HEARING HEARD IN PUBLIC

STRANDGAARD, Peter

Registration No: 78564

PROFESSIONAL CONDUCT COMMITTEE

December 2015

Outcome: Erased with immediate suspension

Peter STRANDGAARD, a dentist, Tandlaege Copenhagen 1995, was summoned to appear before the Professional Conduct Committee on 7 December 2015 for an inquiry into the following charge:

Charge (as amended on 8 December 2015)

"That being registered under the Dentists Act 1984:

1) At all material times you were a United Kingdom registered Dental Practitioner in practise at Genesis Dental Care, Unit H, North Point Shopping Centre, Bransholme, Hull, HU7 4EE ('the Practice')

2) Between October 2012 to October 2014, you provided treatment to and claimed costs for treatment of:

i. Patient AB
ii. Patient JC
iii. Patient LF
iv. Patient EJ-W
v. Patient KW (ref: 10470)
vi. Patient JB
vii. Patient RF
viii. Patient PF
ix. Patient JH
x. Patient LP
xi. Patient CR
xii. Patient KW (ref: 54795)
xiii. Patient TC
xiv. Patient BN

Patient AB

3) You did not provide Patient AB with an adequate standard of care in that you:

(a) for the course of treatment for a replacement crown at UL1 between 19.07.13 to 01.08.13;

(i) did not obtain an up to date medical history form on 19.07.13;

(ii) did not carry out a full examination of Patient AB's mouth;

(iii) did not properly assess the prospects of success for a crown at UL1;

(iv) did not discuss alternative treatment options;

(v) did not discuss the risks and benefits of the alternative treatment options.

(b) for the course of treatment between 16.12.13 to 01.01.14, provided a bite guard without clinical justification

4) Due to the conduct referred to in paragraph 3(a)(iv) and (v) you did not obtain informed consent for the treatment.

5) You did not maintain an adequate standard of record keeping in respect of Patient AB by failing to record:

(a) for the course of treatment between 19.07.13 to 01.08.13;

(i) that you had carried out a full examination of Patient AB's mouth;

(ii) Patient AB's presenting condition;

(iii) Patient AB's general dental condition;

(iv) the local anaesthetic used.

(b) clinical justification for the bite guard provided in the course of treatment between 16.12.13 to 10.01.14

(c) clinical justification for the filling to UL1 provided on 12.12.13

(d) the results of the examination of Patient AB on 17.01.14

(e) for the appointment on or around 06.02.14;

(i) the clinical justification for a partial upper denture to replace UL1 and UR5;

(ii) that UL1 had been extracted prior to the denture being fitted or the reasons for it not being extracted.

6) You made, or caused to be made, inappropriate claims in relation to:

(a) the band 3 claim for the course of treatment provided from 19.07.13 to 01.08.13 as the necessary full examination of Patient AB's oral condition was not carried out;

(b) the band 3 continuation claim for the examination on 17.01.14 and subsequent treatment, which should have been included within the band 3 claim for the treatment provided from 12.12.13 to 06.02.14

Patient JC

7) You did not provide Patient JC with an adequate standard of care in that you:

(a) between 25.07.13 to 28.05.14, for the filling at UR1 you did not:

(i) prepare the tooth properly;

(ii) properly apply the bonding agents;

(iii) ensure the tooth was adequately dry; or

(iv) check the occlusion on the filling.

8) You made, or caused to be made, an inappropriate claim in relation to the band 2 claim for the treatment provided on 25.07.13 that should have been claimed as part of the claim for the course of treatment commenced on 27.03.2013.

Patient LF

9) You did not properly report on the result of the radiograph taken on or around 17.10.13;

10) You made, or caused to be made, inappropriate claims in relation to:

(a) the band 3 claim for the course of treatment provided from 07.10.13 to 01.11.13 that should have been claimed as part of the course of treatment started on 05.06.13; and

(b) the band 3 continuation claim for the bite guard that should have been claimed as part of the course of treatment started on 05.06.13

Patient EJ-W

11) You did not maintain an adequate standard of record keeping in respect of Patient EJ-W by failing to record the results of an examination on:

(a) 08.10.12

(b) 02.07.13

(c) 22.10.13

Patient KW (reference 10470)

12) You did not provide Patient KW with an adequate standard of care in that you:

(a) for the appointment on 04.04.13 did not:

(i) discuss alternative treatment options with Patient KW;

(ii) discuss the risks and benefits of the alternative treatment options

(b) on 14.08.13 you took impressions for a denture when not clinically appropriate to do so

(c) did not refer KW to a suitable colleague for treatment when appropriate to do so in light of the repeated failure of KW's dentures you provided between May 2013 to June 2014

13) You did not maintain an adequate standard of record keeping in respect of Patient KW by failing to record:

(a) for the appointment on 04.04.13:

(i) which alternative treatment options were discussed with Patient KW;

(ii) that Patient KW consented to the extractions;

(iii) the clinical justification for extracting seven of Patient KW's teeth;

(iv) any examination findings;

(v) the clinical justification for prescribing antibiotics;

(vi) the cause of the swelling in the region of UR4

(b) on 14.08.13, the clinical justification for a new denture

(c) for the denture that was made between 20.11.13 and 05.02.14, the reason for the failure of the existing denture

14) You made, or caused to be made, inappropriate claims in relation to the claim for the adjustment of the denture on 28.05.13 and 07.06.13 that were part of the same course of treatment commenced on 25.05.13

Patient JB

15) You did not provide Patient JB with an adequate standard of care in that you:

(a) did not carry out an examination on Patient JB prior to preparing to make her a denture on 22.02.13

(b) did not advise patient JB that root-canal treatment was appropriate prior to the provision of a crown at LR6 on 21.06.13

(c) between 11.10.13 and 02.12.13:

(i) did not extract LR6 at the earliest opportunity; and

(ii) prescribed repeat courses of antibiotics without clinical justification

16) You did not maintain an adequate standard of record keeping in respect of Patient JB by failing to record:

(a) the results of the examination prior to preparing of a new denture on 22.02.13;

(b) whether a full examination was carried out on 05.04.13

(c) appropriate notes of the attendance of Patient JB on 23.05.13;

(d) at the appointment on 21.06.13:

(i) any advice given regarding root-canal treatment on LR6;

(ii) Patient JB's decision following that advice

(e) the clinical justification for repeat courses of antibiotics between 11.10.13 and 20.11.13;

(f) for the appointment on 02.12.13:

(i) details of the extraction;

(ii) whether haemostasis was achieved; and

(iii) what post-operative instructions were provided.

