HEARING HEARD IN PUBLIC

FINDLAY, Ronald Tod

Registration No: 54160

PROFESSIONAL CONDUCT COMMITTEE

OCTOBER - NOVEMBER 2016

Outcome: Erased with Immediate Suspension

Ronald Tod FINDLAY, a dentist, DGDP(UK) 1992, BDS Dund 1980 was summoned to appear before the Professional Conduct Committee on 24 October 2016 for an inquiry into the following charge:

Charge (as amended)

"That, being a registered dentist:

1. You practised in general dentistry at the Princes Street Dental Practice, 165 Princes Street, Dundee and provided care and treatment to the patients set out in Schedule 1 between about December 2006 and December 2014.

Patient A

2. You failed to take bitewing radiographs at appropriate intervals between 7 June 2007 and 10 December 2014 except for a single bitewing radiograph of the left hand side of Patient A's mouth on 6 September 2010.

3. You failed adequately to carry out and/or record an assessment of the health of the periodontal tissues between 7 June 2007 and 15 June 2009.

4. You failed to carry out root canal treatment to an adequate standard:

   (a) to LL6 between 29 June and 15 August 2007, in that:

      (i) you did not use a rubber dam;

      (ii) you did not use a suitable irrigant;

      (iii) you did not use a suitable method to ascertain the working length of the tooth;

      (iv) radiographic investigation showed deficient obturation of the root canal;

   (b) to UR7 between 18 January and 10 February 2010, in that:

      (i) you did not use a rubber dam;

      (ii) you did not use a suitable irrigant;

      (iii) you did not use a suitable method to ascertain the working length of the tooth;

   (c) to UR2 between 7 and 28 February 2011, in that:

      (i) you did not use a rubber dam;

(ii) you did not use a suitable irrigant;

(iii) you did not use a suitable method to ascertain the working length of the tooth;

(d) to UR2 on 16 April 2012, in that:

(i) you did not use a rubber dam;

(ii) you did not use a suitable irrigant;

(iii) you did not use a suitable method to ascertain the working length of the tooth.

5. You prescribed antibiotics inappropriately on:

(a) 23 August 2010;

(b) 7 March 2011;

(c) 21 March 2011;

(d) 12 March 2012.

6. You failed adequately to report on radiographic investigation conducted on:

(a) 15 August 2007;

(b) 10 February 2010;

(c) 7 February 2011;

(d) 16 January 2012.

7. Your record keeping was substandard in that you failed to keep any, or any adequate records in respect of:

(a) an examination on 7 June 2007;

(b) the materials and/or methods used in root canal treatment between 29 June and 15 August 2007;

(c) an examination on 20 October 2008;

(d) an examination on 15 June 2009;

(e) an examination on 18 January 2010;

(f) the materials and/or methods used in root canal treatment between 18 January and 10 February 2010;

(g) an examination on 23 August 2010;

(h) the materials and/or methods used in root canal treatment between 7 and 28 February 2011;

(i) an examination on 9 May 2011;

(j) an examination on 19 September 2011;

(k) an examination on 16 January 2012;

(l) the materials and/or methods used in root canal treatment on 16 April 2012.

Patient B

8. You failed to take bitewing radiographs at appropriate intervals between 22 May 2012 and 28 November 2014.

9. You failed to conduct adequate investigation:

   (a) of the health of UL5 and its suitability to retain a bridge by means of radiographic examination and/or study models between 14 July and 18 August 2014;

   (b) of the suitability of LL6 for a crown or the success of the previous root canal filling by means of radiographic examination between 26 August and 9 September 2014.

10. You failed to carry out root canal treatment to an adequate standard to LL6 between 2 and 13 August 2013, in that:

   (a) you did not use a rubber dam;

   (b) you did not use a suitable irrigant;

   (c) you did not use a suitable method to ascertain the working length of the tooth;

   (d) radiographic investigation showed deficient obturation of the root canal.

11. Your record keeping was substandard in that you failed to keep any, or any adequate records in respect of:

   (a) an examination on 22 May 2012;

   (b) the type and dose of local anaesthetic used on 3 July 2013;

   (c) the materials and/or methods used in root canal treatment between 2 and 13 August 2013.

Patient C

12. You failed to take bitewing radiographs at appropriate intervals between 22 June 2007 and 5 December 2014.

13. You failed adequately to carry out and/or record an assessment of the health of the periodontal tissues between 22 June 2007 and 27 March 2009.

14. You failed to carry out root canal treatment to an adequate standard:

   (a) to UR1 and UL1 on 20 August 2007, in that:

      (i) you did not use a rubber dam;

      (ii) you did not use a suitable irrigant;

      (iii) you did not use a suitable method to ascertain the working length of the tooth;

   (b) to LR7 on 28 May 2008, in that:

      (i) you did not use a rubber dam;

      (ii) you did not use a suitable irrigant;

      (iii) you did not use a suitable method to ascertain the working length of the tooth.

15. You failed to conduct adequate investigation of the suitability of UR1 and UL1 for crowns by means of radiographic examination between 15 and 27 May 2008.

16. You prescribed antibiotics inappropriately on 5 December 2014.

17. You failed adequately to report on radiographic investigation conducted on:

    (a) 22 June 2007;

    (b) 20 August 2007;

    (c) 28 May 2008;

    (d) 27 March 2009;

    (e) 12 February 2014;

    (f) 15 August 2014.

18. Your record keeping was substandard in that you failed to keep any, or any adequate records in respect of:

    (a) the materials and/or methods used in root canal treatment on 20 August 2007;

    (b) what took place at an appointment on 17 December 2007;

    (c) what took place at an appointment on 15 May 2008;

    (d) the materials and/or methods used in root canal treatment on 28 May 2008.

Patient D

19. You failed to take bitewing radiographs at appropriate intervals between 15 January 2007 and 18 December 2014.

20. You failed adequately to carry out and/or record an assessment of the health of the periodontal tissues between 15 January 2007 and 3 February 2009.

21. You failed to conduct adequate investigation:

    (a) of UR6 and UR7 and the surrounding area by means of a radiograph and/or the recording of the health of the tissues on 30 June 2008;

    (b) of UR4 in preparation for a new crown by means of a new periapical radiograph between 5 and 24 October 2011.

22. You prescribed antibiotics inappropriately on:

    (a) 15 January 2007;

    (b) 19 May 2014.

23. You failed adequately to report on radiographic investigation conducted on:

    (a) 14 June 2010;

    (b) 26 August 2013.

24. Your record keeping was substandard in that you failed to keep any, or any adequate records in respect of:

    (a) an examination on 15 January 2007;

    (b) an examination on 10 April 2007;

(c) an examination on 31 October 2007;

(d) the materials and/or methods used in teeth whitening treatment between 30 June and 14 July 2008;

(e) an examination on 3 February 2009;

(f) an examination on 14 February 2012;

(g) an examination on 7 August 2012;

(h) the type and dose of local anaesthetic used on 29 September 2014.

Patient E

25. You failed to take bitewing radiographs when the patient first attended with you on 15 August 2014.

26. You failed adequately to identify and/or treat caries at LL6 between 15 and 28 August 2014.

Patient F

27. You failed to take bitewing radiographs at appropriate intervals between 7 February 2007 and 8 December 2014.

28. You failed adequately to carry out and/or record an assessment of the health of the periodontal tissues between 7 February 2007 and 3 April 2009.

29. Your record keeping was substandard in that you failed to keep any, or any adequate records in respect of:

(a) an examination on 7 February 2007;

(b) an examination on 11 August 2008;

(c) an examination on 3 April 2009;

(d) an examination on 20 April 2010;

(e) an examination on 5 November 2010;

(f) an examination on 27 May 2011;

(g) an examination on 14 November 2011;

(h) an examination on 14 May 2012.

Patient G

30. You failed to take bitewing radiographs at appropriate intervals between 11 June and 9 December 2014.

Patient H

31. You failed to take bitewing radiographs at appropriate intervals between 25 January 2008 and 24 October 2014.

32. You failed adequately to carry out and/or record an assessment of the health of the periodontal tissues between 25 January 2008 and 20 March 2009.

33. You failed to conduct adequate investigation:

(a) of the suitability of UL5 for root canal treatment between 18 and 25 November 2009;

(b) of the suitability of UL5 for root canal treatment between 8 and 19 September 2014.

34. You failed to carry out root canal treatment to an adequate standard:

(a) to UL5 between 18 and 25 November 2009, in that:

(i) you did not use a rubber dam;

(ii) you did not use a suitable irrigant;

(iii) you did not use a suitable method to ascertain the working length of the tooth;

(iv) radiographic investigation showed deficient obturation of the root canal;

(b) to LL6 between 24 March and 18 April 2011, in that:

(i) you did not use a rubber dam;

(ii) you did not use a suitable irrigant;

(iii) you did not use a suitable method to ascertain the working length of the tooth;

(iv) radiographic investigation showed deficient obturation of the root canal;

(c) to UR5 on 4 May 2011, in that:

(i) you did not use a rubber dam;

(ii) you did not use a suitable irrigant;

(iii) you did not use a suitable method to ascertain the working length of the tooth;

(iv) radiographic investigation showed deficient obturation of the root canal;

(d) to UL5 between 8 and 19 September 2014, in that:

(i) you did not use a rubber dam;

(ii) you did not use a suitable irrigant;

(iii) you did not use a suitable method to ascertain the working length of the tooth.

35. You prescribed antibiotics inappropriately on:

(a) 4 May 2011;

(b) 19 September 2014.

36. You failed adequately to report on radiographic investigation conducted on:

(a) 25 November 2009;

(b) 7 June 2010;

(c) 4 May 2011;

(d) 19 September 2014.

37. Your record keeping was substandard in that you failed to keep any, or any adequate records in respect of:

(a) an examination on 25 January 2008;

(b) an examination on 22 August 2008;

(c) an examination on 20 March 2009;

(d) an examination on 6 November 2009;

(e) the materials and/or methods used in root canal treatment between 18 and 25 November 2009;

(f) an examination on 14 December 2010;

(g) the materials and/or methods used in root canal treatment between 24 March and 18 April 2011;

(h) the materials and/or methods used in root canal treatment on 4 May 2011;

(i) an examination on 6 July 2011;

(j) an examination on 20 August 2012;

(k) an examination on 13 March 2013;

(l) the materials and/or methods used in root canal treatment between 8 and 19 September 2014.

