HEARING HEARD IN PUBLIC

OKECHUKWU-FUNK, Steven Obidike Chudi

Registration No: 166242

PROFESSIONAL CONDUCT COMMITTEE

NOVEMBER 2016

Outcome: Erased with Immediate Suspension

Steven Obidike Chudi Okechukwu-Funk, a dentist, Zahnarzt Bonn 1998; was summoned to appear before the Professional Conduct Committee on 2 November 2016 for an inquiry into the following charge:

Charge

"That being a Registered Dentist:

1. At all material times you were practising as a dentist at Smiles 4 U Dental Clinic, 71 Tottenham Lane, London N8 9BE (the "Practice").
2. At appointments with Patient A between 1 November 2013 and 24 October 2014 you failed to obtain informed consent for the treatment of UL6 and/or UR6 and/or UL5 in that you:-
   a. Failed to inform Patient A of all of the treatment options;
   b. Failed to explain to Patient A the risks and benefits of the available treatment options;
   c. Failed to carry out sufficient treatment planning;
   d. Failed to adequately communicate the treatment plan to Patient A;
   e. Failed to give to Patient A sufficient information and time to consider the available treatment options and the risks and benefits of the said options thereof.
3. At appointments with Patient A between 1 November 2013 and 26 September 2014 you failed to provide an adequate standard of care to Patient A in relation to the treatment of UL5 and/or UL6 in that you:-
   a. Failed to diagnose and/or treat adequately or at all the periapical status of UL5;
   b. Failed to provide an adequate treatment plan in relation to UL5 and/or UL6.
4. On 1 November 2013, you took radiographs of Patient A's UL6 that were of unsatisfactory quality.
5. You did not maintain an adequate standard of record keeping or follow a precise system of recording in respect of Patient A's appointments in that:
   a. At appointments between 1 November 2013 and 24 October 2014 you made records that were illegible and/or incomprehensible.
   b. At an appointment with Patient A on 1 November 2013 you failed to record adequately or at all:
      i. that treatment options were discussed with Patient A;

ii. the risks and benefits of the proposed treatment;

iii. the justification for taking a radiograph of Patient A's UL6.

6. Between May 2015 and August 2015, you failed to respond adequately or at all to Patient A's complaint about her dental treatment.

7. Between October 2014 and April 2015, the standard of care provided by you to Patient A was poor in that:

   a. You failed to inform Patient A that you were leaving the Practice;

   b. You failed to arrange for the completion of Patient A's treatment by another dentist.

8. Between May 2015 and August 2015, you provided information to Patient A regarding the continuation of her treatment that was:

   a. Misleading; and/or

   b. Dishonest.

9. For a period of time between at least 13 July 2015 and 03 September 2015 the Registrant failed to adequately co-operate with an investigation into the treatment of a patient conducted by the General Dental Council, including by:

   a. Not providing the dental records for Patient A;

   b. Not providing evidence of your indemnity;

   c. Not providing details of your employment.

At a meeting on 19 August 2016, the PCC determined that the following additional charges should be included under Rule 25(2) of the GDC's Fitness to Practise Rules:

10. Between at least February 2014 and November 2014 you accepted direct payments for the treatment of one or more of your patients, including Patient A, in breach of your arrangements with the Practice on one of more of the following dates:

    d. 18 February 2014

    e. 21 February 2014

    f. 11 April 2014

    g. 2 May 2014

    h. 19 May 2014

    i. 27 June 2014

    j. 11 July 2014

    k. 26 September 2014

    l. 28 November 2014

11. By taking payments directly from Patient A, you failed to ensure that Patient A is able to seek redress and continuation of her treatment directly from the Practice following your departure.

12. In relation to allegations 10 and 11 above, you failed to reimburse the payments to the Practice upon request.

13. Your conduct in relation to allegations 10, 11 and 12 above was:

    a. Misleading and/or

    b. Dishonest

And that by reason of the facts alleged above your fitness to practise as a dentist is impaired by reason of your misconduct."

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

"This is the Professional Conduct Committee's inquiry into the allegation by the GDC that Mr Okechukwu-Funk's fitness to practise is impaired by reason of misconduct. Mr Okechukwu-Funk is neither present nor represented in this hearing.

