HEARING HEARD IN PUBLIC

ELSTON, Julie Helen

Registration number: 63792

PROFESSIONAL CONDUCT COMMITTEE

MAY 2017 – JUNE 2020*

Most recent outcome: Conditions extended for 18 months (with a review)

***See page 30 for the latest determination**

Julie Helen ELSTON, a dentist, BDS Ncle 1988, is summoned to appear before the Professional Conduct Committee on 22 May 2017 for an inquiry into the following charge:

Charge (as amended on 22 May 2017, final charge January 2018)

"That being a Registered Dentist:

1. At all material times you were practising at [address redacted].
2. From 26 January 2005 – 18 April 2013 you were Patient A's General Dental Practitioner (GDP).
3. From 26 January 2005 – 18 April 2013 you failed to carry out a full assessment of Patient A's presenting dental condition adequately and/or at all.
4. You failed to obtain and/or update medical history of Patient A on the following:-
   a. 26 January 2005;
   b. 09 June 2005 ;
   c. 28 November 2006;
   d. 15 December 2006;
   e. 11 January 2007;
   f. 19 June 2007;
   g. 20 July 2007;
   h. 27 February 2008;
   i. 20 May 2009
   j. 19 June 2009
   k. 18 December 2009
   l. 25 June 2010
   m. 10 December 2010;
   n. 06 May 2011;
   o. 02 June 2011;

p. 09 June 2011;

q. 09 December 2011;

r. 21 December 2011;

s. 13 April 2012;

t. 13 July 2012;

u. Withdrawn by the GDC.

5. Between 28 November 2006 and 08 April 2013, you failed to provide any or any adequate treatment plan in respect of:

(a) UL6 and/or;

(b) UL5 and /or;

(c) LR5 and /or;

(d) UL4 and /or;

(e) LL7 and /or;

(f) UR7 and /or;

(g) UL7 and /or;

(h) UR6 and /or;

(i) LR6.

6. You failed to take Bite-wing x-rays on:

(a) 26 January 2005;

(b) 28 November 2006;

(c) 27 February 2008;

(d) 19 June 2009;

(e) 18 December 2009;

(f) 25 June 2010;

(g) 10 December 2010;

(h) 02 June 2011;

(i) 09 December 2011;

(j) 13 July 2012;

(k) 18 April 2013.

7. On 18 April 2013 you failed to adequately treat and/or otherwise manage the caries present at:

(a) LR6 and/or;

(b) UL5 and/or;

8. On 10 December 2010 and/or 6 May 2011 you treated Patient A. In treating the LR5

you failed to obtain informed consent in that you did not:

(a) inform Patient A of all the treatment options;

(b) explain to Patient A the risks and benefits of the available treatment options;

9. On 13 April 2012 you provided Patient A with a crown at UR6. In so doing you failed to obtain informed consent in that you did not:

(a) inform Patient A of all the treatment options;

(b) explain to Patient A the risks and benefits of the available treatment options;

10. On 25 June 2007 you extracted Patient A's UL6. In so doing you failed to obtain informed consent in that you did not:

(c) inform Patient A of all the treatment options;

(d) explain to Patient A the risks and benefits of the available treatment options;

12. On 19 June 2007 in respect of UL6 you:

(a) failed to identify and/or diagnose the cause of Patient A's pain adequately and/or at all;

(b) failed to alleviate Patient A's pain by clinical intervention;

(c) prescribed antibiotics when there was no clinical indication for doing so.

13. On 08 April 2013 in respect of LR6 you:

(a) failed to identify and/or diagnose the cause of Patient A's pain adequately and/or at all;

(b) failed to alleviate Patient A's pain by clinical intervention;

(c) prescribed antibiotics when there was no clinical indication for doing so.

14. You administered a local anaesthetic to Patient A in a quantity in excess of that which was required on:

(a) 19 June 2009 and/or;

(b) 18 December 2009 and/or;

(c) 25 June 2010 and/or;

(d) 02 June 2011 and/or;

(e) 20 October 2012 and/or;

(f) 18 April 2013.

15. On 18 April 2013 as a consequence of your actions at 14 above, Patient A suffered acute and/or severe systemic adverse effects from toxicity.

16. On 22 January 2013 you took a periapical radiograph of Patient A. In so doing you failed to:

(a) ensure the radiograph was of sufficient quality to be of diagnostic value

(b) record an evaluation of the radiograph adequately and/or at all.

17. On 25 June 2007 you failed to take any or any adequate periapical pre-operative

radiograph before extracting Patient A's UL6.

18. On 06 May 2011 you failed to take any or any adequate pre-operative periapical radiograph of Patient A's LR5;

19. On 13 April 2012 you failed to take any or any adequate pre-operative periapical radiograph of Patient A's UR6;

20. On 22 January 2013 you failed to take any or any adequate pre-operative periapical radiograph of Patient A's UL7.

21. On 19 June 2007 Patient A attended with pain at UL6. On 25 June 2007 you extracted the UL6. In so doing you represented to Patient A that root canal therapy was not available on the NHS.

22. Your conduct at 21 above was:

    (a) inappropriate;

    (b) misleading;

    (c) dishonest.

23. Your record-keeping in relation to Patient A was inadequate in that you failed to record any or any adequate:

    (b) the type of local anaesthetic used on:

        I. 28 November 2006

        II. 15 December 2006

        III. 23 January 2007

    (c) The quantity of anaesthetic used on:

        I. 28 November 2006

        II. 15 December 2006

        III. 23 January 2007

    (i) detail of the crown preparation undertaken at LR5 on 6 May 2011;

    (j) detail of the crown preparation undertaken at UR6 on 13 April 2012;

    (k) evaluation of the periapical radiograph taken on 22 January 2013.

