii), 2a(iv), 2a(v), 2a(vi), 2a(vii), 2a(viii), 2b(i), 2c(i), 2c(ii) and 2c(iii).

The Committee noted that your admission to head of charge 1b(i) was only in relation to the implant inserted at Patient A’s LL7. This was following confirmation from Mr Coke-Smyth that the GDC no longer wished to pursue head of charge 1b(i) in relation to the two other teeth, namely the LR6 and LL6.

Mr Coke-Smyth also confirmed that in light of your admissions in respect of heads of charge 1d and 1e, the alternative record keeping allegations at heads of charge 2d and 2e fall away. It was the position of the GDC that you could not have failed to make a record of an assessment that you have admitted that you did not carry out, nor could you have failed to make a record of a diagnosis that you have admitted that you did not make.

**Evidence**

The GDC provided the Committee with documentary evidence which comprised the witness statement and exhibits of Patient A, signed and dated 18 May 2017. These exhibits included: a copy of her clinical records from her usual dental practice; a copy of her Cone Beam Computer Tomogram scan, dated 6 December 2012, which she had undertaken at a practice in Colchester; a copy of her records from the Practice; and copies of correspondence with the Practice regarding the treatment you provided to her. This correspondence also included a letter dated 4 March 2016 from Witness 3, a Professor in Oral Surgery, to whom Patient A was subsequently referred on 19 November 2015. In addition to providing a witness statement, Patient A attended the hearing and gave oral evidence to the Committee.

In respect of your alleged failure to cooperate with the GDC’s investigation, the Committee received a witness statement, signed and dated 6 April 2017, along with a number of exhibits, from a paralegal at Capsticks Solicitors. This is the firm of solicitors instructed by
the GDC in the investigation of your case. The exhibits provided by the paralegal included copies of the letters sent to you by the GDC between 2 June 2016 and 16 January 2017.

By way of expert evidence, the Committee received a report, dated 19 May 2017, prepared by Professor Ian Brook, the expert witness called by the GDC. Professor Brook also gave oral evidence to the Committee, which included his evidence in relation to extracts from two articles. The first article, which was provided by you, is entitled ‘Is 2 mm a safe distance from the inferior alveolar canal to avoid neurosensory complications in implant surgery?’ (PubMed March 2017). The second article, which was provided by the GDC to counter the first article is entitled ‘Prevention of Iatrogenic Inferior Alveolar Nerve Injuries in Relation to Dental Procedures’ (Oral Surgery – Dental Update June 2010).

Further, in the bundle of documents provided to the Committee, was an unsigned and undated copy of your written response to the GDC’s disclosure, which was sent to the GDC on 24 November 2017. During the course of your oral evidence to the Committee, you signed and dated a copy of this written response, and confirmed that you wished its contents to form part of your evidence in chief at this hearing.

**Further evidence received following an application under Rule 57**

Following a late application made by Mr Marwar during his closing submissions under Rule 57 of the GDC (Fitness to Practise) Rules Order of Council 2006, the Committee also accepted into evidence two further documents. These were a copy of an example contract of employment from the Practice and a copy of your resignation letter to the Practice, dated 24 January 2014. In relation to the relevance of these documents, Mr Marwar highlighted that the example contract of employment contained a clause, Clause 4, which stated that the Practice would be responsible for all correspondence between the clinic and patients. In relation to your letter of resignation, Mr Marwar submitted that it gave an insight into your state of mind in choosing to leave your employment at the Practice.

In response to the application, Mr Coke-Smyth did not formally object to the admission of the two documents provided. He stated that it was a matter for the Committee to consider their relevance. Mr Coke-Smyth submitted that, in the event that the documents were admitted into evidence, it would be for the Committee to decide what weight should be placed on them.

Having taken into account the submissions of both parties and after receiving advice from the Legal Adviser, the Committee determined to admit both of the documents into evidence. It took into account that the copy of the contract of employment provided was an example. However, it considered, on balance, that it was relevant to the charge against you, particularly head of charge 3, given your interpretation of Clause 4 in relation to dealing with patient complaints, namely that the Practice dealt with all such complaints. The Committee reached the same conclusion in relation to your letter of resignation. It decided that, on balance, the letter had some relevance to head of charge 3, as it suggested that you remained open to communication from the Practice regarding any patient complaints following leaving the Practice.

In deciding to admit both documents, the Committee noted that this evidence should have been submitted much earlier in the proceedings. It also took into account that the GDC was denied the opportunity to cross-examine you in relation to this new evidence. In the circumstances, the Committee decided that the admission of the documents did not adversely impact the GDC case as the Committee could take all such factors into account and attach such weight to the documents as it saw fit.
The Committee’s assessment of the witnesses who gave evidence at the hearing

Prior to reaching its findings on the alleged facts, the Committee considered the oral evidence given by each of the witnesses.

The Committee first considered the evidence of Patient A. It found her to be an honest and measured witness, who made clear when she could not remember specific events. In fact, the Committee noted that Patient A could not remember the majority of what had happened. The Committee considered this understandable given the passage of time since her treatment by you. It found, however, that she was clear and focused when addressing matters that were of concern to her, such as what she had been trying to achieve with the implants. The Committee considered that Patient A did her best to assist it in its inquiry.

In assessing your credibility, the Committee took into account that English is not your first Language and that some of the oral evidence was given through an interpreter. The Committee found your evidence clear when you were asked more straightforward questions by your lay representative with whom you are familiar, but less clear when you were under pressure during cross-examination. Nevertheless, the Committee found that overall, you were a cooperative witness and gave every assistance to the Committee. Of particular note, however, was your heavy reliance on what your usual practice would have been in the circumstances which was often confused with what actually happened in Patient A’s case. For example, in your written response to the GDC regarding the charges, you mentioned carrying out a detailed assessment of an OPG radiograph in respect of Patient A before placing the implants. However, it transpired in evidence that you had not taken such a radiograph. In the light of this, the Committee was not satisfied that you accurately remembered some of the events that you said you did, especially given the passage of time and the absence of adequate clinical records. The Committee considered that affected the reliability of certain parts of your evidence.

The Committee next considered the evidence of Professor Brook. It found his written report helpful and noted that during his oral evidence he demonstrated a willingness to admit when his opinion changed on certain matters. The Committee considered that he was fair and reasonable in listening to other explanations offered by you. It also found that he was well aware of his overriding duty to assist the Committee rather than any obligation to the party by whom he was engaged. In fact, he did his best to assist both parties, which included his consideration of the article that you produced in relation to the safe distance when placing implants. The Committee was satisfied that Professor Brook gave a reasonable view of what would have been expected from a reasonable dentist in all the circumstances.