Patient I

38. You failed to take bitewing radiographs at appropriate intervals between 19 March 2007 and 22 July 2014.

39. You failed adequately to carry out and/or record an assessment of the health of the periodontal tissues between 19 March 2007 and 18 September 2009.

40. You failed to conduct adequate investigation:

(a) of the suitability of LR3 and LR4 for crowns by way of radiographic examination prior to treatment between 22 January and 5 February 2010;

(b) of the suitability of UR7 for a crown by way of radiographic examination prior to treatment between 20 April and 6 May 2011.

41. You failed to carry out root canal treatment to an adequate standard to LR4 between 25 April and 30 October 2007, in that:

(a) you did not use a rubber dam;

(b) you did not use a suitable irrigant;

(c) you did not use a suitable method to ascertain the working length of the tooth;

(d) the original root filling in April 2007 had to be repeated in October 2007.

42. You placed a crown on LR3 without adequate justification between 22 January and 5 February 2010.

43. You prescribed antibiotics inappropriately on 19 March 2007.

44. You failed adequately to report on radiographic investigation conducted on:
    (a) 25 April 2007;
    (b) 15 October 2007;
    (c) 30 October 2007.
45. Your record keeping was substandard in that you failed to keep any, or any adequate records in respect of:
    (a) the materials and/or methods used in root canal treatment between 25 April and 30 October 2007;
    (b) an examination on 15 October 2007;
    (c) the justification for the re-root filling of LR4 on 30 October 2007;
    (d) an examination on 8 August 2008;
    (e) an examination on 9 March 2009;
    (f) an examination on 31 March 2009;
    (g) an examination on 18 September 2009;
    (h) an appointment on 8 January 2010;
    (i) an examination on 5 November 2010;
    (j) an examination on 23 December 2010;
    (k) an examination on 6 January 2012;
    (l) an examination on 27 July 2012.

Patient J

46. You failed to take bitewing radiographs at appropriate intervals between 23 April 2007 and 7 August 2014.
47. You failed adequately to carry out and/or record an assessment of the health of the periodontal tissues between 23 April 2007 and 7 August 2009.
48. You failed to carry out root canal treatment to an adequate standard to UR2 on 4 June 2008, in that:
    (a) you did not use a rubber dam;
    (b) you did not use a suitable irrigant;
    (c) you did not use a suitable method to ascertain the working length of the tooth.
49. You failed adequately to investigate the cause and symptoms of a periodontal abscess on 5 January 2009.
50. You prescribed antibiotics inappropriately on 5 January 2009.
51. You failed adequately to report on radiographic investigation conducted on:
    (a) 13 May 2008;
    (b) 4 June 2008.

52. Your record keeping was substandard in that you failed to keep any, or any adequate records in respect of:

    (a) an examination on 23 April 2007;

    (b) an examination on 15 October 2007;

    (c) an examination on 13 May 2008;

    (d) the justification for root canal treatment on 4 June 2008;

    (e) the materials and/or methods used in root canal treatment on 4 June 2008;

    (f) an examination on 7 August 2009;

    (g) an examination on 17 March 2010.

Patient K

53. You failed to take bitewing radiographs at appropriate intervals between 22 March 2007 and 29 September 2014 except for a single bitewing radiograph of the right hand side of the mouth on 6 August 2012.

54. You failed adequately to carry out and/or record an assessment of the health of the periodontal tissues between 22 March 2007 and 22 September 2009.

55. You failed to conduct adequate investigation:

    (a) of the condition of UR3 and its suitability for a new crown by way of radiographic examination on or about 3 March 2009;

    (b) of the health of UR1 and its suitability to retain a bridge to UL3 by means of radiographic examination and/or study models between 18 January and 25 January 2010.

56. You failed to carry out root canal treatment to an adequate standard:

    (a) to UR1 on 6 January 2010, in that:

        (i) you did not use a rubber dam;

        (ii) you did not use a suitable irrigant;

        (iii) you did not use a suitable method to ascertain the working length of the tooth;

    (b) to LR6 between 28 September and 4 October 2012, in that:

        (i) you did not use a rubber dam;

        (ii) you did not use a suitable irrigant;

        (iii) you did not use a suitable method to ascertain the working length of the tooth;

        (iv) radiographic investigation showed deficient obturation of the root canal.

57. You prescribed antibiotics inappropriately on 6 August 2012.

58. You failed adequately to report on radiographic investigation conducted on:

    (a) 15 December 2009;

(b) 25 January 2010;

(c) 14 August 2012.

59. Your record keeping was substandard in that you failed to keep any, or any adequate records in respect of:

(a) an examination on 22 March 2007;

(b) an examination on 17 October 2007;

(c) an examination on 6 May 2008;

(d) an examination on 17 February 2009;

(e) what took place at an appointment on 3 March 2009;

(f) what took place at an appointment on 17 March 2009;

(g) an examination on 22 September 2009;

(h) the materials and/or methods used in root canal treatment on 6 January 2010;

(i) the justification for the preparation of UL4 and UL5 for crowns on 26 April 2010;

(j) an examination on 20 October 2010;

(k) the materials and/or methods used in root canal treatment between 28 September and 4 October 2012.

Patient L

60. You failed to take bitewing radiographs at appropriate intervals between 15 December 2006 and 21 August 2014.

61. You failed adequately to carry out and/or record an assessment of the health of the periodontal tissues between 15 December 2006 and 4 February 2011.

62. You failed to carry out root canal treatment to an adequate standard:

(a) to LR4 between 26 October and 5 November 2007, in that:

(i) you did not use a rubber dam;

(ii) you did not use a suitable irrigant;

(iii) you did not use a suitable method to ascertain the working length of the tooth;

(iv) radiographic investigation showed deficient obturation of the root canal;

(b) to LL2 on 4 March 2008, in that:

(i) you did not use a rubber dam;

(ii) you did not use a suitable irrigant;

(iii) you did not use a suitable method to ascertain the working length of the tooth;

(iv) radiographical investigation showed that the treatment on LL2 perforated the apex of the tooth;

(c) to UR5 between 30 November and 15 December 2009, in that:

(i) you did not use a rubber dam;

(ii) you did not use a suitable irrigant;

(iii) you did not use a suitable method to ascertain the working length of the tooth;

(iv) radiographic investigation showed deficient obturation of the root canal;

(d) to LL3 between 29 March and 5 May 2011, in that:

(i) you did not use a rubber dam;

(ii) you did not use a suitable method to ascertain the working length of the tooth;

(iii) you did not use a suitable irrigant;

(iv) radiographic investigation showed deficient obturation of the root canal at LL3;

(e) to UL3 on 6 March 2014, in that:

(i) you did not use a rubber dam;

(ii) you did not use a suitable irrigant;

(iii) you did not use a suitable method to ascertain the working length of the tooth;

(iv) radiographic investigation showed deficient obturation of the root canal at UL3.

63. You failed to carry out adequate treatment planning:

(a) of the fitting of a bridge from LR6 to LR4 between 27 November and 11 December 2007, in that study models were not taken sufficiently far in advance to assist with the design of the bridge;

(b) of the fitting of a bridge from UR1 to UL2, replacing UL1, between 3 and 17 September 2012, in that study models were not taken sufficiently far in advance to assist with the design of the bridge.

64. You prescribed antibiotics inappropriately on:

(a) 12 November 2007;

(b) 1 December 2011;

(c) 17 July 2012;

(d) 28 September 2012.

65. You failed adequately to report on radiographic investigation conducted on:

(a) 26 October 2007;

(b) 27 November 2007;

(c) 4 March 2008;

(d) 29 August 2008;

(e) 30 November 2009;

(f) 15 December 2009;

(g) 29 March 2011;

(h) 3 September 2012.

66. You failed to obtain and/or record the patient's properly informed consent between 15 December 2006 and 21 August 2014 to:

(a) extractions of teeth;

(b) root canal treatments;

(c) restorative treatments;

(d) prosthetic treatments.

67. Your record keeping was substandard in that you failed to keep any, or any adequate records in respect of:

(a) the justification for the root canal treatment on 26 October 2007;

(b) the materials and/or methods used in root canal treatment between 26 October and 5 November 2007;

(c) the justification for a bridge at LR6 to LR4 on 27 November 2007;

(d) the justification for root canal treatment on 4 March 2008;

(e) the materials and/or methods used in root canal treatment on 4 March 2008;

(f) an examination on 29 August 2008;

(g) withdrawn by the GDC;

(h) the materials and/or methods used in root canal treatment between 30 November and 15 December 2009;

(i) the materials and/or methods used in root canal treatment between 29 March and 5 May 2011;

(j) the materials and/or methods used in root canal treatment on 6 March 2014.

Patient M

68. You failed to take bitewing radiographs at appropriate intervals between 9 March 2007 and 15 March 2013.

69. You failed adequately to carry out and/or record an assessment of the health of the periodontal tissues between 9 March 2007 and 6 August 2009.

70. You failed adequately to carry out and/or record a base charting of the teeth between 9 March 2007 and 15 March 2013.

71. You failed adequately to diagnose and/or treat the patient's periodontal disease on:

(a) 18 May 2012;

(b) 15 March 2013.

72. You failed to provide adequate oral hygiene advice between 9 March 2007 and 15 March 2013.

73. Your record keeping was substandard in that you failed to keep any, or any adequate records in respect of:

    (a) an examination on 9 March 2007;

    (b) what occurred at an appointment on 16 August 2007;

    (c) an examination on 21 February 2008;

    (d) an examination on 18 September 2008;

    (e) an examination on 6 August 2009;

    (f) an examination on 18 March 2010;

    (g) an examination on 25 November 2010;

    (h) an examination on 13 June 2011;

    (i) an examination on 18 May 2012.