17) You made, or caused to be made, inappropriate claims in relation to:

(a) the band 3 claim for the treatment provided on 05.04.13 as the necessary full examination of Patient JB was not carried out;

(b) the band 3 claim for incomplete treatment made on 23.05.13 as it was made immediately after Patient JB's attendance and prior to his scheduled return for further treatment on 06.06.13;

(c) the band 3 claim for the crown fitted on 12.07.13, which should have been included within the claim for the course of treatment commenced 22.02.2013.

Patient RF

18) You did not maintain an adequate standard of record keeping in respect of Patient RF by failing to record:

(a) for the appointment on 15.03.13, sufficient details of the examination findings;

(b) for the appointment on 03.10.13, sufficient details of the examination findings save for BPE scores;

(c) for the appointment on 17.01.14, sufficient details of the examination findings.

Patient PF

19) You did not provide Patient PF with an adequate standard of care in that you failed to obtain an updated medical history on:

(a) 14 May 2013;

(b) 8 October 2013;

(c) 10 January 2014; or

(d) 31 January 2014.

20) You did not maintain an adequate standard of record keeping in respect of Patient PF by failing to record:

(a) for the appointment on 14.05.13, sufficient details of the examination findings;

(b) for the appointment on 08.10.13, sufficient details of the examination findings;

(c) for the appointment on 31.01.14, whether an examination took place

(d) medical history updates on:

(i) 14 May 2013;

(ii) 8 October 2013;

(iii) 10 January 2014; or

(iv) 31 January 2014.

21) You made, or caused to be made, inappropriate claims in relation to the band 1 claim for the treatment provided on 31.01.14 as no examination was carried out as necessary.

Patient JH

22) You did not provide Patient JH with an adequate standard of care between 19.03.13 and 14.02.14 as you did not take any bitewing radiographs.

23) You did not maintain an adequate standard of record keeping in respect of Patient JH by failing to record sufficient details of the examination findings for the appointments on:

(a) 19.03.13;

(b) 28.06.13;

(c) 09.07.13;

(d) 15.10.13;

(e) 29.10.13;

(f) 31.01.14;

(g) 14.02.14

Patient LP

24) You did not provide Patient LP with an adequate standard of care in that on 23.07.13 you prescribed antibiotics for Patient LP without clinical justification

25) You did not maintain an adequate standard of record keeping in respect of Patient LP as:

(a) at the appointment on 23.07.13, you failed to record:

(i) the history of the presenting complaint;

(ii) sufficient detail of the of the findings of the examination;

(iii) clinical justification for prescribing antibiotics.

(b) at the appointment on 22.10.13, you failed to record any details of Patient LP's attendance.

26) You made, or caused to be made, an inappropriate claim in relation to the band 3 continuation claim for the treatment provided on 22.10.13 when Patient LP failed to attend.

Patient CR

(27) You did not provide Patient CR with an adequate standard of care in that:

(a) at the appointment on 16.12.13 you:

(i) did not undertake suitable investigations as to the cause of pain;

(ii) incorrectly measured BPE scores;

(iii) did not test any tooth with hot or cold stimulus;

(iv) did not take any radiographs to assist with diagnosis.

(b) at the appointment on 31.01.14, you prescribed antibiotics without clinical justification

28) You did not maintain an adequate standard of record keeping in respect of Patient CR as:

(a) at the appointment on 24.07.13, you failed to record sufficient detail of the examination findings;

(b) at the appointment on 16.12.13, you failed to record:

(i) the findings from the investigations undertaken regarding the cause of pain;

(ii) that radiographs were taken and the results of the same;

(iii) where the diagnosed periodontitis was localised to;

(iv) which teeth were tested for sensitivity.

(c) at the appointment on 31.01.14, you failed to record:

(i) details of the presenting complaint;

(ii) what investigations were undertaken;

(iii) findings of the radiograph;

(iv) the clinical justification for prescribing antibiotics

Patient KW (reference 54795)

29) You did not provide Patient KW with an adequate standard of care in that:

(a) you did not undertake an examination as required on 27.01.14;

(b) on or around 21.02.14, you prescribed antibiotics for Patient KW without clinical justification.

30) You did not maintain an adequate standard of record keeping in respect of Patient KW in that:

(a) for the appointments on 11.12.13 and 16.12.13 you failed to record:

(i) the presenting complaint;

(ii) what examinations were carried out;

(iii) what diagnosis was made;

(iv) what treatment was provided.

(b) for the appointment on 27.01.14, you failed to record that an examination had been carried out.

(c) you failed to record the clinical justification for the prescription of antibiotics to Patient KW on or around 21.02.14

(d) for the appointment on 04.03.14, you failed to record that an examination had been carried out.

31) You made, or caused to be made, inappropriate claims in relation to:

(a) the claim for an incomplete course of treatment on 21.01.14 when the course of treatment was completed on 27.01.14

(b) the band 3 claim made on 27.01.14 as no examination was undertaken;

(c) the band 3 claim relating to the denture fitted on 04.03.14 as no examination was undertaken.

Patient TC

32) You did not provide Patient TC with an adequate standard of care in that at the appointment on 20.06.13, you did not carry out a periodontal examination on a new patient

33) You did not maintain an adequate standard of record keeping in respect of Patient TC in that for the appointment on 20.06.13, you failed to record:

(a) the results of the periodontal examination;

(b) what examinations were carried out;

(c) the findings of the examination;

(d) the clinical justification for a bite-guard.

34) You made, or caused to be made, an inappropriate claim in relation to the band 3 claim for incomplete treatment between 24.07.13 to 14.08.13, which was a continuation of the original band 3 course of treatment commenced on 20.06.13.

Patient BN

35) You did not provide Patient BN with an adequate standard of care in that you failed to obtain an updated medical history on:

(a) 11.12.13

(b) 19.12.13

(c) 09.01.14

(d) 23.01.14

(e) 06.02.14

(f) 21.02.14

(g) 20.03.14

36) You did not provide Patient BN with an adequate standard of care by carrying out an operative treatment on 19.12.13 without an up to date medical history.

