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HEARING HEARD IN PUBLIC

MORRISON, Alan Macdonald

Registration No: 61112

PROFESSIONAL CONDUCT COMMITTEE

JANUARY - FEBRUARY 2016

Outcome: Erasure and immediate order of suspension

This case was heard in parallel with the cases of KELLY, Lorraine Ann [Registration number: 148411] and GRANT, Dawn [Registration No: 148415]

Alan Mcdonald MORRISON, a dentist, BDS Glasg 1986, was summoned to appear before the Professional Conduct Committee on 11 January 2016 for an inquiry into the following charge:

Charge as amended and consolidated on 12 January 2016

MORRISON, Alan Macdonald

"That, being a registered dentist:

1. At all material times you were practising as a dental surgeon, and were the principal dentist, at [address redacted] and the Drongan Dental Surgery at 70 Mill O'Shields Road, Drongan KA6 7AY.
2. Between about 16th November 2012 and September 2013 you failed to maintain adequate infection control for patients at the Practices, in that you:-
   (a) re-used matrix bands for the treatment of patients;
   (b) did not put on new surgical gloves for each patient;
   (c) WITHDRAWN
      i. WITHDRAWN
      ii. WITHDRAWN
   (d) re-used endodontic files for the treatment of patients;
   (e) used amalgam carriers for the treatment of patients which had not been cleaned in a washer disinfector or sterilised;
   (f) used an ultrasonic scaler tip, alternatively ultrasonic scaler tips, for the treatment of patients which had not been cleaned in a washer disinfector or sterilised;
   (g) re-used aspirator tips for the treatment of patients when either:
      i. the aspirator tips were designed to be used on a single occasion and then discarded; or
      ii. you knew that the aspirator tips had not been sterilised;
   (h) re-used impression trays for the treatment of patients when either:

i. the impression trays were designed to be used on a single occasion and then discarded; or

ii. you knew that the impression trays had not been sterilised;

(i) re-used 3:1 tips for the treatment of patients when either:

i. the 3:1 tips were designed to be used on a single occasion and then discarded; or

ii. you knew that the 3:1 tips had not been sterilised;

3. Between about 16th November 2012 and September 2013 you failed to ensure that the Practices maintained adequate infection control for patients at the Practices, in that you:-

(a) caused or permitted the dental nurses, alternatively one of the dental nurses, assisting you to include used matrix bands in the instruments laid out for the treatment of patients;

(b) directed the dental nurses, alternatively one of the dental nurses, assisting you not to put on new surgical gloves for each patient;

(c) caused or permitted the dental nurses, alternatively one of the dental nurses, assisting you, to include steel burs in the instruments laid out for the treatment of patients when either:-

i. the burs were designed to be used on a single occasion and then discarded; or

ii. you knew that the burs had not been sterilised;

(d) caused or permitted the dental nurses, alternatively one of the dental nurses, assisting you to include used endodontic files in the instruments laid out for the treatment of patients;

(e) caused or permitted the dental nurses, alternatively one of the dental nurses, assisting you to include amalgam carriers for the treatment of patients which had not been cleaned in a washer disinfector or sterilised in the instruments laid out for the treatment of patients;

(f) caused or permitted the dental nurses, alternatively one of the dental nurses, assisting you to include an ultrasonic scaler tip, alternatively ultrasonic scaler tips, which had not been cleaned in a washer disinfector or sterilised in their preparations for the treatment of patients;

(g) caused or permitted the dental nurses, alternatively one of the dental nurses, assisting you to include used aspirator tips in the instruments laid out for the treatment of patients when either:

i. the aspirator tips were designed to be used on a single occasion and then discarded; or

ii. you knew that the aspirator tips had not been sterilised;

(h) caused or permitted the dental nurses, alternatively one of the dental nurses, assisting you to include used impression trays in the instruments laid out for the treatment of patients when either:

i. the impression trays were designed to be used on a single occasion and then discarded; or

ii. you knew that the impression trays had not been sterilised;

(i) caused or permitted the dental nurses, alternatively one of the dental nurses, assisting you to include used 3:1 tips in the instruments laid out for the treatment of patients when either:

i. the 3:1 tips were designed to be used on a single occasion and then discarded; or

ii. you knew that the 3:1 tips had not been sterilised;

4. Between 31st December 2009 and 24th September 2013 you failed to ensure that the Practices maintained adequate infection control for patients, in that (in breach of the timescales set out by the Chief Dental Officer for Scotland in her letter dated 5th November 2009) you did not arrange training in infection control for the staff from National Education Scotland.

5. **Amended to:** Between 1st April 2013 or alternatively 1st July 2013 and 24th September 2013 you failed to ensure that the Practices maintained adequate infection control for patients, in that (in breach of the timescales set out by the Chief Dental Officer for Scotland in her letter dated 5th November 2009) the Practices did not contain local decontamination units which complied with the requirements for such Units set out by NHS Scotland.

6. Your actions as set out in Heads of Charge 2, 3, 4 and 5 put patients' health at risk.

7. You responded dishonestly to an investigation into the decontamination procedures at the Practices by NHS Ayrshire & Arran in or about September 2013, in that:-

(a) when NHS Ayrshire & Arran requested copy invoices in respect of the Practice's orders for surgical gloves, single-use and sundry items you claimed:-

(i) that the documents requested had been damaged in a flood;

(ii) that some of the documents requested might be with your accountant;

(iii) that you could not remember the name or address of your accountant;

(b) you provided NHS Ayrshire & Arran with falsified invoices purporting to relate to supplies of dental products (including for matrix bands) made to the [address redacted] between approximately September 2011 and July 2013.

And that in relation to the matters set out above, your fitness to practise as a dentist is impaired by reason of your misconduct."

KELLY, Lorraine Ann

"That, being a registered dental nurse:

8. At all material times you were employed as the Practice Manager of [address redacted] and the Drongan Dental Surgery at 70 Mill O'Shields Road, Drongan KA6 7AY.

9. Between about 16th November 2012 and September 2013 you failed to ensure that the Practices maintained adequate infection control for patients at the Practices, in that you:-

(a) caused or permitted the dental nurses, alternatively one of the dental nurses, to include used matrix bands in the instruments laid out for the treatment of patients;

(b) caused or permitted the dental nurses, alternatively one of the dental nurses, not to put on new surgical gloves for each patient;

(c) caused or permitted the dental nurses, alternatively one of the dental nurses, to include used steel burs in the instruments laid out for the treatment of patients when either:-

  i. the burs were designed to be used on a single occasion and then discarded; or

  ii. you knew that the burs had not been sterilised;

(d) caused or permitted the dental nurses, alternatively one of the dental nurses, to include used endodontic files in the instruments laid out for the treatment of patients;

(e) caused or permitted the dental nurses, alternatively one of the dental nurses, to include amalgam carriers for the treatment of patients which had not been cleaned in a washer disinfector or sterilised in the instruments laid out for the treatment of patients;

(f) caused or permitted the dental nurses, alternatively one of the dental nurses, to include an ultrasonic scaler tip, alternatively ultrasonic scaler tips, which had not been cleaned in a washer disinfector or sterilised in their preparations for the treatment of patients;

(g) caused or permitted the dental nurses, alternatively one of the dental nurses, to include used aspirator tips in the instruments laid out for the treatment of patients when either:

  i. the aspirator tips were designed to be used on a single occasions and then discarded; or

  ii. you knew that the aspirator tips had not been sterilised;

(h) caused or permitted the dental nurses, alternatively one of the dental nurses, to include used impression trays in the instruments laid out for the treatment of patients when either:

  i. the impression trays were designed to be used on a single occasion and then discarded; or

  ii. you knew that the impression trays had not been sterilised;

(i) caused or permitted the dental nurses, alternatively one of the dental nurses, to include used 3:1 tips in the instruments laid out for the treatment of patients when either;

  i. the 3:1 tips were designed to be used on a single occasion and then discarded; or

  ii. you knew that the 3:1 tips had not been sterilised;

10. Between 31st December 2009 and 24th September 2013 you failed to ensure that the Practices maintained adequate infection control for patients, in that (in breach of the timescales set out by the Chief Dental Officer for Scotland in her letter dated 5th November 2009) you did not arrange training in infection control for the staff from National Education Scotland.

11. **Amended to:** Between 1st April 2013 or alternatively 1st July 2013 and 24th September 2013 you failed to ensure that the Practices maintained adequate infection control for patients, in that (in breach of the timescales set out by the Chief Dental Officer for Scotland in her letter dated 5th November 2009) the Practices did not contain local decontamination units which complied with the requirements for such Units set out by NHS Scotland.

12. Your actions as set out in Heads of Charge 9, 10 and 11 put patients' health at risk.

13. You responded dishonestly to an investigation into the decontamination procedures at the Practices by NHS Ayrshire & Arran in or about September 2013, in that, when interviewed, you claimed that gloves were changed between patients, that matrix bands were not re-used and aspirator tips were sterilised before re-use.

14. In or about October/November 2013 you dishonestly attempted to interfere with an investigation into the decontamination procedures at the Practices by NHS Ayrshire & Arran in that you sought to persuade a dental nurse who had previously worked at the Practices not to co-operate with that investigation.

15. On or about 10th June 2014 you threatened and/or attempted to intimidate and/or attempted to upset the dental nurse described at paragraph 14 above with the words ‘your day will come’.

And that in relation to the matters set out above, your fitness to practise as a dental nurse is impaired by reason of your misconduct.”

GRANT, Dawn

“That, being a registered dental nurse:

16. At all material times you were employed as a dental nurse at [address redacted] and the Drongan Dental Surgery at 70 Mill O’Shields Road, Drongan KA6 7AY.

17. Between about 16th November 2012 and September 2013 you failed to ensure that the Practices maintained adequate infection control for patients at the Practices, in that you:-

    (a) included used matrix bands in the instruments laid out for the treatment of patients;

    (b) did not put on new surgical gloves for each patient;

    (c) WITHDRAWN

        i. WITHDRAWN

        ii. WITHDRAWN

    (d) included used endodontic files in the instruments laid out for the treatment of patients;

    (e) included amalgam carriers which had not been cleaned in a washer disinfector or sterilised in the instruments laid out for the treatment of patients;

(f) included an ultrasonic scaler tip, alternatively ultrasonic scaler tips, which had not been cleaned in a washer disinfector or sterilised in the instruments laid out for the treatment of patients;

(g) included used aspirator tips in the instruments laid out for the treatment of patients when either:

i. the aspirator tips were designed to be used on a single occasion and then discarded; or

ii. you knew that the aspirator tips had not been sterilised;

(h) included used impression trays in the instruments laid out for the treatment of patients when either:

i. the impression trays were designed to be used on a single occasion and then discarded; or

ii. you knew that the impression trays had not been sterilised;

(i) included used 3:1 tips in the instruments laid out for the treatment of patients when either:

i. the 3:1 tips were designed to be used on a single occasion and then discarded; or

ii. you knew that the 3:1 tips had not been sterilised;

18. Your actions set out in Head of Charge 17 above put patients' health at risk.

19. You responded dishonestly to an investigation into the decontamination procedures at the Practices by NHS Ayrshire & Arran in or about September 2013, in that, when interviewed, you claimed that gloves were changed between patients, that matrix bands were not re-used and/or that aspirator tips were sterilised before re-use.

And that in relation to the matters set out above, your fitness to practise as a dental nurse is impaired by reason of your misconduct."

Mr Morrison was present and represented. Mrs Kelly was not present or represented. Mrs Grant was not present or represented.

On 5 February 2016 the Chairman announced the findings of fact to the Counsel for the GDC:

"Mr Morrison: This is the Professional Conduct Committee's inquiry into the allegations against you, Mrs Kelly and Mrs Grant.

Preliminary matters

Service and Proceeding in absence

At the commencement of this hearing, Mr Bradly made an application under Rule 54 of the General Dental Council (GDC) (Fitness to Practise) Rules Order of Council 2006 that all reasonable efforts had been made, in accordance with the rules, to send notification of this hearing to Mrs Kelly and Mrs Grant, and that the matter should be heard and determined

notwithstanding their absence. The Committee accepted the advice of the Legal Adviser in relation to this application.

The Committee first considered whether notification of this hearing had been sent in accordance with the 2006 Rules. It had before it copies of the notice of hearing letters dated 9 December 2015 which were sent to Mrs Kelly and Mrs Grant's registered address respectively. The notice contained all the relevant information required by Rule 18. The Committee also saw copies of the Royal Mail track and trace proof of delivery documents which showed that the letters were delivered on 10 December 2015 and both signed for in the printed name "KELLY". The Committee was satisfied that the notices had been served in accordance with Rules 18 and 65 of the 2006 Rules.

The Committee then considered whether to proceed with the hearing in the absence of Mrs Kelly and Mrs Grant. Mr Bradly referred the Committee to the cases of R v Hayward, Jones, Purvis [2001] EWCA Crim 168; R v Jones [2002] UKHL 5; and Tait v The Royal College of Veterinary Surgeons [2003] UKPC 34.