    (l) medical history and /or updated medical history of Patient A on;

        I. 26 January 2005;

        II. 09 June 2005;

        III. 28 November 2006;

        IV. 15 December 2006;

        V. 11 January 2007;

        VI. 19 June 2007;

        VII. 20 July 2007;

VIII. 27 February 2008;

IX. 20 May 2009;

X. 19 June 2009;

XI. 18 December 2009;

XII. 25 June 2010;

XIII. 10 December 2010;

XIV. 06 May 2011;

XV. 02 June 2011;

XVI. 09 June 2011;

XVII. 09 December 2011;

XVIII. 21 December 2011;

XIX. 13 April 2012;

XX. 13 July 2012;

XXI. Withdrawn by the GDC.

(m) assessment of Patient A's presenting dental condition

And that by reason of the facts alleged above your fitness to practise as a dentist is impaired by reason of your misconduct."

On 25 May 2017 the Hearing adjourned part heard and resumed on 15 January 2018.

On 22 January 2018 the Chairman made the following statement regarding the finding of facts:

"Ms Elston:

This is a Professional Conduct Committee hearing. You are represented by Ms Tanchel, Counsel. Mr Grey, Counsel, appears on behalf of the General Dental Council (GDC). The hearing began on 22 May 2017 and went part heard on 25 May 2017 following the conclusion of your evidence. The hearing then resumed on 15 January 2018 at which point the Committee received evidence from Mr Holden, your expert witness.

At the outset of the hearing in May 2017 Mr Grey made an application under Rule 18(1) of the GDC (Fitness to Practise) Rules (the Rules), to amend the charge set out in the Notification of Hearing by withdrawing charges 4(u) and 23(l)(xxi). These two charges relate to alleged failures concerning an appointment that took place on 2 April 2013, which the Committee has heard was on a date when you were not working. He also invited the Committee to make the following minor typographical corrections to the charges:

Charge 15 – delete '12' and replace it with '14'

Charge 17 – delete UR6 and replace it with 'UL6'

Charge 23(k) – delete the word 'periodical' and replace it with the word 'periapical'

Ms Tanchel confirmed that she did not oppose this application. The Committee accepted the advice of the Legal Adviser. It was satisfied that the amendments to the charge could be

made without injustice. Accordingly, it acceded to Mr Grey's application and agreed to withdraw charges 4(u) and 23(l)(xxi) and to make the typographical corrections in the terms set out above.

Thereafter, Ms Tanchel, on your behalf, made a number of admissions to the charges. During the course of your oral testimony you made further admissions. At the close of all the evidence, Ms Tanchel confirmed that your admissions to the charges were as follows: 1, 2, 6 in its entirety, 14(f), 15, 16 in its entirety, 17, 18,19, 20, 23(b) and 23(c) in their entireties, 23(i), 23(j), 23(k), 23(l)i- xx and 23(m). The Committee has noted these admissions.

At the material times you were Patient A's General Dental Practitioner (GDP). Patient A first saw you on 26 January 2005 and continued to see you until 18 April 2013. On 18 April 2013 Patient A attended for the extraction of LR6 where you administered her with injections of local anaesthetic. When those failed to have the required numbing effect, you continued to administer local anaesthetic to Patient A. Following the injections Patient A began to feel unwell. An ambulance was called, and Patient A was taken immediately to hospital. Patient A suffered severe systemic adverse effects from toxicity as a result of your administration of local anaesthetic. Patient A complained to the GDC about the treatment she received from you.

The GDC alleges that you failed to provide an adequate standard of care to Patient A from 26 January 2005 to 18 April 2013. This includes, but is not limited to, failing to obtain and/or update Patient A's medical history; failing to provide any or any adequate treatment plan in respect of a number of teeth; failing to adequately treat and/or otherwise manage caries in respect of two teeth and administering local anaesthetic in a quantity in excess of that which was required on a number of occasions. Further, on 18 April 2013, as a result of your administration of local anaesthetic to Patient A she suffered adverse effects from toxicity. The GDC makes a specific allegation that your conduct towards Patient A on 25 June 2007 was dishonest in that you represented to her that root canal therapy was not available on the NHS when you knew that it was.

In support of its case, the GDC relies on the evidence of Patient A as well as copies of her dental and hospital records. It also relies on the expert evidence of Ms Karpeta.

Patient A provided the GDC with two statements dated 16 January 2016 and 11 March 2016 respectively. The latter statement was produced in response to a number of questions put to her by the GDC. She also gave oral evidence before the Committee in which she confirmed that the content of the two statements were true to the best of her knowledge. Patient A gave evidence of the short-term and long-term effect on her health following the incident that took place on 18 April 2013, which necessitated her being admitted to hospital. She accepted that she could not always remember whether you carried out certain assessments or treatment on her and was clear in her evidence when this was the case. The Committee considered that Patient A was willing to admit when she could not recall events and was mindful of the post-traumatic stress she experienced and the loss of memory that she encountered after being hospitalised on 18 April 2013. Nevertheless, the Committee considered that, Patient A's overall account of events was clear and reliable. She came across as a witness who was trying her best to assist the Committee and who did not appear to be vindictive towards you.

The Committee has also had regard to your oral evidence. It did not have the benefit of receiving a signed witness statement from you. Instead, you provided oral evidence at the hearing in May 2017 and the Committee has read the transcripts of that evidence. In your evidence you explained that during the period in question you had around 6,000 to 7,000

patients on your list and that you would see on average 40 patients a day. You worked five days a week at that time. You made a number of admissions at the beginning of the hearing as well as during the course of your evidence. This included poor record keeping and a failure to take radiographs. You also accepted that you administered local anaesthetic to Patient A in a quantity in excess of that which was required on 18 April 2013, as a consequence of which she suffered adverse effects from toxicity. You described to the Committee your normal practice of treating patients between 2005 and 2013 and explained that your dental nurse would take notes of those consultations on your behalf. You had no reason to believe that you would have deviated from your normal practice in respect of Patient A. The Committee found you to be a credible witness. However, due to the number of patients you saw and the lack of clinical records, your recollection of events could not be relied upon. Where there was a conflict between your evidence and that of Patient A as to a matter of fact (such as whether you informed her of all the treatment options), the Committee has preferred the evidence of Patient A.

