

GENERAL DENTAL COUNCIL

AND

TANASICIUC, Mihai Dan

[Registration number: 109293]

NOTICE OF INQUIRY

SUBSTANTIVE HEARING

Notice that an inquiry will be conducted by a Practice Committee of the General Dental Council, at:

**CCT Venues-Smithfield
Two East Poultry Avenue
Smithfield
London
EC1A 9PT**

Commencing at **10:00 am 18 November 2019.**

The heads of charge contained within this sheet are current at the date of publication. They are subject to amendments at any time before or during the hearing. For the final charge, findings of fact and determination against the registrant, please visit the Recent Hearings page at www.gdc-uk.org after this hearing has finished.

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| Committee Members: | Gavin Scott | (Dentist) (Chair) |
| | Richard van Noort | (Lay) |
| | Laura Bryson | (DCP) |
| Legal Adviser: | Jeremy Barnett | |

CHARGE

Mihai Dan TANASICIUC, a dentist, DMD Iasi 2004, is summoned to appear before the Professional Conduct Committee on 18 November 2019 for an inquiry into the following charge:

“That being a dentist registered under the Dentists Act 1984 under registration number (109293):

Patient A

1. Between around 21 May 2014 and around 13 April 2016 you failed to provide an adequate standard of care to Patient A in that:
 - a. On or around 21 May 2014 you failed to carry out any, or any adequate, assessment in that:
 - i. You did not adequately investigate the cause of Patient A's recorded symptoms of pain;
 - ii. You did not take an x-ray of Patient A when it was clinically indicated to do so.
 - b. Prior to commencing orthodontic treatment on a date unknown between August 2014 and around 8 April 2015 you failed to take a pan oral x-ray when it was clinically indicated to do so;
 - c. Prior to commencing orthodontic treatment on a date unknown between August 2014 and around 8 April 2015 you failed to carry out any, or any adequate treatment planning.
 - d. On a date or dates unknown between August 2014 and around 13 April 2016 you provided orthodontic treatment to Patient A which was not clinically indicated, including:
 - i. The provision of plastic composite material;
 - ii. The provision of an inappropriate appliance to the lower arch.
2. In relation to the provision of composite material and/or crown preparation treatment provided to Patient A on a date or dates unknown between 21 May and August 2014 you failed to obtain informed consent in that:
 - a. You did not discuss, adequately or at all, the risks and benefits of the treatment options;
 - b. You did not communicate, adequately or at all, the treatment plan;

- c. You did not provide a written treatment plan.
3. In relation to the orthodontic treatment provided to Patient A on a date or dates unknown between August 2014 around 13 April 2016 you failed to obtain informed consent in that:
 - a. You did not discuss, adequately or at all, the risks and benefits of the treatment options;
 - b. You did not communicate, adequately or at all, the treatment plan;
 - c. You did not provide a written treatment plan.
4. In relation to the four radiographs taken of Patient A on or around 8 April 2015 you failed to:
 - a. Make any, or any adequate, record of justification;
 - b. Make any, or any adequate, report on the radiographs;
 - c. Grade the radiographs.
5. In relation to the radiograph of Patient A taken on or around 21 June 2015 you failed to:
 - a. Make any, or any adequate, record of justification;
 - b. Make any, or any adequate report on the radiographs;
 - c. Grade the radiographs.
6. You failed to maintain an adequate standard of record keeping in relation to Patient A in that:
 - a. You did not record adequate detail of appointments, including:
 - i. On or around 28 January 2015;
 - ii. On or around 8 April 2015;
 - iii. On or around 26 May 2015;
 - iv. On or around 21 June 2015.
 - b. You did not take any record, of appointments including:
 - i. On or around 12 July 2014;
 - ii. On or around 2 May 2015;
 - iii. On or around 6 July 2015;
 - iv. On or around 6 August 2015;
 - v. On or around 17 August 2015;
 - vi. On or around 26 August 2015;
 - vii. On or around 7 September 2015;
 - viii. On or around 16 September 2015;

- ix. On or around 1 October 2015;
- x. On or around 13 October 2015;
- xi. On or around 29 October 2015;
- xii. On or around 12 November 2015;
- xiii. On or around 23 December 2015;
- xiv. On or around 6 January 2016;
- xv. On or around 18 January 2016;
- xvi. On or around 2 February 2016;
- xvii. On or around 4 February 2016;
- xviii. On or around 20 February 2016;
- xix. On or around 2 March 2016;
- xx. On or around 16 March 2016;
- xxi. On or around 29 March 2016;
- xxii. On or around 13 April 2016.

