General
Dental
Council

HEARING HEARD IN PUBLIC

KOZLICKI, Krzysztof Piotr

Registration No: 109045

PROFESSIONAL CONDUCT COMMITTEE

MARCH 2020

Outcome: Erased with Immediate Suspension

Krzysztof Piotr KOZLICKI, a dentist, Lek Dent Katowice 1986, was summoned to appear before the Professional Conduct Committee on 24 February 2020 for an inquiry into the following charge:

Charge

"That being registered as a dentist:

Patient B

1. On 19 June 2017, you failed to provide an adequate standard of care to Patient B in that you:
    a. failed to write an adequate report of the radiograph taken on the 19 June 2017;
    b. pre-entered notes in Patient B's dental records regarding the radiograph taken on the 19 June 2017.
2. On 21 November 2018, you failed to take a written or verbal medical history from Patient B before commencing treatment.
3. On 21 November 2018, you failed to:
    a. discuss all material risks and benefits of proposed treatment in relation to Patient B; and/or
    b. make a record of any discussion of the of risks and benefits of proposed treatment in relation to Patient B.
4. You failed to obtain informed consent for the treatment provided to Patient B on 21 November 2018.

Patient C

5. On 8 May 2017, you failed to:
    a. discuss all material risks and benefits of proposed treatment with Patient C;
    b. make a record in Patient C's dental records of any discussion relating to material risks and benefits of proposed treatment.
6. On 8 May 2017, you failed to:
    a. discuss alternative treatment options with Patient C; and/or
    b. make a record in Patient C's dental records of any discussion relating to alternative treatment options.
7. On 8 May 2017, you failed to:

a. discuss the prognosis for UR1 with Patient C; and/or

b. make a record in Patient C's dental records of any discussion relating to the prognosis for UR1.

8. On 8 May 2017, you provided an inadequate standard of restoration on UR1.

9. Between 26 July 2016 and 21 December 2018, you failed to provide an adequate standard of care to Patient C in that:

a. there was an inadequate report on the radiographs taken on:

i. 8 May 2017;

ii. 18 October 2018;

iii. 21 November 2018; and,

iv. 6 December 2018.

b. you failed to write reports on the periapical radiographs taken on:

i. 18 October; and,

ii. 6 December 2018.

c. on the following dates you entered pre-entered notes in Patient C's dental records, namely:

i. 25 July 2016;

ii. 25 April 2017;

iii. 8 May 2017;

iv. 8 November 2017;

v. 17 April 2018;

vi. 18 October 2018.

d. you failed to carry out and/or record a full assessment of the patient's presenting dental condition.

10. On 6 November 2018, you removed an excessive amount of coronial tissue from UR1.

11. On 21 November 2018, you failed to:

a. discuss treatment options with Patient C; and/or

b. make any record in Patient C's dental records of any discussion relating to Patient C's treatment options.

12. On 21 November 2018 you failed to:

a. to discuss all material risks and benefits of proposed treatment with Patient C; and/or

b. make any record in Patient C's dental records of any discussion relating to the risks and benefits of Patient C's proposed treatment.

13. On 21 November 2018, you failed to communicate effectively with Patient C in that you failed to properly explain the procedure to be undertaken.

14. You provided a poor standard of endodontic treatment to UR1, in that you:

    a. failed to use a rubber dam whilst root filling UR1 on 21 November 2018;

    b. took a radiograph of Patient C before the coronal seal had been achieved on 21 November 2018;

    c. failed to provide a treatment plan for the UR1 on 21 November 2018;

    d. used an air rotor to expand and shape the canal orifice during the root filling of UR1.

15. On 06 and/or 21 November 2018, you failed in your duty of candour, in that you failed to explain to patient C that:

    a. excessive tooth tissue had been removed from UR1;

    b. the lateral wall of UR1 had been compromised;

    c. the prognosis for UR1.

Patient D

16 You did not provide an adequate standard of care to Patient D in that:

    a. you failed to carry out and/or record dental charting on:

        i. 5 September 2016;

        ii. 3 April 2017;

        iii. 3 October 2017;

        iv. 26 April 2018; and,

        v. 9 August 2018.

    b. on 12 August 2016, you failed to diagnose caries, either clinically and/or with a radiograph at:

        i. UL7;

        ii. LL5; and

        iii. LL6.

    c. you failed to report a radiograph had been taken of UL7, LL5, LL6 on the 12 August 2016.

17. On 12 August 2016, you inappropriately prescribed antibiotics to Patient D.

18. Following your examination of Patient D on 3 April 2017, you failed to identify periodontal disease in UL7.

19. You failed to accurately report on the radiograph taken on 26 April 2018.

20. You pre-entered notes in Patient D's dental records regarding the radiograph on the following dates:

    a. 26 April 2018;

    b. 9 August 2018.

21. You provided a poor standard of restoration of LL6.

22. On 2 November 2018, you did not carry out sufficient diagnostic assessment of LL5.

23. On 2 November 2018, you root filled LL5 without having recorded the reasons for doing so in Patient D's dental records.

24. On 23 November 2018, you:

    a. perforated the medial aspect of Patient D's LL5;

    b. failed to identify that you had perforated the medial aspect of Patient D's LL5;

    c. irrigated Patient D's LL5 with 3% sodium hydroxide solution.

25. On 7 December 2018, you failed to adequately communicate with Patient D, in that you failed to confirm with Patient D the treatment that was due to be provided.

26. On 7 December 2018, you failed to obtain informed consent for the treatment provided.

27. You provided a poor standard of endodontic treatment to LL5 on the 7 December 2018, in that you:

    a. perforated the mesial wall of Patient D's LL5 tooth;

    b. failed to identify the perforation in the mesial aspect of LL5 from the radiographs taken on;

    c. used a sodium hypochlorite solution to irrigate the perforated LL5;

    d. failed to refer the patient to a specialist having perforated the mesial aspect of LL5.

28. You failed to use a rubber dam during the patient's root canal treatment on:

    a. 7 December 2018;

    b. 7 January 2019.

29. On 7 December 2018, you failed in your duty of candour, in that you failed to explain to patient D:

    a. why the procedure was stopped;

    b. the treatment options available following perforation;

    c. the risk of post-operative pain due to the incorrect use of sodium hydrochloride;

    d. the reduced prognosis for the tooth.

30. Following the appointment on 7 December 2018, you failed to provide appropriate aftercare to Patient D, in that:

    a. you failed to monitor patient D for periodontal disease;

    b. you failed to monitor patient D for bone loss;

    c. failed to include the filling in LL6 in the patient's treatment plan;

    d. failed to provide a filling in LL6.

31. On 7 January 2019, you failed to provide an adequate standard of care during the root filling of LL5, in that you failed to use a rubber dam.

Patient E

32. You did not provide an adequate standard of care to Patient E in that:
    a. you inappropriately prescribed antibiotics to Patient E on 16 November 2018;
    b. you failed to use a rubber dam:
        i. whilst taking the periapical radiograph on the 19 December 2018;
        ii. whilst administering local anaesthetic on 9 January 2019;
        iii. whilst root filling LL6 on the 9 January 2019.
    c. you removed excessive coronial tissue from LL6.
33. On 9 January 2019, you failed to adequately communicate with Patient E, in that you failed to confirm with Patient E the treatment that was due to be provided.
34. On 9 January 2019, you failed to obtain informed consent from Patient E:
    a. prior to starting treatment;
    b. prior to administering local anaesthetic.
35. You failed in your duty of candour, in that you failed to explain to Patient E:
    a. that excessive coronial tissue had been removed from LL6 on 9 January 2019;
    b. the impact on the prognosis for LL6;
    c. the treatment options available following perforation of LL6.