In addition, the Committee has had regard to the expert evidence adduced in this case. This comprised the written and oral evidence of Ms Karpeta. She produced a report dated 4 March 2016 in which she set out the reasons why she was critical of your treatment of Patient A. The Committee also had regard to the written and oral evidence of Mr Holden. He produced a report dated 24 June 2016. Ms Karpeta and Mr Holden had a meeting in March 2017 in which they discussed the areas of dispute between them. Following that meeting they produced a joint report dated 19 March 2017 in which they set out the areas of agreement reached between them and identified those issues on which they disagreed and the reasons for disagreement. Both experts confirmed in their evidence that the joint report superseded the opinions set out in their separate reports.

The Committee heard from Ms Karpeta that she currently has a patient list of approximately 2,000 patients and that she practises two to three days a week, seeing, on average, around 50 to 75 patients a week. She explained that her experience in relation to the auditing of clinical records derived from her three years' experience as an expert witness in GDC proceedings. Ms Karpeta accepted under cross examination that she reviewed clinical records only when she had been asked to do so, either by the GDC or by those who represented the registrant when it was suspected that something may have gone wrong. Ms Karpeta accepted that she had not carried out a role in auditing record keeping or assessing the clinical care provided to patients in practices between 2000 and 2014.

The Committee heard from Mr Holden that he is an assessor of facilities at hospitals and general practice that provide conscious sedation technique as part of a national good governance scheme. In that position he reviews the dental records of some 200 patient records in a year, randomly selected, across a wide section in terms of speciality and geographic location of dental practitioners. Mr Holden gave evidence about the changes in the GDC's standards and other published guidance in relation to a number of areas of dental practice, including the provision of a treatment plan, record keeping and the prescribing of antibiotics during the times under consideration (2005 and 2013) in this case. He took the view that your record keeping, while lacking in detail, was not out of keeping of that he had seen in the primary and secondary sectors.

The Committee has borne in the mind the background and experience of both experts. It considered that at times, Ms Karpeta's opinion appeared to be based on a "gold standard", despite her assertions to the contrary, rather than the standard of a reasonably competent general dental practitioner working in a busy practice, such as yourself. It considered that Mr

Holden had a good understanding of the standard expected of an experienced general dental practitioner, given his role as an assessor, where he assesses a wide variety of records. Taking all these factors into account, the Committee has given greater weight to Mr Holden's opinion over that of Ms Karpeta.

The Committee has accepted the advice of the Legal Adviser. In respect of the charge 22(c), which alleges that your conduct was dishonest, the Committee received advice from the Legal Adviser of the test it must apply, as set out in the Supreme Court judgment in the case of Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67. This was as follows:

> "... When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence going to whether he genuinely held the belief, but it is not a requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established by the fact-finder the tribunal must then consider whether that conduct was dishonest by the standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest."

The Committee has taken into account all the evidence presented to it. It 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 did not need to prove anything. In accordance with the Legal Adviser's advice the Committee has considered each charge separately. I will now announce the Committee's findings as follows:

1	Admitted and found proved
2	Admitted and found proved
3	Found not proved You told the Committee that you would have carried out an assessment of Patient A's presenting dental condition although you have accepted that there is no note to confirm that it was carried out. Ms Karpeta referred to the Faculty of General Dental Practice "Clinical Examination & Record Keeping Guidelines" (the Guidelines) (2001 and 2009 editions) which set out (Chapter 4) what should be examined at each attendance and when new abnormalities are to be noted. This included the undertaking of a basic periodontal examination (BPE), extra and intra oral examination and special investigations in the form of radiographs. Ms Karpeta, having assessed the clinical records, could find no evidence of these assessments for the period in question. Mr Holden's opinion was that the Faculty's Guidelines were recommendations as opposed to being mandatory. During your oral evidence you told the Committee that BPE charts had previously been provided to the GDC by your solicitors. The Committee was subsequently provided with the BPE charts for July 2012 and January 2013. This head of charge spans a period of 8 years. It accepts Mr Holden's evidence that there has been "sea of change" with dental records between 2001 and 2006 as during this time clinical records were not very detailed. The Committee is satisfied that the BPE charting shows that adequate assessments have been

	carried out during the latter two years of the charge and thus finds the charge not proved.
4. a	Found proved Your evidence was that it was your usual practice to ask the patients when they came in if there were any medical conditions that you should know about or whether they were suffering from any medical complications. You also explained that the patient's medical history was recorded on the computer system known as Paragon. Patient A agreed that medical histories were taken sporadically, although she was not specific on the dates as to when this was carried out. Ms Karpeta's opinion was that the patient's medical history should have been obtained/updated, given that 26 January 2005 was the first appointment and the first course of treatment. Mr Holden's oral evidence was that it was necessary to obtain and/or update the patient's medical history if a new course of treatment was commenced. The Committee is satisfied that for the appointment on 26 January 2005, given that Patient A was a new patient you had a duty to take her medical history. In the absence of any evidence in the records of a medical history having been taken the Committee finds this charge proved.
4. b, 4.c - 4.o & 4.q – 4.s	Found proved The records show that you carried out an amalgam filling at UR5 on 9 June 2005, which was a new course of treatment. There is no evidence of a recorded and/or updated medical history in Patient A's dental records. The Committee accepts Mr Holden's evidence that it is necessary to obtain and/or update the patient's medical history if a new course of treatment was commenced. It also accepts Ms Karpeta's evidence that there was nothing to show of the obtaining and/or updating of the medical history for this appointment.
4. p	Found not proved This charge relates to an appointment for 9 June 2011. The Committee has already found proved that for the previous appointment, 2 June 2011 (charge 4.o above) you failed to obtain and/or update a medical history of Patient A. The Committee finds that the appointment on 9 June 2011 is part of the same course of the treatment as 2 June 2011 and as such it is not satisfied that you were required to have updated the medical history on this occasion. Accordingly, it finds this charge not proved.
4. t.	Found not proved The Committee's attention has been drawn to a copy of a medical history form which states "Date completed 16/07/2012". You explained to the Committee that at the appointment on 13 July 2012 Patient A was given a medical history form. You believed that the patient may have taken the form home, filled it in and returned it to the surgery, the information was then entered into the system on 16 July 2012. The Committee accepted your evidence on this matter and notes that your account is supported by the documentary evidence.