The Committee’s Findings of Fact

The Committee considered all the evidence presented to it. It took account of the closing submissions made by Mr Coke-Smyth on behalf of the GDC and those made by Mr Marwa on your behalf. The Committee accepted the advice of the Legal Adviser. It considered each head of charge separately, bearing in mind that the burden of proof rests with the GDC in respect of all charges and that the standard of proof is the civil standard, namely the balance of probabilities. This means that the Committee has determined whether it was more likely than not that the matters alleged in this case occurred.

The Committee’s findings in relation to each head of charge are as follows:

| 1. | You failed to provide an adequate standard of care to Patient A between 12 December 2012 and 12 November 2013 in that: |
1.a. Prior to the implant treatment which you provided on 9 January 2013 you did not adequately investigate and/or assess:

1. a. i. The history of Patient A’s presenting condition;

**Found proved.**

This charge relates to whether you adequately investigated or assessed the history of Patient A’s presenting condition.

Professor Brook’s evidence did not assist on this point as to what he would have considered to be the relevant history of the presenting complaint. However, in his evidence about this charge he said that “You need to carry out these particular aspects of investigation in order to formulate the treatment plan and ensure the good prognosis for the treatment plan. And also to determine what the Patient requires.” Mr Coke-Smyth on behalf of the GDC did not clarify with Professor Brook as to what he would have expected in terms of the relevant history of the patient’s presenting condition.

Patient A told the Committee that she could not remember whether you asked her about the history of her presenting condition.

In your oral evidence you identified that Patient A had missing teeth which had been extracted over the years and that she had restored dentition that was well maintained. You stated that it was the gaps left by the missing teeth that the patient wanted to fill with implants.

The Committee noted that you had not recorded in the patient notes either the presenting condition or any history which related to it. Your oral evidence on this point was reliant on what your general practise was rather than what you actually did. The Committee also relied on its finding in relation to charge 1(a)(iii) to support its conclusion that you had not taken an adequate history of the patient’s presenting condition.

Having considered all the evidence, the Committee determined on the balance of probabilities that you did not adequately investigate and/or assess the history of Patient A’s presenting condition.

1.a. ii. Patient A’s needs and aspirations;

**Found not proved.**

The Committee found that Patient A was very clear in her evidence that she did have discussions at the Practice regarding her needs and aspirations. However, she was unable to recall whether those discussions had been with you. In her witness statement, Patient A stated that she could recall asking “a lot of questions of the Practice staff who duly responded”. In answer to questions from the Committee, Patient A stated that her aspiration was “A new beautiful mouth” and she could recall the questions she had asked at the Practice. She told the Committee that she was satisfied that her questions had been answered. She stated that she would not have gone ahead otherwise.

The Committee concluded on the evidence that Patient A’s needs and aspirations had been adequately investigated and/or assessed. Whilst the patient could not specifically recall whether you had been involved in responding to her questions,
the Committee could see no reason why you, as the treating dentist, would not have had some input. Accordingly, the Committee found this allegation not proved.

1.a.iii. Patient A's previous dental history;

Found proved.

The Committee accepted the evidence of Professor Brook that a patient’s dental history is one of the factors that needs to be explored “including enquiry into and attention to factors that have resulted in loss of teeth”. You stated that you did investigate and/or assess Patient A’s dental history. The Committee took into account your oral evidence in this regard, which is detailed in the Committee’s findings in respect of head of charge 1a(i) above, as well as your explanation of what took place at your initial consultation with Patient A, as set out in your written response to the charges. You identified that Patient A had missing teeth, as well as some restorations. The Committee also had regard to your clinical notes where you recorded against ‘Dental history’ that “Patient has own CT scan”. There is also reference elsewhere in the clinical notes that Patient A had previously been offered bridges.

The Committee was satisfied that you did carry out some form of investigation and/or assessment of Patient A’s dental history. However, taking into account the evidence of Professor Brook, the Committee concluded that you had not adequately investigated or assessed the patient’s previous dental history to determine the prognosis of the treatment that you proposed to provide. As the Committee stated previously, based on Professor Brook’s opinion, it would have expected the presence of more detailed information in relation to Patient A’s missing teeth. Furthermore, it was agreed evidence that this patient previously wore a denture. There is no reference to this in the clinical notes in relation to dental history and you did not address in your oral evidence or written statement why the patient had stopped wearing it.

Taking all the evidence into account, the Committee determined on the balance of probabilities that you did not adequately investigate and/or assess Patient A’s dental history.

1.a.iv. Patient A’s periodontal health;

Found proved.

It was the opinion of Professor Brook, which the Committee accepted, that Patient A’s periodontal status should have been taken into account in the planning of her treatment. In his report he said that “… assessment of periodontal health and specifically the result of BPE [Basic Periodontal Examination] – lack of assessment and recording is significant as this aspect of dental health can affect the prognosis of implant treatment and thus informs patients consent to care” He stated in his oral evidence that he would “expect analysis of the periodontal status of the patient to assure myself that they were maintaining their existing teeth and could maintain the implants. So I’d expect a BPE and I would expect a periodontal examination.”

You told the Committee that you carried out a BPE in respect of Patient A, but that you did not make a record of the BPE scores. You explained that the absence of a
record was because the patient was “in a good condition at this time” and you asserted that the mark that could be seen in the clinical records, next to ‘BPE recorded’, was “a minus”. The Committee did not accept your evidence in this regard. Given the nature and purpose of a BPE, the Committee determined that, had you undertaken a BPE, you and/or a nurse, would have recorded on the patient’s records your examination results, as you undertook it.

In the absence of any record of BPE scores and a periodontal assessment, the Committee decided on the balance of probabilities that this head of charge is proved.

1.a. v. The evaluation of the hard and soft tissues of the face and jaws;
Found proved.

In relation to an evaluation of the hard and soft tissues of the face and jaws, Professor Brook explained to the Committee the clinical evidence he would have expected to see. This included reference to “a clinical evaluation of the ridges where the implants were to be placed, the width, palpation, perhaps the thickness of the soft tissues…the quality of the soft tissues, any inflammation and bleeding.” Professor Brook said that, extra orally, he would have expected the “face site” to be recorded.