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

On 3 March 2020 the Chairman made the following statement regarding the finding of facts:

"This is the Professional Conduct Committee's inquiry into the facts which form the basis of the allegation against Mr Kozlicki that his fitness to practise is impaired by reason of misconduct. Mr Kozlicki did not attend the hearing and was not represented. Ms Natasha Tahta of Counsel presented the General Dental Council's (GDC) case.

Preliminary Matters

At the outset of the hearing, Ms Tahta made an application under Rule 54 of the General Dental Council (Fitness to Practise) Rules 2006 ("the Rules") that the hearing should proceed in Mr Kozlicki's's absence. She submitted that the notification of hearing had been served on Mr Kozlicki in accordance with Rules 13 and 65.

Decision on Service of the Notice of Hearing (24 February 2020)

The Committee received from the GDC an indexed hearing bundle of 955 pages, which contained a copy of the Notice of Hearing ('the notice'), dated 22 January 2020, thereby complying with the 28-day notice period. The hearing bundle also contained a Royal Mail 'Track and Trace' receipt confirming that the notice was sent to Mr Kozlicki's registered address by Special Delivery. A copy of the notice was also emailed to Mr Kozlicki on 22 January 2020.

The Committee was satisfied that the notice sent to Mr Kozlicki contained proper notification of today's hearing, including its time, date and venue, and the other prescribed information including

notification that the Committee had the power to proceed with the hearing in Mr Kozlicki's absence.

On the basis of the information provided, the Committee was satisfied that notice of the hearing had been served on Mr Kozlicki in accordance with Rules 13 and 65.

Decision on Proceeding in the Registrant's Absence (24 February 2020)

The Committee next considered whether to exercise its discretion under Rule 54 of the Rules to proceed with the hearing in the absence of Mr Kozlicki. The Committee approached the issue of proceeding in absence with the utmost care and caution. It took into account the factors to be considered in reaching its decision, as set out in the case of *R v Jones (Anthony) [2002] UKHL 5* and *GMC v Adeogba & Visvardis [2016] EWCA Civ 162.* It remained mindful of the need to be fair to both Mr Kozlicki and the GDC, taking into account the public interest and Mr Kozlicki's own interests.

The Committee noted that the GDC had taken all possible steps to notify Mr Kozlicki of the hearing, and that they had informed him that he could also attend the hearing by telephone or video link as an alternative to attending in person. It noted that Mr Kozlicki had downloaded the notice, as evidenced by the download receipt which was received by the GDC by email. It also noted the email dated 12 February 2020 from Mr Kozlicki to the GDC, which stated that he will not be attending the hearing as he will no longer be practising in the UK. Furthermore, Mr Kozlicki sent an email to the GDC dated 17 February 2020 and stated, '*I am not going to send any further explanations, I am not going to discuss this matter*'.

The Committee concluded that it was clear that Mr Kozlicki had waived his right to attend the hearing, and he was satisfied that the hearing could proceed in his absence. Given that Mr Kozlicki has voluntarily absented himself and had not requested an adjournment, the Committee determined that it should proceed in his absence having regard to the public interest in the expeditious disposal of cases. It concluded that no useful purpose would be served by an adjournment of this hearing.

In those circumstances, the Committee determined that it was fair and appropriate to proceed with the hearing in the absence of Mr Kozlicki.

Rule 18 Application to Amend the Charge (24 February 2020)

Ms Tahta subsequently made an application under Rule 18 of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules") to amend the charge. She submitted that the amendments would consist of some charges being deleted, the correction of typographical errors, some dates being amended and the inclusion of two additional sub-charges. She submitted that the additional charges are all in line with the conclusions of the report by the expert witness, Mr David Igoe.

In conclusion, she stated that the overall changes would result in no injustice to Mr Kozlicki as they consist mostly of charges being deleted. The other amendments are required so that the charges reflect more accurately the information in Mr Igoe's report and the evidence in the documentary bundle, which Mr Kozlicki has been in receipt of for some time.

The Committee accepted the advice of the Legal Adviser on the Rule 18 application. It was of the view that the amendments made the charges clearer and easier to follow. With regard to the additional charges, it noted that these arose out of the findings in Mr Igoe's report, which Mr Kozlicki has already received as part of the documentary evidence. The additional charges therefore would contain no new information and there would be no injustice caused to Mr Kozlicki

if these charges were included. Indeed, the Committee noted that the changes overall would be beneficial to Mr Kozlicki as 12 heads of charge have been deleted.

Therefore, the Committee granted the application in its entirety.

Background

The case involves the care Mr Kozlicki provided to four patients, Patients B, C, D and E, whilst working as an Associate Dentist. In September 2016, concerns were raised by the Local Area Team about Mr Kozlicki's practice. The main concerns involved his radiographic and endodontic practice.

In September 2018, as a result of these concerns, NHS England imposed conditions on Mr Kozlicki's practice. As part of the conditions, NHS England arranged for Witness B to visit Mr Kozlicki and observe him in practice. These observations took place on 21 November 2018 when Mr Kozlicki treated Patients B and C, 7 December 2018 when he treated Patient D and 9 January 2019 when he treated Patient E. The concerns relating to Mr Kozlicki's treatment of these patients form the basis of the charge before this Committee.

Evidence Received and Assessment of Oral Evidence

By way of factual evidence from the GDC, the Committee was provided with statements from Witness A dated 14 October 2019, Witness B dated 15 October 2019, Witness C dated 16 October 2019 and from Witness D dated 6 December 2019. It also received a report from an expert witness, Mr David Igoe, dated 17 December 2019, and heard oral evidence from him. In addition, it heard oral evidence from Witness B by Skype and telephone. The statements from Witnesses A, C and D were admitted as evidence without the need for them to attend the hearing. The Committee was also provided with a bundle of documentary evidence including patient records and radiographs.

Witness B

The Committee found Witness B to be a credible witness. It noted that she was an independent observer of good standing, who produced a factual report shortly after her observation of his practice which the Committee could rely on. It further noted that during her oral evidence she relied on the findings in her report when she could not remember specific events. The Committee concluded that it could accept her evidence.

Mr David Igoe

The Committee accepted Mr Igoe's evidence and the conclusions in his expert report. The Committee was of the view that his report was very detailed and assisted it in its consideration of the case. The Committee also noted that he was consistent in his oral evidence. The Committee concluded that it could rely on his oral evidence and his expert report.

The Committee's Findings of Fact

The Committee has considered all the evidence presented to it, both oral and documentary. It took account of the submissions made by Ms Tahta on behalf of the GDC. The Committee heard and accepted the advice of the Legal Adviser. In accordance with that advice 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 alleged matters are found proved on the balance of probabilities.

