HEARING HEARD IN PUBLIC

NAISBY, David George

Registration No: 51366

PROFESSIONAL CONDUCT COMMITTEE

AUGUST 2016

Outcome: Erased with Immediate Suspension

David George Naisby, a dentist, was summoned to appear before the Professional Conduct Committee on 19 August 2016 for an inquiry into the following charge:

Charge (as amended on 15 August 2016)

"That, being a registered dentist:

1. Between 11 January 2010 and 16 April 2014 you provided dental care and treatment to Patient A, a minor, identified in Schedule 1[1].

2. Between 11 January 2010 and 16 April 2014, you failed adequately and/or at all to:

   (a) carry out:

      (i) treatment planning;

      (ii) dental charting;

      (iii) an assessment of the caries risk level;

      (iv) an assessment of the current state of the dentition;

   (b) obtain:

      (i) an initial medical history;

      (ii) an updated medical history;

   (c) provide:

      (i) an oral and/or written treatment plan;

      (ii) dietary advice;

      (iii) hygiene advice;

   (d) take radiographs when these were clinically indicated on the dates set out in Schedule 2.

3. On dates set out in Schedule 3, you provided ozone treatment to Patient A's lower deciduous molars ("the ozone treatment").

[1] Please note that the schedules are private documents and cannot be disclosed

4. In respect of the ozone treatment, you failed adequately and/or at all to provide Patient A and/or Patient A's parent(s) with:
   (a) an explanation as to:
      (i) its nature and/or purpose;
      (ii) its clinical justification;
      (iii) the risks and/or benefits;
   (b) a leaflet and/or other explanatory written document;
   (c) alternative options for care including:
      (i) preventative care;
      (ii) radiographic evaluation followed by appropriate treatment;
   (d) post-operative advice on the dates set out in Schedule 4.
5. You failed to obtain informed consent for the ozone treatment.
6. From 1 June 2012 you failed adequately and/or at all to:
   (a) assess the cause of deterioration of the LRD and LRE;
   (b) review and/or cease ozone treatment from when it was clinically appropriate owing to the presence of secondary caries at LRD and/or LRE.
7. On 19 September 2012 and subsequently, you failed to take bitewing radiographs which were clinically indicated owing to the caries risk level of the patient.
8. You did not maintain appropriate records of your care and treatment of Patient A including failing to record adequately and/or at all:
   (a) the presence of carious lesions on the posterior molars on 11 January 2010;
   (b) the presence of carious lesions on LRD on 31 August 2011;
   (c) in the alternative to 2(a) – (c) above:
      (i) an oral and/or written treatment plan;
      (ii) dental charting;
      (iii) an assessment of the caries risk level;
      (iv) an initial medical history;
      (v) an updated medical history;
      (vi) dietary advice;
      (vii) hygiene advice;
   (d) in the alternative to 4(a) above in respect of the ozone treatment your discussion with Patient A and/or Patient A's parents on:
      (i) its nature and/or purpose;
      (ii) its clinical justification;
      (iii) the risks and/or benefits;

(e) in respect of the ozone treatment:

(i) in the alternative to paragraph 4(b) above, your explanation and/or discussion as to alternative treatment options;

(ii) in the alternative to paragraph 4(d) above, post-operative advice on the dates set out in Schedule 4;

(iii) in the alternative to paragraph 5 above, the obtaining of informed consent;

(iv) in the alternative to paragraph 6(a) above, your assessment and or treatment of the secondary caries at LRD and LRE;

(v) in the alternative to 6(b) above, your review and/or assessment as to whether this remained clinically appropriate when secondary caries was present at LRD and/or LRE;

(f) on 1 June 2012 the prognosis of longevity of LRE and LRD;

(g) dental history of the facture at LLE present on 19 September 2012;

(h) on 2 October 2013 and 16 April 2014 an assessment of the need for further orthodontic treatment.

Patient B

9. At all material times between 28 January 2005 and 4 July 2013 ('the Relevant Period') you:

a. practised from the Black Isle Dental Studio, Mounteagle Road, Culbokie, Dingwall, Inverness, Scotland ('the Practice');

b. had the care of Patient B, identified in Schedule 5.

10. During the Relevant Period, you failed to provide an adequate standard of care to Patient B in that you:

a. failed to carry out any or any adequate assessments of his periodontal condition on or about:

i. 23 October 2007;

ii. 20 January 2009;

iii. 14 August 2009;

iv. 17 March 2010;

v. 3 September 2010;

vi. 23 March 2011;

vii. 27 April 2012;

viii. 03 October 2012;

ix. 04 July 2013;

b. failed to carry out adequate treatment planning in that you:

i. failed adequately or at all to prepare and/or provide to Patient B a written treatment plan setting out available options, including the risks and benefits of each, following the de-coronation of LL1 on or about 10 April 2012;

ii. failed adequately or at all to prepare and/or provide to Patient B a written treatment plan setting out available options, including the risks and benefits of each, after having established a need for root canal treatment at LL7 on or about 31 July 2012 and/or 9 August 2012;

c. alternatively, failed adequately or at all to discuss verbally with Patient B his available treatment options on or about:

i. 10 April 2012 in relation to LL1;

ii. 31 July 2012 and/or 9 August 2012 in relation to LL7;

d. failed to take a periapical radiograph of LL1 on or about 10 April 2012 when this was clinically indicated;

e. failed on or about 12 April 2011 and/or 3 August 2011 to discuss with Patient B, adequately or at all, the risks and benefits of treatment in relation to:

i. UR2;

ii. UR1;

iii. UL1;

iv. UL2;

f. further or alternatively, failed in all the circumstances to use best endeavours to ensure that Patient B understood the risks of the said treatment on or about 12 April 2011 and/or 3 August 2011;

g. failed adequately or at all to diagnose Patient B's periodontal disease on:

i. 23 October 2007;

ii. 20 January 2009;

iii. 14 August 2009;

iv. 17 March 2010;

v. 3 September 2010;

vi. 23 March 2011;

vii. 27 April 2012;

viii. 03 October 2012;

ix. 4 July 2013;

h. failed adequately or at all to treat Patient B's periodontal disease by way of root surface debridement on:

i. 23 October 2007;

ii. 20 January 2009;

iii. 14 August 2009;

iv. 17 March 2010;

v. 3 September 2010;

vi. 23 March 2011;

vii. 27 April 2012;

viii. 03 October 2012;

ix. 4 July 2013;

i. failed on one or more of the above dates and/or at any time to inform Patient B of his periodontal disease;

j. undertook cosmetic dental treatment:

i. on or about 18 January 2008 without first resolving apical pathology present at UR1 and/or UR2;

ii. between 23 March 2011 and 18 August 2011, at UR2, UR1, UL1 and/or UL2, without first providing treatment for Patient B's periodontal disease in the adjacent sextants;

k. provided a poor standard of treatment at:

