HEARING HEARD IN PUBLIC

HAMMOND, John Edward

Registration No: 44208

PROFESSIONAL CONDUCT COMMITTEE

JUNE 2015

Outcome: Erasure with immediate suspension

John Edward HAMMOND, a dentist, BDS Wales 1970, was summoned to appear before the Professional Conduct Committee on 1 June 2015 for an inquiry into the following charge:

Charge (as amended on 1 June 2015)

"That, being a registered dentist:

1. At all material times you were a United Kingdom registered Dental Practitioner practising at Park Road Dental Practice in Loughborough ("the Practice").

Patient A

2. From around 1987 to 30 July 2013, you were Patient A's dentist.

Assessment & Treatment

3. At appointments on 25 January 2013 and 26 July 2013, you failed to carry out necessary assessments, including
    i. A full medical history
    ii. A Basic Periodontal Examination (BPE)
    iii. A full extraoral examination
    iv. A full intraoral examination
    v. Standard of oral hygiene
4. At an appointment on 30 July 2013, you failed to provide an adequate standard of treatment, in that the restoration of UR6 was sub-standard.
5. Between 13 July 2011 to 30 July 2013, you failed to;
    (a) diagnose periodontal disease.
    (b) adequately treat periodontal disease.
    (c) diagnose significant hard tissue issues.
    (d) adequately treat significant hard tissue issues.
6. From 1988 to 2013 you failed to
    (a) Take any routine bitewing radiographs
    (b) Take any radiographs when clinically indicated
7. You failed to provide any preventative and/or oral hygiene advice to Patient A.

8. You failed to diagnose and treat cavities that needed filling.

9. You failed to diagnose and treat gum disease that needed to be treated.

10. You gave the impression to Patient A that he was receiving the best possible level of care under your private retainer scheme when in fact your standard of care was wholly inadequate for any dentist.

11. Due to the failings set out in Allegations 3 to 10 above you caused Patient A unnecessary harm in terms of his dental health.

Record Keeping

12. Your records for Patient A contain no details in respect of:

    (a) Medical history

    (b) A full extraoral examination

    (c) Soft tissues having been checked

    (d) A Basic Periodontal Examination (BPE)

    (e) Levels of oral hygiene

    (f) Presence or absence of any complaint except on 26 July 2013 when a fractured tooth was noted at UR6

    (g) Diagnosis of periodontal disease

    (h) Treatment plan in respect of periodontal disease

    (i) Diagnosis of any significant hard tissue issues

    (j) Treatment plan in respect of hard tissue issues

    (k) Details of local anaesthetic for the appointment on 30 July 2013

    (l) Materials used for the restoration of UR6 on 30 July 2013

    (m) Post-operative instructions following the appointment on 30 July 2013

    (n) An appointment of 20 July 2011

13. Your records were illegible.

14. You inappropriately used NHS stationary for Patient A's records when providing private dental care.

Cooperation with the GDC

15. You did not cooperate with an investigation conducted by the GDC, by not responding to correspondence dated;

    (a) 24 March 2014

    (b) 14 May 2014

Patient B

16. From 1983 to 30 June 2013 you were Patient B's dentist.

Assessment & Treatment

17. From 1983 to 2013, you failed to;
    (a) Take routine bitewing radiographs
    (b) Take other radiographs when clinically indicated
    (c) Conduct basic periodontal examinations
    (d) Diagnose periodontal disease
    (e) Provide any reasonable or adequate periodontal treatment yourself or refer Patient B to a hygienist when one was available.
18. Your failure to undertake investigations and treatment led to
    (a) UR5 and UL5 being beyond restorative treatment,
    (b) UR6 having to be extracted
    (c) LL7 having to be extracted
    (d) LL6 requiring a surface amalgam restoration
19. From 1 January 2011 to 30 June 2013 you failed to;
    (a) Carry out assessments, including
        i. A full medical history
        ii. A Basic Periodontal Examination (BPE)
        iii. A full extraoral examination
        iv. A full intraoral examination
        v. Standard of oral hygiene
20. In relation to LL7 which was extracted on 6 June 2013 (according to Patient B – Dental Records unclear) you failed to carry out necessary diagnostic assessments, including;
    (a) Taking investigative radiographs
    (b) Investigating the cause of the extraction being necessary
    (c) Taking and/or updating and/or checking the patient's medical history
    (d) Providing clinical justification for the extraction
    (e) Providing a diagnosis and/or treatment options to the Patient
    (f) Obtaining valid consent for the extraction
    (g) Providing post-operative instructions to the Patient
21. You told Patient B that her teeth were healthy and strong when in fact she was suffering from undiagnosed gum disease.
22. You failed to appropriately treat a periodontal abscess over a period of approximately 10 years.
23. You failed to provide any preventative advice to Patient B.