- c. On a date or dates unknown between 21 May 2014 and around 13 April 2016 you did not make any, or any adequate, record of the treatment planning;
- d. In the alternative to paragraph 2 above you failed to make any record that informed consent had been obtained;
- e. In the alternative to paragraph 3 above you failed to make any record that informed consent had been obtained.

Patient B

- 7. Between around 5 August 2014 and around 4 May 2016 you failed to provide an adequate standard of care to Patient B in that:
 - a. Prior to commencing temporary bridgework on a date or dates unknown between around 5 August 2014 and 4 May 2016 you failed to carry out any, or any adequate, assessment in that you did not take an x-ray of Patient B when it was clinically indicated to do so;
 - b. Prior to placing plastic composite on Patient B's upper left quadrant on a date or dates unknown between around 5 August 2014 and 4 May 2016 you failed to adequately assess Patient B's occlusion including:
 - i. You did not measure and/or record Patient B's bite position;
 - ii. You did not measure and/or record wear on Patient B's teeth;
 - iii. You did not take any or any adequate study model.

- c. On a date or dates unknown between around 5 August 2014 and 4 May 2016 you failed to diagnose caries at UL6;
 - d. On a date or dates unknown between around 5 August 2014 and 4 May 2016 you placed plastic composite on Patient B's upper teeth and you allowed this material to remain in place for an excessive period;
 - e. On a date or dates unknown between around 5 August 2014 and 4 May 2016 you placed plastic composite in Patient B's upper left quadrant in order to adjust Patient B's bite elevation;
 - f. Prior to carrying out root canal treatment on a date or dates unknown between around 5 August 2014 and 4 May 2016 you failed to carry out any or any adequate investigation into Patient B's presenting symptom of pain.
8. In relation to the bridgework provided to Patient B's upper right quadrant on a date or dates unknown between around 5 August 2014 and around 4 May 2016 you failed to obtain informed consent in that:
- a. You did not discuss, adequately or at all, the risks and benefits of the treatment options;
 - b. You did not communicate, adequately or at all, the treatment plan.
9. In relation to the plastic composite placed in Patient B's upper left quadrant on a date or dates unknown between around 5 August 2014 and around 4 May 2016 you failed to obtain informed consent in that:
- a. You did not discuss, adequately or at all, the risks and benefits of the treatment options;
 - b. You did not communicate, adequately or at all, the treatment plan.
10. In relation to the root canal treatment provided to Patient B on a date or dates unknown between around 5 August 2014 and around 4 May 2016 you failed to obtain informed consent in that:
- a. You did not discuss, adequately or at all, the risks and benefits of the treatment options;
 - b. You did not communicate, adequately or at all, the treatment plan.
11. In relation to two undated radiographs taken of Patient B you failed to:
- a. Make any, or any adequate, record of justification;
 - b. Make any, or any adequate report on the radiographs;
 - c. To grade the radiographs.

12. You failed to maintain an adequate standard of record keeping in relation to Patient

B in that:

- a. You did not record sufficient detail, including:
 - i. On or around 5 February 2015;
 - ii. On or around 21 January 2016;
 - iii. On or around 9 March 2016;
 - iv. On or around 23 March 2016.
- b. You did not take any record, including:
 - i. On or around 5 August 2014;
 - ii. On or around 16 December 2014;
 - iii. On a date unknown around February or March 2015;
 - iv. On or around 12 November 2015;
 - v. On or around 3 December 2015;
 - vi. On or around 16 December 2015;
 - vii. On or around 12 January 2016;
 - viii. On or around 21 January 2016;
 - ix. On or around 13 April 2016;
 - x. On or around 4 May 2016.

Patient C

1. Between around 23 September 2013 and around 19 April 2016 you failed to provide an adequate standard of care to Patient C in that:

- a. Prior to placing implants at UR4 and/or UR5 and/or UR6 and/or UL5 you did not carry out any, or any adequate, treatment planning, in that:
 - i. You did not carry out any, or any adequate, assessment of Patient C's occlusion; and/or
 - ii. You did not take any, or any adequate, study models; and/or
 - iii. You did not make any, or any adequate, diagnostic wax ups of the intended final result; and/or
 - iv. You did not, adequately or at all, account for the lack of space in the upper right quadrant; and/or
 - v. You did not follow a detailed sequential treatment plan;
 - vi. You did not produce a written treatment plan.