You gave evidence on what your usual practice would have been in the circumstances, which you said would include the checking of the soft and hard tissues of a patient’s mouth. Whilst you could not make specific reference to what you did in Patient A’s case, you explained what you would have examined. You stated that … “I also check the teeth, and then the palpation, check the soft tissue and also the area where the implants are planned to be placed.” The Committee also had regard to your clinical notes in respect of Patient A where it is recorded “Soft tissues checked: starting with the lips, gingival (buccal and labial aspects), tongue, floor of mouth”. Also recorded is “Extra oral examination – TMJ, lymph nodes, smile line and mid line.” It is important to note that there are no results recorded in the patient’s clinical notes by you in relation to these examinations and they could not therefore have provided a reliable indicator for treatment options.

Whilst the Committee was satisfied that you carried out a general examination of Patient A, it found little evidence that you had carried out an adequate investigation and/or assessment taking into account the patient’s clinical notes and the opinion of Professor Brook. In the circumstances, the Committee determined on the balance of probabilities that your assessment of Patient A was not adequate, as it did not include all that would be expected in relation to a patient attending for implant treatment.

1.a. vi. The evaluation of the dentition;
Found proved.

Professor Brook told the Committee that he would have expected an evaluation of all of Patient A’s teeth, anterior and posterior. He said he would expect an analysis of the existing teeth, to ensure that they were sound and that they would last with the treatment that was being proposed. You stated in evidence that you would have evaluated Patient A’s dentition in accordance with your usual practice, such as Patient A having missing teeth and some restorations, but you could not assist
with what you actually did in the present case. Upon further questioning from the Committee you said that you had evaluated the dentition but that it was not totally recorded. Patient A could not recall whether such an evaluation took place.

The Committee noted there was a treatment plan, dated 12 December 2012, in relation to the implants. However, there did not appear to be any notes or evaluation of that plan, either within the treatment plan itself or with the patient’s clinical notes. In light of these factors and Professor Brook’s evidence, the Committee concluded that the assessment you undertook was inadequate.

Taking all the evidence into account, the Committee determined on the balance of probabilities that you did not adequately investigate and/or assess Patient A’s dentition.

1.a.vii. The bone height and position of the Inferior Dental Canal (IDC) for the proposed implant at LR6, LL6 and/or LL7;

Found proved.

In his report, Professor Brook emphasised the importance of evaluating the bone height. He stated that it was important to mitigate surgical complications or misadventures that can occur during drilling of bone and implant placement. It was his opinion that “A competent surgeon will thus be aware of the need to plan ‘safe distance’ between the apex of the implant and any vital structures…” Professor Brook stated that in Patient A’s case, considering the type of implant used, a planned ‘safe distance’ would have been to leave 2mm between the implant and the IDC.

Professor Brook stated that it was clear from your clinical notes that you had assessed Patient A’s Cone Beam Computer Tomogram (CBCT) scan. However, it was his opinion that you did not assess it adequately, as your choice of implant length failed to include a safe distance of 2mm. The Committee noted that you did not agree with the opinion of Professor Brook in relation to what constituted a safe distance in Patient A’s case.

You told the Committee in evidence that you would routinely investigate and/or assess bone height in the circumstances. The Committee noted that this evidence was based on what you would have done rather than what you did. In the Committee’s view, you could not provide a reliable recollection of what you did in Patient A’s case. It considered this evident from the error you made in your written response to the charges in which you stated “started the treatment after the detailed assessment of the panoramic radiograph (OPG) and the 3 dimension scan (CBCT).” However, in your oral evidence you conceded that your reference to an OPG was incorrect, as such a radiograph had not been taken in respect of Patient A. You accepted that you only had access to the CBCT scan that the patient had provided.

You also told the Committee that your plan to place the implant at LL7 at an angle and closer than 2mm to the IDC was safe. You explained this for the first time in your oral evidence. You made a diagram on a flip chart to illustrate your point which the Committee took into account. You provided no explanation as to why you did not record this in the treatment plan, the patient’s clinical notes or in your witness statement provided to this Committee. In particular there was nothing in
these documents which made any mention of angulation, why you had reached this decision and the proposed angle at which you were going to place the implant. You said that even though you had not recorded the angulation you had determined this at the patient’s assessment in December 2012 and recalled the angulation. The Committee found your account to be implausible on this point given the importance of placing the implant precisely and the likelihood that if an alternative method of treatment had been planned, it would have been recorded.

The Committee accepted Professor Brook’s evidence, that 2mm is the minimum safe distance between an implant and the IDC and that an adequate assessment of Patient A’s CBCT would have enabled you to plan this safely. The Committee took account of the depth at which you placed the implants, which suggests that the relevant investigations and/or assessments in relation to bone height and the position of the IDC had not been undertaken. In addition, the Committee noted that there was no information in Patient A’s clinical notes as to how you planned the placement of the implants.

In all the circumstances the Committee was satisfied on the balance of probabilities that this head of charge is proved.

1.a.viii. The Cone Beam Computer Tomogram (CBCT) scan dated 6 December 2012 provided to you by Patient A;
Found proved.

The patient’s notes confirm that she produced her own CBCT scan and that you undertook some assessment of the scan. It noted, however, that you only made reference to Patient A’s upper jaw in your clinical record and the fact that she required a sinus lift. There is no reference to the patient’s lower jaw, which indicated to the Committee that your assessment of the CBCT scan was inadequate. It considered that had you sufficiently assessed the scan, you would have recorded all the information relevant to the proposed treatment. The Committee took into account your evidence in which you maintained that you carried out a “detailed assessment” of the scan. However, it was of the view that had you done so, you would have written it down. It saw no reason why you would record some of the relevant details in relation to the upper jaw and not in relation to the lower jaw.

The Committee was satisfied on the balance of probabilities that this head of charge is proved.

1.b. On 9 January 2013 you:

1. b. i. Inserted implants at incorrect depths at LR6, LL6 and/or LL7;
Admitted and found proved in relation to the LL7 only.

It was confirmed by Mr Coke-Smyth in his closing submissions that no evidence was offered by the GDC in relation to the LR6 and LL6.

1. b. ii. Did not carry out an adequate post-surgical assessment of the implant at LL7;
Admitted and found proved.

1.b. iii. Did not recognise that the implant you had inserted at LL7 was impinging upon the
Inferior Dental Canal (IDC);

**Found proved.**

In reaching its decision, the Committee had regard to the submissions made by both parties in relation to the definition of the word ‘impinging’. The Committee agreed that the word ‘impinging’ has a broad meaning, which can include ‘the penetration of’, but can also mean ‘having an affect upon’, the latter being the basis on which the GDC put its case. The Committee took into account that there is no allegation that you penetrated Patient A’s IDC. Taking this into account, the Committee had regard to the evidence before it.

