General
Dental
Council

HEARING PARTLY HEARD IN PRIVATE*

***** The Committee has made a determination in this case that includes some private information.

That information has been omitted from the text.

WEBLEY, John James

Registration No: 53077

PROFESSIONAL CONDUCT COMMITTEE

JANUARY 2020

Outcome: Suspension for 3 months

John James WEBLEY, a dentist, BDS Newcastle University 1979, was summoned to appear before the Professional Conduct Committee on 13 January 2020 for an inquiry into the following charge:

Charge (as amended on 13 and 14 January 2020)

"That being a registered dentist:

1. Between 01.01.2013 and 31.12.2015, ["the relevant period"] you provided dental services at the SpaDental Practice, 21 Burgess Road, Southampton, SO16 7AP ["the practice"].

PART A (Allegations relating to Clinical Care and Record-keeping)

2. On various dates during the relevant period you treated the patients listed at Schedule A attached.
3. You failed to provide an adequate standard of care and/or maintain an adequate standard of record-keeping in respect of **Patient A** in that you:
    a. On 08.05.2013:
        i. Failed to make an adequate record of the care provided;
        ii. [withdrawn];
        iii. [withdrawn];
    b. On 26.06.2013:
        i. Failed to record an extra-oral examination;
    c. On 11.07.2013:
        i. Failed to make an adequate record of Local Anaesthetic used;
        ii. [withdrawn];
    d. On (or before) 01.07.2015:

i. Failed to record the update to Patient A's medical history appropriately;

ii. Failed to take an appropriate radiograph, at any time, prior to extracting Patient A's UR7;

iii. Failed to obtain Patient A's informed consent for the extraction;

iv. Failed to make an adequate record of Local Anaesthetic used;

v. Fitted a permanent chrome partial denture without leaving sufficient time for healing/resorption process;

e. Between 12.10.2015 and 14.10.2015:

i. Failed to take an appropriate radiograph, at any time, prior to extracting Patient A's UL7;

ii. Failed to obtain Patient A's informed consent for the extraction;

iii. Failed to make an adequate record of Local Anaesthetic used;

iv. Failed to take an appropriate radiograph post-extraction in circumstances whereby you were uncertain whether or not there were roots left in situ;

v. Failed to obtain Patient A's informed consent to leave roots in situ.

4. You failed to provide an adequate standard of care and/or maintain an adequate standard of record-keeping in respect of **Patient B** in that you:

a. Failed to take appropriate diagnostic radiographs (bitewings) during a period of over 3 years;

b. On 29.01.2013:

i. Failed to record an extra-oral examination;

c. On 12.02.2013:

i. Failed to make an adequate record of Local Anaesthetic used;

d. On 20.08.2013:

i. Failed to record an extra-oral examination;

e. On (or before) 12.11.2013:

i. Failed to take an appropriate radiograph prior to preparing Patient B's UR1 for a crown;

ii. Failed to obtain informed consent for the crown treatment;

iii. Failed to make an adequate record of Local Anaesthetic used.

5. You failed to maintain an adequate standard of record-keeping in respect of **Patient C** in that you:

a. On 12.10.2015:

i. Failed to record the update to Patient C's medical history appropriately;

ii. Failed to make an adequate record of Local Anaesthetic used.

6. You failed to provide an adequate standard of care and/or maintain an adequate standard of record-keeping in respect of **Patient D** in that you:

   a. On 09.03.2015 and/or 14.07.2015:

      i. Failed to take an appropriate radiograph to investigate other possible treatment options for Patient D's UL7;

      ii. Failed to obtain informed consent for the treatment provided to the UL7;

      iii. Failed to make an adequate record of Local Anaesthetic used on 09.03.2015;

      iv. Failed to record the update to Patient D's medical history appropriately prior to the extraction;

      v. Failed to make an adequate record of Local Anaesthetic used on 14.07.2015;

   b. Failed to make any, or an adequate, record of the extraction undertaken.

7. You failed to provide an adequate standard of care and/or maintain an adequate standard of record-keeping in respect of **Patient E** in that you:

   a. On 18.06.2015:

      i. [withdrawn]

      ii. Failed to make an adequate record of Local Anaesthetic used;

   b. On 25.11.2015:

      i. Failed to take an appropriate diagnostic radiograph in respect of Patient E's UR6;

      ii. Failed to take appropriate diagnostic radiographs during the course of Patient E's examination;

      iii. Failed to make an adequate record of Local Anaesthetic used;

      iv. Failed to make any, or an adequate, record of extraction undertaken;

      v. [withdrawn].

8. You failed to maintain an adequate standard of record-keeping in respect of **Patient F** in that you:

   a. [withdrawn]:

      i. [withdrawn];

   b. On 04.03.2014:

      i. [withdrawn];

      ii. [withdrawn];

      iii. [withdrawn];

      iv. Failed to make any, or an adequate, record of the procedure undertaken;

      v. [withdrawn].

9. You failed to provide an adequate standard of care and/or maintain an adequate standard of record-keeping in respect of **Patient H** in that you:

   a. On 16.01.2013:

      i. Failed to make an adequate record of Local Anaesthetic used;

   b. On 11.09.2013:

      i. Failed to update and/or record the update to Patient H's medical history appropriately in that you failed to note medication being taken;

   c. On (or before) 18.08.2015:

      i. Failed to update and/or record the update to Patient H's medical history appropriately;

      ii. Failed to take an appropriate radiograph prior to extracting the patient's UL7 on 18.08.2015;

      iii. Failed to obtain informed consent for the extraction of the patient's UL7;

      iv. [withdrawn];

   d. On (or before) 19.10.2015:

      i. Failed to update and/or record the update to Patient H's medical history appropriately in that you failed to investigate further the positive answers given;

      ii. Failed to take an appropriate radiograph prior to extracting the patient's UR6;

      iii. Failed to obtain informed consent for the extraction of the patient's UR6;

      iv. Used infiltration local anaesthetic for the extractions undertaken which was insufficient in the circumstances;

      v. Failed to make an adequate record of Local Anaesthetic used;

      vi. [withdrawn];

      vii. Failed to arrange an appropriate review appointment for Patient H.