And that, by reason of the facts alleged, your fitness to practise is impaired by reason of:

    (a) misconduct; and/or

    (b) deficient professional performance."

On 3 November 2016 the Chairman made the following statement regarding the finding of facts:

Service and proceeding in the absence of the Registrant

Mr Findlay is neither present nor legally represented at the Professional Conduct Committee (PCC) hearing of his case scheduled between 24 October and 4 November 2016. In his absence, the Committee first considered whether the General Dental Council (GDC) had served the Notice of Hearing on Mr Findlay in accordance with Rules 13 and 65 of the GDC (Fitness to Practise) Rules Order of Council 2006 (the Rules).

The Committee has been provided with a bundle of documents which contains a copy of the Notice of Hearing dated 20 September 2016 from Capsticks Solicitors (acting on behalf of the GDC) to Mr Findlay. The Notice of Hearing was sent by special delivery and first class post to Mr Findlay at his registered address and was also emailed to him and to the MDDUS, his legal representatives, on 21 September 2016. The letter sets out the date, time and location of this hearing. The Royal Mail track and trace receipt confirms that the item was delivered to Mr Findlay's registered address on 21 September 2016 and was also signed for in the name of 'Findlay'. The Committee is satisfied that the Notice of Hearing letter sets out the information required in compliance with Rule 13 and that it was sent to Mr Findlay more than 28 days in advance of the hearing, also in accordance with Rule 13. Accordingly, the Committee is satisfied that service has been properly effected in accordance with Rules 13 and 65.

The Committee then went on to consider whether to hear this case in the absence of Mr Findlay, in accordance with Rule 54. Mr FitzGerald, on behalf of the GDC, invited the Committee to do so since the documents before it indicate that Mr Findlay is aware of this PCC hearing but has chosen not to attend or be represented. Mr FitzGerald referred to

several emails from the MDDUS to the GDC over the course of several months leading up to this hearing which stated that Mr Findlay has retired from dentistry, has no intention of returning to practise and would not be in attendance or be represented at the hearing. Further, MDDUS, on behalf of Mr Findlay, has not requested an adjournment of this hearing or sought to challenge the GDC's case against him. Mr FitzGerald also referred to the serious nature of the allegations against Mr Findlay and submitted that there is a public interest in proceeding with the hearing so as to deal with his case expeditiously.

The Committee considered the submissions made on behalf of the GDC. It accepted the advice of the Legal Adviser. It has borne in mind that the discretion to proceed in the absence of the respondent must be exercised with the utmost care and caution and that it must have in mind the need for fairness to Mr Findlay as well as to the GDC. MDDUS, in their letter to the GDC dated 6 October 2016 state: "We would draw to your attention, once again, that Mr Findlay will not attend the forthcoming hearing and does not wish to be represented at this hearing. There will be no defence disclosure. … He does not wish to engage simply because he has retired from dentistry and is now drawing his pension…". The Committee has concluded that Mr Findlay has voluntarily absented himself from this hearing. He has not sought an adjournment of this hearing and the Committee is of the view that an adjournment is unlikely to secure his attendance on a future occasion, given his stated intention that he does not wish to engage in these proceedings. Furthermore, the Committee, having regard to the serious nature of the allegations against Mr Findlay, is satisfied that there is a clear public interest in proceeding with the hearing to enable an expeditious disposal of Mr Findlay's case. It notes that the GDC is due to call several witnesses to give evidence this week and has had regard to the potential inconvenience to them, were the hearing not to proceed. Accordingly, the Committee decided that it is fair and just to proceed in the absence of Mr Findlay, in accordance with Rule 54. The Committee has drawn no adverse inference from Mr Findlay's non-attendance at this hearing.

Background to the case and summary of the GDC's case

The GDC alleges that Mr Findlay's fitness to practise is impaired by reason of his misconduct and/or deficient professional performance concerning his treatment of 13 patients (Patients A to M) at the Princes Street Dental Centre in Dundee (the Practice) between December 2006 and December 2014. The GDC's case arises from a report by the Clinical Director (Witness 1) to the GDC in March 2015 regarding concerns she had about Mr Findlay's practice. In view of her concerns Witness 1 decided to conduct her own investigation and did so by reviewing the clinical records of the patients treated by Mr Findlay on a single day in May 2014. She reported on her review of 15 sets of patient records and set out in writing a series of significant clinical concerns arising from her review.

Separately from Witness 1's report, the GDC received a complaint from Patient L in June 2015 and a complaint from Patient M in October 2015, concerning Mr Findlay's treatment.

The GDC's case is based on an expert report by Dr Igoe, a General Dental Practitioner, called on behalf of the GDC. This report on the patient records (Patients A to M) was supported by the witness statements of Patients L and M and their oral evidence. It is alleged that Mr Findlay failed to provide an adequate standard of dental care over the period between December 2006 and December 2014. Dr Igoe identified a number of common failings in Mr Findlay's practice concerning these patients, including a failure to take bitewing radiographs; a failure to carry out and/or record assessments of the health of periodontal tissues, such as in the form of a basic periodontal examination (BPE) or any other recording of the pocket depths around the teeth; a failure to carry out adequate investigations; a failure

to carry out root canal treatment (RCT) to an adequate standard; inappropriate prescribing of antibiotics; a failure to report adequately on radiographic investigation and a failure to keep adequate records. The GDC contends that Mr Findlay's failures resulted in poor outcomes or harm to his patients.

Amendment of the charges

At the close of the GDC's case Mr FitzGerald made an application under Rule 18(1) to amend the charges as follows:

> Charge 15 - amend 'on' to 'between 15 and' so that the charge reads: 'You failed to conduct adequate investigation of the suitability of UR1 and UL1 for crowns by means of radiographic examination between 15 and 27 May 2008.'
>
> Charge 17(e) – amend '2' to '12' so that the date reads: '12 February 2014'
>
> Charge 21(b) – delete the words 'and/or a vitality test' so that the charge reads: 'of UR4 in preparation for a new crown by means of a new periapical radiograph between 10 and 24 October 2011.'
>
> Charge 26 – amend '1' to '15' so that the date reads: '15 and 28 August 2014.'
>
> Charge 63(a) – delete 'and/or you did not obtain radiographs of a diagnostic standard necessary to prepare the teeth for a new bridge' so that the charge reads: 'of the fitting of a bridge from LR6 to LR4 between 27 November and 11 December 2007, in that study models were not taken sufficiently far in advance to assist with the design of the bridge.'
>
> Charge 67(g) – delete this paragraph.

Mr FitzGerald made this application in the light of Dr Igoe's evidence. He submitted that some of the proposed amendments effectively reduced the criticisms against Mr Findlay and/or amounted to amendments to the dates, which were apparent from reading the patients' records. The Committee accepted the advice of the Legal Adviser. It was satisfied that the amendments could be made without injustice. Accordingly, the Committee acceded to Mr FitzGerald's application.

While in camera deliberating on the facts, the Committee identified some further errors in relation to the dates. It therefore proposed to amend the charges to incorporate the correct dates as follows:

> Charge 21(b) – delete '10' and amend the date to read '5 and 24 October 2011'
>
> Charge 52(g) – amend the date to read '17 March 2010'

The Committee resumed in open session and invited Mr FitzGerald to comment on the proposed amendments. He agreed to the changes and the Committee concluded that the amendments could be made without prejudice to Mr Findlay.

Evidence

The Committee has been provided with a bundle of documents submitted by the GDC. In addition, the Committee received oral evidence from Patient L and Patient M. They confirmed the content of their signed witness statements. The Committee considered that both patients gave clear and consistent evidence in respect of their treatment by Mr Findlay and has accepted their evidence.

The Committee received expert opinion evidence from Dr Igoe. He produced a report dated 18 August 2016 in which he set out his conclusions relating to the care provided for Patients A to L. He provided a second report, also dated 18 August 2016, in which he set out his opinion regarding Patient M. At the outset of his oral evidence, Dr Igoe confirmed the opinions set out in his reports for each of the patients, which had been based on his assessment of the patients' notes and any radiographic evidence that was available. The Committee also had the benefit of the patients' records and, having independently examined them, came to most of the same conclusions as Dr IgoeAanti. As part of his evidence Dr Igoe referred to various relevant standards, including the following:

- The GDC's Standards for Dental Professionals
- The Faculty of General Dental Practitioners' guidance on the following: 'Selection Criteria for Dental Radiography'; 'Standards in Dentistry'; 'Clinical Examination and Record Keeping' and 'Antimicrobial Prescribing for General Dental Practitioners and
- The Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).

Dr Igoe's opinions in respect of the shortcomings regarding Mr Findlay's treatment of Patients L and M were supported by their oral evidence as well as the patients' notes. For example, in her oral evidence Patient L was clear that Mr Findlay did not insert a rubber dam in her mouth at any time. Dr Igoe explained to the Committee that in his experience, patients would be able to remember if a rubber dam had been used. Patient M gave consistent and reliable evidence in line with his witness statement. The Committee noted that in certain cases, Dr Igoe revised his opinion in the light of the evidence. Overall, it considered that he gave a fair, balanced and objective opinion and it has accepted his evidence. However, on occasions where the Committee has not accepted the evidence of Dr Igoe, it has set out it reasons.

No defence documents have been provided on behalf of Mr Findlay. However, in their letter dated 14 October 2016, MDDUS stated that Mr Findlay accepted the criticisms set out in Dr Igoe's report regarding, for example radiographic practices, periodontal care and record keeping.

Committee's findings of fact

The Committee has considered all the evidence presented to it, both oral and written. It has also considered the submissions made by Mr FitzGerald on behalf of the GDC.

The Committee has accepted the advice of the Legal Adviser. In accordance with that advice it has considered each charge separately. The Committee is aware that the burden of proof rests with the GDC, and that Mr Findlay need not prove anything. It has considered each charge against the civil standard of proof, namely, the balance of probabilities.

The Committee has read all of the patient notes and considered the available radiographs which were said to be applicable to each charge before reaching its own independent findings.