24. In relation to Allegations 17 to 23 you caused Patient B unnecessary harm in terms of her dental health.

Record Keeping

25. Your records for Patient B contain no details in respect of:

(a) Medical history

(b) A full extraoral examination

(c) Soft tissues having been checked

(d) Hard tissues having been checked

(e) A Basic Periodontal Examination (BPE)

(f) Levels of oral hygiene

(g) Social history

(h) Radiographic investigations

(i) The standard of the patient's oral hygiene

(j) Treatment provided to LR6 at an appointment in 2012

(k) Justification for treatment to LR6

(l) Justification for treatment to LL7 in 2013

(m) Consent for the extraction of LL7

(n) Type, amount or method of administration of local anaesthetic for the extraction of LL7.

(o) Investigations and treatment provided to prevent further tooth loss

(p) Post-operative instructions following the extraction of LL7

(q) Diagnosis of periodontal disease

26. You failed to adhere to the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) for radiographs that had been taken.

27. Your records were illegible.

28. You inappropriately used NHS stationary for Patient B's records when providing private dental care.

Cooperation with the GDC

29. You did not cooperate with an investigation conducted by the GDC, by not providing full patient records when requested on;

(a) 20 September 2013

(b) 12 November 2013

(c) 20 December 2013

(d) 18 February 2014

(e) 28 March 2014

AND, by reason of the facts stated, your fitness to practise as a Dentist is impaired by reason of your misconduct."

Mr Hammond was not present and was not represented. On 3 June 2015 the Chairman announced the findings of fact to the Counsel for the GDC:

"Ms Culleton

Mr Hammond is neither present nor represented.

At the outset of the hearing, on behalf of the General Dental Council (GDC), you made an application to proceed in Mr Hammond's absence, pursuant to Rule 54 of the GDC (Fitness to Practise) Rules 2006 ('the Rules').

The Committee first considered whether Mr Hammond had been sent notification of this hearing in accordance with Rules 13 and 65. It saw a copy of the Notification of Hearing letter, dated 27 April 2015, which was sent to Mr Hammond's registered address, at his request, by Special Delivery and by first class post. The Committee was satisfied that the letter contains proper notification of this hearing, including its time, date and location, as well as notification that the Committee has the power to proceed with the hearing in Mr Hammond's absence. The letter also included the allegations and it set out the potential outcomes of this hearing and their consequences for the registrant. A Royal Mail 'track and trace' receipt confirms the letter was delivered and signed for on 5 May 2015 in the printed name of "HAMMOND". The Committee noted that Mr Hammond responded in a written letter dated 12 May 2015 where he confirmed he had received the Notice of Hearing and that he would not be attending today's hearing. On the basis of all of this information, the Committee was satisfied that all reasonable efforts had been made in accordance with the Rules to send notification to Mr Hammond and that the requirements of service had been met.

The Committee next considered whether to exercise its discretion under Rule 54 to proceed with the hearing in Mr Hammond's absence. It took into account the advice of the Legal Adviser regarding the principles set out in the case of R v Jones [2003] 1 AC 1HL, including the need to be fair to Mr Hammond, as well as to the GDC. The Committee also had regard to the public interest in the expeditious consideration of the allegations in this case.

The Committee was satisfied that Mr Hammond was aware of this hearing today. It noted that the GDC rang Mr Hammond on 7 May 2015, where Mr Hammond stated that he did not wish to attend this hearing. He indicated that he intended no discourtesy to the Committee by his non-attendance.

In all the circumstances, the Committee was satisfied that Mr Hammond had voluntarily absented himself from these proceedings and, as such, there would be no merit in an adjournment. It further noted that he did not seek an adjournment. The Committee had regard to the public interest given the serious nature of the allegations in this case, and was satisfied that it was fair and appropriate to proceed with the hearing in Mr Hammond's absence.