The Committee bore in mind that its discretion to proceed with a hearing in the absence of a respondent is not an absolute discretion and it 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.

In a letter dated 6 January 2016 Mrs Kelly's legal representatives, RadcliffesLeBrasseur, stated that "Allegations relating to Mrs Kelly's fitness to Practise are to be considered at a Conduct Committee hearing commencing on [11 January 2016]…We are writing to inform you that Mrs Kelly will not be attending the hearing and no representative will be in attendance at the hearing to act on her behalf…We would be grateful if you would kindly inform us as to the outcome of the hearing". The Committee concluded that Mrs Kelly had wholly waived her right to attend this hearing by deliberately and voluntarily absenting herself from it. Mrs Kelly has not requested for an adjournment of the hearing and the Committee was not satisfied that an adjournment would secure her attendance at a future date.

In a letter dated 6 January 2016 Mrs Grant's legal representatives, RadcliffesLeBrasseur, stated that "Mrs Grant is due to appear before the Professional Committee on [11 January 2016]. Although we remain instructed in this matter by MDDUS, we do not have any instructions on the case from Mrs Grant. In these circumstances, we do not propose to engage with the hearing in respect of Mrs Grant and no representative will be in attendance at the Conduct Committee during the hearing". Mrs Grant has not made an application for an adjournment and given the contents of the letter dated 6 January 2016, the Committee was not satisfied that an adjournment would secure her attendance at a future date. The Committee concluded that Mrs Grant had absented herself voluntarily from this hearing.

Given that this case involves more than one registrant, the Committee had regard to: the undesirability of separate hearings; the effect of delay on the memories of the witnesses scheduled to give oral evidence to the Committee, although witness statements have been obtained; fairness to Mr Morrison who is present and represented in the hearing; and the public interest in the expeditious disposal of the case against all three registrants. In accordance with Rule 54, the Committee determined that it was fair and appropriate to proceed with the hearing notwithstanding Mrs Kelly and Mrs Grant's absence.

Joinder application

At the commencement of the hearing Mr Bradly made an application under Rule 25(1) of the General Dental Council (GDC) (Fitness to Practise) Rules Order of Council 2006 ("the 2006 Rules) to join, formally, the allegations against you, Mrs Kelly and Mrs Grant. Rule 25(1) states:

> "Unless they are of the view that there is a risk of prejudice to the fairness of the proceedings, and upon taking the advice of the legal adviser, the Professional Conduct Committee or the Professional Performance Committee may consider allegations against two or more respondents at the same hearing where –
>
> (a) the allegation against each respondent arises out of the same circumstances; or
>
> (b) in the view of the Professional Conduct Committee or the Professional Performance Committee, it would be just to do so."

Mr Bradly submitted that the allegations against you, Mrs Kelly and Mrs Grant arise out of the same circumstances. He informed the Committee that throughout the preparation of the cases, all the parties anticipated that the allegations would be heard jointly and there have been no objections raised by any party, either on the grounds of prejudice or fairness, to the proceedings being joined. Mr Bradly submitted that there are a number of allegations by the Council which are common to all three registrants and having separate hearings could result in inconsistencies in the Committee's findings. He concluded that it would be fair and appropriate for the Committee to consider the allegations against the three registrants together in order for it to carry out a proper inquiry into the Council's case.

Mr Fortune, on your behalf, did not oppose the application. However he reminded the Committee of the need to ensure fairness and justice in the proceedings by considering the evidence relating to each individual registrant separately.

The Committee noted that the allegations against you, Mrs Kelly and Mrs Grant arise out of the same circumstances and the same complaints, and some of the allegations are replicated between all three registrants. There are no formal observations from Mrs Kelly or Mrs Grant on the application to join the allegations, but the Committee noted that during the investigative process both were represented by Solicitors who were aware of the GDC's intention to hear the case of all three registrants together. The Committee concluded that it would be undesirable to conduct separate hearings of the allegations faced by you, Mrs Kelly and Mrs Grant. The Committee noted that to hear these cases separately would mean calling predominantly the same witnesses to give the same evidence on three separate occasions. The Committee determined that there was no risk of prejudice or unfairness to you, Mrs Kelly or Mrs Grant in considering the allegations together and granted the application.

The Committee then received consolidated charges which contained the allegations against the three registrants.

Application to amend the charge

At the conclusion of the GDC's case, Mr Bradly made an application under Rule 18 of the 2006 Rules to withdraw heads of charge 2(c)(i), 2(c)(ii), 17(c)(i) and 17(c)(ii) because during her oral evidence, DN2 incorrectly identified a Tungsten Carbide metal bur which is reusable if cleaned and sterilised, as a stainless steel bur which is single use. Mr Bradly submitted that on the basis of this evidence he could not invite the Committee to make a positive finding on these charges. Mr Fortune did not oppose the application. The Committee granted the application.

Mr Bradly also made an application to amend the time period referred to in heads of charge 5 and 11 following the evidence of Witness 1 that the deadline given to dental practices for the installation of local decontamination units was extended. He submitted that there was no injustice in making the amendment because it would shorten the period of the breach alleged against you and Mrs Lorraine Kelly. He submitted further that the Council's primary case was that the breach commenced from 1st April 2013 however the alternative formulation would enable the Committee to decide on the correct date on the basis of the evidence it had heard. Mr Bradly applied to amend the dates from "31st December 2011 and 24th September 2013" to "1st April 2013, or alternatively 1 July 2013 and 24th September 2013". The Committee granted the application and decided to include both dates because a decision on a particular date at that stage would have required an analysis of the evidence which it could not undertake until all the evidence had been heard, closing submissions made with legal advice, and the Committee commenced its private deliberations.

Admissions

At the outset of this hearing you admitted head of charge 1 and head of charge 7(b), together with the stem of head of charge 7(b). Following the amendment to head of charge 5, at the conclusion of the GDC's case, you then admitted head of charge 4 and head of charge 5, but only from the later date namely 1st July 2013.

Background

You are, and were at all material times, the Practice Principal of [address redacted], and the Drongan Dental Surgery ('the Drongan Practice'). You worked as a dental surgeon at these practices. Mrs Kelly, a registered dental nurse and co-respondent in this case was your Practice Manager during the relevant period. Mrs Grant, a registered dental nurse and co-respondent in this case was one of the dental nurses working at the practice during the period of time covering the allegations.

The allegations arose out of a complaint made to the GDC by NHS Ayrshire and Arran, a Health Board in Scotland ('the Health Board').

In September 2013 Dental Nurse 1 ('DN1') attended an interview at the [address redacted]. Following that interview, DN1 made a report to the Health Board of what she said she had been told by the Practice Manager, Mrs Kelly, which indicated to DN1 that poor infection control procedures were in place at the practice. DN1 reported that she had been advised by Mrs Kelly that "we do things a bit differently here" or words to that effect and was told that the practice reused gloves and matrix bands and did not sterilise aspirator tips. Although offered the job DN1 did not in fact take up the offer and so never worked at either practice.

In November 2013 Dental Nurse 2 ('DN2') who had worked at both the [address redacted] and Drongan Practices, between November 2012 and September 2013, also made a report to the Health Board. DN2 did not know DN1. DN2 gave a direct account of poor infection control practices by herself, other dental nurses and you. DN2 first reported that when she worked at your practice, matrix bands, gloves and endodontic files were reused. DN2 subsequently reported, following questions from the Health Board, that other items, including those previously reported, had been reused at your practices. These items included stainless steel burs, amalgam carriers, ultrasonic scaler tip, aspirator tips, impression trays and 3:1 tips.

These reports led to investigations by the Health Board, including a practice inspection and interview of all staff for both practices on 24 September 2013 and an unannounced inspection

of both practices on 26 November 2013. The September 2013 inspection identified a number of concerns which included:

- only one dental nurse had received the correct training in relation to infection control practices and processes despite the directive by the Chief Dental Officer in Scotland that all practices should make arrangements to receive training in decontamination and infection control procedures from National Education Scotland (NES) by end of December 2009;
- the washer disinfector at the [address redacted] had not been installed and the Drongan practice did not have a washer disinfector despite the requirement in Scotland that every dental practice should have a working washer disinfector.

During the Health Board's investigations requests were made for you to provide invoices of single-use and sundry items. In responding to the request for invoices, you provided NHS Ayrshire and Arran with invoices purporting to relate to supplies of dental products made to the [address redacted] between approximately September 2011 and July 2013. The Health Board had concerns about the validity of some of the invoices you provided and requested an analysis of the treatments provided at your practices over the same period covered by the invoices in order to measure the estimated number of gloves required to practice safely. The analysis carried out showed that your practices may not have been purchasing the items of concern in sufficient quantities to meet the number of patients seen at your practice and the treatments which had been carried out. The Health Board concluded that a number of the invoices you had supplied to them were not genuine.

Findings of Facts

Witnesses

The Committee received, from the Council, signed and dated witness statements and heard oral evidence from DN1, DN2, Witness 1, Witness 6 and Witness 7.

The Committee found DN1's evidence credible and reliable. DN1 attended the interview at the [address redacted] on a Friday and she contacted her previous tutor with her concerns the following Monday. The Committee was of the view that it was unlikely that DN1's recollection was faulty. It was also unlikely that she fabricated the concerns in light of the evidence from DN1 that she was offered the position and was happy to accept, until the concerning comments were made by Mrs Kelly after the interview. Furthermore her evidence was supported by the evidence of DN2 who was unknown to her and yet raised the exact same issues in her complaint about the reuse of matrix bands and gloves, and the lack of sterilisation of aspirator tips. It was also supported by the false invoices which you admit creating and which the Committee decided you had created to hide the fact that the practice was reusing single use items. In addition DN1's evidence was supported, to some extent, by the findings of the Health Board that there were cross-infection control issues at the practices. The Committee could not see any reason why DN1 would have made up the comments she attributes to Mrs Kelly.

DN2 trained and qualified as a dental nurse whilst working at your practices. Her role included working as your dental nurse 2 days per week. The Committee found DN2's evidence to be clear, consistent, credible and reliable. Although DN2 was unable to differentiate between stainless steel burs and tungsten carbide burs, the Committee did not consider that this affected the credibility of her evidence. Mr Fulford, expert witness in General Dental Practice

who was called by the Council to give evidence told the Committee that in his experience some staff found it difficult to identify the material that metal burs are made of.

The Committee considered DN2's evidence to be reliable because in so far as it related to matrix bands, gloves and aspirator tips, it mirrored the evidence of DN1 who was unknown to her. There was no evidence to suggest that DN2 could have known about the detail of DN1's complaint at the time she made her complaint and the Committee was satisfied that this was more than just a coincidence. Furthermore, as with DN1, DN2's evidence was supported by the falsified invoices which you accept you created. As detailed in the reasons given below at head of charge 2(a), the Committee rejected your assertion that you falsified invoices to cover up the fact that, on your account, Mrs Kelly was stealing from another practice. The Committee was satisfied that the reason you falsified those invoices was to cover up the fact that single use items were being reused in your practices. Also, as with DN1, DN2's evidence was supported to some extent by the findings of the Health Board following their inspection, as detailed above. The Committee could not see any motive for DN2 to fabricate her allegations which amounted to admissions by her of breaches to the cross infection control procedures. She was cross-examined at length and although there were some areas of her oral evidence that differed slightly from her statement, the Committee did not consider them to be significant and did not consider they cast doubt upon her reliability as a witness, save for in one instance when dealing with impression trays. The Committee noted that DN2 did not raise her concerns with anyone else at the practices or with Defence Witness 6. DN2 said that she said nothing to Defence Witness 6 because at the time she was working for you she was still learning and did not know everything. She also said that she was concerned about getting into trouble with the Health Board and she feared for her job. The Committee did not consider this to have diminished her credibility or reliability as a witness.

Witness 1, Witness 6 and Witness 7 gave evidence on their involvement in the investigations carried out by the Health Board. Much of Witness 1 and Witness 6's evidence related primarily to actions that were taken at the Health Board in relation to the concerns raised and were not challenged. Where their evidence contradicted your evidence for example, for Witness 1 in relation the time period for invoices requested, Witness 1 conceded that she could not recall the period requested initially and when the period was subsequently extended. This difference in evidence was not considered to be detrimental to the credibility of her evidence.

Witness 7's evidence was supported by invoices provided by you and in his analysis he made assumptions which were more favourable to you than need be, in using the falsified invoices which reduced the impact of the shortfall of gloves and matrix bands. In addition Witness 7 had assisted in mentoring you and supporting your application for re-registration following erasure. There was nothing to suggest that his evidence was biased towards you in any detrimental way.

The Committee noted that the unchallenged evidence of Witness 7's calculations in relation to the numbers of gloves ordered compared with the numbers of gloves that would have been needed, added further support to the evidence given by DN1 and DN2.