In the Committee’s view, having had regard to the evidence, it is a matter of fact that the implant you inserted at LL7 impinged on the patient’s IDC. It was agreed evidence that Patient A had reported numbness and that you suggested that the relevant implant be removed, which later occurred. The Committee considered that logically, the implant would not have been removed, if it was not thought to be impinging on the IDC.

The Committee noted, however, that your recognition was in hindsight. In determining whether you failed to provide an adequate standard of care to Patient A in this regard, the Committee considered whether you should have recognised that the implant was impinging on the IDC when you placed it in the patient’s mouth on 9 January 2013. Post-operatively you took a DPT radiograph to check the position of the implants. It was Professor Brook’s evidence that, it was unclear from the DPT radiograph, as to whether the implant at LL7 was impinging on the IDC. He stated that a further intra-oral radiograph should have been taken in the circumstances. He accepted that the taking of such a radiograph can be considered as controversial, but that there is a body of opinion that does advocate the taking of post-operative radiographs provided a reason is given. Professor Brook stated that the justification for a further intra-oral radiograph in Patient A’s case would have been to assess more clearly the relationship between the implants placed and the patient’s IDC.

The Committee accepted the evidence of Professor Brook. It decided that, given that the DPT radiograph you took did not provide a clear picture as to whether the implants were safely placed and not impinging on the IDC, you had a further duty to take a second intra-oral radiograph in order to have provided an adequate standard of care to Patient A. This would have enabled you to recognise that the implant at LL7 was impinging on the IDC. The Committee noted that you conceded in your evidence that you should have taken such a radiograph.

The Committee was satisfied on the balance of probabilities that this head of charge is proved.

1.b. iv.  *Did not remove the implant at LL7;*

**Found proved.**

The Committee found that it was matter of fact that you did not remove the implant at LL7 on the day of treatment on 9 January 2013. The evidence was that the implant was removed by another dentist, two days later on 11 January 2013. However, the Committee considered whether you failed to provide an adequate standard of care to Patient A in waiting until the next day before suggesting that
the implant should be removed in response to the patient’s reported numbness.

In reaching its decision, the Committee accepted the evidence of Professor Brook that had you undertaken an adequate post-operative assessment, including the taking of an intra-oral radiograph, you would have realised that the immediate removal of the implant or at least its repositioning away from the IDC, was required. In light of this evidence the Committee decided that it was a reasonable to infer that the implant should have been removed on 9 January 2013. By not removing it then, you failed to provide an adequate standard of care to the patient.

The Committee was satisfied on the balance of probabilities that this head of charge is proved.

1.c. You did not obtain informed consent for the implant treatment you provided on 9 January 2013 in that you did not adequately explain to Patient A:

1. c. i. The alternative treatment option of a lower partial denture;

Found proved.

Key to the issue of informed consent is the provision of all information in terms of what the treatment involves, including the benefits and risks and whether there are reasonable alternative treatments.

The Committee had regard to the consent form dated 9 January 2013 and specifically considered whether (a) it contained all relevant information and (b) the information contained therein was adequately explained to Patient A.

It was the opinion of Professor Brook that, if the Committee found that you did not discuss with Patient A the option of a partial denture, especially in the light of the patient’s significant bone loss and the risk of Inferior Alveolar Nerve (IAN) damage, your care fell far below standard.

In her witness statement, Patient A stated that “No other options were discussed really”. She stated that she had gone to the Practice because she wanted to know if she was suitable for implants; that is what she was interested in. With specific reference to dentures, she stated that these were not discussed as an option, but that she had already been given the option previously and had dentures years ago which broke.

You admitted in your evidence that dentures were not discussed in any detail with the patient and noted that she had worn dentures before. In your written response to the charges you stated that “Since Patient A found Perfect Profiles when she was searching for an implant specialist clinic and she also consulted with her own dentist previously, as a well prepared patient arrived to Perfect Profiles. I am of the view that Patient A was completely aware of the alternative possibilities from her own dentist.”

The Committee considered whether you should have adequately explained to Patient A the alternative treatment option of a lower partial denture. In doing so, it had regard to the required standard at the time, as set out in the GDC’s publication ‘Principles of Patient Consent (May 2005)’. Paragraph 1.4 of the publication states “Find out what your patients want to know, as well as telling them what you think they need to know. Examples of information which patients may want to know include: why you think a proposed treatment is necessary; the
The Committee was satisfied on the basis of Paragraph 1.4 that you did have a duty to discuss alternative treatment options, including a lower partial denture with Patient A. It noted that on the consent form the patient signed in respect of her treatment, it is stated that alternatives were explained. However, having considered all the evidence, the Committee found that this was not the case and that you did not explore alternative options with the patient. It therefore determined that you failed in your duty and consequently did not obtain the patient’s informed consent for treatment.

The Committee was satisfied on the balance of probabilities that this head of charge is proved.

1. c. ii. The high risk of Inferior Alveolar Nerve (IAN) damage when placing implants at LR6, LL6 and/or LL7;

Found proved.

The Committee accepted the evidence of Professor Brook that there was a high risk of IAN damage. In fact, he stated that it was a specific risk for Patient A and that he would have expected her to have been informed. Professor Brook also noted that the consent form provided to the patient was very general and did not relate to the specifics of her case.

You told the Committee that you had explained the high risk to Patient A, although you stated that you did not specifically say that she was at high risk of permanent numbness from the implants. You said that you told her that the risk was “higher than average”. You also accepted the generality of the consent form given to the patient.

Patient A stated in her oral evidence that she was not told about the high risk of IAN damage, including permanent numbness. She stated that had she been made aware of this, she would not have gone ahead with the implant treatment. The Committee found that Patient A’s oral evidence was very clear on this matter and the Committee accepted it. It decided, on the balance of probabilities, that you did not adequately explain the high risk of IAN damage in her case, given her lack of appreciation of the seriousness of the issue. Accordingly, you did not obtain the patient’s informed consent for treatment.

The Committee was satisfied on the balance of probabilities that this head of charge is proved.

1. c. iii. The use of Xenografts.

Found proved.

It was Professor Brook’s opinion that you would have known at the material time that you could use Xenografts derived from pig collagen or cow bone for Patient A’s sinus lift. He stated that for some patients, the implantation of animal products is considered unacceptable and that patients have a right to know and consent to material that is implanted into them.
Patient A stated in her oral evidence that she could not recall whether you explained to her the origin of the material that you would be using for her sinus lift. She told the Committee that perhaps she had not been concerned about the issue.

