General Dental Council | protecting patients, regulating the dental team

HEARING HEARD IN PUBLIC

HENRY, Alan William

Registration No: 53052

PROFESSIONAL PERFORMANCE COMMITTEE

JULY 2017

Outcome: Erased with Immediate Suspension

Alan William HENRY, a dentist, BDS Ncle 1979, was summoned to appear before the Professional Performance Committee on 10 July 2017 for an inquiry into the following charge:

Charge (as amended on 10 July 2017)

"That, being a registered dentist:

At all material times you were a United Kingdom registered Dental Practitioner practising at 35 Ormskirk Road, Preston, PR1 2QP ("the Practice").

Patient A

1 You did not provide Patient A with an adequate standard of care as you did not adequately assess her periodontal condition at appointments between 7 December 2006 to 17 May 2011 except for the appointment on 28 September 2009.

2 As a result of the conduct described in paragraph 2, you did not:

(a) adequately treat Patient A's periodontal condition

(b) provide suitable treatment options to Patient A.

3 Between 14 January 2005 to 15 December 2014, you did not provide Patient A with an adequate standard of care by failing to:

(a) provide her with suitable alternative treatment options when appropriate

(b) advise Patient A of the extent of her periodontal condition

(c) refer Patient A for specialist periodontal treatment in a timely manner after the appointment on 28 September 2009

(d) provide Patient A with appropriate oral health advice on a regular basis.

4 As a result of the conduct described in paragraphs 2b and 3a, you did not obtain informed consent for treatment between 14 January 2005 to 15 December 2014.

5 You did not carry out a full mouth periodontal assessment on Patient A at the appointments of:

(a) 28 September 2009

(b) Withdrawn by the GDC

(c) 18 November 2014.

6 You did not provide Patient A with an adequate standard of care as you did not take suitable radiographs when clinically appropriate at appointments between 5 December 2006 to 17 May 2011 except for 1 July 2010.

7 You prescribed Patient A with antibiotics without clinical justification on:

(a) 23 August 2007

(b) 28 September 2009

(c) 22 March 2010

(d) 23 August 2010

(e) 10 January 2011

(f) 21 March 2011

(g) Withdrawn by the GDC

(h) 23 December 2013

(i) 17 January 2014

(j) 27 June 2014.

8 The treatment as set out in paragraph 7 increased the risk of harm to Patient A's health.

9 You did not prepare adequate treatment plans for the courses of treatment undertaken on:

(a) 29 May 2007

(b) 20 July 2010

(c) Withdrawn by the GDC.

10 By using a periochip in isolation to other suitable treatment, you provided treatment to Patient A that was not clinically appropriate on:

(a) 28 September 2009

(b) 9 October 2009

(c) Withdrawn by the GDC

(d) Withdrawn by the GDC

(e) 2 December 2014.

11 You failed to maintain an adequate standard of record keeping for Patient A in that you:

(a) did not record the clinical justification for prescribing antibiotics on

(i) 23 August 2007
(ii) 28 September 2009
(iii) 22 March 2010
(iv) 23 August 2010
(v) 10 January 2011
(vi) 21 March 2011
(vii) 21 March 2011
(viii) 23 December 2013
(ix) 17 January 2014
(x) 27 June 2014.

(b) did not record the clinical justification for using a periochip in isolation on:
(i) 28 September 2009
(ii) 9 October 2009
(iii) 16 November 2012
(iv) 12 September 2013
(v) 2 December 2014.

(c) did not record sufficient details of the examinations carried out on:
(i) Withdrawn by the GDC
(ii) 9 November 2005
(iii) 10 May 2006
(iv) 22 November 2006
(v) 8 March 2007
(vi) 15 November 2007
(vii) Withdrawn by the GDC
(viii) Withdrawn by the GDC
(ix) Withdrawn by the GDC
(x) Withdrawn by the GDC
(xi) Withdrawn by the GDC
(xii) Withdrawn by the GDC
(xiii) Withdrawn by the GDC
(xiv) Withdrawn by the GDC
(xv) Withdrawn by the GDC
(xvi) Withdrawn by the GDC

(xvii) 30 December 2013.

(d) did not record the treatment plans prepared for the courses of treatment undertaken on:

(i) 29 May 2007

(ii) 20 July 2010

(iii) 31 August 2010.

Patient B

12 Between May 2005 to December 2014 you did not provide Patient B with an adequate standard of care:

(a) with the exception of 13 September 2005, you did not carry out adequate diagnostic assessments on Patient B when clinically appropriate;

(b) you did not prepare any treatment plans for Patient B

13 By using a periochip in isolation to other suitable treatment, you provided treatment to Patient B that was not clinically appropriate on:

(a) 8 July 2005

(b) 14 February 2006

(c) 16 July 2014

14 You failed to adequately assess and report the findings from the radiograph taken on 21 May 2002.

15 You did not provide Patient B with an adequate standard of care by not taking suitable radiographs when clinically appropriate at appointments between May 2005 to September 2014

16 As a result of the conduct described in paragraph 15, you did not adequately assess Patient B's bone loss and periodontal disease.

17 As a result of the conduct described in paragraphs 15 and / or 16, you did not adequately treat Patient B's periodontal disease.

18 Between July 2005 to July 2014, you did not provide Patient B with appropriate oral hygiene advice at clinically appropriate intervals.