The Committee also received signed and dated witness statements from Witness 2, Witness 3, Witness 4, Witness 5, Witness 8 and Witness 9. Their witness statements were admitted as agreed evidence against you because you did not challenge what they said. However, as against Mrs Kelly and Mrs Grant, they were admitted as unagreed hearsay evidence following an application made by Mr Bradly under Rule 57(1) and (2) of the 2006 Rules. When considering the weight to attach to these statements as against Mrs Kelly and Mrs Grant the

Committee noted that there was nothing from either registrant to challenge or contradict this evidence.

The Committee received three expert reports dated 2 October 2015 in relation to the allegations against you, Mrs Kelly and Mrs Grant and a supplementary report dated 15 January 2016, and heard oral evidence from Mr Fulford, expert witness in General Dental Practice, called by the Council. His evidence was largely unchallenged and the Committee accepted his expert opinion.

The Committee received, on your behalf, signed and dated witness statements and heard oral evidence from Defence Witness 1, Defence Witness 2, Defence Witness 3, Defence Witness 4, Defence Witness 5 and Defence Witness 6. Although apparently credible in their accounts, where there was conflict with the evidence provided by the GDC, the Committee preferred the evidence of DN2 for the reasons outlined under its findings on the individual heads of charge.

The witness statement of defence witness 5 was admitted as hearsay evidence following an application by Mr Fortune under Rule 57(1) and (2) of the 2006 Rules. The Committee noted that defence witness 5, an associate dentist at the practice in 2014, did not work at either practice at the time of the alleged cross infection control matters. The Committee thus decided that his evidence added nothing to the issues it had to decide because it post-dated the relevant period. Also admitted as hearsay evidence under Rule 57 were emails from J.D, I.K, R.C, P.M, I.C, J.S, J.A.C, J.L, and P.B. The Committee attached little weight to these emails which did not contain declarations of truth, were not signed and were not formally produced by any witness. By not attending to give evidence the Committee was unable to ask the authors of these emails any questions and to assess their credibility. Furthermore some of these emails were provided by your patients who could not be expected to have a full awareness of the infection control measures required or undertaken at the practice.

The Committee also heard oral evidence from you. Your description of the management of your practices indicated that you had adopted a relaxed approach to the general administration of the practices, including cross-infection control procedures and processes. The Committee found that your evidence was at times contradictory for instance when examined in chief you said you were not provided with details of the complaint made to the Health Board. However when you were cross-examined you accepted that on the day you were asked to close your surgeries voluntarily you were shown a letter containing the allegations which you read. The Committee also did not accept your explanation of or why you falsified the invoices for the reasons detailed in head of charge 2(a).

The Committee considered all the oral and documentary evidence presented in this hearing. It took account of the submissions made by Mr Bradly on behalf of the GDC and those made by Mr Fortune on your behalf. The Committee accepted the advice of the Legal Adviser. He advised the Committee that the burden is on the Council to prove, on the balance of probabilities, the facts alleged against you. You are not required to prove anything. He also reminded the Committee to consider each registrant separately.

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

Allegations relating to you:

1.	*At all material times you were practising as a dental surgeon, and were the principal dentist, at [address redacted] and the Drongan Dental Surgery at 70 Mill O'Shields Road, Drongan KA6 7AY.*

	Admitted and proved
2.	*Between about 16th November 2012 and September 2013 you failed to maintain adequate infection control for patients at the Practices, in that you:-*
2.(a)	*re-used matrix bands for the treatment of patients* - Not admitted but proved Dental Nurse 2 commenced working at your practice in November 2012. Her evidence was that within a few weeks of starting work at the practice, she was instructed to reuse matrix bands. She gave a clear recollection of the process of cleaning matrix bands at your practice and reusing them. Dental Nurse 2's evidence was that she witnessed you reusing matrix bands. She could not recall who instructed her to reuse the matrix bands but said that it would either have been you or Mrs Kelly. She said that she spoke to Defence Witness 1 and Mrs Grant and they both said that they too had been told to reuse matrix bands and that is what they did. Dental Nurse 1, who had never met Dental Nurse 2, reported that she was told by Mrs Kelly that the practice reused matrix bands. The Committee received contrasting evidence from the dental nurses called on your behalf. They gave clear and credible evidence that they did not reuse matrix bands whilst working at your practice. In particular Defence Witness 1, who worked at your practice during the period this Committee is concerned with, told the Committee that no conversation took place with Dental Nurse 2 about reusing single use items. Defence Witness 1 was clear in her evidence that she did not reuse matrix bands at the practices. Although apparently credible the Committee noted that the defence witnesses who dealt with the cross infection control issues at the practices all still worked for you and therefore had a clear motive to support the account given by you. The Committee also noted that there was no other independent support for these accounts. The Committee preferred the evidence of Dental Nurse 2 and Dental Nurse 1. It concluded that there was a culture of reusing matrix bands and other single use items at the practice when Dental Nurse 2 started work in November 2012. Dental Nurse 1 was informed of this culture by Mrs Kelly after accepting the role of a full-time dental nurse at the practice in September 2013. When you were asked by the Health Board for invoices for single use items, including matrix bands, to demonstrate that the practice had been purchasing sufficient quantities, you provided falsified invoices. Witness 7's analysis of the invoices produced for the purchase of matrix bands, including the falsified invoices, found a significant shortfall. His analysis estimated a requirement of 1,196 matrix bands but found that your practice purchased 264. If one relied solely on the genuine invoices you produced then that figure fell yet further. In your evidence you admitted that you had reused matrix bands but only on two occasions and sometime ago. You denied knowingly reusing them on any other occasion. Your evidence was that you were not involved in the day to day running of your practices and that Mrs Kelly was solely responsible for the ordering of stock. You said that when the Health Board requested invoices, Mrs Kelly informed you that there were none and that she had been stealing stock from another practice. You told the Committee that you falsified the invoices to cover up

	this fact. You told the Committee that you did not ask Mrs Kelly for any details of what she had been stealing or in quantities or for how long or indeed why she felt the need to steal at all. You told the Committee that you were friends with the owner of the other practice and that when you told him about the theft committed by Mrs Kelly, he was unconcerned and did not ask for any detail either. The Committee found your account to be wholly unconvincing and concluded that the falsification of the invoices carried out by you was to cover-up the culture of reusing single use items in your practices, a culture of which you were well aware, which you allowed to take place and which you followed yourself. In light of your admitted dishonesty and the Committee's conclusion that you created false invoices to hide the fact that you were reusing single use items, the Committee did not believe your denials and preferred the evidence of DN2.
2.(b)	*did not put on new surgical gloves for each patient* - Not admitted but proved Dental Nurse 2 worked with you 1 or 2 days per week. Her evidence was that throughout her employment with you, she witnessed you not changing gloves between patients every time she worked with you. She also gave a clear account of being told by you not to change the gloves she had used to remove dirty instruments. Dental Nurse 1 told the Committee that Mrs Kelly informed her that the practice reused gloves. These accounts are supported by the shortfall in the number of gloves purchased by the practice. Witness 7 compared the number of patients who had attended your practices and the number of gloves purchased and found a significant shortfall. For example in the year 2012/2013 if those patients who attended your practices more than once only attended twice, your practice would have needed 170 boxes of 50 pairs of gloves but only 125 boxes were purchased. The Committee has already found that you falsified invoices in order to cover up the culture of reusing single use items in your practices. You admitted to the Committee in your oral evidence that you had on occasion reused the same gloves when seeing patients from the same family. You denied using the same gloves between patients at any other time. For the same reasons as given in 2(a) the Committee did not accept your account.
2.(c)	WITHDRAWN
2.(c)(i)	WITHDRAWN
2.(c)(ii)	WITHDRAWN
2.(d)	*re-used endodontic files for the treatment of patients* - Not admitted but proved Dental Nurse 2 gave clear evidence on the reuse of endodontic files at your practices. She recalled that when she started work at your practice, she followed the correct procedure of disposing endodontic files after each use. However you told her that there were no more files left and when you asked what had happened to them, she said she had disposed the files after use. Mrs Kelly subsequently told Dental Nurse 2 not to dispose the endodontic files but to reuse them which she did. The Committee drew the inference that you had spoken to Mrs Kelly about

	DN2 disposing endodontic files. Dental Nurse 2's account was supported by the falsified invoices you created which included endodontic files. The Committee concluded that the falsification of invoices was done to cover up the culture of reusing single use items in your practices including endodontic files. You denied reusing endodontic files but for the same reasons given in 2(a) the Committee did not accept your account.
2.(e)	*used amalgam carriers for the treatment of patients which had not been cleaned in a washer disinfector or sterilised* - Not admitted but proved Dental Nurse 2 was instructed to reuse amalgam carriers and as your dental nurse she witnessed you reusing amalgam carriers. The Committee accepted her evidence.
2.(f)	*used an ultrasonic scaler tip, alternatively ultrasonic scaler tips, for the treatment of patients which had not been cleaned in a washer disinfector or sterilised* - Not admitted but proved Dental Nurse 2 told the Committee that the practices had one ultrasonic scaler tip. She explained how the scaler tip was wiped down with alcohol wipes. Her account was supported by the finding of the Health Board's unannounced inspection of your practices that there was no scaler tip at the Drongan Practice. When the staff were asked about the ultrasonic scaler tip for the practice, the inspectors were told that the scaler tip was at the [address redacted]. The Committee concluded that on the evidence that there was one ultrasonic scaler tip between both practices and it was more likely than not that the ultrasonic scaler tip was reused by you, not least because it would not have bene possible to clean and sterilise the scaler tip in the time available between patients. You denied using a scaler tip that was not sterilised but for the reasons as given in 2(a) the Committee did not accept your account.
2.(g)	*re-used aspirator tips for the treatment of patients when either:*
2.(g)(i)	*the aspirator tips were designed to be used on a single occasion and then discarded* - Not admitted but proved Dental Nurse 2 was clear in her evidence that she witnessed you reusing aspirator tips. You told the Committee that you used two types of aspirator tips – reusable aspirator tips and single use aspirator tips. When challenged DN2 maintained that the single use aspirator tips were reused at your practices. The Committee preferred Dental Nurse 2's evidence. Her account was supported by the inclusion of aspirator tips in the falsified invoices which the Committee concluded was done in order to cover-up the culture of reusing single use items at your practices. You denied reusing single use aspirator tips but for the reasons given in 2(a) the Committee did not accept your account.
2.(g)(ii)	*you knew that the aspirator tips had not been sterilised* - Not admitted and not proved DN2 said that she used both single use and reusable aspirator tips. DN1 said that Mrs Kelly told her that the practice did not sterilise aspirator tips. However, the

	Committee could not be satisfied on the balance of probabilities that you would have known that a reusable aspirator had not been sterilised because it would not appear any different and it was not clear whether the charge related to single use or reusable aspirators.
2.(h)	*re-used impression trays for the treatment of patients when either:*
2.(h)(i)	*the impression trays were designed to be used on a single occasion and then discarded* - Not admitted and not proved DN2's evidence was that impression trays were reused at the practices. However her account when cross-examined differed from her initial evidence and she could not account for this. Thus on this point, the Committee found DN2 to be less reliable. Accordingly, and in the absence of any supporting evidence the Committee could not be satisfied on the balance of probabilities that impression trays designed to be used on a single occasion were reused at your practices.
2.(h)(ii)	*you knew that the impression trays had not been sterilised* - Not admitted. Given that head of charge 2(h)(i) was found not proved, this charge falls.
2.(i)	*re-used 3:1 tips for the treatment of patients when either*:
2.(i)(i)	*the 3:1 tips were designed to be used on a single occasion and then discarded* - Not admitted but proved DN2 described how 3:1 tips were put through the ultrasonic bath before putting them back in the drawer to be used on a different patient. She said that she witnessed you reusing the 3:1 tips. Her evidence was supported by the falsified invoices which included 3:1 tips and which the Committee found were created to cover up the culture of reusing single use items at your practices. You denied reusing single use 3:1 tips but for the reasons given in 2(a) the Committee did not accept your account.
2.(i)(ii)	*you knew that the 3:1 tips had not been sterilised* - Not admitted and not proved The Committee heard in evidence that the practices also had metal reusable tips in addition to single use 3:1 tips. The Committee was not clear whether the charge related to reusable or single use 3:1 tips and consequently could not find this charge proved. This was because if it was a reusable 3:1 tip there would be no way that you would be able to tell visually if it had been sterilised or not.
3.	*Between about 16th November 2012 and September 2013 you failed to ensure that the Practices maintained adequate infection control for patients at the Practices, in that you:-*
3.(a)	*caused or permitted the dental nurses, alternatively one of the dental nurses, assisting you to include used matrix bands in the instruments laid out for the treatment of patients* - Not admitted but proved DN2 worked with you and witnessed you using reprocessed matrix bands and the Committee has already found at 2(a) that you were reusing single use matrix bands. You told the Committee that you trained your dental nurses on how to set up