The Committee has taken into account all of the evidence presented to it, and also the submissions made by you on behalf of the General Dental Council (GDC). It has accepted the advice of the Legal Adviser. In accordance with that advice it has considered each head of charge separately.

The Committee bore in mind that the burden of proof lies with the GDC and that Mr Hammond is not required to prove or disprove anything; further that the standard of proof is the civil standard, so that the GDC must satisfy the Committee, on the balance of probabilities, that each individual head and sub-head of charge is proved.

The specific allegations in this case relate to the standard of care and treatment he provided to Patient A and Patient B between 1982 and 30 July 2013. They also concern Mr Hammond's poor record keeping and his failure to cooperate with the GDC during their investigation.

During the course of the hearing, the Committee received a number of documents including copies of Mr Hammond's dental records in respect of both patients. The Committee noted that the original patient records and radiographs were not able to be located and placed before the Committee.

The Committee heard oral evidence from Patient A and Patient B. The Committee found them both to be credible, although noted that both patients only became aware of matters when seen by subsequent dentists.

The Committee heard expert evidence from Dr Igoe, called by the GDC. Dr Igoe wrote his report on the basis of hearsay evidence which was from the written statements of the two dentists that subsequently treated Patients A and B. Dr Igoe was only in possession of Patient A's original records and photocopies of Patient B's records. Dr Igoe only had photocopies of any radiographs associated with this case.

The Committee had no sight of any of the original patient records or radiographs.

The Committee also received written statements from subsequent treating dentist A and subsequent treating dentist B, Professional C, a receptionist at Gorse Covert Dental Practice, and Professional D, a Senior Caseworker at the GDC.

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

1.	Proved
2.	Proved
3. i)	Proved
3. ii)	Proved
3. iii)	Proved
3. iv)	Proved In respect of charges 3 i) – 3 iv), the Committee notes that there has been an absence of any record made of these assessments being carried out. The Committee is persuaded by Patient A who stated that these were not carried out. The Committee also noted the opinion of Dr Igoe that a reasonably competent practitioner would carry out these assessments. Therefore on the balance of probabilities the committee is satisfied that these were not carried out by the registrant.
3. v)	Not proved The Committee notes that the records indicate that the registrant carried out a scale and polish on 25 January 2013 and he prescribed a scale and polish on 26

	July 2013, this indicates that he must have assessed Patient A's standard of oral hygiene.
4.	Not proved The Committee was not persuaded that the registrant's treatment of Patient A's UR6 on 13 July 2013 was sub standard. The Committee had not received sufficient evidence to support this charge. There was no overt decay associated with this tooth. It was only subsequent treating dentist A's opinion that the filling in the UR6 did not look stable.
5. a)	Not proved
5. b)	Not proved The Committee found no record or any mention of any visit for the date of 13 July 2011. The Committee does acknowledge that the registrant saw Patient A on dates between 20 July and 30 July 2013. The Committee considers that the GDC has not provided sufficient evidence to confirm that Patient A did have periodontal disease during this period. The Committee considers that even if Patient A had periodontal disease, the registrant prescribed a scale and polish which Dr Igoe agreed was the correct treatment for the mild form of the condition.
5. c)	Not proved
5. d)	Not proved When Patient A first consulted the subsequent treating dentist A in January 2013, the LR8 had just broken over the Christmas holidays. In his statement, subsequent treating dentist A said "the teeth looked fine and there were no obvious signs of decay". Dr Igoe said in evidence "there is no evidence of decay in the bitewing radiographs". The Committee consider that the GDC has not provided sufficient evidence to demonstrate that Patient A had significant hard tissue issues during these dates.
6. a)	Proved The Committee is persuaded by the assessment of Dr Igoe that no routine bitewing radiographs were taken in that period. There is no evidence in the patient records that routine bitewings radiographs were taken during this period.
6. b)	Not proved The Committee notes that 3 radiographs were taken during this period. This was confirmed by Dr Igoe. Further, the Committee is persuaded by the evidence of Patient A who confirms that a digital radiograph was taken by the registrant on 28 May 2009. Therefore the Committee is satisfied that this may have been clinically justified.
7.	Not proved. The Committee is satisfied that the registrant had provided preventative oral hygiene advice through his treating hygienist who had given oral hygiene instructions to Patient A. Patient A's notes indicate that a discussion regarding