The Committee's findings in relation to each head of charge are as follows:

Patient B	
1.	On 21 November 2018, you failed to:
1 a.	discuss the risks and benefits of proposed treatment in relation to Patient B; **FOUND PROVED** The Committee noted that Patient B attended an emergency appointment on this date for a fractured tooth, and Witness B observed this consultation. It is clear from the dental records, that the patient was likely to have understood that they were undergoing a temporary filling. However, the Committee accepted the findings in Witness B's report when she stated that, '*there was no discussion of treatment options, risks or benefits of the proposed treatment*'. The Committee also noted that there were other treatment options available, but these were not relayed to Patient B. It further noted that, although there is evidence that Mr Kozlicki did discuss the risks and benefits of treatments with Patient B at other appointments, there is no evidence that he did so on this occasion. Accordingly, the Committee found this head of charge proved.
1 b.	obtain informed consent for the treatment provided to Patient B. **FOUND PROVED** Following the Committee's findings at charge 1.a. that Mr Kozlicki failed to discuss the risks and benefits of the proposed treatment, it logically follows that Mr Kozlicki did not obtain informed consent from Patient B. It therefore also finds this head of charge proved.
Patient C	
2.	On 8 May 2017, you provided Patient C with an inadequate standard of restoration on the UR1. **FOUND PROVED** The Committee noted that Witness B did not observe Mr Kozlicki during this appointment. It considered the conclusions in Mr Igoe's report but noted that his opinion was based on a radiograph dated approximately 17 months after the appointment. The Committee considered whether it was possible that the restoration could have been undertaken by a different dentist during this period or the caries could have developed after the appointment. The Committee concluded, however, that Patient C had regularly been seen by Mr Kozlicki during this period and there was no evidence that he had attended another practice during this time The Committee reviewed the radiograph and was of the view that it was an inadequate standard of restoration. It concluded therefore, based on this radiograph and the findings in Mr Igoe's report, that this head of charge is found proved.
3.	Between 26 July 2016 and 21 December 2018, you failed to provide an adequate standard of care to Patient C in that:

	FOUND PROVED In light of the fact that all of head of charge 3 has been found proved below, then it follows that Mr Kozlicki did not provide an adequate standard of care to Patient C. The Committee noted that as a registered dentist he had a duty to provide an adequate standard of care to his patients and that the findings below prove that he had failed in this regard.
3. a.	a. you failed to write an adequate report on the radiograph taken on 8 May 2017; **FOUND PROVED** The Committee accepted the evidence in Mr Igoe's report that the entry in the records was inaccurate and was not a true representation of what was shown in the radiograph. He asserted that there was not an adequate report for the radiograph taken on this date as '*the findings of the radiographs appear to be pre-entered*'. The Committee noted that this was in contravention of the IRMER regulations that are statutory and mandatory. The Committee reviewed the radiograph and the patient's records and concurred with his opinion. The Committee therefore found this head of charge proved.
3. b.	b. You failed to write reports on the radiographs taken on the:
3. b. i.	18 October 2018; **FOUND PROVED** The Committee considered the patient's records and noted that in the entry dated 18 October 2018 there was no report on the radiographs taken on this date. Furthermore, there is an entry in the records for the next appointment on 6 November 2018 that makes reference to radiographs being taken at the previous appointment, i.e. 18 October. The Committee noted that there are copies of radiographs dated 8 October 2018 in the documentary bundle, however, the records show that there was no appointment on the 8 October 2018. It accepted Mr Igoe's evidence that it was more likely that this was an error and that they were taken on 18 October 2018. The Committee concluded therefore that it was more likely than not that the radiographs were taken on 18 October 2018, and not on 8 October 2018, and that the entry in the dental records for 6 November 2018 makes reference to these radiographs. It found that Mr Kozlicki did not report on these radiographs and therefore it found this head of charge proved.
3. b. ii.	6 December 2018. **FOUND PROVED** The Committee had sight of the radiographs taken on 6 December 2018 and the patient's records for that appointment which make no reference to the radiographs. The Committee also accepted the findings in Mr Igoe's report which stated that there was no report of the radiograph in the patient's records. This charge was found proved.

3.c.	You failed to record that two periapical radiographs were taken on 17 April 2018; **FOUND PROVED** The Committee accepted the evidence from Mr Igoe, who stated in his report that two periapical radiographs were taken but only one reported on. The Committee noted that there is evidence in the documentary bundle of two radiographs being taken on 17 April 2018. However, the entry in the patient's records for this date show that only one of the radiographs was acknowledged and reported on. The Committee was satisfied that Mr Kozlicki must have repeated the radiograph as the first one should have been graded a grade 3. The second radiograph was graded a grade 1 and this was the one that was reported on in the records. The Committee therefore found this head of charge proved.
3. d.	On the following dates you failed to adequately amend pre-entered examination notes in Patient C's dental records, namely:
3. d. i	25 July 2016; **FOUND PROVED** The Committee reviewed the patient records for this appointment and noted that there was an entry stating, '*BWs-taken last time-OK*'. However, there was no evidence of bitewing radiographs being taken at the previous appointment, indeed the Committee noted that they had been in fact taken two years previously. The Committee also accepted Mr Igoe's evidence who stated that he was not critical of Mr Kozlicki using a template when entering the records if they were amended accurately which they were not on this occasion. The Committee found this head of charge proved.
3. d. ii.	25 April 2017; **FOUND PROVED** The Committee reviewed the patient records and noted that they mention again that bitewing radiographs were taken. However, there is no evidence for this. The Committee also noted that the records for this appointment were strikingly similar to the notes entered for the appointment on 25 July 2016. It therefore found this head of charge proved.
3. d. iii.	8 November 2017 **FOUND PROVED** The Committee noted from the patient records that the entries for this date were inconsistent with the entries for the previous appointment. For example, Mr Kozlicki stated that there was '*no gums recession*' on 8 November 2017, however, this contradicted the entry for the previous appointment on 8 May 2017 which stated there was '*moderate gums recession'*. It therefore found this head of charge proved.
3. d. iv.	17 April 2018; **FOUND PROVED** The Committee noted that the entry for this record stated that, '*BWs-taken last*

	time-OK', however, the records indicate that bitewing radiographs were not taken at the previous appointment in November 2017 but on 8 May 2017. The Committee concluded that the records were again inconsistent and inaccurate, and therefore found this head of charge proved.
3. d. v.	18 October 2018. **FOUND PROVED** The Committee reviewed the patient records for this date and noted the following entries, '*OH good fair poor, Cessation advise yes no, Capacity yes no, Caries risk low medium high*'. The Committee therefore concluded that the pre-entered notes had not been amended and found this head of charge proved.
4.	Between 6 November 2018 and 21 December 2018, you:
4. a.	removed an excessive amount of coronal tissue from Patient C's UR1; **FOUND PROVED** The Committee noted the findings of Witness B's report which were based on her observations at this appointment. The Committee accepted Mr Igoe's evidence, which was based on Witness B's report, the patient records and the radiographs. Mr Igoe stated that an excessive amount of coronal tissue was removed and the Committee accepted his evidence. It also viewed the radiograph and noted that it was clear that an excessive amount of coronal tissue had been removed. This head of charge was found proved.
4. b.	compromised the lateral wall of Patient C's UR1; **FOUND PROVED** The Committee accepted the evidence of Mr Igoe and Witness B that the lateral wall of Patient C's UR1 was compromised as a result of excessive removal of dentine. This was consistent with the radiographic evidence which showed that the lateral wall had been compromised.
4. c.	provided a substandard post and core to Patient C's UR1. **FOUND PROVED** The Committee accepted the evidence of Mr Igoe and noted that the radiographic evidence shows that the length of the post was inadequate and would have had an adverse impact on the treatment. It found this head of charge proved.
5.	On 21 November 2018, you failed to:
5. a.	discuss treatment options with Patient C; **FOUND PROVED** The Committee accepted the evidence of Witness B, who attended and observed this appointment, that the treatment options were not discussed with Patient C. Witness B is critical of Mr Kozlicki's communication skills. The Committee noted from Witness B's evidence that there had been a material change in the clinical situation as the tooth had fractured since the previous appointment. Therefore, the