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

1.	Found proved The documentary evidence before the Committee establishes that Mr Findlay practised in general dentistry at the Practice and he provided care and

	treatment to Patients A to M between about December 2016 and December 2014.
2.	Found proved The patient records confirm that Patient A was under Mr Findlay's care between 7 June 2007 and 10 December 2014, during which time Patient A attended for 11 examinations. Dr Igoe noted that there was a reference in Patient A's notes to one bitewing radiograph having been taken on the left hand side of Patient A's mouth on 6 September 2010. The Committee saw two undated bitewing radiographs at pages 46 and 47 of the clinical records and both related to the left hand side of the mouth. The Selection Criteria for Dental Radiography Guidance (the Guidance) provided by the Faculty of General Dental Practitioners is that bitewing radiographs should be taken at new examinations and thereafter every two years. Dr Igoe explained that the taking of radiographs is an essential part of the examination and continuing care of the patient so as to diagnose problems early. He was critical of the omission of regular bitewing radiographs. The Committee considers that the taking of two radiographs over the course of 7 years and over the course of 11 examinations does not accord with the Guidance and amounts to an inadequate standard.
3.	Found proved Dr Igoe's evidence was that there is no recording of the health of the periodontal tissues and there is no recording of any findings of the examination. The Committee found no recording in the patient's records.
4.(a)(i)	Found proved There is no radiographic evidence that a rubber dam was used during root canal treatment for this patient and there is no reference to it in Patient A's notes. If a rubber dam were present, the clamp used to retain the dam on the tooth would be visible on a radiograph taken during the root canal treatment. Dr Igoe's evidence is that patients would remember if a rubber dam had been used. Patient L told the Committee that she had no recollection of a rubber dam being used in her mouth during five root canal treatments. The Committee accepts Patient L's evidence and considers that it is more likely than not that it was Mr Findlay's habitual practice not to use a rubber dam. Accordingly, the Committee finds this charge proved.
4.(a)(ii)	Found not proved Dr Igoe's opinion was that the notes do not record the use of a suitable irrigant. He went on to explain in his oral evidence that the poor outcomes of many of the root canal treatments on Patients A to L strongly suggested that no suitable irrigant was used. He also gave his opinion that suitable irrigants could not be used where a rubber dam was not applied. The Committee considered that it was possible, in certain circumstances, to use irrigant solutions without a rubber dam, but with other methods of isolation.
4.(a)(iii)	Found proved There is a note in Patient A's records of the size and taper of files used. However, there is no record of the working length for this tooth. Dr Igoe's

	opinion is that there is no evidence 'that a suitable method of ascertaining the working length of the tooth was used'.
4.(a)(iv)	Found proved Dr Igoe referred to a later periapical radiograph which shows large areas of radiolucency at the apices of both roots. The root fillings visible on this radiograph are very short of the apices of LL6 and therefore indicative of deficiency in the obturation of the root canals.
4.(b)(i)	Found proved This is for similar reasons as set out at Charge 4(a)(i).
4.(b)(ii)	Found not proved This is for similar reasons as set out at Charge 4(a)(ii).
4.(b)(iii)	Found not proved The UR7 was root filled on 10 February 2010. The notes record the estimated or actual working length of each of the canals for three separate roots along with a recording of the width and the taper of the instruments used. Dr Igoe's opinion was that there was no indication that a suitable method was used to ascertain the working length of the tooth. He explained that it is normal either to take a radiograph to measure the working length or to use an apex locator which does not rely on a radiograph being taken. The Committee accepts that Mr Findlay carried out and recorded measurements of the working length based on the records of 10 February 2010 of three roots measured at 21, 20 and 20mm respectively. The Committee cannot be sure on the balance of probabilities that Mr Findlay did not use a suitable method to ascertain the working length of the tooth.
4.(c)(i)	Found proved This is for similar reasons as set out at Charge 4(a)(i).
4.(c)(ii)	Found not proved This is for similar reasons as set out at Charge 4(a)(ii).
4.(c)(iii)	Found not proved This is for similar reasons as set out at 4(b)(iii).
4.(d)(i)	Found proved The Committee has seen a copy of a diagnostic radiograph dated 16 April 2012, which shows that no dam clamp was present. In addition, the Committee has also had regard to its similar reasons as set out at Charge 4(a)(i).
4.(d)(ii)	Found not proved This is for similar reasons as set out at Charge 4(a)(ii).
4.(d)(iii)	Found not proved This is for similar reasons as set out at Charge 4(b)(iii).

5.(a)	Found proved Patient A attended for an appointment on 23 August 2010 and the notes record: "Complained of sensitivity UL6. Oral hygiene fair. Has had swelling LL6. Prescribed amoxicillin 500mg re LL6 as a precaution." Dr Igoe's opinion was that the prescription of the Amoxicillin was inappropriate as a way of treating the patient's presenting pain as it was not prescription as an adjunct to an attempt to alleviate the patient's pain and the source of infection. His opinion was that no attempt had been made by Mr Findlay to investigate the swelling and no clinical observations other than the presence of swelling are in the notes. Dr Igoe referred to the 'Antimicrobials Prescribing for General Dental Practitioners' (2012), section 3.1, which sets out the three scenarios where antimicrobial prescribing in primary care is appropriate. The Committee has accepted Dr Igoe's evidence that none of the scenarios were indicated in this case.
5.(b)	Found proved The Committee accepts Dr Igoe's opinion on this matter for similar reasons to those set out at Charge 5(a).
5.(c)	Found proved A crown was fitted to the UR2 and a course of Metronidazole was prescribed. There is no record in the patient's notes as to reasons why Mr Findlay prescribed antibiotics on this occasion. The Committee accepts Dr Igoe's opinion that the prescription of antibiotics on this occasion was inappropriate for similar reasons to those set out at Charge 5(a).
5.(d)	Found not proved The notes for 12 March 2012 record: "Complained of swelling UR2. One radiograph Grade 1 area UR2 not resolved. Has Amoxicillin from King's Cross. Prescribed Metronidazole 400mg x 15. Ref. DDH re apicect." Dr Igoe's opinion was that the prescribing of further antibiotics on this occasion was inappropriate as it was not an adjunct to treatment but treatment itself. However, the Committee considers that due to a post crown being in situ it would not have been possible to access the root canal and the infection and that it was a reasonable course of action to prescribe Metronidazole pending Patient A's referral to specialist services.
6.(a) – 6(d).	Found proved There is no evidence of a clinical evaluation or findings of the radiograph that was taken for each of these dates.
7.(a)	Found proved There is a record of dental charting that took place on 7 June 2007 and there is reference to a treatment plan. However, there are no medical or social histories; no soft tissue and temporo-mandibular joint (TMJ) assessment; and no periodontal assessment. Dr Igoe was critical of the standard of record keeping for that appointment. He noted that there is no recording of the health of the periodontal issues or any recording of any finding of the examination, including an examination of the soft tissues and presence of any disease or

	pathology. Dr Igoe referred to the relevant standards as set out in the GDC's 'Standards for the Dental Team' and the guidance set out in the Faculty of General Dental Practitioners. Dr Igoe's opinion was that Mr Findlay should have recorded positive or negative findings, or 'NAD' if there is no issue. No such findings are recorded in Patient A's clinical notes. He explained that where a dentist fails to record such findings it is not possible for the dentist, or any subsequent treating dentist, to determine the health of the dental tissues at a particular time, and this can have a significant impact on future treatment. There is no specific recording in the notes of the examination of 7 June 2007 having taken place, apart from a fee claim reference. The Committee accepts Dr Igoe's opinion that the record keeping was substandard given the absence of information set out above.
7.(b)	Found proved The LL6 was root filled on 29 June 2007. There is no record of the treatment details from the appointments between 29 June 2007 and 15 August 2007. The Committee has also had regard to Dr Igoe's overall criticism of Mr Findlay's record keeping as set out at Charge 7(a).
7.(c) – 7.(d)	Found proved This is for similar reasons as set out at Charge 7(a).
7.(e)	Found proved Except for a record of the BPE score, there is no record in the notes of any other findings.
7.(f)	Found proved The Committee considered the notes relating to the root canal treatment to UR7. They were unable to find any reference to materials and/or methods used, other than a note that the tooth was temporised with Cresophene and cotton wool.
7.(g)	Found proved There is a note in the records that the patient attended, complaining of sensitivity at UL6. It further states: "OH fair. Has had swelling LL6 …". Dr Igoe was critical of the absence of any findings in the records concerning the swelling at LL6. The Committee has also had regard to Dr Igoe's overall criticism of the record keeping as set out at Charge 7(a).
7.(h)	Found proved This is for similar reasons as set out at Charge 7(f).
7.(i) – 7.(k)	Found proved This is for similar reasons as set out at Charge 7(a).
7.(l)	Found proved This is for similar reasons as set out at Charge 7(f).
8.	Found proved

	The documentary evidence before the Committee establishes that Mr Findlay provided treatment to Patient B between 22 May 2012 and 28 November 2014. Dr Igoe's opinion was that part of the examination of a new patient should have included, as a minimum, bitewing radiographs. There is no evidence in the clinical records of bitewing radiographs having been taken for this period. He referred to the presence of caries at LL6 in 2013, which, he said, would have been diagnosed had Mr Findlay taken bitewing radiographs routinely.
9.(a)	Found proved Dr Igoe's opinion was that the vitality of the UL5 should have been assessed and impressions taken for study models to determine the suitability of the remaining teeth for the bridge. He considered that 'the bare minimum' that should have occurred was a radiographic examination into the health of the UL5. There is nothing in the clinical records to show that radiographs and/or study models were done. The Committee accepts Dr Igoe's opinion on this matter.
9.(b)	Found proved There is no evidence in the clinical notes of a radiographic examination having taken between 26 August and 9 September 2014.
10.(a)	Found proved This is for similar reasons as set out at Charge 4(a)(i).
10.(b)	Found not proved This is for similar reasons as set out at Charge 4(a)(ii).
10.(c)	Found not proved This is for similar reasons as set out at Charge 4(b)(iii).
10.(d)	Found proved Dr Igoe referred to radiographic evidence which shows the gutta percha point in the distal canal a considerable distance from the apex of the tooth, which indicated that the obturation of the canal was deficient. He opined that the standard of the root canal treatment fell far below the standard expected of a reasonably competent dentist as the prognosis of the tooth was adversely affected by the inadequate obturation of the distal canal. The Committee agrees with Dr Igoe.
11.(a)	Found proved Patient B's first appointment with Mr Findlay took place on 22 May 2012. An extensive examination was recorded as having been carried out and the notes record: "Complained of nil. OH fair.' A base charting of the teeth was recorded and the BPE scores were also recorded with scores of 212 and 222. Dr Igoe was critical of the absence of the recording of any findings of the examination, such as the soft tissues and presence or absence of any disease or pathology. The Committee accepts Dr Igoe's opinion on this matter and has also had regard to its similar reasons set out at Charge 7(a).