	oral hygiene had taken place with the patient.
8.	Not proved The Committee has received no evidence from the GDC to support this charge. Dr Igoe confirmed in evidence that there was no evidence in the radiographs that decay was present.
9.	Not proved The Committee considers that the GDC has not provided sufficient evidence to confirm that Patient A did have periodontal disease during this period. The Committee considers that even if Patient A had gum disease, the registrant prescribed a scale and polish which Dr Igoe agreed was the correct treatment for the mild form of the condition. Subsequent treating dentist A's diagnosis was not conclusive in this matter.
10.	Not proved. Patient A stated that he was always under the impression that he was receiving a better standard of care, having entered the registrant's private retainer scheme. Patient A stated his shock when notified by his subsequent treating dentist of his findings. The Committee considers that the registrant did not give the best level of care to Patient A. However based upon the evidence presented to it, the Committee is satisfied that the standard of care given by the registrant was not wholly inadequate. Therefore the Committee finds this charge in its entirety not proved.
11.	Not proved. The Committee considered this charge only in relation to the proved charges 3i) – v) and 6.a . There was no evidence of Patient A being caused any actual harm; further Dr Igoe's evidence only went so far as to say there was a potential harm.
12. a)	WITHDRAWN
12. b)	Proved There are no details of any extra oral examinations.
12. c)	Not proved The notes indicate that some details regarding soft tissues were checked as recorded on 2 December 1996
12. d)	Not proved The Committee found that a record was made on 17 November 2002 regarding a basic periodontal examination.
12. e)	WITHDRAWN
12. f)	Not proved. The Committee found notes made on 17 May 1996, 22 December 1997, 17 May 2000 and 18 December 2000, which confirm that these were recorded.
12. g)	Proved.

	The Committee considers that as a matter of fact that his records contained no diagnosis of periodontal disease. The Committee considers that he had a duty to record this.
12. h)	Proved The Committee found no record being made of any treatment plan in respect of periodontal disease.
12. i)	Not proved. The Committee found entries on 17 May 1996 and 26 July 2013 in relation to a broken tooth and chipped tooth which constitute hard tissue issues.
12. j)	Not proved. The Committee found entries on 11 April 1995 and 26 July 2013 to confirm that the registrant has recorded a treatment plan in respect of hard tissues.
12. k)	Proved. The Committee found no record of this in the patient notes.
12. l)	Proved. The Committee found no record of this in the patient notes.
12. m)	Proved. The Committee found no record of this in the patient notes.
12. n)	Proved The Committee found no record of this in the patient notes.
13.	Not proved. The Committee considers that whilst parts of the registrant's records were difficult to read, they were not illegible in totality having only received copies of his records as the originals were never produced before this Committee. The Committee considers that they could read the copies partially and that they were not illegible.
14.	Proved. The Committee is persuaded by the evidence of Dr Igoe that this was inappropriate.
15. a)	Proved
15. b)	Proved The Committee is persuaded by the unchallenged evidence of Professional D who confirms that the registrant failed to cooperate with the GDC on these dates.
16.	Proved. The Committee is satisfied that the registrant was Patient B's dentist between these dates.
17. a)	Proved.

	The Committee found no evidence to indicate that the registrant took any routine bitewing radiographs between these dates.
17. b)	Proved The Committee found no evidence to indicate that the registrant had taken any radiographs between these dates.
17. c)	Proved The Committee found no evidence in Patient B's notes to confirm that a basic periodontal examination was performed between these dates.
17. d)	Proved. The Committee found no evidence in Patient B's notes to indicate that the registrant had diagnosed Patient B's periodontal disease between these dates.
17.e)	Not proved The Committee considered that the registrant referred Patient B to a hygienist on 8 August 1988, as confirmed in the notes
18. a)	Not proved UR5 was restored by the subsequent treating dentist B and the UL5 was missing when she was examined by subsequent treating dentist B.
18. b)	Proved
18. c)	Proved The Committee was satisfied that Patient B had undiagnosed periodontal disease. The registrant's failure to undertake investigations and treatment of the periodontal disease led to significant bone loss, requiring UR6 and LL7 to subsequently to be extracted.
18. d)	Not proved. The Committee considers that based on the balance of probabilities that the LL6 would have required restoration at some point. The Committee considers that in respect of any failures o the part of the registrant, the restoration at LL6 would have required a replacement at some stage.
19. a)	Proved.
19. a) i)	Proved
19. a) ii)	Proved
19. a) iii)	Proved
19. a) iv)	Proved
19. a) v)	Proved. In respect of charges 19. a), 19 a) i) –v), the Committee has found nothing recorded in Patient B's notes to confirm that these assessments were carried out.
20. a)	Proved

