HEARING HEARD IN PUBLIC

WOLLNER, Christian

Registration No: 84880

PROFESSIONAL CONDUCT COMMITTEE

APRIL 2019

Outcome: Erased with immediate suspension

Christian Wollner, a dentist, Lic Odont Madrid 2001, was summoned to appear before the Professional Conduct Committee on 25 April 2019 for an inquiry into the following charge:

Charge

"That being a registered dentist:

1. You failed to provide an adequate standard of care to Patient A in that:
    a. You failed to undertake appropriate treatment planning in respect of Patient A in that:
        i. You did not take bitewing radiographs:
            a. in or around October 2010;
            b. in or around October 2012.
        ii. You did not take radiographs prior to providing treatment;
            a. on 11 June 2012;
            b. on 26 February 2014.
        iii. You did not undertake and/or record a Basic Periodontal Examination:
            a. on 28 January 2013;
            b. on 6 August 2014;
    b. You failed to treat the cause of an infection at UL45 prior to commencing further treatment.
2. Between 3 January 2011 and 1 September 2014, you failed to maintain an adequate standard of record keeping in respect of Patient A's appointments, in that:
    a. On 11 June 2012 you did not record:
        i. which tooth was treated;
        ii. whether any caries were present on the tooth which was treated;
        iii. the extent of any existing restorations on the tooth;
        iv. the type of crown that was fitted.
    b. On 28 June 2012 you did not record:

i. which tooth was treated;

ii. the type of crown that was fitted;

iii. what adjustments were necessary.

c. On 7 August 2012 you did not record;

i. a diagnosis for the cause of the infection at UL4;

ii. justification for the prescription of Erythromycin.

d. On 28 January 2013 you did not record justification for the prescription of Erythromycin.

e. On 6 February 2013 you prescribed Amoxicillin to Patient A despite Patient A being allergic to Penicillin.

f. On 6 February 2013 you did not record justification for the prescription of Amoxicillin.

g. On 14 February 2013 you did not record justification for the prescription of Erythromycin.

h. You did not record an adequate report of radiographs taken on:

i. 16 August 2012;

ii. 6 August 2014.

i. You did not retain copies of treatment plans dated:

i. 13 June 2011;

ii. 5 April 2012;

iii. 18 May 2012;

iv. 11 June 2012;

v. 26 September 2012;

vi. 15 October 2012;

vii. 28 January 2013.

3. From 25 September 2017 up to at least 12 December 2018 you failed to co-operate with the Council's investigation in that you failed to provide the Council with evidence of your indemnity insurance.

And that, in consequence of the matters set out above, your fitness to practise is impaired by reason of your misconduct."

Mr WOLLNER was not present and was not represented. On 25 April 2019 the Chairman announced the findings of fact to the Counsel for the GDC:

Service

"Mr Thomas appears on behalf of the General Dental Council (GDC) at the Professional Conduct Committee (PCC) hearing of Mr Wollner's case. Mr Wollner is neither present nor

represented at the hearing. In Mr Wollner's absence the Committee first considered whether the GDC had complied with serving the Notice of Hearing on Mr Wollner in accordance with Rules 13 and 65 of the GDC (Fitness to Practise) Rules Order of Council 2006 (the Rules). In so doing, it has borne in mind the submissions made by Mr Thomas and has accepted the advice of the Legal Adviser.

The Committee has received a copy of the Notice of Hearing, dated 15 March 2019, which was sent to Mr Wollner's registered address, a dental surgery, by way of special delivery. The Committee is satisfied that the letter contains proper notification of the PCC hearing, including its time, date as well as its location (CCT venues, Smithfield). The Royal Mail Track and Trace receipt confirms that the item was delivered to Mr Wollner's registered address on 18 March 2019, more than 28 days in advance of today's hearing. Further, the receipt confirms that the letter was signed for, albeit the envelope was later returned to the GDC with a note "no longer works at this practice." In addition, the Committee has had regard to the documents before it which show that the Notice of Hearing was emailed to Mr Wollner via the GDC's secure file share on 15 March 2019. Finally, the Committee has had sight of the email dated 4 April 2019 and a letter which was sent by special delivery dated 5 April 2019 from the GDC to Mr Wollner which informs him that the hearing will now be taking place at the GDC's offices at Wimpole Street, albeit the dates and time of the hearing are the same. Taking all this information into account, the Committee is satisfied that Notice of Hearing has been served on Mr Wollner in compliance with the Rules.

Proceeding in the absence of Mr Wollner

The Committee then considered whether to exercise its discretion under Rule 54 to proceed in Mr Wollner's absence. Mr Thomas submitted that it would be appropriate to proceed in the absence of Mr Wollner. He referred to the documents which demonstrate the steps taken by the GDC to contact Mr Wollner in relation to these proceedings and the absence of any response from him. Mr Thomas advised that Mr Wollner has a duty to inform the GDC where there has been a change in his registered address and to co-operate with the GDC in respect of complaints against him. He has not done so. Mr Thomas submitted that Mr Wollner has voluntarily absented himself from these proceedings and that there is nothing to suggest that an adjournment would secure his attendance at a later date. Finally, Mr Thomas indicated that the GDC intended to call Mr Canty (the GDC's expert) to give evidence at this hearing. Further, the GDC's Caseworker, who has produced a witness statement, was also available to give evidence.