10. You failed to provide an adequate standard of care and/or maintain an adequate standard of record-keeping in respect of **Patient I** in that you:

   a. On (or before) 19.04.2013:

      i. Failed to take an appropriate radiograph of Patient I's UL6, at any time, prior to re-cementing the crown on Patient I's UL6;

      ii. Provided treatment to Patient I for the UL6 which was ineffective and/or of limited value to the patient;

      iii. Failed to record providing appropriate Oral Hygiene Instructions;

   b. On (or before) 04.06.2013:

      i. Failed to take an appropriate radiograph of Patient I's UL5, at any time, prior to re-cementing the crown on Patient I's UL5;

ii. Provided treatment to Patient I for the UL5 which was ineffective and/or of limited value to the patient;

iii. Failed to make an adequate record of Local Anaesthetic used;

iv. Failed to record providing appropriate Oral Hygiene Instructions;

c. On (or before) 26.07.2013:

i. Failed to take an appropriate radiograph of Patient I's UL5 at any time prior to taking impressions to "redo" crown;

ii. Failed to make an adequate record of Local Anaesthetic used;

iii. Failed to make an adequate record of the procedure undertaken;

d. On 30.01.2014:

i. Failed to make an adequate record of Local Anaesthetic used on 30.01.2014;

e. On (or before) 25.02.2014:

i. Failed to take an appropriate radiograph of Patient I's UL6 at any time prior to fitting a new crown;

f. On (or before) 07.12.2015:

i. Failed to take appropriate diagnostic radiographs (bitewings).

11. You failed to maintain an adequate standard of record-keeping in respect of **Patient J** in that you:

a. [withdrawn];

b. On 03.04.2013:

i. Failed to record an extra-oral examination;

c. On 06.06.2013 and 07.06.2013:

i. Failed to make an adequate record of your clinical findings and/or a history of pain complained of in relation to the LL4;

ii. Failed to make an adequate record of Local Anaesthetic used on 07.06.2013.

12. You failed to provide an adequate standard of care and/or maintain an adequate standard of record-keeping in respect of **Patient K** in that you:

a. Failed to provide appropriate treatment for Patient K's LR8 at any time prior to 25.01.2013;

b. On (or before) 25.01.2013:

i. Failed to take an appropriate radiograph, at any time, prior to extracting the patient's LR8;

ii. Failed to record a discussion relating to the risks and benefits of the extraction proposed;

iii. Failed to make an adequate record of Local Anaesthetic used;

c. On 01.03.2013:

i. [withdrawn];

ii. Failed to review the fractured root at Patient K's LR8;

iii. Failed to take an appropriate radiograph of Patient K's LR8 area;

iv. Failed to record an extra-oral examination;

d. On 22.03.2013:

i. Failed to make an adequate record of Local Anaesthetic used;

e. On 02.04.2013:

i. Failed to make an adequate record of the history of pain complained of in relation to Patient K's LR7;

f. On or before 05.04.2013:

i. Failed to consider Root Canal Treatment prior to placing a crown at Patient K's LL6;

g. On 25.04.2013:

i. Failed to make an adequate record of Local Anaesthetic used;

h. On 12.11.2013:

i. Failed to make an adequate record of Local Anaesthetic used;

i. On 10.12.2013:

i. Failed to record an extra-oral examination;

ii. Failed to take appropriate diagnostic radiographs;

j. On 04.02.2014:

i. Failed to report on radiograph taken;

ii. Failed to make an adequate record of Local Anaesthetic used;

iii. Failed to make any, or an adequate, record of treatment provided.

13. You failed to provide an adequate standard of care and/or maintain an adequate standard of record-keeping in respect of **Patient M** in that you:

a. On 05.09.2013:

i. Failed to record an extra-oral examination;

ii. Failed to take appropriate diagnostic radiographs;

iii. Failed to undertake or arrange for further assessment having recorded BPE scores of 3;

b. On 19.09.2013:

i. Failed to make an adequate record of Local Anaesthetic used and whether the possible extent of numbness had been explained to patient;

c. On 14.11.2013:

i. Failed to make an adequate record of Local Anaesthetic used;

d. [withdrawn]:

i. [withdrawn];

e. On 02.06.2014:

i. Failed to make an adequate record of Local Anaesthetic used;

f. On 30.06.2014:

i. [withdrawn]

g. On 12.08.2014:

i. Prescribed antibiotics which was inappropriate in the circumstances;

ii. [withdrawn];

h. On 19.08.2014:

i. [withdrawn];

ii. Failed to make an adequate record of the Local Anaesthetic used;

i. On 01.09.2014:

i. Prescribed antibiotics which was inappropriate in the circumstances;

ii. Failed to undertake further investigations as to the cause of Patient M's ongoing pain post-extraction.

14. You failed to provide an adequate standard of care and/or maintain an adequate standard of record-keeping in respect of **Patient N** in that you:

a. On 19.10.2015:

i. Failed to record the update to Patient N's medical history appropriately;

ii. Failed to take an appropriate radiograph at any time prior to extracting Patient N's UL7;

iii. Continued to provide treatment when Patient N indicated that he was in pain;

iv. Failed to take a post extraction radiograph in circumstances where you were uncertain whether or not there were roots left in situ;

v. Failed to obtain Patient N's informed consent to leave roots in situ;

vi. Failed to obtain Patient N's informed consent for the extraction;

vii. Failed to make an adequate record of Local Anaesthetic used.

PART B (Allegations relating to Personal Conduct)

15. You failed during the relevant period to maintain adequate standards of cross-infection control in that you:

a. Did not always wear a mask when treating patients;

b. Did not, when wearing a mask, always change the mask between patients;

c. [withdrawn];

d. Did not maintain adequate hand hygiene;

e. Continued to work and treat patients when you were very unwell and coughing profusely;

f. Did not follow safe procedures in relation to clean and dirty instruments;

g. Did not adhere to appropriate clean and dirty zones within the surgery setting.

16. You failed to co-operate with other members of the dental team during the relevant period in that you:

a. Refused to allow Witness 1 to use suction when she was performing her duties as your dental nurse;

b. Informed your colleagues that you would do no more than the "minimum required to avoid being struck off" or words to that effect.