5. (a)	Found proved Patient A's evidence was that you did not provide her with a written treatment plan and her account is supported by the absence of any written treatment plans in the notes. Ms Karpeta considered that the treatment plan was a necessary part of the treatment and consent process for a patient. She referred to paragraph 1.6 of the GDC's Standards (2005) which state: "whenever a patient is returning for treatment following an examination or assessment, give them a written treatment plan and cost estimate." Ms Karpeta was critical of your failure to provide any or any adequate treatment plan for the dates set out in the charges. Mr Holden's evidence was that he could find no copies of the expected treatment plans in the notes. Both experts agree that as a minimum, a FP17 DC form needed to be provided if the patient is returning for treatment. The Committee is satisfied that Patient A was returning for treatment to the UL6 and therefore a treatment plan was required, as per paragraph 1.6 of the GDC's standards. There is no FP17 DC form for the treatment to the UL6 or indeed any treatment plans for the UL6 and therefore finds this charge proved.
5. (b), 5.(d) - 5.(f)	Found not proved In respect of these charges, the Committee, having examined the patient's records, is satisfied that on these occasions the treatment had been carried out on the same day as the assessment without the need for the patient to return. Accordingly, there was no requirement for a treatment plan and thus there is no culpable failure on your part in not providing a treatment plan.
5. (c), 5.(h) & 5.(i)	Found proved These are for the same reasons as set out at 5.(a) above.
5. (g)	Found proved The Committee notes that there is a FP17 DC form for treatment to the UL7 dated January 2013, which was signed by Patient A. This was the only FP17 DC form contained in the clinical notes. However, it notes that you also provided treatment to the UL7 on 9 June 2011, following the assessment which had been carried out at an earlier appointment (2 June 2011) for which there is no FP17 DC form or treatment plan. Accordingly, it finds this charge proved.
6.(a) – 6.(k)	Admitted and found proved
7. (a)	Found not proved Your evidence was that from looking at the radiograph and the patient's symptoms, the LR6 would have been unrestorable. Ms Karpeta's evidence was that the periapical radiograph taken at the previous appointment (8 April 2013) showed the presence of caries lesions distally and in close proximity to the pulp chamber. Ms Karpeta was critical of the fact that you did not remove the crown, followed by caries removal for pain relief. She explained that as the LR7 was already missing, the loss of the adjacent LR6 would result in a larger edentulous space with possible complications. In short, Ms Karpeta considered that you should have treated

	the caries rather than extracting the LR6. Mr Holden disagreed with Ms Karpeta and said that the tooth was non-salvageable. He explained that the extraction had been discussed on 8 April 2013 when Patient A saw another dentist who had told her that that only option was to extract the tooth. In his oral evidence Mr Holden explained that the option of removing the crown could have led to a poor outcome and in his opinion your proposed treatment and management of the tooth, as recorded in the patient's notes, was appropriate. The Committee prefers Mr Holden's evidence that your proposed treatment plan was appropriate.
7.(b)	Found not proved In your notes for 18 April 2013 you have recorded "UL5 - Amalgam Filling MO/DO Surface – Temporary dressing – sedanol, life and ledermix placed." You also recorded "Pt says she has been having pain from UL5 for 2/52." You explained under cross examination that you treated the UL5 by removing the caries and placing a dressing and that you had planned to treat the tooth at a later date because Patient A was in pain with the LR6 and it was best to deal with it first. Ms Karpeta considered that the chief complaint of the patient attending on this date was pain from the UL5 due to caries, which was identified and recorded. She considered that the caries should have been removed adequately prior to the dressing placement and said that were the Committee to reach the conclusion that the caries had been removed she would not be critical. Mr Holden considered that it was acceptable to dress the tooth and make plans for the definitive care at a later date. He considered that at this appointment it was unknown how much care Patient A required, and he would not expect all the definitive treatment to be carried out. In short, he considered that the emergency treatment carried out was acceptable. The Committee is satisfied that you had removed the caries adequately and dressed the tooth in readiness for Patient A to come back at a later date.
8.(a) - 8.(b)	Found proved Patient A's evidence was that in general you did not explain to her the risks and benefits of treatment and often said to her "You need this treatment". Your evidence was that it was your usual practice to discuss the risks and benefits with the patient and that in respect of the LR5 you explained that you would have told Patient A that the treatment options were to refill, leave and monitor or crown the tooth. You further explained that Patient A would have told you what option she would choose. Ms Karpeta considered that as per the clinical records, on 10 December 2010, the LR5 received treatment for the third time. She considered that there was no record for consent for the treatment for the LR5 on 10 December 2010, which was a pinned composite, and 6 May 2011, which was for the provision of a crown. Her evidence was that the risks and benefits of using dentine pins should have been explained. Mr Holden considered that Ms Karpeta's criticisms appeared to be based on the assumption that a failure to record the process was a failure to obtain informed consent. His experience was that in reviewing the records and watching primary care

	dental practitioners work, it was very unusual for practitioners not to go through a consent process properly and observed that failures in record keeping were common place. However, Mr Holden accepted that if the Committee found that the patient was not informed of the treatment options and the risks and benefits, then the process of consent would be invalid. The Committee found Patient A's evidence on this matter to be credible and consistent and in the light of that evidence, it is satisfied that you did not explain to her the treatment options and the risks and benefits at the appointments for 10 December 2010 and 6 May 2011. You yourself accepted that you have no specific recollection of these appointments - you gave evidence in general terms as to the treatment options you would have offered to Patient A. The Committee is satisfied that that Patient A was not given the alternative treatment options and thus you failed to obtain informed consent in respect of the LR5.
9.(a) – 9.(b)	Found proved For the reasons set out at charge 8 above, the Committee accepted Patient A's evidence. Patient A attended on 13 April 2012 for a crown preparation following two previously failed restorations. Ms Karpeta considered that you failed to obtain consent for that restoration and took the view that other treatment options should also have been given. The Committee agrees with Ms Karpeta.
10.(c) – 10.(d)	Found proved Patient A's evidence, both in her signed witness statement and in her oral evidence, was that the only option you gave to her was that the tooth needed to be extracted. Her recollection was that "other options were never discussed". She explained that had the option of saving the tooth been given, she would have taken that option. During the course of her evidence, Patient A was shown an extract from the clinical notes for that appointment which states: "molar RCT opnly available privately so XLA done due to cost. Extraction UL6". On seeing that extract Patient A maintained her position that the only option that was given to her was that the UL6 needed "to come out". Your evidence is that at the appointment on 25 June 2007 you had established that the UL6 was non-vital and that the tooth needed to be extracted. You also explained that the entry recorded in Patient A's notes, which states "molar RCT opnly available privately…" was written by your dental nurse contemporaneously. In common with your usual practice at this time, you stated that you did not check your notes to confirm their accuracy and that your notes "do not back up the discussion that actually did take place." The Committee has accepted Patient A's recollection that the discussion regarding molar RCT did not take place. Her evidence was consistent throughout that the extraction of the UL6 was the only option discussed for that tooth. Ms Karpeta's evidence was that by not explaining the treatment options, given the risks and benefits, you failed to obtain informed consent. The Committee agrees and therefore finds this charge proved.
12.(a)	Found not proved

