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HEARING HEARD IN PUBLIC

PATEL, Tushar Kantibhai

Registration No: 61782

PROFESSIONAL CONDUCT COMMITTEE

OCTOBER 2019

Outcome: Suspension for 12 months

Tushar Kantibhai PATEL, a dentist, MFGDP(UK) 1998 BDS University of Sheffield 1986, was summoned to appear before the Professional Conduct Committee on 14 October 2019 for an inquiry into the following charge:

Charge (as amended)

"That being registered as a dentist:

1. Between 5 June 2017 and 18 July 2017 you provided treatment to Patient A.
2. Patient A informed you she was on Warfarin.
3. Between 5 June 2017 and 18 July 2017 you failed to discuss, or adequately record any discussions, with Patient A regarding her complex medical history.

13 June 2017

4. On 13 June 2017 you extracted UR6, UR5 root, UR3, LR1 and LL1
5. You failed to ensure that Patient A's International Normalised Ratio ('INR') had been checked no more than 72 hours before treatment and that it was safe to proceed.
6. You failed to:
   (a) discuss, or record any discussion, with Patient A regarding her INR or bleeding history;
   (b) advise, or record any advice given to, Patient A regarding her increased risks of bleeding following extractions;
   (c) consider, or record any consideration given to, limiting the number of extractions per visit;
   (d) pack and/or suture the extraction sockets;
   (e) provide Patient A with post-operative instructions relevant to her increased risks together with emergency contact details.

18 July 2017

7. On 18 July 2017 you extracted UR2, UR1, UL1, UL2 and UL3.
8. You failed to ensure that Patient A's INR had been checked no more than 72 hours before treatment and that it was safe to proceed.

9. You failed to:

   (a) discuss, or record any discussion, with Patient A regarding her INR or bleeding history;

   (b) advise, or record any advice given to, Patient A regarding her increased risks of bleeding following extractions;

   (c) consider, or record any consideration given to, limiting the number of extractions per visit;

   (d) ensure the extractions were carried out early in the day;

   (e) pack and/or suture the extraction sockets;

   (f) provide Patient A with post-operative instructions relevant to her increased risks together with emergency contact details.

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

On 15 October 2019 the Chairman made the following statement regarding preliminary matters:

"Mr Patel,

This is a Professional Conduct Committee hearing to consider an allegation that your fitness to practise is impaired by reason of misconduct. You are present and represented by Mr McDonagh. Ms Barnfather appears on behalf of the General Dental Council (GDC).

At the outset of the hearing the Committee raised some questions with Ms Barnfather as to the GDC's approach regarding paragraphs 5 and 6 of Ms Glass's (the GDC's expert) addendum report dated 9 September 2019. In paragraph 5 Ms Glass opined that she would have expected a General Dental Practitioner to recognise that Thrombotic Thrombocytopenic Purpura (TTP) was a 'relevant medical condition' and that it could have a detrimental effect on the early phase of the blood coagulation process. She further opined that you should have sought further advice from Patient A's General Medical Practitioner or Specialist Haematologist Anticoagulation Clinic prior to carrying out any dental treatment likely to cause bleeding. Paragraph 6 sets out Ms Glass's opinion on whether extractions were contraindicated in a GDP setting. Ms Glass's opinion was that "based on the information above related to the fact that Patient A had a history of TPP and considering the fact that she was also taking the anticoagulant medication Warfarin, this leads me to opine that extractions for Patient A were contraindicated in a general practice setting." There is no allegation against you in respect of the two matters identified in paragraphs 5 and 6.

Ms Barnfather advised the Committee that these matters had been considered carefully by the GDC. In respect of paragraph 6, the GDC had taken the view that it could not rule out that extractions could have taken place in a GDP setting had the correct pre-treatment investigations and advice been provided, as well as adherence to the relevant guidelines to reduce the risk of post-operative bleeding. She also invited the Committee to have regard to paragraph 5 of Ms Glass's report when considering her opinion set out in paragraph 6. Regarding paragraph 5, the GDC puts its case that you failed to obtain the appropriate information as to Patient A's medical history before extracting the teeth in 2017, as set out in the charges against you. Concerning Ms Glass's opinion in her addendum report, paragraph 5, that you should have sought further advice, Ms Barnfather advised the Committee that

this matter was encompassed by charge 3 because no such advice could have been sought without a discussion with Patient A and her consent to this.

In short, Ms Barnfather submitted that the matters set out in Ms Glass's addendum report had been considered by the GDC; and that the charges against you, as currently drafted, reflect the gravamen (the most significant, material and grievous aspects of the allegations) of the matters in relation to your treatment of Patient A. Mr McDonagh concurred with Ms Barnfather's assessment of the GDC's position and invited the Committee to proceed on the basis of the charges before it.

