General Dental Council | protecting patients, regulating the dental team

**HEARING HEARD IN PUBLIC**

**HASSAN, Ayesha**

**Registration No: 238536**

**PROFESSIONAL CONDUCT COMMITTEE**

**DECEMBER 2019**

**Outcome: Suspension for 9 months with immediate suspension (with a review)**

Ayesha HASSAN, a dental nurse, NVQ L3 Dental Nursing & VRQ L3 Dental Nursing City & Guilds 2012, was summoned to appear before the Professional Conduct Committee on Monday 9 December 2019 for an inquiry into the following charge:

**Charge**

"That, being a registered dental professional:

1. Between 30 April 2018 and 7 June 2018, you failed to maintain adequate standards of cross infection control in that you:
    a. Did not change gloves in accordance with practice policies;
    b. Dropped an aspirator on the floor during treatment and continued to use it.
2. Your conduct in respect of Charge 1a and/or 1b put patient's safety at risk
3. Between 30 April 2018 and 7 June 2018, you failed to:
    a. Record dental charting correctly;
    b. Prepare, mix and handle dental biomaterials correctly;
    c. Provide adequate chairside support to the operator during treatment.
4. Your conduct in respect of Charge 3a and/or 3b and/or 3c put patient's safety at risk
5. Between 28 June 2018 to 19 September 2018 you failed to co-operate with an investigation by the GDC by not providing:
    a. Any evidence of indemnity and,
    b. Details of your employer.

AND that by reason of the facts alleged, your fitness to practise is impaired by reason of misconduct."

On 11 December 2019 the Chairman made the following statement regarding the finding of facts:

"Ms Hassan,

The allegations against you arise from your employment as a dental nurse at the Talking Teeth Dental Practice, Widnes (the "Practice") between 30 April 2018 and 7 June 2018. By email to the General Dental Council (GDC) on 06 June 2018, Ms B, a dental nurse and the

then compliance manager at the Practice, raised concerns regarding your capability as a dental nurse. There was before the Committee in the bundle provided by the GDC, reference to matters and hearsay which were not directly relevant to the charges before the Committee and which were potentially prejudicial to you. Ms Denholm, for the GDC, submitted that this material was not being relied upon by the GDC and that it should have been redacted from the bundle. Accordingly, the Committee disregarded that material.

*Recusal*

The Committee considered of its own motion whether to recuse itself in light of the unredacted material which it had read in advance of the hearing. When reading that material it had been immediately apparent to each member that the material was irrelevant to the charges and that it was hearsay which would not be corroborated by any of the evidence which would be called by the GDC in support of the charges. The Committee had no difficulty in disregarding that material from its mind. There is no risk of that material influencing its decision making. In those circumstances, a fair minded and well-informed observer would not conclude that there was any risk of bias. In those circumstances, there was no need for the Committee to recuse itself.

*Hearsay application 09 December 2019*

At a Preliminary Meeting of the Professional Conduct Committee on 19 November 2019, it was directed that:

3. By 26 November 2019, the Registrant shall notify the Council whether or not the witness statements previously served on the Registrant are agreed. If the witness statements are not agreed, to notify the Council whether she has any questions for the witnesses.

4. If no response is received by 26 November 2019, in relation to Direction 3 above, all witnesses relied upon by the Council will not be required to attend the hearing before the Committee in person but should remain available to provide evidence by telephone or Skype.

No response was received from you by 26 November 2019 and the attendance of the Council's witnesses was therefore not required. The Committee however determined that it would be appropriate to call the following witnesses via telephone so that questions could be put to them to test and clarify their evidence:

a. Ms B;

b. Ms E, the lead dental nurse at the Practice at the time of the alleged events;

c. Mr Z, a dentist at the Practice with whom you had worked.

Before the witnesses were called, Ms Denholm applied for the following evidence to be admitted as hearsay:

a. Exhibit HB/1 to Ms B's witness statement, so far as it reported matters which Ms B had not herself witnessed; and

b. paragraphs 23 to 26 of Ms B's statement;

You stated that you disputed the accounts given by Ms B and Ms E and indeed you disputed the need for their evidence.

The Committee accepted the advice of the Legal Adviser. From the authorities he identified the following four broad considerations relevant to whether evidence should be admitted as hearsay. First, each case must be decided on its own facts and in its own circumstances.