Decision on Service of Notification of Hearing

At the commencement of the hearing, Mr Renton, Counsel on behalf of the General Dental Council (GDC) made an application under Rule 54 of the General Dental Council (Fitness to Practise) Rules Order of Council 2006 that the hearing should proceed in the absence of Mr Okechukwu-Funk. He submitted that all reasonable efforts had been made to notify Mr Okechukwu-Funk of this hearing.

The Committee had before it a copy of the notification of hearing letter dated 27 September 2016 which was sent to Mr Okechukwu-Funk's registered address by 'international signed for' and first class post. It was satisfied that the letter contained all the requirements for notice as set out in Rule 13 of the Rules. The Committee noted the Royal Mail track and trace print out, bearing the same reference number as on the notification of hearing letter, indicating that the letter was delivered on 30 September 2016. A copy of the letter was also sent to Mr Okechukwu-Funk via email dated 27 September 2016. The Committee was satisfied that service had been effected in accordance with Rules 13 and 65.

Decision on proceeding in the Registrant's absence

The Committee then considered whether to proceed with this hearing. It bore in mind that its discretion to proceed with a hearing in the absence of the Registrant should be exercised with the utmost care and caution. In making its decision the Committee took account of the principles set out in R v Jones [2003]. It also took account of the submissions made by Mr Renton. The Committee accepted the advice of the Legal Adviser.

The Committee noted that the GDC had made numerous unsuccessful attempts to contact Mr Okechukwu-Funk in relation to this hearing. There was no evidence before this Committee of any response from Mr Okechukwu-Funk to the GDC's correspondence. In the absence of any information from Mr Okechukwu-Funk the Committee concluded that he had absented himself from these proceedings. There was no application for an adjournment from Mr Okechukwu-Funk. The Committee was of the view that adjourning this hearing today would not secure his attendance at a future date.

The Committee considered the public interest in the expeditious disposal of this case. Having satisfied itself that the notice of hearing had been duly sent and that all reasonable efforts had been made, in accordance with the Rules, to inform Mr Okechukwu-Funk of this

case, the Committee was of the view that there was a public interest in conducting the hearing. It determined to proceed notwithstanding the absence of the registrant.

Expert Opinion

The Committee had before it a report dated 20 July 2016 and heard oral evidence from Dr Jefferies, expert in General Dental Practice.

The Committee also had before it witness statements from Patient A dated 13 June 2016; from Witness J.S, the Practice Principal of Smiles 4 U, dated 25 May 2016; and from Witness L.B, GDC Caseworker, dated 8 March 2016. The Committee did not hear oral evidence from these witnesses but it noted that their evidence was unchallenged by the registrant. It accepted their evidence.

Decision on the facts

The Committee has carefully considered the oral and documentary evidence presented. It has taken into account the submissions made by Mr Renton. It has accepted the advice of the Legal Adviser.

The Committee has drawn no adverse inferences from Mr Okechukwu-Funk's absence in this hearing.

The Committee's findings in relation to each head and sub-head of charge are:

1.	At all material times you were practising as a dentist at Smiles 4 U Dental Clinic, 71 Tottenham Lane, London N8 9BE (the "Practice") – **Proved** In his witness statement, JS, the Practice Principal stated that the registrant, Mr Okechukwu-Funk was one of the practice's associates. He also said that the registrant joined the practice around 2011-2012.
2.	At appointments with Patient A between 1 November 2013 and 24 October 2014 you failed to obtain informed consent for the treatment of UL6 and/or UR6 and/or UL5 in that you:-
2. (a)	Failed to inform Patient A of all of the treatment options – Dr Jefferies' opinion was that Patient A should have been given the options of doing nothing, dentures, bridges or implants. He told the Committee that consent involves discussing treatment options, risks and benefits and the cost of treatment with patients prior to any consent forms being signed. He was also of the opinion that because implant treatment was a major surgical procedure, he would expect documentation in full of the discussions with the patient, including a signed consent form. In her witness statement, Patient A stated that she made the initial appointment because of a missing tooth that needed to be replaced. She also stated that she did not specifically ask for an implant at that time and she wanted to find out the best method of replacing the tooth. Patient A stated that the registrant advised her that he would carry out implant