i. UR1 and/or UR2, between approximately 12 April 2011 and 18 August 2011, in that you failed to take clinically indicated steps to resolve radiographically evident periapical pathology, by way of 're root' treatment or apicectomy, prior to the provision of cosmetic crowns;

ii. UL1, between approximately 12 April 2011 and 23 September 2011, in that you failed to take clinically indicated steps to resolve radiographically evident periapical pathology, by way of 're root' treatment or apicectomy prior to the provision of cosmetic crowns;

iii. LL1, between approximately 12 April 2011 and 23 September 2011, in that you failed to take clinically indicated steps to resolve radiographically evident periapical pathology, by way of 're root' treatment or apicectomy, prior to the provision of cosmetic crowns;

iv. LL1, between approximately 12 April 2011 and 23 September 2011 in that you failed to take any or any adequate steps to assess, diagnose or treat radiographically evident bone loss;

v. LL1, on or about 4 July 2013, in that you failed to take any or any adequate steps to resolve and/or stabilise radiographically evident periapical pathology and/or vertical bone resorption;

vi. LL7, on or about 20 January 2009 and/or 14 August 2009, in that you failed to take any or any adequate steps to resolve radiographically evident carious lesions by way of excavation and/or filling replacement;

vii. LR1, on or about 9 September 2011, in that you carried out the provision of a crown without first exhausting more conservative and/or less invasive options such as external whitening;

viii. LL7, on or about 31 July 2012, in that you prescribed a course of antibiotics which was not clinically indicated, instead of conducting an appropriate operative intervention when the latter was clinically indicated;

ix. LL7, on or about 9 August 2012, in that you failed to 'temporise' the tooth and/or refer Patient B to a specialist, namely an endodontist.

11. Further or alternatively, during the Relevant Period, you failed to obtain informed consent from Patient B in respect of treatments provided on or about:

a. 23 October 2007, namely, a scale and polish;

b. 20 January 2009, namely, a scale and polish;

c. 14 August 2009, namely, a scale and polish;

d. 17 March 2010, namely, a scale and polish;

e. 23 March 2011 and/or 12 April 2011, namely, a scale and polish and/or restorative treatment at:

i. UR2;

ii. UR1;

iii. UL1;

iv. UL2;

v. LL1;

vi. LR1;

vii. LR2;

f. 10 April 2012, namely, treatment provided in relation to the fractured and/or de-coronated crown at LL1;

g. 31 July 2012 and/or 9 August 2012, namely, root canal treatment.

12. Alternatively, you failed during the Relevant Period to record adequately or at all whether and/or how you had obtained informed consent from Patient B, on one or more of the above dates.

13. Further or alternatively, during the Relevant Period, you failed to maintain an adequate standard of record keeping in respect of Patient B's appointments, in that you:

a. failed to record, adequately or at all, any or any adequate evaluation of radiographs taken on or about one or more of the following dates:

i. 25 January 2007;

ii. 14 December 2007;

iii. 20 January 2009;

iv. 14 August 2009;

v. 3 September 2010;

vi. 12 April 2011;

vii. 9 August 2012;

viii. 4 July 2013;

b. further or alternatively you:

i. failed to record the taking of and/or justify one or more radiographs taken on 14 December 2007;

ii. on or about 14 December 2007, failed to record adequately or at all the 'working length' of the LL1 from the corresponding radiograph;

c. failed to record and/or retain a copy of, any or any adequate written treatment plan in respect of proposed cosmetic treatment on or about 23 March 2011 and/or 12 April 2011;

d. failed to record and/or retain a copy of any or any adequate written treatment plan in relation to treatment proposed following the de-coronation of LL1 on or around 10 April 2012;

e. failed to record and/or retain a copy of any or any adequate written treatment plan in relation to treatment provided at LL7 after establishing the need for root canal treatment on or about 31 July 2012 and/or 9 August 2012.

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

Mr Naisby was not present and was not represented. On 18 August 2016 the Chairman announced the findings of fact to the Counsel for the GDC:

"Mr Mulchrone,

Mr Naisby is neither present nor represented at this Professional Conduct Committee (PCC) hearing. At the outset, on behalf of the General Dental Council (GDC), you made an application under Rule 54 of the GDC (Fitness to Practise) Rules 2006 ('the Rules'), for the hearing to proceed in Mr Naisby's absence.

The Committee took into account your submissions in respect of that application. It accepted the advice of the Legal Adviser.

Service

The Committee first considered whether Mr Naisby had been sent notification of the hearing in accordance with Rules 13 and 65. It saw a copy of the Notification of Hearing (NOH), dated 13 July 2016, which was sent to Mr Naisby's registered address by Special Delivery and to a known alternative address in Mexico by 'International signed for' post and by Air Mail. A copy of the NOH was also sent to Mr Naisby by email. The Committee was satisfied that the NOH contained proper notification of today's hearing, including its date, time and location, as well as notification that the PCC had the power to proceed with the hearing in Mr Naisby's absence. The Committee was satisfied that all reasonable efforts had been made by the GDC to send notification to Mr Naisby in accordance with the Rules and that the requirements of service had been met.

Proceeding in the absence of the respondent

The Committee next considered whether to exercise its discretion under Rule 54 to proceed with the hearing in the absence of Mr Naisby. It approached this issue with the utmost care and caution. It took into account the advice of the Legal Adviser regarding the criteria

approved by the House of Lords in *R v Jones [2003] 1 AC 1HL* and the observations of the Administrative Court in *GMC v Adeogba and GMC v Visvardis [2016] EWCA 162.* The Committee considered the need to be fair to both parties, as well as the public interest in the expeditious disposal of this case.

The Committee had regard to the correspondence sent by the GDC to Mr Naisby at both his registered address and his alternative address. There has been very limited engagement by Mr Naisby, with his only contact with the GDC occurring during the early stages of the investigation process. This was by way of a letter to a GDC caseworker dated 13 October 2014. Mr Naisby has not made any further contact with the GDC since that time.

The Committee was satisfied that Mr Naisby was aware of the investigation into his fitness to practise. The evidence suggests that, with the exception of the one letter referred to above, he has chosen not to engage with the processes of his regulatory body. The Committee concluded that Mr Naisby's absence was voluntary and it considered that an adjournment would not make his attendance on a future date any more likely. Further, it noted that Mr Naisby had not requested an adjournment. In all the circumstances, the Committee determined that it was fair, reasonable and in the public interest to proceed with the hearing in the absence of Mr Naisby.

Applications under Rule 25(2) and Rule 18 of the Rules

Following the relevant legal advice, the Committee acceded to two further applications made by you on behalf of the GDC. It first agreed to join additional allegations to the original charge, under Rule 25(2). These further allegations related to a second patient, Patient B. In acceding to this application, the Committee was satisfied that Mr Naisby had been properly notified in accordance with the Rules. It was also satisfied that the additional allegations were of a similar kind and that the requirements of Rule 25(2) had been met. The charge was revised accordingly.