The Committee has considered the submissions made on behalf of the GDC and has accepted the advice of the Legal Adviser. It has borne in mind that the discretion to proceed in the absence of the respondent must be exercised with the utmost care and caution and that it must have in mind the need for fairness to Mr Wollner as well as to the GDC. The Committee notes the attempts made by the GDC on a number of occasions to secure Mr Wollner's engagement in these proceedings, including by letter, email and telephone, and the absence of any response from him. The Committee has concluded that Mr Wollner has voluntarily absented himself from these proceedings. Further, given Mr Wollner's lack of engagement with the GDC, there is nothing to suggest that he would attend on a future occasion, were it minded to adjourn this hearing. The Committee has also had regard to the fact that the matters alleged against Mr Wollner are of some age and that there is a public interest in the expeditious disposal of the case. It notes that the GDC intends to call at least one witness in support of its case. Having regard to all these

factors, the Committee has decided that it is fair and appropriate to proceed in the absence of Mr Wollner in accordance with Rule 54.

The GDC's Case

At the material times Mr Wollner was a dentist practising at Euro Dental Surgery (the Surgery). On 17 August 2016 the GDC received a complaint from Patient A in relation to the treatment he received from Mr Wollner between October 2010 and September 2014. The main thrust of Patient A's complaint was that in February 2013 Mr Wollner prescribed Amoxicillin (an antibiotic) to Patient A despite the fact that Patient A was allergic to Penicillin. Patient A stated that a short while after taking the Amoxicillin he developed an allergic reaction. He was taken by ambulance to hospital where he was told that he had had an anaphylactic reaction to the Amoxicillin. Patient A also complained about other aspects of the treatment provided by Mr Wollner. The clinical records and the handwritten records show that between 18 October 2010 and 1 September 2014 Patient A attended for 23 appointments.

Separate to the matters relating to Patient A, the GDC alleges that from 25 September 2017 until at least 12 December 2018 Mr Wollner failed to co-operate with the GDC's investigation in that he failed to provide the GDC with evidence of his indemnity insurance.

The Committee notes from the Notice of Hearing letter that Case Management Directions were made at the preliminary meeting on 22 February 2019. This included a direction that Mr Wollner was required to notify the GDC by no later than 13 March 2019 of any admissions arising from the charge. Mr Wollner did not respond to the Directions and therefore the Committee has proceeded on the basis that the charges and sub-charges remain in dispute.

In considering whether the charges and sub-charges have been found proved, the Committee has taken into account all the evidence adduced by the GDC. This comprises the documentary information provided by Patient A, including copies of his dental and medical records. The Committee has had regard to the expert evidence of Mr Canty, a dental practitioner, with specialist experience in oral surgery and special care dentistry. He provided a report dated 10 December 2018 in which he set out his opinion in relation to the matters alleged. In that report, Mr Canty confirmed that in preparation of the report, he had reviewed Patient A's initial complaint, copies of Patient A's records and the criteria used to assess the level of Mr Wollner's performance. Mr Canty set out how he assessed whether the care provided fell below or far below the average level of care. His evidence was that the category "far below" was in circumstances where a dentist provided care at such a low level that it fails to meet even the most basic of standards, fails to comply with statutory regulations, causes harm to the patient or is likely to cause harm to the patient.

Mr Canty also gave oral evidence before the Committee in which he broadly confirmed the criticisms set out in his report, albeit in respect of a number of areas he modified his opinion. Overall, the Committee found Mr Canty to be a credible and reliable witness, although it did not accept all of his opinions.

The Committee has also had regard to a signed witness statement dated 2 October 2018 from a GDC Caseworker. He provided the dates upon which the GDC sent correspondence (by letter and/or email) to Mr Wollner, requesting him to provide evidence of indemnity insurance between the period 25 September 2017 and 26 July 2018, which Mr Wollner failed to do. This included the GDC reminding Mr Wollner of his obligation to co-operate with any inquiries from the GDC under Standard 9.4 of the GDC's '*Standards for*

the Dental Team'. In view of Mr Wollner's failure to engage with the GDC's investigation, his case was transferred to the Case Examiner Support Team on 26 July 2018. The Committee found the GDC's Caseworker evidence to be helpful.