17. You failed during the relevant period and/or after that to maintain appropriate standards of behaviour towards other members of staff at the practice in that you:

a. Spoke rudely to one or more members of staff in front of other members of staff and/or patients;

b. Argued with one or more members of staff in the reception/waiting area of the practice;

c. Made inappropriate and/or unpleasant personal comments to one or more members of staff;

d. Treated one of more members of staff unreasonably when they were unwell and/or had personal issues;

e. Challenged one or more members of staff when you learned that they had raised and/or reported concerns.

AND, by reason of the facts stated, your fitness to practise as a Dentist is impaired by reason of your Misconduct."

On 13 January 2020, the Chairman made the following statement on preliminary matters:

"Mr Webley

At this hearing the Committee made a determination that includes some private information. That information has been omitted from the public version of this determination, and that public document has been marked to show where private material has been removed.

You are present at this hearing of the Professional Conduct Committee (PCC) and are represented by Mr Anthony Haycroft of Counsel, instructed by Radcliffes LeBrasseur solicitors. Ms Rebecca Harris of Counsel, instructed by the GDC's In-House Legal Presentation service, appears for the Council.

This determination sets out decisions taken on the first day of the hearing, namely 13 January 2020. This written determination was delivered in session on the following day, namely 14 January 2020.

Preliminary matters

At the outset of the hearing Ms Harris applied to amend and withdraw a number of the heads of charge in accordance with Rule 18 of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules'). Mr Haycroft supported the application on your behalf. The Committee, having accepted the advice of the Legal Adviser, was content to accede to the application to amend the heads of charge in question. The schedule of charge was duly amended.

IN PRIVATE

[Text omitted]

IN PUBLIC

Admissions to the heads of charge

Mr Haycroft made a number of admissions to the heads of charge that you face. All of the heads of charge save for heads of charge 9 (d) (iv), 12 (c) (ii), 12 (f) (i), 13 (f) (i), 14 (a) (iii), 15 (d), 15 (e), 16 (a) and 16 (b) were admitted. These admissions were noted by the Committee."

On 20 January 2020 the Chairman made the following statement regarding the finding of facts:

"Mr Webley,

You are present at this hearing of the Professional Conduct Committee (PCC) and are represented by Mr Anthony Haycroft of Counsel, instructed by Radcliffes LeBrasseur solicitors. Ms Rebecca Harris of Counsel, instructed by the GDC's In-House Legal Presentation Service, appears for the Council.

Background

The allegations giving rise to these proceedings relate to the standard of care that you provided to 12 patients in the period from 1 January 2013 to 31 December 2015, including allegations relating to your record keeping, cross-infection control and hygiene practices. Failures were also alleged about your conduct and communication with other members of the dental team, in that period and subsequently. The allegations that you face relate to your practice at your then place of work, namely the SpaDental practice, which is situated in Southampton, Hampshire.

Evidence

The Committee heard oral evidence from a dental hygienist who previously worked with you in a dental nursing capacity and who as set out above is referred to for the purposes of these proceedings as Witness 1; a dental hygienist who previously worked with you as a dental nurse and who is referred to as Witness 3; from a dentist who previously worked with you and who is referred to as Witness 4; from your current practice manager who previously worked with you in the capacity of dental nurse and who is referred to as Witness 5; from the GDC's expert witness, namely Ms Hilary Firestone. The Committee also heard your evidence.

The Committee has also been provided with documentary material in relation to the heads of charge that you face. This information includes the witness statements and documentary exhibits of the witnesses in this case, who include the witnesses referred to above, and Witness 2, who previously worked with you as a Dental Nurse. The Committee has also received the expert reports of Ms Firestone, and a witness statement provided by you.

Findings

The Committee has taken into account all the evidence presented to it, both written and oral. It has considered the submissions made by Ms Harris on behalf of the GDC and those made by Mr Haycroft on your behalf.

The Committee has accepted the advice of the Legal Adviser. The burden is on the GDC to prove each allegation on the balance of probabilities.

The Committee found Witness 4 to be a very credible witness, who was careful to be accurate in her account and who did not overstate matters.

Witness 1 gave evidence honestly and to the best of her recollection. However, her recollection was not entirely clear and she appeared to conflate her general recollection with her recollection of specific events.

Witness 3 gave evidence honestly and to the best of her recollection. She was clear where she could not recall matters. As to you allegedly not washing your hands in the surgery, she was very clear about this. Her evidence concerning your hand hygiene was particularly persuasive.

Witness 5 had a clear recollection of the main matters to which she referred. She was an honest witness who gave her evidence to assist the Committee as best she could.

The Committee found Ms Firestone to be an impressive expert witness. She was fair and measured throughout her oral and written evidence. She applied the standard of a reasonably competent general dental practitioner working to the standards which were in force at the relevant time. She was transparent when giving her opinion, which was carefully reasoned and which she was willing to reflect upon and change in view of the evidence as it evolved. She neither overstated nor understated matters.

The Committee found that you did your best to assist the Committee when giving evidence. You also frankly accepted and admitted the majority of the many charges against you.

The Committee, assisted by the evidence schedules provided by the parties, reviewed the evidence, including the clinical records and expert opinion, before deciding whether it would be appropriate to accept your admissions.

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

1.	*Between 01.01.2013 and 31.12.2015, ["the relevant period"] you provided dental services at the SpaDental Practice, 21 Burgess Road, Southampton, SO16 7AP ["the practice"].* **Admitted and found proved.**

2.	*On various dates during the relevant period you treated the patients listed at Schedule A attached.* **Admitted and found proved.**
3.	*You failed to provide an adequate standard of care and/or maintain an adequate standard of record-keeping in respect of Patient A in that you:*
3. (a)	*On 08.05.2013:*
3. (a) (i)	*Failed to make an adequate record of the care provided;* **Admitted and found proved.**
3. (a) (ii)	*Withdrawn*
3. (a) (iii)	*Withdrawn*
3. (b)	*On 26.06.2013:*
3. (b) (i)	*Failed to record an extra-oral examination;* **Admitted and found proved.**
3. (c)	*On 11.07.2013:*
3. (c) (i)	*Failed to make an adequate record of Local Anaesthetic used;* **Admitted and found proved.**
3. (c) (ii)	*Withdrawn*
3. (d)	*On (or before) 01.07.2015:*
3. (d) (i)	*Failed to record the update to Patient A's medical history appropriately;* **Admitted and found proved.**
3. (d) (ii)	*Failed to take an appropriate radiograph, at any time, prior to extracting Patient A's UR7;* **Admitted and found proved.**
3. (d) (iii)	*Failed to obtain Patient A's informed consent for the extraction;* **Admitted and found proved.**