	treatment. She also stated that the registrant mentioned the use of a bridge as an alternative option but that he did not recommend it. Patient A confirmed that a bridge or an implant were the only treatment options discussed. Patient A stated that in January 2014 the registrant advised her that an additional extraction of a tooth next to the implant site was necessary but no treatment options were discussed. From the evidence before it the Committee found that the registrant failed to inform Patient A of all the treatment options and as such he failed to obtain informed consent for the treatment he provided.
2. (b)	Failed to explain to Patient A the risks and benefits of the available treatment options – **Proved** In her witness statement, Patient A stated that although she had a rough idea of what implant procedure involved from friends and family, she was not aware of "the finer details such as the possibility of rejections and complications but Steve briefly explained this to me." From the evidence before it the Committee found that the registrant failed to inform Patient A of the risks and benefits of the available treatment options and as such he failed to obtain informed consent for the treatment he provided.
2. (c)	Failed to carry out sufficient treatment planning – **Proved** From Patient A's statement it was apparent to the Committee that she was not clear on the details of the proposed treatment. Patient A stated that she understood that the treatments would involve surgery and a period of recovery prior to placing a crown. Patient A also describes how by January 2014 it was discovered that the upper right implant which was placed in December 2013 was not stable. She stated that the registrant "became less sure, he seemed to be improvising as he went along "let's try this" or "let's try that". There was no proper plan and it did not feel like we were having a proper discussion about the options." There is no treatment plan within the clinical records for Patient A. The Committee noted the document titled 'private treatment plan' and dated 1 November 2013. It was of the view that the document was a quotation for the proposed implant treatment and was not a treatment plan as it did not set out the stages of treatment.
2. (d)	Failed to adequately communicate the treatment plan to Patient A – **Proved** In her statement Patient A said that "there was no proper plan and it did not feel like we were having a proper discussion about the options".

	There is no evidence within the clinical records of a treatment plan for the proposed treatment. From the evidence before it the Committee found that the registrant failed to adequately communicate the treatment plan to Patient A and as such he failed to obtain informed consent for the treatment he provided.
2. (e)	Failed to give to Patient A sufficient information and time to consider the available treatment options and the risks and benefits of the said options thereof – **Proved** The Committee accepted the opinion of Dr Jefferies that Patient A should have been given at least 24 hours to consider the treatment proposed. There is no evidence in the records to show that the patient was given time to consider the proposed treatment before proceeding with the surgery. From the evidence before it the Committee found that the registrant failed to give Patient A sufficient information and time to consider the available treatment options and the risks and benefits, and as such he failed to obtain informed consent for the treatment he provided.
3.	At appointments with Patient A between 1 November 2013 and 26 September 2014 you failed to provide an adequate standard of care to Patient A in relation to the treatment of UL5 and/or UL6 in that you:-
3. (a)	Failed to diagnose and/or treat adequately or at all the periapical status of UL5 – **Not Proved** During his oral evidence Dr Jefferies was shown electronic versions of the radiographs which he had considered at the time of writing his report. Dr Jefferies was previously supplied with paper copies of the radiographs. His opinion was that having seen a better quality of the relevant radiograph, he would hesitate to draw a definitive conclusion on the periapical status of the UL5.
3. (b)	Failed to provide an adequate treatment plan in relation to UL5 and/or UL6 – **Proved** The Committee accepted Dr Jefferies' opinion that the treatment planning was poor because the registrant failed to diagnose the UL5 and placed an implant at the UL6 site which subsequently failed. He considered that this led to ongoing issues for Patient A which put her health at risk.
4.	On 1 November 2013, you took radiographs of Patient A's UL6 that were of unsatisfactory quality – **Not Proved** Dr Jefferies considered electronic copies of the radiographs during his oral evidence and conceded that some of the radiographs, though not perfect, were of an adequate quality. The original radiographs were not before the Committee. It was told that