However, the Committee took into account that there is no reference to any discussion about the Xenografts in your clinical notes or on the consent form provided to Patient A. The clinical notes simply refer to a sinus lift. You accepted that this was this case. The Committee also heard from you that it was usually the responsibility of the Practice Co-ordinator to demonstrate the bone graft procedure to patients. Whilst you told the Committee that you did mention to Patient A that the Xenografts to be used were made from animal products, the Committee considered that you were again referring to what your normal practice would have been rather than what you actually did. In reaching its conclusion, the Committee had regard to the absence of any information to indicate what you told Patient A. Given Professor Brook’s opinion of the importance of such a conversation, the Committee would have expected some record of Patient A’s consent to the use of the material.

Taking all the evidence into account, the Committee determined on the balance of probabilities that you did not provide an adequate explanation to Patient A as to the use of Xenografts. Accordingly, the Committee found that you did not obtain the patient’s informed consent for the use of the Xenografts.

1.d. On 23 January 2013 you:

1. d. i. Did not adequately assess or examine Patient A’s IAN injury;
Admitted and found proved.

1. d. ii. Did not adequately diagnose Patient A’s IAN injury;
Admitted and found proved.

1.d. iii. Did not refer Patient A for, or provide her, specialist care in respect of her IAN injury;
Admitted and found proved.

1.e. On 29 October 2013 you:

1. e. i. Removed the implant at LL6 without sufficient clinical justification;
Found proved.

The entry in the patient’s clinical notes dated 29 October 2013 record that the implant at LL6 was “2mm proximity to ID nerve”.

Professor Brook’s evidence was that the removal of the implant at LL6 was not supported by the radiographic information that was available. He stated that the LL6 was close but not impinging on the IDC; its removal was not indicated. In his report he stated that “… 10 months had passed from placement of the implant and it could thus be expected to have integrated and that removal put the IAN at further risk of damage”. He said that “removal of the LL6 exposed Patient A to unnecessary surgery, risked further damage to the IAN and deprived Patient A of a functional implant such that in the longer term a lower partial denture was
required”. He said that “removal of LL6 implant was care falling far below standard”.

You stated in oral evidence that you decided to remove the implant of LL6 to avoid all potential risk factors that could cause numbness. When cross examined you agreed that when assessing the radiograph the LL6 was 2mm away from the IDC and that any risk of damage to the IDC would be “tiny”. Notwithstanding this you said that you removed the LL6 as you were acting in the best interests of the patient, on the basis that “even a minimal risk could be eliminated and reduced to zero”. When you were asked whether you would have removed LL6, if faced with the same circumstances again, your answer was “no”.

In finding this head of charge proved, the Committee accepted the evidence of Professor Brook and also took into account your evidence and on the balance of probabilities decided that you did remove the implant at LL6 without sufficient clinical justification.

1. e. ii. Did not adequately assess or examine Patient A's IAN injury;  
Admitted and found proved.

1.e. iii. Did not adequately diagnose Patient A's IAN injury;  
Admitted and found proved.

1.e. iv. Did not refer Patient A for, or provide her, specialist care in respect of her IAN injury.  
Admitted and found proved.

2. You failed to maintain an adequate standard of record keeping in respect of Patient A's appointment from 12 December 2012 to 12 November 2013 in that:

2.a. Prior to the implant treatment which you provided on 9 January 2013 you did not adequately record:

2. a. i. The history of Patient A's presenting condition;  
Admitted and found proved.

2. a. ii. Patient A's needs and aspirations;  
Admitted and found proved.

2.a. iii. Patient A's previous dental history;  
Admitted and found proved.

2.a. iv. Patient A's periodontal health;  
Admitted and found proved.

2. a. v. The evaluation of the hard and soft tissues of the face and jaws;  
Admitted and found proved.

2.a. vi. The evaluation of the dentition;  
Admitted and found proved.

2.a.vii. The bone height and position of the Inferior Dental Canal (IDC) for the proposed
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<td><strong>implant at LR6, LL6 and/or LL7;</strong></td>
<td><strong>Admitted and found proved.</strong></td>
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<td><strong>2.a.viii.</strong></td>
<td><strong>An evaluation of the height and position of the Inferior Dental Canal (IDC) for the proposed implant at LR6, LL6 and/or LL7;</strong></td>
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<td><strong>Admitted and found proved.</strong></td>
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<td><strong>2.b.</strong></td>
<td><strong>In respect of the implant treatment provided on 9 January 2013 you did not adequately record:</strong></td>
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<td><strong>2. b. i.</strong></td>
<td><strong>Your post-surgical assessment of the implant at LL7;</strong></td>
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<td><strong>Admitted and found proved.</strong></td>
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<td><strong>2. b. ii.</strong></td>
<td><strong>That the implant at LL7 was impinging upon the Inferior Dental Canal (IDC);</strong></td>
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<td><strong>Found proved.</strong></td>
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<td>The Committee has already found that the implant at LL7 was impinging on Patient A’s IDC. This information is not recorded in your clinical notes for the patient on 9 January 2013. Given that the Committee also found that you did not recognise that the implant was impinging the IDC until the next day, it would not have expected there to have been a record for 9 January 2013. However, in the Committee’s view, you should have recognised the fact and you should have recorded it. Instead, you recorded that all the implants were in a good position, which was incorrect. The Committee finds this head of charge proved.</td>
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<td><strong>2.c.</strong></td>
<td><strong>You did not adequately record discussions of the following matters necessary for Patient A to provide informed consent for the implant treatment you provided on 9 January 2013:</strong></td>
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<td><strong>2. c. i.</strong></td>
<td><strong>The alternative treatment option of a lower partial denture;</strong></td>
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<td><strong>Admitted and found proved.</strong></td>
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<td><strong>2. c. ii.</strong></td>
<td><strong>The high risk of Inferior Alveolar Nerve (IAN) damage when placing implants at LR6, LL6 and/or LL7;</strong></td>
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<td><strong>Admitted and found proved.</strong></td>
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<td><strong>2. c. iii.</strong></td>
<td><strong>The use of Xenografts;</strong></td>
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<td><strong>Admitted and found proved.</strong></td>
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<td><strong>2.d.</strong></td>
<td><strong>In respect of the treatment provided on 23 January 2013 you did not adequately record:</strong></td>
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<td><strong>2. d. i.</strong></td>
<td><strong>Assessment of Patient A’s IAN injury;</strong></td>
</tr>
<tr>
<td><strong>In light of your admission to head of charge 1d(i) above, the Committee was not required to consider this alternative head of charge.</strong></td>
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<tr>
<td><strong>2. d. ii.</strong></td>
<td><strong>Diagnosis of Patient A’s IAN injury;</strong></td>
</tr>
<tr>
<td><strong>In light of your admission to head of charge 1d(ii) above, the Committee was not required to consider this alternative head of charge.</strong></td>
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2.e. In respect of the treatment provided on 29 October 2013 you did not adequately record:

2. e. i. **Assessment of Patient A’s IAN injury;**

In light of your admission to head of charge 1e(ii) above, the Committee was not required to consider this alternative head of charge.