3. (d) (iv)	*Failed to make an adequate record of Local Anaesthetic used;* **Admitted and found proved.**
3. (d) (v)	*Fitted a permanent chrome partial denture without leaving sufficient time for healing/resorption process;* **Admitted and found proved.**
3. (e)	*Between 12.10.2015 and 14.10.2015:*
3. (e) (i)	*Failed to take an appropriate radiograph, at any time, prior to extracting Patient A's UL7;* **Admitted and found proved.**
3. (e) (ii)	*Failed to obtain Patient A's informed consent for the extraction;* **Admitted and found proved.**
3. (e) (iii)	*Failed to make an adequate record of Local Anaesthetic used;* **Admitted and found proved.**
3. (e) (iv)	*Failed to take an appropriate radiograph post-extraction in circumstances whereby you were uncertain whether or not there were roots left in situ;* **Admitted and found proved.**
3. (e) (v)	*Failed to obtain Patient A's informed consent to leave roots in situ.* **Admitted and found proved.**
4.	*You failed to provide an adequate standard of care and/or maintain an adequate standard of record-keeping in respect of Patient B in that you:*
4. (a)	*Failed to take appropriate diagnostic radiographs (bitewings) during a period of over 3 years;* **Admitted and found proved.**
4. (b)	*On 29.01.2013:*
4. (b) (i)	*Failed to record an extra-oral examination;* **Admitted and found proved.**
4. (c)	*On 12.02.2013:*

4. (c) (i)	*Failed to make an adequate record of Local Anaesthetic used;* **Admitted and found proved.**
4. (d)	*On 20.08.2013:*
4. (d) (i)	*Failed to record an extra-oral examination;* **Admitted and found proved.**
4. (e)	*On (or before) 12.11.2013:*
4. (e) (i)	*Failed to take an appropriate radiograph prior to preparing Patient B's UR1 for a crown;* **Admitted and found proved.**
4. (e) (ii)	*Failed to obtain informed consent for the crown treatment;* **Admitted and found proved.**
4. (e) (iii)	*Failed to make an adequate record of Local Anaesthetic used.* **Admitted and found proved.**
5.	*You failed to maintain an adequate standard of record-keeping in respect of Patient C in that you:*
5. (a)	*On 12.10.2015:*
5. (a) (i)	*Failed to record the update to Patient C's medical history appropriately;* **Admitted and found proved.**
5. (a) (ii)	*Failed to make an adequate record of Local Anaesthetic used.* **Admitted and found proved.**
6.	*You failed to provide an adequate standard of care and/or maintain an adequate standard of record-keeping in respect of Patient D in that you:*
6. (a)	*On 09.03.2015 and/or 14.07.2015:*
6. (a) (i)	*Failed to take an appropriate radiograph to investigate other possible treatment options for Patient D's UL7;* **Admitted and found proved.**

6. (a) (ii)	*Failed to obtain informed consent for the treatment provided to the UL7;* **Admitted and found proved.**
6. (a) (iii)	*Failed to make an adequate record of Local Anaesthetic used on 09.03.2015;* **Admitted and found proved.**
6. (a) (iv)	*Failed to record the update to Patient D's medical history appropriately prior to the extraction;* **Admitted and found proved.**
6. (a) (v)	*Failed to make an adequate record of Local Anaesthetic used on 14.07.2015;* **Admitted and found proved.**
6. (b)	*Failed to make any, or an adequate, record of the extraction undertaken.* **Admitted and found proved.**
7.	*You failed to provide an adequate standard of care and/or maintain an adequate standard of record-keeping in respect of Patient E in that you:*
7. (a)	*On 18.06.2015:*
7. (a) (i)	*Withdrawn*
7. (a) (ii)	*Failed to make an adequate record of Local Anaesthetic used;* **Admitted and found proved.**
7. (b)	*On 25.11.2015:*
7. (b) (i)	*Failed to take an appropriate diagnostic radiograph in respect of Patient E's UR6;* **Admitted and found proved.**
7. (b) (ii)	*Failed to take appropriate diagnostic radiographs during the course of Patient E's examination;* **Admitted and found proved.**
7. (b) (iii)	*Failed to make an adequate record of Local Anaesthetic used;* **Admitted and found proved.**
7. (b) (iv)	*Failed to make any, or an adequate, record of extraction undertaken;* **Admitted and found proved.**

7. (b) (v)	*Withdrawn*
8.	*You failed to maintain an adequate standard of record-keeping in respect of Patient F in that you:*
8. (a)	*Withdrawn*
8. (a) (i)	*Withdrawn*
8. (b)	*On 04.03.2014:*
8. (b) (i)	*Withdrawn*
8. (b) (ii)	*Withdrawn*
8. (b) (iii)	*Withdrawn*
8. (b) (iv)	*Failed to make any, or an adequate, record of the procedure undertaken;* **Admitted and found proved.**
8. (b) (v)	*Withdrawn*
9.	*You failed to provide an adequate standard of care and/or maintain an adequate standard of record-keeping in respect of Patient H in that you:*
9. (a)	*On 16.01.2013:*
9. (a) (i)	*Failed to make an adequate record of Local Anaesthetic used;* **Admitted and found proved.**
9. (b)	*On 11.09.2013:*
9. (b) (i)	*Failed to update and/or record the update to Patient H's medical history appropriately in that you failed to note medication being taken;* **Admitted and found proved.**
9. (c)	*On (or before) 18.08.2015:*
9. (c) (i)	*Failed to update and/or record the update to Patient H's medical history appropriately;* **Admitted and found proved.**

