HEARING HEARD IN PUBLIC

McNALLY, Damian

Registration No: 72174

PROFESSIONAL CONDUCT COMMITTEE

SEPTEMBER 2018 – SEPTEMBER 2019

Outcome: Suspension extended for 12 months (with a review)**

**** See page 17 for the latest determination**

Damian McNALLY, a dentist, BDS Dund 1996, was summoned to appear before the Professional Conduct Committee on 17 September 2018 for an inquiry into the following charge:

Charge

"That you, a registered dentist:

1. Failed to provide an adequate standard of care to Patient A from 15 March 2016 to 11 April 2017 in that during a course of implant treatment you:
    a. On 15 March 2016 or thereafter, failed to adequately plan Patient A 's treatment in that you:
        i. did not undertake or record an assessment of the occlusion and/or temporomandibular joint;
        ii. did not use or record study models and/or a surgical guide
    b. on 15 March 2016, failed to complete an adequate written treatment plan, in that you did not record:
        i. the treatment options discussed
        ii. the risks and benefits of the proposed treatment.
    c. on 25 October 2016, you did not consider or record, in respect of UL3, how the implant angle would compromise the final reconstruction;
    d. on 25 October 2016, inappropriately placed four implants too far buccally;
    e. on 15 March 2016, did not record a report in relation to a OPT radiograph and/or four periapical radiographs taken of the upper teeth.
2. Failed to provide an adequate standard of care to Patient B from 6 March 2015 to 28 October 2016, in that during a course of implant treatment you:
    a. prior to implant treatment at UR4, failed to adequately undertake a pre-treatment assessment of:
        i. the UR3 which had an apical radiolucency; and/or
        ii. the UR5 which had an apical radiolucency and/or caries

b. failed to undertake adequate treatment planning in that you did not include in your treatment plan:

i. adequate management of the UR3 and UR5

c. failed to obtain or record informed consent, in that you:

i. did not discuss or record the risks and benefits of the proposed treatment;

ii. did not discuss or record the available treatment options with Patient B;

iii. did not record a consent form.

d. failed to maintain an appropriate standard of record-keeping in that you did not record a report on the radiographs taken on 2 April 2015 and/or 27 April 2016 and/or 12 October 2016.

e. failed to adequately manage Patient B's post-treatment care in that you:

i. did not carry out remedial work when an implant and adjacent tooth had to be removed due to loss of bone density and infection; and/or

ii. did not arrange for another practitioner to continue Patient B's care.

3. From 7 June 2017 to 8 January 2018, you failed to co-operate with an investigation conducted by the GDC, including by not providing the GDC with any evidence of indemnity.

4. Between 5 April 2017 and 19 July 2018, you failed to maintain a correct and up to date registered address

AND, in light of the matter(s) above, your fitness to practise is impaired by reason of your misconduct."

As Mr McNally did not attend and was not represented at the hearing, the Chairman made the following statement regarding proof of service and a Rule 57 application to admit witness statements. He addressed this to the Counsel for the GDC.

Decision on service of the Notification of Hearing

"The Committee first considered whether notice of the hearing had been served on Mr McNally in accordance with Rules 13 and 65. It received a bundle of documents containing a copy of the Notification of Hearing letter, dated 7 August 2018. Also contained within the bundle was a Royal Mail 'Track and Trace' receipt confirming that the letter was sent to Mr McNally's registered address by Special Delivery. The Committee took into account that there is no requirement within the Rules for the General Dental Council (GDC) to prove receipt of the letter. However, it noted from the 'Track and Trace' information that an attempt had been made to deliver the letter, but nobody was there to sign for it. A further Notification of Hearing letter and bundle was sent on 16 August 2018, which was received and signed for by "D MCNALLY". A copy of the letter was also sent to him by email.

The Committee was satisfied that the Notification of Hearing letter of 7 August 2018 contained proper notification of the hearing, including its start date, time and venue, as well as notification that the Committee could proceed with the hearing in Mr McNally's absence. On the basis of the information provided to it, the Committee was satisfied that notice of the hearing had been served on Mr McNally in accordance with the Rules.

Decision on whether to proceed with the hearing in the absence of Mr McNally

The Committee next considered whether to exercise its discretion under Rule 54 of the Rules to proceed with the hearing in the absence of Mr McNally and/or any representative on his behalf. It approached the issue with the utmost care and caution. The Committee had regard to the factors to be considered in reaching its decision as set out in the case of R v Jones [2003] 1 AC 1HL, and the public interest considerations referred to in Adeogba v GMC [2016] EWCA CIV 162 as well as the obligation on professionals to engage with their regulator. It took into account that fairness to Mr McNally was of primary importance, but also remained mindful of the need to be fair to the GDC. The Committee also took into account the public interest in dealing with Mr McNally's case expeditiously.

The Committee noted that Mr McNally has engaged with the GDC to a very limited extent. It took account of a teleconference that was held on 19 July 2018 between Mr McNally and the GDC. Mr McNally was asked to confirm whether he was going to be present at the hearing to which he responded that he would find it difficult to attend personally as the hearing is in London, but he could attend via Skype. An email was sent to Mr McNally on 30 August 2018 asking him to indicate whether he did wish to attend by Skype; no response was forthcoming. The Committee noted that the last contact from Mr McNally was during the teleconference held on 19 July 2018.