There is no automatic rule as to the admissibility or otherwise of hearsay. Secondly, the reason why the witness is not present can be relevant to the issue of fairness (here this is in reference not to Ms B and Ms E as witnesses themselves, but to potential witnesses to which they refer in their statements who have not been called by the GDC to give evidence). Thirdly, whether the hearsay evidence is the sole or decisive evidence in support of any particular charge: if it is, then it is less likely to be fair to admit it as hearsay than if it is not. Fourthly, the degree to which the hearsay evidence is controversial or highly disputed.

The Committee does not know why the witnesses in question were not being called. The hearsay as it stands consists largely of anecdotal references relating to what others are alleged to have said of your competency and performance as a dental nurse. The Committee determined that it would not be fair to admit the evidence as hearsay. The hearsay is in broad terms and is the sole evidence and therefore uncorroborated by other evidence. You would have no opportunity to challenge that evidence through questioning and the admissibility of that evidence would be unfair to you. The Committee therefore refused Ms Denholm's application.

*Hearsay application 10 December 2019*

The Committee heard from the three witnesses referred to above. Prior to calling Mr N. Entwistle, who had been instructed by the GDC for his expert opinion, Ms Denholm applied for parts of a report exhibited to Ms E's witness statement to be admitted as hearsay. This was to allow to remain in evidence the alleged factual basis on which Mr Entwistle had formed the following opinion in his report dated 03 July 2019:

> 10. It is alleged that the Registrant could not use the computer system and was unable to chart teeth. In particular it is alleged that the Registrant:
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> • When asked to chart upper left 6 tooth, occlusal surface (UL6o), charted lower left 6
>
> tooth, mesial surface (LL6m)
>
> • When told to chart the upper tooth, she charted the upper left 6 mesio-occlusal (UL6mo)
>
> • Has no understanding of mixed dentition charting
>
> • On 29 May 2018 could not chart occlusal decay on a tooth
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> …
>
> 17. It is alleged that the Registrant:
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> • …
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> • Did not know what to set up for a re-cementation of a crown
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> …
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> 22. It is alleged that:
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> • The dentist is "constantly fixing the aspirator" and having to show the Registrant
>
> what to do
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> ...
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> 23. If the Committee determines that the Registrant was not able to provide adequate
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> chairside support to the operator during treatment, including by
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> • not being able to, or not taking reasonable care to aspirate correctly and/or
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> …

> in my opinion that conduct would fall far below the standard expected of a reasonably competent dental nurse since in my opinion it would potentially jeopardise the quality of care provided by a dentist and would fail to put the interests of patients first.

The document in question was a report produced by Ms E, which appears at pages 59 to 61 of the main bundle before the Committee (Exh1) and which was exhibited by her as exhibit 2 to her statement. Mr Entwistle's opinion on the above was based solely on that report. The Committee determined that Ms E's report, so far as it referred to matters which she did not herself witness, should not be admitted as hearsay for the same reasons already given in respect of the application on 09 December 2019.

That hearsay account was the sole and decisive evidence in support of the matters to which Ms E referred and on which Mr Entwistle then based his opinion, as cited above. Further, at the third bullet point under paragraph 10 of his report ("Has no understanding of mixed dentition charting"), the phrasing Mr Entwistle used was inconsistent with the evidence given by Ms E, who witnessed only one example of incorrect mixed dentition charting. She signed off dental charting on your training log. She stated to the Committee that she would sign matters off on that log if there were only "minor concerns" in respect of the issues arising during training. Only one alleged incident of incorrect charting had been observed by Ms E, as set out in her witness statement.

In his report at paragraph 9, Mr Entwistle stated: *"…I would not expect any dental nurse to be perfect, and I accept that extremely rarely, charting errors do occur even when checked by a supervising dentist…"*

Having regard to the four factors identified by the Legal Adviser in his advice to the Committee, the Committee was not satisfied that it would be fair to allow the evidence to be admitted as hearsay. Accordingly, the Committee did not allow the following parts of Mr Entwistle's report to be admitted in evidence: the first four bullet points under paragraph 10; the second bullet point under paragraph 17; and paragraphs 22 and 23 (in respect of the first bullet points in both paragraphs).

*The factual inquiry*

The Committee heard oral evidence via telephone from Ms B, Ms E and Mr Z.

The Committee then heard oral evidence from Mr Entwistle, in which he expounded upon the matters referred to in his report and in which he confined his opinion to the alleged matters now remaining in evidence.