2. e. ii. **Diagnosis of Patient A’s IAN injury.**

In light of your admission to head of charge 1e(iii) above, the Committee was not required to consider this alternative head of charge.

As confirmed by Mr Coke-Smyth in his closing submissions, in light of your admissions to heads of charge 1d(i), 1d(ii), 1e(ii) and 1e (iii) above, the alternative record keeping allegations at heads of charge 2d(i), 2d(ii), 2e(i) and 2e(ii), fall away.

3. **Following a complaint from Patient A in respect of the treatment you provided to her you failed to respond to her adequately or at all.**

**Found not proved.**

In reaching its decision, the Committee accepted the GDC’s submission at the outset of the hearing, that this particular head of charge relates to the email sent by Patient A to the Practice, dated 18 August 2014. This is what was referred to by the GDC as the patient’s complaint and you accepted in evidence that it was indeed the written complaint, to which you responded via the Practice on 28 August 2014.

In considering your duty in respect of the complaint, the Committee had regard to Paragraph 5.3.7 of the GDC’s ‘Standards for the Dental Team (September 2013). This paragraph states: “You should try to deal with all the points raised in the complaint and, where possible, offer a solution for each one.”

The Committee was satisfied that you had an obligation to respond to Patient A’s written complaint, although it did not interpret this to mean that there was a duty for you to respond to her directly. The Committee was not critical that your response was by way of an email, dated 28 August 2014, to the Practice, in which you indicated what action should be taken. The Committee took into account that you had left the Practice by this time.

In assessing whether your response was adequate in the circumstances, the Committee considered the detail of Patient A’s complaint and whether you had dealt with the points she raised and offered solutions. The Committee concluded that you had done so. In its view, the substance of Patient A’s written complaint of 18 August 2014 was a request for a refund. In your response to the Practice on 28 August 2014, you agree to the patient’s request for a refund. Whilst the Committee found that your response was not what might be considered ‘the gold standard’ you responded to what the patient was asking for at that time and provided a solution. The Committee therefore found, on the balance of probabilities that you did adequately respond to the patient’s complaint.

4. **Between 2 June 2016 and 16 January 2017 you failed to adequately cooperate with the GDC’s investigation into your fitness to practice in that following a formal
request you did not provide:

4. a. **details of your current employers;**
   *Found proved.*

4. b. **details of any relationships you had with the NHS as a performer or contractor;**
   *Found proved.*

4. c. **details of your indemnity provider and cover arrangements.**
   *Found proved.*

The Committee considered heads of charge 4a, 4b and 4c separately, but made the same finding in respect of each allegation.

In reaching its decision, the Committee took into account the evidence provided by the GDC, which included copies of the letters dated 2 June 2016, 11 July 2016 and 2 August 2016 with their delivery receipts. These are the letters that were sent to you requesting the information set out at 4a to c above. The Committee received no evidence to indicate that there was any response or cooperation from you in respect of these letters. In evidence, you confirmed that the letters were sent to your registered address, as held by the GDC at the time.

You told the Committee that over the period in question, there had been difficulties in receiving post to your then registered address and as a result the letters were never received by you. The Committee was not convinced by this explanation and you provided no evidence to substantiate this claim. In particular, the Committee was of the view that it was unlikely that you would not have received at least one of the letters sent to you, over a three-month period, for which there was proof of delivery.

In all the circumstances, the Committee found heads of charge 4a to c proved on the balance of probabilities.

We move to Stage Two.”

On 16 April 2018 the Professional Conduct Committee hearing was adjourned part-heard following announcement of the findings of fact. The hearings resumed on 3 September 2018.

On 6 September 2018 the Chairman announced the determination as follows:

“Having announced its finding on all the facts, the Committee heard submissions on the matters of misconduct, impairment and sanction.

You gave evidence under oath, with the assistance of an interpreter. You told the Committee that the bundle of documents that you have provided for this stage of the proceedings is documents relating to, and representing, your current practice of planning and treatment. You took the Committee through each of the documents and explained what they were. You explained that you have treated several hundred patients and the radiographs in the bundle are just a selection that you chose to present for this hearing to demonstrate your current practice. You told the Committee that you have attended training courses internationally, in Israel, Korea, Italy and Germany.
You said that you have reflected upon these proceedings and have found it a helpful learning experience in order to improve your treatment planning. You explained that you found it difficult to reflect on the Committee’s findings of fact determination as it is about you, but you accept that the Committee was looking at past mistakes and examines how a practitioner has improved on those past shortcomings. You said that it was difficult for you to consider what a member of the public would think about the findings made against you as you are involved in the case, but you will have to consider that. Regarding the matters that you admitted and those the Committee found proved you said that with further reflection and study these areas could be improved.

Mr Coke-Smyth referred the Committee to the case of Roylance v GMC (no. 2) [2000] 1 AC 311 which defines misconduct as ‘a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.’ Mr Coke-Smyth submitted that the Committee must consider whether the facts found proved by the Committee would be considered to be serious and fall far below the standards expected. He outlined the relevant GDC standards and invited the Committee to consider these when determining whether the facts found proved amount to misconduct.

Mr Coke-Smyth then moved on to the issue of current impairment and addressed the Committee on the factors that it must consider in respect of your conduct, including whether it was easily remediable, has been remedied, and is unlikely to be repeated. He invited the Committee to consider your level of insight. He also addressed the Committee on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the GDC as a regulatory body. Mr Coke-Smyth referred the Committee to the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin). He submitted that even if the Committee were to find that you have remediated your misconduct the harm caused to Patient A would require a finding of current impairment on public interest grounds.

Mr Coke-Smyth submitted that there is little evidence of your insight and any remediation that you may have done. Further, there is evidence of actual harm caused to Patient A. He submitted that it would be difficult to conclude that there was no risk of repetition. Mr Coke-Smyth submitted that you are currently impaired by reason of your misconduct.

