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HEARING HEARD IN PUBLIC

TOM-LAWYER, Oreofe Grace

Registration No: 212210

PROFESSIONAL CONDUCT COMMITTEE

APRIL 2019 – JANUARY 2020

Outcome: Conditions for 12 months with immediate conditions (with a review)

Oreofe Tom-Lawyer, a dentist, LDS Royal College of Surgeons Of England 2016, was summoned to appear before the Professional Conduct Committee on 01 April 2019 for an inquiry into the following charge:

Charge (as amended on 3 April 2019)

"That, being a registered dentist:

1. At an appointment on or around 5 December 2016 you failed to treat Patient A with adequate dignity and respect, including by:
   a) Withdrawn by the GDC;
   b) Withdrawn by the GDC;
   c) Withdrawn by the GDC
2. At an appointment on or around 16 January 2017 you failed to treat Patient C with adequate dignity and respect, including by:
   a) speaking in a rude and/or inappropriate manner to Patient C;
   b) handling Patient C's lip with unnecessary roughness.
3. At an appointment on or around 16 January 2017 with Patient C you failed to:
   a) check Patient C's medical history;
   b) discuss with Patient C whether the size and/or symptoms of her lesions had changed since 10 October 2016;
   c) discuss the risks of surgery with Patient C, adequately or at all;
   d) obtain valid consent for surgery;
   e) carry out a mental nerve block injection prior to injecting Patient C's lower lip;
   f) maintain adequate communication with Patient C during the course of surgery;
   g) ensure Patient C was provided with adequate post-operative advice and/or instructions. successful half time submission
4. At an appointment on or around 16 January 2017 with Patient C you failed to provide an adequate standard of surgery, in that you:
   a) Withdrawn by the GDC

i. Withdrawn by the GDC

ii. Withdrawn by the GDC .

b) in respect of the polyp excised from the lower lip you made unnecessarily deep surgical incisions.

5. On or around 6 February 2017 you referred Patient D for a procedure that was not clinically justified, namely a CT scan of both orbital regions.

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

On 4 April 2019, Mr MacDonald (Counsel for Ms Tom-Lawyer) made a submission under Rule 19(3) on behalf of Ms Tom-Lawyerr. The Chairman made the following response:

"Mr MacDonald, on behalf of Ms Tom-Lawyer, has made an application under Rule 19(3) of the General Dental Council (GDC) (Fitness to Practise) Rules Order of Council 2006 (the Rules) that there is no case to answer in respect of charges 2(b), 3(a), 3(b), 3(c), 3(d), 3(g) and 4(b). These charges relate to an appointment that took place on 16 January 2017 when Ms Tom-Lawyer carried out a surgical procedure for the removal of a polyp from the inside of Patient C's right cheek and a polyp from her lower lip. Patient C is the complainant in this case, who is a registered nurse.

Rule 19(3) states:

> "When the presenter has completed presenting evidence, the respondent or the respondent's representative may open the case for the defence, which may include a submission that there is no case to answer."

Mr MacDonald made detailed submissions in respect of each of the charges that form the basis of the application. He referred to parts of the GDC's case where he said there was weakness and/or an absence of evidence upon which no Committee, properly directed, could find the matters proved. This included aspects of Patient C's evidence where she was unable to recollect whether or not something did nor did not happen on 16 January 2017. Mr MacDonald referred to the absence of evidence from other healthcare professionals who were present when the surgery was carried out on Patient C. He also drew the Committee's attention to aspects of Mr Smith's evidence (the GDC's expert, a Consultant Oral and Maxillofacial Surgeon) where he submitted Mr Smith made a concession (namely charge 3(g)) or where the evidence provided by him in respect of charge 4(b) was so tenuous that no Committee, properly directed, could find it proved.

Mr Micklewright, on behalf of the GDC, opposed Mr MacDonald's application. He referred in detail to aspects of the GDC's evidence in support of his contention that there was a case to answer for each of the charges in question. He placed reliance on the evidence of Patient C, particularly given that as she was a trained nurse, she would have a greater awareness of what is involved in obtaining patient consent and a general understanding of the behaviour expected of a registered healthcare professional towards a patient. He also relied on the evidence of Mr Smith as well as Patient C's medical records in support of the GDC's case that Ms Tom-Lawyer failed to obtain valid consent for surgery.

The Committee has considered the submissions made by both Counsel, during the course of which both made reference to the cases of *R. v. Galbraith,* 73 Cr.App.R. 124, CA and *R v*

Shippey (Colin) [1988] Crim. L.R. 767, which are relevant in considering a 'no case to answer' application..

The Committee has accepted the advice of the Legal Adviser as to the approach it should adopt in considering a 'no case to answer' application. It has borne in mind that the burden of proof is on the GDC and that the civil standard of proof applies, namely on the balance of probabilities. The Committee is aware that it is not reaching any findings of fact at this stage of the proceedings.

The Committee has taken into account all the evidence presented to it, both documentary and oral. This includes the GDC's hearing bundle which contains a copy of a witness statement of the then Divisional Director (the Director) for Surgery and Anaesthetics at East Lancashire NHS Trust (the Trust), signed and dated 19 December 2018; a copy of the witness statement of Patient C, signed and dated 11 October 2018 as well as copies of her medical records. Also included with Patient C's statement is her letter of complaint dated 25 January 2017 to the Trust, written several days after the surgical procedure had been carried out. In that letter Patient C complains about Ms Tom-Lawyer's manner towards her and the treatment provided during surgery, as well as the pain she experienced afterwards. Patient C refers to having returned to the day unit on 20 January 2017 where she was seen by a Specialist Oral Surgeon. She also states that she returned for a follow up appointment on 25 January 2017. The Committee received a report dated 7 December 2018, and a supplementary report dated 1 April 2019 from Mr Smith.

The Committee also received oral evidence from the Director, Patient C (via Skype) and Mr Smith. Each witness confirmed the content of their respective witness statements as being true and accurate and commended their statements and exhibits to the Committee as their evidence. Further, each of the witnesses was examined by Mr Micklewright, cross-examined by Mr MacDonald and were asked questions by the Committee.

The Committee has considered Mr MacDonald's application in respect of each charge separately, having regard to the GDC's evidence, and has determined as follows:

Charge 2(b) – At an appointment on or around 16 January 2017 you failed to treat Patient C with adequate dignity and respect, including by:

handling Patient C's lip with unnecessary roughness.

The Committee has received evidence from Patient C in support of this charge. The Committee also received evidence from Mr Smith as to the approach that should be adopted before giving an injection of anaesthetic to a patient, which differed from the account provided by Patient C. The Committee is satisfied that it has received evidence from the GDC, both factual and expert, upon which, taken at its highest, it could find this matter proved. It does not consider that this evidence is so manifestly unreliable that it could not properly rely on it. It therefore refuses Mr MacDonald's application on this charge.