9. (c) (ii)	*Failed to take an appropriate radiograph prior to extracting the patient's UL7 on 18.08.2015;* **Admitted and found proved.**
9. (c) (iii)	*Failed to obtain informed consent for the extraction of the patient's UL7;* **Admitted and found proved.**
9. (c) (iv)	*Withdrawn*
9. (d)	*On (or before) 19.10.2015:*
9. (d) (i)	*Failed to update and/or record the update to Patient H's medical history appropriately in that you failed to investigate further the positive answers given;* **Admitted and found proved.**
9. (d) (ii)	*Failed to take an appropriate radiograph prior to extracting the patient's UR6;* **Admitted and found proved.**
9. (d) (iii)	*Failed to obtain informed consent for the extraction of the patient's UR6;* **Admitted and found proved.**
9. (d) (iv)	*Used infiltration local anaesthetic for the extractions undertaken which was insufficient in the circumstances;* **Not proved.** The Committee was not satisfied from the evidence that the patient was in fact in pain.
9. (d) (v)	*Failed to make an adequate record of Local Anaesthetic used;* **Admitted and found proved.**
9. (d) (vi)	*Withdrawn*
9. (d) (vii)	*Failed to arrange an appropriate review appointment for Patient H.* **Admitted and found proved.**
10.	*You failed to provide an adequate standard of care and/or maintain an adequate standard of record-keeping in respect of Patient I in that you:*
10. (a)	*On (or before) 19.04.2013:*

10. (a) (i)	*Failed to take an appropriate radiograph of Patient I's UL6, at any time, prior to re-cementing the crown on Patient I's UL6;* **Admitted and found proved.**
10. (a) (ii)	*Provided treatment to Patient I for the UL6 which was ineffective and/or of limited value to the patient;* **Admitted and found proved.**
10. (a) (iii)	*Failed to record providing appropriate Oral Hygiene Instructions;* **Admitted and found proved.**
10. (b)	*On (or before) 04.06.2013:*
10. (b) (i)	*Failed to take an appropriate radiograph of Patient I's UL5, at any time, prior to re-cementing the crown on Patient I's UL5;* **Admitted and found proved.**
10. (b) (ii)	*Provided treatment to Patient I for the UL5 which was ineffective and/or of limited value to the patient;* **Admitted and found proved.**
10. (b) (iii)	*Failed to make an adequate record of Local Anaesthetic used;* **Admitted and found proved.**
10. (b) (iv)	*Failed to record providing appropriate Oral Hygiene Instructions;* **Admitted and found proved.**
10. (c)	*On (or before) 26.07.2013:*
10. (c) (i)	*Failed to take an appropriate radiograph of Patient I's UL5 at any time prior to taking impressions to "redo" crown;* **Admitted and found proved.**
10. (c) (ii)	*Failed to make an adequate record of Local Anaesthetic used;* **Admitted and found proved.**
10. (c) (iii)	*Failed to make an adequate record of the procedure undertaken;* **Admitted and found proved.**
10. (d)	*On 30.01.2014:*

10. (d) (i)	*Failed to make an adequate record of Local Anaesthetic used on 30.01.2014;* **Admitted and found proved.**
10. (e)	*On (or before) 25.02.2014:*
10. (e) (i)	*Failed to take an appropriate radiograph of Patient I's UL6 at any time prior to fitting a new crown;* **Admitted and found proved.**
10. (f)	*On (or before) 07.12.2015:*
10. (f) (i)	*Failed to take appropriate diagnostic radiographs (bitewings).* **Admitted and found proved.**
11.	*You failed to maintain an adequate standard of record-keeping in respect of Patient J in that you:*
11. (a)	*Withdrawn*
11. (b)	*On 03.04.2013:*
11. (b) (i)	*Failed to record an extra-oral examination;* **Admitted and found proved.**
11. (c)	*On 06.06.2013 and 07.06.2013:*
11. (c) (i)	*Failed to make an adequate record of your clinical findings and/or a history of pain complained of in relation to the LL4;* **Admitted and found proved.**
11. (c) (ii)	*Failed to make an adequate record of Local Anaesthetic used on 07.06.2013.* **Admitted and found proved.**
12.	*You failed to provide an adequate standard of care and/or maintain an adequate standard of record-keeping in respect of Patient K in that you:*
12. (a)	*Failed to provide appropriate treatment for Patient K's LR8 at any time prior to 25.01.2013;* **Admitted and found proved.**

12. (b)	*On (or before) 25.01.2013:* **Admitted and found proved.**
12. (b) (i)	*Failed to take an appropriate radiograph, at any time, prior to extracting the patient's LR8;* **Admitted and found proved.**
12. (b) (ii)	*Failed to record a discussion relating to the risks and benefits of the extraction proposed;* **Admitted and found proved.**
12. (b) (iii)	*Failed to make an adequate record of Local Anaesthetic used;* **Admitted and found proved.**
12. (c)	*On 01.03.2013:*
12. (c) (i)	*Withdrawn*
12. (c) (ii)	Failed to review the fractured root at Patient K's LR8; **Admitted and found proved.** You admitted this charge following the oral evidence of Ms Firestone. You did not have a radiograph and accepted that this was an essential element of adequately reviewing the fractured root.
12. (c) (iii)	*Failed to take an appropriate radiograph of Patient K's LR8 area;* **Admitted and found proved.**
12. (c) (iv)	*Failed to record an extra-oral examination;* **Admitted and found proved.**
12. (d)	*On 22.03.2013:*
12. (d) (i)	*Failed to make an adequate record of Local Anaesthetic used;* **Admitted and found proved.**
12. (e)	*On 02.04.2013:*
12. (e) (i)	*Failed to make an adequate record of the history of pain complained of in relation to Patient K's LR7;* **Admitted and found proved.**

12. (f)	*On or before 05.04.2013:*
12. (f) (i)	*Failed to consider Root Canal Treatment prior to placing a crown at Patient K's LL6;* **Not proved.** Although not recorded in the notes, your evidence was that you would have considered Root Canal Treatment as it was your normal practice to consider that treatment in respect of such teeth. Ms Firestone's opinion was that, had a reasonably competent dentist considered Root Canal Treatment, she or he would have performed it by 5 April 2013. The Committee took into account Mr Haycroft's submission that the way this charge is drafted does not allow for the possibility that you considered Root Canal Treatment and made an erroneous decision not to perform it. In all the circumstances, the Committee concluded that the Council has not proved the allegation to the required standard.
12. (g)	*On 25.04.2013:*
12. (g) (i)	*Failed to make an adequate record of Local Anaesthetic used;* **Admitted and found proved.**
12. (h)	*On 12.11.2013:*
12. (h) (i)	*Failed to make an adequate record of Local Anaesthetic used;* **Admitted and found proved.**
12. (i)	*On 10.12.2013:*
12. (i) (i)	*Failed to record an extra-oral examination;* **Admitted and found proved.**
12. (i) (ii)	*Failed to take appropriate diagnostic radiographs;* **Admitted and found proved.**
12. (j)	*On 04.02.2014:*
12. (j) (i)	*Failed to report on radiograph taken;* **Admitted and found proved.**