37) You did not maintain an adequate standard of record keeping in respect of Patient BN for the appointment on 11.12.13 as you failed to record:

(a) what was examined;

(b) what the findings of the examination were.

38) You made, or caused to be made, inappropriate claims in relation to:

(a) one of the two band 3 claims made for the period 11.12.13 to 23.01.14 when only one claim was appropriate;

(b) the band 3 claim made on 21.02.14, which should have been part of the course of treatment commenced on 11.12.13

39) Your conduct in relation to the inappropriate claims referred to in paragraphs 6, 8, 10, 14, 17, 21, 26, 31, 34 and 38 above was:

(a) misleading;

(b) dishonest.

40) You have not adequately co-operated with a GDC investigation concerning your fitness to practice by failing to provide the GDC with details of your employment and indemnity insurance for the relevant period following written requests made on:

(a) 5 January 2015;

(b) 22 January 2015;

(c) 10 March 2015;

(d) 12 March 2015

(e) 13 March 2015;

(f) 18 March 2015

AND, by reason of the facts stated, your fitness to practise as a dentist is impaired by reason of your misconduct and/or deficient professional performance".

On 11 December 2015 the Chairman made the following statement regarding the finding of facts:

"Ms Culleton

The Committee has taken into account all the evidence presented to it. It has accepted the advice of the Legal Adviser. In accordance with that advice it has considered each head of charge separately.

Mr Strandgaard is neither present nor represented.

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

The Committee first considered whether Mr Strandgaard had been sent notification of this hearing in accordance with Rules 13 and 65. It saw a copy of the Notification of Hearing letter, dated 22 October 2015, which was sent to Mr Strandgaard's registered address by Special Delivery and by first class post. The Committee was satisfied that the letter contained proper notification of this hearing, including its time, date and location, as well as notification that the Committee had the power to proceed with the hearing in Mr Strandgaard's absence. The letter also included the allegations and it set out the potential outcomes of this hearing and their consequences for the registrant. A Royal Mail 'track and trace' receipt confirms the letter was returned to sender on 5 November 2015. The GDC made various attempts by email, telephone and by post to contact Mr Strandgaard, who failed to respond to any of them.

On the basis of all of this information, the Committee was satisfied that all reasonable efforts had been made in accordance with the Rules to send notification to Mr Strandgaard and that the requirements of service had been met.

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

The Committee have noted that the last communication from Mr Strandgaard to the GDC was in April 2015. The GDC made numerous efforts to contact Mr Strandgaard. The Committee had further noted that Mr Strandgaard had not sought an adjournment and has not made any efforts to contact the GDC since the notification of the hearing. Any

adjournment at this stage would only serve to delay the conclusion of this case. The Committee noted that these matters date back to 2012, involving 14 patients, and concern serious matters of probity and clinical issues. There are also various witnesses due to give evidence.

In all the circumstances, the Committee was satisfied that Mr Strandgaard had voluntarily absented himself from these proceedings and, as such, there would be no merit in an adjournment. The Committee had regard to the public interest in the serious nature of the allegations in this case, and it was satisfied that it was fair and appropriate to proceed with the hearing in Mr Strandgaard's absence.

Application to amend charge:

Shortly after the Committee's decision to proceed in Mr Strandgaard's absence it heard an application made by Ms Culleton under rule 18 to remove some of the wording as well as to amend typographical errors in charges 9, 20 (c), and 21

Ms Culleton submitted that there would be no prejudice to Mr Strandgaard were the charge to be amended. The Committee accepted the advice of the Legal Adviser in respect of amending the charges.

In the circumstances the Committee decided to permit the amendment as there would be no injustice to Mr Strandgaard in doing so.

The Committee determined to amend the wording of head of charge 18(c), to refer to 17 January 2014 instead on 27 January 2014. The Committee did not consider that there would be any unfairness to Mr Strandgaard, by making this amendment.

Background

Mr Strandgaard was employed as an Associate Dentist at the Genesis Dental Care Practice Hull between July 2012 and August 2014. On 3 June 2014 the Clinical Director at Genesis received a letter from the North Humber and Yorkshire Local Area Team (the LAT) requesting copies of 15 patient records relating to patients who were under the care of Mr Strandgaard. The LAT had noted that data from NHS claims submitted by Genesis showed them to be an "outlier" in a number of areas. Following subsequent visits to the practice, two LAT Dental advisors stated that they had reviewed the records and found that 80% of the claims made by Mr Strandgaard between April 2013 and April 2014 were inappropriate.

During this time the practice also had concerns with regards to Mr Strandgaard's practice and undertook audits of his patient records which revealed deficiencies in his record keeping. The practice had received complaints from over 30 patients regarding the care they had received from Mr Strandgaard. Mr Strandgaard met with the clinical lead who discussed his findings with him, Mr Strandgaard was insistent that he had done nothing wrong. On 15 August 2014 Mr Strandgaard walked out of the practice and did not return again. It is alleged that Mr Strandgaard's conduct in respect of the alleged inappropriate claims was both misleading and dishonest.

It is also alleged that Mr Strandgaard failed to adequately cooperate with the GDC investigation by failing to provide details of his employment and indemnity insurance.

Findings of Fact

In reaching its decisions on the facts, the Committee considered all the evidence presented in this case. The Committee had regard to the submissions made by Ms Culleton.

The Committee accepted the advice of the Legal Adviser. In accordance with that advice, it has considered each charge separately. The Committee drew no adverse inference from the non-attendance of Mr Strandgaard.

The Committee was conscious that the burden of proof rests with the GDC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that the facts of a charge will only be proved if the Committee finds that it is more likely than not that the facts occurred as alleged. The Committee reminded itself that Mr Strandgaard was not required to prove or disprove anything.

The evidence put before the Committee included a number of documents, including an expert report prepared by Dr Kramer dated 31 July 2015, the dental records and radiographs relating to the 14 patients referred to in the charges. The Committee also had sight of the written statements of Witnesses KW1 and KW2. The Committee also saw four reports produced by Witness 2 as well as a full review from Witness 4. The Committee took into account that this evidence had not been tested in cross examination.