Charge 3(a) - At an appointment on or around 16 January 2017 with Patient C you failed to: check Patient C's medical history

The Committee received evidence from Mr Smith that the Registrant should have checked whether the patient's medical history had changed since being seen in the outpatient department on 8 December 2016 by a different clinician. The Committee has also had regard to the medical evidence regarding the letter of referral from Patient C's GP to the Trust in October 2016. That letter refers to Patient C being on medication, including Tranexamic Acid. Thereafter, there is nothing in the clinical notes relating to the patient's

medical history taken on the day of surgery.

Patient C's evidence was that Ms Tom-Lawyer spent "all of 20 seconds" explaining the procedure to her. When asked in cross-examination whether Ms Tom-Lawyer asked her about her medical history, Patient C accepted that she was unable to remember whether or not that conversation took place.

The Committee is satisfied that it has received evidence from the GDC upon which, taken at its highest, it could find the matter proved. It does not consider that this evidence is so manifestly unreliable that it could not properly rely on it. It therefore refuses Mr MacDonald's application on this charge.

Charge 3(b) - discuss with Patient C whether the size and/or symptoms of her lesions had changed since 10 October 2016

The Committee received evidence from Mr Smith that the surgeon would specifically want to know about any changes to the two lesions in the patient's mouth, on her lip and cheek, and in particular, whether there had been any change in size or change in symptoms over the previous two months. Patient C, in cross-examination, said that she did not remember being asked about the size and/or symptoms of her lesions.

The Committee is satisfied that it has received evidence from the GDC upon which, taken at its highest, it could find the matter proved. It does not consider that this evidence is so manifestly unreliable that it could not properly rely on it. It therefore refuses Mr MacDonald's application on this charge.

Charge 3(c) – discuss the risks of surgery with Patient C, adequately or at all

The Committee received evidence from Mr Smith that in his opinion the Registrant should discuss any potential risks with the patient before commencing surgery. This included the risk of possible numbness or altered sensation of part of the lower lip which can follow surgery on the lip. He also referred to the risk of pain and swelling after surgery, which, he said, the patient should be warned about. In addition, the Committee received evidence from the Director regarding the consent process at the Trust. Her evidence was that the Trust's practice was to take consent at the time of the consultation, which was before the actual surgery. However, she considered that it was incumbent on the clinician carrying out the surgery to go through the risks of surgery with the patient at the outset.

Patient C's evidence was that Ms Tom-Lawyer spent "all of 20 seconds explaining the procedure to me." The Committee is satisfied that it has received evidence from the GDC upon which, taken at its highest, it could find the matter proved. It does not consider that this evidence is so manifestly unreliable that it could not properly rely on it. It therefore refuses Mr MacDonald's application on this charge.

Charge 3(d) – obtain valid consent for surgery

The Committee has received evidence from Mr Smith as to the nature of the consent process. It also received evidence from the Director as the Trust's policy on obtaining valid consent for surgery, at the time of the consultation in the outpatient clinic and confirming that process with the patient on the day of surgery. She described the consent process as being ongoing. Patient C's evidence was that Ms Tom-Lawyer spent "all of 20 seconds" explaining the procedure to her. The Defence places some reliance on the fact that the form dated 16 January 2017 contained in the GDC's hearing bundle, which is recorded in the name of the Scrub practitioner, has circled 'Yes' in response to the question 'Consent form signed and

confirmed with patient.' It also relies on the Director's evidence that the normal process at the Trust would have been for the consent form to have been available and read out to the patient on the day that the surgery was scheduled to take place. There is no consent form before the Committee. The Committee has received evidence from Mr Smith and the Director about the verbal discussions that should take place between the clinician carrying out the procedure and the patient.

The Committee is satisfied that it has received evidence from the GDC upon which, taken at its highest, it could find the matter proved. It does not consider that this evidence is so manifestly unreliable that it could not properly rely on it. It therefore refuses Mr MacDonald's application on this charge.

Charge 3(g) – ensure Patient C was provided with adequate post-operative advice and/or instructions

The Committee received evidence from Mr Smith regarding the duty of care to the patient in providing post-operative care instructions. Patient C accepted that after the procedure had been completed, she was provided with a leaflet containing post-operative advice from the nurse. That information included advice on the use of analgesics. Patient C also gave evidence of the steps she took post-operatively which suggest that she followed the advice/instructions given. In cross examination Mr Smith conceded that it was reasonable for that advice to have been given by the nurse in the presence of the surgeon. Mr Smith added the caveat that he would still expect the surgeon to explain any complications since there are certain matters a nurse would be less competent to deal with. The Committee is not satisfied that the evidence produced by the GDC, taken at its highest, is capable of leading to a finding of inadequacy relating to the post-operative advice. The Committee therefore allows Mr MacDonald's application on this charge.

Charge 4(b) - At an appointment on or around 16 January 2017 with Patient C you failed to provide an adequate standard of surgery, in that you:

In respect of the polyp excised from the lower lip you made unnecessarily deep surgical incisions.

There is evidence that the original lesion was recorded on assessment on 8 December 2016 as being 4mm in diameter. Patient C complained of experiencing pain post-operatively and returned to the outpatient clinic on 20 January 2017 where she was seen by a Specialist Oral Surgeon. Mr Smith referred to the hospital records for that appointment which state: "Right lower lip large defect in lip mucosa which has pus exuding. 4 sutures remain in wound of approx 12 mm length". A diagram showed the defect to be 3- 4mm deep.

The Committee is satisfied that it has received evidence from the GDC upon which, taken at its highest, it could find the matter proved. It does not consider that this evidence is so manifestly unreliable that it could not properly rely on it. It therefore refuses Mr MacDonald's application on this charge.

On 5 April 2019 the hearing adjourned part heard and resumed on 4 November 2019.

On 5 November 2019 the Chairman made the following statement regarding the finding of facts:

"Ms Tom-Lawyer

This is a Professional Conduct Committee hearing to consider an allegation that your fitness to practise is impaired by reason of misconduct. You are present and represented by Mr MacDonald. Mr Micklewright represents the General Dental Council (GDC). The hearing

began on 1 April 2019 and adjourned, part heard on 5 April 2019, the Committee having heard all of the evidence at the factual stage of the inquiry. The hearing resumed on 4 November 2019 when the Committee heard submissions from both parties on the facts and received legal advice from the Legal Adviser.

Amendment to the charge dealt with at the hearing in April 2019

At the outset of the hearing Mr Micklewright made an application under Rule 18(1) of the GDC (Fitness to Practise) Rules Order of Council 2006 (the Rules), to amend the charge by deleting the entirety of charge 1. He submitted that the deletion of charge 1 would reduce the scope of the misconduct alleged against you and therefore there could be no unfairness to you. Mr MacDonald confirmed that he had no objection to the application. The Committee accepted the advice of the Legal Adviser. It was satisfied that the withdrawal of charge 1 could be made without injustice. Accordingly, it acceded to the GDC's application.