20. b)	Proved
20. c)	Proved
20. d)	Proved
20. e)	Proved
20. f)	Proved
20. g)	Proved The Committee did not find anything in the patient notes to indicate that these assessments have been performed. The Committee is persuaded by the statement of Patient B to support the fact that the registrant had failed to carry out the necessary diagnostic assessments as stated in charges 20 a) – 20 g) above.
21.	Proved The Committee is persuaded by the comments made in Patient B's statement that she was told by the registrant that "her teeth were strong and perfectly healthy". When Patient B consulted subsequent treating dentist B, his findings were that she had severe and long standing periodontal disease with associated bone loss. The Committee considers that based on the balance of probabilities that Patient B had gum disease during and after receiving treatment from the registrant.
22.	Proved The Committee is persuaded by the Patient B's evidence that she had suffered from repeated abscesses over a period of approximately ten years.
23.	Not proved The Committee is satisfied that the registrant did provide advice through his hygienist on at least one occasion.
24.	Proved Patient B had extensive periodontal disease and that some of her teeth needed to be extracted. The Committee is persuaded by the statement of the subsequent treating dentist B who states that Patient B had long standing periodontal disease.
25. a)	Proved The Committee found no record of this in the patient notes.
25. b)	Proved The Committee found no record of this in the patient notes.
25. c)	Not proved The Committee found some reference to soft tissues having been checked in the patient notes on two occasions in 2003
25. d)	Not proved.

	The Committee found some reference to hard tissues having been checked in Patient B's notes on June 1983 and 15 June 1987.
25. e)	Proved. The Committee found no record of this in Patient B's notes.
25. f)	Proved. The Committee found no record of this in Patient B's notes.
25. g)	Proved The Committee found no record of this in Patient B's notes.
25. h)	Not proved The Committee found some reference in Patient B's notes on October 2000 with regards to a radiographic investigation.
25. i)	Proved. The Committee found no record of this in Patient B's notes.
25. j)	Proved. The Committee found no record of this in Patient B's notes
25. k)	Proved. The Committee found no record of this in Patient B's notes.
25. l)	Proved. The Committee found no record of this in Patient B's notes.
25. m)	Proved. The Committee found no record of this in Patient B's notes.
25. n)	Proved. The Committee found no record of this in Patient B's notes.
25. o)	Proved. The Committee found no record of this in Patient B's notes.
25. p)	Proved. The Committee found no record of this in Patient B's notes.
25. q)	Proved. The Committee found no record of this in Patient B's notes.
26.	Proved The Committee were not in possession of the originals of Patient B's records or radiographs. The Committee is satisfied that radiographs were taken by the registrant, however there was no justification in the records for the taking of these radiographs which is a failure to adhere to the IRMER regulations. This is supported by the evidence of Dr Igoe.

27.	Not proved. The Committee considers that whilst parts of the registrant's records were difficult to read, they were not illegible in totality having only received copies of his records as the originals were never produced before this Committee. The Committee considers that they could read the copies partially and that they were not illegible.
28.	Proved. The Committee is persuaded by the evidence of Dr Igoe. The Committee is satisfied that the registrant did use NHS stationary and considers that it is inappropriate to do so.
29. a)	Proved
29. b)	Proved
29. c)	Proved
29. d)	Proved
29. e)	Proved The Committee is persuaded by the unchallenged evidence of Professional D who confirms that the registrant failed to cooperate with the GDC on these dates.

We move to Stage Two."

On 4 June 2015 the Chairman announced the determination as follows:

"Ms Culleton

The Committee has considered all the evidence presented to it. It has taken account of the submissions made by you on behalf of the General Dental Council (GDC). It has accepted the advice of the Legal Adviser.

This case involves Mr Hammond's treatment of Patient A and Patient B at the Park Road Dental Practice, Loughborough for almost thirty years.