The Committee heard oral evidence from five witnesses called by the GDC including Dr Kramer, the GDC expert witness. The Committee found Dr Kramer to be a credible witness who is experienced and knowledgeable in his field. The Committee also heard evidence from Witnesses 1, 2, 3 and 4. The Committee found Witness 1's evidence to be vague and at times he failed to give clear and concise answers. The Committee found the oral evidence of witnesses 2, 3 and 4 to be credible, and noted their evidence relied on paper exercises.

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

1.	Proved.
2. i)	Proved.
2. ii)	Proved.
2. iii)	Proved.
2. iv)	Proved.
2. v)	Proved.
2. vi)	Proved.
2. vii)	Proved.
2. viii)	Proved.
2. ix)	Proved.
2. x)	Proved.
2. xi)	Proved.

2. xii)	Proved.
2. xiv)	Proved. The Committee received uncontentious background evidence that Mr Strandgaard worked at Genesis Dental Care and treated the patients as set out in Head of Charges 2 (i)-(xiv).
3. a) i)	Proved The Committee noted that Mr Strandgaard had provided a medical history form a year earlier for this patient. Whilst there was evidence that the medical history was checked on that date, no new form was completed.
3. a) ii)	Proved. The Committee had found no evidence of a full examination being carried out on the patient's mouth.
3. a) iii)	Proved. The Committee saw the radiograph taken on 25 July 2013. The Committee accepted the evidence of Dr Kramer, the GDC expert who stated that it was totally inappropriate not to properly assess this.
3. a) iv)	Proved. The Committee found no evidence that Mr Strandgaard had discussed alternative treatment options with the patient. His only comment in the records being "I imagine the prognosis to be relatively poor".
3. a) v)	Proved. Having found charges 3(a) (i) – (iv) proved, the Committee therefore finds this charge proved.
3. b)	Proved. The Committee noted the records. The Committee found no evidence of clinical justification for the provision of a bite guard for this patient.
4.	Proved. The Committee considered that a patient cannot give informed consent if they are not provided with the appropriate information.

5. a) i)	Not proved. Having found that he had not carried out a full examination of the patients mouth (3a ii) he could not have recorded such.
5. a) ii)	Proved. The Committee found no evidence of any record made of Patient AB's presenting condition.
5. a) iii)	Proved. The Committee found no evidence of any BPE, soft tissue existing restorations being recorded.
5. a) iv)	Proved. The Committee found no evidence of any record of any local anaesthetic used.
5. b)	Proved. The Committee found no evidence of any clinical justification for the provision of a bite guard.
5. c)	Proved. The Committee found no record being made for the clinical justification for the filling.
5. d)	Proved.
5. e) i)	Proved.
5. e) ii)	Proved. The Committee noted that Mr Strandgaard had stated that he had fitted a bridge. However the Committee found no indication in the patient notes that the UL1 had been extracted and if it had not been extracted, and why not.
6. a)	Proved. The notes confirm that no full examination had been carried out. Therefore as the Committee have established that a full examination had not been carried out on these dates, the Committee finds that the payment claimed was inappropriate.
6. b)	Proved.

	The Committee considers that the treatment should have been contained in one band 3 claim between these dates, as per NHS regulations as confirmed by Dr Kramer.
7. a) i)	Not proved.
7. a) ii)	Not proved.
7. a) iii)	Not proved.
7. a) iv)	Not proved. The Committee accepted that the filling had to be replaced on five occasions. However although this could have been for the reasons suggested in heads of charge 7(a) (i) –(iv) , it could also have been for other reasons. There were no comments in the patient notes made by Mr Strandgaard on any occasion, and therefore the Committee was unable to find charges 7 a)(i) – (iv) proved.
8.	Proved. The Committee considers that the treatment (within a six month period) should have been provided under the band 2 claim submitted on 25 July 2013.
9.	As amended – Not proved. The Committee considered that there was some report within the patient's record of the radiograph taken on 17 October 2013.
10. a)	Proved. The Committee notes that Mr Strandgaard had treated this tooth once already. All treatment provided between these dates should have been included in the single Band 3 claim made on 5 June 2013.
10. b)	Proved. For the same reasons as given above.
11. a)	Proved.
11. b)	Proved.
11. c)	Proved. The Committee finds that there were no records at all for any of

	these three dates and there should have been.
12. a) i)	Proved. The Committee found that the registrant has not discussed anything with the patient. There was no entry in the notes made of any discussions being had.
12. a) ii)	Proved. Having found the above charge proved the Committee is satisfied that the registrant did not discuss the risks and benefits.
12. b)	Proved. The Committee accepted the evidence of Dr Kramer who stated that Mr Strandgaard should have waited at least six months before taking impressions for a replacement denture.
12. c)	Proved. The Committee is satisfied that it was in this patient's best interests to be referred to a colleague. There is no reference to a referral, in the clinical notes, and the patient witness statement records that she herself arranged to see another dentist.
13. a) i)	Proved The Committee had regard to the clinical records. The clinical record for the appointment on 4 April 2013 does not give any detail of any alternate treatment options that were discussed with the patient.
13. a) ii)	Proved The Committee had regard to the clinical records. There is no record of any consent being obtained at the appointment on 4 April 2013. However the Committee noted that consent was obtained at a later appointment, immediately prior to carrying out the extractions.
13. a) iii)	Proved The Committee had regard to the clinical records. The clinical record for the appointment on 4 April 2013 does not contain a note of any clinical justification for extracting seven teeth.
13. a) iv)	Proved

	The Committee had regard to the clinical records. The clinical record for the appointment on 4 April 2013 does not contain the findings of the examinations undertaken.
13. a) v)	Not Proved The Committee had regard to the clinical records. The clinical record does not indicate antibiotics being prescribed during the appointment on 4 April 2013.
13. a) vi)	Not Proved The Committee had regard to the clinical records. The clinical record for the appointment on 4 April 2013 does not mention any swelling in the region of the UR4. The swelling in the region of the UR4 was recorded during a subsequent appointment.
13. b)	Proved The Committee had regard to the clinical records. The clinical record for the appointment on 14 August 2013 does not record any justification for the provision of a new denture.
13. c)	Proved The Committee had regard to the wording of this charge. It read the charge as meaning a failure to record the reason for the failure of the denture that was made during the appointments between 20 November 2013 and 5 February 2014. There was no record within the patient's notes of the reason for the failure of any of the dentures made for this patient.
14.	Proved The records indicate that Mr Strandgaard claimed a UDA for the adjustment of the denture. The Committee accepted the expert opinion of Dr Kramer that it was usual practice to include early adjustment of a denture within the same course of treatment.
15. a)	Proved The Committee had regard to the clinical records for patient JB. There is nothing recorded in the clinical notes for the appointment on 22 February 2013. At the next appointment Mr Strandgaard undertook the second stage of denture treatment. As such the Committee found proved that Mr Strandgaard did not carry out an examination on Patient JB prior to preparing to make her a denture on 22 February 2013.