19 You prescribed Patient B with antibiotics without clinical justification on:

(a) 1 July 2005

(b) 15 June 2006

(c) 21 August 2006

(d) 29 August 2006

(e) 28 December 2006

(f) 3 August 2014

20 The treatment as set out in paragraph 19 increased the risk of harm to Patient B's health.

21 You failed to maintain an adequate standard of record keeping for Patient B in that you:

(a) did not record the clinical justification for prescribing antibiotics on:

(i) 1 July 2005

(ii) 15 June 2006

(iii) 21 August 2006

(iv) 29 August 2006

(v) 28 December 2006

(vi) 3 August 2014

(b) did not record the clinical justification for using a periochip in isolation on:

(i) 8 July 2005

(ii) 14 February 2006

(iii) 16 July 2014

(c) did not record details of the anaesthetic used on:

(i) 25 October 2006;

(ii) 3 January 2007.

(d) did not record adequate details for any or all the appointments when:

(i) scaling was noted as being carried out;

(ii) extractions were noted as being carried out.

(e) did not adequately record sufficient information regarding the referrals made for Patient B

(f) did not adequately record the treatment plans for Patient B.

And in relation to the facts alleged your fitness to practise is impaired by reason of your performance and / or misconduct."

On 10 July 2017 Ms Vanstone on behalf of the GDC made an application under Rule 57 of the GDC (Fitness to Practise) Rules 2006 for the Committee to admit Patient A and Patient B's statement as hearsay evidence in their absence. The Chairman made the following response:

"Ms Vanstone, on behalf of the General Dental Council (GDC), has made an application under Rule 57 of the GDC (Fitness to Practise) Rules 2006 ('the Rules') for this Committee to admit Patient A's statement, dated 11 May 2016, and Patient B's statement dated 10 May 2016, as hearsay evidence, in their absence. She set out the background to her application.

Patient A and Patient B (who are married to each other, Patient A is the wife and Patient B is the husband) are the main complainants in this case. Ms Vanstone explained that up until recently both witnesses had been co-operating with the GDC and had agreed to give evidence in person. However, Patient A is unable to attend the hearing due to her health condition and Ms Vanstone provided medical evidence in support of that. Patient B is now Patient A's full-time carer and as a consequence, he is unable to attend the hearing. She submitted that the evidence of Patient A and Patient B is relevant to the charges against Mr Henry, albeit the GDC is intending to call Mr Canty (GDC expert witness) to provide further evidence in support of its case. She also submitted that there is nothing to suggest that the witnesses have fabricated their accounts and indeed no challenge to their evidence has been put forward by Mr Henry. Ms Vanstone also asked the Committee to have regard to the serious nature of the charges against Mr Henry.

Ms Vanstone informed the Committee that prior to making the application, Blake Morgan Solicitors (acting on behalf of the GDC) had informed the Medical Protection Society (MPS) on behalf of Mr Henry that the GDC was intending to make the hearsay application. The solicitor at the MPS had replied by email dated 10 July 2017 in which she stated: "I have spoken to Mr Henry and explained the situation. He has no wish to obstruct this process and so consents to your application having been assured, by me, that the Committee is bound to apply particular care before concluding that the statements can be given any weight in the absence of corroborative evidence and given that they are contradictory in some respects."

In short, Ms Vanstone submitted that it would be fair to admit the statements of Patient A and Patient B as hearsay evidence. During the course of her submissions, she referred the Committee to the case of Thorneycroft V NMC which, she said, was relevant in considering this application.

The Committee has considered carefully the submissions made by Ms Vanstone. It has accepted the advice of the Legal Adviser. In considering this application, the Committee has had regard to the overarching issue of justice and fairness as well as the provisions set out in Rule 57.

The Committee notes from the information before it that up until recently Patient A and Patient B were intending to give evidence in person at this hearing. It considers that it has received good and cogent reasons for their non-attendance, given the medical evidence presented to it today. The Committee is satisfied that their evidence is relevant to the charges against Mr Henry, albeit it is not the only evidence provided by the GDC in support of its case. The Committee will be able to take into account the other documentary evidence before it, as well as that of Mr Canty in assessing the evidence of Patient A and Patient B. Furthermore, it notes that the allegations in this case are serious in that they relate to clinical matters which engages issues concerning patient safety. Finally, the Committee has had regard to the confirmation today from the MPS that Mr Henry does not object to this application. In due course, the Committee will decide what weight, if any, it attaches to the evidence of Patient A and Patient B.

Accordingly, the Committee has concluded that it would be in the interests of justice to receive the witness statements of Patient A and Patient B by way of hearsay evidence."

Mr Henry was not present and was not represented. On 12 July 2017 the Chairman announced the findings of fact to the Counsel for the GDC:

Service and proceeding in absence

"Mr Henry is not present or represented at the Professional Performance Committee (PPC) hearing of his case. In his absence, the Committee first considered whether the General Dental Council (GDC) had served the Notice of Hearing on Mr Henry in accordance with Rules 13 and 65 of the GDC (Fitness to Practise) Rules Order of Council 2006 (the Rules).