The Committee has accepted the advice of the Legal Adviser. It 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, namely on the balance of probabilities. Mr Wollner need not prove anything. In accordance with that advice the Committee has considered each charge separately. I will now announce the Committee's findings as follows:

1. a. i. a.	*You failed to provide an adequate standard of care to Patient A in that:* *You failed to undertake appropriate treatment planning in respect of Patient A in that: You did not take bitewing radiographs:* *in or around October 2010* **Found not proved** On 18 October 2010 Patient A attended for an appointment and the handwritten notes for that appointment state "PCO [Patient complained of] sore gum upper left 3 area." The computerised clinical records record "temp cover has fallen out. Placed Structur 2 and advised patient that this might not stay for long..." Mr Canty noted that there was no record that any bitewing radiographs were taken in respect of this patient. He considered that in view of the patient's caries risk being recorded as low, he would have expected Mr Wollner to have taken bitewing radiographs at approximately 24-month intervals. His evidence, as set out in his report, was that during the period under review, bitewing radiographs should have been taken on or about October 2010 and October 2012. During the course of his evidence, Mr Canty explained that radiographs provided additional information that was not possible to obtain with a clinical examination alone. He also referred to relevant guidance in respect of the taking of radiographs, including the "*NRPB, Department of Health (2001) Guidance Notes for Dental Practitioners on Safe Use of x-Ray equipment".* In his oral evidence, and in response to questions put to him by one of the panellists on the Committee, Mr Canty accepted that the appointment for 18 October 2010 could be considered to be for emergency treatment and therefore he was no longer critical of Mr Wollner's failure to carry out bitewing radiographs in or around October 2010. However, he maintained his overall criticism of Mr Wollner's failure to carry out appropriate radiographic assessments in accordance with relevant guidance. The Committee accepted Mr Canty's evidence on this matter. It has concluded that the appointment on 18 October 2010 was in respect of emergency treatment and in the light of the concession made by Mr Canty, it is not satisfied that Mr Wollner had a duty to take a bitewing at this particular appointment.
1. a. i. b.	*in or around October 2012* **Found not proved** Patient A attended for three appointments in October 2012 – 15

	October, 25 October and 30 October. For the 15 October appointment, the computer records show that the patient had attended because the crown to the upper left 4 had come out. The treatment plan was to recement the crown. On 25 October 2012, the computer records show that the crown had fallen out again and there is a detailed note as to what was discussed with the patient. The computer records for the appointment on 30 October 2012 record "adjusted core to re cement his own crown crown fit ok". Mr Canty's position was that bitewing radiographs should have been taken on or about October 2010 and October 2012, for the reasons set out at 1(a)(i)(a) above. He maintained this position in his oral evidence and said that this requirement was important by October 2012, given that bitewing radiographs had not been taken for Patient A in a two year period. Mr Canty did not accept the suggestion put to him by one of the panellists on the Committee that all these appointments were emergency appointments. However, the Committee considers that it is clear from the entries in the clinical records that these three appointments were for emergency treatment for the same tooth in relation to the crown which had fallen out. It therefore rejects Mr Canty's evidence on the issue as to whether these appointments were for emergency treatment. In these circumstances, while it considers that Mr Wollner had a duty to take bitewing radiographs in a two year period, the Committee is not satisfied that the GDC has established to the requisite standard that he had a duty to do so at the appointments in October 2012. Accordingly, it finds this charge not proved.
1. a. ii. a.	*You did not take radiographs prior to providing treatment* *on 11 June 2012* **Found proved** The clinical notes show that on 11 June 2012 Mr Wollner prepared a tooth according to the treatment plan and consent form for a crown, and that 'crown prep' took place at this appointment. However, the tooth notation is not recorded. Mr Canty's evidence was that a radiograph should have been taken at that appointment as part of the assessment before carrying out crown work. He explained that the radiograph would have provided additional information that was not possible to obtain with clinical examination alone. Mr Canty also referred to the "*Faculty of General Dental Practitioners (UK)(2009) Clinical Examination & Record-Keeping"* guidance. Mr Canty maintained his position that he would have expected radiographs to have been taken to see the presence of any pathology before embarking on treatment. The Committee accepts Mr Canty's evidence and finds this charge proved.
1. a. ii. b.	*On 26 February 2014* **Found proved** The clinical notes report that Patient A had swallowed the crown and that post crown preparation was carried out at UL4. There is no evidence of a radiograph having been taken at this appointment. Mr