	matrix bands correctly so that they could be used on pre-molar and molar teeth. This demonstrated your knowledge of matrix bands. The Committee was satisfied that it was more likely than not that you knew that you were being handed a reprocessed matrix band. Accordingly, the Committee found that you permitted DN2 to reuse matrix bands. There was no evidence that you had told DN2 to reuse matrix bands and thus the Committee did not find that you had caused her to include used matrix bands in the instruments laid out for the treatment of patients. However, in light of the significant shortfall in the number of matrix bands purchased by your practices. The Committee drew the inference that you must have also permitted the other dental nurses at your practices to reuse matrix bands. You denied this allegation but for the reasons given in 2(a) the Committee did not accept your account. The Committee noted the denial by defence witnesses 1, 2 and 3 of working in this way, but rejected these accounts for the same reasons as given at 2(a).
3.(b)	*directed the dental nurses, alternatively one of the dental nurses, assisting you not to put on new surgical gloves for each patient* - Not admitted and not proved DN2's evidence was that as far as she was aware most of the employees at the practices did not change their gloves. You told her to keep her gloves on to remove dirty instruments and Mrs Kelly told her to reuse gloves. The Committee was satisfied that there was a culture of reuse of gloves. However it was not satisfied that you were actually directing DN2 to reuse gloves between patients, or that you actually directed other nurses to do the same, rather than just permitted this culture to persist.
3.(c)	*caused or permitted the dental nurses, alternatively one of the dental nurses, assisting you, to include steel burs in the instruments laid out for the treatment of patients when either:-*
3.(c)(i)	*the burs were designed to be used on a single occasion and then discarded; or* - Not admitted and not proved In light of the withdrawal of the allegation at 2(c), the Committee found this not proved.
3.(c)(ii)	*you knew that the burs had not been sterilised* - Not admitted and not proved In light of the withdrawal of the allegation at 2(c), the Committee found this not proved.
3.(d)	*caused or permitted the dental nurses, alternatively one of the dental nurses, assisting you to include used endodontic files in the instruments laid out for the treatment of patients* - Not admitted but proved The Committee found that you permitted dental nurses to include used endodontic files in the instruments laid out for the treatment of patients. This was on the basis of DN2's evidence in relation to endodontic files, the culture of reusing single use items in your practices, the shortfall in purchases as identified by the Health Board and the falsification of invoices to cover up the culture of reuse at your practices. You denied this allegation but for the reasons given in 2(a) the Committee did not accept your account. The Committee noted the denial by defence witnesses 1, 2

	and 3 of working in this way, but rejected these accounts for the same reasons as given at 2(a).
3.(e)	*caused or permitted the dental nurses, alternatively one of the dental nurses, assisting you to include amalgam carriers for the treatment of patients which had not been cleaned in a washer disinfector or sterilised in the instruments laid out for the treatment of patients* - Not admitted but proved The Committee was satisfied that the amalgam carriers were reused without being sterilised. You would have noticed that the amalgam carriers were not put in the tray in front of you to go to the Local Decontamination Unit (LDU) and the Committee considered that over time you must have seen DN2 clean the amalgam carrier with a wipe rather than sending it off for cleaning and sterilising. The Committee therefore drew the inference that you must have known that the amalgam carriers were being reused and you therefore permitted that reuse at least in so far as it relates to DN2. DN2 did not say that she spoke to other dental nurses about the reuse of amalgam carriers. You denied this allegation but for the reasons given in 2(a) the Committee did not accept your account. The Committee noted the denial by defence witnesses 1, 2 and 3 of working in this way, but rejected these accounts for the same reasons as given at 2(a).
3.(f)	*caused or permitted the dental nurses, alternatively one of the dental nurses, assisting you to include an ultrasonic scaler tip, alternatively ultrasonic scaler tips, which had not been cleaned in a washer disinfector or sterilised in their preparations for the treatment of patients* - Not admitted but proved The Committee accepted DN2's evidence that there was only one ultrasonic scaler tip at your practices. It concluded that it was more likely than not that ultrasonic scaler tip was reused without being cleaned in a washer disinfector, because they had yet to be installed, and without being sterilised because there was insufficient time between patients to have carried this out. In light of the fact that there was only one ultrasonic scaler tip at the practices, the Committee found that you must have permitted the other dental nurses at your practice to reuse the ultrasonic scaler tip without it being cleaned in a washer disinfector or sterilised. The Committee also noted in Witness 6's evidence that during the unannounced inspection on 26th November 2013 the Health Board team found that there were no air scaler tips at the Drongan Practice and were told that "they" had been taken to the [address redacted]. This suggested that the number of scaler tips available was insufficient. You denied this allegation but for the reasons given in 2(a) the Committee did not accept your account. The Committee noted the denial by defence witnesses 1, 2 and 3 of working in this way, but rejected these accounts for the same reasons as given at 2(a).
3.(g)	*caused or permitted the dental nurses, alternatively one of the dental nurses, assisting you to include used aspirator tips in the instruments laid out for the treatment of patients when either:*
3.(g)(i)	*the aspirator tips were designed to be used on a single occasion and then discarded* - Not admitted but proved

	The Committee found that you permitted dental nurses to include used aspirator tips in the instruments laid out for the treatment of patients. This was on the basis of DN2's evidence in relation to aspirator tips, which included seeing other nurses reusing aspirator tips, the culture of reusing single use items in your practices and the falsification of invoices to cover up the culture of reuse. You denied this allegation but for the reasons given in 2(a) the Committee did not accept your account. The Committee noted the denial by defence witnesses 1, 2 and 3 of working in this way, but rejected these accounts for the same reasons as given at 2(a).
3.(g)(ii)	*you knew that the aspirator tips had not been sterilised* - Not admitted and not proved DN2 said that she used both single use and reusable aspirator tips. The Committee could not be satisfied on the balance of probabilities that you would have known that a reusable aspirator had not been sterilised and it was not clear whether the charge related to single use or reusable aspirators.
3.(h)	*caused or permitted the dental nurses, alternatively one of the dental nurses, assisting you to include used impression trays in the instruments laid out for the treatment of patients when either:*
3.(h)(i)	*The impression trays were designed to be used on a single occasion and then discarded* - Not admitted and not proved DN2's evidence was that impression trays were reused at the practices. However her account when cross-examined differed from her initial evidence, as referred to in 2(h)(i). The Committee could not be satisfied on the balance of probabilities that impression trays designed to be used on a single occasion were reused at your practices.
3.(h)(ii)	*you knew that the impression trays had not been sterilised* - Not admitted and not proved. Given that head of charge 3(h)(i) was found not proved, this charge falls.
3.(i)	*caused or permitted the dental nurses, alternatively one of the dental nurses, assisting you to include used 3:1 tips in the instruments laid out for the treatment of patients when either:*
3.(i)(i)	*the 3:1 tips were designed to be used on a single occasion and then discarded* - Not admitted but proved DN2 described how 3:1 tips were put through the ultrasonic bath before putting them back in the drawer to be used on a different patient. She said that she witnessed you reusing the 3:1 tips. Furthermore, DN2 said she witnessed other dental nurses reusing 3:1 tips. Her evidence was supported by the falsified invoices which included 3:1 tips and which the Committee found were created by you to cover up the culture of reusing single use items at your practices. Accordingly the Committee found that you permitted the dental nurses to include single use 3:1 tips in the instrument tray. You denied this allegation but for the reasons given in 2(a) the Committee did not

	accept your account. The Committee noted the denial by defence witnesses 1, 2 and 3 of working in this way, but rejected these accounts for the same reasons as given at 2(a).
3.(i)(ii)	*you knew that the 3:1 tips had not been sterilised* - Not admitted and not proved The Committee heard in evidence that the practices also had metal reusable tips in addition to single use 3:1 tips. The Committee was not clear whether the charge related to reusable or single use 3:1 tips and consequently could not find this charge proved. This was because if it was a reusable 3:1 tip there would be no way that you would be able to tell visually if it had been sterilised or not.
4.	*Between 31st December 2009 and 24th September 2013 you failed to ensure that the Practices maintained adequate infection control for patients, in that (in breach of the timescales set out by the Chief Dental Officer for Scotland in her letter dated 5th November 2009) you did not arrange training in infection control for the staff from National Education Scotland* - Admitted and proved
5.	**Amended to read:** *Between 1st April 2013 or alternatively 1st July 2013 and 24th September 2013 you failed to ensure that the Practices maintained adequate infection control for patients, in that (in breach of the timescales set out by the Chief Dental Officer for Scotland in her letter dated 5th November 2009) the Practices did not contain local decontamination units which complied with the requirements for such Units set out by NHS Scotland* - Admitted as amended and proved The Committee noted that despite the deadline for practices to have a working local decontamination unit and washer disinfector in place by the end of December 2012, a deadline of June 2013 was given by Dolby Medical who were to connect and commission the washer disinfectors at your practices. The Committee decided that the appropriate date for this allegation is 1st July 2013.
6.	*Your actions as set out in Heads of Charge 2, 3, 4 and 5 put patients' health at risk* - Not admitted but proved The Committee accepted the opinion of Mr Fulford. Having found proved allegations on cross infection control, in particular that matrix bands, gloves, endodontic files, amalgam carriers, ultrasonic scaler tip, aspirator tips and 3:1 tips which were single use items were reused by you, the Committee was satisfied that your actions put patients' health at risk. The whole purpose of cross infection controls in dental practices is to reduce the risk of cross infection between patients. If those controls are not being adhered to the Committee considers it therefore follows that patients' health must be put at more risk since otherwise there would be no need for such control measures.
7.	*You responded dishonestly to an investigation into the decontamination procedures at the Practices by NHS Ayrshire & Arran in or about September 2013, in that:* - Admitted in so far as it relates to 7(b).
7.(a)	*when NHS Ayrshire & Arran requested copy invoices in respect of the Practice's orders for surgical gloves, single-use and sundry items you claimed:-*
7.(a)(i)	*that the documents requested had been damaged in a flood* - Not admitted and

	not proved You told the Committee that your car had been caught in a flood in the summer of 2012 and a number of documents from your accountant which were in your car were damaged. The Committee could not be satisfied on the balance of probabilities that at the time you gave that response you did not honestly believe that the invoices being requested may have been some of those affected in the flood in 2012. It was unclear on the evidence exactly what time span the request for invoices covered. It seemed to go from 6 months to one year and then possibly two years. If two years that would have taken it to the time of the flood.
7.(a)(ii)	*that some of the documents requested might be with your accountant* - Not admitted and not proved Although you denied saying this the Committee considered you probably did but that it was reasonable for you to have thought, on the spur of the moment, that some of your invoices might have been with your accountant.
7.(a)(iii)	*that you could not remember the name or address of your accountant* - Not admitted and not proved You admitted that this was the case but the Committee could not be satisfied on the balance of probabilities that your response was dishonest because it accepted that on the spur of the moment you may have forgotten the details of your accountant.
7.(b)	*you provided NHS Ayrshire & Arran with falsified invoices purporting to relate to supplies of dental products (including for matrix bands) made to the [address redacted] between approximately September 2011 and July 2013* - Admitted and proved

Allegations relating to Mrs Kelly:

8.	*At all material times you were employed as the Practice Manager of [address redacted] and the Drongan Dental Surgery at 70 Mill O'Shields Road, Drongan KA6 7AY* – Proved There is evidence before the Committee that Mrs Kelly was the Practice Manager for your practices although she was predominantly based at the [address redacted]. The dental nurses who worked at the Drongan Practice also referred to Mrs Kelly as the Practice Manager and the person to whom they referred any stock update requests.
9.	*Between about 16th November 2012 and September 2013 you failed to ensure that the Practices maintained adequate infection control for patients at the Practices, in that you:-*
9.(a)	*caused or permitted the dental nurses, alternatively one of the dental nurses, to include used matrix bands in the instruments laid out for the treatment of patients* – Proved DN1's evidence was that she was told by Mrs Kelly that the practice reused

	matrix bands. DN2 said she was instructed to reuse matrix bands although she could not recall who instructed her to do so. Mr Morrison told the Committee that as the Practice Manager, Mrs Kelly had the responsibility of ordering stock for the practices. This was confirmed by the dental nurses who worked at his practices and gave evidence to this Committee, including DN2. He also told the Committee that he had created false invoices to show that more matrix bands were ordered than was in fact the case and the Committee has already found as a matter of fact that Mr Morrison did this to hide the culture of reusing single use items at your practices. The Committee was satisfied that Mrs Kelly caused the dental nurses to include matrix bands in the instruments laid out for the treatment of patients because she had the responsibility of ordering stock at the practices. The Committee noted the response that Mrs Kelly gave to Witness 1 when interviewed on 24th September 2013 that matrix bands were disposed of after use. However, Mrs Kelly has not attended this hearing and has not adopted that response and also has provided no written submissions. Accordingly, in light of its earlier finding the Committee rejected this assertion and preferred the evidence presented by the GDC.
9.(b)	*caused or permitted the dental nurses, alternatively one of the dental nurses, not to put on new surgical gloves for each patient* – Proved DN1's evidence was that she was told by Mrs Kelly that the practice reused gloves. DN2 gave clear evidence that she was instructed by Mrs Kelly to reuse gloves. This evidence was supported by the falsified invoices. The Committee was satisfied that Mrs Kelly caused the dental nurses not to put on new surgical gloves for each patient because she had the responsibility, as the Practice Manager, of ordering stock at the practices. As with 9(a) the Committee rejected the response given by Mrs Kelly to Witness 1 on 24th September 2013.
9(c)	*caused or permitted the dental nurses, alternatively one of the dental nurses, to include used steel burs in the instruments laid out for the treatment of patients when either:-*
9.(c)(i)	*the burs were designed to be used on a single occasion and then discarded* - Not proved In light of the withdrawal of the allegation at 2(c), the Committee found this not proved.
9.(c)(ii)	*you knew that the burs had not been sterilised* - Not proved In light of the withdrawal of the allegation at 2(c), the Committee found this not proved.
9.(d)	*caused or permitted the dental nurses, alternatively one of the dental nurses,*

	to include used endodontic files in the instruments laid out for the treatment of patients – Proved The Committee found that Mrs Kelly caused dental nurses to include used endodontic files in the instruments laid out for the treatment of patients. This was on the basis of DN2's evidence in relation to endodontic files, the culture of reusing single use items at the practices, the shortfall in purchases as identified by the Health Board, the falsification of invoices to cover up the culture of reuse at the practices and as Practice Manager, Mrs Kelly was responsible for ordering stock. As with 9(a) the Committee rejected the response given by Mrs Kelly to Witness 1 on 24th September 2013.
9.(e)	*caused or permitted the dental nurses, alternatively one of the dental nurses, to include amalgam carriers for the treatment of patients which had not been cleaned in a washer disinfector or sterilised in the instruments laid out for the treatment of patients* - Not proved DN2's evidence was that she was instructed to reuse amalgam carriers however she could not recall who instructed her to do so. In addition DN2 did not witness other dental nurses at the practices reusing amalgam carriers. There was no evidence of a shortfall in amalgam carriers and therefore the Committee could not find this charge proved on the balance of probabilities.
9.(f)	*caused or permitted the dental nurses, alternatively one of the dental nurses, to include an ultrasonic scaler tip, alternatively ultrasonic scaler tips, which had not been cleaned in a washer disinfector or sterilised in their preparations for the treatment of patients* – Proved Having found that it was more likely than not that the ultrasonic scaler tip was reused on the basis of DN2's evidence that there was only one in the practices, the Committee was satisfied that Mrs Kelly caused the dental nurses to reuse the ultrasonic scaler tip. As the Practice Manager and the person in charge of stock she must have known that there was only one ultrasonic scaler tip. The Committee also noted in Witness 6's evidence that during the unannounced inspection on 26th November 2013 the Health Board team found that there were no air scaler tips at the Drongan Practice and were told that "they" had been taken to the [address redacted]. This suggested that the number of scaler tips available was insufficient.
9(g)	*caused or permitted the dental nurses, alternatively one of the dental nurses, to include used aspirator tips in the instruments laid out for the treatment of patients when either:*
9.(g)(i)	*the aspirator tips were designed to be used on a single occasions and then discarded* – Proved The Committee found that Mrs Kelly caused the dental nurses to include used single use aspirator tips in the instruments laid out for the treatment of patients. This was on the basis of DN2's evidence in relation to aspirator tips, the culture of reusing single use items at the practices, the falsification of invoices to cover up the culture of reuse at the practices and as the Practice

	Manager, Mrs Kelly had the responsibility of ordering stock. As with 9(a) the Committee rejected the response given by Mrs Kelly to Witness 1 on 24th September 2013.
9.(g)(ii)	*you knew that the aspirator tips had not been sterilised* – Proved DN1's evidence was that Mrs Kelly told her that aspirator tips were not sterilised at the practice. The Committee was satisfied that Mrs Kelly knew that aspirator tips were not sterilised and that she caused the dental nurses to include used aspirator tips in the instruments laid out for the treatment of patients. As the Practice Manager she had the responsibility of ordering stock for the practices.
9(h)	*caused or permitted the dental nurses, alternatively one of the dental nurses, to include used impression trays in the instruments laid out for the treatment of patients when either:*
9.(h)(i)	*the impression trays were designed to be used on a single occasion and then discarded* - Not proved DN2's evidence was that impression trays were reused at the practices. However her account when cross-examined differed from her initial evidence, as referred to in 2(h)(i). The Committee could not be satisfied on the balance of probabilities that impression trays designed to be used on a single occasion were reused at the practices.
9.(h)(ii)	*you knew that the impression trays had not been sterilised* – Not admitted. Given that head of charge 9(h)(i) was found not proved, this charge falls.
9.(i)	*caused or permitted the dental nurses, alternatively one of the dental nurses, to include used 3:1 tips in the instruments laid out for the treatment of patients when either;*
9.(i)(i)	*the 3:1 tips were designed to be used on a single occasion and then discarded* – Proved The Committee found that Mrs Kelly caused dental nurses to include used 3:1 tips in the instruments laid out for the treatment of patients. This was on the basis of DN2's evidence in relation to 3:1 tips, the culture of reusing single use items at the practices, the shortfall in purchases as identified by the Health Board and the falsification of invoices to cover up the culture of reuse at the practices. In addition Mrs Kelly, as the Practice Manager, had the responsibility of ordering stock for the practices.
9.(i)(ii)	*You knew that the 3:1 tips had not been sterilised* - Not proved There was no evidence to show that Mrs Kelly would have known that the reusable 3:1 tips were not being sterilised and the charge is not clear about whether it is referring to single use or reusable 3:1 tips. The Committee has already accepted the evidence of Mr Morrison and other defence witnesses that there were both kinds of 3:1 tips at the practices.
10.	*Between 31st December 2009 and 24th September 2013 you failed to ensure that the Practices maintained adequate infection control for patients, in that (in*

	breach of the timescales set out by the Chief Dental Officer for Scotland in her letter dated 5th November 2009) you did not arrange training in infection control for the staff from National Education Scotland – Not proved The Committee found that there was insufficient evidence to indicate that Mrs Kelly had a duty to ensure that the Practices maintained adequate infection control for patients. The notifications from the Chief Dental Officer in Scotland were addressed to NHS contractors. Mr Morrison accepted responsibility for ensuring that the requirements of the Chief Dental Officer were met. There was no evidence to indicate that Mr Morrison had delegated that responsibility to Mrs Kelly. The Committee could not find this charge proved.
11.	**Amended to read:** *Between 1st April 2013 or alternatively 1st July 2013 and 24th September 2013 you failed to ensure that the Practices maintained adequate infection control for patients, in that (in breach of the timescales set out by the Chief Dental Officer for Scotland in her letter dated 5th November 2009) the Practices did not contain local decontamination units which complied with the requirements for such Units set out by NHS Scotland* - Not proved For the same reasons as in head of charge 10 above.
12.	*Your actions as set out in Heads of Charge 9 put patients' health at risk* – Proved The Committee accepted the opinion of Mr Fulford. Having found proved allegations on cross infection control, in particular that matrix bands, gloves, endodontic files, ultrasonic scaler tip, aspirator tips and 3:1 tips which were single use items were reused by you, the Committee was satisfied that Mrs Kelly's actions put patients' health at risk. The whole purpose of cross infection controls in dental practices is to reduce the risk of cross infection between patients. If those controls are not being adhered to the Committee considers it therefore follows that patients' health must be put at more risk since otherwise there would be no need for such control measures.
13.	*You responded dishonestly to an investigation into the decontamination procedures at the Practices by NHS Ayrshire & Arran in or about September 2013, in that, when interviewed, you claimed that gloves were changed between patients, that matrix bands were not re-used and aspirator tips were sterilised before re-use* – Proved The Committee has found that Mrs Kelly caused all three of these items to be reused by the dental nurses. It follows that she was not therefore telling the truth when interviewed by Witness 1 on 24th September 2013. The Committee decided that this would be viewed as dishonest by the ordinary standards of reasonable and honest people and that Mrs Kelly would have known that to be the case.
14.	*In or about October/November 2013 you dishonestly attempted to interfere with an investigation into the decontamination procedures at the Practices by NHS Ayrshire & Arran in that you sought to persuade a dental nurse who had previously worked at the Practices not to co-operate with that investigation* –

	Proved The Committee accepted the evidence of DN2 that during a telephone conversation, Mrs Kelly informed DN2 that someone had been making allegations that the practice did not change matrix bands after every patient and that if DN2 was asked about this, she was to say that it was nothing to do with her as she no longer worked at the practice.
15.	*On or about 10th June 2014 you threatened and/or attempted to intimidate and/or attempted to upset the dental nurse described at paragraph 14 above with the words 'your day will come'* – Proved The Committee accepted the evidence of DN2. It found that Mrs Kelly attempted to upset DN2 by saying to her "your day will come". DN2 said that she was frightened and upset by these comments.

Allegations relating to Mrs Grant:

16.	*At all material times you were employed as a dental nurse at [address redacted] and the Drongan Dental Surgery at 70 Mill O'Shields Road, Drongan KA6 7AY* - Proved The notes of the Health Board's interview of Mrs Grant during the practice inspection in September 2013 state that Mrs Grant had been working at Mr Morrison's practices for 15 years. The Committee accepted this evidence.
17.	*Between about 16th November 2012 and September 2013 you failed to ensure that the Practices maintained adequate infection control for patients at the Practices, in that you:-*
17.(a)	*included used matrix bands in the instruments laid out for the treatment of patients* - Proved DN1's evidence was that she was told by Mrs Kelly that the practice reused matrix bands. DN2 said she was instructed to reuse matrix bands although she could not recall who instructed her to do so. She said she discussed the reuse of matrix bands with Mrs Grant and that Mrs Grant had said to her that she too had been told to reuse matrix bands and that is what she did. The Committee noted the response that Mrs Grant gave to Witness 1 when interviewed on 24th September 2013 that matrix bands were disposed of after use. However, Mrs Grant has not attended this hearing and has not adopted that response and also has provided no written submissions. Accordingly, in light of its earlier finding the Committee rejected this assertion and preferred the evidence presented by the GDC. DN2's account was supported by the falsified invoices which included matrix bands and which the Committee found were created by Mr Morrison to cover up the culture of reusing single use items at the practices and the significant shortfall of matrix bands as evidenced by Witness 7.

17.(b)	*did not put on new surgical gloves for each patient* - Proved DN1's evidence was that she was told by Mrs Kelly that the practice reused gloves. DN2 gave clear evidence that she was instructed by Mrs Kelly to reuse gloves. She said that she had discussed the reuse of gloves with Mrs Grant and that Mrs Grant had said to her that she too had been told to reuse gloves and that is what she did. This evidence was supported by the falsified invoices which the Committee found were created by Mr Morrison to cover up the culture of reusing single use items at the practices and the significant shortfall of gloves as evidenced by Witness 7.
17.(c)	WITHDRAWN
17.(c)(i)	WITHDRAWN
17.(c)(ii)	WITHDRAWN
17.(d)	*included used endodontic files in the instruments laid out for the treatment of patients* - Proved The Committee found this charge proved on the basis of DN2's evidence on endodontic files. She said that she witnessed Mrs Grant putting single use endodontic files through the ultrasonic bath and not sterilising them. She said that she had discussed the reuse of endodontic files with Mrs Grant and that Mrs Grant had said to her that she too had been told to reuse endodontic files and that is what she did. DN2's evidence was supported by the evidence of falsification of invoices which the Committee found were created by Mr Morrison to cover up the culture of reusing single use items at the practices.
17.(e)	*included amalgam carriers which had not been cleaned in a washer disinfector or sterilised in the instruments laid out for the treatment of patients* – Not proved DN2's evidence was that amalgam carriers were being reused as she was instructed to reuse them and she witnessed you reusing amalgam carriers. However she did not witness Mrs Grant reusing amalgam carriers. In addition there was no evidence presented of a shortfall in the purchase of amalgam carriers. The Committee could not find this charge proved on the balance of probabilities.
17.(f)	*included an ultrasonic scaler tip, alternatively ultrasonic scaler tips, which had not been cleaned in a washer disinfector or sterilised in the instruments laid out for the treatment of patients* - Proved Having found that it was more likely than not that the ultrasonic scaler tip was reused on the basis of DN2's evidence that there was only one in the practices, the Committee was satisfied that Mrs Grant reused the ultrasonic scaler tip. There would have been insufficient time between patients to clean