At the close of the GDC's case on 3 April 2019, Mr Micklewright made a further application under Rule 18(1) to amend the charge by withdrawing charges 4(a)(i) and 4(a)(ii). This application was made in the light of the evidence given by Mr Smith, GDC expert, Consultant Oral and Maxillofacial Surgeon in cross-examination by Mr MacDonald. It was put to Mr Smith that it was not possible for him to say that the surgery on Patient C's cheek on 16 January 2017 fell below the standard expected of a competent practitioner, and he agreed with that. In the light of that concession, the GDC took the view that there was no real prospect of proving, on the balance of probabilities, the facts alleged at 4(a)(i) and 4(a)(ii). Mr MacDonald confirmed that he did not oppose the application. The Committee accepted the advice of the Legal Adviser. It was satisfied that withdrawing charges 4(a)(i) and 4(a)(ii) could be made without injustice. Accordingly, it acceded to the GDC's application.

The GDC's case

You are registered with the GDC as a General Dentist, although this case concerns your treatment of Patients C and D in your capacity as an Oral and Maxillofacial Surgeon. At the material times you were employed by East Lancashire Hospitals NHS Trust (the Trust) at the Royal Bolton Hospital (the Hospital) as a Senior Clinical Fellow in Oral and Maxillofacial Surgery. Patient C, a registered nurse, attended an appointment at the outpatient department of the Hospital on 8 December 2016. This followed a referral by her GP on 10 October 2016, requesting an excision of a swelling on her lower lip. The clinical notes for 8 December 2016 indicate that Patient C had two isolated benign fibrous nodules (polyps). Both polyps were reported as requiring excision, under local anaesthetic.

You excised the two polyps on 16 January 2017 at the day care unit of the Hospital. The GDC alleges that at that appointment you failed to treat Patient C with adequate dignity and respect, as particularised in charge 2. It also alleges a number of failures regarding the treatment you provided to Patient C (charge 3) and that you failed to provide Patient C with an adequate standard of surgery (charge 4).

Patient C attended follow up appointments at the outpatient clinic on 20 January 2017 and 25 January 2017. On 25 January 2017 Patient C sent a letter of complaint about you to the Hospital. In that letter she described your manner as "quite abrupt and rude", that she found the procedure "excruciating" and general felt unwell afterwards.

Finally, as a separate matter, the GDC alleges that on or around 6 February 2017 you referred Patient D for a procedure that was not clinically justified, namely a CT scan of both orbital regions (charge 5).

The evidence considered

At the outset of the hearing on 1 April 2019 Mr MacDonald, on your behalf, admitted charge 5. The Committee noted your admission but decided to defer its decision until it had received all the evidence in this case.

In considering whether the charges against you have been found proved, the Committee has taken into account all the evidence presented to it. This includes the GDC's hearing bundle which contains, inter-alia, a copy of the witness statement of Patient C, signed and dated 11 October 2018; a copy of the witness statement of the then Divisional Director (the Director) for Surgery and Anaesthetics at the Trust, signed and dated 19 December 2018; an extract (undated) of your observations regarding Patient D to the GDC's case examiners, as well as copies of the dental records for Patients C and D.

Patient C gave oral evidence via Skype. She gave evidence as to what took place at the appointment with you on 16 January 2017. She describes your spending approximately 20 seconds explaining the procedure to her and what would happen. On Patient A's account, she had no recollection of you asking her any questions. She also describes finding your manner to be "very rude and abrupt". Patient C then described what happened when you injected her with anaesthetic into her lip and cheek. She describes the pain in the lower lip as being "unbearable". She also gave evidence of your "really pulling my lip down and injecting into it." She gave a visual demonstration of this via Skype. Patient C's evidence was that once the area was numb, you started the procedure which she believed lasted for approximately 25 minutes. Patient C maintained that the facts set out in her witness statement were true.

The Committee has borne in mind that as Patient C is a registered nurse, she would have a better idea as to the appropriate expectations of interactions between patients and medical professionals. It has also borne in mind that she made a complaint soon after the events in question. The Committee had no evidence from the other healthcare professionals who were present. The Committee considered that Patient C's evidence was reliable and consistent with that set out in her written statement and in her complaint made on 25 January 2017, soon after the events in question.

The Director provided evidence as to the process of ordering a CT scan at the Trust under the CRISS system and how she became aware of a situation where you had ordered a CT scan for the wrong patient (Patient D). She also gave evidence as to the consent process at the Trust. She explained that Trust policy is that consent is taken at an appointment prior to the date of surgery. In cross-examination the Director agreed that her expectation would be that the full consent process would have taken place at the consultation before surgery but be confirmed on the day of surgery. The Committee found the Director to be a credible and a reliable witness.

The Committee received expert evidence on behalf of the GDC from Mr Smith, a Consultant Oral and Maxillofacial Surgeon, currently working in this field. He was also a former Senior Lecturer in this field at the University of Sheffield. He produced a report dated 7 December 2018, and a supplementary report dated 1 April 2019, in which he clarified two points raised in his original report. Mr Smith confirmed that his opinion had been based on his personal experience and current clinical practice in Oral and Maxillofacial Surgery (over 35 years). He confirmed that the standard that he had applied in judging your conduct was applying a reasonable standard of care expected of a reasonably competent Registrant. The Committee also received oral evidence from Mr Smith in which he broadly confirmed the

opinions set out in his reports. He also provided a visual demonstration as to how the surgeon would go about everting the lower lip prior to carrying out surgery. Overall, the Committee considered that Mr Smith was knowledgeable in the areas of your practice he was asked to opine on, and that he was applying the appropriate standard, not the gold standard. It found his evidence to be measured and reliable.

The Committee has noted that in some of the earlier drafts of Mr Smith's report, which were put to him in cross-examination by Mr MacDonald, his opinion differed. These points were explored fully with Mr Smith by Mr MacDonald. However, the Committee was satisfied that the elements of difference did not materially affect the overall quality of Mr Smith's evidence. It notes that he made appropriate concessions in respect of charges 4(a)(i) and (ii). Accordingly, it has given weight to Mr Smith's opinion.

The Committee gave careful consideration to your oral evidence in which you set out your own account of events relating to the surgical procedure that you carried out on Patient C on 16 January 2017. Your evidence was that the procedure was carried out in the presence of a junior clinician, who was observing what you were doing and two nurses, who assisted you with the procedure. You described giving a "running commentary" throughout the procedure to the junior clinician, this would mean Patient C, whose eyes were covered while you were operating on her, was aware what was going on.