The Committee received advice from the Legal Adviser on this matter. Following a short break, the Committee announced that it was content to proceed on the basis of the charges before it, subject to receiving an agreed statement from parties. Following a further break, the Committee received a signed report dated 14 October 2019 from Ms Glass in which she stated that she was asked to elaborate on her opinion as set out in paragraphs 5 to 7 of her addendum report dated 9 September 2019. At paragraph 4 of that report Ms Glass states: "In explaining whether the extractions were contraindicated there is no separate criticism to the matters set out in the main report and at paragraph 5 of the addendum report. I cannot rule out that extractions could have taken place in a GDP setting with the correct pre-treatment investigations and advice, staged as per the guidelines to reduce the risk of post-operative bleeding, and with adequate post-operative management of the sockets and post-operative advice." In the light of Ms Glass's opinion on this matter, the Committee is satisfied that the GDC has comprehensively addressed the gravamen of the issues in this case, as reflected in the charges, as currently drafted and that the over-arching objective, including the public interest, is protected. Having ventilated these matters in public prior to the commencement of proceedings, and given both parties an opportunity to comment, the Committee has decided to proceed with the case. Neither party raised any objection to this course of action.

Application to amend the charge

Ms Barnfather made an application under Rule 18(1) of the GDC (Fitness to Practise) Rules Order of Council 2006 (the Rules), to amend the charge set out in the Notice of Hearing as follows:-

Charges 3 and 6(a) – insert the word 'adequately' before the word 'discuss'

Charges 5 and 8 – delete the words 'and that it was safe to proceed'

Ms Barnfather submitted that the amendments, which had been suggested by Mr McDonagh, would meet the merits of the GDC's case and there would be no injustice to parties. Mr McDonagh confirmed that he did not oppose the application. The Committee accepted the advice of the Legal Adviser. Having regard to the merits of the case and the fairness of proceedings, the Committee was satisfied that the proposed amendments could be made without injustice. Accordingly, it acceded to the GDC's application."

On 15 October 2019 the Chairman made the following statement regarding the finding of facts:

"Mr Patel,

The GDC's case

Between 5 June 2017 and 18 July 2017 you provided treatment to Patient A. Patient A took Warfarin (an anticoagulant which reduces the ability of the blood to form clots or coagulate). Warfarin has been widely used for over 50 years and the risk of post-operative bleeding complications associated with dental extractions for patients taking it is of concern to dentists. You were aware that Patient A took Warfarin. Patient A also had a complex medical history.

You first examined Patient A on 13 May 2013 when you diagnosed and discussed her advanced periodontal disease. This included the need for extraction of some of her teeth. Extractions of several teeth were planned to be carried out at the next appointment. Patient A failed to return to have the proposed extractions carried out until four years later. She attended on 5 June 2017, complaining of her "teeth falling out". She completed a medical history form which noted a number of things, including the fact that she was taking Warfarin and that she carried a Warfarin warning card. Two radiographs were taken, and you made a note of your findings in the clinical records. You noted that Patient A required to have all of her upper teeth extracted and an immediate full upper denture fitted; her lower incisors were to be extracted and a partial lower denture fitted.

Patient A next attended on 13 June 2017 at 11.20 where you extracted the UR6, UR5 root, UR3, LR1 and LL1. You made a note "HAEM/POIG" (meaning Haemostasis achieved and Post-Operative Instructions Given). Impressions were taken for dentures. On 20 June 2017 at 11.45 Patient A attended for a denture bite registration. On 12 July 2017 Patient A attended for a try-in stage of the denture construction and for second impressions. You also carried out a scale and polish of Patient A's lower teeth.

On 18 July 2017 at 15.15 Patient A attended for the extraction of UR2, UR1, UL1, UL2 and UL3. You made a note in the records stating "HAEM/POIG". You fitted a full upper denture and a partial lower denture.

At around 21.50 on 18 July 2017 Patient A attended the Emergency Department at King's College Hospital, suffering from bleeding from the upper arch extraction sites. The bleeding was arrested by gauze, pressure and local anaesthetic and the patient was advised not to rinse for 24 hours. Patient A was discharged back home.

Patient A collapsed at home sometime in the early hours of 19 July 2017. She was bleeding from her mouth. She was taken by ambulance to King's College Hospital Department. Attempts to save her were unsuccessful and she was declared dead at 09.26 on 19 July 2017.

In due course there was a coroner's investigation into the death of Patient A. Following an investigation an inquest hearing commenced on 5 March 2018. Her Majesty's Coroner determined on 21 March 2018 that the medical cause of death for Patient A was:

1. Haemorrhage from tooth extraction site
2. Warfarin treatment and dental extraction.

You notified the GDC of this matter on 13 April 2018.

The GDC instructed Ms Glass, a registered dentist, to give an opinion as to whether your conduct in the treatment of Patient A in the period leading up to her death fell short of the conduct expected of a registered General Dental Practitioner. She produced a report dated 29 October 2018. Ms Glass had regard to the clinical records from you in relation to the care of Patient A from 13 May 2013 to 18 July 2017, the clinical records from King's College

Hospital and the judgement of the inquest dated 21 March 2018. Ms Glass also referred to the current standards in dentistry, relevant to aspects of the care provided by you, in particular, the Scottish Dental Clinical Effectiveness Programme (SDCEP): Management of Patients Taking Anticoagulant or Antiplatelet Drugs. Dental Clinical Guidelines August 2015 (SDCEP Guidance). She explained that this Guidance had been widely disseminated throughout the profession.