	Canty's evidence was that a radiograph should have been taken at this appointment as part of the assessment before carrying out crown work. In his oral evidence Mr Canty explained that the UL4 had a history of a crown repeatedly failing and that it was important to take a radiograph at this appointment. The Committee has accepted Mr Canty's evidence on this matter.
1. a. iii. a.	*You did not undertake and/or record a Basic Periodontal Examination:* *on 28 January 2013* **Found not proved** The clinical notes for 28 January 2013 record "pt has had excruciating pain on lower left quadrant over the weekend. Very painful to bite down….E/O Examination shows: NIL; I/O Examination: 35 has been filed down so that pt could floss by emergency dentist." Mr Canty's evidence, as set out in his report, was that he would have expected Mr Wollner to have carried out BPEs at least annually in accordance with the *British Society of Periodontology (2011) guidance.* He noted that Mr Wollner's practice was to record the scores within computerised records, as recorded on 13 June 2011 and 2 February 2012, and there was no record of BPE scores at this appointment or that on 6 August 2014. In his oral evidence Mr Canty clarified that in his opinion a BPE should have been undertaken as part of the course of treatment started on 28 January 2013. He conceded, however, that as this was an emergency appointment, he did not consider it was a failure to not undertake a BPE at the appointment on 28 January 2013. Whilst the Committee accepts the expert evidence that a BPE should have been carried out in early 2013, in accordance with the *British Society of Periodontology's guidance,* it is not satisfied that this should have been carried out specifically on 28 January 2013. This was because the entry in the clinical notes for that appointment suggests that it was for the provision of emergency treatment to alleviate Patient A's pain in the lower left quadrant. In the Committee's view, the priority would have been for Mr Wollner to deal with Patient A's presenting complaint and to have carried out BPEs as part of a routine check-up for Patient A at another appointment. Accordingly, the Committee finds this charge not proved.
1. a. iii. b.	*on 6 August 2014* **Found proved** The Committee took into account the same evidence as set out in charge 1.a.iii.a above. The clinical notes record "Crown has fallen out ULQ. … Recement of crown attempted but unsuccessful… " Mr Canty's evidence, as set out at 1.a.iii.a above, was that he would have expected Mr Wollner to have carried out BPEs at least annually and that there was no evidence of this having taken place at this appointment. In oral evidence Mr Canty reaffirmed his opinion that this was an appointment at which a BPE could be carried out and therefore it was a failure on the

	part of Mr Wollner not to carry out such an examination in accordance with the guidance. The Committee noted that it was now more than two years since Mr Wollner had carried out a BPE (as it was his practice to record findings of any BPEs) and it was incumbent on him to carry out a BPE at the next appropriate appointment. In light of the clinical notes, the Committee accepted Mr Canty's opinion that this was an appropriate appointment at which to carry out a BPE. Accordingly, the Committee finds this charge proved.
1. b.	*You failed to treat the cause of an infection at UL45 prior to commencing further treatment* **Found proved** Mr Canty's evidence was that Mr Wollner had a duty to treat the cause of the infection at UL45 prior to commencing further treatment on 26 February 2014. He noted that on 26 February 2014, when Patient A had attended an appointment, having swallowed the crown at UL4, some discussions, including the poor long-term prognosis of UL4 are recorded in the notes. However, at that appointment Mr Wollner decided to replace the post crown. Mr Canty observed that there was no record that Mr Wollner had investigated the cause of or treated the underlying infection associated with this tooth before carrying out the crown. Further, a radiograph was not taken on 26 February 2014 as part of the assessment of UL4 prior to crowning. Mr Canty opined that the deficiencies of the root fillings at UL45 and the presence of infection were evident on the radiograph taken by Mr Wollner on 16 August 2012 but remained untreated. He was therefore critical of Mr Wollner's failure to treat the cause of infection from 16 August 2012 (the date when the radiograph was taken, which showed infection) to 26 February 2014, when he provided a new crown at UL4. Between those dates, the crown fell out on more than one occasion and was recemented, but there is nothing in the clinical records to show that Mr Wollner treated the cause of the infection at UL45. In his oral evidence Mr Canty maintained his criticism and explained that repeatedly replacing the crown over a period of time without treating the underlying infection was a serious failing. He explained that the provision of a new crown in 2014 was a definitive form of treatment that was irreversible and prevented other treatment options. The Committee accepts Mr Canty's evidence on this matter and finds this charge proved.
2. a. i. – 2.a.iiii	*Between 3 January 2011 and 1 September 2014, you failed to maintain an adequate standard of record keeping in respect of Patient A's appointments, in that:* *On 11 June 2012 you did not record:* *which tooth was treated* *whether any caries were present on the tooth which was treated*