Mr Coke-Smyth addressed the Committee on the matter of sanction and outlined the aggravating and mitigating factors. He submitted that the minimum sanction appropriate to satisfy the public interest and to protect the public is that of 12 months suspension with a review. He referred the Committee to the specific matters for consideration in respect of all sanctions available, as set out in the ‘Guidance for the Practice Committees, including Indicative Sanctions Guidance’ as published by the GDC, effective from 1 October 2016 (the ISG).

You chose to make your submissions, through the interpreter, rather than have Mr Marwa make them for you. You told the Committee that you accept that in the case of Patient A the LL7 implant was too close to the nerve. However, your planning included an angle to avoid impingement on the nerve. You said that you also accept that you should have referred Patient A to the specialist sooner, and that in 2012 and 2013 your record keeping wasn’t the best. You stated that you have learned an ‘awful lot’ from this case and throughout these proceedings.
You outlined your career background, including that you started out working in another country in a family practice. You subsequently came to the United Kingdom (UK) where you worked in a larger surgery. Under these circumstances you learned how important accurate and detailed record keeping is. You said you have not worked in the UK since February 2014; therefore, you could not submit any evidence regarding your changed note-taking technique.

You explained that although you defended your position at the start of this hearing you now accept that the 2mm safety margin is right. However, you have always said that a safety margin was needed. You stated that the bundle of radiographs handed up for this stage are of your patients, and you take exception to being questioned about where they came from.

You maintained that you had undertaken a risk assessment of Patient A and that she was aware of the risks of the surgery. You said that you had given her a consent form to read and that all of the risks were contained on that.

You told the Committee that your sub-optimal planning had triggered an unfortunate chain of events for Patient A. You maintained that the nerve damage was caused by somebody else, but you accepted responsibility for what you had done. You said that you are ‘only human’ and that you erred, but you have learned from this. You explained that your view is that these proceedings will only help public perception of the profession, given that you have learned from your mistakes. You accept that you will be sanctioned but ask that the Committee take into account that you have already been subject to interim suspension. You said that you have changed your practise and will never have another issue like this again.

The Committee fully considered all the evidence in this case as well as the submissions made by Mr Coke-Smyth and those made by you. It accepted the advice of the Legal Adviser, which included the factors relevant to the considerations of the Committee.

**Decision on whether the facts found proved amount to misconduct:**

When determining whether the facts found proved amount to misconduct the Committee had regard to the terms of the relevant professional standards in force at the time of the incidents.

The Committee, in reaching its decision, had regard to the public interest and accepted that there was no burden or standard of proof at this stage. The Committee used its professional judgement when reaching its decision.

The Committee has concluded that your conduct was in breach of each of the sections of the relevant standards as set out below

**Standards for Dental Professionals (2005)**

**Standard 1**

**Put patients’ interests first and act to protect them**

1.3 Work within your knowledge, professional competence and physical abilities. Refer patients for a second opinion and for further advice when it is necessary, or if the patient asks. Refer patients for further treatment when it is necessary to do so.

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.
Standard 2

Respect patients’ dignity and choices

2.2 Recognise and promote patients’ responsibility for making decisions about their bodies, their priorities and their care, making sure you do not take any steps without patients’ consent (permission). Follow our guidance ‘Principles of patient consent’.

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.

Standard 5

Maintain your professional knowledge and competence

5.3 Find out about current best practice in the fields in which you work. Provide a good standard of care based on available up-to-date evidence and reliable guidance.

Standards for the Dental Team (2013).

Standard 7.1

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

Standard 9.4

You must co-operate with any relevant formal or informal inquiry and give full and truthful information

Standard 9.4.1

If you receive a letter from the GDC in connection with concerns about your fitness to practise, you must respond fully within the time specified in the letter. You should also seek advice from your indemnity provider or professional association.

The Committee appreciated that the above breaches do not automatically result in a finding of misconduct. However, the Committee was of the view that the breaches in this case are serious, occurred over a protracted period of time and involved multiple areas of dentistry.

Whilst the Committee noted the submission that the record keeping failures, in isolation, may have been less serious, it was of the view that your record keeping was far below the standards expected. The Committee was of the view that the failings in this case were serious and occurred over a protracted period of time. Your conduct led to a real risk of significant harm, and there was actual avoidable permanent harm caused to Patient A.

The Committee concluded that your conduct as found proved, both individually and collectively, fell significantly below the standards expected of a registered dental professional and amounted to misconduct.

Decision on impairment:

The Committee proceeded to decide if, as a result of your misconduct, your fitness to practise is currently impaired.
The Committee has borne in mind that its primary function is not only to protect patients but also to take account of the wider public interest, which includes maintaining confidence in the dental profession and the GDC as a regulator and upholding proper standards and behaviour.

Dental professionals occupy a position of privilege and trust in society and must make sure that their conduct at all times justifies both their patients’ and the public’s trust in the profession. In this regard the Committee considered the judgment in the case of Grant in which it was made clear that the Committee’s considerations should include whether public confidence would be undermined if a finding of current impairment was not made in the particular circumstances of the case.

The Committee did consider that you had put a patient at risk of harm, and there was actual harm caused to Patient A. Your misconduct did bring the profession into disrepute and breached fundamental tenets of the profession. The Committee considered that not causing avoidable harm and obtaining proper valid consent are fundamental tenets of the profession.

The Committee considered the matter of your insight. It had the opportunity to hear directly from you at this stage, rather than from your representative. It also had regard to an email referring to the transcript of day three of the hearing (January 2018), that was sent by Mr Marwa after the Committee retired. The Committee considered that the answer you gave in cross-examination, referred to by Mr Marwa, when read, in context of the rest of the questioning, did not constitute evidence of you stating prior to this September that you would abide by the 2mm safe planning distance.

When assessing your insight, the Committee carefully considered your oral evidence and your submissions. The Committee found that you had started to develop some insight but that this was limited at this stage. You made a series of assertions as to how you had changed and improved your practice, but this was unsupported by any documentary evidence. For example, you suggested that you used a software programme to assist with record keeping but provided no documentary evidence to demonstrate how this constituted an improvement in your practice. Similarly, you said you had adopted new and improved consent procedures, but without any written evidence to support this. You told the Committee that you have made changes to your practice with regard to placing implants, including using a template and using software that does not allow you to go beyond the safety zone, however again there was no documentary evidence of this. As such, the Committee considered your evidence to be vague and generalised and insufficient to demonstrate of insight or remediation.