The Committee has seen a copy of the Notice of Hearing letter dated 26 May 2017 which was sent by Blake Morgan Solicitors, acting on behalf of the GDC, to Mr Henry's registered address by special delivery. The letter sets out the date, time and location of the hearing, as well as the particularised facts of the charge, in compliance with Rule 13. The Royal Mail receipt confirms attempted delivery of the item to Mr Henry's registered address and that it was returned "back to sender" on 22 June 2017. The same letter was also sent by first class post. Furthermore, the Committee has seen a copy of a letter dated 26 May 2017 from Blake Morgan Solicitors to Mr Henry's solicitor at the Medical Protection Society (MPS), attaching a copy of the Notification of Hearing. The Committee, having heard the Legal Adviser's advice, is satisfied that proper service of the Notification of Hearing has been effected, in accordance with Rules 13 and 65.

The Committee then went on to consider, in accordance with Rule 54, whether to hear this case in the absence of Mr Henry. Ms Vanstone, on behalf of the GDC, invited the Committee to do so on the basis that Mr Henry is aware of today's hearing but has not engaged thus far in relation to these proceedings. She also made the point that Mr Henry has not requested an adjournment of the hearing.

The Committee has considered the submissions made by Ms Vanstone. It has accepted the advice of the Legal Adviser. It has borne in mind that the discretion to proceed in the absence of the respondent must be exercised with the utmost care and caution and that it must have in mind the need for fairness to Mr Henry as well as to the GDC. The Committee has concluded that Mr Henry is aware of today's hearing but has chosen not to engage with the GDC in relation to these proceedings. It has received no request for an adjournment. Furthermore, there is nothing to suggest that Mr Henry would attend on a future occasion, were this Committee minded to adjourn this hearing. The Committee has drawn the inference that Mr Henry has voluntarily absented himself from this hearing. Having regard to all these matters, the Committee has decided, in accordance with Rule 54, that it is fair to proceed in the absence of Mr Henry.

Withdrawal of charges at the outset

At the outset of the hearing Ms Vanstone confirmed that the GDC was withdrawing charges 5(b); 7(g); 9(c); 10(c) - 10(d); 11(c)(i) and 11(c)(vii) - 11(c)(xvi). Accordingly, the Committee did not consider them.

The GDC's case against Mr Henry and the evidence received

The GDC's case involves concerns raised by Patient A on behalf of herself and her husband, Patient B, concerning the standard of care Mr Henry provided to her while practising at the Ormskirk Road Practice in Preston (the Practice). Patient A wrote a letter to Mr Henry dated 24 April 2015, expressing her concerns about the dental treatment she and Patient B had received from him between 1994 and September 2014. A subsequent treating dentist made a diagnosis of advanced gum disease for Patient A and gave a poor prognosis for her remaining teeth. Patient A advised that her husband, Patient B, had "lost very many teeth" and also attended a subsequent treating dentist. Patient A did not receive a response

to her letter of complaint. On 25 May 2015, she submitted a complaint for herself and on behalf of Patient B to the GDC.

Mr Henry has not participated in these proceedings and no defence case has been put forward either by him or on his behalf. The Committee has drawn no adverse inference from Mr Henry's non-attendance at this hearing.

There have been no admissions in this case. The Committee has therefore considered each of the charges against Mr Henry, apart from the charges which the GDC withdrew at the outset of the hearing. In so doing, the Committee has considered all the documents contained in the GDC prosecution bundle. This includes the witness statements of Patients A and B, which the Committee agreed to receive as hearsay evidence. Patients A and B had engaged with the GDC but were unable to attend due to problems with Patient A's health. According to Patient A's witness statement, she had attended Mr Henry for over 30 years, seeing him regularly every six months until 2004/05. She described noticing a "build-up of plaque" and difficulty cleaning her teeth. Treatment carried out by Mr Henry included dental examinations, x rays, scaling and polishing, fillings, prescribing antibiotics and the application of Periochips. On Patient A's account, no explanation for the cause of repeated infections and loose teeth was given.

Patient B's witness statement indicated that he had been an NHS patient of Mr Henry for over 30 years and had attended for regular check-ups every six months. He had attended Mr Henry for numerous appointments between 29 April 1995 and 18 September 2014. Patient B states that he began to have difficulty with his gums in the early 2000s which, he states, resulted in the loss of six teeth over a relatively short period of time. Treatment carried out by Mr Henry included dental examinations, x rays, scaling and polishing, fillings, extractions, prescribing antibiotics and the application of Periochips.

The Committee has borne in mind that Patient A and Patient B's evidence has not been tested by way of cross examination or questions by the Committee. Furthermore, it notes that whilst recollection can be less accurate with time, overall, the Committee considered that Patient A and Patient B's evidence was fair and objective, without being emotive or vindictive in any way. Their accounts were broadly supported by the dental records.

The Committee has also had regard to the expert evidence from Mr Canty, called on behalf of the GDC. He produced a report dated 20 May 2016. Overall, the Committee considered that Mr Canty gave fair and objective opinions. In the Committee's view, Mr Canty was clear in his evidence as to criteria he used to assess Mr Henry's level of care and where he considered it to fall below or far below the standard of care expected of a reasonably competent dentist. The Committee has accepted Mr Canty's evidence.