The Committee went on to amend head of charge 13c of the revised charge by inserting the number '23' before the word 'March' to complete the applicable date. It was satisfied that this minor amendment could be made without causing injustice to either party.

Background and evidence

The matters in this case relate to Mr Naisby's treatment of two patients, Patient A, a minor and Patient B, an adult patient. The cases of the two patients were referred to the GDC separately, but raised similar concerns.

Patient A's case was referred by way of a complaint made by her mother. It is alleged that between 11 January 2010 and 16 April 2014, Mr Naisby failed adequately to treat Patient A's dental caries. This is said to have resulted in Patient A subsequently requiring extensive treatment, including fillings and extractions.

Patient B's complaint, which was referred to the GDC via the Dental Complaints Service, relates to treatment provided by Mr Naisby between 28 January 2005 and 4 July 2013. It is alleged that Mr Naisby failed to provide an adequate standard of care to Patient B. The treatment Mr Naisby is alleged to have provided to this patient involved root canal treatment and extensive cosmetic dental work. Patient B made his complaint about Mr Naisby when a subsequent treating dentist is said to have informed him that he had chronic periodontal disease, and other dental problems which were evident on x-ray examination and ought to have been identified and treated by his previous treating dentist.

The Committee received documentary evidence which comprised: Mr Naisby's clinical records for Patient A and for Patient B; the clinical records of the subsequent treating dentists for Patient A and for Patient B; the witness statement of Witness A, Patient A's mother; the witness statement of Patient B; and the witness statement of Witness C, Practice Lead at The Rosedene Clinic, one of the practices where Mr Naisby had worked. The Committee also considered Mr Naisby's letter to the GDC dated 13 October 2014.

The Committee heard oral evidence from Witness A, Patient B and Witness C, all of whom participated via Skype. The Committee found both Witness A and Patient B to be credible and reliable witnesses.

By way of expert evidence, the Committee received the reports of, and heard oral evidence from, Ms Vassia Karpeta, the expert witness called by the GDC. Ms Karpeta's first report relates to Patient A's case and her second report relates to the case of Patient B. She confirmed the contents of both reports as part of her evidence. The Committee formed the opinion that Ms Karpeta has both sufficient expertise, such that her opinion could be relied upon, and an excellent grasp of the details of this case.

The Committee's findings of fact

The Committee has considered all of the evidence presented to it. It has taken into account your closing submissions made on behalf of the GDC and it has accepted the advice of the Legal Adviser. It has considered each head of charge separately, bearing in mind that the burden of proof rests with the GDC and that the standard of proof is the civil standard, that is, whether the matters alleged are proved on the balance of probabilities.

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

Patient A	
1.	Proved. This is evidenced by Mr Naisby's clinical records for Patient A.
2. (a)(i)	Proved. The Committee has found that Mr Naisby failed adequately to carry out treatment planning. The Committee was satisfied that Mr Naisby had some form of a treatment plan in mind, as he provided Patient A with a treatment, namely ozone treatment. However, the Committee accepted the evidence of Ms Karpeta regarding the clinical discussions that would have been required to form an adequate treatment plan. There is no evidence of such discussions in the clinical records. Ms Karpeta's opinion, which the Committee accepted, was that the lack of a record in this instance was an indication that the discussions did not take place. The Committee also took into account Ms Karpeta's oral evidence that, following the necessary enquiries, she was satisfied that she had received and seen all of the clinical records for Patient A.
2. (a)(ii)	Proved. The Committee has found that Mr Naisby failed to carry out any dental charting.

	The Committee accepted the oral evidence of Ms Karpeta, who stated that Mr Naisby had an obligation to carry out dental charting for Patient A at the first appointment. She further explained that she would have also expected Mr Naisby to update any dental charting at each subsequent dental appointment with the patient. There is no evidence of any initial or subsequent dental charting in the clinical records for Patient A. The Committee accepted that accurate charting was particularly important for a patient with previous caries experience.
2. (a)(iii)	Proved. The Committee has found that Mr Naisby failed to carry out any assessment of the caries risk level. The Committee accepted the evidence of Ms Karpeta, who stated that Mr Naisby was under a duty to carry out such an assessment, particularly as during the period in question, Patient A had presented with recurring teeth fractures. Ms Karpeta told the Committee that assessing Patient A's caries risk level would have assisted with the formulation of a treatment plan. There is no evidence in the clinical records that Mr Naisby carried out the required assessment.
2. (a)(iv)	Proved. The Committee has found that Mr Naisby failed adequately to carry out an assessment of the current state of the dentition. There is some evidence of an assessment in the clinical records for Patient A. Mr Naisby noted that mixed dentition was present, that the patient would require orthodontic treatment in future and he briefly noted the patient's oral hygiene status. However, the Committee accepted the evidence of Ms Karpeta that more detail was required for his assessment to be deemed adequate. This would have included a comprehensive description of the caries present and potential orthodontic problems.
2.(b)(i)	Proved. The Committee has found that Mr Naisby failed to obtain an initial medical history. The Committee accepted the oral evidence of Ms Karpeta that Mr Naisby was under a duty to obtain an initial medical history in relation to Patient A at the first appointment. She stated in her report on Patient A's case that *"It is important that a comprehensive medical history should be obtained for all patients so that treatment can be delivered safely."* There is no information at all regarding an initial medical history in the clinical records for the patient.
2. (b)(ii)	Proved. The Committee has found that Mr Naisby failed to obtain an updated medical history. There is no initial or updated medical history in the clinical records for Patient A. The Committee considered that any update would have been indicated in the clinical records, even if the initial medical history had been

	lost, although it noted that there has been no such suggestion.
2. (c)(i)	Proved. The Committee has found that Mr Naisby failed to provide an oral or written treatment plan. The Committee accepted the evidence of Ms Karpeta that Mr Naisby should have provided a treatment plan in respect of Patient A. The evidence of Witness A, which the Committee also accepted, was that she felt that Mr Naisby had not given her enough information at the time. In the light of this evidence, the Committee concluded that it was more likely than not that Mr Naisby did not provide a treatment plan, either oral or written.
2. (c)(ii)	Proved. The Committee has found that Mr Naisby failed to provide dietary advice. The Committee accepted the opinion of Ms Karpeta that Mr Naisby ought to have given such advice. In her witness statement, Witness A stated that no dietary advice was given by Mr Naisby. The Committee noted the opinion of Ms Karpeta that this failure did not fall far below the standard expected of a general dental practitioner. However, it considered that in the case of Patient A, taking into account this patient's history of dental problems, Mr Naisby's failing to provide dietary advice might be regarded as a serious one.
2. (c)(iii)	Proved. The Committee has found that Mr Naisby failed adequately to provide hygiene advice. There is one entry in the clinical records that Mr Naisby gave oral hygiene instructions in relation to Patient A on 19 September 2012. The Committee accepted the evidence of Ms Karpeta that this single entry does not constitute adequate hygiene advice.
2. (d)	Proved. The Committee accepted the evidence of Ms Karpeta, as set out in her first report, that radiographs were clinically indicated on each of the five dates listed in Schedule 2 to the charge and that Mr Naisby was obliged to take the radiographs. There is no evidence in the clinical records that Mr Naisby took any radiographs on the dates in question. In the absence of such evidence, the Committee was satisfied that it was more likely than not that none were taken.
3.	Proved. This is evidenced by the clinical records for Patient A.
4. (a)(i)	Proved.
4. (a)(ii)	Proved.
4. (a)(iii)	Proved.