Patient A had been a patient since 1987 and had been attending for regular 6 monthly check ups. Patient A received a letter dated 23 September 2013 from another local dentist informing him that he was now to be referred to their practice as Mr Hammond's practice was to go into receivership. Patient A decided to seek alternative treatment from another dentist, subsequent treating dentist A. It was during an examination on 10 January 2014 that he was informed by subsequent treating dentist A, that his teeth were in a poor state and needed serious repair, and were not at a good enough level of health to be admitted onto his private dental plan.

Patient B had been a patient since 1983 and had also been attending regular check ups. It was during a visit on 6th June 2013, that Patient B was notified by Mr Hammond of his financial difficulties. After this last appointment with Mr Hammond, Patient B decided to seek another dentist and approached subsequent treating dentist B. After a full examination, subsequent treating dentist B informed Patient B that she needed a filling, a root filling, an extraction and prolonged periodontal treatment. Patient B was also notified that she had

advanced gum disease. Patient B was requested to urgently see a hygienist as there was a great deal of work that needed to be done in her mouth.

Patient B in particular required extensive and costly treatment as a result of the matters which had not been diagnosed or treated by Mr Hammond.

The Committee has found proved a significant number of failings in relation to the care provided by Mr Hammond to Patient A and in particular Patient B. Mr Hammond's failings can be categorized in three areas, assessments and treatment, record keeping and failure to cooperate with the GDC.

The Committee found proved wide ranging and serious failures in respect of both patients.

In respect of assessment and treatment, Mr Hammond failed to carry out necessary assessments such as a full medical history, basic periodontal examinations (BPE) and also full extraoral and intraoral examinations. He also failed to take any routine bitewing radiographs for both patients over a twenty year period.

There were failures in respect of his record keeping. In particular his records did not contain various details such as a full extraoral examination, diagnosis and treatment plan of periodontal disease and hard tissue issues. He also failed to record details of any local anesthetics used.

In respect of Patient B, Mr Hammond also failed to appropriately treat Patient B's periodontal abscess over a period of approximately 10 years. The Committee were particularly concerned regarding Mr Hammond's failure to carry out necessary diagnostic assessments regarding Patient B's teeth. This failure led to Patient B suffering unnecessary harm in terms of her dental health. Mr Hammond failed to diagnose periodontal disease, which resulted in Patient B's UR6 and LL7 having to be extracted.

The Committee also found proved that Mr Hammond inappropriately used NHS stationary when providing private dental care for both patients over a significant number of years.

Finally, the Committee found proved that Mr Hammond failed to cooperate with an investigation conducted by the GDC by not responding nor providing full patient records on various occasions when requested to do so.

On behalf of the GDC, Ms Culleton submitted that Mr Hammond's failings constitute serious misconduct in this case and that Mr Hammond's fitness to practise is currently impaired.

In reaching its decisions the Committee exercised its own independent judgment and it reminded itself of its primary duty, that is to consider the protection of patients, the maintenance of public confidence in the profession and the declaring and upholding of proper standards of conduct and behaviour.

Misconduct

The Committee first considered whether the facts found proved in this case amount to misconduct. It was satisfied on the evidence before it that Mr Hammond failed to adhere to his overriding duty as a dentist to put the patients' interests first and act to protect them. Mr Hammond's conduct breached the following duties set out in the GDC standards guidance *'Standards for Dental Professionals'*:

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

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.

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'.

The Committee considered that Mr Hammond's overall treatment of these patients demonstrated a comprehensive range of failures concerning basic and fundamental dental practice. His failings were repeated, serious and over a prolonged period of time. Mr Hammond's failure to diagnose periodontal disease over such a long period of time caused unnecessary harm to Patient B. In the Committee's view his failures related to very basic and fundamental areas of dentistry such as record keeping, assessment, treatment planning, diagnosis, the use of radiographs. He also to cooperate with his regulating body and cumulatively his conduct fell far below the standards expected of a general dental practitioner. The Committee is satisfied that Mr Hammond's acts and omissions which spanned over a long period of time concerning these patients, amounted to misconduct of a serious kind.