The Committee has taken into account all the evidence presented to it. It has accepted the advice of the Legal Adviser. The Committee has borne in mind that the burden of proof is on the GDC and that it must decide the facts according to the civil standard of proof, namely on the balance of probabilities. Mr Henry need not prove anything. In accordance with his advice the Committee has considered each charge separately. I will now announce the Committee's findings in relation to each of the charges as follows:

1.	Found proved Mr Canty's evidence was that he could find no entries in the clinical notes for the dates referenced in the charge to indicate

	that a BPE had been carried out by Mr Henry, or to indicate that he carried out a more extensive periodontal examination, including a 6-point periodontal charting. Overall, Mr Canty observed that the clinical records lacked "narrative and details of any diagnostic assessments that may have been carried out", except for the appointment dated 28 September 2009. The notes for that appointment record: "distal pocket LR2 5- 6mm to rev/Periochip." Mr Canty explained that he would have expected Mr Henry to have carried out a comprehensive assessment of the patient's periodontal condition, including a full mouth periodontal charting, so that a baseline could have been established. This, Mr Canty considered, would have been required for treatment planning and monitoring the patient's periodontal condition. The Committee accepted this view. There is nothing in the records to indicate that Mr Henry has assessed Patient A's periodontal condition at the times alleged. The Committee accepted Mr Canty's evidence that such an assessment should have been carried out.
2. a)	Found proved In reaching its decision, the Committee has had regard to its finding at charge 1 – namely that Mr Henry did not adequately assess Patient A's periodontal condition. In addition, the Committee has also borne in mind appendix 2 of Mr Canty's report where he has transcribed the clinical records for the appointments in question. Mr Canty's opinion is that there is nothing in the records to indicate that Mr Henry treated Patient A's periodontal condition. The Committee accepted Mr Canty's evidence for the reasons set out at charge 1.
2. b)	Found proved In the light of the Committee's finding that Mr Henry failed to assess or treat Patient A's periodontal condition, the Committee has drawn the inference that he did not provide suitable treatment options to Patient A. This is supported by Patient A's evidence that Mr Henry did not discuss treatment options with her, or the advantages and disadvantages of any particular treatment. Furthermore, there is nothing in the records to undermine Patient A's evidence in this regard.
3. a)	Found proved The Committee has had regard to its finding at charge 2(b). It has accepted Patient A's evidence on this matter. Mr Canty opined that there was no record indicating that Mr Henry gave advice to Patient A regarding her periodontal condition, given that he had not carried out the appropriate periodontal assessments and he had not diagnosed the extent of her periodontal disease. Further, he could find no record to indicate that treatment options were offered. The Committee accepts Mr Canty's evidence.

3. b)	Found proved Patient A's statement said that Mr Henry never informed her that she had gum or periodontal disease. She explained that she saw another dentist on 22 January 2015. That dentist asked her: "Has no one told you how to look after/brush your teeth?" Patient A's evidence was that she was aware that her gums bled but that she never considered that she might be suffering from gum disease and it had not been mentioned to her by Mr Henry. The Committee found Patient A's evidence credible on this point. It received no evidence that undermined Patient A's account. Mr Canty was critical of Mr Henry's failure to advise the patient of the extent of her periodontal condition and the Committee accepted his view.
3. c)	Found proved It was clear from Patient A's statement that Mr Henry had never referred her for specialist periodontal treatment. There is a record in the notes on 28 September 2009 which indicates that Patient A had pocketing in excess of 5mm. There is no evidence before the Committee that Mr Henry referred her for specialist periodontal treatment in a timely manner after this date. Given the extent of Patient A's pocketing and the fact that her periodontal condition had worsened, the Committee accepted the view of Mr Canty that she should have been referred for specialist periodontal treatment in a timely manner after 28 September 2009.
3. d)	Found proved Patient A's evidence was that she told Mr Henry that she was struggling to brush in between her bottom teeth and pointed to the build-up of plaque. Her statement indicated that Mr Henry did not comment on her brushing or plaque nor offer any advice on improving her brushing technique. The Committee found Patient A's evidence credible on this point. It received no evidence that undermined her account.
4.	Found proved Patient A's statement indicated that in relation to specific treatment provided by Mr Henry, such as a filling or an extraction, she would sign a consent form. In relation to Patient A's periodontal condition, Mr Canty could find no indication in the records that Mr Henry had discussed treatment options with her. Due to the lack of information provided, Patient A was unable to give informed consent. Having regard to its findings that Mr Henry failed to provide her with suitable alternative treatment options or advise her of the extent of her periodontal condition, and accepting the opinion of Mr Canty, the Committee finds this charge proved.
5. a)	Found proved