The witness statement of Ms N. Hadid, a paralegal at the GDC, was taken as read. Her evidence was limited to producing documents from the GDC's records relating to requests it had allegedly made of you for information on your indemnity and employment details.

You participated in the hearing via a Skype video link and represented yourself. The Committee heard evidence from you.

The Committee had regard to the submissions made by Ms Denholm and those which you made. The Committee accepted the advice of the Legal Adviser. The burden is on the GDC to prove each charge on the balance of probabilities.

The Committee found Ms B and Ms E to be honest witnesses. Owing to the passage of time, there was understandably some inconsistency in their recollections as to the chronology and

timeframe of the matters to which they refer. Ms B was unable to give direct evidence of the specific incidents alleged.

The Committee accepted Ms B's evidence as to your period of employment at the Practice, which you confirmed.

The Committee found Ms E to be a credible witness overall in relation to the specific incidents she witnessed, albeit she could not be clear when exactly those incidents occurred. She was responsible for training you at the Practice and the Committee considered her to be fair and objective when signing off certain areas on your training log.

The Committee found Mr Z to be an honest and credible witness who had a clear and consistent recollection of what had occurred during the specific incident to which he referred. He was clearly shocked by the alleged incident and was clear about the steps he had taken to protect the patient, to feedback his concerns to you after the appointment and to then report the matter to his manager.

Mr Entwistle's opinion contained in his report was partly predicated on the hearsay which the Committee ultimately did not allow into evidence. He therefore modified the scope of his opinion and criticisms when giving oral evidence.

The Committee accepted the witness statement of Ms Hadid, which was a production statement.

You made blanket denials to all the charges against you. When questioned, you conceded that your experience of dental charting was limited and that it is an area on which you might need further training. You explained that at your previous practice the dentist did most of the charting himself. You also explained that you know the difference between different surgical instruments but explained that at your previous practice the dentist took out the dental forceps himself, as the drawer containing those was located closer to him.

You stated that you are a qualified dental nurse, that your qualification is evidence of your competency as a dental nurse and that you had been qualified for seven years and never had any complaints. You stated that you believe that there was a vendetta against you at the Practice and that you feel the charges against you are the result of racism towards you. However, you did not put to any witness any allegation of racial bias, nor did you identify any basis in support of this allegation. The Committee could not identify any evidence of any racial bias in respect of the evidence which had been given and the charges which have been brought against you.

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

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| 1. | *Between 30 April 2018 and 7 June 2018, you failed to maintain adequate standards of cross infection control in that you:* |
| 1. a. | AMENDED TO READ: *Did not change gloves ~~in accordance with practice policies~~;*<br><br>**Proved.**<br><br>The Committee accepted the evidence of Ms B that your period of employment at the Practice fell within the timeframe pleaded under charge 1.<br><br>The Committee accepted the evidence of Mr Entwistle that you were under a duty to maintain adequate standards of cross infection control and that the |

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| | matters alleged under charges 1(a) and 1(b) would each be in breach of those standards.<br><br>The GDC's case under charge 1(a) is confined to an alleged incident witnessed by Mr Z. He states that whilst a patient was being treated you removed a pile of contaminated cotton wool rolls which had been used on the patient from the spittoon and placed them in the clinical waste bin; that after doing so you did not immediately change your gloves; and that he observed you for about a minute to see if you would change your gloves but you did not do so and intended to continue treating the same patient while wearing the contaminated gloves.<br><br>Mr Z stated that he then asked you to remain seated to one side whilst he finished treating the patient himself, cutting the appointment short so that he would have time to discuss the matter with you. After the patient left he stated that he explained to you that for cross infection purposes you needed to have immediately changed your gloves after you removed the contaminated cotton wool rolls. He stated that after this discussion you kept the contaminated gloves on and started to clean the clinical areas whilst wearing those contaminated gloves before removing the dirty instruments from the surgery, taking those instruments down from the first floor to another area of the Practice.<br><br>Mr Zstated in his witness statement that this was in breach of the cross infection policy and that he immediately reported the incident by telephone to his manager. In his oral evidence he stated that he was concerned because you had breached two statutory provisions.<br><br>Mr Z was unclear as to when the incident took place but believed it to be "several days" after you had started at the Practice.<br><br>Your evidence was that you would always change your gloves between patients. You denied that the incident as alleged by Mr Z occured.<br><br>The Committee accepted the evidence of Mr Z on the incident to which he refers and finds that you did not change the gloves as reported by him. The Practice Policies pleaded under this charge were not before the Committee. The Committee would therefore not be in a position to find the charge proved as currently drafted, as it would be unable to review the existence and scope of those Policies for itself. The Committee called for further legal advice from the Legal Adviser. The legal advice, which was given in camera and repeated in open session for comment from the parties, was that the Committee has the power to amend the charge by deleting the words "*in accordance with practice policies*" from the charge, provided the Committee is satisfied that no unfairness would be caused to the parties in making the amendment.<br><br>Ms Denholm submitted that the question of amendment was a matter for the Committee's discretion and she referred the Committee to Mr Z's witness statement, in which he refers to the incident breaching Practice policy.<br><br>You expressed no objection to the proposed amendment.<br><br>The Committee was satisfied that no unfairness would be caused to either |