11.(b)	Found not proved The notes record 'No LA' on 3 July 2013. Dr Igoe's opinion was that it would have been difficult to have restored the LL6 without the use of local anaesthetic. He was critical of Mr Findlay's failure to record the type of anaesthetic used and the dose. However, the Committee has seen from the clinical notes that Patient C has a history of not having local anaesthetic. In its judgement, there may be occasions where a patient chooses not to have local anaesthetic. In this situation, there is a clear record to the effect that local anaesthetic was not given. In these circumstances, the Committee finds no criticism in Mr Findlay not recording the type and dose of local anaesthetic used.
11.(c)	Found proved This is for similar reasons as set out at Charge 7(f).
12.	Found proved In relation to this patient and the dates, the Committee's reasons are similar to those given at Charge 2.
13.	Found proved This is for similar reasons as set out at Charge 3.
14.(a)(i)	Found proved This is for similar reasons as set out at Charge 4(a)(i).
14.(a)(ii)	Found not proved This is for similar reasons as set out at Charge 4(a)(ii).
14.(a)(iii)	Found proved This is for similar reasons as set out at Charge 4(a)(iii).
14.(b)(i)	Found proved This is for similar reasons as set out at Charge 4(a)(i).
14.(b)(ii)	Found not proved This is for similar reasons as set out at Charge 4(a)(ii).
14.(b)(iii)	Found proved This is for similar reasons as set out at Charge 4(a)(iii).
15.	Found proved Dr Igoe could find no evidence of a radiograph having been taken on 27 May 2008. He was critical of Mr Findlay's failure to take a pre-operative radiograph of the UR1 and UL2 for crowns. The Committee accepts Dr Igoe's opinion on this matter.
16.	Found proved This is for similar reasons as set out at Charge 5(a).

17.(a) to 17.(f)	Found proved There is reference in Patient C's notes to a radiograph having been taken at each of these appointments but there is no report on any of them in the notes.
18.(a)	Found proved Root canal fillings were placed on the UR1 and UL7 and composite restorations were placed on the UR1, UL1 and UL2. The notes for 20 August 2007 state: 'RCT 80 + side packed'. Apart from this, there is no reference to the materials and/or methods used.
18.(b) – 18.(c)	Found proved It is not possible to establish from the notes for these appointments what occurred.
18.(d)	Found proved This is for similar reasons as set out at Charge 7(f).
19.	Found proved This is for similar reasons as set out at Charge 2.
20.	Found proved This is for similar reasons as set out at Charge 3.
21.(a)	Found proved Dr Igoe commented that on 30 June 2008 one periapical radiograph was taken, which showed a significant amount of bone loss around the area of the UR6 and UR7. However, there is nothing in the clinical notes to demonstrate that Mr Findlay investigated a problem with Patient D's periodontal tissues between the areas of the UR6 and UR7.
21.(b)	Found proved The notes for 5 October 2011 state that Patient D "Complained of crown out. UR4 post fractured. Impression for new porcelain bonded crown and post. A2" Dr Igoe considered that the UR4 should not have been prepared for a new post crown without taking a periapical radiograph. The undated periapical radiograph shows a significant amount of bone loss at the UR4 and the prognosis for this tooth was therefore poor.
22.(a)	Found proved The notes record that a prescription for Amoxicillin was given for sinusitis. Dr Igoe's evidence was that this prescription was inappropriate in that a dentist should not prescribe for sinusitis.
22.(b)	Found proved The notes record: '… Prescribed Amoxicillin 500mg x 15 tablets'. Dr Igoe considered that the prescribing of antibiotics in these circumstances was inappropriate in that they were not an adjunct to treatment.
23.(a)	Found proved

	The clinical notes indicate that two radiographs were taken but there is no report on the findings of them. Dr Igoe's opinion was that Mr Findlay's failure to report on the radiographs was contrary to IRMER regulations.
23.(b)	Found proved A bitewing radiograph was taken on the left hand side. However, there is no report of the radiograph, contrary to IRMER regulations.
24.(a) – 24.(c)	Found proved This is for similar reasons as set out at Charge 7(a).
24.(d)	Found proved The notes indicate that a course of tooth whitening was proposed on 30 June 2008. It was completed on 14 July 2008. The Committee notes that there was nothing in the records concerning advice given, how the whitening was undertaken and the materials that were used. The Committee accepts Dr Igoe's criticisms that there was "absolutely no detail regarding this treatment" in the patient's records.
24.(e)	Found proved This is for similar reasons as set out at Charge 7(a).
24.(f)	Found proved. Patient D attended for an examination on 14 February 2012. The clinical record show a BPE score but no other findings.
24.(g)	Found proved This for similar reasons as set out at Charge 7(a).
24.(h)	Found not proved There is no evidence to satisfy the Committee that anaesthetic was used at all during the appointment of 29 September 2014. Given the uncertainty as to whether local anaesthetic was used, the Committee is not satisfied that this charge is proved to the requisite standard.
25.	Found proved Patient E first attended an appointment with Mr Findlay on 15 August 2014. Dr Igoe's opinion was that, as a new patient, Patient E should have undergone a radiographic examination in the form of bitewing radiographs. He also referred to the notes which referred to caries being present on Patient E's teeth, which should have prompted further investigation by way of radiographs. The Committee accepts Dr Igoe's opinion and could find no evidence that Mr Findlay took radiographs at that first appointment.
26.	Found proved as amended The Committee has examined the clinical records of Patient E's appointments between 1 and 28 August 2014 concerning LL6. The records show that caries was not identified or treated. However, caries was identified at LL6 on a subsequent bitewing radiograph taken in December 2014. The notes record

	carious lesion (composite LL6) but Mr Findlay failed to identify fully the caries and to treat it and there is no evidence in the notes that he did so.
27.	Found proved This is for similar reasons as set out at Charge 2.
28.	Found proved This is for similar reasons as set out at Charge 3.
29.(a) - 29.(c)	Found proved This is for similar reasons as set out at Charge 7(a).
29.(d)	Found proved The Committee notes that the clinical record shows a note of a BPE and bleeding gums. Save for this entry, there is no other information regarding the examinations contained in the patient's clinical notes. In the Committee's view, the record keeping was substandard.
29.(e) – 29.(h)	Found proved These are for similar reasons as set out at Charge 7(a).
30.	Found proved This is for similar reasons as set out at Charge 2.
31.	Found proved This is for the similar reasons as set out Charge 2.
32.	Found proved This is for similar reasons as set out at Charge 3.
33.(a)	Found proved Mr Findlay did not take a pre-operative radiograph prior to commencing root canal treatment, so he was unable to assess the suitability of UL5. Dr Igoe referred to a later periapical radiograph taken on 8 September 2014 which showed "a very hazardous root morphology", thus necessitating root canal filling by a specialist practitioner. There was nothing in the dental records regarding any assessment of the UL5 or the Registrant recording any concerns regarding the prognosis for this tooth or the difficulty of carrying out the treatment due to the root morphology.
33.(b)	Found proved Mr Findlay took a pre-operative radiograph on 8 September 2014. He recorded in the notes: "One radiograph Grade 1. Area UL5 and old root canal treatment but acute bends in roots." Dr Igoe's evidence was that, despite having taken a radiograph, Mr Findlay did not adequately investigate the suitability of Patient H's UL5 root, given the difficulties due to the root morphology which should have triggered a specialist referral.
34.(a)(i)	Found proved

	This is for the similar reasons set out at Charge 4(a)(i).
34.(a)(ii)	Found not proved This is for the similar reasons set out at Charge 4(a)(ii)
34.(a)(iii)	Found proved Dr Igoe found no evidence that Mr Findlay used a suitable method to ascertain the working length of the tooth. There is a record of an approximate length [≈ 17mm] in Patient H's notes. However, in the Committee's view, this was inadequate in that no further investigation was undertaken.
34.(a)(iv)	Found not proved The Committee was not satisfied that there was any radiographic evidence, relating to the dates concerned, which could support a finding that there was deficient obturation in Patient H's UR5.
34.(b)(i)	Found proved This is for similar reasons as set out at Charge 4(a)(i).
34.(b)(ii)	Found not proved This is for similar reasons as set out Charge 4(a)(ii).
34.(b)(iii)	Found not proved This is for similar reasons as set out at Charge 4(b)(iii).
34.(b)(iv)	Found proved Dr Igoe referred to the final fill radiograph available which, in his opinion, showed a very poorly obturated root canal with a significant deviation on the canal.
34.(c)(i)	Found proved This is for similar reasons as set out at Charge 4(a)(i).
34.(c)(ii)	Found not proved This is for similar reasons as set out Charge 4(a)(ii)
34.(c)(iii)	Found not proved This is for the similar reasons as set out at Charge 4(b)(iii).
34.(c)(iv)	Found not proved Dr Igoe's evidence was that the final fill radiograph showed the mesial root was poorly obturated. He was of the view that there was no indication as to what materials were used to obturate the canal. The Committee considered carefully the same radiograph but it was unable to see clearly the position of the apex and therefore it could not assess properly the obturation of the root canal.
34.(d)(i)	Found proved This is for similar reasons set out at Charge 4(a)(i).