The Committee was satisfied from the information before it, that Mr McNally had been aware of the current hearing since 19 July 2018 and had received the notice of the hearing at the latest by 16 August 2018. Considering all the information before it and all the circumstances, it was satisfied that Mr McNally had voluntarily decided not to attend the hearing. The Committee noted that Mr McNally had not requested an adjournment. In the circumstances, the Committee concluded that it was unlikely that an adjournment of the hearing would secure Mr McNally's attendance on a future occasion.

Accordingly, the Committee determined that it was fair and in the interests of justice for all concerned, as well as in the public interest, for the hearing to proceed in the absence of Mr McNally.

Rule 57 application to admit witness statements

Miss Scarborough made an application under Rule 57 (1) of the Rules to admit in evidence the written statements of four Witnesses. She submitted that hearsay evidence is admissible in civil proceedings. Alternatively, such evidence was admissible under rule 57(2) which gives the Committee a discretion to treat other evidence as admissible if, after consultation with the Legal Adviser, they consider it would be helpful to the Committee and in the interest of justice for that evidence to be heard. Miss Scarborough submitted that it would be fair to admit the hearsay evidence for the following reasons:

- The evidence of these witnesses were largely production statements which detail the factual chronology of events.
- There is nothing that they could reasonably add to their statements and are all signed.
- Mr McNally has been put on notice by the GDC of its intention to rely on the witness statements and has not raised any objection.

- Mr McNally has not raised any issues in relation to what the witnesses have stated in their statements. Under these circumstances, it would be disproportionate to require them to give evidence simply to confirm the content of the written statements.
- Having regard to the origin and content of their evidence the Committee can be confident that it is demonstrably reliable.

The Committee carefully considered the application and accepted the advice of the Legal Adviser who referred the Committee to the case of Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin). He set out a number of factors to be considered when considering the admissibility of hearsay evidence.

The Committee had regard to the origin and content of the proposed hearsay evidence and to the absence of any objection or issues raised by Mr McNally. It was clear to the Committee that the evidence largely comprised documentary evidence in the form of contemporaneous clinical records and correspondence, and there is no reason to doubt its reliability.

Therefore, the Committee decided to accede to Miss Scarborough's application to admit the hearsay statements under Rule 57."

On 19 September 2018 the Chairman announced the findings of facts:

"In reaching its decisions on the facts, the Committee considered all the evidence adduced in this case. The Committee had regard to the submissions made by Miss Scarbrough, on behalf of the GDC. It accepted the advice of the Legal Adviser. In accordance with that advice, it has considered each charge separately.

The concerns giving rise to this case relate to a) the standard of care provided by Mr McNally to two patients in providing them each with a course of implant treatment, b) a failure to cooperate with the GDC, and c) a failure to maintain a correct address with the GDC.

The Committee has been provided with documentary material in relation to the allegations that Mr McNally faces, including witness statements and documentary exhibits of the witnesses in this case. It also heard oral evidence from Mr Simon Nery, an expert witness instructed by the GDC. The Committee found Mr Nery to be a helpful, knowledgeable and credible witness who was able to address the issues in detail for the Committee to understand. The Committee found him to be a fair and balanced witness.

The Committee had no information from Mr McNally in relation to the allegations, but it bore in mind that he was not required to prove or disprove anything. The Committee was conscious that the burden of proof rests on the GDC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that the facts of a charge will only be proved if the Committee finds that it is more likely than not that the facts occurred as alleged.

Before considering the charges the Committee first looked, in the absence of Mr McNally or any admissions by him, at whether he provided the treatment that is the subject of the charges. It was satisfied, based on the patient records and the patient complaints that it was Mr McNally who provided the treatment. Mr McNally has been provided with the charges and the evidence that the GDC relies upon. In his limited engagement with the process he has not stated that it was not him.

The Committee made the following findings in relation to each head of charge:

1.	*Failed to provide an adequate standard of care to Patient A from 15 March 2016 to 11 April 2017 in that during a course of implant treatment you:*
1.a	*On 15 March 2016 or thereafter, failed to adequately plan Patient A 's treatment in that you:*
1.a(i) 1.a(ii)	*did not undertake or record an assessment of the occlusion and/or temporomandibular joint;* *did not use or record study models and/or a surgical guide* **Found Proved in its entirety** The Committee had sight of the records for Patient A. There was no record of the assessment of the occlusion or the temporomandibular joint (TMJ). The Committee inferred from this that an assessment did not take place given the record does show an examination taking place. The Committee also noted the dental records made by Patient A's subsequent treating dentist. He notes that Patient A's 'occlusion is poorly managed'. There was no record of Mr McNally having used study models or a surgical guide. The Committee inferred from this that Mr McNally did not use these. There was no suggestion that Mr McNally's record keeping was generally inadequate and the Committee considered that if he had used these he would have recorded it. The Committee concluded that it was more likely than not that Mr McNally did not undertake an assessment of the occlusion and the TMJ or use study models or a surgical guide. Mr Nery informed the Committee that, had the treatment been planned properly, the treatment would have been less likely to have failed. He stated that his opinion was that given the particular needs of this patient it was necessary for Mr McNally to have undertaken an assessment of the occlusion and the TMJ. In his report he stated *If no such planning, or inadequate planning was undertaken, then the final result can be severely compromised by poorly placed implants. This can lead to a disappointed patient., as well as increased risk of early failure.* Given that the Committee found that Mr McNally did not undertake these assessments or use the study model and surgical guide it finds that it was more likely than not that Mr McNally failed to adequately plan Patient A's treatment. Accordingly, this charge is found proved.
1.b	*On 15 March 2016, failed to complete an adequate written treatment plan, in that you did not record:*
1.b(i) 1.b(ii)	*the treatment options discussed* *the risks and benefits of the proposed treatment.* **Found Proved in its entirety** The Committee had regard to Patient A's records, including the written