	the extent of any existing restorations on the tooth **Found proved** The Committee reviewed the clinical notes and it had regard to the evidence of Mr Canty. Mr Canty stated that there is no record regarding 11 June 2012 in the clinical notes as to which tooth is being treated, whether any caries was present in the tooth which was treated and the extent of any existing restorations on the tooth. Mr Canty explained the importance of maintaining an adequate standard of record keeping in general terms. He stated that the Registrant has failed to record important information that any treating dentist should record prior to treatment and any subsequent treating dentist would not have the relevant information before him as to past treatment. The Committee accepted Mr Canty's evidence and found these charges proved.
2. a. iv.	*the type of crown that was fitted* **Found not proved** The clinical notes confirm that a temporary restoration was fitted on this date and the note specifies the type of temporary material used. Mr Canty clarified in oral evidence that his criticism related to a failure to record the type of crown to be provided, rather than to any temporary restoration provided. In light of Mr Canty's clarification in oral evidence and having regard to the clinical records the Committee finds this charge not proved.
2. b. i. - 2.b.ii	*On 28 June 2012 you did not record:* *which tooth was treated* *The type of crown that was fitted* **Found not proved** Within the patient records provided to the Committee there is reference to the tooth treated and the type of crown fitted. This was found in the clinical chart and the treatment summary, however it was not within the main body of the clinical notes. Mr Canty was critical of this. However, the Committee finds that the record of this crown was set out in the treatment summary and whilst not ideal, it concluded that it was adequate. It therefore concluded that 2bi and 2bii are not proved.
2. b. iii.	*What adjustments were necessary* **Found proved** The Committee noted that the clinical notes stated only basic information: "adjusted crown until patient happy". Mr Canty stated that other than this information above, "there are no further details of what adjustments were necessary such as the occlusal surfaces or the margins." Mr Canty said that this record was not an adequate clinical record detailing the clinical process to be carried out. He expanded on this aspect of his report in oral evidence. He said a dentist will not always recall treatment they have provided and it is important for any

	subsequent treating dentist to know what treatment has been undertaken. The Committee has accepted Mr Canty's evidence and has found this charge proved.
2. c. i.	*On 7 August 2012 you did not record;* *a diagnosis for the cause of the infection at UL4* **Found proved** The clinical notes record "PCO… pain from upper crown since 5 days ago…..". The word 'diagnosis' appears in the record but is blank. Mr Canty's evidence was that it was apparent from the radiograph taken by Mr Wollner on 16 August 2012 that there was infection at UL45 and that given that antibiotics were prescribed on this occasion he would have expected to have seen a record of a diagnosis in the notes. There is no note of a diagnosis. The Committee accepts Mr Canty's evidence on this matter and finds this charge proved.
2. c. ii.	*justification for the prescription of Erythromycin* **Found proved** The clinical notes record "Script Erythromycin 500mg every 8 hours for 8 days." There is no record of a diagnosis for the cause of the infection at the UL4 and there is no record of the justification for the prescription of the Erythromycin, the dose or the number of days prescribed. Mr Canty's evidence was that 5 days is the normal dose and there was no rationale as to Mr Wollner's decision to prescribe 8 days. He maintained this position in his oral evidence. The Committee accepts Mr Canty's evidence on this matter and finds this charge proved.
2. d.	*On 28 January 2013 you did not record justification for the prescription of Erythromycin* **Found proved** The clinical notes for this appointment record that Patient A had "excruciating pain from the lower left quadrant over the weekend" and attended another practice where a course of Metronidazole was prescribed. On 28 January 2013 Erythromycin 500mg, every 8 hours for 8 days, was prescribed. The notes for this date also record "Pt adv to take stronger course of Abs to settle tooth down." Mr Canty was critical of the absence of any justification recorded for this prescription or why it was prescribed for a non-standard duration and frequency. The Committee accepts Mr Canty's evidence on this matter and finds this charge proved.
2. e.	*On 6 February 2013 you prescribed Amoxicillin to Patient A despite Patient A being allergic to Penicillin* **Found not proved** The stem of this charge is put on the basis of a failure to maintain an adequate standard of record keeping. However, the conduct complained of relates to prescribing and not record keeping, which is

	dealt with at charge 2.f. below. Accordingly, it finds this charge not proved.
2. f.	*On 6 February 2013 you did not record justification for the prescription of Amoxicillin* **Found proved** Amoxicillin 500mg for 8 days was prescribed by Mr Wollner on 6 February 2013. The Committee notes from the evidence before it that Patient A suffered an adverse reaction to the Amoxicillin as recorded in the hospital records for later that same day. The clinical notes record that Amoxicillin had been prescribed by Mr Wollner on that date with the comment: "Patient afirmes [sic] not to be allergic to penicillin." The Committee's attention has been drawn to a handwritten patient record for 5 September 2007 which states that Patient A is "allergic to Penicillin + Erythromycin" with an additional note beside this stating "?? 08 Mar 2013 pt says he is fine with erythromycin". Mr Canty's evidence was that there is no record as to why Amoxicillin was prescribed on 6 February 2013 in light of the previously recorded allergy. He explained that he would have expected there to have been a record in the notes in further detail about his discussion with the patient and there was insufficient information to that effect. The Committee accepts Mr Canty's evidence and finds this charge proved.
2. g.	*On 14 February 2013 you did not record justification for the prescription of Erythromycin* **Found proved** Erythromycin 500mg for 8 days was prescribed by Mr Wollner on 14 February 2013. Mr Canty's evidence was that there was no justification as to why this antibiotic was prescribed on this date, when the patient had received a course of antibiotics some 14 days earlier. The Committee accepts Mr Canty's evidence and finds this charge proved.
2. h. i.	*You did not record an adequate report of radiographs taken on:* *16 August 2012* **Found not proved** The Committee had regard to the clinical notes of 16 August 2012.The notes state the notation of the tooth, that a periapical radiograph was taken and "an abscess visible inside the tooth". Mr Canty in his report states that in his opinion Mr Wollner failed to record an adequate report of the clinical findings of the radiographs taken on 16 August 2012. He expanded on this in his oral evidence. He said that there is no reporting of a lack of root filling in UL4 and the inadequacy of the root filling in the UL5. He also referred to the standard set out in the G*uidance Notes for Dental Practitioners on the Safe use of x-ray equipment NRPB, Dept of Health (2001*). The Committee considered this guidance, however it came to a different conclusion than Mr Canty having regard to all the evidence. The Committee finds that in the context of this appointment