	Patient A's clinical records were supplied electronically. The Committee considered that due to the possibility that the quality of the radiographs would have deteriorated as a result of documents being reproduced, it could not conclude that the radiographs before it were of unsatisfactory quality when they were first taken by the registrant.
5.	You did not maintain an adequate standard of record keeping or follow a precise system of recording in respect of Patient A's appointments in that:
5. (a)	At appointments between 1 November 2013 and 24 October 2014 you made records that were illegible and/or incomprehensible – **Proved** The Committee accepted the opinion of Dr Jefferies that the registrant's handwritten notes were illegible and difficult to discern. He said that the significance of legible notes is so that a subsequent treating practitioner would be able to understand the treatment provided previously. The computer records were of a slightly better quality but contained abbreviations which were incomprehensible.
5. (b)	At an appointment with Patient A on 1 November 2013 you failed to record adequately or at all:
5. (b)(i)	that treatment options were discussed with Patient A – **Proved** The clinical records do not contain a record of the discussions with Patient A on the options of treatment.
5. (b)(ii)	the risks and benefits of the proposed treatment – **Proved** The clinical records do not contain a record of the discussions with Patient A on the risks and benefits of the treatment options that were discussed or of the available treatment options.
5. (b)(iii)	the justification for taking a radiograph of Patient A's UL6 – **Proved** The clinical records do not contain a justification for the radiograph of Patient A's UL6.
6.	Between May 2015 and August 2015, you failed to respond adequately or at all to Patient A's complaint about her dental treatment – **Proved** The Committee noted the email correspondence between Patient A and the registrant. Patient A had made numerous attempts to contact the registrant to arrange the completion of her treatment which she had paid for in full. The Committee found that the registrant's responses to Patient A were inadequate.
7.	Between October 2014 and April 2015, the standard of care provided by you to Patient A was poor in that:

7. (a)	You failed to inform Patient A that you were leaving the Practice – **Proved** In her statement patient A stated that the registrant carried out a third surgery in her upper left tooth in September 2014 to remove the failed implant. Patient A stated that she did not see the registrant after this treatment. She said that from that point and between January and May 2015 the practice cancelled or rescheduled her appointments with the registrant without a reason for the cancellations. Patient A subsequently discussed her concerns with JS who informed her that the registrant had left the practice.
7. (b)	You failed to arrange for the completion of Patient A's treatment by another dentist – **Proved** In her statement Patient A stated that the bulk of her treatment had been paid for but "her dentist had disappeared and she had no contact from him". She also stated "As far as I was concerned my treatment was left incomplete and I had been given no aftercare or advice before he left." Patient A said she asked the practice to reimburse her or complete her treatment with another dentist but she was told that she had been paying the registrant directly and not the practice and as such her treatment could not be completed without further payment.
8.	Between May 2015 and August 2015, you provided information to Patient A regarding the continuation of her treatment that was:
8. (a)	Misleading; and/or – **Proved** From the email correspondence between Patient A and the registrant, the Committee noted that Patient A was assured of appointments being arranged at the practice for the completion of her treatment. No such appointments were arranged by the registrant and Patient A heard nothing back from him. Patient A had, by this time paid the registrant directly for the bulk of her treatment. In her statement she said that she paid the registrant on a card machine which he had in his treatment room and not at the practice reception. The Committee had before it evidence of Patient A's bank statements showing payments in excess of £2000 to "Funk Ltd". The Committee concluded that the registrant gave Patient A the expectation that she would get an appointment for the completion of her treatment when he was no longer working at the practice. It found that his conduct was misleading.
8. (b)	Dishonest – **Proved** Patient A had paid for the bulk of her treatment prior to May 2015. She made these payments directly to the registrant in his surgery with the registrant's own card machine, without the knowledge of the practice. The registrant left