	treatment plan. There was no record made that Mr McNally had discussed the treatment options with Patient A. The Committee also noted that there was no record of the risks and benefits of the proposed treatment. In his report Mr Nery stated: *On 15/03/16 Patient A signed a document "treatment plan and investment". This was in fact a breakdown of the cost of the proposed treatment, but had no detail of options discussed, or risks and benefits of the proposed treatment…* The Committee accepted the evidence of Mr Nery and considered that a written treatment plan should contain the treatment options and the risks and benefits of the proposed treatment. By not recording this, the Committee concluded that it was more likely than not that Mr McNally failed to complete an adequate written treatment plan. Accordingly, this charge is found proved.
1.c	*on 25 October 2016, you did not consider or record, in respect of UL3, how the implant angle would compromise the final reconstruction;* **Found Proved** The Committee had regard to Patient A's records. There is no record on this date, in respect of UL3, how the implant angle would compromise the final reconstruction. In his report Mr Nery stated: *There are records of the implant torques, lengths and diameters. There is no indication of how the angles of the implants might connect to the final reconstruction in the upper arch. This is vital as the implant positions and angulations must take account of the intended final screw hole positions to ensure an aesthetic pleasing and functional reconstruction. Failure to do this can result in a reconstruction which is unacceptable or not fit for purpose because of aesthetic or functional failings.* The Committee noted that there was no record after the implants were placed regarding the angle of the implants, nor did Mr McNally address this on subsequent visits when Patient A raised concerns about the implant. The Committee inferred from all the information that Mr McNally did not consider, in respect of UL3, of how the implant angle would compromise the final reconstruction. The Committee also concluded that by failing to consider this Mr McNally did not provide an adequate standard of care to Patient A. Accordingly, this charge is found proved.
1.d	*on 25 October 2016, inappropriately placed four implants too far buccally;* **Found Proved** The Committee had regard to the evidence of Mr Nery, who stated in his report *Comment on implant positioning: All four implants have been placed too far buccally. This resulted in buccal bone being very thin or even absent, which leads to increased risk of gingival recession, bone loss,*

	periimplantitis and implant failure. Placement of the implants too far buccally in what appeared to be adequate bone fell far below the standard one would expect as it increased the risk of failure and left the patient needing to have the four failing implants removed and replaced within a short time. The Committee also had sight of CT scans and the radiographs which confirm the evidence given by Mr Nery. The Committee accepted the evidence of Mr Nery and concluded that it was more likely than not that on 25 October 2016 Mr McNally inappropriately placed four implants too far buccally. Further, that by doing so Mr McNally failed to provide an adequate standard of care to Patient A. Accordingly, this charge is found proved.
1.e	*on 15 March 2016, did not record a report in relation to a OPT radiograph and/or four periapical radiographs taken of the upper teeth.* **Found Proved** The Committee had sight of the dental records for Patient A. There was no record of the radiographs having been reported on. The Committee considered the report of Mr Nery, who stated that *Should there be a tendency to not report, or if an important finding was not reported this could fall far below as it could have potential for harm in the care of the patient.* The Committee accepted the evidence of Mr Nery and concluded that by not recording a report in relation to the radiographs Mr McNally failed to provide an adequate standard of care to Patient A. Accordingly, this charge is found proved.
2.	Failed to provide an adequate standard of care to Patient B from 6 March 2015 to 28 October 2016, in that during a course of implant treatment you:
2.a	*prior to implant treatment at UR4, failed to adequately undertake a pre-treatment assessment of:*
2.a(i)	*the UR3 which had an apical radiolucency; and/or* *the UR5 which had an apical radiolucency and/or caries* **Found Proved in its entirety** The Committee had regard to the evidence of Mr Nery. In his report he stated: *UR3 had an apical radiolucency on the radiographs of 2/4/15 and 27/4/16. Failure to diagnose or treat this meant that infection was being left within the surgical area of UR4, risking implant failure.* *Caries at UR5 should have been treated after referral to Mr. McNally by [another dentist]. Examination of the referral bitewing radiograph of 6/3/15, and his own peri-apical radiograph of 2/4/15 should have* *made it obvious that caries was present at UR5, which was likely to have*