	that the report was adequate and included findings relevant to the patient's management and prognosis. The Committee therefore finds this charge not proved.
2. h. ii.	*6 August 2014* **Found proved** The clinical notes show notation of the tooth, that a periapical radiograph was taken and the radiograph report noted "a short root with periapical periodontitis". Mr Canty's criticism was in light of the absence of root canal treatment on the UL4 and the inadequate root filling on the UL5, this was an inadequate report given the treatment attempted. The Committee accepts Mr Canty's evidence given the nature of this appointment, where the recementing of a post crown was being attempted that the report of the radiograph was inadequate. The Committee therefore finds this charge not proved.
2. i. i. – 2.i.vii	*You did not retain copies of treatment plans dated:* *13 June 2011* *5 April 2012* *18 May 2012* *11 June 2012* *26 September 2012* *15 October 2012* *28 January 2013* **Found not proved** The clinical notes record that NHS treatment plan forms FP17(DC) were signed by Patient A on the dates above. Mr Canty's evidence was that none of these forms were provided to him for review. His evidence was that he would have expected copies of these forms or equivalent private treatment forms to have been available for review, but the Surgery has reported that none were available. In oral evidence Mr Canty conceded that retention of records could be affected by administrative procedures within the Surgery and so he was not particularly critical. No explanation was provided to the Committee as to why the treatment forms were unavailable. Further the Committee was not satisfied to the required standard that it had sufficient evidence before it to demonstrate that the lack of treatment plans was the fault of Mr Wollner. Accordingly, the Committee finds this charge not proved.
3.	*From 25 September 2017 up to at least 12 December 2018 you failed to co-operate with the Council's investigation in that you failed to provide the Council with evidence of your indemnity insurance.* **Found proved**

	The Committee considered the factual evidence which the GDC Caseworker set out in his witness statement and his oral evidence. He detailed the efforts made by the GDC to engage with the Registrant during the period from 25 September 2017 until 26 July 2018. The Committee was not provided with any evidence to demonstrate a lack of engagement up to the specific date of "at least 12 December 2018", as set out in the Charge, although the Committee accepts that there is no evidence of the Registrant engaging with the GDC investigation at all. The correspondence from the GDC to Mr Wollner was mostly sent by secure email and/or registered post and there was one failed telephone call. No response was received during the period from 25 September 2017 until 26 July 2018. In a letter dated 25 September 2017 Mr Wollner was asked to provide copies of his current professional indemnity certificate and the indemnity certificates for the relevant periods to which the charges relate. He was given until the 9 October 2017 to respond. Mr Wollner is under a duty to co-operate with the Council's investigation under 9.4 of the standards for the dental team. There is no evidence that Mr Wollner provided the GDC with evidence of the relevant indemnity certificates at all. As a practising dentist Mr Wollner was required to hold indemnity insurance at all times in accordance with the standards for the dental team; standard 1.8. Accordingly, the Committee finds this charge proved insofar as it refers to the period from 25 September 2017 until 26 July 2018.

We move to Stage Two."

On 25 April 2019 the Chairman announced the determination as follows:

"Mr Thomas, on behalf of the General Dental Council (GDC), made submissions in accordance with Rule 20(1)(a) of the Fitness to Practise Rules 2006.

Previous fitness to practise history

Mr Thomas advised the Committee that Mr Wollner has a previous fitness to practise history. On 2 December 2016, a Professional Conduct Committee (PCC) found proved matters relating to Mr Wollner's diagnostic assessment, record keeping, periodontal record keeping, radiographical record keeping, treatment of patients, and compliance with fitness to practise investigations. Mr Wollner was suspended for a period of 12 months with an immediate suspension.