	The clinical notes for 19 June 2007 recorded the following: "ul6 very ttp pt c/o of severe pain rx antibiotics may need extraction… Urgent Trt – Acute mucosal conditions". Ms Karpeta considered that it was most likely that the UL6 was developing symptoms of acute pulpitis and that the appropriate clinical intervention was by way of removing the filling and placement of a sedative dressing. Mr Holden took the view that your entry "ttp" (tender to percussion) was consistent with a pathology involving irreversible pulpitis. He also considered that the provision of the antibiotics with the note "Acute mucosal conditions" at that appointment would support your diagnosis. The Committee agrees with Mr Holden's evidence and considers that it is clear from your records for that appointment that you have identified and diagnosed the cause of Patient A's pain adequately. Accordingly, it finds this charge not proved.
12.(b)- 12.(c)	Found not proved You explained that you prescribed antibiotics at the appointment on 19 June 2007 so as to reduce swelling at UL6 and with a view to treating the tooth at a later date once the infection had subsided. Ms Karpeta referred to the Faculty of General Dental Practice's guidelines on the use of antimicrobials as an adjunct to the management of active infectious disease. In her opinion, a responsible body of dental professionals would not prescribe antibiotics for symptoms of pulpitis and she was critical of your actions in prescribing them to alleviate Patient A's pain. Mr Holden gave evidence about the changes in the guidance in the prescribing of antibiotics since 2007. He considered that in 2007 a reasonable body of general dental practitioners might have prescribed antibiotics for symptoms of irreversible pulpitis (as was the situation in this case). The Committee prefers Mr Holden's evidence on this matter, noting his observations on the changes in the guidance.
13.(a) – 13.(b)	Found not proved Patient A attended on 8 April 2013 with severe pain from the lower right quadrant. The clinical notes record that an intra-oral and extra-oral examination was carried out. Ms Karpeta's evidence was that the radiograph taken on that day showed carious lesions distally in close proximity to the pulp. She stated that the pain was caused by acute pulpitis and that you failed to identify this. Ms Karpeta further gave evidence that the pain symptoms would not subside with antibiotics. Mr Holden's evidence was that the tooth was tender to percussion (ttp) and the offer of an extraction with an implicit diagnosis of irreversible pulpitis was appropriate. The clinical notes indicate a diagnosis of "distal caries and distal deficiency in LR6 crown …. tooth still very ttp therefore considerable amount of infection present." The Committee has concluded that you had identified and diagnosed the cause of Patient A's pain and that you took appropriate steps to alleviate the pain.
13.(c)	Found not proved The records show that you issued one prescription for antibiotics and you identified caries. The records also state that you warned Patient A of a poor prognosis if restored and advised her the best option was to extract the LR6.

	You gave evidence that there was a large swelling present and there was no other option but to prescribe antibiotics. Mr Holden's evidence was that although the antibiotics do not treat the infection, they reduce the infection so that treatment can be carried out. The Committee agrees with Mr Holden's opinion on this matter. The Committee is satisfied, from the entries in the clinical notes, that you had recorded an indication for prescribing them.
14.(a) – 14.(e)	Found not proved The charge alleges that you administered a local anaesthetic to Patient A in a quantity in excess of that which was required on a number of occasions. The Committee received expert evidence on this matter and notes that Ms Karpeta and Mr Holden disagree as to the dosage required for a patient. The Committee was told that the only guidelines regarding the use of local anaesthetic are the absolute maximum dosage allowed. You told the Committee that you would round up the cartridges used on the record, even if only half a cartridge was used. You also explained that the notes reflected how many cartridges were opened, not necessarily the amount of anaesthetic that was actually used. Furthermore, you said that you formed your opinion on how much local anaesthesia to use from treating Patient A over a long period of time. The Committee accepted your evidence on this matter. Ms Karpeta's evidence was that she reviewed your records and said that you were administering more than the average practitioner and that your average dose for Patient A was 2 cartridges. She considered that 1 cartridge would be sufficient to achieve analgesia and she would always be critical if 2 cartridges were used. This criticism was based on her professional opinion for current practise and teaching. Mr Holden referred to the British National Formulary (BNF) and the manufacturers' data sheets. He told the Committee that in some dental schools, students are taught to use up to 300mg of lignocaine. He explained that in clinical practice, it is common to use up to 500mg of lignocaine. However, the BNF states a maximum dose of 500mg and for dental use, it refers to the manufacturers' data sheets, which also states a 500mg maximum. He also stated that the utilised dose is that required to achieve adequate anaesthesia to complete the planned treatment. Much would depend, he said, on the patient's size, body mass, tolerance and any spillage whilst administering the drug. Mr Holden also explained that local teaching hospitals set their own protocols as to the levels to be adminstered. He considered that a responsible body of practitioners would administer 1 to 2 cartridges of local anaesthetic (of 2.2ml per cartridge) for the treatment of a tooth, which he considered would be acceptable. He explained that at 3 cartridges, a responsible body of practitioners might consider why the anaesthetic was not working before considering administering further quantities or changing the method of administration. The Committee preferred Mr Holden's evidence on this matter. It found that your use of anaesthetic was not in excess. It noted that you regularly used 1 to 2 cartridges for Patient A.