	The Committee considered 4(a)(i), 4(a)(ii) and 4(a)(iii) separately, but arrived at the same conclusion in respect of each. In respect of the ozone treatment, the Committee has found that Mr Naisby failed adequately to provide Patient A and/or Patient A's parent(s) with an explanation as to its nature and purpose, clinical justification or the risks and/or benefits. The Committee heard evidence from Witness A that Mr Naisby provided some explanation as to the nature and purpose of the treatment. She stated that Mr Naisby had only provided a brief explanation. She said that he had told her that the ozone treatment was completely harmless and that it could help prevent Patient A's decay from getting worse. Witness A was very certain about her recollection on this matter and told the Committee how she had carried out her own research into ozone treatment, as she had not received enough information from Mr Naisby. The Committee had regard to Mr Naisby's letter, dated 13 October 2014. He provides no other comment in relation to this particular allegation. The Committee took into account that Witness A herself had undergone ozone treatment several years previously, however it considered this irrelevant in terms of how the treatment was to be used in relation to Patient A. Ms Karpeta told the Committee that an adequate explanation about the nature of the ozone treatment in Patient A's case should have included information about its effectiveness and its antimicrobial properties. There is no evidence either in the clinical records or in Mr Naisby's letter that these factors were explained. The Committee considered Witness A to be a knowledgeable and intelligent person, who would have understood if more had been explained to her.
4. (b)	Proved. In respect of the ozone treatment, the Committee has found that Mr Naisby failed to provide Patient A and/or Patient A's parent(s) with a leaflet or other explanatory written document. It was the evidence of Ms Karpeta that ozone treatment was an unusual treatment to use in isolation of other more conventional treatments. She stated that as Mr Naisby had relied solely on the ozone treatment in Patient A's case, she would have expected some form of explanatory document to have been provided to the patient's parents. The Committee accepted Witness A's evidence that she received no such document.
4. (c)(i)	Proved. In respect of the ozone treatment, the Committee has found that Mr Naisby failed adequately to provide Patient A and/or Patient A's parent(s) with alternative options for care including preventative care. There is only one entry in the clinical records for Patient A of oral hygiene advice being given on 19 September 2012. The Committee accepted Ms Karpeta's criticism about this single instance of advice, as she considered that more supplementary information relating to preventative care should

	have been given to the patient and/or the patient's parent(s).
4. (c)(ii)	Proved. In respect of the ozone treatment, the Committee has found that Mr Naisby failed to provide Patient A and/or Patient A's parent(s) with alternative options for care including radiographic evaluation followed by appropriate treatment. As already set out in the Committee's findings at 2(d), there is no evidence that Mr Naisby took any of the radiographs that were clinically indicated.
4. (d)	Proved. In respect of the ozone treatment, the Committee has found that Mr Naisby failed adequately to provide Patient A and/or Patient A's parent(s) with post-operative advice on the dates set out in Schedule 4 to the charge. The Committee accepted Ms Karpeta's opinion that Mr Naisby did have an obligation to give post-operative advice on each of the occasions in question. She told the Committee that such advice would have included oral hygiene instruction, a recommendation that the patient limit their sugar intake and advice on the use of fluoride. There is only evidence in the clinical records for Patient A that hygiene advice was given on one occasion. Further Witness A confirmed to the Committee that she did not receive enough detailed information from Mr Naisby.
5.	Proved. The Committee accepted the opinion of Ms Karpeta that informed consent could not have been given in relation to Patient A, if other alternative options for treatment had not been explained. The Committee has already found that Mr Naisby did not explain adequately the risks and benefits of the ozone treatment. Witness A stated that she felt that she did not receive enough information from Mr Naisby about the treatment and, with hindsight, does not consider that she gave her informed consent. Taking into account Ms Karpeta's evidence that ozone treatment is not generally used as a stand-alone treatment, the Committee considered that it was particularly important that Mr Naisby obtained informed consent. On the evidence before it, he did not do so.
6. (a)	Proved. The Committee has found that from 1 June 2012, Mr Naisby failed adequately to assess the cause of deterioration of the LRD and LRE. There is nothing relevant recorded in the clinical records for Patient A other than Mr Naisby's conclusion that the LRD and LRE had fractured. The Committee was satisfied that this information did not amount to an adequate assessment of the cause of the deterioration of the teeth. Whilst it noted that Mr Naisby identified that there were fractures, it considered that he failed to carry out investigations to find out why. It accepted Ms Karpeta's opinion that more information would be required for an assessment to be deemed adequate. She stated that she would have expected to see an actual reason for the deterioration such as a reference to caries or trauma, as well as

	radiographic investigation.
6. (b)	Proved. The Committee has found that from 1 June 2012, Mr Naisby failed to review or cease ozone treatment. The Committee was satisfied from what radiographs there are, taken by the subsequent treating dentist, that there was secondary caries in Patient A's LRD and LRE. By Mr Naisby's own admission, as contained in his letter of 13 October 2014, ozone treatment is only suitable for early onset caries. The clinical records for Patient A show that Mr Naisby continued the use of the ozone treatment, despite the presence of secondary caries in the two teeth in question. There is no evidence in the clinical records for Patient A or in Mr Naisby's letter to suggest that he reviewed his continued use of the treatment.
7.	Proved. 19 September 2012 is one of the dates set out in Schedule 2 to the charge and the Committee has already found at 2(d) that on this date, Mr Naisby failed to take a radiograph that was clinically indicated. It has also found that he did not take any radiographs subsequently.
8. (a)	Proved.
8. (b)	Proved. The Committee considered 8(a) and 8(b) separately, but reached the same finding in respect of both. The Committee has found that Mr Naisby did not maintain appropriate records, as he did not record at all the presence of carious lesions on 11 January 2010 and 31 August 2011. Mr Naisby must have identified the presence of carious lesions on the dates in question, as he chose to provide and continue providing ozone treatment to Patient A. However, there is no record that he identified caries on either date in the clinical records for Patient A.
8. (c)(i)-(vii)	Having found heads 2(a) to (c) proved, the Committee has made no findings in relation to the alternative allegations at 8(c)(i) to (vii).
8. (d)(i)-(iii)	Having found head 4(a) proved, the Committee has made no findings in relation to the alternative allegations at 8(d)(i) to (iii).
8. (e)(i)-(v)	Having found head 4(b), 4(d), 5, 6(a) and 6(b) proved, the Committee has made no findings in relation to the alternative allegations at 8(e)(i) to (v).
8. (f)	Proved. The Committee accepted the evidence of Ms Karpeta that the prognosis of longevity for LRD and LRE needed to be dicussed with Patient A and/or Patient A's parents, given the history of these teeth. That history included multiple fractures and five ozone treatments. There is nothing in the clinical records for Patient A to suggest that such a conversation took place and Witness A stated that the prognosis of the teeth was not dicussed. The Committee has accepted her evidence.