The Committee heard from you that each patient was allocated a slot of 30 minutes in which to complete the procedure. Prior to commencing the procedure, you checked the referral letter dated 10 October 2016 from Patient C's GP to the Trust, which set out the reason for the referral and her medical history. You also say that you had sight of the notes of the outpatient consultation on 8 December 2016 which set out the treatment proposed. Your evidence is that that you would have ensured that Patient C had consented to the treatment before proceeding. The Committee felt that your evidence was generalised as to what your usual practice was as opposed to a specific recollection as to what took place when you treated Patient C on 16 January 2017. Accordingly, the Committee gave less weight to your evidence where you did not have a specific recollection.

The Committee has had regard to the submissions made by both parties. During the course of Mr MacDonald's submissions, he referred the Committee to paragraph 59 in the case of Miller & Another and the Health Service Commissioner for England [2018] EWCA Civ 144 in which Judge Sir Ernest Ryder stated: *"It is also conceded that the ombudsman's evidence from one of her most experienced Directors, Mr Kellett, contained an unfortunate use of language when he said "if it is not written down it didn't happen unless there is other corroborating evidence". I do not accept that this was an erroneous use of language: it reflected the practice of and language used by officials in the documents to which this court was taken ie unless the doctor had noted something in the clinical records, poor practice is assumed. Aside from reinforcing an impression of pre-determination, that is an inappropriate way to conduct an investigation: it merely engenders defensive note taking by doctors rather than clinical good practice. It is important to look for corroborating contemporaneous notes and also for evidence of good recording and safeguarding practices but it is also important to listen to what a professional says".*

The Committee has accepted the advice of the Legal Adviser. The Committee has borne in mind that the burden of proof is on the GDC and that it must decide the facts according to the civil standard of proof, on the balance of probabilities. You need not prove anything. The Committee has considered each charge separately. I will now announce the Committee's findings in relation to each charge:

2.	*At an appointment on or around 16 January 2017 you failed to treat Patient C with adequate dignity and respect, including by:*
2(a)	*speaking in a rude and/or inappropriate manner to Patient C* **Found not proved** Mr Smith's opinion was that when carrying out surgery under local anaesthesia, a surgeon would recognise that the patient will be very anxious and nervous and therefore it was essential to develop a rapport with the patient in order to alleviate some of that anxiety. Patient C, in her complaint to the Trust dated 25 January 2017, states that your manner towards her at the appointment on 16 January 2017 was "quite abrupt and rude". In her witness statement, Patient C describes finding your manner towards her as being "very rude and abrupt". In her oral evidence Patient C confirmed this position and explained that she found you to be "just quite cold, quite stand-offish really.... just quite abrupt was the only way I can describe it." You maintain that you were not aware that you were speaking in a rude and/or inappropriate manner to Patient C. The Committee finds that Patient C's evidence was consistent in that she found your manner towards her to be abrupt and rude. However, it heard no specific evidence from Patient C that you spoke to her in a rude or inappropriate manner. In addition, no other witnesses were called in support of this charge even though, on Patient C's account, and your own evidence, other staff were present throughout the procedure. The Committee accepted your evidence. Accordingly, the Committee finds this charge not proved.
2(b)	*handling Patient C's lip with unnecessary roughness* **Found proved** Mr Smith's opinion was that it was good practice to gently stretch the soft tissues taut before giving an injection of dental anaesthetic solution as the injection would be less painful. He provided the Committee with a visual demonstration of the correct procedure, which involved rolling the lip gently around the thumbs so as to allow the surgeon easy access to the lesions. He explained that it was still possible to gently roll the lip even if the patient was anxious and the mentalis muscle was very taut. Patient C's evidence, as set out in her witness statement, was that she found your manner towards her as "very rough". She states that you were "really pulling" her lip down. She also provided a visual demonstration of how you handled her lips before giving the anaesthetic, which the Committee notes was different from the demonstration provided by Mr Smith. The Committee has accepted Patient C's evidence and finds that you handled her lip with unnecessary roughness, contrary to the way you should have handled it, as described by Mr Smith.
3	*At an appointment on or around 16 January 2017 with Patient C you failed to:*
3(a)	*check Patient C's medical history* **Found not proved**

	Mr Smith's opinion was that you had a duty to check Patient C's medical history, to see whether it had changed during the two month period between being seen at the outpatient department on 10 October 2016 and her appointment with you on 16 January 2017. He also explained that it would be important to check to see whether the patient was taking any new medication. Patient C's recollection was that you spent 20 seconds explaining the procedure to her and what would happen. She had no recollection as to whether you asked her any questions. When cross-examined about this point, Patient C accepted that she was unable to recall whether or not you asked her about her medical history. The Committee has placed less reliance on Patient C's evidence given her acceptance that she had no specific recollection on this matter. Your evidence is that you would have checked with Patient C to see if there had been any changes to her medical history, including if she had any allergies, as this was part of your normal routine. The Committee has seen a copy of the day care unit treatment room care plan dated 16 January 2017 which, under the heading "Allergies", records "None", thus supporting your account. In the absence of any other evidence in support of this charge adduced by the GDC, the Committee finds this charge not proved.
3(b)	*discuss with Patient C whether the size and/or symptoms of her lesions had changed since 10 October 2016;* **Found not proved** Mr Smith's evidence was that it would be important for the surgeon to know if there had been any changes to the two lesions since 10 October 2016. Patient C was unable to recollect whether you had asked her if her lesions had changed at all since the last appointment, although her recollection was that they had not grown. However, she accepted that if that exchange had taken place, it would not have been a particularly long one. Your evidence was that you would have checked with Patient C to see if anything had changed in the lesions that were due to be removed because on some occasions, the lesions could have disappeared and you do not have to carry out the procedure for which they are listed. Accordingly, the Committee could not find this charge proved.
3(c)	*discuss the risks of surgery with Patient C, adequately or at all;* **Found proved** Mr Smith opined that you should have discussed any potential surgical risks with the patient, in particular the risk of possible numbness or altered sensation of part of the lower lip which can follow surgery on the lip. He also considered that it would have been good practice to discuss and warn the patient what to expect after surgery, in particular pain and swelling. Patient C's evidence was that you spent around 20 seconds explaining the procedure to her and what would happen. She maintained this position when cross-examined about this matter and said that the conversation would not have been "much longer" than 20 seconds. She also describes your