Ms Glass's evidence was that the Guidance was aimed at providing recommendations and practical advice to inform bleeding risk assessment and decision making for the treatment of this patient group. A dentist would be expected to follow them, particularly when there is a significant patient safety concern in terms of the potential risk of bleeding complications following invasive dental procedures. Attached to her report were extracts from the appendices from the SDCEP Guidance, including a table setting out the Post-operative bleeding risks for dental procedures.

In summary, Ms Glass was critical of your failure to ask Patient A for more information regarding her complex medical history, her bleeding history and her International Normalised Ratio (INR) (the time taken for a clot to form in a blood sample, relative to a standard). She was also critical of your failure to ask to see Patient A's INR warning card. This information should have been recorded in Patient A's clinical records but there was no such information in her records. Ms Glass also considered that having identified that Patient A was taking Warfarin, you should have ensured that her INR was checked ideally no more than 24 hours (or at most 72 hours had previous levels been stable) before the dental extractions. In Ms Glass's opinion, the result of the INR test would have provided a more accurate assessment of Patient A's risk of post-extraction bleeding. There was nothing in the notes to indicate that you ensured when Patient A's INR had last been checked before the extractions on either occasion.

Ms Glass opined that you should have taken steps to manage Patient A's risk of bleeding during and after treatment. In her view, you should have considered staging the treatment by limiting the number of extractions to no more than three per visit. In Ms Glass's opinion, this would have reduced the volume of the sockets and thus reduced the size of the potential bleeding site. She considered that you should have planned treatment to be carried out early in the day so as to allow time for the management of prolonged bleeding or rebleeding episodes. Further, Ms Glass was of the view that you should have considered packing or suturing the extraction sockets to increase the chance of achieving primary haemostasis. Finally, Ms Glass considered that you should have provided Patient A with written post-treatment advice and emergency contact details. In summary, Ms Glass was critical of your failure to ensure the safety of Patient A and to appropriately manage her increased risk of bleeding, as highlighted in her medical history.

Ms Glass provided the GDC with an addendum report dated 10 September 2019 in which she was asked to comment on a number of features of your care of Patient A, including the matters set out in paragraphs 5 and 6 (dealt with in the PCC's determination on 'preliminary matters') as well as the post-operative care provided by you at each appointment. She maintained her view that given the patient's increased risk of post-extraction bleeding, you should have packed and/or sutured the extraction sites on 13 June 2017 and 18 July 2017.

In that same report Ms Glass was asked to comment on matters relating to Patient A's INR. She referred to the SDCEP Guidelines which state "Warfarinised patients will have a record of their INR test results, which they should present when attending for dental treatment." She considered that you should have asked to see evidence of the most recent INR tests.

Failing that, she considered that you should have sought confirmation from the Patient's GMP.

At the outset of the hearing Mr McDonagh, on your behalf, admitted all of the charges against you, albeit there was a qualified admission in respect of charges 6 (c) and 9(c) in that you did consider limiting the number of extractions. You extracted 10 teeth in total over the course of two visits. You accepted that you should have extracted no more than 3 teeth per visit. The Committee noted your admissions but decided to defer its decision until it had received all the evidence in this case.

In considering whether the charges against you have been found proved, the Committee has taken into account all the evidence presented to it. This includes the expert evidence of Ms Glass. It was open to the Committee to hear oral evidence from Ms Glass. However, as there were no questions for Ms Glass, the Committee decided that this was not necessary. It also noted that you did not challenge the contents of her reports. Overall, the Committee considered that Ms Glass gave a balanced and fair assessment of your treatment of Patient A, with reference to the relevant professional standards in dentistry. It has accepted Ms Glass's evidence.

The Committee has also had regard to your witness statement, signed and dated 10 October 2019. In that statement you accept that there were significant failings in the care you provided to Patient A on 13 June 2017 and 18 July 2017. You also accept the most serious consequences of your actions and the conclusions of Her Majesty's Coroner on 21 March 2018. Further, you stated that you wished to put on record your sincere remorse and unhesitating acknowledgement of the contribution of your actions to the tragic outcome for Patient A. You provided responses to each of the charges. Having made full admissions to the allegations you did not give oral evidence at this stage of the proceedings. Mr McDonagh indicated that you would be giving evidence at a later stage.

The Committee has accepted the advice of the Legal Adviser. The Committee has borne in mind that the burden of proof is on the GDC and that it must decide the facts according to the civil standard of proof, on the balance of probabilities. You need not prove anything. The Committee has considered each charge separately. In the light of your admissions and having accepted Ms Glass's evidence, the Committee has found the charges proved. Its findings are as follows.