	options for the patient had changed and this should have been explained by Mr Kozlicki. Furthermore, there is no evidence in the patient records of treatment options being discussed. The Committee found this head of charge proved.
5. b.	discuss the risks and benefits of proposed treatment with Patient C. **FOUND PROVED** Following the Committee's findings at head of charge 5.a. that Mr Kozlicki failed to discuss the treatment options with Patient C, the Committee concluded that it was more likely than not that Mr Kozlicki also did not discuss the risks and benefits of the proposed treatment. It therefore finds this head of charge proved.
6.	On 21 November 2018, you failed to communicate effectively with Patient C in that you failed to properly explain the procedure to be undertaken. **FOUND PROVED** The Committee accepted the evidence of Witness B that given the fact that the clinical situation had changed Mr Kozlicki had a duty to explain the procedure that was to be undertaken to Patient B, which she stated he failed to do. Also, consistent with its findings at charge 5, where it was found proved that he did not discuss the treatment options or the risks and benefits of the proposed treatment then it is more likely than not that he had also failed to properly explain the procedure to be undertaken. Accordingly, it found this head of charge proved.
7.	On 21 November 2018, you provided a poor standard of endodontic treatment to Patient C's UR1, in that you: **FOUND NOT PROVED** The Committee has found heads of charge 7.a. and 7.c. not proved. The Committee has found 7.b. proved but was of the view that if a rubber dam was in place then there'll be no bacterial ingression and therefore a coronal seal would not be necessary.
7. a.	failed to use a rubber dam whilst taking a radiograph of the UR1; **FOUND NOT PROVED** The Committee noted that Witness B stated in her contemporaneous report that a rubber dam was in place during her observation. In her oral evidence she stated that there was a clamp in place and Mr Kozlicki may have taken the rubber dam off before taking the radiograph. The evidence of Mr Igoe was that there was no rubber dam in place as a clamp is not visible on the radiograph. The Committee viewed the radiograph but was unable to determine whether a rubber dam was in place. It also noted that the radiograph was reported as being a post-operative radiograph but it appears to the Committee to have been taken mid-treatment. The Committee concluded that this head of charge is not proved due to the contradictory evidence available, which meant that it could not be determined

	whether the rubber dam was in place at the time of the radiograph.
7. b.	took a radiograph of the UR1 before the coronal seal had been achieved; **FOUND PROVED** The Committee accepted Mr Igoe's evidence and was of the view that there was clear evidence from the radiograph that the coronal seal had not been achieved at the time the radiograph was taken. It found this head of charge proved.
7. c.	used an air rotor to expand and shape the canal orifice during the root filling of the UR1. **FOUND NOT PROVED** The Committee considered Mr Igoe's report and the radiograph. The Committee noted that based on the radiograph, it was more likely than not that an air rotor was used but this may not have been on 21 November 2018 as it was also used at the appointment on 6 November 2018. The Committee also noted Witness B's report that an air rotor was used at this appointment but could not conclude it was used to shape the canal orifice. The Committee concluded therefore that this head of charge is not proved.
8.	On 21 November 2018, you failed in your duty of candour, in that you failed to explain to Patient C that:
8. a.	excessive tooth tissue had been removed from the UR1; **FOUND PROVED** The Committee considered the radiograph, it noted Witness B's evidence that Mr Kozlicki had not informed Patient C that excessive tooth tissue had been removed. It accepted the evidence of Mr Igoe that any reasonably competent dentist should have realised this and that he had a duty to explain this to the patient. The Committee found no evidence that Mr Kozlicki had informed Patient C of this and, therefore, found this head of charge proved.
8. b.	the lateral wall of the UR1 had been compromised; **FOUND PROVED** The Committee found no evidence that Mr Kozlicki had informed Patient C that the lateral wall of the UR1 had been compromised. It found this head of charge proved.
8. c.	the prognosis for the UR1. **FOUND PROVED** The Committee accepted the evidence of Mr Igoe that the prognosis for the UR1 had been significantly reduced. The Committee found no evidence that Mr Kozlicki had informed Patient C of this. The Committee found this head of charge proved.
Patient D	
9.	You failed to provide an adequate standard of care to Patient D in that:

	FOUND PROVED In light of the fact that all of head of charge 9 has been found proved below, then it follows that Mr Kozlicki did not provide an adequate standard of care to Patient C. The Committee noted that as a registered dentist he had a duty to provide an adequate standard of care to his patients and that the findings below prove that he had failed in this regard.
9. a.	on 12 August 2016, you failed to diagnose caries visible radiographically, at:
9. a. i.	UL7; **FOUND PROVED** The Committee accepted Mr Igoe's report which concluded that caries was visible radiographically on the UL7. It accepted his evidence and it also had sight of the radiograph, which showed caries, and the patient records, which had no record of caries being diagnosed at that point. It therefore found this head of charge proved.
9. a. ii.	LL5; **FOUND PROVED** As above, the Committee noted and accepted the findings of Mr Igoe's report which concluded that caries was visible radiographically on the LL5. It also noted that caries had been diagnosed in LL5 by Mr Kozlicki at a subsequent appointment approximately two months later. It therefore found this head of charge proved.
9. a. iii.	LL6. **FOUND PROVED** As above, the Committee noted and accepted the findings of Mr Igoe's report which concluded that caries was visible radiographically on the LL6. It also noted that caries had been diagnosed in LL6 by Mr Kozlicki at a subsequent appointment approximately two months later. It therefore found this head of charge proved.
9. b.	you failed to adequately report on radiographs taken on:
9. b. i.	12 August 2016; **FOUND PROVED** As per its findings at charge 9.a.i. the Committee accepted Mr Igoe's evidence and noted that there was no report of this radiograph in the patient records. It found this head of charge proved.
9. b. ii	26 April 2018; **FOUND PROVED** The Committee noted and accepted Mr Igoe's report and his oral evidence that an inadequate report was made on this radiograph.