	explanation as being "brief". Your evidence was that you checked with the patient to make sure that she was happy for the procedure to go ahead and that you explained again to her briefly the procedure and the risks. In the light of this evidence, the Committee finds that a discussion took place between you and Patient C about the procedure you were about to embark on. It also accepts Patient C's evidence that the conversation was brief, lasting around 20 seconds. The Committee considered there would not have been enough time to adequately discuss the risks of surgery with Patient C in addition to other matters.
3(d)	*obtain valid consent for surgery* **Found proved** The Director gave evidence as to the Trust's policy on obtaining valid consent for surgery both at the time of the consultation in the outpatient clinic and when confirming the process with the patient on the day of surgery. Mr Smith opined that you had a duty to obtain valid consent for surgery when you met Patient C. His evidence was that it was important to talk to the patient beforehand, to go through the process, telling them what you are doing. He explained that the surgeon should again reiterate to the patient the risks of the surgery. You have accepted that it was your responsibility to ensure that you had obtained valid consent for surgery from Patient C and that you believe you did so. You explained that you would have seen a copy of the referral letter dated 10 October 2016, which set out the purpose of the procedure, the patient's medication and her medical history. You also say that you did not think it would take very long to go through the consent process. In support of the proposition that you did obtain valid consent for surgery, the Committee's attention has been drawn to a copy of the day care unit treatment room care plan dated 16 January 2017 which, under the heading "Consent form signed and confirmed with patient", the word "Yes" has been circled. However, Mr Smith considered that the consent form was simply a document to say that a discussion had taken place. The Committee has accepted Mr Smith's evidence on this matter. In the light of his evidence, and its finding that 3(c) that you did not discuss the risks of surgery with Patient C, adequately, or at all, it finds this charge proved.
3(e)	*carry out a mental nerve block injection prior to injecting Patient C's lower lip* **Found proved** It is common ground that you did not carry out a mental nerve block injection prior to injecting Patient C's lower lip. The main issue is whether you had a duty to carry out a mental nerve block injection, as is the GDC's case. Mr Smith's evidence was that injections of dental local anaesthetic solution directly into the lower lip itself could be very painful. His view was that you should have given Patient C at least one mental nerve block on the right side, and possibly a second on the left side, before giving injections directly into the lower lip itself. He explained that injections given into the lip itself are then given 4 to 5 minutes later, when the lip is numb, usually adjacent to the lesion, and are generally painless as the lip is already anaesthetised. Mr

	Smith was cross-examined on this point, but he maintained his position as to the need to carry out a mental nerve block injection to make the lip numb before injecting directly into the lip itself. He considered that all reasonable practitioners would try to carry out the surgery as painlessly as possible and that providing a mental nerve block first would be a technique which is very commonly used. Mr Smith referred to Patient C's evidence in which she describes experiencing pain to her lower lip, saying that it was "unbearable" and "more painful than childbirth". In your evidence you accepted Mr Smith's evidence that the lower lip is an area where a patient can feel particular pain when injected, more so than other areas of the mouth. You also agreed that had you administered a mental nerve block it probably would have lessened the pain described by Patient C. The Committee agrees with Mr Smith's evidence on this matter. It is satisfied that you had a duty to carry out a nerve block injection prior to carrying out this treatment and that all reasonable practitioners would have done so. It has received no further expert evidence that undermines Mr Smith's evidence on this matter. Accordingly, it finds this charge proved. It did not accept your explanation that it would be "overkill" to anaesthetise the whole area, given that it was a small polyp.
3(f)	*maintain adequate communication with Patient C during the course of surgery* **Found not proved** It is common ground that there were other medical professionals present during the procedure. You told the Committee that a junior clinician was observing what you were doing and there were two nurses who assisted you with the procedure. Patient C accepted that the junior clinician communicated with her during the procedure. You described giving a "running commentary" throughout the procedure to the junior clinician: this would mean Patient C, whose eyes were covered while you were operating on her, was aware what was going on. In these circumstances, the Committee is not satisfied that this charge has been proved to the requisite standard.
3(g)	*ensure Patient C was provided with adequate post-operative advice and/or instructions.* This charge falls away in view in the Committee's ruling that there is no case to answer under Rule 19(3), as set out in its determination dated 4 April 2019.
4(b)	*At an appointment on or around 16 January 2017 with Patient C you failed to provide an adequate standard of surgery, in that you:* *in respect of the polyp excised from the lower lip you made unnecessarily deep surgical incisions* **Found proved** Patient C's evidence was that she experienced severe pain post-operatively and returned to hospital on 20 January 2017 where she was seen by a

	Specialist Oral Surgeon. Mr Smith was critical of the depth of the surgical incisions that you made. In his evidence, Mr Smith referred to the hospital records for that appointment which provides a description of the wound. This referred to a "large defect in lip mucosa which has pus exuding, 4 sutures remain in wound of approx 12 mm length". There is a diagram of the lips which records "… open & infected ~ 3 - 4mm deep". Mr Smith explained the incision needed to go through the mucosa, which was a definite line of tissue and that the incision into the tissues in order to excise the polyp needed to be 1 to 1.5 millimetres or at most 2 millimetres. He also explained that any surgery on the lip carried a risk in injuring the nerve, particularly the deeper you go with the excision. While Mr Smith conceded that it was difficult to say exactly how deep the incision was made, based on the description provided in the records, and that Patient C suffered an injury to the nerve, he considered that the incisions were too deep. The Committee accepted Mr Smith's evidence on this matter and finds this charge proved.
5	*On or around 6 February 2017 you referred Patient D for a procedure that was not clinically justified, namely a CT scan of both orbital regions.* **Admitted and found proved** This is in the light of your admission as well as the documentary evidence before it.

We move to Stage Two."

On 6 November 2019 the hearing adjourned part-heard and resumed on 3 January 2020."

On 3 January 2020 the Chairman announced the determination as follows:

> ''This is the resumed hearing of Ms Tom-Lawyer's case which was adjourned part heard on 6 November 2019. At that stage of proceedings, the Committee had handed down its determination on the facts and it had received evidence on stage two of the proceedings. Ms Tom-Lawyer, who was present at the hearing, gave evidence and the Committee heard submissions from Mr Micklewright, on behalf of the General Dental Council (GDC), and from Mr MacDonald, on behalf of Ms Tom-Lawyer. It also received legal advice from the Legal Adviser before retiring into camera to deliberate on stage two. Owing to time constraints, it was not possible for the Committee to complete its deliberations and it indicated that the hearing would reconvene on a date to be confirmed. In due course, the GDC sought parties' availabilities and it was agreed that the resumed hearing would take place on 3 January 2020.
>
> Ms Denholm represents the GDC at this hearing. Ms Tom-Lawyer is neither present nor represented at today's hearing. The Committee received an email dated 2 January 2020 from a member of staff from the GDC's In-House Legal Team, giving information from Ms Tom-Lawyer's representative in which he stated that neither Ms Tom-Lawyer nor any representative would be in attendance at today's hearing. Ms Denholm invited the Committee to proceed in the absence of Ms Tom-Lawyer in accordance with Rule 54 of the GDC (Fitness to Practise) Rules Order of Council 2006 (the Rules). Ms Denholm submitted that Ms Tom-Lawyer and her representatives are aware of today's hearing, as confirmed by

their email dated 2 January 2020. She submitted that there has been no request for an adjournment and further, there is a public interest in completing the hearing today, given that it has been adjourned part heard previously.

The Committee has accepted the Legal Adviser's advice and accepted the submissions made by Ms Denholm. In addition, there is no indication that Ms Tom-Lawyer would attend if the hearing was postponed. In these circumstances, the Committee is satisfied that it is appropriate to proceed in the absence of Ms Tom-Lawyer in accordance with Rule 54.