1	*Between 5 June 2017 and 18 July you provided treatment to Patient A* **Admitted and found proved**
2	*Patient A informed you she was on Warfarin* **Admitted and found proved**
3	*Between 5 June 2017 and 18 July 2017 you failed to adequately discuss, or adequately record any discussions, with Patient A regarding her complex medical history* **Admitted and found proved** You accepted that you failed to make a record regarding any discussions with Patient A about her complex medical history. However, you do not accept that there was no discussion at all. You say that you would have checked with Patient A as to whether her Medical History Questionnaire was complete. You also say that you raised the issue of Warfarin with Patient A and that you asked

	her for her latest INR reading on 13 June 2017. Ms Glass considered that you should have explored Patient A's medical history, seeking clarification about her medical conditions, as there may have been other factors that increased her risk of bleeding. There was nothing in the clinical records or the subsequent actions by you that indicated that you had further discussions with Patient A about her medical history, her bleeding history, her Warfarin medication or her INR. The Committee accepts Ms Glass's evidence that you had a duty to record this information. It considers that had you had a discussion with Patient A about her complex medical history, you would have recorded this information on her patient notes. The fact that Patient A stated that she was on Warfarin would have been an important consideration for you in terms of any future treatment you were proposing and thus it would have been important to record this discussion. There is nothing about this in the notes at the appointment on 13 June 2017 or 18 July 2017 and therefore the Committee finds this charge proved.
	13 June 2017
4	*On 13 June 2017 you extracted UR6, UR5 root, UR3, LR1 and LL1* **Admitted and found proved** The medical records confirm that you extracted the five teeth referred to in this charge.
5	*You failed to ensure that Patient A's International Normalised Ratio ('INR') had been checked no more than 72 hours before treatment* **Admitted and found proved** The SDCEP Guidance, under the Summary of Recommendations, states: "For dental treatment likely to cause bleeding, with a low or higher risk of bleeding complications: • Ensure that the patient's INR score has been checked, ideally no more than 24 hours before the procedure. If the patient has a stable INR, checking the INR no more than 72 hours before is acceptable." You accepted this allegation, albeit you say that you asked Patient A what her latest INR score was, and she confirmed that it was under 4. You said that indication provided you with reassurance to continue with the treatment. However, you accept that you did not check when her last INR reading was taken and that you should have done so. Having regard to the SDCEP's guidelines, the Committee finds that you had a duty to check Patient A's INR no more than 72 hours before treatment. In the light of your admission, the Committee finds that you failed to do so.
6.	*You failed to:*
(a)	*adequately discuss, or record any discussion, with Patient A regarding her INR or bleeding history* **Admitted and found proved** The SDCEP's Guidance, under the heading "Assessing Bleeding Risk", makes it

	clear that you must ask the patient about their bleeding history and their INR. There is no record of such discussions with Patient A. You accepted that the discussion was inadequate and that you failed to record your discussion. The Committee finds this charge proved for the same reasons set out at charge 3 above.
(b)	*advise or record any advice given to Patient A regarding her increased risks of bleeding following extractions;* **Admitted and found proved**
(c)	*Consider, or record any consideration given to, limiting the number of extractions per visit* **Admitted and found proved** The SDCEP's Guidance states that for dental treatment likely to cause bleeding, with a low or higher risk of bleeding complications: • For procedures with a higher risk of post-operative bleeding complications consider carrying out the treatments in a staged manner. Under the heading, "Assessing Bleeding Risk", there is a table which sets out the dental procedures that are likely to cause bleeding. The Guidance classifies the extraction of more than 3 teeth as having a higher risk of post-operative bleeding complications and Ms Glass's opinion was that for this reason, no more than 3 teeth should be extracted on one occasion. You extracted 5 teeth on each occasion. You admitted this charge, albeit you say that you gave consideration as to limiting the number of extractions over two appointments. However, you accepted that the extractions should have been limited to 3 per sessions. Accordingly, the Committee finds this charge proved.
(d)	*Pack and/or suture the extraction sockets* **Admitted and found proved** Ms Glass considered that you should have packed and/or sutured the extraction of sockets which would have reduced the risk of post-extraction haemorrhage and reduced the size of the open wound and increased the chance of achieving primary haemostasis. You have accepted this charge. In the light of your admission, as well as the opinion of Ms Glass, the Committee finds this charge proved.
(e)	*Provide Patient A with post-operative instructions relevant to her increased risks together with emergency contact details.*
	Admitted and found proved The Committee finds that you had a duty to provide Patient A with written post-treatment advice that was targeted at her increased risk of bleeding as well as emergency contact details. You accepted that the advice you provided was generic in nature. Accordingly, the Committee finds this charge proved.
	18 July 2017
7.	*On 18 July 2017 you extracted UR2, UR1, UL1, UL2 and UL3*