	been restorable. *UR5 also had root resorption and an apical radiolucency on the peri-apical radiograph of 2/4/15. The failure to diagnose and treat this fell far below the standard one would expect of a GDP.* *The failure to diagnose and treat caries and the apical radiolucency and root resorption at UR5 throughout 2015 and early 2016 led to progression and worsening prognosis.* *The prognosis for UR5 was very poor, maybe hopeless by the time of the radiograph of 27/4/16 as it had developed an apical radiolucency and the extent of caries had likely made the tooth unrestorable.* The Committee had regard to the patient records which showed that another treating dentist had identified caries on UR5, however Mr McNally did not address this as part of the treatment of Patient B. The Committee also had sight of radiographs taken prior to the implant being placed. These radiographs show the apical radiolucency at UR3 and an apical radiolucency and/or caries at UR5. The Committee considered all the information presented to it and concluded that it was more likely than not that Mr McNally, prior to implant treatment at UR4, failed to adequately undertake a pre-treatment assessment of UR3 and UR5. Further, the Committee concluded that Mr McNally failed to provide an adequate standard of care to Patient B from 6 March 2015 to 28 October 2016. Accordingly, this charge is found proved in its entirety.
2.b	*failed to undertake adequate treatment planning in that you did not include in your treatment plan:*
2.b(i)	adequate management of the UR3 and UR5 **Found Proved** In his report Mr Nery wrote *UR5 had a peri-apical radiolucency and gross caries below the bridge retainer. The previously root treated UR3 also had a peri-apical radiolucency. Both these teeth were immediately adjacent to the proposed implant area, and neither were managed. An implant at UR4 was absolutely contra-indicated without addressing UR3 and UR5 first. For a treatment plan to not include these was inadequate and fell far below.* The Committee also had sight of the records for Patient B. There was no record made by Mr McNally regarding the management of UR3 and the only record relating to UR5 was 'Happy to monitor'. The Committee concluded that that Mr McNally failed to undertake adequate treatment planning in that he did not include in his treatment plan adequate management of the UR3 and UR5. Given this, the Committee also concluded that Mr McNally failed to provide an adequate standard of care to Patient B from 6 March 2015 to 28 October 2016. Accordingly, this charge is found proved.

2.c	*failed to obtain or record informed consent, in that you:*
2.c(i) 2.c(ii) 2.c(iii)	*did not discuss or record the risks and benefits of the proposed treatment;* *did not discuss or record the available treatment options with Patient B;* *did not record a consent form.* **Found Proved in its entirety** In his oral evidence Mr Nery stated that Patient B could not have given informed consent given that the treatment was contraindicated. In his report Mr Nery wrote *The record of 21/07/16 ends "TCA implant surgery". There is no record of discussion about how UR4 might be replaced, or options such as to leave the space, place a bridge or a denture. There is no consent form with advice, risks and benefits, and the risks posed by the adjacent UR3 and UR5. I cannot say what was said verbally, but there is no record of any discussion of the treatment plan risks and benefits – in particular that implant treatment prior to resolving UR5 and UR3 was contraindicated and therefore consent could not be valid as the patient was not informed.* The Committee noted that Mr McNally did not record having discussed the risks and benefits of the proposed treatment or any available treatment options. Given that this was not recorded, the Committee inferred that the discussion did not take place. Further there is no consent form contained within the records. The Committee concluded that it was more likely than not that Mr McNally did not discuss with Patient B the risks and benefits of the proposed treatment or the available treatment options and no consent form was completed. Given the above the Committee concluded that Mr McNally failed to obtain informed consent from Patient B and thus failed to provide an adequate standard of care to Patient B from 6 March 2015 to 28 October 2016. Accordingly, this charge is found proved in its entirety.
2.d	*failed to maintain an appropriate standard of record-keeping in that you did not record a report on the radiographs taken on 2 April 2015 and/or 27 April 2016 and/or 12 October 2016.* **Found Not proved in respect of 2 April 2015** **Found Proved in respect of 27 April and 12 October 2016.** The Committee had regard to the records of Patient A. It was noted in the records that a radiograph was taken on 2 April 2015 and that it was recorded that it was grade 1 and he was happy to monitor. Although the Committee considered this to be an inadequate record there was a record made on this date. There was no record of a report made in respect of the radiographs taken on 27 April 2016 or on the 12 October 2016. The Committee concluded that it was more likely than not that that Mr McNally failed to maintain an adequate standard of record keeping in respect of the two dates, and thus failed to provide Patient B with an adequate standard of care from 6 March

	2015 to 28 October 2016. Accordingly, the Committee finds this charge proved in respect of 27 April and 12 October 2016.
2.e	*failed to adequately manage Patient B's post-treatment care in that you:*
2.e(i) 2.e(ii)	*did not carry out remedial work when an implant and adjacent tooth had to be removed due to loss of bone density and infection; and/or* *did not arrange for another practitioner to continue Patient B's care.* **Found Proved in its entirety** The Committee had regard to the witness statement from a member of staff at the Dental Complaints Service (DCS). She wrote that *The registrant confirmed he would pay for the consultation that patient had with new dentist (£290) and would re-do implant free of charge in his surgery.* *On the same day, a call was made to the patient's husband to determine whether the patient is happy to accept the offer proposed by the Registrant. The patient accepted.* Later in her statement she confirms that attempts to contact Mr McNally were made several times following this. Whilst Mr McNally did send Patient B a cheque for £200 he did not arrange to provide any remedial treatment or arrange for this to be done by another practitioner. The Committee had evidence from Patient B's subsequent treating dentist who confirmed that it was he who carried out the remedial work for Patient B. The Committee concluded that Mr McNally failed to adequately manage Patient B's post-treatment care in that he did not carry out remedial work or arrange for another practitioner to continue Patient B's care and thus failed to provide an adequate standard of care to Patient B from 6 March 2015 to 28 October 2016. Accordingly, this charge is found proved.
3.	*From 7 June 2017 to 8 January 2018, you failed to co-operate with an investigation conducted by the GDC, including by not providing the GDC with any evidence of indemnity.* **Found Proved** The Committee had sight of the correspondence sent to Mr McNally from the GDC. It noted that the initial letter sent to Mr McNally, dated 24 May 2017, in relation to Patient A's complaint was sent to Mr McNally's registered address, his former place of work, and there was nothing to suggest whether this was forwarded to his home address. The Committee also had sight of an email, dated 16 June 2017, sent to an email address, used by Mr McNally in the course of his subsequent communications with the GDC, attaching the notification of the investigation in relation to Patient B's complaint and making a second request for information. The earliest date that the Committee could be satisfied that Mr McNally knew about any investigation was therefore 16 June when the second