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| | party in making the amendment. Accordingly, the Committee exercises its direction to amend the charge under Rule 18 of the General Dental Council (Fitness to Practise) Rules 2006 to delete the words "*in accordance with practice policies*". In light of the amendment the Committee finds the charge proved. |
| 1. b. | *Dropped an aspirator on the floor during treatment and continued to use it.*<br><br>**Proved.**<br><br>Ms E stated that she witnessed you drop an aspirator on the floor, that you picked it up and that you then put it in a patient's mouth. Ms E was unsure of the exact date of the alleged incident and stated that she did not prevent you from using the aspirator on the patient as she did not want to alarm the patient. She stated that after the appointment ended she asked you if you had dropped the aspirator on the floor, as she was not sure what she had seen. She stated that you confirmed you had dropped the aspirator on the floor, picked it up again and used it on the patient. She stated that she explained to you that you must not do that again under any circumstances because of patient safety.<br><br>Your evidence to the Committee was that you do not recall any occasion on which you had dropped an aspirator on floor. Further, you stated that you would never continue using an aspirator after it had been dropped on the floor: you would have changed the aspirator in those circumstances. You stated that you would have had no reason to continue using an aspirator which had been dropped on the floor.<br><br>You stated that there had been no discussion between you and Ms E about this matter.<br><br>The Committee accepted the evidence of Ms E and found that you did drop the aspirator on the floor, that you picked it up off the floor and that you then used it on the patient. |
| 2. | *Your conduct in respect of Charge 1a and/or 1b put patient's safety at risk*<br><br>**Proved.**<br><br>The evidence of Mr Entwistle was that these matters would fall "*far below the standard expected of a reasonably competent dental nurse, due to the deplorably serious risk to patient, dental staff and public wellbeing and safety resulting from possible cross-infection posed by not maintaining proper procedures*". The Committee accepted that opinion. |
| 3. | *Between 30 April 2018 and 7 June 2018, you failed to:* |
| 3. a. | *Record dental charting correctly;*<br><br>**Not proved.**<br><br>The evidence of Ms E was that she observed you incorrectly entering into the Practice computer system the charting instructions given to you by the treating dentist in respect of a child patient, with the result that the charting you recorded was "*a totally wrong set of charting to what the dentist had* |

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| | *said*". Ms E then amended the records so that the charting was correct.<br><br>Ms E had also signed off dental charting on your training log, which means that following her training and supervision of you she had nothing more than "minor concerns" regarding your competency in this area.<br><br>Your evidence was that you recorded the charting correctly but you conceded that dental charting is an area for which you need more confidence and training, as your dentist at the previous practice did the majority of the charting although you did some.<br><br>The Committee found that the incident referred to by Ms E occurred. The Committee next considered in particular whose duty it was to ensure that the charting was accurately recorded in respect of the occasion on which the incident occurred.<br><br>The Committee accepted the evidence of Mr Entwistle in his report that:<br><br>9. Whilst the responsibility for making and keeping accurate dental charting records lies with a dentist, I would expect that a reasonably competent dental nurse would take reasonable care to accurately record dental charting notation as instructed by the dentist to ensure that no inappropriate treatment or extraction was provided in error for a patient. I would not expect any dental nurse to be perfect, and I accept that extremely rarely, charting errors do occur even when checked by a supervising dentist, however these are normally detected by a dentist before any harm occurs to a patient.<br><br>On this occasion you were new to the Practice and you were under the direct supervision of Ms E as part of your induction training. In those circumstances, the Committee was not satisfied that the GDC has proved this charge as pleaded, as the inaccuracy in you recording the charting was not a failure for which you were ultimately responsible nor was the charting ultimately recorded incorrectly: you entered the charting under direct supervision and your errors were then corrected with the result that the charting was in fact accurately recorded. |
| 3. b. | *Prepare, mix and handle dental biomaterials correctly;*<br><br>**Proved.**<br><br>The Committee accepted the evidence of Ms E that on one occasion she witnessed that you had mixed Zinc Oxide with water rather than eugenol cement. The Committee accepted the evidence of Mr Entwistle that the role of a dental nurse includes "preparing, mixing and handling dental bio-materials" and that:<br><br>4. I would expect a reasonably competent dental nurse to have the necessary skill, knowledge and training to diligently apply themselves to these duties under the direction of a dentist or other registrant.<br><br>...<br><br>15. I would expect a reasonably competent dental nurse to be familiar with the careful preparation of a fairly extensive range of materials used by a dentist in treatment of patients, and to be able to consistently, accurately and reliably prepare those materials normally used by the dentist with which |