	Admitted and found proved
8.	*You failed to ensure that Patient A's INR had been checked no more than 72 hours before treatment.* **Admitted and found proved** This is for the same reasons as set out at charge 5 above.
9.	*You failed to:*
(a)	*Discuss or record any discussion with Patient A regarding her INR or bleeding history;* **Admitted and found proved** This is for the same reasons as set out at charge 6(a) above.
(b)	*Advise, or record any advice given to, Patient A regarding her increased risks of bleeding following extractions;* **Admitted and found proved** This is for the same reasons as set out at charge 6(b) above.
(c)	*Consider or record any consideration given to, limiting the number of extractions per visit.* **Admitted and found proved** This is for the same reasons as set out at charge 6(c) above.
(d)	*Ensure the extractions were carried out early in the day* **Admitted and found proved** The SDCEP's Guidance states "Plan treatment for early in the day and week." The records indicate that you carried out the extractions around 15.15 on 18 July 2017 which was much later in the day, and not in accordance with Guidance. Accordingly, the Committee finds this charge proved.
(e)	*Pack and/or suture the extraction sockets;* **Admitted and found proved**
(f)	*Provide Patient A with post-operative instructions relevant to her increased risks together with emergency contact details* **Admitted and found proved** This is for the same reasons as set out at charge 6(e) above.

We move to Stage Two."

On 18 October 2019 the Chairman announced the determination as follows:

"Mr Patel: Having announced its findings of fact, the Committee has considered the submissions made by Ms Barnfather on behalf of the General Dental Council (GDC) and

those made by Mr McDonagh on your behalf. It has accepted the advice of the Legal Adviser.

Ms Barnfather confirmed that you have no previous fitness to practise history. She submitted that the shortcomings in your treatment of Patient A are serious, relating to a number of crucial omissions, which were repeated on more than one occasion. There was, she submitted, an opportunity for you at each of the five appointments you saw Patient A to have appraised yourself of her medical history and to review the treatment proposed, but this was not done. In short, Ms Barnfather said that your repeated failure to follow relevant guidance that is well known to a dentist, and thus your failure to weigh up the risks of the treatment provided for Patient A, were serious. She submitted that the matters found proved amount to misconduct.

Ms Barnfather invited the Committee to find that your fitness to practise is currently impaired by reason of your misconduct. This was, she said, a case where the failings were so serious that a finding of current impairment is necessary in the public interest. The public interest includes the maintenance of public confidence in the dental profession and declaring and upholding appropriate standards of conduct of dental professionals.

Ms Barnfather submitted that this was a case so serious that the issue was whether erasure was the only sanction sufficient to address your impairment or whether a lengthy period of suspension would be sufficient. Ms Barnfather submitted that given the serious nature of the misconduct and your disregard for Patient A's safety, any lesser sanction would not address the public interest in this case. During the course of Ms Barnfather's submissions she referred the Committee to Annex A, paragraph 27 of the GDC's "Guidance for the Practice Committees, including Indicative Sanctions Guidance" (the Guidance) (Effective October 2016, updated May 2019). This paragraph states that if a patient suffers serious harm which could and should have been avoided, and the dental professional knew better (or ought to have known better, but failed to inform him or herself adequately) then the PCC will need to consider whether the registrant has demonstrated behaviour that is incompatible with continued registration.

Mr McDonagh conceded that the facts found proved amount to misconduct and that your fitness to practise is currently impaired by reason of that misconduct. In terms of sanction, Mr McDonagh submitted that the Committee can properly conclude that the public interest can be served by the imposition of a Suspension Order. He made a number of points in support of that contention, including your full acceptance of your wrongdoing, your expressions of remorse and contrition and the steps you have taken to ensure that there will be no repetition of the failures in respect of Patient A. Mr McDonagh referred to the documentary evidence which shows you have complied with the undertakings imposed on your registration by NHS England. These included you undertaking a self-audit of 15 extraction cases, four on Warfarinised patients, and 11 where there were complex medical histories or co-morbidities since 19 July 2017. You were also required to nominate a supervisor, a non-related colleague, to report monthly on each of the extractions you performed as part of this undertaking.

In addition, Mr McDonagh referred to the other steps you have taken since the events in question. This included arranging, on your own initiative, visits to the Department of Special Care Dentistry at King's College Hospital to observe the management of medically compromised patients and attending specialist clinics in oral surgery to assist and observe minor oral procedures. You also self-referred to the GDC in April 2018 and relinquished your role as a vocational trainer. He reminded the Committee of the supportive testimonials

submitted on your behalf, which attest to your professionalism and the fact that you have practised as a dentist for some 30 years without any reported complaints. In summary, Mr McDonagh submitted that you have embarked on a long journey of remediation, that you have addressed the concerns identified in this case and that the public interest can be properly satisfied with a Suspension Order.

Misconduct

The Committee has first considered whether the facts found proved amount to misconduct. In so doing, it has had regard to all of the evidence before it, as well as the submissions made by both parties. The Committee has kept in mind the GDC's "Standards for the Dental Team" (September 2013) and the Scottish Dental Clinical Effectiveness Programme: Management of Patients Taking Anticoagulant or Antiplatelet Drugs, Dental Clinical Guidelines August 2015 (SDCEP Guidance), this latter document having been referred to by Ms Glass, the GDC's expert.