	the tip in a washer disinfector or sterilise it. The Committee also noted in Witness 6's evidence that during the unannounced inspection on 26th November 2013 the Health Board team found that there were no air scaler tips at the Drongan Practice and were told that "they" had been taken to the [address redacted]. This suggested that the number of scaler tips available was insufficient.
17.(g)	*included used aspirator tips in the instruments laid out for the treatment of patients when either:*
17.(g)(i)	*the aspirator tips were designed to be used on a single occasion and then discarded* - Proved DN1's evidence was that she was told by Mrs Kelly that the practice did not sterilise aspirator tips. DN2's evidence was that she was instructed to reuse aspirator tips although she could not recall who instructed her to do so. DN2 also recalled witnessing Mrs Grant reusing aspirator tips. This evidence was supported by the falsified invoices which the Committee found were created by Mr Morrison to cover up the culture of reusing single use items at the practices.
17.(g)(ii)	*you knew that the aspirator tips had not been sterilised* – Proved DN1 told the Committee that she was told by Mrs Kelly that the practice did not sterilise aspirator tips. DN2 was clear in her evidence that she witnessed Mrs Grant reusing aspirator tips. In addition the Committee noted that during her interview at the practice inspection in September 2013, Mrs Grant explained that aspirator tips were cleaned with "brittle brushes". She did not mention sterilisation of aspirator tips. The Committee found that, based on the evidence set out above and the falsified invoices which were created by Mr Morrison to cover up the culture of reusing single use items, it was more likely than not that Mrs Grant knew that aspirator tips had not been sterilised.
17.(h)	*included used impression trays in the instruments laid out for the treatment of patients when either:*
17.(h)(i)	*The impression trays were designed to be used on a single occasion and then discarded* – Not proved DN2's evidence was that impression trays were reused at the practices. However her account when cross-examined differed from her initial evidence, as referred to in 2(h)(i). The Committee could not be satisfied on the balance of probabilities that impression trays designed to be used on a single occasion were reused at the practices.
17.(h)(ii)	*you knew that the impression trays had not been sterilised* – Given that head of charge 17(h)(i) was found not proved, this charge falls.
17.(i)	*included used 3:1 tips in the instruments laid out for the treatment of patients when either:*
17.(i)(i)	*The 3:1 tips were designed to be used on a single occasion and then*

	discarded - Proved DN2 described how 3:1 tips were put through the ultrasonic bath before putting them back in the drawer to be used on a different patient. She said that she witnessed Mrs Grant reusing single use 3:1 tips. Her evidence was supported by the falsified invoices which included 3:1 tips and which the Committee found were created by Mr Morrison to cover up the culture of reusing single use items at the practices. The Committee found that on the balance of probabilities Mrs Grant included 3:1 tips in the instruments laid out for the treatment of patients when she knew they were designed to be used on a single occasion and then discarded.
17.(i)(ii)	*you knew that the 3:1 tips had not been sterilised* - Proved DN2's evidence was that she witnessed Mrs Grant reusing single use 3:1 tips that had not been sterilised. Her evidence was supported by the falsified invoices which included 3:1 tips and which the Committee found were created by Mr Morrison to cover up the culture of reusing single use items at the practices. The Committee found that on the balance of probabilities Mrs Grant included 3:1 tips in the instruments laid out for the treatment of patients when she knew that the 3:1 tips had not been sterilised.
18.	*Your actions set out in Head of Charge 17 above put patients' health at risk* - Proved The Committee accepted the opinion of Mr Fulford. Having found proved allegations on cross infection control, in particular that matrix bands, gloves, endodontic files, ultrasonic scaler tip, aspirator tips and 3:1 tips which were single use items were reused by you, the Committee was satisfied that Mrs Grant's actions put patients' health at risk. The whole purpose of cross infection controls in dental practices is to reduce the risk of cross infection between patients. If those controls are not being adhered to the Committee considers it therefore follows that patients' health must be put at more risk since otherwise there would be no need for such control measures.
19.	*You responded dishonestly to an investigation into the decontamination procedures at the Practices by NHS Ayrshire & Arran in or about September 2013, in that, when interviewed, you claimed that gloves were changed between patients, that matrix bands were not re-used and/or that aspirator tips were sterilised before re-use* – Proved The Committee has found proved that Mrs Grant reused single use gloves and matrix bands. It follows that she was not therefore telling the truth when interviewed by Witness 1 on 24th September 2013. The Committee decided that this would be viewed as dishonest by the ordinary standards of reasonable and honest people and that Mrs Grant would have known that to be the case. In relation to aspirator tips the Committee noted that when interviewed by Witness 1 Mrs Grant said she cleaned aspirator tips with a brittle brush. She

	did not claim that they were sterilised before reuse. Accordingly, the Committee did not include aspirator tips in its finding of dishonesty.

We move to Stage Two."

On 10 February 2016 the Chairman announced the determination as follows:

"Having announced its determination on the facts found proved, the Committee heard submissions from Mr Bradly on behalf of the GDC and from Mr Fortune on behalf of Mr Morrison. No submissions were received on behalf of Mrs Kelly or Mrs Grant. The Committee accepted the advice of the Legal Adviser.

At this stage of the proceedings, the Committee was required to consider whether the facts it had found proved in respect of each registrant amounted to misconduct. In this context, misconduct means serious misconduct i.e. conduct which falls seriously short of the standards to be expected of a registrant.

If the Committee found that misconduct was established, it was next required to consider whether the registrants' fitness to practise was currently impaired by reason of that misconduct. In reaching its decision on current impairment, the Committee exercised its own independent judgement.

The Committee was referred to the cases of *Calhaem v GMC* [2007] EWHC 2606 (Admin), Zygmunt v GMC [2008] EWHC 2643 (Admin), Azzam v GMC [2008] EWHC 2711 (Admin), Cheatle v GMC [2009] EWHC 645 (Admin), *CHRE v NMC and Grant* [2011] EWHC 927 (Admin), *R (on the application of Cohen) v GMC* [2008] EWHC 581 (Admin), *Dr Cheng Yeong v GMC* [2009] EWHC 1923 (Admin) and Professional Standards Authority for Health and Social Care v Nursing and Midwifery Council and Mr D. Wilson [2015] EWHC 1887 (Admin).

The Committee bore in mind that current impairment requires consideration of the misconduct, any steps taken to remedy that misconduct, the likelihood of repetition, any remorse and insight demonstrated.

In considering sanction, the Committee had in mind the need to apply a proportionate sanction to each registrant depending on the nature of the misconduct and its findings in respect of current impairment. It reminded itself that the purpose of a sanction is not to be punitive although it may have that effect. The Committee also bore in mind its duty to protect the public and declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession. In relation to each registrant it carefully considered the GDC's Guidance for the Professional Conduct Committee, including Indicative Sanctions Guidance (October 2015). The Committee considered with great care the extensive documentary material provided on your behalf together with the submissions made by both Mr Bradly and Mr Fortune.

MORRISON, Alan Macdonald

History

Mr Fortune on your behalf agreed with Mr Bradly on the case law referred to. He made no submissions on misconduct.

The Committee was provided with details of your fitness to practise history with the GDC. You appeared before the Professional Conduct Committee in June 2005. The facts of that case

involved the provision of conscious sedation to a prisoner who was a nervous patient when you provided dental services at H.M. Prison Kilmarnock. The facts found proved involved clinical failings and included a finding that you allowed another prisoner at the Prison, who was not qualified, to inject your patient with the sedative medication and you failed to ensure that you were appropriately trained in sedation techniques. That Committee directed that your registration be erased.

In July 2006 you applied successfully to be restored to the Dentists Register. This Committee was provided with a copy of the restoration determination.

Misconduct

The Committee first considered whether the facts found proved amounted to misconduct. It made multiple findings of reusing single use items. In particular the Committee found that you failed to maintain adequate infection control for patients at your practices in that you reused single use items, you used items which had not been cleaned in a washer disinfector or sterilised, you permitted the dental nurses assisting you to include used single use items in the instruments laid out for the treatment of patients, you did not arrange training in infection control for your staff as required by the Chief Dental Officer for Scotland and your practices did not contain local decontamination units which complied with the requirements for such units set out by NHS Scotland. The Committee found that these failings in cross-infection control procedures put patients' health at risk.

In addition to the clinical failings in cross-infection control, you admitted and the Committee found proved that you responded dishonestly to an investigation by the Health Board into the decontamination procedures at your practices in that you provided the Health Board with falsified invoices purporting to relate to supplies of dental products made to your practices between September 2011 and July 2013. Following the reports by DN1 and DN2 of cross-infection control breaches, the Health Board invited you to agree to the closure of your practices on a voluntary basis pending its investigation into the reports. A practice inspection and investigation were carried out by the Health Board. You were asked about the reuse of single use items as reported by DN1 and DN2. The Committee noted from the records of the Health Board investigation that when interviewed, you denied reusing single use items. However the Committee found that you reused single use items and that you permitted other dental nurses at your practices to include used single use items in the instruments laid out for the treatment of patients. The Committee concluded that there was a culture of reusing single use items at your practices driven by your Practice Manager and actively supported by you. As part of the Health Board's investigations, invoices for single use and sundry items were requested. You then created false invoices of single use items and you presented them to the Health Board as genuine. You told the Committee that you created the false invoices with a view to getting your practices re-opened. You also told the Committee that you created these invoices to cover-up the fact that your practice manager had been stealing single-use items from another practice and that this was the reason why you were unable to produce sufficient genuine invoices. For the reasons already given the Committee wholly rejected that account and found that you created the false invoices in order to cover-up the culture of reusing single use items at your practices. Thus, not only did you behave dishonestly in creating false invoices, you also sought to blame your practice manager and you lied to this Committee.

You say that you have accepted the Committee's findings but you have not gone on to explain why you were reusing single use items. The only reason the Committee could determine for

reusing single use items was to save money, thus indicating that there was a financial incentive behind your actions.

Cross infection control procedures have been at the forefront of dental practices for many years. The cross-infection control failings and the dishonest conduct found proved were serious departures from the standards of conduct expected of a dental practitioner and fell significantly short of the standards expected of the profession. Your attempts to cover-up the culture of reusing single use items at your practices could have hampered the Health Board's investigations into the extent of exposure of your patients and staff to cross-infection, and may have resulted in a continuation of the culture of reuse if the cover-up had been successful. Furthermore your culture of reusing single use items put patients at real risk of harm.

Your actions breached the GDC's Standards for Dental Professionals (May 2005) (the 2005 Standards) which were in force until September 2013, in particular:

Principle 1: Put patients' interests first and act to protect them

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

Paragraph 1.7: If you believe that patients might be at risk because of your health, behaviour or professional performance, or that of a colleague, or because of any aspect of the clinical environment, you should take action. You can get advice from appropriate colleagues, a professional organisation or your defence organisation. If at any time you are not sure how to continue, contact us.

Paragraph 2.1: Treat patients politely and with respect, in recognition of their dignity and rights as individuals.

Principle 4: Co-operate with other members of the dental team and other healthcare colleagues in the interests of patients.

Paragraph 4.1: Co-operate with other team members and colleagues and respect their role in caring for patients.

Paragraph 4.3: Communicate effectively and share your knowledge and skills with other team members and colleagues as necessary in the interests of patients. In all dealings with other team members and colleagues, make the interests of patients your first priority. Follow our guidance 'Principles of dental team working'.

Principle 5: Maintain your professional knowledge and competence

Paragraph 5.3: Find out about current best practice in the fields in which you work. Provide a good standard of care based on available up-to-date evidence and reliable guidance.

Principle 6: Be trustworthy

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

Paragraph 6.2: Apply these principles to clinical and professional relationships, and any business or educational activities you are involved in.

Paragraph 6.3: Maintain appropriate standards of personal behaviour in all

walks of life so that patients have confidence in you and the public have confidence in the dental profession.

The Committee was of the view that reusing single use items for the treatment of patients, permitting other dental nurses to include used single use items in the instruments laid out for treatment, denying that single use items were reused at your practices and creating false invoices purporting to relate to the supply of dental products when that was not the case are serious failings that would be regarded as deplorable by fellow practitioners. The Committee was in no doubt that the facts found proved amounted to misconduct.

Impairment

The Committee was of the view that all the cross-infection control failings are remediable. It noted the bundle of remediation presented on your behalf which included:

- A report dated 7 January 2016 from J.L.;
- A report dated 7 January 2016 from T.T, your mentor;
- Communication reports dated 22 May 2015, 1 October 2015 and 7 January 2016 from D.M, CPD advisor;
- Personal Development Plan;
- National Education Scotland Action Plan
- Department of Health Audit tool report
- Reports on sterilisation cycle audit, diagnostics radiograph audit, bitewing radiograph audit, radiograph reporting audit, root treatment audit, crown audit, fillings audit, record card audit, re-called attendance audit, laboratory audit, staff meeting audit, infection control audit on hand hygiene, single use items audit;
- Minutes of practice meetings;
- Practice protocols;
- Templates;
- Training and CPD certificates;
- Reflective logs on CPD courses attended; and
- Installation reports

The Committee also received letters dated 9 June 2015, 17 June 2015 and 30 September 2015 from N.C. of NHS Ayrshire and Arran in relation to the inspection of your practices. She stated that the findings were satisfactory in the areas inspected. The Committee noted from D.M.'s communication reports the progress you had made with your PDP and that D.M. had no concerns. It also noted from the report of T.T. dated 7 January 2016 that "in terms of decontamination, there have been improvements in the decontamination process with the practices; however, there are lapses within the surgery in terms of cross contamination of multiple surfaces and drawers and with the general flow of instrumentation within the surgery. AMM requires being more vigilant and focussed on this important aspect of the decontamination process within the surgery." The Committee was disappointed that although a period of two years has passed between the initial concerns and this hearing, when cross-infection control should have been a priority, there remain some concerns about cross

contamination in your practices. Although you have taken substantial steps at remedying the cross-infection control issues raised about your practices, the Committee was not satisfied that they had all been remedied. It was therefore of the view that there remained a risk of repetition of the behaviour which led to the findings made by this Committee.