8. (g)	Proved. The Committee was satisfied on the evidence of Witness A that Mr Naisby did not discuss the dental history of the fractured LLE present on 19 September 2012. In reaching its decision, the Committee took into account Ms Karpeta's answer to a question from the Committee about the possibility of the LLE having fractured before Patient A was ever seen by Mr Naisby. Ms Karpeta referred the Committee to the notes of Patient A's first appointment with Mr Naisby in January 2010, where there is no mention of a fracture at that time. Further, the Committee accepted Ms Karpeta's opinion that it is unlikely that Mr Naisby would have started ozone treatment on a tooth that had already fractured.
8. (h)	Proved. The Committee has found that the assessment made by Mr Naisby was not adequate. Mr Naisby has made reference in the clinical records for Patient A to the need for future orthodontic treatment. However, the Committee accepted the opinion of Ms Karpeta that more information was required for the assessment to be deemed adequate. She told the Committee that further detail about the orthodontic requirements of Patient A would have provided the basis for when certain interventions needed to be carried out.
Patient B	
9. (a)	Proved.
9. (b)	Proved. The factual matters at 9(a) and 9(b) are evidenced by Mr Naisby's clinical records for Patient B.
10.(a)(i)	Proved.
10.(a) (ii)	Proved.
10.(a)(iii)	Proved.
10.(a)(iv)	Proved.
10.(a)(v)	Proved.
10.(a) (vi)	Proved.
10.(a)(vii)	Proved.
10.(a)(viii)	Proved.
10.(a)(ix)	Proved. The Committee considered 10(a)(i) to (ix) separately, but reached the same finding in respect of each allegation. The Committee has found that Mr Naisby failed to carry out adequate assessments of Patient B's periodontal condition on all of the dates in question. There is evidence in the clinical records for Patient B that Mr Naisby did carry out some assessment, as he undertook Basic Periodontal

	Examinations (BPEs). However, the Committee accepted the evidence of Ms Karpeta that Mr Naisby was required to do more. She stated that the guidelines issued by the British Society for Periodontology indicate that six-pocket charting should be undertaken following BPE scores of 3, as was the case with Patient B on these dates. There is no evidence in the clinical records for Patient B to suggest that more detailed assessment of the periodontal condition was carried out by Mr Naisby.
10.(b)(i)	Proved. The Committee has found that Mr Naisby did not prepare or provide a treatment plan to Patient B on or about 10 April 2012. The Committee accepted the evidence of Ms Karpeta, who stated in her second report that, as the LL1 had then recently been treated by way of a cosmetic crown, Mr Naisby should have explored the reason for its failure, compiled a written treatment plan and placed it in the clinical records. She also confirmed that a copy of the written treatment plan setting out the different options for treatment, including their risks and benefits should have been provided to the patient. Given Ms Karpeta's opinion, the Committee concluded that a written treatment plan should have been provided to Patient B regardless of the emergency repair work carried out at LL1 on or about the date in question. There is no evidence of such a written treatment plan in the clinical records for Patient B. The Committee has concluded that a treatment plan was neither prepared nor provided.
10.(b)(ii)	Proved. The Committee has found that Mr Naisby did not prepare or provide any treatment plan to Patient B on or about 31 July 2012 and 9 August 2012. The Committee accepted the evidence of Ms Karpeta, who stated in her second report that Mr Naisby should have provided a written treatment plan to the patient, setting out the different options for treatment of the LL7, including their risks and benefits. Ms Karpeta highlighted that one of the treatment options should have been the referral of Patient B to a specialist. There is no evidence of such a written treatment plan in the clinical records for Patient B. The Committee has concluded that a treatment plan was neither prepared nor provided.
10.(c)(i)	Proved.
10.(c)(ii)	Proved. In making its findings at 10(c)(i) and 10(c)(ii), the Committee considered the wording of the stem at 10(c) and did not regard these allegations as alternatives to 10(b)(i) and 10(b)(ii). The Committee considered that the provision of written treatment plans and oral discussions were both actions that Mr Naisby could have undertaken. The Committee considered 10(c)(i) and 10(c)(ii) separately, but reached the same finding in respect of both allegations. The Committee has found that Mr Naisby failed adequately to discuss verbally with Patient B his available treatment options on or about 10 April 2012 and on or about 31 July 2012

	and on or about 9 August 2012. Witness B told the Committee that Mr Naisby did discuss with him the treatments that he eventually carried out in respect of the LL1 and LL7. He stated, however, that there was no discussion about other treatment options or risks or benefits. Patient B said that he had no reason to doubt Mr Naisby's decisions. On the basis of Patient B's evidence, the Committee concluded that there had been little or no discussion about treatment options on the occasions in question.
10.(d)	Proved. The Committee accepted Ms Karpeta's evidence that Mr Naisby should have taken a periapical radiograph on or about 10 April 2012. She explained to the Committee that whilst there were previous radiographs of LL1, these were not adequate. There is no evidence to suggest that a periapical radiograph was taken on 10 April 2012 and the Committee has concluded that it was more likely than not that Mr Naisby did not take one.
10.(e)(i)	Proved.
10.(e)(ii)	Proved.
10.(e) (iii)	Proved.
10.(e) (iv)	Proved. The Committee considered 10(e)(i) and 10(e)(iv) separately, but reached the same findings in respect of all the allegations. The Committee has found that on or about 12 April 2011 and 3 August 2011 Mr Naisby failed to discuss with Patient B adequately the risks and benefits of treatment. The Committee was satisfied that there was evidence of some discussion with the patient, but it was not satisfied that the discussion was adequate. Patient B told the Committee that he was not informed of the risks and benefits of the treatments carried out on the respective dates. He also told the Committee that he had been unaware that he had periodontal disease. In the Committee's view, any discussion that excluded the mention of the periodontal disease, which was one of Patient B's main dental problems, was not adequate.
10.(f)	Proved. In the light of its findings at 10(e) above, the Committee has found that Mr Naisby failed in all circumstances to use best endeavours to ensure that Patient B understood the risks of the said treatment on or about 12 April 2011 and on or about 3 August 2011. The Committee accepted the evidence of Ms Karpeta that Mr Naisby had a duty to ensure that Patient B understood the risks.
10.(g)(i)	Proved.
10.(g)(ii)	Proved.
10.(g)(iii)	Proved.