	The clinical notes for 28 September 2009 record the following: "distal pocket LR2 5-6mm to rev/Periochip." Mr Canty's opinion is that in view of the length of the pocket depths, Mr Henry should have carried out a full periodontal assessment. There is no evidence that such an assessment took place on that occasion. The Committee accepts Mr Canty's evidence on this matter.
5. c)	Found proved The clinical notes for 18 November 2014 record the following: "Vertical bone loss LL4; pocket depth 4-5 mm; Periochip." Mr Canty's opinion is that given the pocket depths recorded, Mr Henry should have carried out a full periodontal assessment. There is no evidence that such an assessment took place on that occasion. The Committee accepts Mr Canty's evidence on this matter.
6.	Found proved For the period between 5 December 2006 and 17 May 2011, save for the appointment on 1 July 2010, Mr Canty could find no evidence that any other radiographs were taken over this five-year period. Mr Canty's opinion was that given that Patient A had BPE scores of 3, he would have expected radiographs to have been taken to assess the alveolar bone levels. He could find nothing to indicate that Mr Henry had either considered or carried out radiographic assessments at appropriate intervals, as part of a "structured process to assist in assessment and diagnosis." He went on to explain that he would have expected this assessment to have been either carried out or considered by the Registrant at least every two to three years to aid in diagnosis and treatment planning. The Committee accepted Mr Canty's evidence in that regard.
7. a)– f) & h) – j)	Found proved There is an entry in Patient A's clinical notes for each of the appointments listed in the charges which records that antibiotics were prescribed on each of those occasions. Mr Canty could find no narrative accompanying any of these entries giving the justification for the prescription. Mr Canty's opinion is supported by the evidence of Patient A, who said that she was offered a prescription of antibiotics immediately over the phone without any clinical assessment or examination.
8.	Found proved Mr Canty gave oral evidence as to the risk of harm to Patient A's health caused by Mr Henry prescribing antibiotics without clinical justification. He explained that where antibiotics are repeatedly prescribed their effectiveness will be reduced. The prescription of antibiotics treats the symptoms but fails to treat the existing clinical problem, which in turn increases the risk of patient harm.

9.a)– b)	Found proved Mr Canty could find no treatment plans for the dates 29 May 2007 and 20 July 2010, which he would have expected to see for the band 2 courses of treatment undertaken on those dates. Overall, Mr Canty was critical of Mr Henry's treatment planning which he described as being "carried out on a piecemeal basis, without any overarching plan in place." The Committee accepted Mr Canty's opinion on this matter.
10 a) - b) & e)	Found proved Patient A describes Mr Henry using a Periochip and there is a note in the clinical records of its use on the dates in question. Mr Canty explained that a Periochip should be used as an adjunct to other periodontal therapy such as root surface debridement and that, if used in isolation, it would have little, if any, therapeutic effect. There is nothing in the clinical records to indicate that other suitable periodontal therapy was being carried out on these occasions. The Committee accepted Mr Canty's opinion on this matter.
11. a) i) – vi) & viii) – x)	Found proved (i) to (x), save for charge (vii), which is the same date as that set out in charge (vi). The Committee has accepted the evidence of Mr Canty that there is no note in the clinical records to show a rationale or justification for the antibiotics prescribed. In his view, it is important to record the clinical justification for the prescribing of the antibiotics on each occasion and a failure to do so amounts to a failure to maintain an adequate standard of record keeping.
11. b) i) – ii) & v)	Found proved Mr Canty could find no record of the clinical justification for using a Periochip in isolation on any of the dates in question. Having examined the records, the Committee has accepted Mr Canty's evidence.
11. b) iii) – iv)	Found not proved There is no record for the use of a Periochip on 16 November 2012 and 12 September 2013. Therefore, there is no requirement for a record of a clinical justification for the use of a Periochip.
11. c) ii), iii), iv), v), vi) and xvii)	Found proved For each of the dates in question, the word "exam" is recorded in the clinical notes but these refer to little or no detail of the examination carried out. Mr Canty explained that he would have expected to have seen a comprehensive record of the findings of the examinations, including any abnormalities or changes found in the face, neck, soft tissue of the mouth such as the cheeks and tongue, the hard tissues, bone and temporomandibular joints. He

	also considered that an examination of the teeth and restorations should be recorded, together with any other findings. Further, if there were no changes, then this should be recorded. The Committee accepted Mr Canty's evidence in this regard.
11. d) i) – ii)	Found proved The Committee accepted Mr Canty's evidence that no treatment plans had been recorded for these dates.
11. d) iii)	Found not proved There is a record of some treatment planning on 31 August 2010.
12. a)	Found proved Mr Canty could find nothing in the clinical records to indicate that any adequate assessment was carried out, with the exception of an entry on 13 September 2005 which states "perio charting." Mr Canty was critical of Mr Henry's failure to carry out adequate diagnostic assessments, describing his approach to treatment as being piecemeal. The Committee accepts Mr Canty's evidence.
12. b)	Found proved In reaching its decision, the Committee has had regard to its finding at charge 12(a). The Committee has also had regard to the absence of any written treatment plans in the clinical records.
13. a) – c)	Found proved The Committee had regard to Mr Canty's evidence that the Periochip should be used as an adjunct to other periodontal therapy and if used in isolation, it would have little, if any, therapeutic effect. There is a note in Patient B's clinical records that a Periochip was used for each of these appointments. However, there is nothing in the clinical records to show that other appropriate treatment such as oral hygiene instruction, scaling, or root surface debridement, was provided.
14.	Found proved A radiograph was taken on 21 May 2002. Mr Canty was critical of Mr Henry's "lack of qualitative assessment and report of findings" for that radiograph. The Committee, having examined the records for 21 May 2002, can find no information in the clinical notes regarding an assessment of the radiograph taken. The Committee accepts Mr Canty's evidence on this matter.
15.	Found proved Patient B's statement indicates that he could not remember any x-rays being taken by Mr Henry, or being referred for an x-ray by Mr Henry. Mr Canty could find no record in Patient B's clinical notes that Mr Henry had either considered or carried our radiographic assessments at appropriate intervals, as part of a structured