	the practice without informing Patient A or arranging for the continuation of Patient A's treatment. After numerous attempts by Patient A to contact the registrant, he responded on two occasions with assurances of arranging appointments for her. These appointments were never made. The Committee concluded that between May and August 2015 the registrant was actively avoiding Patient A's attempts to contact him for the completion of her treatment. It found that the registrant's conduct would be considered dishonest by the reasonable and honest person. It also found that he would have known that his conduct would be regarded as dishonest by the reasonable and honest person.
9.	For a period of time between at least 13 July 2015 and 03 September 2015 the Registrant failed to adequately co-operate with an investigation into the treatment of a patient conducted by the General Dental Council, including by:
9. (a)	Not providing the dental records for Patient A – **Proved** The Committee accepted the evidence of L.B that a number of unsuccessful requests were made to the registrant to provide the dental records for Patient A.
9. (b)	Not providing evidence of your indemnity – **Proved** The Committee accepted the evidence of L.B that a number of unsuccessful requests were made to the registrant to provide evidence of his indemnity.
9. (c)	Not providing details of your employment – **Proved** The Committee accepted the evidence of L.B that a number of unsuccessful requests were made to the registrant to provide details of his employment.
	Rule 25 Allegations
10.	Between at least February 2014 and November 2014 you accepted direct payments for the treatment of one or more of your patients, including Patient A, in breach of your arrangements with the Practice on one of more of the following dates: In his statement, J.S, the practice principal explained that each associate in his practice would charge their patients the fee for the specific treatment. A percentage of that fee was then given back to the associate after any laboratory fees had been deducted. The fees charged were paid into the practice's general bank account and the relevant percentage of the monthly payments taken for all treatments was then paid back to the associates each month. J.S stated that around February 2014 he became aware that the registrant was paying some of the payments from patients into his own bank account instead of the practice account. J.S later discovered that the

	registrant had his own card machine to receive payments into his own bank account. J.S produced a list of payments made by patients, including Patient A, directly to the registrant which total £15712.
10. (a)	18 February 2014 – **Proved** This date appeared on the list of payments by patients made directly to the registrant.
10. (b)	21 February 2014 – **Proved** This date appeared on the list of payments by patients made directly to the registrant.
10. (c)	11 April 2014 – **Proved** This date appeared on the list of payments by patients made directly to the registrant.
10. (d)	2 May 2014 – **Proved** This date appeared on the list of payments by patients made directly to the registrant.
10. (e)	19 May 2014 – **Proved** This date appeared on the list of payments by patients made directly to the registrant.
10. (f)	27 June 2014 – **Proved** This date appeared on the list of payments by patients made directly to the registrant.
10. (g)	11 July 2014 – **Proved** This date appeared on the list of payments by patients made directly to the registrant.
10. (h)	26 September 2014 – **Proved** This date appeared on the list of payments by patients made directly to the registrant.
10. (i)	28 November 2014 – **Proved** This date appeared on the list of payments by patients made directly to the registrant.
11.	By taking payments directly from Patient A, you failed to ensure that Patient

	A is able to seek redress and continuation of her treatment directly from the Practice following your departure – **Proved** Dr Jefferies' opinion was that it would be down to the goodwill of the practice to continue Patient A's treatment in circumstances where the registrant had taken 100% of the payment for treatment. Patient A was unable to obtain a continuation of her treatment which put her at a financial disadvantage.
12.	In relation to allegations 10 and 11 above, you failed to reimburse the payments to the Practice upon request – **Proved** There is no evidence before the Committee that the registrant reimbursed the practice for the outstanding monies owing as a result of the work he carried out.
13.	Your conduct in relation to allegations 10, 11 and 12 above was:
13. (a)	Misleading and/or – **Proved in relation to 10 and 11** The Committee found that the registrant's conduct in taking payments from patients directly in his surgery, including from Patient A was misleading conduct. The failure to reimburse the practice was dishonest rather than misleading.
13. (b)	Dishonest – **Proved in relation to 10, 11 and 12** The Committee found that the registrant's conduct in taking payments directly from patients in his surgery, contrary to the arrangement he had with the practice and failing to reimburse the practice for costs which he had accrued, would be considered dishonest by the reasonable and honest person. It also found that the registrant would have known that keeping funds which he was not completely entitled to would be regarded as dishonest by the reasonable and honest person.

We move to Stage Two."

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

"Having announced its findings on the facts as alleged, the Committee heard submissions on misconduct, impairment and sanction from Mr Renton on behalf of the General Dental Council (GDC). It accepted the advice of the Legal Adviser.