34.(d)(ii)	Found not proved This is for similar reasons as set out at Charge 4(a)(ii).
34.(d)(iii)	Found proved This is for similar reasons as set out at Charge 4(a)(iii).
35.(a) – 35.(b)	Found proved These are for similar reasons as set out at Charge 5(a).
36.(a) – 36.(d)	Found proved These are for similar reasons as set out at Charge 6.
37.(a) – 37.(d), 37 (f), 37(i) - 37(k)	Found proved These are for similar reasons as set out at Charge 7(a).
37.(e), 37.(g) - 37.(h) and 37.(l),	Found proved These are for similar reasons as set out at Charge 7(f).
38.	Found proved These are for similar reasons as set out at Charge 2.
39.	Found proved These are for similar reasons as set out at Charge 3.
40.(a) – 40.(b)	Found proved No radiographs were taken between the dates alleged in this charge and accordingly the Committee finds these charges proved.
41.(a)	Found proved These are for similar reasons as set out at Charge 4(a)(i).
41.(b)	Found not proved These are for similar reasons as set out at Charge 4(a)(ii).
41.(c)	Found proved The Committee notes that there are no measurements recorded, whereas for other patients, Mr Findlay has made a note of the measurements. Dr Igoe's evidence is that the records do not indicate that a suitable method was used to ascertain the working length of the root. The Committee agrees.
41.(d)	Found not proved Dr Igoe's criticism is based on Mr Findlay having to repeat the root filling so

	soon after the initial root canal treatment (a matter of some four months), which, he said, would indicate that the initial treatment was not satisfactory. He accepted that he was unable to determine the standard of the root canal treatment as there are no radiographs available and he also agreed that the poor standard of record keeping did not assist on this matter. The Committee considers that it is unable to judge the adequacy of the root canal treatment in the absence of a post-operative radiograph and the absence of any written explanation as to why the root canal treatment had to be repeated.
42.	Found proved Dr Igoe's evidence was that there was no record of the baseline charting or subsequently of any restoration being present on the LR3. He was concerned that there was no record in the notes as to the clinical justification for the crown on LR3 as well as Mr Findlay's failure to take pre-operative radiographs of the tooth. The Committee accepts Dr Igoe's evidence that Mr Findlay placed a crown on LR3 without adequate justification between 22 January and 5 February 2010.
43.	Found not proved The clinical notes confirm that Mr Findlay prescribed 400mg of Metronidazole to Patient I on 19 March 2007. On that occasion Mr Findlay administered anaesthetic to perform root canal treatment. The treatment procedure was not in fact completed because the tooth was so painful, and further treatment was planned.
44.(a) - 44.(c)	Found proved The Committee has found no reports of the radiographs taken on these dates.
45.(a)	Found proved This is for similar reasons as given at Charge 7(f).
45.(b), 45.(d) – 45.(i) & 45.(k) – 45.(l)	Found proved This is for similar reasons as given at Charge 7(a).
45.(c)	Found proved The Committee found no justification in the clinical records for re-treating LR4 on 30 October 2007, the original root treatment having been done on 25 April 2007.
45. (j)	Found not proved No examination is recorded for that date because an examination had been carried out on 5 November 2010.
46.	Found proved This is for similar reasons as set out at Charge 2.
47.	Found proved

	This is for similar reasons as set out at Charge 3.
48.(a)	Found proved This is for similar reasons as set out at Charge 4(a)(i).
48.(b)	Found not proved This is for similar reasons as set out at Charge 4(a)(ii).
48.(c)	Found not proved This is for similar reasons as set out at Charge 4(b)(iii).
49.	Found proved The clinical notes of 5 January 2009 record "perio abcess". However, there is nothing in the notes to indicate what steps were taken to investigate it apart from a periapical radiograph. The Committee found this to be inadequate investigation of the cause and symptoms of the abscess.
50.	Found proved This is based on Mr Findlay's failure to investigate the cause and symptoms of the abscess.
51.(a) - 51.(b)	Found proved These are for similar reasons as set out at Charge 6
52.(a) - 52.(c), 52.(f) - 52.(g)	Found proved These are for similar reasons as set out at Charge 7(a).
52.(d)	Found proved In the clinical notes for 4 June 2008 a root canal at UR2 is recorded but no justification has been noted.
52.(e)	Found proved This is for similar reasons as set out at Charge 7(f).
53.	Found proved This is for similar reasons as set out at Charge 2.
54.	Found proved This is for similar reasons as set out at Charge 3.
55.(a)	Found proved In the clinical notes dated 3 March 2009 there is no reference to the suitability for a new crown at UR3 and there is no radiograph recorded.
55.(b)	Found proved The clinical records for 18 January 2010 to 25 January 2010 refer to the provision of a bridge from UR1 to UL3. No radiographs are recorded and no

	study models appear to have been taken.
56.(a)(i)	Found proved This is for similar reasons as set out at Charge 4(a)(i).
56.(a)(ii)	Found not proved This is for similar reasons as set out at Charge 4(a)(ii).
56.(a)(iii)	Found not proved This is for similar reasons as set out at Charge 4(b)(iii).
56.(b)(i)	Found proved This is for similar reasons as set out at Charge 4(a)(i).
56.(b)(ii)	Found not proved This is for similar reasons as set out at Charge 4(a)(ii).
56.(b)(iii)	Found not proved This is for similar reasons as set out at Charge 4(b)(iii).
56.(b)(iv)	Found proved This is for similar reasons as set out at Charge 4(a)(iv).
57.	Found proved This is for similar reasons as set out at Charge 5(a).
58.(a) – 58.(c)	Found proved This is for similar reasons as set out at Charge 6.
59.(a) – 59.(d), 59(g) and 59 (j)	Found proved This is for similar reasons as set out at Charge 7(a).
59.(e) & 59(f)	Found proved This is for similar reasons as set out at Charge 18(b).
59.(h) & 59.(k)	Found proved These are for similar reasons as set out at Charge 7(b).
59.(i)	Found proved The Committee found no justification recorded in the notes for preparing UL4 and UL5 for crowns on 26 April 2010.
60.	Found proved This is for similar reasons as set out at Charge 2.
61.	Found proved

	This is for similar reasons as set out at Charge 3.
62.(a)(i)	Found proved Patient L was clear in her evidence that she had no recollection of Mr Findlay using a rubber dam on any of the 5 occasions when he performed root treatments. In addition, this is for similar reasons as set out at Charge 4(a)(i).
62.(a)(ii)	Found not proved This is for similar reasons as set out at Charge 4(a)(ii).
62.(a)(iii)	Found proved This is for similar reasons as set out at Charge 4(a)(iii).
62.(a)(iv)	Found not proved Dr Igoe's criticism was based on a radiograph taken on 6 March 2014, which, he said, showed deficient obturation of the root canal. The Committee considers that the radiograph dated 6 March 2014 is not sufficiently clear to indicate that the obturation of the root canal was deficient.
62.(b)(i)	Found proved This is for similar reasons as set out at Charge 62(a)(i).
62.(b)(ii)	Found not proved This is for similar reasons as set out at Charge 4(a)(ii).
62.(b)(iii)	Found not proved There is a reference in Patient L's notes dated 4 March 2008 to a working length of 21 mm. In addition, Dr Igoe noted that two radiographs had been taken, the purpose of which, he said, would have been to assist with the determination of an estimated working length.
62.(b)(iv)	Found proved The Committee has seen a copy of a radiograph dated 5 May 2011 which shows a perforated root.
62.(c)(i)	Found proved This is for similar reasons as set out at Charge 62(a)(i).
62.(c)(ii)	Found not proved This is for similar reasons as set out at Charge 4(a)(ii).
62.(c)(iii)	Found not proved This is for similar reasons as set out at Charge 4(b)(iii).
62.(c)(iv)	Found proved Dr Igoe referred to the radiograph 17 July 2012, which, in his opinion, showed a poorly obturated root canal that was significantly short of the apex. The Committee, having seen a copy of that radiograph, agrees with Dr Igoe.

62.(d)(i)	Found proved This is for similar reasons as set out at Charge 62(a)(i).
62.(d)(ii)	Found not proved This is for similar reasons as set out at Charge 4(b)(iii).
62.(d)(iii)	Found not proved This is for similar reasons as set out at Charge 4(a)(ii).
62.(d)(iv)	Found proved Dr Igoe referred to the subsequent radiograph of the LL3 which showed that the root filling appears to be short of the apex. The Committee, having seen a copy of that radiograph, agrees with Dr Igoe.
62.(e)(i)	Found proved This is for similar reasons as set out at Charge 62(a)(i).
62.(e)(ii)	Found not proved This is for similar reasons as set out at Charge 4(a)(ii).
62.(e)(iii)	Found not proved This is for similar reasons as set out at Charge 4(b)(iii).
62.(e)(iv)	Found proved Dr Igoe referred to the radiograph of UL3 dated 6 March 2014 which shows the root filling on UL3 without the post in place. In his opinion, the radiograph demonstrates that the root filling was deficient. The Committee, having seen a copy of the radiograph, agrees with Dr Igoe.
63.(a)	Found proved Patient L attended an appointment with Mr Findlay on 27 November 2007. The notes record that Mr Findlay took study models at the same time as the LR6 and LR4 were prepared for the bridge. Dr Igoe's opinion is that study models should have been done at the assessment stage to assist in the design of the bridge, as was the situation in this case. The Committee, having regard to the timing of the appointment (30 minutes) set out in Patient L's notes, agrees with Dr Igoe's opinion. It considers that Mr Findlay would not have had sufficient time between taking the study models and preparing the teeth for the bridge.
63.(b)	Found proved This has been found proved for the similar reasons set out at Charge 63(a).
64.(a) – 64.(d)	Found proved The patient's clinical notes record that Patient L attended appointments on 12 November 2007; 1 December 2011; 17 July 2012 and 28 September 2012 when, on each of these occasions, antibiotics were prescribed (Metronidazole). Dr Igoe's evidence was that antibiotics should not be prescribed as a means of dealing with a patient's presenting pain and should only be used as adjunct to treatment. He considered that there was no clinical justification for the