	letter was sent to his email address. The date for him to respond was set out in this letter as 30 June 2017. The Committee noted that both of the letters above required Mr McNally to provide proof of his indemnity cover. The Committee was aware that several emails were sent to Mr McNally, attaching these letters, between June 2017 and January 2018. The first response from Mr McNally was by return email, dated 9 January 2018. The Committee was therefore satisfied that Mr McNally had a duty to provide the information that was requested but failed to do so. In not doing so Mr McNally failed to co-operate. Accordingly, this charge is found proved.
4.	*Between 5 April 2017 and 19 July 2018, you failed to maintain a correct and up to date registered address* **Found Proved** The Committee had sight of an email, dated 6 June 2017 from Mr McNally's former employer. This stated that, as of 4 April 2017, Mr McNally no longer worked at that practice. In a telephone note of a conversation that took place on 19 July 2018 it was confirmed that the GDC still had Mr McNally's former place of employment as his registered address. It was during this conversation that Mr McNally provided his updated address for correspondence to be sent. The Committee had sight of the Dentist Register Regulations 2014. Regulation 9 states *A registered dentist must notify the Council without delay of any changes to or errors in their registration details, and for these purposes 'registration details' includes any information the dentist was required to provide as part of the dentists application for registration.* Regulation 12(d) makes it clear that this includes '*The address which that person wishes to be entered in the dentists register as their address.'* The Committee concluded that as Mr McNally was under a duty to update his registered address when any changes occurred, and not doing so constituted a failure on his part. Accordingly, this charge is found proved.

We move to Stage Two."

On 19 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.

Miss Scarbrough informed the Committee that Mr McNally received a published warning, for a period of 12 months, from the GDC Investigating Committee on 30 May 2013. She informed the Committee that the warning was for unrelated matters; that Mr McNally had been convicted twice, on two separate occasions, of practising private dentistry in Northern Ireland when not registered.

Miss Scarbrough 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. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances*. She submitted that the falling short must be a serious departure rather than a mere act of negligence.

Miss Scarbrough submitted that this case involves fundamental failings in dentistry over a protracted period of time. The clinical matters relate to two patients and involve a wide range of key areas of practice. She referred to the standards that the GDC say have been breached and to the Principle of Patient Consent, published by the GDC.

Next, Miss Scarbrough moved on to the issue of current impairment and addressed the Committee on the factors that it must consider in respect of Mr McNally's conduct, including whether it was easily remediable, has been remedied, and is unlikely to be repeated. Miss Scarbrough submitted that as there is no information from Mr McNally regarding his current practice and what, if any remediation he has undertaken or insight he has developed, there is a real risk of repetition. She submitted that there is a real risk of harm to the public.

Miss Scarbrough 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. She referred the Committee to the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin).

Miss Scarbrough submitted that Mr McNally is currently impaired by reason of his misconduct.

Miss Scarbrough addressed the Committee on the matter of sanction. She 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). Miss Scarbrough submitted that were Mr McNally to have engaged with the hearing and demonstrated a level of insight and remediation this may be a case suitable for conditions. However, in the absence of any information from Mr McNally about his current circumstances, and demonstrating his insight, the only appropriate sanction is that of 12 months suspension with a review.

The Committee fully considered all the evidence in this case as well as the submissions made by Miss Scarbrough. 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 Mr McNally's conduct was in breach of each of the sections of the *Standards for the Dental Team* (2013) as set out below.

Principle 1:

Put patients' interests first.

Standard 1.8

You must have appropriate arrangements in place for patients to seek compensation if they have suffered harm

Principle 2:

Communicate effectively with patients.

Standard 2.3

You must give patients the information they need, in a way they can understand, so that they can make informed decisions

Principle 3:

Obtain valid consent

Standard 3.1

You must obtain valid consent before starting treatment, explaining all the relevant options and the possible costs.

Standard 3.2

You must make sure that patients (or their representatives) understand the decisions they are being asked to make.

Standard 3.3

You must make sure that the patient's consent remains valid at each stage of investigation or treatment

Principle 4:

Maintain and protect patient information

Standard 4.1

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

Principle 5:

Have a clear and effective complaints procedure

Standard 5.3

You must give patients who complain a prompt and constructive response

Principle 6:

Work with colleagues in a way that is in the patients' best interest

Standard 6.3

You must delegate and refer appropriately and effectively

Standard 6.5

You must communicate clearly and effectively with other team members and colleagues in the interests of patients

Principle 7:

Maintain, develop and work within your professional knowledge and skills

Standard 7.1

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

Principle 9:

Make sure your personal behaviour maintains patients' confidence in you and the dental profession

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.