10.(g)(iv)	Proved.
10.(g)(v)	Proved.
10.(g)(vi)	Proved.
10.(g)(vii)	Proved.
10.(g)(viii)	Proved.
10.(g)(ix)	Proved. The Committee considered 10(g)(i) to 10(g)(ix) separately, but reached the same finding in respect of all the allegations. The Committee has found that Mr Naisby wholly failed to diagnose Patient B's periodontal disease on all of the dates in question. The Committee took into account that, in respect of Patient B, Mr Naisby recorded BPEs of 3 on some occasions. It had regard to the evidence of Ms Karpeta that BPEs are a screening tool and not a diagnostic tool. She told the Committee that Mr Naisby should have made a diagnosis. On the basis of her evidence, the Committee was satisfied that the BPE scores could not constitute a diagnosis. There is no other evidence in the clinical records for Patient B to suggest that Mr Naisby reached a diagnosis.
10.(h)(i)	Proved.
10.(h)(ii)	Proved.
10.(h)(iii)	Proved.
10.(h)(iv)	Proved.
10.(h)(v)	Proved.
10.(h)(vi)	Proved.
10.(h)(vii)	Proved.
10.(h)(viii)	Proved.
10.(h)(ix)	Proved. The Committee considered 10(h)(i) to 10(h)(ix) separately, but reached the same finding in respect of all the allegations. The Committee has found that Mr Naisby wholly failed to treat Patient B's periodontal disease by way of root surface debridement on all of the dates in question. The Committee accepted the evidence of Ms Karpeta that Patient B's periodontal condition was such that root surface debridement was the treatment required. She told the Committee that root surface debridement is usually carried out under local anaesthetic and over a number of appointments. There is no evidence in the clinical records to suggest that a local anaesthetic was administered to Patient B on any of the dates in question. Further, Patient B told the Committee that having subsequently experienced root surface debridement, he was certain that Mr Naisby never provided him with this treatment. The Committee accepted this evidence.

10.(i)	Proved. The Committee has found that Mr Naisby failed to inform Patient B of his periodontal disease on all of the dates in question. The Committee accepted the evidence of Patient B, who said that he had been unaware that he had periodontal disease until it was diagnosed by his subsequent treating dentist. Patient B told the Committee that he now understands the relevance of BPE scores, but did not during the time he was under the care of Mr Naisby.
10.(j)(i)	Proved. The Committee was satisfied on the evidence that Mr Naisby did undertake cosmetic dental treatment for Patient B on or about 18 January 2008 without resolving the apical pathology at UR1 and UR2. It accepted Ms Karpeta's evidence that Mr Naisby should have resolved the pathology prior to starting the cosmetic work.
10.(j)(ii)	Proved. The Committee was satisfied on the evidence that Mr Naisby did undertake cosmetic dental treatment for Patient B between 23 March 2011 and 18 August 2011 at UR2, UR1, UL1 and UL2. It has already accepted that root surface debridement was not carried out at any time by Mr Naisby to treat Patient B's periodontal disease. The Committee accepted the evidence of Ms Karpeta that this should have been done prior to the cosmetic work in order to constitute adequate treatment.
10.(k)(i)	Proved.
10.(k)(ii)	Proved.
10.(k)(iii)	Proved. The Committee considered 10(k)(i) to 10(k)(iii) separately, but reached the same finding in respect of all three allegations. There is no evidence to suggest that Mr Naisby took any clinically indicated steps to resolve Patient B's periapical pathology prior to the provision of cosmetic crowns. The Committee accepted the evidence of Ms Karpeta that he should have taken the required steps, either by way of 're root' treatment or apicectomy, in order to ensure the longevity of the crowns. The Committee was therefore satisfied that Mr Naisby provided a poor standard of treatment to Patient B, as alleged on all of the dates concerned.
10.(k)(iv)	Proved. The Committee has found that Mr Naisby failed to take any steps to assess, diagnose or treat radiographically evident bone loss. The Committee was satisfied from the radiographic evidence that there was bone loss at LL1. It accepted the evidence of Ms Karpeta that this should have been assessed, diagnosed and treated by Mr Naisby. The Committee found no evidence to suggest that he did do so. It concluded that Mr Naisby provided a poor standard of care to Patient B, as alleged on or about the two

	dates in question.
10.(k)(v)	Proved. The Committee has found that Mr Naisby failed to take any steps to resolve and stabilise the radiographically evident periapical pathology and vertical bone resorption. The Committee was satisfied from the radiographic evidence that these problems were evident at LL1. It accepted the evidence of Ms Karpeta that they should have been resolved and stabilised by Mr Naisby. The Committee found no evidence to suggest that he did so. It concluded that Mr Naisby provided a poor standard of care to Patient B, as alleged on or about the date in question.
10.(k)(vi)	Proved. The Committee has found that Mr Naisby failed to take any steps to resolve the radiographically evident carious lesions. The Committee was satisfied from the radiographic evidence that there were carious lesions at LL7. It accepted the evidence of Ms Karpeta that these should have been resolved by Mr Naisby. The Committee found no evidence to suggest that he did do so. It concluded that Mr Naisby provided a poor standard of care to Patient B, as alleged on or about the two dates in question.
10.(k)(vii)	Proved. The Committee accepted the evidence of Ms Karpeta. She stated that more conservative treatment should have been undertaken as a first option, particularly as the LR1 was a previously unrestored tooth. The Committee was satisfied from her evidence that the provision of a crown, which involves irreversible preparation of an already narrow tooth, should not have been Mr Naisby's first choice of treatment. It concluded that Mr Naisby provided a poor standard of care to Patient B, as alleged on or about the date in question.
10.(k)(viii)	Proved. On the basis of Ms Karpeta's evidence, the Committee was satisfied that an operative intervention was required in the circumstances. The Committee accepted Ms Karpeta's opinion that there was no justification for the provision of antibiotics. The Committee concluded that Mr Naisby provided a poor standard of care to Patient B, as alleged on or about the date in question.
10.(k)(ix)	Proved. The Committee accepted Ms Karpeta's opinion that he should have "temporised" the LL7 and referred Patient B to a specialist endodontist. There is no evidence to suggest that he did either of these things. The Committee concluded that Mr Naisby provided a poor standard of care to Patient B, as alleged on or about the date in question.