	prescribing of antibiotics on any of these occasions; there is nothing recorded in the clinical notes to indicate to Dr Igoe took steps to find out the cause of the pain, and to treat it. The Committee has accepted Dr Igoe's opinion.
65.(a) – 65.(h)	Found proved The patient's clinical notes record that radiographs were taken on the relevant dates. Having scrutinised the patient's notes carefully, the Committee could find no report of the findings of the radiographs. Dr Igoe's evidence is that Mr Findlay's failure to report on radiographic investigation for each of these occasions is contrary to IRMER regulations.
66.(a) – 66.(d)	Found proved Patient L was clear in her oral evidence that Mr Findlay did not discuss with her treatment plans or options at any time. She had no recollection of Mr Findlay discussing with her the carrying out of root canal treatment. In her witness statement Patient L says that no treatment options were explained to her. Dr Igoe noted from the dental records that Patient L attended for approximately 40 courses of treatment with Mr Findlay. There was no evidence in the records of any discussions with her regarding the treatment options available or any reasonable alternatives that might have been open to her. The Committee has seen only one entry in Patient L's notes dated 27 March 2013, which relates to the issues of consent. In that entry Mr Findlay records that he discussed root canal treatment or extraction of UR6. It considers that this entry alone is insufficient to satisfy it that Mr Findlay had obtained Patient L's informed consent. The Committee has accepted the evidence of Patient L and that of Dr Igoe and finds that Mr Findlay failed to obtain informed consent for the treatments set out at Charges 66(a) to 66(d).
67.(a)	Found proved Patient L attended for an appointment on 26 October 2007 and root canal treatment was started on LR4. Dr Igoe was critical of the absence of any record regarding the reason for the attendance, the patient's attending complaint or the findings of the examination that would indicate why the LR4 required root canal treatment.
67.(b)	Found proved There is no record of the materials and/or methods used in root canal treatment between 26 October 2007 and 5 November 2007.
67.(c)	Found proved Patient L attended for an appointment on 27 November 2007 when a treatment plan was formulated, a radiograph was taken and study models were taken. The Committee is satisfied that the record keeping was substandard in that there was no justification recorded for the bridge in advance of its preparation.
67.(d)	Found proved There is no record of the justification for root canal treatment on 4 March 2008.
67.(e) &	Found proved

67(h)	There is no indication in the records as to the materials and/or methods used in root canal treatment for the dates set out in the charge.
67.(f)	Found proved Patient L attended for an examination on 29 August 2008. No findings of the examination were recorded.
67(i) – 67(j)	Found proved These are for similar reasons as set out at charge 7(f).
68.	Found proved Dr Igoe explained that bitewing radiographs should be taken at new examinations and thereafter every two years. He could find no evidence that bitewing radiographs were taken between 9 March 2007 and 15 March 2013. The Committee notes that following Patient M's move to a new practice in 2013, the new treating dentist discovered a significant amount of periodontal disease. This supports Dr Igoe's evidence that had bitewing radiographs been taken at appropriate intervals, the periodontal disease and the extent of the bone loss would have been identified at an earlier stage.
69.	Found proved Patient M thought that around 2004 Mr Findlay might have used a dental probe to check his teeth on one occasion only.
70.	Found proved The Committee considered the clinical notes and was unable to find a base chart at any point.
71.(a)	Found proved The clinical notes for 18 May 2012 include a BPE charting, showing scores of 2 1 2 2 1 2 and record a scale and polish. The BPE scores from a subsequent treating dentist on 8 October 2013 were 3 3 4 3 3 4 As only 17 months had elapsed between these appointments, the Committee agrees with Dr Igoe's opinion that it was highly unlikely that such a deterioration could have occurred in this period.
71.(b)	Found proved Similar reasons apply as above. The period between the final scaling on 15 March 2013 and the subsequent evaluation was only 7 months.
72.	Found proved Patient M's evidence was that what usually happened at his appointments was that Mr Findlay would have a quick look in his mouth and would tell him that 'everything was fine and there were no issues'. He then explained that Mr

	Findlay would usually carry out a scale and polish; he did not discuss anything further with him about his oral hygiene, other than to tell him to continue to cleaning his teeth twice daily and to brush and up and down. The Committee has accepted Patient M's evidence and that of Dr Igoe in relation to this matter.
73.(a); 73.(c) - 73.(i)	Found proved The Committee noted that none of the clinical records relating to these examinations contain any details whatsoever.
73.(b)	Founds proved The Committee could find no record of what occurred at the appointment on this date.

We move to Stage Two."

On 4 November 2016 the Chairman announced the determination as follows:

"Mr FitzGerald, on behalf of the GDC, made submissions in accordance with Rule 20(1)(a) of the Fitness to Practise Rules 2006. His primary submission is that Mr Findlay's fitness to practise is currently impaired by reason of misconduct and that the appropriate sanction is one of erasure. The Committee has accepted the advice of the Legal Adviser.

At the outset of his submissions, Mr FitzGerald advised the Committee of Mr Findlay's previous history with the GDC. In April 2005 the Professional Conduct Committee (PCC) considered Mr Findlay's case in relation to his conviction for having formed a fraudulent scheme to obtain money from NHS Scotland and dental patients. That PCC determined to suspend Mr Findlay's registration for a period of 3 months. In October 2015 a PCC considered allegations against Mr Findlay in respect of 10 patients. The conduct took place at the same location as that in the present case and over a similar period (between May 2003 and December 2014). They related to repeated failures of treatment and care in a wide range of areas, including recording and updating medical histories; a failure to carry out and/or record periodontal assessments; inappropriate prescribing of antibiotics; failing to take radiographs; failing to record discussions with patients concerning treatment options and the risks or benefits of treatment; a failure to keep adequate records and poor quality root canal treatment. Mr Findlay did not engage in the proceedings before the PCC. That PCC concluded there was very little evidence of insight. It determined that Mr Findlay's fitness to practise was impaired by reason of his misconduct and directed that his registration be suspended for a period of 12 months. The PCC reviewed that suspension order at a hearing in October 2016. Mr Findlay did not engage in the proceedings, having indicated that he had ceased practice. There was no evidence of any remediation. The suspension order was extended for a further period of 12 months.

Misconduct

The Committee first considered whether the facts found proved amount to misconduct. In so doing, it has had regard to all the evidence before it, as well as the submissions made by Mr FitzGerald. Additionally, the Committee has kept in mind the expert evidence of Dr Igoe (called on behalf of the GDC) as well as the relevant guidance referred to in his evidence. This includes the GDC's Standards for Dental Professionals; The Faculty of General Dental Practitioners' guidance on the following: 'Selection Criteria for Dental Radiography'; 'Standards in Dentistry'; 'Clinical Examination and Record Keeping' and 'Antimicrobial

Prescribing for General Dental Practitioners and the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).

Mr FitzGerald submitted that the facts found proved amount to misconduct. He referred to the aggravating features of this case, including the serious failures of basic principles of good dental practice and patient care, the fact that the failures were repeated with multiple patients over a prolonged period and the absence of any improvement during this time. Mr FitzGerald also referred to the poor outcomes and actual harm caused to Patients L and M.

The Committee has exercised its own professional judgement on misconduct. This case concerns the treatment and care Mr Findlay provided to 13 patients (Patients A to M) at the Princes Street Dental Practice (the Practice) between December 2006 and December 2014. The Committee has set out its findings and its reasons for them in detail in its determination on the facts. Common failings that appear in relation to the care that these 13 patients received, and which were repeated during the time when Mr Findlay treated them, include the following:

- A failure to conduct and/or record adequate examinations, such as a failure to record the health of the periodontal tissues
- A failure to take bitewing radiographs when patients first attended as new patients and thereafter, at appropriate intervals, or at all
- A failure to report on radiographs where they have been taken
- A failure to conduct adequate investigations, such as by means of radiographic examination, before embarking on treatments
- Poor standard of root canal treatments
- Inappropriate prescriptions of antibiotics
- A failure to keep proper records
- A failure to obtain and/or record one patient's properly informed consent over a number of years regarding complex treatments.

The Committee received evidence that on a number of occasions, Mr Findlay's failures resulted in poor outcomes or actual harm to two of his patients. In relation to Patients A to L, Dr Igoe summarised the position as follows: "There is repeated and consistent evidence that the Registrant failed to adhere to regulations and guidelines in place at the time and that the standard of care provided by the Registrant to the twelve patients fell far below that expected of a reasonably competent practitioner working in general practice." He referred to Mr Findlay's repeated failure to adhere to relevant guidance, including prescribing guidelines and IRMER regulations.

In respect of Patient L, Dr Igoe commented that her dental records indicate that she attended for approximately 40 courses of treatment with Mr Findlay. The Committee has found that during that time Mr Findlay failed to obtain and/or record her informed consent regarding complex treatment. She was not, in Dr Igoe's view, allowed to have an active role in deciding what treatment was to be carried out. The Committee received evidence that Patient L suffered serious harm as a result of the poor standard of care provided by Mr Findlay. Patient L subsequently saw another treating dentist, Dr R, who advised her that some 13 teeth needed to be extracted. The impact on Patient L is reflected in her statement where she describes the fact that she had no idea about the poor state of her teeth until she

saw another dentist in 2015. The Committee heard evidence from Patient L as to the impact this had on her in which she describes the long and hard process of further dental work being proposed by Dr R. Patient L states: "Nobody has touched my teeth since the Registrant and nobody will."

In relation to the final patient (Patient M), Dr Igoe's conclusion is similar. He observed that during the six years when Mr Findlay treated Patient M, no radiographs were taken at any time and the treatment provided was no more than a scale and polish and insufficient oral hygiene instructions. It was clear to Dr Igoe from the radiographs, BPE scores and treatment provided by the subsequent treating dentist that the amount of periodontal treatment provided by Mr Findlay was insufficient for Patient M's needs. In summary, Dr Igoe's opinion was that the standard of care provided by Mr Findlay in respect of this patient fell far below that expected of a reasonably competent practitioner working in general practice. The Committee considered Mr Findlay's treatment of Patient M to amount to "supervised neglect."