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, wide ranging and occurred over protracted period of time. Further, the clinical failings involved two patients.

Record keeping is a fundamental area of practice and good record keeping assists in the safe delivery of care to patients, ensures continuity of care and helps to identify any risks to the patients. A failure to maintain adequate records, including failing to report on radiographs and failing to record necessary information on treatment plans, can lead to a compromise in the care of patients and undermine the continuity of care. The Committee considered that this is a serious falling short of what is expected of a dentist.

Mr Nery wrote in his report that his expert opinion was that the failings identified fell far below the standards, he also said that both patients were worse off after the treatment provided by Mr McNally. He wrote that the treatment provided to Patient B and the identified failings were far below the standard expected. He specifically stated in reference to Patient A:

> *Had Mr. McNally planned and executed this case to the standard of a competent GDP practising advanced implant dentistry Patient A would not have had such early restoration fractures and implant failures. This left Patient A worse off than she started in that she had gone through a course of invasive surgical and prosthetic treatment with loss of bone, and will need to go through the whole process again.*

The Committee accepted Mr Nery's opinion and considered that the serious implications for the patients compounded Mr McNally's failings. Both patients were caused harm, both physically and financially. The Committee considered that not communicating effectively with the patients and failing to obtain informed consent is far below the standards expected. The Committee also considered that the clinical failings fell far below the standards expected.

The Committee considered that failing to co-operate with his regulator, by failing to provide evidence of his indemnity and failing to update his registered address, was a serious

departure by Mr McNally from the standards expected of a registrant. The GDC made significant repeated efforts to obtain this information from Mr McNally and he did not respond. It concluded that this did amount to a serious departure from acceptable standards expected of a registered dental professional.

The Committee considered that Mr McNally's conduct as found proved 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 Mr McNally's misconduct, his 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 current impairment was not found in the particular circumstances of the case.

The Committee considered that the wide-ranging clinical failings identified are capable of remediation; however, it had no evidence that Mr McNally has taken any steps to remediate any of the failings identified. The non-co-operation with the GDC may be more of an attitudinal issue and more difficult to remediate, although the Committee did not consider it to be irremediable. There was no apology from Mr McNally to the patients, or for his disregard of the role of the GDC in investigating the complaints against him. The Committee also had no reflection from him. The Committee was not provided with any evidence of continuing professional development or any training that Mr McNally may have done to address the issues highlighted in this case.

The Committee considered Mr McNally has demonstrated very limited insight into the effects of his misconduct on patients and the profession. His main concern appears to be his own financial position. Mr McNally has not demonstrated an appreciation of the impact of his misconduct on his patients or on the reputation of the profession.

The Committee did consider that Mr McNally had put patients at risk of harm, and actual harm was caused to both Patient A and Patient B. His misconduct did bring the profession into disrepute and breached fundamental tenets of the profession. Given the lack of remediation and lack of insight demonstrated by Mr McNally the Committee was satisfied that there remains a real risk of repetition of the behaviour identified, thus putting patients at further 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. This is particularly so given the risk of repetition, the real risk of significant harm and the actual harm caused without any acknowledgment from Mr McNally regarding the seriousness of his failings.

Accordingly, the Committee has concluded that Mr McNally's fitness to practise is currently impaired, both for public protection and public interest, by reason of his misconduct.

Decision on sanction

The Committee next considered what sanction, if any, to impose on Mr McNally's 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 Mr McNally's 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 or risk of harm to a patient or another;
- blatant or wilful disregard of the role of the GDC and the systems regulating the profession;
- lack of insight demonstrated;
- misconduct sustained or repeated over a period of time;
- previous warnings, convictions or other adverse findings;

Mitigating

- The Committee was unable to identify any mitigating circumstances.

In the light of the findings against Mr McNally, the Committee has determined that it would be inappropriate to conclude this case without taking any action or with a reprimand, as neither would address the risk of repetition or the identified risk to the public. The Committee did not consider that the findings against Mr McNally are at the lower end of the spectrum.

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. It was aware for conditions to be workable there has to be a measure of positive engagement with the process and the Committee has to be satisfied that Mr McNally would be willing to comply. Given his lack of positive engagement the Committee could not be satisfied that Mr McNally would comply with conditions. The Committee determined that it would not be appropriate to conclude this case with conditions.

The Committee then considered whether a suspension order would be proportionate and appropriate in this case. The Committee is in no doubt that Mr McNally's misconduct and the harm caused to two patients was wholly unacceptable and, in its view, seriously 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 considered that a lesser sanction would not be sufficient in this case to protect patients and the public, particularly given the risk of repetition and the risk of harm to patients.

The Committee then considered whether the issues identified are fundamentally incompatible with Mr McNally 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 protect the public, address the public interest and give Mr McNally the opportunity to reflect upon and demonstrate insight into his misconduct and to address his remediation and reflect upon the findings made by this Committee.