15. b)	Proved The Committee had regard to the clinical records for patient JB. The records indicate that Mr Strandgaard provided a crown for the patient on 21 June 2013. The Committee accepts the expert opinion that the tooth should not have been crowned until the tooth had received root canal treatment. The records do not indicate that Mr Strandgaard advised the patient that root canal treatment should have been undertaken.
15. c) i)	Not Proved The Committee had regard to the clinical records which indicate that the patient received treatment for the LR6 for three weeks. It was not until the fourth appointment that the tooth was extracted. At the previous 3 appointments the patient was prescribed antibiotics. The Committee considered the expert opinion of Dr Kramer. However, the Committee noted that the clinical records for the third appointment indicate that the patient did not want an extraction. The records also indicate that at the first appointment, Mr Strandgaard diagnosed the prognosis as being poor and considered that the tooth might need to be extracted.
15. c) ii)	Not proved The clinical records indicate that at the first appointment when antibiotics were prescribed, that there was an abscess. The record for the second appointment indicates improvement, but that there remained an abscess. The Committee considered that there was a clinical justification given for the prescription of antibiotics.
16. a)	Not Proved Having found that Mr Strandgaard did not carry out the examination on 22 February 2013, he could not have recorded the results of the examination.
16. b)	Not Proved The appointment book within the records indicates that there was a late cancellation of the appointment on 5 April 2013.
16. c)	Proved The appointment book indicates that the patient attended on 23 May 2013. The clinical records indicate that there was an examination on that date. The Committee did not consider that it was an appropriate note, as it was insufficient.

16. d) i)	Proved The clinical records for the appointment on 21 June 2013 did not contain any indication that advice was provided regarding root canal treatment.
16. d) ii)	Not Proved Having found that the patient was not provided advice regarding root canal treatment on 21 June 2013, the patient could not have made a decision “following that advice”. Accordingly the Committee has found this charge not proved.
16. e)	Not Proved The clinical records identify the presence of pain and swelling, the presence of an abscess and furcational involvement. The Committee considered that there was a note of some justification for the prescription of antibiotics.
16. f) i)	Proved The Committee had regard to the clinical records for the appointment on 2 December 2013. It does not contain the details of the extraction, such as the type of anaesthetic administered.
16. f) ii)	Proved The Committee had regard to the clinical records for the appointment on 2 December 2013.There was no note that haemostasis had been achieved.
16. f) iii)	Proved The Committee had regard to the clinical records for the appointment on 2 December 2013.There is no mention that post-operative instructions were provided.
17. a)	Not Proved The Committee noted the report of Dr Kramer, that Mr Strandgaard submitted a Band 3 claim relating to the fitting of a denture on 5 April 2013. However, the Committee was not provided with the evidence on which that statement was based. Further, the Committee had regard to the appointment book which indicated that the patient cancelled the appointment on 5 April 2013.
17. b)	Proved

	The records suggest there were 3 appointments on the same date, 23 May 2013. However the records note the provision of treatment across those appointments, which cannot possibly have been provided on the same date, as laboratory work was required. The Committee accepts the expert opinion that a claim was made during the course of this treatment and that the claim should not have been made until the treatment was completed. The treatment must have been incomplete on 23 May 2015, when the claim was made.
17. c)	Proved The records indicate a course of treatment commenced on 22 February 2013. The records also show that LR6 was crowned on 12 July 2013, approximately 4 months later. The Committee accepted the expert opinion of Dr Kramer that all of this treatment should have been included in a single band 3 claim.
18. a)	Proved The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer.
18. b)	Proved The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer. There is no detail recorded regarding the examination undertaken.
18. c)	Proved, as amended. The Committee note that the course of treatment ended on 27 January 2014. The examination was carried out on 17 January 2014. The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer. The Committee considered that there were not sufficient details of the examination, on 17 January 2014, recorded within the records.
19. a)	Proved The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer. There is no updated medical history for this date. Mr Strandgaard should have updated the medical history for each new course of treatment.
19. b)	Proved The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer. There is no updated medical history for this date. Mr Strandgaard should have updated the medical

	history for each new course of treatment.
19. c)	Proved The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer. There is no updated medical history for this date. Mr Strandgaard should have updated the medical history for each new course of treatment.
19. d)	Proved The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer. There is no updated medical history for this date. Mr Strandgaard should have updated the medical history for each new course of treatment.
20. a)	Proved The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer. There is no detail recorded of the examination provided on 14 May 2013.
20. b)	Proved The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer. There is no detail recorded of the examination provided on 8 October 2013.
20. c)	Proved The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer. There is no detail recorded of the examination provided on 31 January 2014.
20. d) i)	Proved The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer. There is no updated medical history for this date. Mr Strandgaard Should have updated the medical history for each new course of treatment.
20. d) ii)	Proved The Committee had regard to the clinical records and accepted the expert opinion of Mr Kramer. There is no updated medical history for this date. Mr Strandgaard should have updated the medical history for each new course of treatment.
20. d) iii)	Proved