	The Committee had sight of the patient records and the radiograph and noted that there were significant omissions in Mr Kozlicki's report of the radiograph in that he had failed to record that there was significant bone loss and a defect below the crown on a molar tooth. It also noted that Mr Kozlicki had reported on the radiograph a week after the appointment took place. It therefore found this head of charge proved.
9. b. iii.	9 August 2018; **FOUND PROVED** The Committee noted and accepted Mr Igoe's report and his oral evidence that an inadequate report was made on this radiograph. It had also viewed the radiograph and the patient's records which showed that there were omissions in the report regarding bone loss in the bifurcation area and a periapical infection on one of the lower teeth. It therefore found this head of charge proved.
9. b. iv.	2 November 2018; **FOUND PROVED** The Committee accepted Mr Igoe's evidence and noted that the patient's records do not record the defect in the LL6, the inadequate restoration and the general bone loss which is visible on the radiograph. It found this head of charge proved.
9. b. v.	7 December 2018 **FOUND PROVED** The Committee took into consideration Mr Igoe's report, his oral evidence, the radiograph and the patient records. It noted that there was no report of this radiograph in the records and therefore no information in respect of the clinical findings on LL6 and LL5. It found this head of charge proved.
10.	On 12 August 2016, you inappropriately prescribed antibiotics to Patient D. **FOUND PROVED** The Committee accepted the findings in Mr Igoe's report and considered the patient records. It concluded that antibiotics were inappropriately prescribed to Patient D. It therefore found this head of charge proved.
11.	You provided a poor standard of restoration to Patient D's LL6 on 18 October 2016. **FOUND PROVED** The Committee noted the findings of Mr Igoe's report, which concluded that Mr Kozlicki had provided a poor standard of restoration to Patient D's LL6. It further noted that Mr Igoe had based his opinion on a radiograph taken nearly two years after the appointment, however, there was no evidence that Patient D had seen another dentist in the intervening period and therefore concluded, on the balance of probabilities, that Mr Kozlicki was responsible for the poor standard of restoration.
12.	Between 12 August 2016 and 7 January 2019 you failed to adequately treat periodontal disease in Patient D.

	FOUND PROVED The Committee accepted Mr Igoe's evidence that Mr Kozlicki had responsibility for treating Patient D's periodontal disease. The Committee had sight of the patient records and the radiographs. It noted that there was evidence of periodontal disease from the radiographs over that time period. The Committee accepted Mr Igoe's evidence that it would have been appropriate to undertake a six-point pocket chart. There was no record of a six-point pocket chart or of adequate treatment of the periodontal disease during this period. It therefore found this head of charge proved.
13.	On 23 November 2018, you provided Patient D with a poor standard of endodontic treatment, in that you: **FOUND PROVED** In light of the fact that all of head of charge 13 has been found proved below, then it follows that Mr Kozlicki did not provide an adequate standard of care to Patient D. The Committee noted that as a registered dentist he had a duty to provide an adequate standard of care to his patients and that the findings below prove that he had failed in this regard.
13. a.	perforated the mesial aspect of the LL5; **FOUND PROVED** The Committee considered Mr Igoe's report and accepted his conclusion that the mesial aspect of the LL5 was perforated. However, it noted that there was a conflict as to when the perforation occurred. Witness B's evidence was that it took place on 7 December 2018, and Mr Igoe believed that it took place on 23 November 2018. The Committee viewed the patient's records for 23 November 2018 that stated that the canal was found with a 16.2mm depth and that a paper point had been used. The Committee also noted the radiographic evidence that at the appointment on 7 December 2018 the canal had not been found. The Committee preferred the evidence of Mr Igoe and concluded on the balance of probabilities that is more than likely that enough tooth structure had been removed to cause such a perforation on 23 November 2018. However, Mr Kozlicki had clearly thought he had accessed the canal. The Committee found this head of charge proved.
13. b.	failed to identify that you had perforated the mesial aspect of the LL5; **FOUND PROVED** The Committee accepted the evidence of Dr Igoe that Mr Kozlicki should have identified that he had perforated the mesial aspect of the LL5 and there is evidence from the patient records that he did not identify it. The Committee found this head of charge proved.
13. c.	irrigated the LL5 with 3% sodium hypochlorite solution. **FOUND PROVED**

	The Committee viewed the patient's records for this date and noted that Mr Kozlicki had entered that he had used '*disinfection, - parcan*', i.e. sodium hypochlorite solution. The Committee therefore found this head of charge proved.
14.	On 7 December 2018, you failed to adequately communicate with Patient D, in that you failed to confirm with Patient D the treatment that was due to be provided. **FOUND PROVED** The Committee noted and accepted the evidence of Witness B's report, in which she concluded that Mr Kozlicki' '*did not confirm with the Patient the purpose of their visit*'. The Committee concluded that even though Patient D would likely have known the treatment he was going to be receiving it was Mr Kozlicki's duty to confirm it with them, which he failed to do. Accordingly, the Committee found this head of charge proved.
15.	On 7 December 2018, you failed to obtain informed consent for the treatment provided to Patient D. **NOT PROVED** The Committee considered this head of charge in conjunction with head of charge 14 above. Again, it had sight of Witness B's report. Although it was satisfied that Mr Kozlicki should have re-affirmed consent with Patient D, he did not have a duty to re-establish the '*informed consent* ' he had obtained at the start of the treatment in circumstances where there was no change in the treatment plan at that time. Accordingly, it found this head of charge not proved.
16.	You provided Patient D with a poor standard of endodontic treatment on the 7 December 2018, in that you: **FOUND PROVED** In light of the fact that all of head of charge 16 has been found proved below, then it follows that Mr Kozlicki provided a poor standard of endodontic treatment to Patient D on 7 December 2018. The Committee noted that as a registered dentist he had a duty to provide an adequate standard of care to his patients and that the findings below proved that he had failed in this regard.
16. a.	failed to identify the perforation in the mesial aspect of the LL5; **FOUND PROVED** The Committee noted and accepted Witness B's evidence that Mr Kozlicki failed to identify the perforation in the mesial aspect of the LL5 prior to a radiograph being taken. Accordingly, it found this head of charge proved.
16. b.	used a sodium hypochlorite solution to irrigate the perforated LL5; **FOUND PROVED** The Committee noted and accepted Witness B's evidence that she observed Mr Kozlicki using a sodium hypochlorite solution to irrigate the perforated LL5. It further noted that at that point Patient D was experiencing pain and she stopped the procedure for a radiograph to be taken. It found this head of charge proved.

16. c.	failed to offer to refer the patient to a specialist having perforated the mesial aspect of the LL5. **FOUND PROVED** The Committee accepted Dr Igoe's report and agreed with his findings that a referral to a specialist should have been offered and that Mr Kozlicki failed to do this. Therefore, this head of charge was found proved.
17.	On 7 December 2018, you failed in your duty of candour, in that you failed to adequately explain to Patient D: **FOUND PROVED** The Committee noted the findings of Witness B's report and accepted them. Witness B had observed this appointment and stated in her report that, Mr Kozlicki '*did not explain to Patient D that something had gone wrong with the procedure'*. The Committee also considered Dr Igoe's report. Dr Igoe stated that Mr Kozlicki, '*has a duty of candour when things do not go to plan and, in my opinion, he failed to inform the patient about the adverse incident*'. The Committee noted that there was no evidence in the patient's records of any explanations given to Patient D on this date. In light of these findings, the Committee found charges 17.a, 17.b, 17.c and 17.d proved.
17. a.	that you had perforated the mesial aspect of the LL5; **FOUND PROVED**
17. b.	the treatment options available following perforation; **FOUND PROVED**
17. c.	c. the risk of post-operative pain due to the incorrect use of sodium hypochlorite; **FOUND PROVED**
17. d.	the reduced prognosis for the LL5. **FOUND PROVED**
18.	Following the appointment of 7 December 2018, you failed to provide adequate aftercare to Patient D, in that you failed to deal with the substandard filling in the LL6. **FOUND PROVED** The Committee accepted the evidence of Mr Igoe's report and the evidence of Witness B who commented at this visit about the status of this tooth. Mr Igoe stated that Mr Kozlicki had, '*failed to provide appropriate care for this patient as there was no monitoring of the periodontal disease and bone loss and the substandard filling on LL6 had not been attended to and was not part of the treatment plan*'. The Committee also noted that there was no reference to LL6 in the patient's notes following this appointment. Therefore this head of charge was found proved.