The Committee did not consider that Mr McNally demonstrated deep-seated attitudinal issues, and a period of suspension would give him the opportunity to demonstrate to a reviewing Committee that he has reflected upon and remediated all the deficiencies identified. The Committee was satisfied that his misconduct was not fundamentally incompatible with him 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 Mr McNally the opportunity to reflect and provide evidence 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 dental professional and send a message to the profession that this type of conduct is not acceptable.

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 participation from Mr McNally, evidence of further training that focuses on the breaches of standards highlighted in this decision, a written personal reflective piece from Mr McNally on what he has learned from this process and demonstrating his insight, the impact of his misconduct on the public and the profession and evidence of any other remediation that he may have undertaken. The reviewing Committee may also be assisted by testimonials.

The current interim order on Mr McNally's registration is hereby revoked in accordance with the Dentists Act 1984.

Decision on immediate order

The Committee considered whether to make an order for the immediate suspension of Mr McNally's registration. In so doing, it has had regard to the submissions made by Miss Scarbrough, who invited the Committee to make such an order on the grounds that it is necessary to protect the public and is otherwise in the public interest. The Committee has accepted the advice of the Legal Adviser.

In accordance with the Dentists Act 1984 (as amended) the Committee has determined that it is necessary to direct that Mr McNally's 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 concluded that not imposing an immediate order and allowing Mr McNally to practice during the period before the substantive order takes effect would place the public at risk given the lack of insight demonstrated and the lack of evidence of remediation provided. The Committee was also 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 Mr McNally's registration will be suspended forthwith. Unless Mr McNally exercises his right of appeal, the substantive direction of suspension will take effect 28 days from the date upon which this determination is deemed served. Should Mr McNally exercise his 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."

On 1 October 2019 at a review hearing, the Chair announced the determination as follows:

"This is a resumed hearing of Mr McNally's case.
Mr McNally is neither present nor represented. The General Dental Council (GDC) is also not in attendance. It relies on written submissions, in which it submits that: (i) service of the notification of hearing had been effected on Mr McNally in accordance with the General Dental Council (Fitness to Practise) Rules 2006 (the Rules); (ii) the hearing should proceed in his absence; (iii) his fitness to practise remains impaired by reason of misconduct and (iv) that an order of suspension for an extended period be directed.

Decision on service of the Notification of Hearing

The Committee considered whether notice of the hearing had been served on Mr McNally in accordance with rules 28 and 65 of the Rules. It received a bundle of documents containing a copy of the Notification of Hearing letter, dated 28 August 2019, and a Royal Mail 'Track and Trace' receipt confirming that delivery was attempted to Mr McNally's registered address by Special Delivery. A copy of the letter was also sent to him by email on the same date.

The Committee was satisfied that the letter contained proper notification of today's review hearing, including its time, date and venue, as well as notification that the Committee had the power to proceed with the hearing in Mr McNally's absence. On the basis of the information provided, the Committee was satisfied that notice of the hearing had been served on Mr McNally in accordance with the Rules.

Decision on proceeding with the hearing in the absence of Mr McNally

The Committee next considered whether to exercise its discretion under Rule 54 of the Rules to proceed with the hearing in the absence of Mr McNally. It approached this issue with the utmost care and caution. The Committee took into account the factors to be considered in reaching its decision as set out in the case of *R v Jones [2003] 1 AC 1HL*. It remained mindful of the need to be fair to both Mr McNally and the GDC, and it had regard to the public interest in the expeditious review of the suspension order in place on Mr McNally's registration.

The Committee noted from the Notification of Hearing letter of 28 August 2019 that Mr McNally was asked to confirm by 04 September 2019, whether he would be attending today's hearing and/or whether he would be represented. The information before the Committee indicates that there has been no response from Mr McNally. He has not provided

a reason for his non-attendance, either in person or remotely, nor has he requested an adjournment. The Committee therefore concluded that Mr McNally had voluntarily absented himself from today's proceedings. It decided that an adjournment was unlikely to secure his attendance on a future date. The Committee also noted that Mr McNally did not attend and was not represented at the initial PCC hearing of his case in September 2018. The Committee noted the current order is due to expire on 21 October 2019 when Mr McNally would be free to practise unrestricted.

In all the circumstances, the Committee determined that it was fair and in the public interest to proceed with the hearing in the absence of Mr McNally and/or any representative on his behalf.

Background to Mr McNally's case

Mr McNally's case was first considered by the PCC at a hearing in September 2018. That Committee was of the view that the breaches in this case were serious, wide ranging and occurred over a period of time. The Committee determined:

"Record keeping is a fundamental area of practice and good record keeping assists in the safe delivery of care to patients, ensures continuity of care and helps to identify any risks to the patients. A failure to maintain adequate records, including failing to report on radiographs and failing to record necessary information on treatment plans, can lead to a compromise in the care of patients and undermine the continuity of care. The Committee considered that this is a serious falling short of what is expected of a dentist.

…

The Committee considered that failing to co-operate with his regulator, by failing to provide evidence of his indemnity and failing to update his registered address, was a serious departure by Mr McNally from the standards expected of a registrant. The GDC made significant repeated efforts to obtain this information from Mr McNally and he did not respond. It concluded that this did amount to a serious departure from acceptable standards expected of a registered dental professional."