The PCC reviewed the order on 12 December 2017 when it found that Mr Wollner's fitness to practise remained impaired. It directed that the suspension order be extended for a period of 12 months. In its determination the PCC commented:

> *'In the light of the Committee's outstanding concerns about public safety, it determined that it would be wholly inappropriate to terminate the current suspension order or to allow it to lapse. It decided that some ongoing restriction of Mr Wollner's registration is necessary to safeguard the public and to uphold the wider public interest.'*

The PCC reviewed the order on 27 November 2018 and directed that the order be extended for a further period of six months. At that hearing, the PCC observed that Mr Wollner had not engaged with the process, nor was there any indication that he would engage in the future. It commented on his pattern of non-engagement which had persisted for 2 years. In the Committee's judgement, there was:

> *'no evidence or other material from him suggesting any insight, reflection or remediation. In these circumstances, the Committee determined that there remains a real risk of repetition. There is therefore a risk of harm to the public should he be allowed to practise without restriction. Public confidence in the profession and this regulatory process would also be seriously undermined if no finding of impairment were maintained today, given Mr Wollner's failure to demonstrate any insight, reflection or remediation in relation to his misconduct.'*

Submissions on behalf of the GDC

Mr Thomas submitted that the findings against Mr Wollner amount to misconduct and that his fitness to practise is currently impaired by reason of his misconduct. The GDC's position is that although Mr Wollner has complied with the existing suspension order on his registration, he has not provided any information or engaged with the GDC. Mr Thomas submitted that the appropriate sanction is an order of erasure.

The Committee has exercised its own professional judgement on the matters under consideration. It has accepted the advice of the Legal Adviser.

Misconduct

The Committee first considered whether the facts found proved against Mr Wollner amount to misconduct. In so doing, it has had regard to all the evidence before it, including the expert evidence of Mr Canty (called on behalf of the GDC), as well as the submissions made by Mr Thomas.

This case concerns the treatment and care Mr Wollner provided to Patient A between October 2010 and September 2014 while he was practising at Euro Dental Surgery (the Surgery). In summary, the Committee has found that Mr Wollner failed to provide an adequate standard of care to Patient A, by:

- Failing to take radiographs prior to providing treatment on two occasions.
- Failing to undertake and/or record a Basic Periodontal Examination on 6 August 2014.
- Failing to treat the cause of an infection at UL45 prior to commencing further treatment.

In addition, the Committee has found that Mr Wollner failed to maintain an adequate standard of record keeping at appointments between June 2012 and August 2014, including failing to record justification for prescriptions on four occasions and failing to record an adequate report of a radiograph taken on one occasion.

Further, he has failed to co-operate with the GDC's investigation between 25 September 2017 and 26 July 2018, including failing to provide evidence of his indemnity insurance.

Mr Canty's opinion was that Mr Wollner's work fell far below the expected standard in a number of the areas. In respect of patient care, Mr Canty's opinion was that the failure to treat the cause of an infection, prior to commencing further treatment fell far below the

expected standard. In respect of the record keeping allegations, Mr Canty's opinion was that when taken collectively, they amounted to a falling far below the expected standard. He also referred to Mr Wollner's failure to adhere to relevant guidance, including the GDC's Standards (2005 and 2013 versions); The Faculty of General Dental Practitioners' Guidance on "Clinical Examination and Record Keeping" (2009) and the British Society of Periodontology's guidance on "Basic Periodontal Examination" (2011). The Committee accepts Mr Canty's opinion.

Having regard to the findings against Mr Wollner, the Committee is satisfied that he has breached the GDC's Standards relevant at the material times (2005 and 2013 versions). For the 2005 Standards, the Committee has found that he has breached the following standards:

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

1.6: Make sure your patients are able to claim any compensation they may be entitled to by making sure you are protected against claims at all times, including past periods of practice.

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

For the 2013 version the Committee has also had regard to Mr Wollner's breach of the following standards:

7.1: Provide good quality care based on current evidence and authoritative guidance.

9.4 Co-operate with any relevant formal or informal inquiry and give full and truthful information.

The Committee considers that a number of the findings against Mr Wollner are serious. These include the failure over a sustained period to treat the cause of an infection prior to commencing further treatment, failing to record a diagnosis for the cause of that infection, failing to record an adequate radiographic report and failing to co-operate with the GDC's investigation**.** The Committee considers that Mr Wollner's care of Patient A caused harm by his failure to adequately treat the cause of Patient A's infection over a sustained period.

The Committee takes a serious view of Mr Wollner's failure to engage with the GDC over a long period of time, including his failure to provide evidence of indemnity insurance. The GDC makes it clear that all dental professionals must have indemnity cover in place so that patients can claim any compensation they may be entitled to. It is the registrant's responsibility to ensure that such cover is appropriate and is maintained. The public is entitled to expect that registered dental professionals will engage with their professional body and provide evidence of indemnity cover to the regulator when requested. A failure to do so undermines public confidence in the profession and demonstrates a disregard for the role of the regulator. Accordingly, the Committee has determined that the facts found proved amount to misconduct.

<u>Current impairment</u>

The Committee next considered whether Mr Wollner's fitness to practise is currently impaired by reason of his misconduct. Throughout its deliberations, it has borne in mind that its primary duty is to address the public interest, which includes the protection of patients, the maintenance of public confidence in the profession and the declaring and upholding of proper standards of conduct and behaviour.

The Committee has had regard to the factors set out in Cohen v General Medical Council [2008] EWHC 581 (Admin).