11.(a)	Proved.
11.(b)	Proved.
11.(c)	Proved.
11.(d)	Proved.
11.(e)(i)	Proved.
11.(e)(ii)	Proved.
11.(e)(iii)	Proved.
11.(e)(iv)	Proved.
11.(e)(v)	Proved.
11.(e)(vi)	Proved.
11.(e)(vii)	Proved.
11.(f)	Proved.
11.(g)	Proved. The Committee considered heads of charge 11(a) to 11(g) separately, but reached the same finding in respect of each of the allegations. On the basis of Ms Karpeta's evidence, the Committee concluded that informed consent could only have been obtained if Patient B was aware of all the viable options for treatment. It was satisfied from Patient B's evidence that he was not aware of all the treatment options. The Committee has therefore found that informed consent was not obtained on the dates in question in respect of the treatments Mr Naisby provided to Patient B.
12.	Having found heads of charge 11(a) to 11(g) proved, the Committee has made no findings in relation to the alternative allegation at head of charge 12.
13.(a)(i)	Proved. The Committee has found that Mr Naisby failed to record any evaluation of the radiographs taken on 25 January 2007. The Committee accepted the evidence of Ms Karpeta that recording an evaluation is required by law under the *Ionising Radiation (Medical Exposure) Regulations 2000.* The Committee was therefore satisfied that Mr Naisby had an obligation to record an evaluation. There is no record of an evaluation in the clinical records for this date.
13.(a)(ii)	Proved. The Committee has found that Mr Naisby failed to record any adequate evaluation of the radiographs taken on 14 December 2007. The Committee noted that a working length is recorded in the relevant clinical records. However, taking into account the evidence of Ms Karpeta about what forms an adequate evaluation, the Committee was not satisfied

	that this single reference to the working length was adequate.
13.(a)(iii)	Proved. The Committee has found that Mr Naisby failed to record any evaluation of the radiographs taken on 20 January 2009. There is no record of an evaluation in the clinical records for this date.
13.(a)(iv)	Proved. The Committee has found that Mr Naisby failed to record any adequate evaluation of the radiographs taken on 14 August 2009. There is an indication in the relevant clinical records that Mr Naisby carried out some evaluation, as it is recorded that the bitewings were “ok”. However, the Committee considered that this brief entry was not an adequate evaluation.
13.(a)(v)	Proved. The Committee has found that Mr Naisby failed to record any adequate evaluation of the radiographs taken on 3 September 2010. There is an indication in the relevant clinical records that Mr Naisby carried out some evaluation, as it is recorded “NAD”, which Ms Karpeta said probably meant ‘nothing abnormal detected’. However, the Committee considered that this brief entry was not an adequate evaluation.
13.(a)(vi)	Proved. The Committee has found that Mr Naisby failed to record any evaluation of the radiographs taken on 12 April 2011. There is no record of an evaluation in the clinical records for this date.
13.(a)(vii)	Proved. The Committee has found that Mr Naisby failed to record any evaluation of the radiographs taken on 9 August 2012. There is no record of an evaluation in the clinical records for this date.
13.(a)(viii)	Proved. The Committee has found that Mr Naisby failed to record any evaluation of the radiographs taken on 4 July 2013. There is no record of an evaluation in the clinical records for this date.
13.(b)(i)	Proved. The Committee has found that Mr Naisby failed to record or justify the taking of one radiograph on 14 December 2007. This radiograph was taken in respect of the UL1 and UR1 and there is no record of any such radiograph in the relevant clinical records concerning these teeth. The Committee was satisfied from the evidence of Ms Karpeta that Mr Naisby should have made a record and should have justified his taking of the radiograph.

13.(b)(ii)	Not proved. The Committee was not satisfied that the radiographic evidence was sufficient to conclude that the working length recorded by Mr Naisby was inadequate. Ms Karpeta's opinion was that the extrusion of the root filling material implied an incorrect recording of the working length. However, the Committee has found that the extrusion was more likely to have been an operative error because there is a radiograph showing a working length without extrusion. It has therefore found that the GDC has not discharged its burden in relation to this head of charge.
13.(c)	Proved.
13.(d)	Proved.
13.(e)	Proved. The Committee considered 13(c) to 13(e) separately, but reached the same finding in respect of each of the allegations. The Committee has found that Mr Naisby failed to record or retain any written treatment plans in respect of the treatments provided on the dates in question. There is no evidence of any written treatment plans in the clinical records for Patient B and the Committee noted Ms Karpeta's evidence that these should have been included in the notes. The Committee concluded that it was more likely than not that Mr Naisby had neither recorded nor retained any.

We move to Stage Two."

On 18 August 2016 the Chairman announced the determination as follows:

"Mr Mulchrone,

Mr Naisby is neither present nor represented at this hearing. You have presented the case for the General Dental Council (GDC).

The Committee has considered all of the evidence presented to it. It has taken into account your submissions made on behalf of the GDC, as well as the letter of 13 October 2014, which was sent by Mr Naisby to the GDC during the early stages of investigation. The Committee has accepted the advice of the Legal Adviser.

At this stage of the proceedings, the Committee's tasks have been to consider whether the facts found proved against Mr Naisby amount to misconduct, and if so, whether his fitness to practise is currently impaired by reason of that misconduct. If current impairment is found, the Committee proceeds to consider what sanction, if any, to impose on Mr Naisby's registration.

Misconduct

The Committee has found all but one of the allegations proved in this case. It has made no findings in respect of allegations which were put forward as alternatives. The facts found proved relate to the dental care and treatment Mr Naisby provided to two patients, Patient A, a minor and Patient B, an adult patient.

Mr Naisby treated Patient A between 11 January 2010 and 16 April 2014 and Patient B between 28 January 2005 and 4 July 2013. In Mr Naisby's care and treatment of both patients, there were a significant number of failings in fundamental areas of dentistry. These included failings in:

- obtaining and updating medical history;
- treatment planning;
- obtaining informed consent;
- assessments and dental charting;
- diagnosing and appropriately treating caries;
- diagnosing and treating periodontal disease;
- radiography;
- antibiotic prescribing;
- the provision of relevant advice;
- identifying the need for specialist referral; and
- record keeping.

In considering whether the proven facts in this case amount to misconduct, the Committee has taken into account that a finding of misconduct in this regulatory context requires a serious falling short of the standards to be expected of a registered dental professional. It had regard to the GDC standards as set out in *'Standards for Dental Professionals (May 2005)'*: These were the standards applicable for most of the relevant period. The Committee considered the following paragraphs of that publication:

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

1.3 Work within your knowledge, professional competence and physical abilities. Refer patients for a second opinion and for further advice when it is necessary, or if the patient asks. Refer patients for further treatment when it is necessary to do so.

1.4 Make and keep accurate and complete patient records, including a medical history, at the time you treat them. Make sure that patients have easy access to their records.

1.5 Give patients who make a complaint about the care or treatment they have received a helpful response at the appropriate time. Respect the patient's right to complain. Make sure that there is an effective complaints procedure where you work and follow it at all times. Co-operate with any formal inquiry into the treatment of a patient.

1.10 Do not make any claims which could mislead patients.

2.2 Recognise and promote patients' responsibility for making decisions about their bodies, their priorities and their care, making sure you do not take any steps without patients' consent (permission). Follow our guidance 'Principles of patient consent'.