This case concerns the treatment you provided to Patient A between 5 June 2017 and 18 July 2017, namely the extraction of five of her teeth on 13 June 2017 and a further five teeth on 18 July 2017. At the outset Patient A completed a medical history questionnaire on 5 June 2017 in which she stated that she was on Warfarin. She also provided information of her other health concerns, which were complex in nature. You were aware that Patient A was on Warfarin at the time of the events in question and indeed you recorded this fact in her clinical notes on 5 June 2017.

The Committee received expert evidence from Ms Glass regarding the risk of post-operative bleeding complications associated with dental extractions for patients taking Warfarin, which should be well known to dentists. The SDCEP Guidance provides recommendations and practical advice to inform bleeding risk assessment for the treatment of dental patients taking Warfarin. The Committee has heard that a dentist would be expected to follow the Guidance, particularly as there are significant patient safety concerns as to the potential risk of bleeding complications following invasive dental procedures. The Guidance sets out that before providing dental treatment for patients taking anticoagulants, their bleeding risk should be assessed. This includes checking the patient's International Normalised Ratio (INR), ideally no more than 24 hours before the procedure, or, if the patient has a stable INR, checking it no more than 72 hours before treatment. In the event that the patient's INR is 4 or above, the Guidance recommends that the treatment is delayed until the level has been reduced to 4.

The Committee has found proved that between 5 June 2017 and 18 July 2017 (over the course of five appointments) you failed to adequately discuss, or adequately record any discussions, with Patient A regarding her complex medical history. This was in spite of the fact that Patient A had provided you with a full medical history questionnaire at the appointment on 5 June 2017, before you embarked on any treatment.

The Committee has found further failures regarding the appointments on 13 June 2017 and 18 July 2017. It has found proved that for both appointments you failed to ensure that Patient A's INR had been checked no more than 72 hours before treatment. Indeed, on your own evidence, you accepted that you relied on Patient A informing you that her INR was below 4 without actually verifying that information yourself. For both appointments you failed to adequately discuss, or record any discussion, with Patient A regarding her INR or bleeding history. You also failed to advise or record any advice given to Patient A regarding her increased risks of bleeding following extractions. Further you failed to consider or record any consideration given to limiting the number of extractions per visit. You extracted five teeth at

each appointment where the recommended number was not more than three. In addition, you failed to pack and/or suture the extraction sockets. You also failed to provide Patient A with specific post-operative instructions relevant to her increased risks together with emergency contact details.

Finally, in respect of the appointment on 18 July 2017, which took place around 15.15, the Committee found proved you failed to ensure that the extractions were carried out early in the day. This placed Patient A at a greater risk of harm in the event of post-operative bleeding from the extraction site because the surgery would be closed, making contact with you more difficult.

Your failures placed Patient A at a significant and avoidable risk of harm and were also contrary to the SDCEP Guidance.

The Committee has heard that later on the evening of 18 July 2017 Patient A suffered bleeding from the extraction site and presented at the Emergency Department at King's College Hospital. She was seen, attended to and was discharged with advice. Patient A collapsed at home sometime in the early hours of 19 July 2017. She was bleeding from her mouth. Patient A was taken by ambulance to King's College Hospital Department. Attempts to save her were unsuccessful and sadly she passed away that same morning.

In your evidence, you accepted fully the shortcomings in your treatment of Patient A, the serious consequences of your actions and the conclusions of Her Majesty's Coroner made on 21 March 2018. You placed on record your sincere remorse and acknowledgement of the contribution of your actions to the tragic outcome for Patient A. You told the Committee that you were conversant with the National Patient Safety Agency (NPSA) guidance for the management of patients taking anticoagulant or antiplatelet drugs (which is the same as the SDCEP Guidance for Warfarinised patients) but you were unable to offer any explanation as to why you did not follow this guidance, despite the fact that you knew that Patient A was on Warfarin.

The Committee considers that you have breached a number of the standards set out in the GDC's 'Standards for the Dental Team (September 2013)'. These are as follows:

1. Put patients' interests first.

4.1.1 You must make and keep complete and accurate patient records, including an up-to-date medical history, each time that you treat patients.

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

The Committee takes a serious view of the findings against you. There were multiple errors and a failure to follow the appropriate guidance at the appointments between 5 June 2017 and 18 July 2017. In the Committee's view, these were basic errors which placed Patient A at significant risk of harm, when this could have, and should have been avoided. As an experienced dental professional, you should have been able to follow authoritative guidance in respect of the treatment of a patient on a medication with well-known complications associated with dental extractions. This amounted to a repeated disregard for patient safety which, in the Committee's judgement, can be properly described as serious. The Committee has determined that the facts found proved amount to misconduct.

Current impairment

The Committee next considered whether your fitness to practise is currently impaired by reason of your misconduct.

In reaching its decision on impairment, the Committee exercised its own independent judgement. It has borne in mind that the over-arching objective of the GDC is the protection of the public, which involves the pursuit of the following:

a) to protect, promote and maintain the health, safety and well-being of the public;

b) to promote and maintain public confidence in the profession;

c) to promote and maintain proper professional standards and conduct for members of the profession.