14.(f)	Admitted and found proved
15.	Admitted and found proved
16.(a)	Admitted and found proved
16.(b)	Admitted and found proved
17.	Admitted and found proved
18.	Admitted and found proved
19.	Admitted and found proved
20.	Admitted and found proved
21.	Found not proved In support of this charge the GDC relies on the entry in Patient A's clinical notes for 25 June 2007 which states "molar RCT opnly available privately so XLA done due to cost. Extraction UL6". The GDC's case is that by virtue of this entry you represented to Patient A that root canal therapy was not available on the NHS. Your evidence is that you did not write or check this entry and that your dental nurse would have done this. You explained that your practice was busy and that you saw on average some 40 patients a day over five days a week. You say you do not remember this appointment in 2007 and that you only became aware of this entry when the complaint was made by Patient A to the GDC in 2013. You also explained that you did not undertake private work so there would have been no benefit to you in giving such erroneous advice. The Committee accepted your evidence on this matter. For the reasons set out at charge 10 above, the Committee has accepted Patient A's evidence that on 25 June 2007 the only option that was given to her was that the tooth needed to be extracted and no other treatment options were discussed. Patient A was adamant that if an option was given to her to save the tooth she would have taken it. Having regard to all these factors, the Committee is not satisfied that on 25 June 2007 you represented to Patient A that root canal therapy was not available on the NHS.
22.(a) – 22.(c)	Found not proved These charges have been found not proved given that the Committee has found charge 21 above not proved.
23.(b)(I) – 23.(b)(III)	Admitted and found proved
23.(c)(I) – 23.(c)(III)	Admitted and found proved
23.(i)	Admitted and found proved
23.(j)	Admitted and found proved

23.(k)	Admitted and found proved
23.(l)(l) – 23.(l)(xx)	Admitted and found proved
23. (m)	Admitted and found proved

We move to Stage Two."

On 23 January 2018 the Chairman announced the determination as follows:

"Ms Elston:

The Committee has had regard to the submissions made by Mr Grey, on behalf of the General Dental Council (GDC), and those made by Ms Tanchel, on your behalf, in accordance with Rule 20 of the Fitness to Practise Rules 2006.

Mr Grey informed the Committee of your fitness to practise history. In November 2017 you appeared before the Professional Conduct Committee (PCC) in relation to a dissimilar matter. The PCC directed that your registration be subject to an order of suspension for a period of six months, with a review hearing to take place before the expiry of that order. This Committee has been informed that the current suspension order is due to expire on 15 June 2018.

Turning to this case, Mr Grey submitted that the findings against you in relation to your treatment of Patient A amount to misconduct. In support of that contention he referred to the serious nature of the clinical findings against you, including your failure to obtain Patient A's informed consent for treatment, your failure to take radiographs and to carry out treatment planning as well as your administration of a local anaesthetic to Patient A in quantities in excess of that which was required on 18 April 2013 as well as your poor record keeping. Mr Grey also referred to paragraphs of the GDC's "Standards for Dental Professionals" (May 2005) and its "Principles of Patient Consent" (May 2005) which, he said, you have breached.

Mr Grey referred to the evidence of remediation provided and asked the Committee to consider whether you have sufficiently addressed all of the issues identified in this case. He made the point that although you have been subject to an interim order of conditions since 2015, you only began actively engaging with the remediation process in 2016. In short, Mr Grey submitted that there remains a risk of repetition of the matters identified and therefore a finding of current impairment is necessary. He also submitted that given the serious nature of the findings against you, including on 18 April 2013 administering local anaesthetic to Patient A in a quantity in excess of that which was required, a finding of current impairment is necessary in the wider public interest so as to declare and uphold appropriate standards of conduct amongst dental professionals. In terms of sanction, Mr Grey submitted that the appropriate outcome is that your registration be suspended for a period of time which would be commensurate to the current order of suspension directed by the PCC in November 2017. He said that an order of conditions would not be workable or measurable, given that your registration is currently suspended.

Ms Tanchel conceded that the findings against you amount to misconduct and accepted on your behalf that you do not seek to minimise your failings. However, she referred to the evidence of your remediation, as contained in the Defence bundle, and invited the Committee to conclude that you have addressed the concerns identified in this case and that

you are safe to practise without any restrictions. She described you as having embarked on a painful and lengthy path of remediation. In addition, Ms Tanchel referred to the lapse of time since the events in question, there being no further allegations against you (save for the matters that resulted in you appearing before the PCC in November 2017) and the fact that you have been compliant with the interim order of conditions imposed on you. In short, Ms Tanchel submitted that your fitness to practise is not impaired. She also contended that findings in this case are not sufficiently serious to merit the suspension of your registration.

The Committee has had regard to the submissions made by both parties. It has accepted the advice of the Legal Adviser.

Misconduct

The Committee has 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 Dental Professionals, as well as the expert evidence of Ms Karpeta (called on behalf of the GDC) and that of Mr Holden (called on your behalf).

The Committee has exercised its own professional judgement on misconduct. This case concerns the treatment and care you provided to one patient (Patient A) while you were practising at your own dental surgery at Skelton-in-Cleveland (the Practice) between 2005 and 2013. Patient A saw you on at least 21 occasions during the period. The findings against you include the following:

- Administering local anaesthetic to Patient A on 18 April 2013 in a quantity in excess of that which was required, which resulted in the patient suffering from local anaesthetic toxicity and being admitted to a high dependency unit;
- A failure to obtain and/or update medical history of Patient A over a period of some 7 years, spanning from January 2005 to July 2012;
- A failure to provide any or any adequate treatment plans between November 2006 and April 2013;
- A failure to take bitewing radiographs between January 2005 and April 2013 in relation to a number of teeth;
- A failure to obtain informed consent from Patient A in respect of the treatment of the LR5, the crown at UR6 and the extraction of the UL6;
- A failure to ensure that the periapical radiograph of Patient A taken on 22 January 2013 was of sufficient quality to be of diagnostic value and record an evaluation of the radiograph adequately and
- Poor record keeping over a prolonged period of time.