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| | they are working. |
| 3. c. | *Provide adequate chairside support to the operator during treatment.*<br><br>**Proved.**<br><br>The matter alleged under this charge is limited to an alleged failure to hand the dentist the correct forceps on one occasion. The Committee accepted the evidence of Ms E that she witnessed you bringing the dentist the lower forceps when the dentist had requested upper forceps. The Committee accepted the evidence of Mr Entwistle that the difference between upper and lower forceps should have been obvious to any dental nurse and that you were under a duty to bring the dentist the correct forceps as part of providing adequate chairside support. |
| 4. | *Your conduct in respect of Charge 3a and/or 3b and/or 3c put patient's safety at risk*<br><br>**Not proved.**<br><br>The GDC made no positive submissions here in respect of charges 3(b) and 3(c).<br><br>The matters found proved would have caused delay and inconvenience to the treating dentist. The Committee is not satisfied however that patient safety was at risk. The dentist was in ultimate control of the procedure. There was no risk to the patient's safety in respect of the incorrect mixing of dental biomaterial, as it would have been immediately apparent to the dentist from the consistency of the mixture that it had been mixed incorrectly and the material would not therefore have been used on the patient. Likewise, the dentist would have recognised that the incorrect forceps had been brought to them and would then have requested that you bring the correct forceps. |
| 5. | *Between 28 June 2018 to 19 September 2018 you failed to co-operate with an investigation by the GDC by not providing:* |
| 5. a. | *Any evidence of indemnity and,*<br><br>**Proved.**<br><br>The Committee has seen the repeated attempts made by the GDC to request from you details of your indemnity and details of your employer. The requests were made by telephone, email and letter. This was as part of the GDC's fitness to practise investigation. There is no evidence before the Committee that you provided the requested details to the GDC. As a registered dental professional you are under a duty to cooperate with the GDC in respect of its investigation. The Committee rejected your account that you never received any requests for this information. |
| 5. b. | *Details of your employer.*<br><br>**Proved.**<br><br>As above. |

We move to Stage Two."

On 12 December 2019 the Chairman announced the determination as follows:

"Ms Hassan,

At this stage of the proceedings the Committee is to decide whether the facts found proved amount to misconduct and, if so, whether your fitness to practise as a dental nurse is currently impaired by reason of that misconduct. If the Committee finds current impairment, it will then decide on what sanction (if any) to impose on your registration.

Ms Denholm confirmed that you have no fitness to practise history. She submitted that the facts found proved amount to misconduct, citing *Roylance v. The General Medical Council* [1999] UKPC 16 at para 38:

> …The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances… The professional misconduct must be serious…

And *Nandi v General Medical Council* [2004] EWHC 2317 (Admin) at para 31:

> The adjective "serious" must be given its proper weight...

Ms Denholm submitted that your actions breached professional expectations and fell seriously short of the standards expected of a dental nurse. She referred the Committee to the opinion of Mr Entwistle in respect of:

a. your failings in cross infection control on the two occasions found proved (the failure to change gloves and the picking up of an aspirator from the floor and putting in a patient's mouth): *"…those failings would amount to falling far below the standard expected of a reasonably competent dental nurse, due to the deplorable and serious risk to patient, dental staff and public wellbeing and safety resulting from possible cross-infection posed by not maintaining proper procedures.*";

b. your failure to have provided adequate chairside support in respect of the occasion when you incorrectly mixed Zinc Oxide with water rather than eugenol: "…*that failing would fall far below the standard expected of a reasonably competent dental nurse since such conduct would in my opinion jeopardise the quality and outcome of patient care, and thereby fails to put the interests of patients first*.";

c. your failure to have provided adequate chairside support on the occasion when you brought the dentist the incorrect forceps: "*…that conduct would fall far below the standard expected of a reasonably competent dental nurse since in my opinion it would potentially jeopardise the quality of care provided by a dentist and would fail to put the interests of patients first*."