	approach to assist in assessment and diagnosis. He considered that, given Patient B's clinical signs and symptoms, Mr Henry should have taken regular radiographs to assess the degree of bone loss and any caries that might have been present. The Committee accepts Mr Canty's evidence on this matter.
16.	Found proved It was Mr Canty's opinion that, as a result of a failure to take appropriate radiographs, the extent of Patient B's periodontal disease and bone loss was not comprehensively assessed and diagnosed by Mr Henry. The Committee accepted this evidence.
17.	Found proved As a consequence of the Committee's findings at Charges 15 and 16, this was found proved.
18.	Found proved Patient B's statement indicates that Mr Henry never discussed with him his oral health and what he might do to improve it. This evidence is supported by Mr Canty's report that he could find nothing in the clinical records to show that Mr Henry provided Patient B with any oral hygiene advice or instruction.
19. a) – b) & d) – f)	Found proved Mr Canty provided an analysis of Patient B's records in which he identified five occasions where antibiotics were prescribed without any justification for the prescriptions being recorded. The Committee accepted Mr Canty's analysis.
19. c)	Found not proved For the appointment for 21 August 2006, Mr Henry has recorded "Flagyl tabs, UR6 mobile LR76 tender to Rev?" Mr Canty comments that there is no dosage or duration for the prescription. However, unlike the other appointments set out in the charges above, which have been found proved, Mr Canty does not level any criticism about a failure to prescribe antibiotics without clinical justification. The Committee accepted his view that the entry provides some clinical justification for the prescription.
20.	Found proved, save in relation to 19(c) This is for the same reasons as set out at Charge 8 relating to Patient A.
21. a) i) – ii) & iv) – vi)	Found proved In reaching its decision the Committee has had regard to its findings at Charge 19. Mr Canty was critical of Mr Henry's failure to record the clinical justification for the prescribing of the antibiotics. The Committee accepted Mr Canty's evidence in this regard.

21. a) iii)	Found not proved As a consequence of the Committee finding Charge 19(c) not proved, this charge could not be proved.
21. b) i) – iii)	Found proved There is no record of the clinical justification for using a Periochip in isolation on the dates in question.
21. c) i) – c) ii	Found proved The clinical notes do not detail the local anaesthetic being administered on 25 October 2006 and 3 January 2007. The clinical records for both dates simply state "XL" along with a tooth notation. Mr Canty considered that the record should have recorded the type of local anaesthetic used, its dosage or expiry date. The Committee accepts Mr Canty's evidence on this matter.
21. d) i) – ii)	Found proved Mr Canty's evidence is that there is a lack of narrative throughout the clinical records to describe any of the clinical procedures undertaken during the period of review. The Committee accepted Mr Canty's evidence on this matter.
21. e)	Found proved Mr Henry's references to referrals contain little or no relevant detail. Mr Canty's opinion supports this.
21. f)	Found proved Treatment plans are not recorded for Patient B. Mr Canty's opinion supports this."

On 12 July 2017 the Chairman announced the determination as follows:

"Ms Vanstone, on behalf of the GDC, made submissions on the matters set out in Rule 20(1)(a) of the Fitness to Practise Rules 2006. She submitted that the findings against Mr Henry involve basic and fundamental areas of dentistry, cover a period of some 12 years and amount to misconduct. She also submitted that it was open to the Committee to conclude that Mr Henry's fitness to practise is currently impaired by reason of his deficient professional performance and/or misconduct. There was, she submitted, a risk of repetition. Ms Vanstone referred the Committee to the relevant caselaw. In terms of the disposal of the case, Ms Vanstone submitted that the GDC was seeking an order of suspension. The Committee has received no submissions from Mr Henry or from his solicitor at the Medical Protection Society on the matters set out in Rule 20(1)(a). The Committee has considered the submissions made by the GDC and has accepted the advice of the Legal Adviser.

Previous fitness to practise history

Ms Vanstone advised the Committee of Mr Henry's previous history with the GDC. There was a previous case, which was first considered by the Professional Performance

Committee (PPC) at a hearing that took place in June 2016. Mr Henry was not present or represented at that hearing. That case related to a complaint made by a patient to the GDC about the care and treatment provided by Mr Henry to her, her husband and her granddaughter, who was a minor at the time of treatment. The PPC considered that the deficiencies found proved in that case spanned a period of 13 years and involved some areas of basic dentistry. In particular, it noted that the dental records of the patients were extremely poor and in the PPC's view, demonstrated a pattern of poor record-keeping over a number of years. The PPC found that the standard of Mr Henry's professional performance in this respect was unacceptably low and constituted deficient professional performance. It also found that his failings were serious and amounted to misconduct.

The PPC determined that Mr Henry's fitness to practise was impaired by reason of his deficient professional performance and his misconduct. It concluded that conditions could be formulated to protect the public and address the discrete areas where deficiencies were found in his practice. The PPC therefore directed that Mr Henry's registration be subject to an order for conditional registration for a period of 6 months.

The PPC reviewed the order at a hearing on 7 December 2016. Mr Henry did not attend that hearing and he was not represented. That PPC noted that there had been no engagement by Mr Henry in relation to the GDC's proceedings against him and there was no evidence of remediation or insight into the matters concerned. It noted that the Interim Orders Committee in January 2016 was informed that Mr Henry had indicated that he had retired from dental practice. The PPC's determination also referred to the fact that Mr Henry had intended to apply for voluntary removal.