	The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer. There is no updated medical history for this date. Mr Strandgaard should have updated the medical history for each new course of treatment.
20. d) iv)	Proved The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer. There is no updated medical history for this date. Mr Strandgaard should have updated the medical history for each new course of treatment.
21.	Proved The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer. The records indicate a scale and polish was undertaken on 31 January 2014. There is no evidence that an examination was undertaken. In order to have claimed the Band 1 for the appointment on 31 January 2014, an examination should have been carried out.
22.	Proved The Committee had regard to the clinical records which indicate that the patient had periodontitis and there is nothing to suggest that radiographs were taken between 19 March 2013 and 14 February 2014. The Committee accepted the expert opinion of Dr Kramer that at least one set of bitewing radiographs should have been taken during this period.
23. a)	Proved The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer. The records indicate that an examination was undertaken, however while BPE scores are recorded, there is not a sufficient record of the details of the examination findings.
23. b)	Proved The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer. The records indicate that an examination was undertaken, however while BPE scores are recorded, there is not a sufficient record of the details of the examination findings.
23. c)	Not Proved The Committee had regard to the clinical records. The Committee

	considered that there is nothing to suggest that an examination was carried out on this date.
23. d)	Proved The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer. The records indicate that an examination was undertaken, however while BPE scores are recorded, there is not a sufficient record of the details of the examination findings.
23. e)	Not Proved The Committee had regard to the clinical records. The Committee considered that there is nothing to suggest that an examination was carried out on this date.
23. f)	Proved The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer. The records indicate that an examination was undertaken, however while BPE scores are recorded, there is not a sufficient record of the details of the examination findings.
23. g)	Not Proved The Committee had regard to the clinical records. The Committee considered that there is nothing to suggest that an examination was carried out on this date.
24.	Proved The Committee had regard to the clinical records for the appointment on 23 July 2013. The records indicate that antibiotics were prescribed but no clinical justification is recorded.
25. a) i)	Proved The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer.
25. a) ii)	Proved The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer.
25. a) iii)	Proved The Committee had regard to the clinical records and accepted the

	expert opinion of Dr Kramer.
25.b)	Not Proved The appointment book within the records indicates that the patient did not attend on 22 October 2013.
26.	Not Proved The Committee noted the statement of Dr Kramer, that Mr Strandgaard submitted a Band 3 claim relating to the appointment on 22 October 2013. However, the Committee was not provided with the evidence on which that statement was based. Further, the appointment book within the records indicates that the patient did not attend on that date.
27. a) i)	Proved The Committee had regard to the clinical records which indicate that the patient complained of pain. The records do not contain any note of investigation into the cause of the pain. The Committee accepted the expert opinion of Dr Kramer.
27. a) ii)	Proved The records indicate that the patient was diagnosed with localised periodontitis. However, the BPE scores recorded were '1' for each sextant. The Committee accepted the expert opinion of Dr Kramer that these scores were not consistent with the diagnosis.
27. a) iii)	Proved The Committee had regard to the clinical records which contain no evidence that Mr Strandgaard undertook vitality testing. The Committee accepted the expert opinion of Dr Kramer that this should have been undertaken.
27. a) iv)	Proved The Committee had regard to the clinical records which do not indicate that radiographs were taken to assist with the diagnosis. The Committee accepted the expert opinion of Dr Kramer that radiographs should have been taken.
27. b)	Proved The Committee had regard to the clinical records which do not contain any clinical justification for the antibiotics prescribed.

28. a)	Proved The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer.
28. b) i)	Not Proved Having found that Mr Strandgaard did not undertake investigations of the cause of the pain, he could not have recorded such.
28. b) ii)	Not Proved The Committee found that radiographs were not taken on this date, he could not have recorded such.
28. b) iii)	Proved The Committee had regard to the clinical records, which indicate a diagnosis of localised periodontitis but do not record the location of the periodontitis.
28. b) iv)	Not Proved The Committee found that Mr Strandgaard did not test the teeth for sensitivity.
28. c) i)	Proved The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer that this should have been recorded.
28. c) ii)	Proved The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer that this should have been recorded.
28. c) iii)	Proved The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer that this should have been recorded.
28. c) iv)	Proved The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer that this should have been recorded.
29. a)	Proved The Committee had regard to the clinical records and accepted the

	expert opinion of Dr Kramer that an examination should have been undertaken on 27 January 2014, when you carried out an extraction. The records do not indicate that a full examination was ever undertaken up to and including the appointment on 27 January 2014.
29. b)	Proved The Committee had regard to the clinical records which indicate that antibiotics were prescribed on 21 February 2014, but do not record a clinical justification.
30. a) i)	Proved The Committee had regard to the clinical records and note the presenting complaint was not recorded. The Committee accepted the expert opinion of Dr Kramer that this should have been recorded.
30. a) ii)	Proved The Committee had regard to the clinical records. The records do not indicate what examinations were carried out on those dates. The Committee accepted the expert opinion of Dr Kramer that this should have been recorded.
30. a) iii)	Proved The Committee had regard to the clinical records. The records do not indicate what, if any, diagnosis was made. The Committee accepted the expert opinion of Dr Kramer that this should have been recorded.
30. a) iv)	Proved The Committee had regard to the clinical records. The records do not indicate what treatment was provided on those dates. The Committee accepted the expert opinion of Dr Kramer that this should have been recorded.
30. b)	Not Proved The Committee has found that Mr Strandgaard did not carry out an examination on this date. Accordingly he could not record it.
30. c)	Not Proved The Committee has found that Mr Strandgaard did not have a clinical justification for the prescription of antibiotics made on this

	date. Accordingly he could not record the clinical justification.
30. d)	Proved The Committee had regard to the clinical records. There is no record that an examination was carried out. The Committee accepted the expert opinion of Dr Kramer that this should have been recorded.
31. a)	Proved The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer that the treatment claimed for should have been included as part of the previous claim, as it was for one course of treatment.
31. b)	Proved The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer that there needed to be an examination undertaken on 27 January 2014, in order for that claim to be made. There is no record of an examination being undertaken.
31. c)	Proved The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer that there needed to be an examination undertaken on 4 March 2014, in order for that claim to be made. There is no record of an examination being undertaken.
32.	Proved The Committee had regard to the clinical records which do not indicate that a periodontal examination was carried out. It accepted the expert opinion of Dr Kramer that the periodontal examination should have been carried out on that date.
33. a)	Not proved The Committee has found that Mr Strandgaard did not carry out the periodontal examination on this date. Accordingly he could not record the results of the examination.
33. b)	Proved The Committee had regard to the clinical records which contain a note ‘clinical examination’ but do not detail what clinical examinations were undertaken. It accepted the expert opinion of Dr