As to your failure to co-operate with the GDC as part of its investigation, Ms Denholm referred the Committee to principle 9.4 from the *Standards for the Dental Team* (September 2013) (the "Standards"). In respect of the matters referred to above, Ms Denholm also referred the Committee to principles 1.5, 1.7 and 7.2.

As to the question of impairment, Ms Denholm submitted that not to make a finding of impairment would undermine public confidence in the profession and this regulatory process: there has been no material regarding remediation or insight; you still have not responded to the GDC's requests for evidence of your indemnity and your employment details; you still do

not accept the seriousness of your behaviour; and still do not accept any shortcomings in your Practice.

In respect of sanction, Ms Denholm submitted that the purpose of a sanction is not to be punitive, although it may have that effect, but to protect the public and wider public interest. She addressed the Committee on the range of sanctions available to it and submitted that a period of suspension for 9 months would be appropriate in the circumstances of this case.

You made no submissions at this stage of the proceedings, save that you maintained that the allegations against you were false. You stated that you had no Continuing Professional Development (CPD) activity, testimonials or other remediation evidence to put before the Committee.

*Decision*

The Committee accepted the advice of the Legal Adviser.

The Committee had regard to the *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016).

Misconduct is a serious departure from the standards reasonably expected of a dental professional. In deciding whether the facts found proved amount to misconduct, the Committee had regard to the following principles from the Standards:

> 1.5: You must treat patients in a hygienic and safe environment
>
> 1.7.7 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 must take prompt and appropriate action.
>
> 9.4: You must co-operate with any relevant formal or informal inquiry and give full and truthful information

In the Committee's judgment, your failures in cross infection control were serious. The Committee accepted Mr Entwistle's opinion that your conduct fell far below the standard reasonably expected of a dental nurse. These were fundamental breaches of the most basic responsibilities of a dental nurse. Patients were put at a risk of harm by your actions, for which there was no excuse. This was a serious breach of the Standards.

Your failure to co-operate with the GDC as part of its investigation into your behaviour is also serious in the Committee's judgment. Your conduct undermined the regulatory role of the GDC and the very scheme of professional regulation. The purpose of professional registration is defeated if the registrant does not even respond to the requests made by the regulator as part of a regulatory investigation. You had been given ample and repeated opportunity to provide the requested information and you failed to do so. This was a serious breach of the Standards.

As to your failure to correctly mix the dental material correctly and your failure to bring the dentist the correct forceps, these were negligent acts which were isolated on the evidence before the Committee and which did not put the patients at risk of harm in respect of the two occasions to which those matters relate.

Accordingly, the Committee does not find the matters proved under charges 3(b) and 3(c) to be so serious as to meet the threshold of misconduct. It finds that the facts found proved under charges 1, 2 and 5 are so serious as to amount to misconduct.

The Committee next considered whether your fitness to practise as a dental nurse is currently impaired by reason of your misconduct. It considered whether your misconduct is remediable, whether it had been remedied and the risk of repetition. The Committee also had regard to the wider public interest, which includes the need to declare and uphold appropriate standards of conduct and behaviour.

In the Committee's judgment, you have shown very limited insight indeed. Your defence to the charges against you was that you are in fact a qualified dental nurse and that any defect in your performance would be the fault of your training provider for issuing you with the qualification and the GDC for recognising that qualification. Even upon reading the Committee's findings of fact and the reasons given why the Committee found the matters proved against you, you rigidly maintained your blanket denial that you had done anything wrong.

Your insight is limited to an acknowledgment under questioning that you might need further training so far as charting is concerned. You also show some insight by acknowledging that failing to change gloves between patients and using an aspirator in a patient's mouth after the aspirator had been dropped on the floor would pose cross infection risks. However, you deny that you had ever engaged in such conduct and your limited insight in this regard is purely theoretical.