The PPC in December 2016 determined that Mr Henry's fitness to practise remained impaired. It concluded that conditions were no longer sufficient and directed that the current order be replaced with one of suspension for a period of 12 months. The PPC also recommended that the order be reviewed before its expiry.

Misconduct in relation to the matters found proved by this Committee

The Committee first considered whether the facts found proved amount to misconduct. In so doing, it has had regard to all the evidence before it, as well as the submissions made by Ms Vanstone. Additionally, the Committee has kept in mind the expert evidence of Mr Canty (called on behalf of the GDC) as well as the relevant guidance referred to in his evidence. This includes the GDC's "Standards for Dental Professionals" (2005); its "Standards for the Dental Team" (2013) as well as the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).

This case concerns the treatment and care Mr Henry provided to Patients A and B at the Ormskirk Road Practice (the Practice) between 2006 and 2014. The Committee has set out its findings and its reasons for them in detail in its determination on the facts. The failings in relation to the treatment of Patient A and Patient B include the following:

- A failure to adequately assess and treat Patient A's periodontal condition between December 2006 and May 2011. This included a failure to carry out a full mouth periodontal assessment of Patient A.
- A failure to refer Patient A for specialist periodontal treatment in a timely manner after the appointment in September 2009.
- A failure to take suitable radiographs where clinically appropriate for Patient A between December 2006 and May 2011, save for 1 July 2010.

- A failure to obtain Patient A's consent for treatment between 14 January 2005 and 15 December 2014.
- Prescribing antibiotics without clinical justification on numerous occasions in respect of Patient A and Patient B.
- A failure to maintain an adequate standard of record keeping in respect of Patient A and Patient B, including a failure to record the clinical justification for the prescribing of antibiotics.
- A failure to prepare and/or record adequate treatment plans for the courses of treatment undertaken on numerous occasions.
- The use of Periochips in isolation to other suitable treatment, which was not clinically appropriate.

The Committee received expert evidence that Mr Henry's failures resulted in poor outcomes for Patients A and B. In the case of Patient A, there was a poor prognosis for her entire dentition and in the case of Patient B, the loss of six teeth over a relatively short period of time. Mr Canty's evidence was that the standard of care provided by Mr Henry in respect of these two patients fell far below that expected of a reasonably competent practitioner working in general practice. This was both in relation to the clinical matters and the standard of Mr Henry's record keeping. The Committee accepts Mr Canty's evidence.

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

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

2.2 Recognise and promote patients' responsibility for making decisions about their bodies, their priorities and their care, making sure you do not take any steps without patients' consent (permission). Follow our guidance 'Principles of patient consent'.

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

5.3 …. Provide a good standard of care based on available up-to-date evidence and reliable guidance.

The GDC 'Standards for the Dental Team' (September 2013) also contains the same principles which have been breached, including in the areas of putting patients' interests first and obtaining valid consent. In particular, the Committee has had regard to the following:

1.1.1 You must discuss treatment options with patients and listen carefully to what they say. Give them the opportunity to have a discussion and to ask questions.

2.3.6 You must give patients a written treatment plan, or plans, before their treatment starts and you should retain a copy in their notes.

3.3.1 You must make sure you have valid consent before starting any treatment or investigation.

4.1 Make and keep contemporaneous, complete and accurate patient records.

7.1 Provide good quality care based on current evidence and authoritative guidance.

The Committee considers that Mr Henry has repeatedly breached the above guidance as well as failing to comply with the IRMER regulations in that he failed to record a clinical evaluation of the radiograph taken for Patient B. Finally, the Committee has had regard to Mr Henry's failure to follow the Faculty of General Dental Practitioners' guidance on "Antimicrobial Prescribing for General Dental Practitioners" which indicates the need to record the prescription details in the notes. Having regard to the repeated failures in respect of his treatment and care of Patients A and B, involving basic and fundamental aspects of dentistry spread over a period of some 12 years, the Committee has concluded that Mr Henry's conduct fell far below the standards reasonably expected of a registered dentist. Both patients suffered harm as a result of Mr Henry's acts and omissions. Accordingly, the Committee has determined that the facts found proved are serious and amount to misconduct.

Deficient professional performance

The Committee then went on to consider whether the facts found proved amounted to deficient professional performance. In so doing, it has borne in mind the case of Calhaem v General Medical Council [2007] EWHC 2606 where it was noted that: "Deficient Professional Performance" …connotes a standard of professional performance which is unacceptably low and which (save in exceptional circumstances) has been demonstrated by reference to a fair sample of the 'doctor's' work."

The Committee has taken into account that the findings in the case relate to two patients - Patient A and Patient B and that the analysis of Patient A and Patient B's records carried out by Mr Canty came about following Patient A's complaint to the GDC. There is no evidence before the Committee of any other analysis of Mr Canty's patient records. In the Committee's judgement, the records for two patients, who are the main complainants in this case, do not constitute a "fair sample" of Mr Henry's work. Accordingly, the Committee is not satisfied that the findings of fact against Mr Henry amount to a finding of deficient professional performance.