Impairment

The Committee then considered whether, in the light of Mr Hammond's misconduct, his fitness to practise is currently impaired. Having regard to the facts of this case, the Committee is satisfied that Mr Hammond's fitness to practise was impaired at the time of the events in question. In considering whether his fitness to practise remains impaired today, the Committee took into account the comments of Silber J. in Cohen v GMC [2008] EWHC 581 (Admin) that "it must be highly relevant in determining if a doctor's fitness to practise is impaired that first, his conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated".

The Committee noted that no evidence has been provided regarding any steps Mr Hammond has taken to remediate his misconduct.

The Committee had sight of a 2 page hand written letter from Mr Hammond dated 12 May 2015. In this letter he does not give any insight into his deficiencies. Mr Hammond states that he has now retired from dentistry and does not wish to be registered anymore.

The failings revealed in this case are extensive. The Committee considers that Mr Hammond has demonstrated deep seated attitudinal issues in this case. The Committee considers that irrespective of whether these are theoretically remediable no evidence has been placed before it to establish that Mr Hammond has taken any steps to address the concerns which have been identified in this case. Mr Hammond has chosen not to engage in these proceedings and has not provided any evidence of remediation to demonstrate that he is fit to practise. Therefore the Committee is satisfied that there remains a real risk of repetition.

Having taken into account the protection of the public, and also the public interest in these matters, the Committee has determined that Mr Hammond's fitness to practise is currently impaired by reason of his misconduct.

Sanction

The Committee next considered what sanction, if any, to impose on Mr Hammond's registration. In so doing, it took into account the *'Guidance for the Professional Conduct Committee (November 2009)'*. It has borne in mind that the purpose of a sanction is not to be punitive, but to protect patients and the wider public interest. In deciding on the appropriate sanction the Committee applied the principle of proportionality, weighing the public interest with his own interests.

It considered the sanctions available to it starting from the least serious.

The Committee determined that in the light of the seriousness of the findings against Mr Hammond, it would be inappropriate to conclude this case with no further action.

The Committee next considered whether to issue a reprimand. Mr Hammond's misconduct is not of a minor degree or a one-off event. It covered a long period of time and appears to be entrenched. The Committee concluded that a reprimand would be disproportionate and wholly insufficient to protect patients and safeguard the wider public interest.

In considering whether conditions would be adequate, the Committee took into account the lack of engagement by Mr Hammond and was not confident that he would comply with any conditions it imposed. In Mr Hammond's absence and his lack of engagement with the proceedings, there was no evidence to change that view. Given the seriousness of the Committee's findings, it concluded that conditions could not be formulated that were sufficient, workable, and measurable or appropriate in this case.

The Committee next considered whether suspension would adequately address the failings found against Mr Hammond.

The Committee determined that the severity of Mr Hammond's failings has damaged public confidence in dental profession. Mr Hammond's poor practice over a long period of time ultimately resulted in actual harm. The Committee also took into account the absence of any mitigating factors and that there was no evidence of insight whatsoever. The Committee has concluded that a period of suspension would not reflect the seriousness of Mr Hammond's misconduct, which is fundamentally incompatible with professional registration. It determined that patients would not be adequately protected and public confidence would be undermined if a period of suspension were to be imposed on Mr Hammond's registration.

For all these reasons, the Committee determined that the only appropriate and proportionate sanction was one of erasure. As a consequence the Committee directs, pursuant to section 27B (6)(a) of the Dentists Act 1984, as amended, that Mr Hammond's name be erased from the Dentists Register."

"Ms Culleton,

The Committee has heard your submissions on behalf of the GDC. It has accepted the advice of the Legal Adviser.

You submitted that in the light of the Committee's findings, it is necessary for the protection of the public and otherwise in the public interest for an immediate suspension order to be imposed.

The Committee determined that it is necessary, for the protection of the public and is otherwise in the public interest to impose an order for immediate suspension on Mr Hammond's registration. The Committee was of the view that in the light of the seriousness of its findings, the dental profession would be undermined if Mr Hammond was allowed to practice during the appeal period.

The effect of the foregoing direction and this order is that Mr Hammond's registration will be suspended forthwith and unless he exercises his right of appeal, the substantive direction will take effect 28 days from when notification is deemed served on him. Should Mr Hammond exercise his right of appeal, this order for immediate suspension will remain in place pending the resolution of any appeal proceedings.

The interim order for suspension currently on Mr Hammond's registration is hereby revoked.

That concludes the case."