Whilst the clinical matters in this case are easily remedied through learning and reflection, there is no evidence of any remediation whatsoever, as you deny the allegations, do not recognise any shortcoming in your practice and do not otherwise seek to address the concerns raised in this case. Likewise, your failure to co-operate with the GDC is remediable through a change in attitude towards professional regulation and your duties as a registrant. However, there is nothing whatsoever before the Committee to indicate any such change in attitude, save for your increasing participation in this hearing, which is encouraging to the Committee.

In the Committee's judgment, there remains a risk of you repeating your misconduct. There is therefore a real risk of harm to patients in respect of your practice as a dental nurse.

Further, public confidence in the profession would also be seriously undermined if no finding of impairment were made in this case. Your misconduct involves serious matters in respect of which you show extremely limited insight. A fair minded and well informed member of the public would lose confidence in the dental profession and this regulatory process if no finding of impairment were made.

Accordingly, the Committee finds that your fitness to practise as a dental nurse is currently impaired by reason of your misconduct.

The Committee considered what sanction (if any) to impose on your registration. The purpose of a sanction is not to be punitive, although it may have that effect, but to protect the public and the wider public interest.

The Committee considered the aggravating and mitigating factors. The aggravating features in this case are risk of harm to patients, your misconduct being sustained and repeated, your disregard for the role of the GDC and the systems regulating the profession and your lack of insight. In mitigation, the Committee recognised that you are of previous good character.

The Committee considered each sanction in ascending order of severity.

To conclude this case with no further action or a reprimand would be wholly inappropriate, owing to your serious failings in cross infection control and your lack of insight. You have not remedied your misconduct and there is a risk of repetition. No further action or a reprimand would not protect the public from harm and would not otherwise be sufficient to maintain public confidence in the profession and this regulatory process.

The Committee next considered whether conditions of practice could be formulated to be workable, measurable and proportionate. The Committee considered that conditions could be formulated to address the clinical matters in this case. However, you have not engaged with the GDC enough for the Committee to be confident that you would comply with any conditions on your registration. Without any insight into your shortcomings, you also would not be able to demonstrate a level of engagement necessary in conditional registration for the purposes of remediation and patient protection. You do not accept the Committee's findings against you and do not accept that there are any shortcomings in your practice. You consider your qualification as being conclusive of your fitness to practise as a dental nurse.

Further, you did not engage meaningfully with the training opportunities you had been given at the Practice. It is therefore difficult to see how you would engage in remediation through conditional registration when you believe you are already qualified to carry out your role without causing any risk to patients or otherwise falling short of the Standards of your profession.

Accordingly, the Committee was not satisfied that conditions could be formulated to be workable at this stage in the circumstances of this case.

The Committee next considered whether to direct that your registration be suspended. There was no harm caused to patients from your misconduct, only a risk of harm. Your misconduct is remediable through reflection, insight and learning. Although you show only limited insight, you have shown increasing engagement in this process from the first day of the hearing when you agreed to participate via a Skype link. A period of suspension would protect the public, maintain public confidence in the profession and give you time to reflect upon your misconduct to demonstrate insight and remediation.

In assessing the adequacy of suspension, the Committee considered erasure and concluded that erasure would be disproportionate and punitive. There is no evidence of any deep seated personality or professional attitudinal problems and at this stage there is no evidence of any persistent lack of insight.

Accordingly, the Committee directs that your registration be suspended for a period of 9 months. This period is to allow you sufficient time to reflect and to provide evidence of remediation. The suspension shall be reviewed prior to its expiry. The reviewing Committee may be assisted by the following:

a. a Personal Development Plan, training and reflection tailored to address the failings identified in this case;

b. a reflective piece showing the importance of co-operating with the GDC;

c. any testimonials from paid or unpaid employment (whether or not in the field of dentistry); and

d. continued engagement in these proceedings by attending the review hearing (whether in person or via telephone/Skype).

The Committee now invites submissions on the question of an immediate order.

The Committee is satisfied that it is necessary for the protection of the public and is otherwise in the public interest to order that your registration as a dental nurse be suspended forthwith under section 36U(1) of the Dentists Act 1984. In reaching its decision, the Committee balanced the public interest with your interests. It would be inconsistent with the decision the Committee has made not to make an immediate order.

The effect of this order is that your registration is suspended immediately. Unless you exercise your right of appeal, the substantive 9 month period of suspension will commence 28 days from when notification of this decision is served on you. Should you exercise your right of appeal, this immediate order shall remain in force pending the disposal of the appeal.

That concludes the hearing."