	Kramer that the details of what examinations were undertaken, should have been recorded.
33. c)	Proved The Committee had regard to the clinical records which do not record the findings of the examinations carried out. It accepted the expert opinion of Dr Kramer that this should have been recorded.
33. d)	Proved The Committee had regard to the clinical records which do not record the clinical justification for the provision of a bite-guard. It accepted the expert opinion of Dr Kramer that this should have been recorded.
34.	Proved The Committee accepted the expert opinion that the treatment provided between 24 July 2013 and 14 August 2013, was a continuation of the original treatment which was commenced on 20 June 2013. Accordingly it should have formed part of the original band 3 claim.
35. a)	Proved The Committee had regard to the clinical records. There is no indication that an updated medical history was taken on this date. The Committee accepts the expert opinion of Dr Kramer that an updated medical history should have been taken.
35. b)	Proved For the same reasons as at 35.a) above.
35. c)	Proved For the same reasons as at 35.a) above.
35. d)	Proved For the same reasons as at 35.a) above.
35. e)	Proved For the same reasons as at 35.a) above.
35. f)	Proved

	For the same reasons as at 35.a) above.
35. g)	Proved For the same reasons as at 35.a) above.
36.	Proved The Committee had regard to the clinical records. There is no indication that an updated medical history was taken prior to the operative treatment being carried out on 19 December 2013. The Committee accepts the expert opinion of Dr Kramer that an updated medical history should have been taken prior to the provision of any operative treatment.
37. a)	Proved The Committee had regard to the clinical records which do not contain details of what was examined. The Committee accepted the expert opinion of Dr Kramer that this should have been recorded.
37. b)	Proved The Committee had regard to the clinical records which do not contain details of the findings of the examination undertaken. The Committee accepted the expert opinion of Dr Kramer that this should have been recorded.
38. a)	Proved The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer.
38. b)	Proved The Committee had regard to the clinical records and accepted the expert opinion of Dr Kramer
39. a)	Proved in relation to heads of charge 6.a), 6.b), 8, 10.a), 10.b), 14, 17.b), 17.c), 21, 31.a), 31.b), 31.b c), 34 and 38. Not proved in relation to heads of charge 17.a) and 26. The Committee has found proved that Mr Strandgaard made or caused inappropriate claims to be made, as set out in heads of charge 6.a), 6.b), 8, 10.a), 10.b), 14, 17.b), 17.c), 21, 31.a), 31.b), 31.b c), 34 and 38, either by making them himself or by providing the records as the basis for these claims. The Committee

	considered that Mr Strandgaard's conduct, in making or causing these claims to be made, was misleading by representing that they were appropriate. The Committee did not find misleading conduct proved, in relation to heads of charge 17.a) and 26, as it did not find heads of charge 17.a) and 26 proved.
39. b)	Proved in relation to heads of charge 6.a), 6.b), 8, 10.a), 10.b), 14, 17.b), 17.c), 21, 31.a), 31.b), 31.b c), 34 and 38. Not proved in relation to heads of charge 17.a) and 26. In relation to the inappropriate claims found proved (in relation to heads of charge 6.a), 6.b), 8, 10.a), 10.b), 14, 17.b), 17.c), 21, 31.a), 31.b), 31.b c), 34 and 38) the Committee concluded that a reasonable member of the dental profession would consider that deliberately submitting inappropriate claims for payment was dishonest. It considered that there were numerous instances of inappropriate claims made over a long period of time. Mr Strandgaard was under an obligation to familiarise himself with the rules of claiming for UDAs and submit claims appropriately. Witnesses 2, 3 and 4 who carried out the initial investigations into Mr Strandgaard's claiming, all worked within probity and accountability associated with NHS contracts. They identified that Mr Strandgaard was an outlier with respect to UDAs and described his claiming as excessive for the general area but also within the practice in which he worked. They considered there was a stark difference between the claims made by Mr Strandgaard and other dentists working within the practice. These witnesses informed the Committee that they had never before seen such a high level of claiming activity from an individual performer. The Committee determined that this level of inappropriate claiming, which included numerous instances of double claiming, was clearly dishonest. The Committee did not find dishonesty proved, in relation to heads of charge 17.a) and 26, as it did not find heads of charge 17.a) and 26 proved.
40. a)	Proved The Committee had regard to the evidence of written communication sent to Mr Strandgaard asking for details of his employment and indemnity insurance. It also had regard to the statement of the GDC caseworker that Mr Strandgaard did not respond to these requests. The Committee finds that Mr

	Strandgaard did have a duty to provide this information, as it is a requirement under both sets of the standards, which were in place at the relevant times.
40. b)	Proved For the same reasons at 40.a) above.
40. c)	Proved For the same reasons at 40.a) above
40. d)	Proved For the same reasons at 40.a) above
40. e)	Proved For the same reasons at 40.a) above
40. f)	Proved For the same reasons at 40.a) above

We move to Stage Two."

On 15 December 2015 the Chairman announced the determination as follows:

"Ms Culleton

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

Deficient Professional Performance and Misconduct

The Committee considered whether the facts found proved amount to deficient professional performance and also misconduct. It took into account that the meaning of misconduct within this regulatory context is a serious breach of the standards to be expected in the circumstances. The Committee considered the GDC's professional standards as set out in its publication 'Standards for Dental Professionals (May 2005)'. It paid particular attention to the following paragraphs:

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.

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

- communicating effectively with patients;
- explaining options (including risks and benefits); and
- giving full information on proposed treatment and Possible costs.

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

The matters in this case include clinical failures and record keeping failures, as well as dishonest conduct in making inappropriate claims. There are also findings that Mr Strandgaard failed to co-operate with the GDC's investigation into his fitness to practise by failing to provide key information when requested on six occasions.

The Committee noted that Mr Strandgaard's clinical and record keeping failings were numerous involving 14 patients. His failures involved fundamental aspects of dentistry and persisted over a prolonged period of time. The Committee assessed Mr Strandgaard failings against the standard of a reasonably competent dentist. It determined that his performance fell far below that standard.

The Committee found that the facts found in respect of Charges 1-37 amounted to deficient professional performance.