The Committee considered that you have breached the following standards of the 'Standards for Dental Professionals' (May 2005):

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

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.

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

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

5.2: Continuously review your knowledge, skills and professional performance. Reflect on them, and identify and understand your limits as well as your strengths.

The Committee also considered that you have breached the following principles from the GDC's 'Principles of Patient Consent':

1.1: For consent to be valid, the patient must have received enough information to make the decision. This is what we mean by 'informed consent'.

1.2: You should give patients the information they want and need, in a way they can use, so that they are able to make informed decisions about their care.

1.3: Giving and getting consent is a process, not a one-off event. It should be part of an ongoing discussion between you and the patient.

1.4: Find your what your patients want to know, as well as telling them what you think they need to know. Examples of information which patients may want to know include:

- why you think a proposed treatment is necessary;
- the risks and benefits of the proposed treatment;
- what might happen if the treatment is not carried out; and
- other forms of treatment, their risks and benefits, and whether or not you consider the treatment is appropriate.

1.6: Whenever a patient is returning for treatment following an examination or assessment, give them a written treatment plan and cost estimate.

1.8: Giving a patient clear information to help them make a decision may involve using written material, visual or other aids.

The Committee has borne in mind that the failings relate to one patient only. Nevertheless, the Committee considers that the findings were multiple and repeated over a sustained period of time, encompassing basic aspects of dentistry, including a failure to obtain and/or update medical history, a failure to provide an adequate treatment plan, a failure to take radiographs and failure to obtain patient consent. Further, the Committee considers that your record keeping was woefully inadequate – and you yourself have accepted that it was poor. The failures identified in this case were basic and compromised Patient A's safety.

The Committee takes a particularly serious view of your conduct in administering an excessive dose of local anaesthetic to Patient A on 18 April 2013 during the course of treatment. This caused Patient A to suffer with severe systemic adverse effects of toxicity and necessitated her being admitted to hospital that day. Patient A gave evidence of the short term and long term effects on her health following you administering an excessive dose of local anaesthetic. She described, and the Committee saw for itself, how her speech and

her eyesight had been affected by the incident in question. She had also been diagnosed with severe post traumatic stress disorder. Both experts agreed that the overdose of local anaesthetic compromised patient safety and fell seriously below the standard expected of a reasonably competent dental practitioner.

The Committee has had regard to the extent and repetitive nature of the omissions against you concerning Patient A, your breaches of the GDC's standards, as well as Ms Karpeta's and Mr Holden's opinion, that in a number of areas of your clinical practice, your conduct fell seriously far below the standard expected of a reasonably competent dental practitioner. It has concluded that the findings against you are serious and amount to misconduct.

Current impairment

The Committee next considered whether your fitness to practise is currently impaired by reason of your misconduct. In so doing, it has had regard to all the evidence before it, including the remediation bundle presented on your behalf and as well as the supplementary bundle. The remediation bundle includes: copies of letters dated 7 June 2016 and 3 January 2018 from the Postgraduate Dental Dean, NHS Health Education England; a copy of your Personal Development Plan (PDP); copies of certificates of the courses you have attended between July 2013 and December 2017 as part of your Continuing Professional Development (CPD); evidence of registration on future CPD courses; a report dated 22 December 2017 from Mr Wild, your supervisor, appointed by the GDC since December 2015 and copies of your reflective statements. The bundle also contains copies of your record keeping audits covering the period from May 2016 and November 2017; copies of your local anaesthetic audit covering the period February 2016 to August 2016 and a radiography audit report. In addition, the Committee has had regard to copies of the Practice policies you have produced, some of which are dated December 2015. Finally, the Committee has seen copies of the supportive testimonials from your patients.

The Committee has considered all the submissions carefully. It has exercised its own independent judgement on the matter. It has borne in mind that its duty is to consider the public interest, which includes the protection of patients, the maintenance of public confidence in the profession and the declaring and upholding of proper standards of conduct and behaviour.

The Committee first considered the nature of your misconduct, which relates to wide ranging failings concerning one patient. It considers that your misconduct in relation to clinical failings is remediable. The Committee has had regard to the progress you have made in remediating the shortcomings identified in this case, as set out in the letter dated 7 June 2016 from Ms Sharma, Postgraduate Advisor for the Salaried Dental Services, Health Education North East. She referred to the meetings that have taken place with you since September 2015 and describes how you have actively engaged with the remediation process. She commented that you had sought out and attended appropriate professional events, as well as undertaking audits in consent, record keeping, complaints handling and radiography. Mr Smith, Postgraduate Dental Dean, HH North East, in his letter dated 3 January 2018, confirmed that you have continued to engage with the Dental Dean in that you have had regular meetings with him to discuss your progress with your PDP. He commented that you have updated your PDP and he was satisfied that most of the objectives have now been completed. He also referred to your engagement with relevant CPD in the identified areas.

The Committee's attention has been drawn to a report dated 22 December 2017 from Mr Wild, your supervisor. He was appointed to oversee and monitor your progress with regard to your compliance with the interim order of conditions. He confirmed that he has had regular weekly meetings with you and describes the first few months of those meetings as being "Intense". He described the changes you have introduced in developing comprehensive recording systems for radiographs and local anaesthetic and more fundamental changes to the way you worked, given that you had very long clinical lists and you were very busy. This included the recruitment of a therapist on a temporary basis who was able to take on some of the work that would have been done by you. This was to enable you to comply with the GDC's conditions. Mr Wild set out the other changes introduced to your practice, such as in your record keeping. His opinion is that you have made "significant strides" in the completeness of your records. Overall, Mr Wild considers that there has been a distinct change in your practice from around 2016, when he noticed that you appeared to understand the purpose of the support he was providing to you. In summary, Mr Wild considers that you have made huge positive strides in the right direction. He comments that you have complied with the GDC's conditions and you have shown a commitment to improve yourself.