Mr Micklewright confirmed on 6 November 2019 that Ms Tom-Lawyer has no previous fitness to practise history. He addressed the Committee on each of the matters found proved – which he categorised into three clinical areas: a failure to obtain valid consent from Patient C; a failure regarding surgical technique and in managing Patient C's pain and thirdly, referring Patient D for a CT scan that was not clinically indicated and which resulted in the patient being exposed to unnecessary radiation. Mr Micklewright invited the Committee to have regard to the issue of consent, as set out in the GDC's "Guidance for the Practice Committees, including Indicative Sanctions Guidance" (October 2016, updated May 2019) (the Guidance). Mr Micklewright invited the Committee to have regard to the fact that there have been breaches of the GDC's "Standards for the Dental Team" (September 2013). In short, he submitted that the findings against Ms Tom-Lawyer amount to misconduct.

The GDC's position is that Ms Tom-Lawyer's fitness to practise is currently impaired, both on the grounds that there is an ongoing risk that necessitates a finding of impairment as well as on the grounds of the public interest. Mr Micklewright described the evidence of remediation as being "work in progress" and submitted that the Committee cannot be satisfied, on the evidence before it, that Ms Tom-Lawyer no longer presents a risk of repetition of the matters identified in this case.

Mr Micklewright submitted that the appropriate sanction in this case is an order of conditions for a period of 12 to 18 months, depending on the Committee's view of the adequacy and extent of remediation shown.

Mr MacDonald submitted that the errors found proved in this case do not amount to serious professional misconduct. He made submissions as to why each of the charges, either individually or cumulatively, do not meet the threshold of seriousness with which a regulator is concerned. Mr MacDonald submitted that if the Committee concludes that some of the charges do amount to misconduct, then they do not amount to current impairment. He described them as isolated incidents, not deliberate wrongdoing. Mr MacDonald drew the Committee's attention to the steps Ms Tom-Lawyer has made to modify her practice, as well as the positive evidence as to her current fitness to practise. He referred to the two Personal Development Plans (PDP) and the actions she has taken to address the areas covered by the charges, as well as the supportive reference from a named Consultant Maxillofacial Surgeon at Queen Elizabeth University Hospital, Glasgow (the Consultant).

In short, Mr MacDonald said that this was a case where the failings were not deliberate and where there is little of risk of repetition such that a finding of impairment is not required in the public interest.

Misconduct

The Committee has first considered whether the facts found proved amount to misconduct. In so doing, it has had regard to all the evidence before it, including the expert evidence of Mr Smith. The Committee has also had regard to the GDC's "Standards for the Dental

Team" (September 2013) (the Standards) as well as the GDC's "Guidance for the Practice Committees, including Indicative Sanctions Guidance" (October 2016, updated May 2019) (the Guidance).

The Committee has found proved the following findings against Ms Tom-Lawyer relating to the appointment that took place with Patient C on 16 January 2017 as follows:

- She failed to treat Patient C with adequate dignity and respect in that she handled Patient C's lip with unnecessary roughness.
- She failed to discuss the risks of surgery with Patient C, adequately or at all and she failed to obtain valid consent for surgery.
- She failed to carry out a mental nerve block injection prior to injecting Patient C's lower lip.
- She failed to provide an adequate standard of surgery, in that in respect of the polyp excised from the lower lip she made unnecessarily deep surgical incisions.

The Committee considers that these findings are serious. Patients have a right to expect an adequate standard of surgery and that their dental pain and anxiety will be managed appropriately throughout a procedure. Ms Tom-Lawyer failed in this regard in that she handled Patient C's lip with unnecessary roughness and chose not to carry out a mental nerve block injection prior to injecting her lip, even though it was open to her to do so. In her evidence, Patient C described the pain she experienced in her lower lip as being "unbearable" and "more painful than childbirth". Further, Patient C was left with post-operative complications.

The GDC's "Guidance" states "the issue of informed or valid consent is a cornerstone of the public interest and must be paramount in a registrant's mind prior to carrying out any treatment or investigation. Failure to obtain consent is a serious matter …". Patient C's evidence was that Ms Tom-Lawyer spent only 20 seconds with her explaining the procedure. The Committee considers that Ms Tom-Lawyer's failure to obtain valid consent for the surgery, particularly where there were known risks that should have been explained to the patient, is a serious omission.

Mr Smith considered that Ms Tom-Lawyer failed to provide an adequate standard of care to Patient C. The Committee agrees with Mr Smith that the matters which it found proved have fallen far below the required standards.

In addition, on 6 February 2017 Ms Tom-Lawyer referred Patient D for a CT scan of both orbital regions, a procedure that was not clinically justified. Patient D was under Ms Tom-Lawyer's care for the management of her sore mouth. Ms Tom-Lawyer accepted that she made an error in referring Patient D for a CT scan by clicking through a dialogue box without checking that it was the correct patient. Ms Tom-Lawyer's error resulted in Patient D receiving unnecessary radiation to the cornea of each eye which has the potential to cause lasting damage. Mr Smith considered that the standard of care provided to Patient D in this regard fell far below the standard expected of a registered dental practitioner. The Committee agrees.

Having regard to the totality of its findings, the Committee considers that Ms Tom-Lawyer breached the following paragraphs of the GDC's "Standards for the Dental Team" (September 2013):

1.2 You must treat every patient with dignity and respect at all times.

1.2.4 You should manage patients' dental pain and anxiety appropriately.

2.2 You must recognise and promote patients' rights to and responsibilities for making decisions about their health priorities and care.

2.2.1 You must listen to patients and communicate effectively with them at a level they can understand. Before treatment starts you must:

- explain the options (including those of delaying treatment or doing nothing) with the risks and benefits of each; and
- give full information on the treatment you propose and the possible costs.

3.1 You must obtain valid consent before starting treatment, explaining all the relevant options and the possible costs.

3.3 You must make sure that the patient's consent remains valid at each stage of investigation or treatment.

7.3 Update and develop your professional knowledge and skills throughout your working life.

The Committee is satisfied that the findings against Ms Tom-Lawyer are serious and amount to misconduct.

Current impairment

The Committee went on to consider whether Ms Tom-Lawyer's fitness to practise is currently impaired by reason of her misconduct. In so doing, it had regard to Ms Tom-Lawyer's oral evidence given at this stage of the proceedings, as well as the documents provided on her behalf. The Committee also had regard to the submissions made by both parties. It accepted the advice of the Legal Adviser.

The documents provided on behalf of Ms Tom-Lawyer included two Personal Development Plans (PDPs) – the first one is dated April 2019 and the second (undated) one has been annotated to cover until the second quarter of 2020. Ms Tom-Lawyer's evidence was that the PDPs were produced in conjunction with the Postgraduate Dental Dean in Scotland, albeit the Committee has received no information from the Postgraduate Dental Deanery as to its involvement in this matter. Further, the PDPs have not been signed by Ms Tom-Lawyer or a representative from the Deanery.