Background

This case concerns the treatment Mr Okechukwu-Funk provided to Patient A between November 2013 and October 2014. The Committee found proved that the registrant;

- failed to obtain informed consent in that he:
  - failed to inform Patient A of all the treatment options,
  - failed to explain to Patient A the risks and benefits of the available treatment options,
  - failed to carry out sufficient treatment planning,
  - failed to adequately communicate the treatment plan to Patient A, and
  - failed to give Patient A sufficient information and time to consider the available treatment options and risks and benefits;
- failed to provide an adequate treatment plan in relation to UL5 and UL6;
- made records that were illegible and incomprehensible;
- failed to record that treatment options were discussed with Patient A, the risks and benefits of the proposed treatment and the justification for taking a radiograph of Patient A's UL6;
- failed to respond adequately to Patient A's complaint about her dental treatment;
- provided a poor standard of care to Patient A in that he:
  - failed to inform Patient A that he was leaving the Practice;
  - failed to arrange for the completion of Patient A's treatment by another dentist;
- provided information to Patient A regarding the continuation of her treatment that was misleading and dishonest;
- failed to adequately co-operate with an investigation into the treatment of a patient conducted by the GDC including by not providing the dental records of Patient A, not providing evidence of his indemnity, and not providing details of his employment;
- accepted direct payments for the treatment of a number of his patients, including Patient A, in breach of his arrangements with the practice, which was misleading and dishonest;
- by taking payments directly from Patient A, he failed to ensure that Patient A is able to seek redress and continuation of her treatment directly from the Practice following his departure which was misleading and dishonest; and
- failed to reimburse the payments to the Practice upon request which was dishonest.

Misconduct

The Committee bore in mind that its decision on misconduct and impairment are matters for its own independent judgement. It first considered whether the facts found proved amount to misconduct. The Committee was referred to the cases of Roylance v GMC [2000] AC 311; Calhaem v GMC [2007] EWHC 2606 (Admin) and Doughty v GDC [1988] AC 164.

The Committee accepted the opinion of Dr Jefferies that the overall care provided to Patient A fell far below the standards expected of a registered Dentist because informed consent was not obtained, treatment was not completed, no effort was made for the continuing care of Patient A and the clinical records were not clear, legible or easily understood. Furthermore the registrant accepted direct payments from patients and did not refund the monies due to the Practice.

The Committee was of the view that the facts found proved were a serious departure from the standards of conduct expected from a dental practitioner. It found serious and multiple

acts and omissions which fell far short of what would be proper and which breached the standards of the profession. The Committee's findings show that the registrant put his financial interests before the interests of his patients. Of the nine principles set out in the GDC's Standards for the Dental Team (September 2013), Mr Okechukwu-Funk breached the following:

Principle 1 Put patients' interest first

Principle 2 Communicate effectively with patients

Principle 3 Obtain valid consent

Principle 5 Have a clear and effective complaints procedure

Principle 6 Work with colleagues in a way that is in patients' best interest

Principle 9 Make sure your personal behaviour maintains patients' confidence in you and the dental profession.

The Committee considered that the registrant's conduct would be regarded as deplorable by fellow practitioners. His dishonest conduct was dishonourable, disgraceful and was compounded by the fact that it was in relation to patients and colleagues who placed their trust in him as a registered dental professional.

The Committee determined that Mr Okechukwu-Funk's failings were so serious that they amounted to misconduct.

Impairment

The Committee next considered whether the registrant's fitness to practise is currently impaired by reason of his misconduct.

The Committee applied the approach formulated by Dame Janet Smith in her Fifth Report from the Shipman case; that is, it should ask itself:

"Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:

a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or

d. has in the past acted dishonestly and/or is liable to act dishonestly in the future."

Patient A did not receive the treatment that she had paid the registrant for. The registrant left the practice without informing Patient A or making arrangements for the completion of her treatment with another dentist. In that time, Patient A stated that the cover screw on the right side implant came off and she became concerned about the possibilities of infection. The registrant's conduct in not providing continuing aftercare of Patient A put the patient at unwarranted risk of harm. The registrant took payments for treatment directly from patients in his surgery using his own card reader connected to his personal bank account, contrary to his arrangement with the practice. His dishonest conduct was not opportunistic but

deliberate and it brought the dental profession into disrepute. Furthermore, his conduct breached a significant number of the standards of the profession.