In relation to the dishonesty findings, the Committee was disappointed at the absence of an acceptance by you of the consequences of your dishonest conduct on the health of your patients and staff. Your reflective statement addresses the dishonest conduct in terms of its impact on you rather than a reflection on the significant harm to patients that could have occurred. By being dishonest to the Health Board the investigations into the cross-infection control allegations now found proved, could have been hampered. You should have been seeking to ensure that the allegations were fully investigated and any necessary measures for the protection of patients put in place. Rather you put your own interests first by creating false invoices of single use items to cover-up the culture of reuse at your practices. Even on your own explanation that you created the false invoices in order to quicken the re-opening of your practices, the Committee was of the view that in so doing you also put your own interests ahead of the interests of your patients and your staff. This is because the Committee considered that there was a likelihood that the culture of reuse of single use items may have continued when the practices re-opened if the allegations had not been fully investigated due to your dishonest actions.

The Committee considered whether there was an attitudinal problem underlying the conduct found proved in this case. The Committee was of the view that your lax approach to the administration of your practices and what appeared to be a disregard of published guidance and procedures indicated that there was also an attitudinal problem. The Committee noted that similarly the Committee in June 2005 found that you ‘breached the Council’s ethical guidance’ and that you disregarded standards and guidance on conscious sedation. More recently the Committee noted from the reports presented that there appeared to be an element of complacency on your part in relation to practice management issues. Mr T.T in his report referred to you as being on occasion reactive rather than proactive during the mentoring process although this was linked to the stresses of preparing for this inquiry. Furthermore your tendency to deceive by creating false invoices and your tendency to lie to this Committee indicate deep seated attitudinal problems.

The Committee noted that dishonesty and attitudinal problems are not so easily remedied. It considered the need to protect the public interest and maintain public confidence in the profession. Your actions in reusing single use items, permitting other dental nurses to include used single use items in the instruments laid out for the treatment of patients, failing to arrange the training of your staff in cross-infection control by NES and failing to ensure that your practices contained local decontamination units which complied with the requirements of NHS Scotland, put patients at unwarranted risk of harm. You breached fundamental tenets of the dental profession and your actions brought the profession into disrepute. In addition, your dishonest conduct was a concerted effort to deliberately deceive the Health Board in relation to the purchase of single use items at your practices. The Committee concluded that public confidence would be undermined if a finding of impairment was not made against you in the circumstances of this case. It determined that your fitness to practise is currently impaired by reason of your misconduct.

Sanction

In considering the issue of sanction, the Committee took account of the mitigating and the aggravating factors in this case. In mitigation the Committee noted:

- You have undertaken substantial remedial action to address the cross-infection control concerns;
- Your admissions to heads of charge 4, 5 and 7(b), indicating some insight into your offending behaviour;
- A number of relevant testimonials and references;
- There was no actual proven harm to your patients as a result of the failures in cross-infection control practices.

The aggravating factors include:

- The failings in cross-infection control put patients and your staff at risk of significant harm.
- On two separate occasions a patient notification exercise was carried out and press statements were issued to local and national media. In the first exercise patients were informed of possible failures in cross-infection control at the practices. In the second exercise letters were sent to in excess of 5000 patients as a result of which some 2,250 patients were blood tested for Blood Borne Viruses. The testing revealed that 4 patients were identified as having Hepatitis C infection. It was not possible to conclude with any certainty however that these patients contracted their infection in your dental practices. The Committee noted however that this situation was likely to have cause significant anxiety to a large number of people.
- The reuse of single use items must have resulted in a financial saving to the practices, suggesting that the motive for reusing was financial;
- Your conduct as found proved breached the trust that the public and your patients placed in you as a registered dental professional;
- You acted dishonestly in order to cover-up the culture of reuse at your practices by creating false invoices;
- You attempted to blame your practice manager for the reasons you had to create false invoices;
- Your conduct in creating the false invoices was premeditated and well-thought out; contacting your friend in America for invoices in dollars and then using them to create invoices would have required a clear thought process which did not indicate panic or chaos as you sought to convince the Committee;
- Your misconduct was sustained and repeated in that you reused single use items for at least the period reflected in the charges, namely between November 2012 and September 2013, and you continued to deny reusing single use items to this Committee;
- You have not demonstrated any insight into the impact of your practice of reusing single use items nor on the potential impact of your dishonesty in seeking to hide from the Health Board the fact that you were not disposing of single use items as required;
- You have been previously erased by the Council and the Committee noted similarities in both cases in that there was an attitudinal problem of not adhering to published standards and guidance.

Taking the above factors into account, the Committee considered the sanctions in ascending order. It determined that the nature of the impairment requires a sanction to be imposed and it would be inappropriate to conclude this case with no further action.

Given the seriousness of the facts found proved, the absence of insight into the impact of your dishonesty, the prolonged nature of the breaches in cross infection control procedures and the potential consequences for patients, the Committee concluded that a reprimand would be wholly inappropriate, inadequate and insufficient.

The Committee then considered whether conditions would be appropriate in this case. It noted that conditions could address the cross infection control concerns which remain. However conditions could not deal with your dishonest conduct and the attitudinal problems the Committee has identified. You have shown a lack of appreciation for the importance of adherence to accepted standards and guidance and the potential consequences of the breaches of cross-infection control procedures on patients. The Committee concluded that conditions are not appropriate in this case.

The Committee next considered whether to suspend your registration. It noted the October 2015 guidance which set out the circumstances when a suspension would be appropriate. All the factors were present in this case. However the Committee was of the view that your failings constituted very serious departures from the standards of the profession and breached the trust of patients. In addition you demonstrated no insight into your dishonest conduct and the Committee identified a deep seated professional attitudinal problem. The Committee concluded that your woeful behaviour, as detailed in this determination, has damaged your fitness to practise and public confidence in the dental profession to the extent that removal of your professional status is the only appropriate and proportionate outcome.

In reaching this decision the Committee recognises the severe impact this will have upon you and that it will prevent you from earning a living in your chosen profession. It also recognises that there will be an impact upon your family and also upon your staff. This is most regrettable. However, in light of the seriousness of the findings made against you the Committee decided that, in line with its duty to protect patients and maintain public confidence in the profession, erasure was the only appropriate outcome.

Accordingly the Committee directs, pursuant to Section 27B (6)(a) of the Dentists Act 1984, that your registration be erased from the Dentists Register.

The interim order of conditions currently on your registration is hereby revoked.

KELLY, Lorraine Ann

Mr Bradly submitted that there was no fitness to practise history with the GDC against Mrs Kelly.

Misconduct

The Committee first considered whether the facts found proved amounted to misconduct. It found that Mrs Kelly caused the dental nurses at the practices to include used single use items in the instruments laid out for the treatment of patients and that her actions put patients' health at risk. In addition Mrs Kelly responded dishonestly to an investigation into the decontamination procedures at the practices by the Health Board in that when interviewed she claimed that gloves were changed between patients, that matrix bands were not reused and aspirator tips

were sterilised before use. As the Practice Manager responsible for ordering stock at the practices, Mrs Kelly would have been aware that ordering inadequate stock for the practices would lead to reuse of single use items. Indeed, from the evidence of DN1 and DN2 it was apparent that Mrs Kelly was the person instructing the dental nurses to reuse single use items. This approach was exacerbated by her flippant response to DN1 of “well no one’s caught anything so far”. In addition Mrs Kelly attempted to interfere with the Health Board’s investigations by seeking to persuade DN2 who, had previously worked at the practices, not to co-operate with the investigation. Subsequently Mrs Kelly attempted to upset DN2 by telling her “your day will come” or words to that effect.

The cross-infection control failings, the dishonest conduct and the attempt to interfere with an investigation found proved against Mrs Kelly were very serious departures from the standards of conduct expected of a registered dental care professional and fell significantly short of the standards expected of the profession.

Mrs Kelly’s actions breached the GDC’s Standards for Dental Professionals (May 2005) (the 2005 Standards) which were in force until September 2013, in particular:

Principle 1: Put patients’ interests first and act to protect them

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

Paragraph 1.7: If you believe that patients might be at risk because of your health, behaviour or professional performance, or that of a colleague, or because of any aspect of the clinical environment, you should take action. You can get advice from appropriate colleagues, a professional organisation or your defence organisation. If at any time you are not sure how to continue, contact us.

Paragraph 2.1: Treat patients politely and with respect, in recognition of their dignity and rights as individuals.

Principle 4: Co-operate with other members of the dental team and other healthcare colleagues in the interests of patients.

Paragraph 4.1: Co-operate with other team members and colleagues and respect their role in caring for patients.

Paragraph 4.3: Communicate effectively and share your knowledge and skills with other team members and colleagues as necessary in the interests of patients. In all dealings with other team members and colleagues, make the interests of patients your first priority. Follow our guidance ‘Principles of dental team working’.

Principle 5: Maintain your professional knowledge and competence

Paragraph 5.3: Find out about current best practice in the fields in which you work. Provide a good standard of care based on available up-to-date evidence and reliable guidance.

Principle 6: Be trustworthy

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

Paragraph 6.2: Apply these principles to clinical and professional relationships, and any business or educational activities you are involved in.

> **Paragraph 6.3:** Maintain appropriate standards of personal behaviour in all walks of life so that patients have confidence in you and the public have confidence in the dental profession.

The Committee was of the view that the facts found proved against Mrs Kelly are serious and would be regarded as deplorable by fellow practitioners. It was in no doubt that they amounted to misconduct.

Impairment

The cross-infection control failings are remediable. However the Committee has received no evidence of remediation from Mrs Kelly. The Committee could not therefore know whether the cross-infection control failings had been remedied. Furthermore in the absence of any evidence of remediation the Committee was of the view that there is a high risk of repetition of the behaviour in the future. The Committee has also not seen any evidence of remorse or insight from Mrs Kelly into her dishonest conduct regarding the cross-infection control concerns and the potential impact of continued breaches of cross-infection control procedures on the health of patients and staff at the Practices.

The Committee considered whether there was also an attitudinal problem. Mrs Kelly informed DN1 that the practice reused gloves and matrix bands and did not sterilise aspirator tips. This demonstrated an awareness of the reuse of single use items at the practice contrary to published guidance and procedures which she would have been aware of as a registered dental nurse. In addition as Practice Manager Mrs Kelly had the responsibility of ordering stock. As a consequence she would have been aware of the reuse of single use items given that inadequate stock was purchased for the practices. Mrs Kelly did not raise concerns of reusing of single use items but rather sought to hamper the investigations of the Health Board by denying that single use items were reused and asking DN2 not to co-operate with the investigation. The Committee concluded that Mrs Kelly had an attitudinal problem in addition to the clinical failings regarding cross-infection control.

The Committee noted that dishonesty and attitudinal problems are not so easily remedied. It considered the need to protect the public interest and maintain public confidence in the profession. By actively encouraging the reuse of single use items and discouraging the sterilisation of aspirator tips and by not ensuring that adequate stock was purchased for the practices and seeking to cover-up the culture of reuse of single use items, Mrs Kelly's actions put patients at unwarranted risk of harm. Her actions breached a substantial number of fundamental tenets of the profession and brought the profession into disrepute given the wide press coverage that the case has received since the reports were first made in 2013. In addition she acted dishonestly as found proved by the Committee. In the absence of any evidence of remediation, remorse or insight the Committee concluded that there was a risk that Mrs Kelly was liable to act in the same way in the future. It concluded that public confidence would be undermined if a finding of impairment was not made against Mrs Kelly in the circumstances of this case. The Committee determined that Mrs Kelly's fitness to practise is currently impaired by reason of her misconduct.

Sanction

In considering the issue of sanction, the Committee took account of the mitigating and the aggravating factors in this case. In mitigation the Committee noted that the only evidence available to it is evidence of Mrs Kelly's previous good character.