The Committee has also been provided with a copy of Ms Tom-Lawyer's Continuing Professional Development (CPD) log covering the cycle January to December 2019; copies of CPD records and training certificates relevant to the issues in this case, including an Advanced Patient Communication Skills Course (completed on 29 April 2018) and Mandatory Training (Scottish Dentistry), in the areas of radiation regulations, radiation protection and informed consent (completed in May 2018). The Committee was also furnished with copies of anonymous feedback questionnaires, completed by medical colleagues (dentists, doctors, nurses and healthcare workers) and patients.

The Committee received an email dated 3 November 2019 from a named Consultant Maxillofacial Surgeon at Queen Elizabeth University Hospital, Glasgow (the Consultant), in which he attached an undated letter of support. The Committee understands that the Consultant is also Ms Tom-Lawyer's Educational Supervisor. The Consultant set out the progress Ms Tom-Lawyer has made within the department of oral and maxillofacial surgery. He notes that during the first few months in the department it was recognised that Ms Tom-

Lawyer needed additional support and that arrangements were made for this to happen. He commented that Ms Tom-Lawyer has made "very good progress" and that she provides locum cover for the department, with no additional supervision requirement. He also stated that Ms Tom-Lawyer has made good progress in addressing the issues in relation to her communication and team working which had been identified. In summary, the Consultant considered that Ms Tom-Lawyer demonstrated a good knowledge and experience in dealing with the range of problems presenting to a UK oral and maxillofacial surgery department.

The Committee also had regard to Ms Tom-Lawyer's evidence. She explained that the matters regarding Patient C and Patient D, which took place on 16 January 2017 and 6 February 2017 respectively at the Royal Bolton Hospital, were raised by the East Lancashire Hospitals NHS Trust (the Trust) prior to her leaving there in March 2017. During that time, Ms Tom-Lawyer continued to carry out polyp excisions. In May 2017 Ms Tom-Lawyer took up a post as a locum dental core trainee in maxillofacial surgery in secondary care for NHS Greater Glasgow and Clyde at Queen Elizabeth University Hospital, Glasgow. This was under the guidance and support of the named Consultant (referred to above). Ms Tom-Lawyer remained in that role until September 2019.

Ms Tom-Lawyer informed the Committee that she was not currently working as a dentist and although she had been applying for posts as a dentist in hospitals and a general dental practice setting, she had not been successful. She suggested that this could be due to the fact that her registration was subject to an interim order of conditions (imposed on her registration on 28 February 2018 by the Interim Orders Committee (IOC). Ms Tom-Lawyer explained that she had had an opportunity to observe another dentist working in general dental practice, with a view to making the transition to general dental practice. She anticipated that she would be required to undertake further training in general dental practice for a period of about a year and then would apply for her performer number under the NHS.

In addition, the Committee was provided with copies of Ms Tom-Lawyer's reflections in respect of her treatment of Patient C and Patient D. She gave evidence about her written reflections, particularly in the areas of consent, pain management during surgery and referring patients for CT scans. She explained that it was her usual practice to obtain valid consent from a patient, whether or not they had been consented previously. Ms Tom-Lawyer explained that going forward, she will be meticulous in checking previous notes and letters to confirm the patient's medical history as well as asking the patient if there have been any changes to their medical history. She said that she will ensure that all the necessary information is recorded in the patient's notes.

The Committee is satisfied that the identified shortcomings in this case (obtaining informed consent, pain management during surgery and making referrals for CT scans) are capable of being remedied. The Committee acknowledged the steps taken by Ms Tom-Lawyer to address some of the shortcomings in her clinical practice. This was demonstrated by Ms Tom-Lawyer's evidence in which she set out the steps she has taken to modify her practice, her maintenance of her PDP and actions specifically to address the matters identified as well as her ongoing CPD. The Committee has also had regard to the positive reference from the Consultant, who speaks of the progress Ms Tom-Lawyer has made as a locum dental core trainee.

However, the Committee has received limited evidence to satisfy itself that the steps Ms Tom-Lawyer has taken have been embedded into her practice over a sustained period of time. It has received no audits of work in the identified areas of concern to demonstrate that the changes Ms Tom-Lawyer says she has introduced into her practice have in fact taken

place. Further, it has received no reports from the Postgraduate Dental Dean as to her progress with her PDP, and whether it has been signed off.

The Committee considers that Ms Tom-Lawyer has demonstrated some insight into the matters in this case. However, it considers that Ms Tom-Lawyer's reflections on the deficiencies in this case are inadequate in that she appeared reluctant to accept full responsibility for her own actions and how they impacted on patient care. In addition, there is a lack of any reflection by Ms Tom-Lawyer on her use of a mental nerve block. The Committee has concluded that Ms Tom-Lawyer's insight is incomplete.

Taking all these factors into account, the Committee considers that there remains a risk of repetition of Ms Tom-Lawyer's shortcomings in her clinical practice and thus she continues to pose a risk to patients. A finding of current impairment is therefore necessary for the protection of the public.

The Committee also considers that public confidence would be undermined if a finding of impairment were not made, given the serious nature of the findings against Ms Tom-Lawyer and where her shortcoming*s* led to harm to Patients C and D. Accordingly, a finding of impairment is required in the public interest.

Having regard to all of these matters, the Committee has determined that Ms Tom-Lawyer's fitness to practise is currently impaired by reason of her misconduct.

Sanction

The Committee next considered what sanction, if any, to impose on Ms Tom-Lawyer's registration. It recognises that the purpose of a sanction is not to be punitive, although it may have that effect, but to protect patients and the wider public interest. The Committee has taken into account the GDC's "Guidance". It has applied the principle of proportionality, balancing the public interest with Ms Tom-Lawyer's own interests.

The Committee has had regard to the aggravating and mitigating factors in this case. The mitigating factors identified by the Committee include:

- Ms Tom-Lawyer has no previous fitness to practise history.
- Her expressions of remorse and apology to Patient C
- Some evidence of remediation
- Developing some insight into the matters identified in this case
- Two and a half years have elapsed since the events in question, with no reported concerns.

The aggravating factor identified by the Committee is evidence of actual harm caused to Patients C and D.

The Committee has considered the range of sanctions available to it, starting with the least restrictive. It has determined that to conclude the case with no further action would not be sufficient for the protection of the public or be in the wider public interest in the light of the risk of repetition of the clinical matters in this case. Likewise, the Committee has concluded that a reprimand would be inappropriate and insufficient, given the risk of repetition. It considers that it is necessary to place some restriction on Ms Tom-Lawyer's practice.