- b. You placed implants when it was inappropriate to do so because it had not been adequately established whether the implants could be successfully restored:
 - i. On or around 5 May 2015 at UR4 and/or UR5 and/or UR6; and/or
 - ii. On or around 3 October 2015 at UL5.
 - c. You did not respond adequately to Patient C's reports of pain following bridgework undertaken on a date unknown between around 15 April 2014 and around 22 February 2015.
 - d. Between around October and December 2015 failed to arrange an emergency appointment when it was requested following the placement of an implant on or around 3 October 2015.
2. You failed to obtain informed consent from Patient C in relation to the placing of implants at UR4 and/or UR5 and/or UR6 and/or UL5 in that:
- a. You did not discuss, adequately or at all, the risks and/or benefits of the proposed treatment and/or alternative treatment options; and/or
 - b. You did not communicate, adequately or at all, the treatment plan; and/or
 - c. You did not provide a written treatment plan.
3. You did not communicate, adequately or at all, to Patient C in relation to the cost of her treatment, including:
- a. You did not provide an adequate written estimate of the cost of the treatment; and/or
 - b. You did not adequately inform Patient C on the increase in the cost of her treatment.
4. You failed to make any or any adequate report of radiographs taken of Patient C including:
- a. On or around 23 September 2013; and/or
 - b. On or around 17 December 2013; and/or
 - c. On or around 18 March 2014; and/or
 - d. On or around 1 April 2014; and/or
 - e. On or around 15 April 2014; and/or
 - f. On or around 18 September 2014; and/or
 - g. On or around 7 November 2014; and/or
 - h. On or around 22 February 2015; and/or
 - i. On or around 5 May 2015; and/or

- j. On or around 1 September 2015; and/or
 - k. On or around 19 September 2015; and/or
 - l. On or around 5 April 2016; and/or
 - m. On or around 19 April 2016.
5. You failed to maintain an adequate standard of record keeping in relation to Patient C in that:
- a. You did not make any, or any adequate, record on the dates set out in Schedule A; and/or
 - b. You did not make any, or any adequate, record of the obtaining and/or updating of Patient C's medical history; and/or
 - c. You did not make any, or any adequate, record of the process of obtaining consent in relation to the placement of implants at UR4 and/or UR5 and/or UR6 and/or UL5.

Patient D

1. On or around 31 May 2016 you failed to take bite wings radiographs and/or an additional periapical radiograph when it was indicated to do so.
2. In the alternative to paragraph 1 above, on or around 31 May 2016 you failed to record any reason that bite wings radiographs and/or an additional periapical radiograph were not taken.
3. Between around 31 May 2016 and 15 January 2017 you failed to take any adequate periapical radiograph of the lower left quadrant when it was indicated to do so prior to commencing treatment for the bridge in the lower left quadrant.
4. In the alternative to paragraph 3 above, between around 31 May 2016 and 15 January 2017 you failed to record any reason for not taking an additional periapical radiograph.
5. You failed to make any, or any adequate, report on the radiographs taken;
 - a. On or around 17 February 2016;
 - b. On or around 31 May 2016.
6. On or around 16 August 2016 you placed a filling at UL3 without first adequately removing the decay.
7. You caused or allowed Patient D to sign an electronic device without ensuring that Patient D was made aware that he was signing a treatment plan on the following occasions:
 - a. On or around 16 August 2016

- b. On or around 19 March 2017;
 - c. On or around 23 April 2017.
8. Your conduct set out at 7 above was lacking in integrity in that you did not ensure that Patient D was aware that he was signing a treatment plan.
9. You failed to maintain an adequate standard of record keeping in relation to Patient D in that:
- a. You did not carry out adequate charting in that restorations which were present were not recorded on the chart in relation to:
 - i. UL6; and/or
 - ii. UL8; and/or
 - iii. LL8.
 - b. You did not make any, or any adequate record of any discussions of the risks and benefits of the treatment provided;
 - c. You did not make any, or any adequate record of any discussions of the treatment options.
 - d. You did not record adequate detail of appointments, including:
 - i. On or around 31 May 2016;
 - ii. On or around 16 August 2016;
 - iii. On or around 30 October 2016;
 - iv. On or around 12 November 2016;
 - v. On or around 29 January 2017;
 - vi. On or around 25 February 2017;
 - vii. On or around 19 March 2017.
 - e. You did not take any record of appointments including:
 - i. On or around 17 February 2016;
 - ii. On or around 15 January 2017.

As a result of the matters set out above your fitness to practise is impaired by reason of your misconduct.”