12. (j) (ii)	*Failed to make an adequate record of Local Anaesthetic used;* **Admitted and found proved.**
12. (j) (iii)	*Failed to make any, or an adequate, record of treatment provided.* **Admitted and found proved.**
13.	*You failed to provide an adequate standard of care and/or maintain an adequate standard of record-keeping in respect of Patient M in that you:*
13. (a)	*On 05.09.2013:*
13. (a) (i)	*Failed to record an extra-oral examination;* **Admitted and found proved.**
13. (a) (ii)	*Failed to take appropriate diagnostic radiographs;* **Admitted and found proved.**
13. (a) (iii)	*Failed to undertake or arrange for further assessment having recorded BPE scores of 3;* **Admitted and found proved.**
13. (b)	*On 19.09.2013:*
13. (b) (i)	*Failed to make an adequate record of Local Anaesthetic used and whether the possible extent of numbness had been explained to patient;* **Admitted and found proved.**
13. (c)	*On 14.11.2013:*
13. (c) (i)	*Failed to make an adequate record of Local Anaesthetic used;* **Admitted and found proved.**
13. (d)	*Withdrawn*
13. (d) (i)	*Withdrawn*
13. (e)	*On 02.06.2014:*
13. (e) (i)	*Failed to make an adequate record of Local Anaesthetic used;* **Admitted and found proved.**

13. (f)	*On 30.06.2014:*
13. (f) (i)	*Withdrawn*
13. (g)	*On 12.08.2014:*
13. (g) (i)	*Prescribed antibiotics which was inappropriate in the circumstances;* **Admitted and found proved.**
13. (g) (ii)	*Withdrawn*
13. (h)	*On 19.08.2014:*
13. (h) (i)	*Withdrawn*
13. (h) (ii)	*Failed to make an adequate record of the Local Anaesthetic used;* **Admitted and found proved.**
13. (i)	*On 01.09.2014:*
13. (i) (i)	*Prescribed antibiotics which was inappropriate in the circumstances;* **Admitted and found proved.**
13. (i) (ii)	*Failed to undertake further investigations as to the cause of Patient M's ongoing pain post-extraction.* **Admitted and found proved.**
14.	*You failed to provide an adequate standard of care and/or maintain an adequate standard of record-keeping in respect of Patient N in that you:*
14. (a)	*On 19.10.2015*
14. (a) (i)	*Failed to record the update to Patient N's medical history appropriately;* **Admitted and found proved.**
14. (a) (ii)	*Failed to take an appropriate radiograph at any time prior to extracting Patient N's UL7;* **Admitted and found proved**

14. (a) (iii)	*Continued to provide treatment when Patient N indicated that he was in pain;* **Not proved.** It was not in dispute that you continued treating Patient N. The mischief alleged under this charge is whether you did so when he indicated that he was in a pain and, if so, whether this amounted to a failure to provide an adequate standard of care. Witness 5's evidence was that Patient N (who did not give evidence) was obviously in pain through his utterances and body language. The records you made for the appointment (for which you have no recollection) state: **19/10/2015 - [JW]** Inferior dental block given 46 Lignospan b13272AA 2017 04 tooth v sensitive despite 4 ml LA, filling removed as far as possible, large area of caries mesiallywith vital exposure beneath, dressed odontopaste and coltosol **19/10/2015 - [JW]** Buccal infiltration given 27 Lignospan B13272AA 2017 04 xla 27, tooth broke on removal (v long thin roots) mb root left in situ, unableelevate, pt informed, leave as is unless infection (tooth vital, infection unlikely) haemostasis achieved post op instr given **19/10/2015 - [JW]** Infra orbital block given … The Committee considered whether and to what extent Patient N was in "pain" during the treatment. It is not established on the evidence before the Committee that he indicated he was in such pain to the extent that it would have been inappropriate for you to have continued to provide the treatment. The evidence shows that you provided two doses of inferior dental block and, subsequently, an infra orbital block. You therefore took what would appear to be appropriate measures to address and manage the Patient's discomfort during the treatment. The Committee is not satisfied from the evidence that your continuing the treatment was a failure to provide an adequate standard of care, as pleaded at the stem to this charge. The stem in the alternative pleaded a failure in record keeping. However, the GDC did not advance any case in respect of this Accordingly, the charge is not proved

14. (a) (iv)	*Failed to take a post extraction radiograph in circumstances where you were uncertain whether or not there were roots left in situ;* **Admitted and found proved.**
14. (a) (v)	*Failed to obtain Patient N's informed consent to leave roots in situ;* **Admitted and found proved.**
14. (a) (vi)	*Failed to obtain Patient N's informed consent for the extraction;* **Admitted and found proved.**
14. (a) (vii)	*Failed to make an adequate record of Local Anaesthetic used.* **Admitted and found proved.**
15.	*You failed during the relevant period to maintain adequate standards of cross-infection control in that you:*
15. (a)	*Did not always wear a mask when treating patients;* **Admitted and found proved.**
15. (b)	*Did not, when wearing a mask, always change the mask between patients;* **Admitted and found proved.**
15. (c)	*Withdrawn*
15. (d)	*Did not maintain adequate hand hygiene.* **Proved**. The evidence of Witnesses 3 and 5 was that they had observed you not washing your hands in the surgery. You did not dispute this: your evidence was that you instead washed your hands in the practice toilet, where you would get changed. Washing your hands in the toilet is clearly far from an adequate standard of hand hygiene. You would have had to use your hands to pass through two doors from the toilet to reach the surgery, including using your hands on the handle of the toilet door. In order to maintain an adequate standard of hand hygiene you would have needed to have also washed your hands in the surgery.