In its deliberations, the Committee has had regard to the following paragraphs of the GDC's 'Standards for Dental Professionals' (May 2005) in place at the time of the majority of the incidents giving rise to the facts that the Committee has found proved. These paragraphs state that as a dentist you must:

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

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

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

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'.

5.2 Continuously review your knowledge, skills and professional performance. Reflect on them, and identify and understand your limits as well as your strengths.

5.4 Find out about laws and regulations which affect your work, premises, equipment and business and follow them.

The GDC 'Standards for the Dental Team' (September 2013) also contains the same principles which have been breached, including in the areas of putting patients' interests first and obtaining valid consent.

The Committee has had regard to the serious nature of the breaches of basic principles of good dental practice and patient care by Mr Findlay. The failures were repeated with multiple patients (13 in this case) over a prolonged period. Dr Igoe's evidence was that in respect of every charge, Mr Findlay's conduct fell far below the standard to be expected. Having regard to its findings of fact, the Committee has concluded that Mr Findlay's conduct fell far below

the standards reasonably expected of a registered dentist, and that fellow professionals would consider those actions to be deplorable. Accordingly, the Committee has determined that the facts found proved amount to misconduct.

Deficient professional performance

Mr FitzGerald submitted that were the Committee to find misconduct in this case, it was not necessary for it to consider whether deficient professional performance was made out. The Committee, having determined that the facts found proved amount to misconduct, is of the view that it was unnecessary to reach a finding on deficient professional performance.

Impairment of fitness to practise

The Committee next considered whether Mr Findlay's fitness to practise is currently impaired by reason of his misconduct. Throughout its deliberations, it has borne in mind that its primary duty is to address the public interest, which includes the protection of patients, the maintenance of public confidence in the profession and the declaring and upholding of proper standards of conduct and behaviour.

Mr FitzGerald submitted that Mr Findlay's fitness to practise is impaired by reason of his misconduct. He referred to the seriousness of the conduct, where poor outcomes and harm were established, and the absence of any remediation.

The Committee considered whether the identified shortcomings in Mr Findlay's practice have been remedied. It has had regard to the poor standard of care and the wide-ranging nature of the identified shortcomings. There is no evidence before the Committee that Mr Findlay has remediated the shortcomings or indeed has any intention of doing so, given his stated intention not to work as a dentist. Indeed, the letter dated 14 October 2016 from MDDUS to the GDC states that Mr Findlay stopped working on 11 December 2014 and that since then, he has not been involved in the practice or business of dentistry. The letter goes on to state that there is no prospect of Mr Findlay seeking to make an application to restore his name to the Dentists' Register or for him to practise overseas. In the absence of any evidence of remediation, the Committee considers that Mr Findlay continues to pose a risk to patients.

The Committee has also considered the issue of Mr Findlay's insight. In the letter dated 14 October 2016 MDDUS states that Mr Findlay accepts the criticism set out in the expert report regarding some aspects of his practice. However, the Committee has considered the minutes of the Associate Contract Review Meeting dated 21 January 2015 (referred to by Witness 1, the Clinical Director of the Practice) in which Mr Findlay said that the failings that had been identified were not representative of his work. The Committee saw from the clinical records that Mr Findlay was recording more information but considered that his records remained inadequate. The Committee considers that Mr Findlay's responses to the widespread failings raises concerns about his insight. There is no evidence to satisfy the Committee that Mr Findlay has acknowledged and remedied the deficiencies in his practice. The Committee therefore considers that there is a risk of repetition of the serious and sustained misconduct that the Committee has found proved, which has resulted in harm being caused to patients. The Committee has also had regard to the risk of repetition in the context of Mr Findlay's previous fitness to practise history. The findings in the present case are similar in nature to a number of the deficiencies identified by the PCC in 2015. The PCC considered that Mr Findlay remained a risk to the public and this Committee has received no evidence to satisfy it that the risks had gone away.

The Committee has further considered the wider public interest, including the need to declare and uphold proper standards of conduct and behaviour, so as to maintain public confidence in the profession. The Committee has found that Mr Findlay failed to provide an appropriate standard of care to 13 patients. The failings involve shortcomings in basic areas of dentistry that were serious and repeated over a sustained period. In addition, the Committee has found that Mr Findlay failed to obtain informed consent – which is a breach of one of the fundamental duties required of a registrant. His conduct harmed patients. In these circumstances, the Committee considers that public confidence would be seriously undermined if a finding of impairment were not made.

Accordingly, the Committee has determined that Mr Findlay's fitness to practise is currently impaired.

Sanction

Having determined that Mr Findlay's fitness to practise is currently impaired by reason of his misconduct, the Committee has considered what sanction, if any, to impose on his registration.

Mr FitzGerald submitted that given the scale of the serious failings of patient care identified in the findings against Mr Findlay, in addition to the previous findings against him, the appropriate sanction is that of erasure. He made the point that such a sanction is necessary given the serious concerns for patient safety and bearing in mind the need to uphold and maintain proper professional standards and conduct for the members of the dental profession. He referred to the relevant sections of the GDC's 'Guidance for the Practice Committees including Indicative Sanctions Guidance' and asked the Committee to have regard to mitigating and aggravating factors in this case. The Committee was referred to paragraph 7.34, which sets out the factors for which the sanction of erasure may be appropriate.

The Committee has considered the range of sanctions available to it, starting with the least restrictive. Throughout is deliberations, the Committee has applied the principle of proportionality, weighing the interests of the public with Mr Findlay's own interests.

The Committee has taken into account the mitigating and aggravating features of this case. Dr Igoe referred to the improvements in Mr Findlay's note keeping from 2011 in that he started to record basic periodontal examinations. However, save for this slight improvement, there is no evidence of remediation. In addition, the Committee has had regard to Mr Findlay's history before the GDC.

The Committee has determined that it would be inappropriate to conclude this case without taking any action or by the issuing of a reprimand. These courses of action would not be sufficient for the protection of patients given the serious nature of the findings in this case. In addition, the Committee considers that Mr Findlay poses a risk to patients.

The Committee next considered whether a period of conditional registration would be appropriate in this case. In so doing, it is aware that any conditions imposed must be proportionate, measurable, workable and verifiable. The Committee takes a serious view of the findings in this case, which concern a poor standard of care over a prolonged period of time. This situation is aggravated by the previous two PCC findings, in which they identified serious concerns about patient safety. It has also had regard to the absence of any evidence of remediation. The Committee notes from MDDUS that "Mr Findlay also accepts the criticism set out in the expert report" and accepts that this demonstrates some insight,

although very limited. Given Mr Findlay's limited engagement with the GDC the Committee has no confidence that he would engage with an order of conditions if one were imposed. Additionally, it notes from MDDUS that Mr Findlay has no intention of practising as a dentist, having retired from dentistry. Taking all these factors into account, the Committee has concluded that conditions would not be sufficient for the protection of the public, or the maintenance of public confidence in the dental profession.

The Committee next considered whether it should impose a period of suspension. The findings against Mr Findlay amount to a serious departure from the relevant professional standards. He failed repeatedly to adhere to regulations and guidelines in place and the standard of care provided by him in relation to the 13 patients in this case fell far below that expected of a reasonably competent practitioner working in general practice. He repeatedly failed to obtain informed consent for one of his patients. That same patient suffered serious harm to such an extent that 13 of her teeth had been recommended for extraction. Another patient, Patient M, has required extensive remedial treatment for periodontal disease which went undiagnosed. In conclusion, the Committee is satisfied that to suspend Mr Findlay's registration would not be sufficient to protect the public, uphold proper standards and maintain public confidence in the dental profession. Furthermore, it would serve no useful purpose given the absence of any remediation and Mr Findlay's stated intention that he no longer wishes to be involved in the practice or business of dentistry.

The Committee has concluded that Mr Findlay's misconduct is so serious that it is fundamentally incompatible with his remaining on the Dentists' Register. Accordingly, the Committee has determined that the appropriate and proportionate sanction in this case is that of erasure. The Committee has taken into account the adverse impact of such a direction on Mr Findlay. However, in the light of the serious nature of the findings against Mr Findlay, the Committee considers that the need to protect patients and the public interest outweighs his own interests in this matter.

The Committee now invites submissions as to whether Mr Findlay's registration should be made subject to an immediate order, pending the substantive direction of erasure taking effect.

Decision on immediate order

Having directed that Mr Findlay's name be erased from the Dentists' Register, the Committee has considered whether to impose an order for immediate suspension of his registration in accordance with Rule 22 of the General Dental Council (GDC)(Fitness to Practise) Rules 2007.

Mr FitzGerald, on behalf of the GDC, submitted that an immediate order of suspension is necessary in the public interest. He agreed that the protection of the public is not the primary reason for making this application given that Mr Findlay's registration is currently suspended by virtue of another Professional Conduct Committee's (PCC) decision in October 2016 to suspend Mr Findlay's registration for a further period of 12 months. He referred to the theoretical risk of patients being placed at risk in the event that Mr Findlay appealed against that PCC's order of suspension and/or this Committee's direction of erasure.

The Committee has considered the balance of risk to patients should Mr Findlay successfully appeal his current order of suspension imposed by another PCC on review in October 2016. If that suspension order fell and this Committee did not make an immediate suspension order today, there is a risk there will be no restriction on Mr Findlay's registration pending the

outcome of any appeal made against the erasure order. The Committee is satisfied that the risk to patients if Mr Findlay is allowed to practise without restriction requires it to take action.

In accordance with Section 30 of the Dentists Act 1984 (as amended) the Committee has determined that it is necessary for the protection of the public and is otherwise in the public interest that Mr Findlay's registration be suspended forthwith.

The effect of this direction is that Mr Findlay's registration will be suspended immediately. Unless Mr Findlay exercises his right of appeal, his name will be erased from the Dentists' Register 28 days from the date on which notice of this decision is deemed to have been served on him. Should Mr Findlay exercise his right of appeal, this immediate order for suspension will remain in place until the resolution of any appeal.

That concludes this case."