The aggravating factors include:

- The failings in cross-infection control put patients and the staff at the practices at risk of significant harm;
- Mrs Kelly abused her position of trust as practice manager by causing others in the practice to follow a policy of reusing single use items;
- Mrs Kelly abused her position of power by seeking to persuade a more junior member of staff not to co-operate with the Health Board's investigation;
- Mrs Kelly's misconduct was sustained and repeated over a period of time;
- Mrs Kelly's misconduct was blatant and wilful as reflected in her comments to DN1 that no one had caught anything so far;
- There was no evidence of insight or remorse;
- Mrs Kelly attempted to cover-up her wrong-doing by lying to the Health Board investigation;
- Mrs Kelly's conduct as found proved breached the trust that the public and patients placed in her as a registered dental care professional;

Taking the above factors into account, the Committee considered the sanctions in ascending order. It determined that the nature of the impairment requires a sanction to be imposed and it would be inappropriate to conclude this case with no further action.

Given the seriousness of the facts found proved, the absence of insight into the impact of Mrs Kelly's dishonesty, the prolonged nature of the breaches in cross infection control procedures and the potential consequences for patients, the Committee concluded that a reprimand would be wholly inappropriate, inadequate and insufficient.

The Committee then considered whether conditions would be appropriate in this case. It noted that conditions could address the issue of cross-infection control. However Mrs Kelly has not engaged with this hearing and thus the Committee does not know what her attitude is to remediation and whether she would be willing to remediate. Furthermore, conditions could not deal with her dishonest conduct and the attitudinal problems identified by the Committee whereby Mrs Kelly caused the practise of reusing single use items to take place without any apparent recognition of the harm such a practice could cause to patients and staff. The Committee has seen no evidence from Mrs Kelly in relation to the failings now found proved against her. Given her lack of engagement the Committee was not confident that conditions would be workable or achievable. Furthermore the dishonest conduct found proved is such that conditions would not be appropriate or sufficient to deal with the public interest arising from such a finding.

The Committee next considered whether to suspend Mrs Kelly's registration. It noted the October 2015 guidance on the circumstances when a suspension would be appropriate. Given that the Committee identified an attitudinal problem in light of Mrs Kelly's clear admission to DN1 of a practice of reusing single use items, lying to the Health Board during its investigation, asking DN2 not to co-operate with the investigation and subsequently upsetting DN2 by telling her that her day will come, the Committee concluded that her behaviour damaged her fitness to practise and public confidence in the dental profession to the extent that removal of her professional status is the only appropriate outcome.

In reaching this decision the Committee recognises the severe impact this may have upon Mrs Kelly and that it will prevent her from earning a living in her chosen profession. This is most

regrettable. However, in light of the seriousness of the findings made against her the Committee decided that, in line with its duty to protect patients and maintain public confidence in the profession, erasure was the only appropriate outcome.

Accordingly the Committee directs, pursuant to Section 36P (7)(a) of the Dentists Act 1984, that Mrs Kelly's registration be erased from the Dental Care Professionals' Register.

The interim order of conditions currently on Mrs Kelly's registration is hereby revoked.

GRANT, Dawn

Mr Bradly submitted that there was no fitness to practise history with the GDC against Mrs Grant.

Misconduct

The Committee first considered whether the facts found proved amounted to misconduct. It found proved that Mrs Grant included used single use items in the instruments laid out for the treatment of patients, included instruments which had not been cleaned in the washer disinfector or sterilised in the instruments laid out for the treatment of patients and that her actions put patients' health at risk. In addition Mrs Grant responded dishonestly to an investigation into the decontamination procedures at the practices by the Health Board in that when interviewed she claimed that gloves were changed between patients and that matrix bands were not reused.

Mrs Grant's actions were a serious departure from the standards of conduct expected of a dental care professional and fell short of the standards expected of the profession. Dental nurses have the responsibility of ensuring that instruments for the treatment of patients are put through the appropriate cross-infection control processes. As a registered dental care professional Mrs Grant had a responsibility to report any breaches of cross-infection control to the appropriate authorities. Rather than do this, Mrs Grant put her interests before that of her patients and colleagues by denying that single use items were reused at the practices.

The Committee was of the view that Mrs Grant's actions breached the GDC's Standards for Dental Professionals (May 2005) (the 2005 Standards) which were in force until September 2013, in particular:

> **Principle 1: Put patients' interests first and act to protect them**
>
> **Paragraph 1.1:** Put patients' interests before your own or those of any colleague, organisation or business.
>
> **Paragraph 1.7:** If you believe that patients might be at risk because of your health, behaviour or professional performance, or that of a colleague, or because of any aspect of the clinical environment, you should take action. You can get advice from appropriate colleagues, a professional organisation or your defence organisation. If at any time you are not sure how to continue, contact us.
>
> **Paragraph 2.1:** Treat patients politely and with respect, in recognition of their dignity and rights as individuals.
>
> **Principle 4:** Co-operate with other members of the dental team and other healthcare colleagues in the interests of patients.

Paragraph 4.1: Co-operate with other team members and colleagues and respect their role in caring for patients.

Paragraph 4.3: Communicate effectively and share your knowledge and skills with other team members and colleagues as necessary in the interests of patients. In all dealings with other team members and colleagues, make the interests of patients your first priority. Follow our guidance 'Principles of dental team working'.

Principle 5: Maintain your professional knowledge and competence

Paragraph 5.3: Find out about current best practice in the fields in which you work. Provide a good standard of care based on available up-to-date evidence and reliable guidance.

Principle 6: Be trustworthy

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

Paragraph 6.2: Apply these principles to clinical and professional relationships, and any business or educational activities you are involved in.

Paragraph 6.3: Maintain appropriate standards of personal behaviour in all walks of life so that patients have confidence in you and the public have confidence in the dental profession.

Mrs Grant's failings were serious and would be regarded as deplorable by fellow practitioners. The Committee was in no doubt that the facts found proved against Mrs Grant amounted to misconduct.

Impairment

The Committee considered that Mrs Grant's failings in relation to cross-infection control are remediable. However it has received no evidence of remediation from Mrs Grant and therefore the Committee did not know whether her cross-infection control failings had been remedied. Furthermore in the absence of any evidence of remediation the Committee could not be satisfied that the failings would not repeated in the future. There is no evidence of remorse or insight from Mrs Grant into her dishonest conduct and the potential impact on the health of patients in denying that single use items were reused thereby potentially hampering the investigations of the Health Board.

The Committee considered whether there was an attitudinal problem underlying the findings made against Mrs Grant. It noted that as a dental nurse at the practices, she would have done as she was instructed. She was not in charge of purchasing stock for the practices. Although these factors did not exonerate her responsibilities as a registered dental professional to ensure that she carried out appropriate cross-infection control practices, the Committee noted from Witness 1's statement that Mrs Grant had worked at the practices for 15 years, she was not formally qualified and she became a registered dental nurse through the GDC's 'grand-parenting clause'. Accordingly the only training she would have received in cross infection control would have been that passed on by Mr Morrison and Mrs Kelly. The Committee concluded that there was no evidence of an attitudinal problem in relation to Mrs Grant.

In relation to the dishonesty findings, the Committee noted that it is a type of conduct which is not easily remedied, albeit the Committee considered her to be in a different category to that of either Mr Morrison or Mrs Kelly. This was because they went rather further than simply denying

the reuse of single use items and they were both in positions of authority over Mrs Grant. In addition to the absence of any evidence of remediation, remorse or insight, the Committee considered the need to protect the public interest and maintain public confidence in the profession. Mrs Grant's actions put patients at unwarranted risk of harm, breached fundamental tenets of the profession and brought the profession into disrepute. Mrs Grant also acted dishonestly by responding falsely to the Health Board's investigations into the cross-infection control allegations now found proved by this Committee. In the absence of any evidence of remediation, the Committee concluded that Mrs Grant might act in the same way in the future. It concluded that public confidence would be undermined if a finding of impairment was not made against Mrs Grant. The Committee determined that Mrs Grant's fitness to practise is currently impaired by reason of her misconduct.

Sanction

In considering the issue of sanction, the Committee took account of the mitigating and the aggravating factors in this case. The Committee noted that the only evidence in mitigation before it was Mrs Grant's previous good character.

The aggravating factors include:

- The failings in cross-infection control put patients at risk of significant harm;
- Mrs Grant acted dishonestly by lying to the Health Board in order to cover-up the culture of reuse at the practices;
- Mrs Grant's conduct as found proved breached the trust that the public and her patients placed in her as a registered dental care professional;
- There is no evidence from Mrs Grant demonstrating her insight into the impact of her dishonest conduct in denying reusing single use items on the health of her patients; and
- The incident was not isolated as it was found proved that the practices did not maintain adequate infection control for patients between 16th November 2012 and September 2013.

Taking the above factors into account, the Committee considered the sanctions in ascending order. It determined that the nature of the impairment requires a sanction to be imposed and it would be inappropriate to conclude this case with no further action.

Given the seriousness of the facts found proved, the absence of insight into the impact of her dishonesty, the prolonged nature of the breaches in cross infection control procedures and the potential consequences for patients, the Committee concluded that a reprimand would be inappropriate, inadequate and insufficient.

The Committee then considered whether conditions would be appropriate in this case. It noted that conditions could address the issues of cross infection control. Although there was dishonesty by Mrs Grant, as stated it was in a different category to the others and whilst the Committee did not condone such behaviour it could understand how a dental nurse in Mrs Grant's position might feel the need to lie in order to protect her positon and that of her employer. This did not mean that she necessarily had deep seated attitudinal problems and therefore the Committee concluded that conditions could address the concerns arising in this case and would protect patients and the public. The Committee therefore determined to impose conditions on Mrs Grant's registration for a period of 12 months.

The conditions as they will appear against the name Dawn Grant in the Dental Care Professionals' register are as follows:

1. She must work with a Postgraduate Dental Dean/Director (or a nominated deputy), to formulate a Personal Development Plan, specifically designed to address the deficiencies in the following areas of her practice:
   - Infection control,
   - GDC Standards in relation to:
     - putting patients' interest first, and
     - raising concerns if patients are at risk.
2. She must forward a copy of her Personal Development Plan to the GDC within 3 months of the date on which these conditions become effective.
3. At any time she is employed, or providing dental services, which require her to be registered with the GDC; she must place herself and remain under the close supervision of a workplace supervisor nominated by her, and agreed by the GDC.
4. She must allow her workplace supervisor to provide reports to the GDC at intervals of not more than 3 months and the GDC will make these reports available to any Postgraduate Dean/Director referred to in these conditions.
5. She must notify the GDC promptly of any professional appointment she accepts and provide the contact details of her employer or any organisation for which she is contracted to provide dental services.
6. She must allow the GDC to exchange information with her employer or any organisation for which she is contracted to provide dental services, and any Postgraduate Dental Dean/Director, reporter, workplace supervisor referred to in these conditions.
7. At any time she is providing dental services, which require her to be registered with the GDC, she must agree to the appointment of a reporter nominated by her and approved by the GDC. The reporter shall be a GDC registrant and who may also be the same person as the workplace supervisor.
8. She must allow the reporter to provide reports to the GDC at intervals of not more than 3 months and the GDC will make these reports available to any Postgraduate Dental Dean/Director, workplace supervisor referred to in these conditions.
9. She must inform the GDC of any formal disciplinary proceedings taken against her, from the date of this determination.
10. She must inform the GDC if she applies for dental employment outside the UK.
11. She must inform within one week the following parties that her registration is subject to the conditions, listed at 1 to 10, above:
    a. Any organisation or person employing or contracting with her to undertake dental work,
    b. Any locum agency or out-of-hours service she is registered with or applies to be registered with (at the time of application),
    c. Any prospective employer (at the time of application),

12. She must permit the GDC to disclose the above conditions, 1 to 11, to any person requesting information about her registration status.

This order for conditions will be reviewed prior to the end of the 12 month period."

"Mr Morrison,

The Committee considered Mr Bradly's application for an immediate order of suspension on your registration. It accepted the advice of the Legal Adviser.

Mr Fortune opposed the application. The Committee took full account of his submissions on your behalf. It carefully considered the impact of an immediate suspension of your registration on your patients, your staff and particularly the impact on you personally.

The Committee noted that you have been subject to conditions on your registration since early 2014 to ensure that you practise safely and that these conditions have been complied with. The Committee noted from the report of Mr T.T. however, that there remained some residual concerns about your cross infection control measures. The Committee was also concerned about your future conduct in light of its findings that you have deep seated attitudinal problems in dealing with the correct standards to be applied in dentistry and that therefore further lapses could occur which could put patients at risk of harm. The Committee therefore concluded that an immediate order was necessary to protect the public from harm.

The Committee was also satisfied that an immediate order should be made in the public interest. In light of its findings that you presided over a culture of the reuse of single use items, that your motive may have been one of financial gain and that you created false invoices to hide this fact when the matter was investigated by the Health Board, the Committee considered that public confidence in the profession would be seriously undermined if you were nevertheless allowed to continue to practice as a dentist.

The Committee therefore orders that your registration be suspended.

The effect of the foregoing direction and this order is that your registration will be suspended forthwith and unless you exercise your right to appeal, the substantive direction for erasure of your registration will take effect 28 days from when notice is deemed served on you. Should you exercise your right to appeal, this order for immediate suspension may remain in place pending the resolution of any appeal proceedings.

That concludes the case for today."