The Committee considered that the failings identified in your case are capable of remediation; however, it was not satisfied that you have remediated them. The training certificates that were provided to the Committee predated these proceedings and a large number of them predated the incidents that led to these proceedings. Further, they did not specifically address the issues found by the Committee.

The Committee had regard to the radiographs you provided, however they lacked any relevant information, such as when they were taken, any clinical reporting or critical review either by yourself or another practitioner, any patient information or what they were purporting to demonstrate. In addition, the Committee could not be assured that they were representative of your current practice. As such the Committee attached little, if any, weight to these radiographs when evaluating your insight and remediation.
The Committee was not provided with any written reflection from you and there were no audits provided which demonstrate your current practice. Whilst the Committee appreciated that you have not been working in the UK since 2014, you have continued to work as a dentist in Hungary and you remain a GDC registrant. You could have provided evidence of your current practice from Hungary, and evidence of your Continuing Professional Development as part of your GDC registration.

Given your lack of remediation and lack of full insight the Committee concluded that there remains a risk of repetition of the failings identified which would put the public at risk of harm.

The misconduct identified in this case was, in the view of the Committee, sufficiently serious that public confidence in the profession would be significantly undermined were the Committee not to make a finding of current impairment.

Accordingly, the Committee has concluded that your fitness to practise is currently impaired by reason of your misconduct.

**Decision on sanction**

The Committee next considered what sanction, if any, to impose on your registration. It recognised that the purpose of a sanction is not to be punitive, although it may have that effect, but rather to protect patients and the wider public interest.

The Committee has taken into account the ISG. The Committee applied the principle of proportionality, balancing the public interest with your own interests. The Committee has considered the range of sanctions available to it, starting with the least serious. The Committee considered the aggravating and mitigating factors as follows:

**Aggravating:**
- Actual harm to Patient A;
- Lack of insight;
- Misconduct sustained or repeated over a period of time;
- Blatant or wilful disregard of the role of the GDC and the systems regulating the profession.

**Mitigating**
- Evidence of previous good character;
- A number of admissions;
- An apology to Patient A at the hearing in January.

In the light of the findings against you, the Committee has determined that it would be wholly inappropriate and irresponsible to conclude this case without taking any action or with a reprimand, as neither would address your lack of insight and the risk of repetition. The Committee did not consider that the findings against you are at the lower end of the spectrum, and it considered that causing avoidable harm to a patient is a very serious matter.

The Committee next considered whether a period of conditional registration would be appropriate in this case. The Committee was mindful that any conditions imposed must be proportionate, measurable and workable. The Committee determined that it would not be possible to formulate appropriate, practical and workable conditions given your lack of
insight and your previous lack of cooperation with the GDC. The Committee was not satisfied that you would be willing to commit fully to or actively engage with any conditions that the Committee may impose. The Committee concluded that it would not be sufficient to conclude this case with conditions as this would not protect the public or to address the public interest.

The Committee then considered whether a suspension order would be proportionate and appropriate. The Committee is in no doubt that your misconduct was wholly unacceptable and, in its view, damaging to the reputation of the profession and to the public’s confidence in the dental profession. The Committee had regard to the ISG in respect of imposing a suspension order.

The Committee noted that your misconduct was sustained over a lengthy period of time and actual harm was caused to Patient A. The Committee had already determined that you lack insight and there remains a risk of repetition.

The Committee then considered whether the issues identified are fundamentally incompatible with you remaining on the Register.

The Committee had regard to the fact that the matters in this case are such that they could be remediated. The Committee considered that a period of suspension, with a review, would give you the opportunity to reflect upon and demonstrate insight into your misconduct and to work on your remediation. The Committee did not consider that you have demonstrated deep-seated attitudinal issues, and a period of suspension would give you the opportunity to demonstrate to a reviewing Committee that you have remediated all the deficiencies identified. The Committee was satisfied that the misconduct was not fundamentally incompatible with you remaining on the Register.

Although it gave it serious consideration, the Committee concluded that, in all the circumstances, erasure would be disproportionate. It considered that a period of suspension would address the public interest concerns in this case and would give you the opportunity to reflect on your misconduct and provide evidence of this to the reviewing Committee.

Taking into account all of the above, the Committee has determined that the appropriate and proportionate sanction in this case is that of suspension for a period of 12 months, with a review prior to the expiry of the order.

The Committee considered that this was proportionate to address the gravity of the matters identified in this case and to mark the importance of maintaining the standards expected of a registered dentist. It would also send a message to the profession that this type of conduct is not acceptable. The Committee considered that this will give you sufficient time to properly reflect on the failings identified and undertake a proper review of your past practice and demonstrate what, if any, changes you have made to ensure that you are a safe practitioner.

Before the end of the period of suspension the order will be reviewed. At the review hearing the Committee may revoke the order, or it may confirm the order allowing it to lapse on expiry, or it may replace the order with another order. Any future Committee reviewing this order is likely to be assisted by evidence of further training that focuses on the breaches of standards highlighted in this decision, a written personal reflective piece from you on what you have learned from this process and demonstrating your insight, the impact of your misconduct on Patient A, the public and the profession and documentary evidence of any other remediation that you may have undertaken.
As a result of the Committee’s decision in this case, the interim order currently imposed on your registration is revoked.”

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**Decision on immediate order**

“The Committee considered whether to make an order for the immediate suspension on your registration. In so doing, it has had regard to the submissions made by Mr Coke-Smyth, who invited the Committee to make such an order, and those made by Mr Marwa, who said that you agreed that an immediate order was necessary. The Committee has accepted the advice of the Legal Adviser.

In accordance with Section 30(1) of the Dentists Act 1984 (as amended) the Committee has determined that it is necessary to direct that your registration be suspended forthwith. The Committee has concluded that immediate action is necessary to protect the public and to otherwise maintain public confidence in the profession. It made this decision having regard to its reasons set out in its previous determinations, including its determination that there remains a risk of repetition. The Committee is satisfied that it would be contrary to the public interest, and inconsistent with its findings, to not impose an immediate order to cover the appeal period, or, if an appeal is lodged, until it has been disposed of.

The effect of the foregoing direction and this order is that your registration will be suspended from today. Unless you exercise your right of appeal, the substantive direction of suspension will take effect 28 days from today. Should you exercise your right of appeal, this immediate order for suspension will remain in place until the resolution of any appeal proceedings.

That concludes the case for today.”