In considering whether the misconduct was liable to be repeated, the Committee noted that there was nothing before it from Mr Okechukwu-Funk on which it could carry out an assessment of any remediation or insight. In the absence of any evidence, the Committee concluded that the misconduct was highly likely to be repeated in the future. Furthermore, the Committee is satisfied that public confidence in the profession would be undermined if a finding of current impairment was not made in this case.

The Committee therefore determined that the registrant's fitness to practise is currently impaired by reason of his misconduct.

Sanction

The Committee next considered what sanction, if any, to impose on Mr Okechukwu-Funk's registration. It reminded itself that the purpose of a sanction is not to be punitive although it may have that effect. The Committee bore in mind the principle of proportionality. It carefully considered the GDC's Guidance for the Practice Committees, including Indicative Sanctions Guidance (October 2015) (PCC Guidance).

The registrant has neither engaged with the GDC's investigations nor in these proceedings. There is nothing by way of mitigation before the Committee evidencing remorse, insight, apology, the nature of his conduct following these events, including any remedial action undertaken. On the other hand, there are multiple aggravating factors emanating from the findings made against Mr Okechukwu-Funk. His misconduct was pre-meditated; he put Patient A at risk of physical harm in terms of the failed implant and the lack of continued care; he put the patients he took direct payments from, including Patient A, at risk of financial harm as they would be unable to seek redress or continuation of treatment; he acted dishonestly in relation to his patients and his professional colleagues for personal financial gain; he abused the trust placed on him by his patients and colleagues; his misconduct spanned a considerable period of time and was covert as his method of taking payments were unknown to the practice. Furthermore he demonstrated a blatant and wilful disregard of the role of the GDC and the systems regulating the profession. His email responses to Patient A, such as they are, demonstrate a complete lack of insight into the effect of his conduct on a patient who trusted his professionalism.

The Committee was of the view that taking no action in this case would be wholly inappropriate and disproportionate to the serious misconduct found against Mr Okechukwu-Funk.

The Committee considered the sanctions in ascending order. It noted from the PCC Guidance that a reprimand would be appropriate where the misconduct is at the lower end of the spectrum and the circumstances do not pose a risk to patients or the public which requires rehabilitation or restriction of practice. The registrant acted dishonestly towards his patients and professional colleagues for his own financial gain thereby breaching the trust placed in him. He has shown no insight into his conduct, his behaviour was not an isolated incident but deliberate and related to multiple patients and there is no evidence of remorse or remediation. The registrant's conduct falls at the higher end of the spectrum of seriousness. The Committee concluded that a reprimand would also be wholly inappropriate in this case.

The Committee then considered whether to impose conditions of practice on the registrant. It bore in mind that conditions must be workable, measurable, relevant and proportionate. The Committee was of the view that in the absence of any engagement by the registrant, it could not be confident in the registrant's capacity to comply with them. His misconduct placed patients and his colleagues directly at risk of financial harm and Patient A was placed at risk of both physical and financial harm. The Committee concluded that conditions would also be wholly inappropriate in a case involving a finding of serious dishonesty.

The registrant's misconduct demonstrate harmful, deep-seated personality and professional attitudinal problems. The Committee was of the view that his behaviour towards his patients and colleagues has damaged his fitness to practise, the public confidence in the dental profession and is fundamentally incompatible with being a registered dental professional. For these reasons the Committee determined that a suspension order would be inappropriate and insufficient given the severity of its findings.

The Committee therefore directs that Mr Okechukwu-Funk's registration be erased from the Dentists Register pursuant to section 27B (6)(a) of the Dentists Act 1984, as amended.

The Committee considered Mr Renton's application that an immediate order should be imposed on Mr Okechukwu-Funk's registration today. It accepted the advice of the Legal Adviser.

The misconduct found against the registrant is serious, breached the standards of the profession, breached the trust of patients and professional colleagues, was deliberate and for his own financial gain. Furthermore he has demonstrated a wilful and blatant disregard for his regulator and shown no insight or remorse for his behaviour. The Committee determined that an immediate order of suspension is necessary for the protection of the public, and is otherwise in the public interest.

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

That concludes the case."