The Committee first considered the nature of your misconduct in relation to your treatment of Patient A. It is in no doubt that the clinical failings in this case were serious and put Patient A at significant and unnecessary risk of serious harm. Nevertheless, it is satisfied that the misconduct in this case, which relates to clinical matters, is capable of being remedied. It then considered whether you have remedied your misconduct. In so doing, the Committee scrutinised carefully the evidence it received of the steps you have taken to address the shortcomings in this case, as set out in the remediation bundle and other documents before it.

The documentary evidence includes: a copy of your Significant Event Analysis (written by you soon after the event in question); a copy of the NHS England undertakings agreed by you; an audit of 15 medically compromised dental patients who presented to you since 19 July 2017 requiring extraction; an additional audit to review the quality of care provided to medically compromised patients that required dental extractions; an audit of randomly selected of patient records; peer review statements from your dental supervisor confirming that there were no areas of concern in relation to the audits; and copies of your reflections on your audits.

Your supervisor's report dated 17 April 2019 confirms that she has worked closely with you on extractions, discussing numerous extraction cases of medically compromised patients, including those taking Warfarin. She states that she has no concerns regarding your treatment of medically compromised patients. She further states that you have held meetings to help other members of the practice and enforce practice policies to ensure that such an incident does not occur again.

The Committee's attention has also been drawn to a letter dated 9 April 2019 from a Consultant in the Department of Oral Surgery, King's College Dental Hospital. She confirms that you have attended morning clinics for medically compromised patients at the Hospital on six occasions between October 2018 and March 2019. She states that during that time, you have had an opportunity to observe the dental management of medically compromised patients. She describes you as being interested and engaged in the sessions you attended.

Finally, the Committee has had regard to the copies of your Personal Development Plans (PDP), dated 2017, 2018 and 2019 and evidence of certificates of attendance at courses that are relevant to the issues raised in this case, as well as your reflections on these.

The Committee considers that you have taken appropriate and substantial steps to remedy the shortcomings in your practice. This includes your compliance with the NHS undertakings, your attendance at clinics for medically compromised patients and targeted CPD.

Furthermore, the Committee notes the positive results of the audits of medically compromised patients requiring dental extractions as well as your engagement with your supervisor. It is clear that you have made improvements to your practice in the treatment of medically compromised patients, including those taking anticoagulant medication, the planning of extractions and documentation of medical history taking.

The Committee considers that you have been open and honest about your failings and that you have been proactive in addressing the specific issues identified in this case. It has given weight to your supervisor's opinion, who, having worked with you for 5 years considers that the chance of the errors you made in respect of Patient A occurring again "is not likely." In the light of the extensive and comprehensive evidence of remediation that you have undertaken, the Committee has concluded that the risk of repetition of the matters relating to your treatment of Patient A is low. It is satisfied that you do not pose a risk of harm to patients. Indeed, the Committee has also borne in mind that the events in question, although extremely serious, occurred in an otherwise unblemished career.

However, the Committee has had regard to the wider public interest. It has borne in mind the repeated failures in relation to your care of Patient A, which placed her at significant and unnecessary risk of serious harm. In the Committee's view, this was not a single error, but a catalogue of errors. Patient A was a vulnerable patient, with a complex medical history. You failed to recognise this situation despite the fact that this information was made known to you. Having regard to these factors, as well as your breaches of professional standards, the Committee considers that a finding of current impairment is necessary in the wider public interest. It considers that public confidence would be undermined if a finding of impairment were not made in this case.

Having regard to all of these matters, the Committee has determined that your fitness to practise is currently impaired by reason of your misconduct.

Sanction

The Committee next considered what sanction, if any, to impose on your registration. It recognises that the purpose of a sanction is not to be punitive. The Committee has taken into account the GDC's "Guidance for the Practice Committees, including Indicative Sanctions Guidance" (updated May 2019). It has applied the principle of proportionality, balancing the public interest with your own interests.

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

- Your expressions of remorse and apology to the family of Patient A
- Full admissions at the outset to all of the charges and acceptance of your failings throughout these proceedings, without seeking to blame others
- Your full compliance with the undertakings agreed with NHS England in October 2018, including supervision, audits and the additional ongoing work you have undertaken to remediate your failures
- The insight you have shown into your shortcomings and the steps you have taken to ensure that you have addressed the concerns identified in this case.

The aggravating factors identified by the Committee include:

- Your misconduct was not a single error but sustained failings over a series of appointments
- Patient A was put at serious risk of harm because of your failures
- Patient A was a vulnerable patient due to her complex medical history
- The trust that Patient A placed in your clinical care was breached

The Committee has considered the range of sanctions available to it, starting with the least restrictive. It has determined that given the serious nature of the misconduct found, to conclude the case with no further action would not be sufficient in the wider public interest. For the same reasons, the Committee is satisfied that a reprimand is inappropriate and insufficient.