15. (e)	*Continued to work and treat patients when you were very unwell and coughing profusely;* **Not proved** There was no evidence before the Committee that you were "very unwell", as pleaded under this charge. Your evidence, which the Committee accepted, was that you were suffering from a persistent cough.
15. (f)	*Did not follow safe procedures in relation to clean and dirty instruments;* **Admitted and found proved.**
15. (g)	*Did not adhere to appropriate clean and dirty zones within the surgery setting.* **Admitted and found proved.**
16.	*You failed to co-operate with other members of the dental team during the relevant period in that you:*
16. (a)	*Refused to allow Witness 1 to use suction when she was performing her duties as your dental nurse;* **Not Proved.** You did not allow Witness 1 to use suction when she was performing her duties as your dental nurse. Your evidence was that this was for patient safety reasons, as she was not (on your account) competent at using suction on patients. You stated that she would move the tube suddenly, which posed a risk to patients and also made it difficult for you when treating them. The Committee does not find that preventing an assisting dental nurse from using suction would in itself be a failure to co-operate with other members of the dental team. This is because it would have been a matter for your judgment as the dentist with ultimate clinical responsibility for the treatment of your patients You did not explain to Witness 1, adequately or all, the reason you were refusing to allow her to use suction on patients. This would in the Committee's judgment amount to a clear failure to co-operate with other members of the dental team. However, this discrete aspect was not pleaded in the phrasing of the charge. What was pleaded was that you "refused" to allow an assisting member of the dental team to carry out a procedure, rather than your failing to communicate the reason for your decision.

16. (b)	*Informed your colleagues that you would do no more than the "minimum required to avoid being struck off" or words to that effect.* **Proved.** The Committee accepted the evidence of Witness 5 that you said this or words to that effect in response to an enquiry about cross infection control. This demonstrates a failure in leadership and a failure to encourage members of the dental team to comply with the high standards set for the profession by the GDC. Accordingly, the Committee finds that you failed to co-operate with other members of the dental team. This charge is therefore proved.
17.	*You failed during the relevant period and/or after that to maintain appropriate standards of behaviour towards other members of staff at the practice in that you:*
17. (a)	*Spoke rudely to one or more members of staff in front of other members of staff and/or patients;* **Admitted and found proved.**
17. (b)	*Argued with one or more members of staff in the reception/waiting area of the practice;* **Admitted and found proved.**
17. (c)	*Made inappropriate and/or unpleasant personal comments to one or more members of staff;* **Admitted and found proved.**
17. (d)	*Treated one of more members of staff unreasonably when they were unwell and/or had personal issues;* **Admitted and found proved.** There was clearly a pattern of behavior towards multiple staff members who were treated unreasonably by you in different respects.
17. (e)	*Challenged one or more members of staff when you learned that they had raised and/or reported concerns.* **Admitted and found proved.**

We move to stage two."

On 21 January 2020 the Chairman announced the determination as follows:

"Mr Webley,

Between 1 January 2013 to 31 December 2015 there were significant failures in your standard of care for some 12 patients, including in respect of your record keeping, radiography practice, antimicrobial prescribing and obtaining of informed consent. Further, you failed to maintain adequate standards of cross-infection control: you did not follow safe procedures for clean and dirty instruments and did not adhere to appropriate clean and dirty zones within the surgery setting. You failed to maintain an appropriate standard of hand hygiene by not washing your hands in the surgery. You also did not routinely wear a mask when treating patients: on the days you did wear a mask, you did not always change it between patients.

You failed to maintain appropriate standards of behaviour towards other members of staff at the practice by, among other things, speaking rudely to them and challenging members of staff when you learned that they had raised concerns. The evidence before the Committee was that some members of staff were reduced to tears by your behaviour.

The matters found proved relate to a period when you were the owner and principal of the practice in question.

Stage Two of the hearing

The Committee had regard to all the remediation evidence put before it. The Committee heard oral evidence from you on your reflection and remediation. You explained the impact these proceedings have had on you, including the order for interim conditional registration. You discussed various health matters which affected your ability to work for a few months from around December 2017 and for part of 2018. You were frank and reflective on your failings. You fully accepted the findings of fact of the Committee. You had admitted almost all of the charges found proved against you. You expressed remorse for your conduct and are deeply ashamed of your standard of behaviour towards other members of staff at the practice.

In respect of the clinical matters, Ms Firestone, the General Dental Council (GDC) instructed expert, stated in her oral evidence at the factual inquiry stage that:

> From all the documents I have considered it is my understanding that Dr W has worked hard towards remediating his faults, which in the main as far as I can ascertain relate to record keeping... All of the failures can be easily remediated and largely this seems to have been accomplished by Dr W. (taken from the note of defence counsel).

In his report dated 24 December 2019, Mr M. Brady, Associate Postgraduate Dean, stated:

> …There has been very significant improvement in Mr Webley's attitude reported by the coach mentor since selling his practice and starting to work again as an associate. Removing the stress of practice ownership seems to have made an immediate positive effect. With this positive attitude comes engagement and insight.
>
> Mr Webley has taken part in many remedial CPD activities over the past four years and the quality of reflection and insight has improved enormously in that time. He has embraced the concept of lifelong learning.
>
> I think there is no current impairment in his practice…

In terms of your fitness to practise history, on 1 November 2011 the Investigating Committee (IC) issued you with advice in relation to concern that you "*failed to investigate pain, diagnose and treat a patient's infection*".

On 26 September 2017, the Case Examiners issued you with advice in relation to the following concerns relating to a different informant to the one in the present proceedings:

1. You failed to treat [the informant] with respect, including by:

a. Discussing [the informant] health in front of colleagues,

b. Saying 'I read your review you had with [another colleague] yesterday and you said you get anxious in a class room? I find that funny considering you were having a good time at the Christmas party 'or words to that effect.

2. You failed to maintain adequate standards of cross infection control.

The Committee read the written submissions of both Counsel, which were supplemented orally. Ms Harris, for the GDC, submitted that the facts found proved amount to misconduct, that your fitness to practise is currently impaired and that the Committee should direct a short period of suspension. Mr Haycroft, on your behalf, conceded the questions of misconduct and impairment on public interest grounds only. He submitted that a reprimand would be the appropriate outcome in this case.

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) (ISG).

Misconduct

Misconduct is a serious departure from the standards reasonably expected of a dental professional. In assessing whether the facts found proved amount to misconduct, the Committee had regard to the *Standards for Dental Professionals*, which were in force until September 2013, when they were replaced by the *Standards for the Dental Team*.