2.4 Listen to patients and give them the information they need, in a way they can use, so that they can make decisions. This will include:

- communicating effectively with patients;
- explaining options (including risks and benefits); and
- giving full information on proposed treatment and possible costs.

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

This case relates to multiple clinical failings in respect of two patients over a long period of time. Mr Naisby's conduct in failing to obtain and update medical history, prescribing antibiotics without justification and failing to take radiographs that were clinically indicated were all matters that placed the patients at serious risk of harm. Mr Naisby also caused actual harm as a result of the shortcomings in his clinical practice. His consistent failure to diagnose and treat dental disease had ramifications for Patient A and Patient B, both of whom required extensive treatment from subsequent treating dentists. The Committee has found that Mr Naisby completely failed to obtain informed consent for the treatments he carried out and it considered that this amounted to a breach of trust between him and his patients, who relied upon his expertise as a dentist. Patient A was a minor and Mr Naisby continuously neglected to provide sufficient information to the parent(s) of this patient so that they could make informed decisions about the patient's dental care. In Patient B's case, the Committee was of the view that Mr Naisby focused on cosmetic treatment, when he should have been resolving the patient's chronic periodontal disease.

Taking all of these matters into account, the Committee agreed with the opinion of Ms Vassia Karpeta, the expert witness called by the GDC, that Mr Naisby's conduct fell far below what was expected of a general dental practitioner in many respects. It has therefore determined that the facts found proved in this case amount to misconduct.

Impairment

The Committee next considered whether Mr Naisby's fitness to practise is currently impaired by reason of his misconduct. In reaching its decision, the Committee has exercised its independent judgement. It has remained mindful of its duty to consider the public interest, which includes the protection of patients, the maintenance of public confidence in the profession, and the declaring and upholding of proper standards of conduct and behaviour.

There were very serious clinical failings on Mr Naisby's part in respect of the two patients in question. The only information that the Committee has from Mr Naisby is his letter of 13 October 2014, which outlines some of his thinking at the time of the events in question, but does not directly address the numerous concerns that have been raised.

There is no evidence of Mr Naisby's insight. In considering the issue of insight, the Committee had regard to the information you provided regarding Mr Naisby's fitness to practise history. Mr Naisby was issued with a letter of advice in November 2006, following concerns about the wording of some of his professional literature, and in April 2011 Mr Naisby was issued with a published warning over his behaviour to his staff and patients. The Committee accepted that these individual matters were not of a similar kind to the allegations found proved at this hearing. However, it noted that those concerns occurred during the relevant time period and that Mr Naisby was reminded in the published warning of

April 2011 of his duty to put his patients first. He repeatedly failed to adhere to this duty in the cases of Patient A and Patient B. There is no evidence of Mr Naisby's remorse or any apology to the two patients in question.

In the absence of any evidence of insight, remorse or restitution, the Committee considered that it was highly likely that Mr Naisby could repeat his misconduct. It therefore decided that there was an ongoing issue of patient safety.

The Committee went on to consider the wider public interest. In its judgement, Mr Naisby's conduct has breached fundamental tenets of the dental profession and has the potential to bring it into disrepute. The Committee was of the view that public confidence in the dental profession would be undermined if a finding of impairment were not made in the circumstances of this case.

Nonetheless, the Committee considered that the deficiencies in Mr Naisby's practice could be capable of being remedied through extensive professional rehabilitation. However, given his lack of engagement with this regulatory process, there is no evidence before this Committee to suggest that he has undertaken any steps to remedy the failings that have been identified.

The Committee has determined that Mr Naisby's fitness to practise is currently impaired

Sanction

The Committee considered what sanction, if any, to impose on Mr Naisby's registration. 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.

In reaching its decision, the Committee took into account the '*Guidance for the Practice Committees including Indicative Sanctions Guidance (effective from October 2015)*'. It considered the range of sanctions available to it, starting with the least serious. The Committee applied the principle of proportionality, balancing the public interest with Mr Naisby's own interests.

In view of Mr Naisby's serious, fundamental and widespread failings and his lack of engagement, the Committee has determined that it would be inappropriate to conclude this case without taking any action in respect of his registration. It reached the same conclusion in respect of a reprimand. These courses of action would not serve to protect the public from potential harm, nor would they satisfy the wider public interest. The Committee also took into account that Mr Naisby had already received a letter of advice and a published warning during the relevant period.

The Committee considered whether to impose conditions on Mr Naisby's registration. It had regard to the fact that any conditions imposed would need to be appropriate, workable and measurable. There has been virtually no engagement by Mr Naisby with the GDC and as such the Committee was not persuaded that he would comply with conditional registration if imposed. Further, the Committee took into account the serious and extensive nature of his misconduct and it concluded that conditions would not be appropriate in any event.

The Committee went on to consider whether to suspend Mr Naisby's registration. It again took into account his serious failings in relation to the two patients, many of which were repeated and persisted over a number of years. In the absence of any evidence of Mr Naisby's insight or remorse, the Committee was of the view that suspending his registration would serve no meaningful purpose. Mr Naisby has failed to engage with his regulatory body

in the face of serious allegations and there has been no evidence to date of any understanding on his part of the gravity of harm he caused to the patients in this case, one of whom was a minor and thus particularly vulnerable. The Committee considered that Mr Naisby's behaviour in this regard is such that it is incompatible with continued registration as a dental professional. It has therefore concluded that a period of suspension would not be sufficient or appropriate.

In all the circumstances, the Committee has determined that the only appropriate and proportionate sanction to protect patients, to uphold proper standards and to maintain public confidence in the profession, is to erase Mr Naisby's name from the Dentists Register.

Unless Mr Naisby exercises his right of appeal, his name will be erased from the Dentists Register 28 days from the date when notice is deemed to have been served upon him.

The Committee now invites submissions from you, on behalf of the GDC, as to whether Mr Naisby's registration should be suspended immediately, pending the taking effect of its substantive determination."

"Mr Mulchrone,

In deciding whether to impose an immediate order on Mr Naisby's registration, the Committee has taken into account your submission made on behalf of the GDC that such an order should be imposed. It has accepted the advice of the Legal Adviser.

The Committee has determined that it is necessary for the protection of the public and is otherwise in the public interest to impose an order for the immediate suspension of Mr Naisby's registration. In light of the Committee's findings, particularly that there is an ongoing risk to the public, the Committee considered that it would be inconsistent not to impose an immediate order in the circumstances.

The effect of the foregoing determination and this order is that Mr Naisby's registration will be suspended from the date on which notice is deemed to have been served upon him. Unless he exercises his right of appeal, the substantive direction for erasure, as already announced, will take effect 28 days from the date of deemed service.

Should Mr Naisby exercise his right of appeal, this immediate order for suspension will remain in place until the resolution of any appeal.

That concludes this hearing."