19.	On 7 January 2019, you failed to provide an adequate standard of care during the root filling of the LL5, in that you failed to use a rubber dam. **FOUND PROVED** The Committee accepted the findings of Dr Igoe's report that stated that Mr Kozlicki had failed to use a rubber dam. It had also reviewed the patient's records and could find no reference to a rubber dam being used. It concluded therefore that a rubber dam was not used and this constituted a failure to provide an adequate standard of care to Patient D during this appointment. It found this head of charge proved.
Patient E	
20.	You failed to provide an adequate standard of care to Patient E in that:
20. a.	you inappropriately prescribed antibiotics to Patient E on 16 November 2018; **FOUND PROVED** The Committee noted and accepted the findings in Dr Igoe's report, that '*antibiotics should be prescribed as an adjunct to treatment and not the treatment itself*'. The Committee also had regard to the FGDP Antimicrobial Prescribing Guidelines and concluded that Mr Kozlicki had inappropriately prescribed antibiotics on this occasion. Accordingly, it found this head of charge proved.
20. b.	you failed to use a rubber dam:
20. b. i.	whilst taking the periapical radiograph on the 19 December 2018; **FOUND PROVED** The Committee noted that the patient's records state that a rubber dam was used. However, when examining the radiographic evidence, the Committee found no evidence of a rubber dam being used or a clamp on the posterior tooth. It concluded therefore that, on the balance of probabilities, Mr Kozlicki had not used a rubber dam and found this head of charge proved.
20. b. ii.	whilst root filling the LL6 on the 9 January 2019; **FOUND PROVED** The Committee noted that Witness B had observed this appointment and accepted the findings in Witness B's report in which it was stated that, 'no rubber dam was used during this procedure'. Accordingly, it found this head of charge proved.
20. c.	you removed excessive coronal tissue from the LL6 between 19 December 2018 and 9 January 2019; **FOUND PROVED** The Committee accepted the evidence in Witness B's report which was based on her observations of the appointment. The Committee also accepted the findings in Mr Igoe's report that, '*excessive tooth tissue was removed*'. It accepted that the fracture is likely to have been as a result of excessive coronal tissue removal given that Mr Kozlicki had over-prepared other teeth, and indicated a pattern of

	clinical behaviour. The Committee concluded that based on the evidence above, this head of charge was found proved.
20. d.	you provided a poor standard of endodontic treatment to the LL6 between 19 December 2018 and 9 January 2019. **FOUND PROVED** The Committee concluded that based on its previous conclusions and findings in relation to charges 20.a., 20.b.i and ii, and 20.c., then this head of charge is also found proved.
21.	On 9 January 2019, you failed to adequately communicate with Patient E, in that you failed to confirm with Patient E the treatment that was due to be provided. **FOUND PROVED** The Committee noted the findings in Witness B's report that there was '*minimal communication*' between Mr Kozlicki and Patient B. It agreed with Witness B that consent should have been '*re-affirmed at this appointment*'. It concluded therefore, based on Witness B's observations at this appointment, that Mr Kozlicki had failed to confirm with Patient E the treatment that was due to be provided. This head of charge was found proved.
22.	On 9 January 2019, you failed to obtain informed consent from Patient E:
22. a.	prior to starting treatment; **FOUND NOT PROVED** The Committee noted and accepted the findings in Dr Igoe's and Witness B's reports. Although the Committee was satisfied that Mr Kozlicki should have re-affirmed consent with Patient E, he did not have a duty to re-establish the '*informed consent* ' he obtained at the start of the treatment in circumstances where there was no change in the treatment plan at that time. Accordingly, it found this head of charge not proved.
22. b.	prior to administering local anaesthetic. **FOUND PROVED** The Committee accepted the evidence in Witness B's report in which it was stated that Mr Kozlicki, '*proceeded to give Patient E a local anaesthetic with no prior explanation*'. It also accepted the oral evidence of Mr Igoe when he stated that there are different types of local anaesthetic and that a patient has to be told what is going to occur before the administration of local anaesthetic. It found this head of charge proved.
23.	You failed in your duty of candour, on 9 January 2019, in that you failed to explain to Patient E:
23. a.	that excessive coronal tissue had been removed from the LL6; **FOUND PROVED** The Committee noted and accepted Mr Igoe's report. It noted from the records

	that Mr Kozlicki had informed Patient E that the tooth had fractured but there is no evidence that he provided any further explanation to the patient. Accordingly, it found this head of charge proved.
23. b.	the impact on the prognosis for the LL6; **FOUND PROVED** The Committee noted and accepted Mr Igoe's report. It noted that Mr Kozlicki had informed Patient E that the tooth had to be extracted but provided no reason for this. He therefore did not explain fully to Patient E the long-term implications for the tooth. It therefore found this head of charge proved.
23. c.	the treatment options available for the LL6. **FOUND PROVED** The Committee noted and accepted Mr Igoe's report. It noted from the patient records that no options were given in regard to the LL6 other than extraction of the tooth. It therefore found this head of charge proved.

We move to Stage Two."

On 4 March 2020 the Chairman announced the determination as follows:

"The Committee has had regard to the submissions made by Ms Tahta, on behalf of the General Dental Council (GDC), in accordance with Rule 20 of the Fitness to Practise Rules 2006. It has also had regard to the indexed bundle of further documentary evidence that Ms Tahta handed up following the announcement of the findings of fact. The Committee has accepted the advice of the Legal Adviser.

The Committee has borne in mind that its decisions on misconduct and impairment are matters for its own independent judgment. There is no burden or standard of proof at this stage of the proceedings. It has had regard to the GDC's "Standards for the Dental Team" (September 2013). The Committee first considered whether the facts found proved amounted to misconduct.

Submissions

In accordance with Rule 20 (1) (a) Ms Tahta informed the Committee that Mr Kozlicki was issued with a letter of advice by the GDC on 14 November 2014. This was as a result of a GDC investigation into the concerns raised about the care provided by Mr Kozlicki to a patient between 2011 and 2013. Ms Tahta submitted that some of the clinical failings that have been found proved at this hearing were also evident in Mr Kozlicki's treatment of this previous patient.

Ms Tahta outlined the specific GDC standards, which in her submission, have been breached. She also cited Mr Igoe's expert report, which concluded that Mr Kozlicki's actions in respect of all the heads of charge proved fell, '*far below that expected of a reasonably competent practitioner working in general practice*'. She submitted that Mr Kozlicki failed in his duty to provide a good standard of care to all four patients. She further submitted that all the facts found proved by the Committee involve serious matters, are a serious departure from the expected standards and do amount to misconduct.

Ms Tahta then moved on to the issue of current impairment and referred to the case of *Cohen v GMC [2008] EWCH 581 (Admin)*. She submitted that it was a matter for the Committee's judgement whether Mr Kozlicki's fitness to practise is currently impaired. Ms Tahta referred the Committee to the factors that it should consider, including any evidence of Mr Kozlicki's insight and remediation. Ms Tahta submitted that Mr Kozlicki has shown no insight into his clinical failings and provided no evidence of remediation.

Ms Tahta addressed the Committee on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and to maintain public confidence in the profession and in the GDC as its regulator. She submitted that the Committee might consider that public confidence in the profession and its regulator would be undermined if a finding of impairment were not made.