In the Committee's judgment, there were widespread clinical failings (which include cross infection control and hygiene practices) across basic aspects of dental practice over an extended period. There were multiple acts and omissions which would be regarded as deplorable by fellow practitioners. The Committee accepted the evidence of Ms Firestone that many of your clinical failings fell far below the standard reasonably expected of you and that you had put your patients at risk of harm. Some of your clinical failings appear to have been attitudinal. Your clinical failings were so widespread and basic that the Committee considered to be clear breach of numerous principles contained in the Standards.

Your behaviour towards other members of staff at the practice were also serious breaches of the standards and would also be regarded as deplorable by fellow practitioners.

The Committee was satisfied that the facts found proved amount to misconduct.

Impairment

The Committee 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 uphold and declare proper standards of conduct and behaviour, so as to maintain public confidence in the profession and this regulatory process.

There has been substantial remediation in respect of the clinical matters. The Committee was satisfied that when these matters were brought to your attention you began a process of developing insight and of seeking to remedy the alleged failings in your practice. The Case Examiners' advice was given to you at the beginning of your period of remediation and therefore has only limited relevance to the Committee's assessment of your fitness to practise today. The advice from the IC is historic and did not involve any findings of fact being made against you.

You have engaged fully with the deanery. Your Personal Development Plan is focused on the areas of deficiency, which you have worked hard to address. Mr Brady was an independent and well-informed individual who had worked with you in respect of your remediation. The Committee was satisfied that you have taken these proceedings very seriously, that you have acknowledged and reflected upon your failings and that you have embedded improvement in your practice.

The Committee was satisfied that the risk of repetition is low and that a finding of impairment is not necessary on public protection grounds.

As to your personal behaviour, you admit the shortcomings in your management skills and your "people skills". You have good insight in this regard, recognising the need for you to change. You have taken steps to remove yourself from management situations. You fully recognise that you are unsuited to a management role and that you lack people skills in that regard. You have done sufficient in the Committee's judgment to make sure that you do not put yourself in a position where the behaviour which the Committee has founded proved would reoccur. You have the insight to avoid those situations.

The Committee was therefore satisfied that the risk of your repeating this aspect of your misconduct is also low and that a finding of impairment is not necessary on public protection grounds.

In the Committee's judgment, a finding of impairment is however necessary to maintain public confidence in the profession in respect of both the clinical matters and your personal behaviour. Your misconduct was so serious and occurred over a period of years. A fair minded and well-informed member of the public would lose confidence in the profession and this regulatory process if no finding of impairment were made.

Sanction

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. In deciding on which sanction, if any, to impose, the Committee applied the principle of proportionality, balancing the public interest with your interests.

The Committee considered the aggravating and mitigating factors in this case.

In mitigation, the Committee recognised that there is evidence of remorse and insight. You gave an apology which the Committee considered to be genuine and you have taken steps to avoid a repetition of your misconduct. Through the passage of time the matters before the Committee are now somewhat historic.

The aggravating features are that many patients were put at risk of harm, that your misconduct was sustained and repeated over a period of years and that you have a fitness to practise history in terms of the IC advice in 2011 and the Case Examiners' advice in 2017.

However, for the reasons already stated, that fitness to practise history did not weigh against you to any significant extent today.

The Committee considered sanction in ascending order of severity.

To conclude this case with no further action would be inappropriate.

The Committee went on to consider a reprimand and had regard to the ISG, which states:

> 7.7 A reprimand is the lowest sanction which can be applied and may therefore be appropriate where the misconduct or level of performance is at the lower end of the spectrum. A reprimand does not impose requirements on a registrant's practice and should therefore only be used in cases where he or she is fit to continue practising without restrictions. A reprimand might be appropriate if the circumstances do not pose a risk to patients or the public which requires rehabilitation or restriction of practice.

The Committee determined that a reprimand would be insufficient to maintain public confidence in the profession and to declare and uphold proper standards of conduct and behaviour. The Committee accepted that you do care about dentistry and your patients. However, there was a sustained period of blatant failures in basic aspects of dental practice. The misconduct in this case is far from "the lower end of the spectrum". There were serious and widespread failings spanning both clinical and behavioural matters, including failures where you had put your patients at risk of harm.

The Committee next considered whether to direct that your registration be made subject to your compliance with conditions. Conditions would not be required to protect the public or to further your remediation, as your misconduct is unlikely to be repeated and you have already demonstrated sufficient remediation. The issue for the Committee is whether conditions would be sufficient to meet the wider public interest. In the Committee's judgment, conditions of practice would not adequately maintain public confidence in the profession and this regulatory process, owing to the seriousness of your misconduct and the need for that misconduct to be marked.

The Committee then considered whether to direct that your registration be suspended for a period of up to 12 months, with or without a review.

The Committee had regard to the impact suspension might have on your ability to practise, as you predominantly practise NHS dentistry and the suspension of your GDC registration will result in the removal of your name from the Performers List, meaning that you would need to reapply to that list. The Committee determined that the procedure and timeframes involved in re-applying to the list were not matters relevant to its consideration on sanction.

You have shown insight and are remorseful. You were frank with the Committee when reflecting on your failings. You have adequately addressed the concerns raised in these proceedings and embedded improvement from your learning into practice. The risk of repetition is low. A period of suspension is necessary in the Committee's judgment to mark the seriousness of your misconduct. In determining the length of suspension, the Committee took account of the fact that the NHS had suspended you for 10 days and then imposed conditions on your entry on their list, that your registration had been made subject to interim conditions at the GDC before undertakings were agreed.

In the Committee's judgment, the minimum period proportionate to the severity of your misconduct is 3 months.

Accordingly, the Committee directs that your registration be suspended for a period of 3 months. The Committee does not require the suspension to be reviewed, as the purpose of the sanction is to mark your misconduct in order to declare and uphold the standards of the profession. The suspension shall therefore lapse upon the expiry of the 3 month period.

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

There is no application for an immediate order.

The Committee is not satisfied that an immediate order is necessary for the protection of the public or that it is otherwise in the public interest. There is no risk to the public. The high bar for the making of an immediate order otherwise on public interest grounds alone is not met in the circumstances of this case.

Unless you exercise your right of appeal, the 3 month period of suspension shall commence 28 days from when notification of the determination and your appeal rights are served on you. Should you exercise your right of appeal, the 3 month period of suspension will not commence until the disposal of the appeal.

That concludes the case."