In the absence of any evidence of remediation, the Committee considers that Mr Wollner continues to pose a risk to patients. There are no testimonials provided from fellow dentists or patients. There is also no current information about Mr Wollner's working arrangements. The Committee has also had regard to the question of Mr Wollner's insight. It has received no evidence from Mr Wollner as to his recognition of his wrong-doing in respect of the allegations.

The Committee has concerns about Mr Wollner's lack of engagement with the GDC in relation to these proceedings.

In the absence of any engagement or evidence of remediation from Mr Wollner, the Committee could not assess the level, if any, of Mr Wollner's insight. The Committee therefore considers that there is a risk of repetition of the misconduct found proved and that Mr Wollner remains a risk to the public and therefore his fitness to practise is currently impaired.

The Committee has further considered the wider public interest, including the need to declare and uphold proper standards of conduct and behaviour to maintain public confidence in the profession. The Committee has found that Mr Wollner failed to provide an appropriate standard of care to Patient A. The clinical failings involve shortcomings in basic areas of dentistry that were serious, with the potential of causing harm to Patient A. Taken together with his lack of engagement with his regulator, the Committee considers that public confidence would be seriously undermined if a finding of impairment were not made.

Accordingly, the Committee has determined that Mr Wollner's fitness to practise is impaired by reason of his misconduct.

Sanction

Having determined that Mr Wollner's fitness to practise is currently impaired by reason of his misconduct, the Committee has considered what sanction, if any, to impose on his registration. In so doing, it has had regard to the GDC's "Guidance for the Practice Committees including Indicative Sanctions Guidance" (October 2016).

The Committee has considered the range of sanctions available to it, starting with the least restrictive. Throughout its deliberations, the Committee has applied the principle of proportionality, weighing the interests of the public with Mr Wollner's own interests.

The Committee has taken into account the mitigating and aggravating features of this case. It is not aware of any mitigating factors in this case. The aggravating factors include actual harm and a risk of harm to patients, misconduct which was sustained and repeated over a period of time given the identified failings in another GDC fitness to practice proceeding where impairment is still found, the absence of any evidence of remediation or insight and his failure to engage with the GDC in relation to his indemnity arrangements. The

Committee has also had regard to Mr Wollner's previous fitness to practise history, and the absence of any engagement by him in relation to those matters.

The Committee has determined that it would be inappropriate to conclude this case without taking any action or by the issuing of a reprimand. These courses of action would not be sufficient for the protection of patients or the wider public interest, given the serious nature of the findings in this case as well as the absence of any remediation or engagement by Mr Wollner with the GDC. In addition, the Committee considers that Mr Wollner poses a risk to patients and that it is necessary to restrict his registration.

The Committee next considered whether a period of conditional registration would be appropriate in this case. In so doing, it is aware that any conditions imposed must be proportionate, measurable, workable and verifiable. Since the Committee has no information about Mr Wollner's current circumstances it considers that conditions would be unworkable. Further, Mr Wollner is not engaging in these proceedings nor has he attended his previous hearings. The Committee takes a serious view of the findings against Mr Wollner as well as the absence of any remediation or insight. Taking all these factors into account, the Committee has concluded that conditions would not be sufficient for the protection of patients, or the wider public in maintaining public confidence in the dental profession.

The Committee next considered whether it should impose a period of suspension. The findings against Mr Wollner amount to serious departures from the relevant professional standards. He failed repeatedly to adhere to regulations and guidelines in place and the standard of care provided by him in relation to Patient A fell far below the expected standard. In addition, the Committee has had regard to Mr Wollner's failure to engage with the GDC over a sustained period of time, including his failure to provide the GDC with evidence of his indemnity insurance. This demonstrates a serious attitudinal issue which undermines public confidence in the profession and its regulator and as such, makes a suspension inappropriate.

The Committee has concluded that Mr Wollner's misconduct is so serious that it is fundamentally incompatible with his remaining on the Dentists' Register. Accordingly, the Committee has determined that the appropriate and proportionate sanction in this case is that of erasure. The Committee has taken into account the adverse impact of such a direction on Mr Wollner. However, in the light of the serious nature of the findings against Mr Wollner, the Committee considers that the need to protect patients and the public interest outweighs his own interests in this matter.

The Committee now invites submissions as to whether Mr Wollner's registration should be made subject to an immediate order, pending the substantive direction of erasure taking effect.

Decision on immediate order

Having directed that Mr Wollner's name be erased from the Dentists' Register, the Committee has considered whether to make an order for immediate suspension of Mr Wollner's registration in accordance with Section 30(1) of the Dentists Act 1984 (as amended) (the Act).

Mr Thomas, 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 nature of the Committee's findings.

Having regard to the risks to patients identified in its decision to make a direction of erasure, the Committee has determined that it is necessary for the protection of the public and is otherwise in the public interest that Mr Wollner's registration be suspended forthwith, in accordance with Section 30(1) of the Act.

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

That concludes this case."