The Committee next considered whether to impose conditions on Ms Tom-Lawyer's registration. It has borne in mind that this case involves clinical shortcomings, which, in the

Committee's view, are remediable. It notes the steps taken thus far by Ms Tom-Lawyer to address the concerns arising from her treatment of Patients C and D, albeit it considers that the work is still in progress. The Committee is satisfied that the clinical matters identified in this case can be addressed by way of conditions and that Ms Tom-Lawyer would comply with them. It was aware that Ms Tom-Lawyer's registration had been subject to an interim order of conditions since February 2018, during which time she has remained compliant with that order.

The Committee considers that the conditions are sufficient for the protection of the public and will satisfy the public interest considerations in this case. Further, the conditions, as proposed, will ensure that Ms Tom-Lawyer's clinical work can be monitored and progressed so as to ensure effective remediation of the deficiencies identified in this case.

Accordingly, the Committee directs that Ms Tom-Lawyer's registration be subject to an order of conditions for a period of 12 months. The Committee is satisfied that this period is appropriate and proportionate to enable Ms Tom-Lawyer to consolidate her remediation and for her to demonstrate full insight into the shortcomings in this case.

The Committee considers that to suspend Ms Tom-Lawyer's registration would be disproportionate to the findings against her and is not necessary for the protection of the public or in the public interest as it would delay the remediation she has embarked on in her practice. In coming to this view, the Committee has also had regard to the supportive testimonial and the anonymous questionnaires submitted on her behalf and the fact that she has no previous findings against her.

The conditions, which are imposed for a period of 12 months, will appear against Ms Tom-Lawyer's name in the Dentists' Register in the following terms:

1. She must notify the GDC promptly of any professional appointment she accepts and provide the contact details of her employer or any organisation for which she is contracted to provide dental services and the Commissioning Body on whose Dental Performers List she is included or Local Health Board if in Wales, Scotland or Northern Ireland.

2. She must allow the GDC to exchange information with her employer or any organisation for which she is contracted to provide dental services, and any Postgraduate Dental Dean/Director (or nominated deputy), or workplace supervisor referred to in these conditions.

3. She must work with a Postgraduate Dental Dean/Director (or nominated deputy), to formulate a Personal Development Plan, specifically designed to address the deficiencies in the following areas of her practice: radiographic practice, surgical techniques and consent process. She must ensure that the Personal Development Plan has been signed off by the Postgraduate Dental Dean/Director (or nominated deputy),

4. She must forward a copy of her Personal Development Plan to the GDC within three months of the date on which these conditions become effective and provide an updated copy of this Personal Development Plan to the GDC at least 14 days prior to any review hearing.

5. At any time she is employed, or providing dental services, which require her to be registered with the GDC; she must place herself and remain under the supervision [* as defined below] of a workplace supervisor nominated by her and approved by the

GDC. The workplace supervisor shall be a GDC registrant in her registration category or higher.

6. She must allow her workplace supervisor to provide reports to the GDC at intervals of 3 months and at least 14 days prior to any review hearing. The GDC will make these reports available to the Postgraduate Dean/Director, referred to in these conditions.

7. a. She must carry out an audit, every 6 months, in the areas of radiographic practice, surgical techniques and consent process. These audits must be signed by her workplace supervisor.

   b. She must provide a copy of these audits to the GDC every 6 months or alternatively, confirm that there have been no such cases.

8. She must inform the GDC of any formal disciplinary proceedings taken against her, from the date of this determination.

9. She must inform the GDC if she applies for dental employment outside the UK.

10. She must inform within one week the following parties that her registration is subject to the conditions, listed at (1) to (9), above:

    - Any organisation or person employing or contracting with her to undertake dental work;
    - Any locum agency or out-of-hours service she is registered with or applies to be registered with (at the time of application);
    - Any prospective employer (at the time of application); and
    - The Commissioning Body on whose Dental Performers List she is included or seeking inclusion, or Local Health Board if in Wales, Scotland or Northern Ireland (at the time of application).

11. She must permit the GDC to disclose the above conditions, (1) to (10), to any person requesting information about her registration status.

* *The registrant's day to day work must be supervised by a person who is registered with the GDC in their category of the register or above. The supervisor need not work at the same practice as the registrant, but must make himself/herself available to provide advice or assistance should they be required. The registrant's work must be reviewed at least once a month by the supervisor via one to one meetings (in person, or by Skype/telephone) and case-based discussion. These monthly meetings must be focussed on all areas of concern identified by the condition*

The Committee will review Ms Tom-Lawyer's case at a hearing to be held shortly before the end of the period of conditional registration. She will be informed of the date and time of that hearing, which she will be expected to attend. Ms Tom-Lawyer will need to satisfy a future Committee that she has complied fully with these conditions and that she has successfully addressed the concerns identified in this case.

Following the adjournment of the hearing in November 2019 the Committee was provided with a correction regarding the status of the previously imposed interim order of conditions on Ms Tom-Lawyer's registration. The correction was provided by the GDC in its written submissions dated 16 December 2019. This correction was agreed by the Defence on 30

December 2019. In summary, Ms Tom-Lawyer ceased to be subject to an interim order on 27 August 2019 due to an administrative oversight on the part of the GDC. This matter came to light following the adjournment of the hearing on 6 November 2019. However, at the time of the hearing in November 2019 Ms Tom-Lawyer reasonably believed that she was subject to an interim order until 15 November 2019, when she was notified of the GDC's error.

The Committee now invites submissions as to whether Ms Tom-Lawyer's registration should be made subject to an immediate order of conditions.

Decision on immediate order of conditions

Having directed that Ms Tom-Lawyer's registration be subject to an order of conditions, the Committee went on to consider whether to make an order for conditional registration forthwith in accordance Section 30(2) of the Dentists Act 1984 (as amended).

Ms Denholm submitted that an order for immediate conditions on Ms Tom-Lawyer's registration is necessary for the protection of the public and is otherwise in the public interest.

The Committee has considered the submissions made by Ms Denholm on behalf of the GDC. It has accepted the advice of the Legal Adviser.

The Committee has had regard to its reasons for finding current impairment, including the risk of repetition of the shortcomings in Ms Tom-Lawyer's clinical practice. In these circumstances, the Committee is satisfied that it would not be appropriate to allow Ms Tom-Lawyer to practise unrestricted during the appeal period and, should an appeal be lodged, pending the resolution of that appeal. Accordingly, the Committee has determined that it is necessary for the protection of the public and is otherwise in the public interest to direct an order for the imposition of conditions on Ms Tom-Lawyer's registration forthwith in accordance with Section 30(2) of the Dentists Act 1984 (as amended).

The conditions are the same as those set out in the Committee's substantive direction, as previously announced.

If, at the end of the appeal period of 28 days, Ms Tom-Lawyer has not lodged an appeal, this immediate order will lapse and will be replaced by the substantive direction of conditional registration for a period of 12 months. If Ms Tom-Lawyer lodges an appeal, this immediate order will continue in effect until that appeal is determined.

That concludes the case."