The Committee that sat in September 2018 considered that the breaches of the GDC's standards, as highlighted by its findings, were serious and were capable of undermining public confidence in the profession. That Committee found that the facts found proved against Mr McNally amounted to misconduct and it determined that his fitness to practise was impaired by reason of that misconduct. In its determination on impairment, that Committee stated that Mr McNally's misconduct was remediable. However, the Committee received no evidence from him in relation to any steps he had taken to address the concerns raised in the substantive case. Nor had the Committee been provided with any evidence of insight. In the absence of such evidence and in view of his lack of engagement with the GDC, the Committee concluded that there remained a risk of repetition.

Accordingly, the Committee decided that Mr McNally's fitness to practise was impaired.

That Committee determined to suspend Mr McNally's registration for a period of 12 months and imposed an immediate order of suspension. It directed a review of his case prior to the end of the 12 month period.

Today's review

This Committee has comprehensively reviewed the current order. In so doing, it has had regard to the GDC bundle, as well as the GDC's submissions.

Decision on impairment

In reaching its decision on whether Mr McNally's fitness to practise remains impaired, the Committee exercised its own judgement. It had regard to the over-arching objective of the GDC, which involves: the protection, promotion and maintenance of the health, safety and well-being of the public; the promotion and maintenance of public confidence in the dental profession; and the promotion and maintenance of proper professional standards and conduct for the members of the dental profession.

The information before this reviewing Committee today indicates that Mr McNally has made no attempts to fulfil the recommendations made by the Committee in September 2018. In this Committee's view, Mr McNally's ongoing failure to engage effectively with the GDC demonstrates that he has not developed insight into the concerns identified at the hearing in September 2018. Taking into account this lack of insight and the absence of any evidence of remediation to show that Mr McNally has addressed the findings of the previous Committee, this Committee concluded that serious concerns remain.

Having taken all the information before it into account, the Committee continues to be concerned about the risk of repetition. In all the circumstances, the Committee decided that a finding of current impairment is necessary for the protection of the public. The Committee also decided that public confidence in the dental profession would be undermined if such a finding were not made in the circumstances of this case.

Accordingly, the Committee has determined that Mr McNally's fitness to practise remains impaired by reason of his misconduct.

Decision on Sanction

The Committee considered what action, if any, to take in respect of Mr McNally's registration. It had regard to its powers under Section 27C(1) of the *Dentists Act 1984 (as amended)*, which sets out the options available to it. The Committee took into account that the purpose of any sanction is not to be punitive, although it may have that effect, but to protect patients and the wider public interest.

The Committee had regard to the '*Guidance for the Practice Committees including Indicative Sanctions Guidance (effective from October 2016 revised May 2019)*'. It applied the principle of proportionality, balancing the public interest with Mr McNally's own interests. It considered the available sanctions in ascending order.

In the light of the Committee's outstanding concerns about public safety, it determined that it would be inappropriate to terminate the current suspension order or to allow it to lapse. It decided that some ongoing restriction of Mr McNally's registration is necessary to safeguard the public and to uphold the wider public interest.

The Committee next considered whether to terminate Mr McNally's suspension order and replace it with an order of conditions. However, the Committee concluded that conditional registration would not be suitable in this case, where the registrant has failed to engage meaningfully in the regulatory process. It also took into account the serious nature of Mr McNally's failings, which have yet to be addressed. It therefore determined that the imposition of conditions would not be appropriate, workable or proportionate.

In all the circumstances, the Committee determined to extend the period of the suspension order on Mr McNally's registration. This Committee has found that he has failed to demonstrate insight, or remediate the misconduct identified and continues not to engage

with his regulator. As a result, the failings identified remain a real concern. In view of this, the Committee concluded that members of the public and the wider public interest would not be sufficiently protected by a lesser sanction than suspension.

The Committee has decided to extend the suspension order by a period of 12 months. In deciding on this period, the Committee took into account the absence of evidence of progress made by Mr McNally since the findings made against him in September 2018. It considered that a significant amount of engagement and remediation will now be required on his part to address all the identified failings. The Committee concluded that a 12 month suspension would afford him such an opportunity, whilst ensuring that members of the public and the wider public interest remain protected adequately.

A Committee will review Mr McNally's case at a resumed hearing to be held shortly before the end of the extended period of suspension. That Committee will consider whether it should take any further action in relation to his registration. He will be informed of the date and time of that resumed hearing.

The Committee considers that a reviewing Committee would be assisted by the points made (below) at the initial hearing:

"Any future Committee reviewing this order is likely to be assisted by participation from Mr McNally, evidence of further training that focuses on the breaches of standards highlighted in this decision, a written personal reflective piece from Mr McNally on what he has learned from this process and demonstrating his insight, the impact of his misconduct on the public and the profession and evidence of any other remediation that he may have undertaken. The reviewing Committee may also be assisted by testimonials."

The Committee further considers that Mr McNally's presence at the next review hearing would be of particular assistance to a reviewing Committee and to Mr McNally, in that it would give him the opportunity to demonstrate a degree of insight and to explain what remediation if any has taken place.

Unless Mr McNally exercises his right of appeal, his current suspension order will be extended by a period of 12 months, from the date when it would have otherwise expired. If Mr McNally does lodge an appeal against this decision, the current suspension order will continue to remain in force until the appeal has been decided.

That concludes this determination."