Impairment

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

The Committee is satisfied that the identified shortcomings in Mr Henry's practice, which relate to clinical matters and record-keeping failings, are potentially remediable. However, there is no evidence before the Committee that Mr Henry has remediated the shortcomings or indeed has any intention of doing so; nor is there any indication that he has insight into his failings. The Committee has also had regard to Mr Henry's lack of engagement in these proceedings and his previous hearings before the GDC. Indeed, the Committee notes that Mr Henry did not attend and was not represented at the review hearing before the PPC in December 2016. In the absence of any evidence of remediation or insight into the matters identified in this case, the Committee considers that there is a risk of repetition of the serious and sustained misconduct found proved.

The Committee has also had regard to the risk of repetition in the context of Mr Henry's previous fitness to practise history. The findings in the present case are similar in nature to a number of the deficiencies identified by the PPC in June 2016. The PPC considered that Mr Henry remained a risk to the public and this Committee has received no evidence to indicate that the position had changed.

The Committee has further considered the wider public interest, including the need to declare and uphold proper standards of conduct and behaviour, so as to maintain public confidence in the profession. The Committee has found that Mr Henry failed to provide an appropriate standard of care to two patients which resulted in actual patient harm. In addition, Mr Henry's failure to obtain informed consent – which is a breach of one of the fundamental duties required of a registrant. In these circumstances, the Committee considers that public confidence would be undermined if a finding of impairment were not made.

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

Sanction

The Committee has considered what sanction, if any, to impose on Mr Henry's registration. In so doing, it has borne in mind the principles set out in the GDC's "Guidance for the Practice Committee, including Indicative Sanctions Guidance" (October 2016). It has borne in mind that the purpose of a sanction is not to be punitive, although it may have that effect.

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

The Committee has taken into account the mitigating and aggravating factors in this case. It has been presented with no mitigating factors. The aggravating factors include the following:

- Harm was caused to Patients A and B
- The misconduct, which involved basic aspects of dentistry, was repeated over a long period of time.
- Mr Henry's previous fitness to practise history.
- The absence of evidence of remorse or insight into the conduct found proved.
- No evidence of any remediation.
- The lack of engagement with the GDC.

The Committee has determined that it would be inappropriate to conclude this case without taking any action or by the issuing of a reprimand. These courses of action would not be sufficient for the protection of patients or the maintenance of public confidence in the dental profession, given the serious nature of the findings in this case and the absence of any evidence of remediation or insight by Mr Henry.

The Committee next considered whether a period of conditional registration would be appropriate in this case. In so doing, it is aware that any conditions imposed must be proportionate, measurable, workable and verifiable. The Committee takes a serious view of the findings in this case, which concern a poor standard of care over a prolonged period of time. There is no evidence that Mr Henry has taken any corrective steps. This situation is

aggravated by Mr Henry's fitness to practise history where the PPC reached serious findings against him in June 2016. The PPC in December 2016 was concerned about Mr Henry's lack of engagement with the GDC and the absence of any remediation. It concluded that conditions were no longer workable and that the conditions order should be replaced with one of suspension. Taking all these factors into account, the Committee has concluded that conditions would not be sufficient for the protection of the public, or the maintenance of public confidence in the dental profession.

The Committee next considered whether it should impose a period of suspension. The findings against Mr Henry amount to a serious departure from the relevant professional standards. He failed repeatedly to adhere to regulations and guidelines in place and the standard of care provided by him in relation to the patients in this case fell far below that expected of a reasonably competent practitioner working in general practice. He failed to obtain informed consent from Patient A. Both patients required extensive remedial treatment as a result of the periodontal disease which was not appropriately addressed Mr Henry. Given the absence of any remediation, Mr Henry's lack of insight or engagement with the GDC, the Committee has concluded that an order of suspension would serve no useful purpose. Accordingly, the Committee is satisfied that to suspend Mr Henry's registration would not be sufficient to protect the public, uphold proper standards and maintain public confidence in the dental profession.

The Committee considers that Mr Henry has neglected his responsibilities to Patients A and B as their treating dentist over a lengthy period of time, leading to serious harm. He has chosen not to engage with the GDC in these proceedings or indeed at his previous hearings before the PPC. He was given an opportunity to demonstrate that he had remediated the shortcomings identified in 2016 but he did not do so. Accordingly, the Committee has determined that the appropriate and proportionate sanction in this case is that of erasure. The Committee has taken into account the adverse impact of such a direction on Mr Henry. However, in the light of the serious nature of the findings against Mr Henry, the Committee considers that the need to protect patients and the public interest outweighs his own interests in this matter.

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

Decision on immediate order

"The Committee has been informed that the interim order of suspension on Mr Henry's registration, which was due to expire yesterday, is no longer current as the High Court did not grant an extension of that order.

Having directed that Mr Henry's name be erased from the Dentists' Register, the Committee has considered, in accordance with Section 30(3) of the Dentists Act 1984 (as amended) whether to make an order for immediate suspension of Mr Henry's registration. Ms Vanstone, on behalf of the General Dental Council (GDC), has submitted that such an order is necessary for the protection of the public and is otherwise in the public interest, given the Committee's findings and reasons for directing erasure.

In the light of its reasons for directing that Mr Henry's name be erased from the Dentists' Register, the Committee is satisfied that it would be perverse to allow him the opportunity to

continue to practise during the intervening appeal period. In accordance with Section 30(3) of the Dentists Act 1984 (as amended), the Committee has determined that it is necessary for the protection of the public and is otherwise in the public interest that Mr Henry's registration be suspended forthwith.

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

That concludes this case."