Ms Tahta next addressed the Committee on the matter of sanction. She made reference to the GDC's Guidance for The Practice Committees including Indicative Sanctions Guidance (October 2016 revised May 2019) (the GDC's sanctions guidance). She submitted that in light of the fact that Mr Kozlicki has shown no insight into his clinical failings and considering the previous concerns investigated by the GDC and NHS England, who imposed conditions on his practice in 2018, his misconduct cannot be remedied and therefore is highly likely to be repeated. She submitted that Mr Kozlicki's actions represent a serious departure from the relevant professional standards and has resulted in serious harm to patients, and therefore the appropriate and proportionate sanction would be one of erasure.

Fitness to Practise History

The Committee took into account all of the evidence presented to it at the fact-finding stage. The Committee also took into account the submissions made by Ms Tahta on behalf of the General Dental Council (GDC) and accepted the advice of the Legal Adviser.

As part of their deliberations the Committee considered Mr Kozlicki's background and the previous concerns raised about his practice by the GDC and NHS England. The Committee noted that Mr Kozlicki first came to the UK in 2005 and was registered with the GDC in 2007. In November 2014 the Investigating Committee of the GDC considered an allegation in respect of concerns that were raised about Mr Kozlicki's treatment of a patient between September 2011 and July 2013, namely:

- Failures in communication with a patient;
- Failure to obtain informed consent;
- A poor standard of restorative care, including endodontic treatment and bridgework;
- Poor radiographic practice;
- Inadequate record keeping;
- Failure to co-operate with a complaint and its investigation.

Having received written submissions from Mr Kozlicki and his solicitors, the GDC issued him with a letter of advice. The Committee noted the following sections from the GDC's letter to Mr Kozlicki as being particularly relevant:

"*The Committee notes that the registrant has attended relevant CPD courses, including courses on radiographic practise (sic), record keeping, treatment planning and complaints handling. In light of this evidence of remediation and insight, the Committee does not consider that there is a real prospect of a Practice Committee finding the Registrant's fitness to practise to be currently impaired.*"

and

"The Committee therefore advises the registrant to:

- *Ensure that where treatment is undertaken, he ensures that the patient understands the treatment to be carried out, fully informed consent is obtained and the treatment provided is of an adequate standard;*
- *Ensure that where radiographs are taken, they are justified, graded and reported on in accordance with requisite guidelines and legislation (including IR(ME)R 2000) and that this information is documented appropriately in the patient's clinical records including any implications for treatment;*
- *Ensure that clinical records should be sufficiently detailed in accordance with current specified practice standards, so as to allow future audit or review, to understand any and all clinical considerations, justifications and potential diagnostic conclusions reached as well as any treatment options discussed;*
- *That concerns raised with respect to any aspect of treatment are addressed sufficiently and in a timely manner, in line with NHS guidance and the GDC's Principles of complaints handling."*

Despite the advice of the Investigating Committee concerns were raised about his practice between 2014 and 2016 by the Local Area Team in the Nottingham area. These concerns were conveyed to the Local Area Team where Mr Kozlicki was subsequently working in Grantham. Witness D was contacted to assist Mr Kozlicki in making sure that he was meeting the necessary requirements of remaining on the performers' list. Witness D worked with Mr Kozlicki between 2016 and 2018 addressing the concerns raised. He noted that there were periods of improvement in Mr Kozlicki's clinical practice as a consequence of his extensive support and Mr Kozlicki's attendance at relevant courses.

The concerns about Mr Kozlicki's practice continued, however, and in August 2018 NHS England imposed conditions on his registration. Witness D stated that, at first, Mr Kozlicki did not want to accept the conditions but was persuaded to comply. As part of these conditions, Witness B was required to visit and observe his practice. After the first observation session with Mr Kozlicki, Witness B provided detailed feedback on the areas of his practice in need of improvement including communication with patients, gaining valid consent, checking medical histories and with regard to accessing root canals.

Following the observation sessions with Mr Kozlicki, Witness B concluded the following in her report:

"*I have completed my three planned visits and as a result of my observations, I can confirm that I have grave concerns as to the suitability (of) Dr KK as an NHS performer. He has received extensive support from his employer in an attempt to mitigate risks identified by NHSE.*

This has been in the form of:

Observations

Audits

360 Feedback

Patient Satisfaction Audits

CPD

PDP

Targeted training

Even after this support over the last 2 – 3 years his practice falls well below the standard I would expect from a qualified dentist working in the NHS in England.

The following have been identified:

Poor communication skills

Failure to obtain consent

Poor endodontic skills, unable to access the pulp chamber, I witnessed 2 cases of lateral perforations

Failure to use rubber dam when carrying out endodontic treatment."

Mr Kozlicki subsequently resigned from the practice.

Misconduct

The Committee considered whether the facts found proved against Mr Kozlicki amounted to misconduct. In doing so it had regard to the GDC publication *Standards for the Dental Team (2013).* It considered that the following sections have particular relevance:

1.1.1 You must discuss treatment options with patients and listen carefully to what they say. Give them the opportunity to have a discussion and to ask questions.

1.4.2 You must provide patients with treatment that is in their best interests, providing appropriate oral health advice and following clinical guidelines relevant to their situation. You may need to balance their oral health needs with their desired outcomes.

If their desired outcome is not achievable or is not in the best interests of their oral health, you must explain the risks, benefits and likely outcomes to help them to make a decision.

2.1 You must communicate effectively with patients – listen to them, give them time to consider information and take their individual views and communication needs into account.

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.*

2.2.2 You should encourage patients to ask questions about their options or any aspect of their treatment.

2.3.1 You should introduce yourself to patients and explain your role so that they know how you will be involved in their care.

2.3.4 You should satisfy yourself that patients have understood the information you have given them, for example by asking questions and summarising the main points of your discussion.

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

3.2 You must make sure that patients (or their representatives) understand the decisions they are being asked to make.

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

7.1 You must provide good quality care based on current evidence and authoritative guidance.

7.2 You must work within your knowledge, skills, professional competence and abilities.

7.3 You must update and develop your professional knowledge and skills throughout your working life.

In addition to the Standards, the Committee also took into account Mr Igoe's expert report. His opinion was that Mr Kozlicki's conduct had fallen far below the relevant standards in respect of all the heads of charge found proved.

The Committee noted that concerns have been raised in the following areas of Mr Kozlicki's practice:

- His poor communication with patients;
- His failure to obtain informed consent;
- His failures in restorative care, including direct restorations and endodontic treatment;
- His poor radiographic practice;
- His inadequate record keeping;
- His failure to adequately treat periodontal disease;
- His inappropriate prescribing of antibiotics;
- His lack of candour.

The Committee noted that these multiple failings were in relation to four patients and over several years. It further noted that his actions caused serious harm to patients and showed a pattern of poor clinical practice. It concluded that his actions demonstrated serious failings in fundamental areas of clinical practice and were a serious breach of GDC Standards and the GDC's guidance on the *Professional Duty of Candour*.

The Committee concluded that, overall, Mr Kozlicki's failings in this case were so serious that they amounted to misconduct.

Impairment

The Committee then considered whether Mr Kozlicki's fitness to practise is currently impaired by reason of his misconduct.

The Committee was mindful of its role to protect the public interest, which includes the need to maintain proper standards of conduct and competence among dental professionals, and to protect patients from risk of harm.