In relation to the matters of probity and non-cooperation with the GDC set out in charges 38 - 40, the Committee had regard to the fact that his inappropriate claiming was deliberate and sustained over a two year period and executed in a number of different ways. The Committee considers that Mr Strandgaard's behaviour was deplorable and unacceptable. Through his dishonest conduct, Mr Strandgaard breached a fundamental tenet to be trustworthy. Mr Strandgaard's failure to cooperate with the GDC investigation also showed a disregard of the fundamental requirement to cooperate with one's regulator.

Having considered the totality of its findings, the Committee was satisfied that the matters as set out in charges 38-40, represent serious departures from the standards expected from a member of the dental profession. It has therefore found that these facts found proved amount to misconduct.

Impairment

The Committee next considered whether Mr Strandgaard's fitness to practise is currently impaired by reason of his misconduct and deficient professional performance.

In reaching its decision, the Committee has exercised its independent judgement. It has borne in mind that its duty is to act in the public interest, which includes the protection of patients, the maintenance of public confidence in the profession and the declaring and upholding of proper standards of conduct and behaviour.

The Committee has taken into account all of the circumstances of this case.

The Committee considered that Mr Strandgaard's clinical and record keeping failings are capable of being remedied. However, it has received no evidence of any remediation. This being the case, the Committee could not say whether or not Mr Strandgaard has addressed any of the shortcomings in his practice. In the absence of any evidence to demonstrate the level of his clinical knowledge and abilities today, the Committee concluded that a finding of current impairment, as a result of his deficient professional performance, is necessary to protect patients from the risk of repetition, which it considers to be highly likely given the circumstances.

The Committee also considered the misconduct found, which includes his dishonesty and his attitudinal issues. Conduct of this kind is very difficult to remedy, although not impossible. The Committee has received no evidence of any insight from Mr Strandgaard about this behaviour.

In view of Mr Strandgaard's lack of insight and the absence of any evidence of remediation, the Committee could not find that Mr Strandgaard had sufficiently addressed the concerns about his integrity, his attitude towards patients and his attitude towards his regulatory body. Therefore, it was not confident that he would not repeat such behaviour in the future. The Committee considered the wider public interest and decided that public confidence in the dental profession and professional standards would be undermined if a finding of impairment were not made in the circumstances of this case.

For all these reasons the Committee has determined that Mr Strandgaard's fitness to practise is currently impaired by reason of his deficient professional performance and misconduct.

Sanction

The Committee considered what sanction, if any, to impose on Mr Strandgaard's registration. It reminded itself that the purpose of a sanction is not to be punitive, although it may have that effect, but to protect patients and in the wider public interest.

The Committee took into account the 'Guidance for the Professional Conduct Committee (November 2009)'. It considered the range of sanctions available to it, starting with the least serious. It applied the principle of proportionality, balancing the public interest with Mr Strandgaard's own interests.

In view of the serious nature of its findings, the Committee has determined that it would be insufficient to conclude this case without taking any action in respect of Mr Strandgaard's registration. It came to the same conclusion in respect of a reprimand. These courses of

action would not provide sufficient protection for the public, nor would they address the wider public interest concerns in this case.

The Committee considered whether to impose conditions on Mr Strandgaard's registration. It took into account that any conditions imposed would have to be clear, workable, relevant and enforceable. The Committee was satisfied that Mr Strandgaard's clinical and record keeping failings could potentially be remedied. Mr Strandgaard has not engaged in these proceedings and has provided no material to suggest that he would comply with any conditions. Further the Committee was not satisfied that a period of conditional registration would address its concerns about his integrity and his attitudinal failings. It therefore determined that the imposition of conditions would not be an appropriate or proportionate sanction.

The Committee carefully considered whether to suspend Mr Strandgaard's registration. In doing so the Committee also considered that there were a number of aggravating features in this case. These are:

- Clinical failings in respect of 14 patients in his care.
- Poor record keeping over a sustained period of time.
- His sustained inappropriate claimings.
- His repeated failure to co-operate with the GDC's investigation into this case

Mr Strandgaard has not engaged with these proceedings and has provided no evidence of any insight and remediation into his clinical failings and dishonesty.

His clinical failings and behaviour amount to serious breaches of fundamental standards within the dental profession. The Committee notes that dishonesty does not inevitably lead to erasure. However Mr Strandgaard has demonstrated no insight into his misconduct and deficient professional performance. In these circumstances the Committee has determined that a period of suspension would not be appropriate. A period of suspension would not be appropriate and nor would it be sufficient in this case, to safeguard the public and to maintain public confidence in the profession. Suspension would serve no useful purpose.

The Committee concluded, taking into account the totality of the matters proved, that a sanction of suspension would not protect the public nor meet the public interest in declaring and upholding proper standards of conduct and behaviour. The Committee considered that Mr Strandgaard's actions and behaviour are incompatible with him remaining as a registered dentist.

In all the circumstances, the Committee has determined that the only appropriate and proportionate sanction is to erase Mr Strandgaard's name from the Dentists Register.

Unless he exercises his right of appeal, his name will be erased from the Dentist Register 28 days from the date when notice of this determination is deemed to have been served upon him.

The Committee now invites submissions from you as to whether Mr Strandgaard's registration should be suspended immediately, pending the taking effect of the substantive determination for erasure.

You submitted that it was necessary for the protection of the public and otherwise in the public interest to impose an immediate order of suspension on Mr Strandgaard's registration.

In deciding whether to impose an immediate order of suspension on Mr Strandgaard's registration, the Committee has considered your submission that such an order should be imposed. The Committee also accepted the advice of the Legal Adviser.

The Committee has determined that it is necessary for the protection of the public and is otherwise in the public interest to impose an order for the immediate suspension of Mr Strandgaard's registration. It has decided that he is not fit to remain on the Dentists Register, therefore it is consistent to impose an immediate order in this case to protect the public. The Committee also considers that public protection as well the public interest in the dental profession and this regulatory process would be undermined if an order were not imposed.

The effect of the foregoing determination and this order is that Mr Strandgaard's registration is suspended immediately. If he does not appeal, the substantive direction for erasure, as already announced, will take effect 28 days from the date when notice is deemed to have been served upon him.

Should Mr Strandgaard exercise his right of appeal, this immediate order for suspension will remain in place until the resolution of any appeal.

Any interim suspension on his registration is hereby revoked.

That concludes this hearing."