The Committee then considered whether a period of conditional registration would be sufficient. In so doing, it is mindful that it is satisfied that you have addressed the clinical failings identified in this case and that its grounds for finding current impairment relate only to the need to maintain public confidence in the dental profession and uphold professional standards. In these circumstances, the Committee has concluded that the imposition of conditions on your registration would not be appropriate to address the public interest concerns in this case.

The Committee then considered whether a suspension order would be appropriate, bearing in mind its findings of misconduct. It has borne in mind that you failed to provide an acceptable standard of care for Patient A, which resulted in serious harm to her. These failings were repeated over several appointments and could have been avoided.

Nevertheless, the Committee has borne in mind the extensive remediation you have carried out to address the serious concerns identified in this case. You have shown remorse for your shortcomings and have been open and honest in your evidence before this Committee. It is clear that the sad death of Patient A and your appearance before this hearing has had a salutary effect on you. While in no way undermining the seriousness of what you did, the Committee recognises that your misconduct occurred in an otherwise unblemished career.

The Committee considered very carefully whether this is a case where an order of erasure is necessary for the wider public interest, given your serious misconduct. The Committee considers that this sanction would be disproportionate, given the mitigating factors in this case, including your insight and your comprehensive remediation. The Committee has also had regard to the testimonials that speak very positively as to your abilities as a dentist and notes that one element of public interest is that where possible an otherwise good dentist should not be lost to the profession. It considers that this is not therefore a case where your behaviour is fundamentally incompatible with being a dental professional and indeed the reports from those who have been involved in your process of remediation suggest otherwise. The Committee is therefore satisfied that an order of suspension is appropriate.

Accordingly, having regard to all of these factors, the Committee has determined to direct that your registration be suspended for the maximum period, which is 12 months. The Committee is satisfied that this period of time is necessary to mark the severity with which it views your conduct, to uphold professional standards and to maintain public confidence in the profession and the regulatory system. It has had regard to the principle of proportionality and the financial impact this order will have on you. However, in the light of its findings, the Committee is satisfied that the public interests outweigh your own interests in this case.

The Committee has considered whether it is necessary for your case to be reviewed before the end of the period of suspension, bearing in mind that the order is for a prolonged period of time, where it could be said that your skills may deteriorate. The Committee has reminded itself that it has not found current impairment on the grounds that you pose a risk of harm to patients. Indeed, the Committee is satisfied that you have engaged in your remediation over a sustained period of time in a very thorough manner and the risk of repetition of the matters in this case is low. While the Committee recognises that by virtue of the order of suspension, you will not be able to practise as a dentist, it considers that the significant remediation you have done specific to the issues in this case will not be lost by you not practising over a period of a year such that it is necessary to review your case prior to the expiry of the order. As a dental professional, you will still be required to meet with the GDC's CPD requirements during the period of suspension and make any CPD declarations or submissions to the GDC when required. In these circumstances, in considering patient safety, the Committee has no concerns about you returning to unrestricted practise at the expiry of the order. You have appeared before this PCC, accepted fully the charges against you, expressed remorse and apologised to the family of Patient A. In these circumstances, the Committee is not satisfied a review hearing would serve any useful purpose or is required to maintain public confidence in the regulatory system.

The Committee now invites submissions as to whether your registration should be suspended immediately.

Decision on immediate order of suspension

Mr Patel: Having directed that your registration be suspended, the Committee has considered whether to make an order for the immediate suspension of your registration in accordance with Section 30(1) of the Dentists Act 1984 (as amended).

Ms Barnfather, on behalf of the GDC, referred the Committee to the basis of imposing an immediate order, as set out in paragraph of 7.38 of the GDC's "Guidance for the Practice Committees, including Indicative Sanctions Guidance" (updated May 2019). She said that only the third bullet point "immediate action is required to protect public confidence in the profession" was relevant in this case and that it was a matter for the Committee to decide whether such action was necessary on this basis. She made no positive submissions that an immediate order is necessary.

Mr McDonagh, on your behalf, submitted that an immediate order is not necessary. He said that the substantive order of 12 months' suspension is sufficient to meet the need to uphold public confidence in the profession. This was not being a case where the Committee has determined that your behaviour is fundamentally incompatible with remaining on the Register. In addition, Mr Mr McDonagh reminded the Committee that you have been practising without restrictions on your registration for the past two years, without any concerns in relation to your practice. The GDC's Interim Orders Committee had considered the matter at an early stage of proceedings and had determined that an interim order was not necessary.

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

The Committee has borne in mind that its reasons for finding current impairment and directing that your registration be suspended are based solely on the grounds of the wider public interest. It notes that you have been practising since the events in question without concerns or restrictions on your registration. The Committee is satisfied that the public

interest is met by its substantive direction of suspending your registration for the maximum period of 12 months. Accordingly, it has determined that it is not necessary in the public interest to impose an immediate order of suspension on your registration.

Unless you exercise your right of appeal, the Committee's substantive direction for the suspension of your registration for a period of 12 months, as already announced, will take effect 28 days from the date when notice is deemed to have been served upon you. That concludes this hearing."