In making its decision the Committee firstly considered whether the failings in this case were capable of being remedied, whether they had been remedied and, finally, whether they were likely to be repeated. It was of the view that the failings were, in principle, capable of being remedied as they all related to clinical matters. However, the Committee noted that Mr Kozlicki had provided no evidence of remediation, regret or remorse, had not issued any apologies to the patients or made any admissions regarding his clinical failings. The Committee considered Mr Kozlicki's insight. It was satisfied that Mr Kozlicki's initial refusal to comply with conditions suggested by NHS England, his failure to accept that he had any failings in his clinical practice and his failure to alter his practice following feedback from fellow professionals indicated that he has no insight into his misconduct. Mr Kozlicki has not engaged with these proceedings and the Committee particularly noted his email to the GDC dated 17 February 2020 in which he stated, '*I am not going to send any further explanations, I am not going to discuss this matter*'.

The Committee further noted that concerns about Mr Kozlicki's practice were wide-ranging and amounted to fundamental failings in significant areas of dentistry. These concerns have been ongoing since 2014, despite the fact that he has been provided with continuous support since then from his Local Area Team and NHS England. The Committee concluded that in these circumstances it appeared that Mr Kozlicki was not capable of remediating these failings and, in fact, the failings had not been remedied.

The Committee considered therefore, without any current evidence of remediation or insight, and the fact that there has been repetition of clinical failings, that there is a significant risk that Mr Kozlicki could repeat the misconduct it has found. In the Committee's view a finding of impairment is necessary for public protection.

The Committee also determined that a finding of impairment was necessary in the wider public interest to maintain public confidence and uphold proper standards of conduct and behaviour among dental professionals. Mr Kozlicki's actions fell far below the required standard expected of a reasonably competent dentist.

The Committee concluded that a reasonable and informed member of the public, fully aware of the facts of the case, would lose confidence in the profession and the dental regulator if a finding of impairment were not made in the circumstances of this case.

The Committee therefore determined that Mr Kozlicki's fitness to practise is currently impaired by reason of his misconduct.

Sanction

The Committee next considered what sanction, if any, to impose on Mr Kozlicki's registration. It recognised that the purpose of a sanction is not to be punitive although it may have that effect. The Committee applied the principle of proportionality balancing Mr Kozlicki's interest with the public interest. It also took into account the *Guidance for the Practice Committees including Indicative Sanctions Guidance, October 2016, revised May 2019, ("PCC Guidance")*.

The Committee considered the aggravating factors in this case which include:

- Actual harm and risk of harm to patients;
- Misconduct sustained or repeated over a period of time;
- Previous adverse findings about his clinical practice from the GDC and NHS England;
- Lack of insight.

The Committee could find no mitigating factors in this case.

The Committee decided that it would be inappropriate to conclude this case with no further action. It would not satisfy the public interest given the serious nature of the misconduct.

The Committee then considered the available sanctions in ascending order starting with the least serious.

The Committee concluded that misconduct of this nature cannot be adequately addressed by way of a reprimand. It cannot be said to be at the lower end of the spectrum. The public would not be sufficiently protected by the imposition of such a sanction as there would be no restriction on his practice. The Committee therefore determined that a reprimand would be inappropriate and inadequate.

The Committee considered whether a conditions of practice order would be appropriate. It noted that the failings involved were wide-ranging and included fundamental areas of dentistry. It noted that conditions had been imposed on Mr Kozlicki previously by NHS England and, although he complied with them, this did not result in a sustained improvement in his clinical practice. In the absence of evidence that Mr Kozlicki has shown any insight into his failings and his lack of engagement in the fitness to practise proceedings, the Committee concluded that imposing conditions on Mr Kozlicki's practice would not be workable or enforceable. The imposition of conditions would also not satisfy the public interest which includes the protection of patients, maintaining public confidence in the profession, and declaring and upholding appropriate standards of conduct and competence among dental professionals.

The Committee next considered whether to suspend Mr Kozlicki's registration for a specified period. It questioned whether a suspension would be sufficient in all the circumstances of the misconduct that it has found. In reaching its decision, the Committee had regard to the factors listed under paragraph 7.28 of the Guidance, which deals with the sanction of suspension, and considered that all of the factors listed applied. In particular, this paragraph makes clear that a suspension may be appropriate where there is no evidence of professional attitudinal problems. The Committee considered, however, that Mr Kozlicki does have such problems. It noted that he has had several opportunities in the past to remedy similar deficiencies in his practice, but he did not do so. He continued to practise and provide a poor standard of care to his patients. For several years he has shown disregard for his statutory obligations, professional guidance and standards, NHS England and his regulator. He has not engaged with the regulatory process in respect of this current case and has made clear that he has no interest in doing so. In these circumstances, the Committee concluded that the suspension of Mr Kozlicki's registration would not be sufficient to maintain the public's confidence in the dental profession.

In considering whether the sanction of erasure was appropriate, the Committee had regard to paragraph 7.34 of the Guidance, which states:

"Erasure will be appropriate when the behaviour is fundamentally incompatible with being a dental professional: any of the following factors, or a combination of them, may point to such a conclusion:

- *serious departure(s) from the relevant professional standards;*
- *where serious harm to patients or other persons has occurred, either deliberately or through incompetence;*
- *where a continuing risk of serious harm to patients or other persons is identified;*
- *a persistent lack of insight into the seriousness of actions or their consequences."*

It was the view of the Committee that all of the above applied in the circumstances of this case. Given the wide-ranging clinical failings identified dating from 2014 and his complete lack of insight the Committee concluded that Mr Kozlicki's behaviour is fundamentally incompatible with being a dental professional.

In all the circumstances, the Committee has determined to erase Mr Kozlicki's name from the Dentists Register.

The Committee now invites submissions from Ms Tahta as to whether an immediate order should be imposed on Mr Kozlicki's registration, pending the taking effect of its determination for erasure."

Decision on Immediate Order

"The Committee has considered whether to make an order for the immediate suspension of Mr Kozlicki's registration in accordance with Section 30(1) of the Dentists Act 1984 (as amended).

Ms Tahta, on behalf of the GDC, submitted that such an order is necessary for the protection of the public and is otherwise in the public interest, given the risk of repetition identified by this Committee.

The Committee has considered the submission made. It has accepted the advice of the Legal Adviser.

The Committee has already identified a continuing risk to the public as Mr Kozlicki has shown no evidence of remediation or provided any insight into his misconduct. In light of this and its reasons for directing that his registration be erased, the Committee is satisfied that it would be inappropriate, given the findings in this case, to allow him to continue to practise during the intervening appeal period. The Committee has determined that an immediate order of suspension is required, both to protect the public and the public confidence in the profession for the same reasons as identified in the substantive order.

The effect of this direction is that Mr Kozlicki's registration will be suspended immediately. Unless Mr Kozlicki exercises his right of appeal, the substantive order of erasure will come into effect 28 days from the date on which notice of this decision is deemed to have been served on him. Should Mr Kozlicki exercise his right of appeal, this immediate order for suspension will remain in place until the resolution of any appeal.

The Committee noted that there was currently an interim order of suspension on Mr Kozlicki's registration. However, it considered that the serious nature of the impairment found in this case justifies the imposition of an immediate order. The interim order of suspension currently on Mr Kozlicki's registration is revoked.

That concludes today's hearing."