The Committee considers that it is clear from the evidence before it that you have some insight into your failings, that you have reflected on your learning and you have remediated some of this in your clinical practice. However, it notes Mr Wild's view that you are still "a work in progress" and it considers that you need to provide further evidence to satisfy the Committee that the remediation you have undertaken thus far is embedded into your practice. It acknowledges that you have provided copies of the Practice policies you have produced but is concerned that some of these documents are some two years old. For these reasons, the Committee considers that your remediation is incomplete, that you continue to pose a risk to patients and therefore you are not safe to practise unrestricted. A finding of impairment is therefore necessary for the protection of patients.

The Committee further considered the wider public interest, in particular the need to declare and uphold proper standards of conduct and behaviour, so as to maintain public confidence in the profession. It has found that you failed to provide an appropriate standard of care to Patient A over a sustained period of time. It takes a serious view of your conduct in administering an excessive dose of local anaesthetic to Patient A on 18 April 2013. This caused Patient A to suffer with severe systemic adverse effects of toxicity and this has caused her ongoing health concerns. Notwithstanding the extensive remediation you have undertaken thus far, the Committee considers that a fully informed member of the public would be concerned if a finding of current impairment were not made in this case. In the Committee's view, the overdose of local anaesthetic on 18 April 2013, and the consequent effects on it on Patient A, were extremely serious. In these circumstances, the Committee considers that public confidence would be undermined if a finding of impairment were not made.

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, although it may have that effect, but to protect patients and the wider public interest. The Committee has taken into account the GDC's "Guidance for the Practice Committees, including Indicative Sanctions

Guidance" (October 2016). It has considered the range of sanctions available to it, starting with the least serious. The Committee has applied the principle of proportionality, balancing the public interest with your own interests.

The Committee has taken into account the mitigating and aggravating features of this case. In mitigation, it has borne in mind your admissions, your compliance with the interim order of conditions as well as the evidence of your remediation of the clinical shortcomings in this case, for which it gives you credit. Furthermore, the Committee has read the supportive testimonials from professional colleagues and patients. The aggravating factors include the serious nature of the clinical findings against you relating to Patient A. In addition, the Committee has had regard to your fitness to practise history before the GDC in November 2017, which resulted in a PCC directing that your registration be suspended.

The Committee considers that it is necessary for the protection of the public and is in the wider public interest to take some action against your registration given the serious nature of the findings against you and the fact that the remediation has not been completed. Mr Wild's view that you are still "a work in progress" and the Committee agrees. In these circumstances, the Committee is satisfied that to conclude the case with no further action or with a reprimand would be insufficient and inappropriate.

The Committee next considered the imposition of conditions on your registration, bearing in mind that any conditions must be proportionate, measurable and workable. It has borne in mind that your registration was subject to interim conditions, and that it is clear from the evidence before the Committee that you were making good progress in addressing the clinical issues identified in this case. The Committee considers that this is a case where, in principle, the clinical concerns that have not yet been embedded fully in your practice, could be achieved by the imposition of conditions on your registration. It considers that it might be open to you to continue to engage with the Postgraduate Dental Dean in respect of updating your PDP and for you to complete online courses as evidence of your CPD. It was therefore not persuaded by the GDC's position that given that your registration is currently subject to an order of suspension by a direction of the PCC in November 2017, it is not possible for your registration to be subject to an order of conditions.

However, the Committee takes a serious view of your conduct in administering an excessive dose of local anaesthetic to Patient A on 18 April 2013 which caused her to suffer with severe systemic adverse effects of toxicity and necessitated her being admitted to hospital. Notwithstanding your reflections on this matter, and the evidence of remediation provided the Committee is concerned about your conduct in this regard.

The Committee has concluded that conditions are insufficient in the wider public interest. Accordingly, the Committee directs that your registration be suspended and is satisfied that this sanction is sufficient to mark the severity with which it views your conduct in administering an excessive dose of local anaesthetic to Patient A. It seeks to maintain public confidence in the regulatory system and to declare and uphold appropriate standards of conduct and competence among dental professionals.

The Committee considered carefully whether this is a case where an order of erasure is necessary for the wider public interest. It considers that this sanction would be disproportionate, given the nature of the findings against you. The Committee has also had regard to the positive testimonials. The Committee is aware that one element of the public interest is that an otherwise good dentist should not be lost to the profession. The Committee has also borne in mind the steps you have taken to address the clinical concerns

in this case and the evidence of your commitment to this process. It considers that this is not a case where your behaviour is fundamentally incompatible with being a dentist. Given these factors, the Committee is satisfied that erasure, which is the most severe sanction, would be disproportionate.

The Committee directs that your registration be suspended for 8 months. It is satisfied that 8 months is necessary and proportionate to mark the gravity of your misconduct. It has also had regard to the principle of proportionality and the impact that a longer period of suspension might have on you. While the Committee is mindful that your registration is already subject to an order of suspension, which is due to expire in June 2018, this Committee has exercised its own independent judgement in deciding on the length of the order appropriate to its findings in case, rather than arriving at a length of order that will effectively end at around the same time as the current order.

A Committee will review your case at a resumed hearing to be held shortly before the end of the period of suspension. That Committee will consider what action it should take in relation to your registration. You will be informed of the date and time of that resumed hearing. At that hearing, the Committee reviewing the order may find it helpful to receive evidence of your continuing professional development.

The Committee now invites submissions from both parties as to whether your registration should be suspended immediately."

"Ms Elston:

In accordance with Rule 21(3) of the General Dental Council (GDC) (Fitness to Practise) Rules Order 2006 the interim order of conditions on your registration is hereby revoked.

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).

Mr Grey, on behalf of the GDC, submitted that an immediate order of suspension is necessary for the protection of the public and is otherwise in the public interest, given the serious concerns outlined by this Committee. Ms Tanchel, on your behalf, did not oppose Mr Grey's application.

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

In accordance with Section 30(1) of the Dentists Act 1984 (as amended) the Committee has determined that it is necessary for the protection of the public and is otherwise in the public interest to order that your registration be suspended forthwith. In reaching its decision, the Committee has concluded, for the reasons set out in its determination at stage two, that you currently pose a risk to the public and that an immediate order is also required in the public interest. Given its reasons for finding current impairment and directing that your registration be suspended, the Committee is satisfied that it would be inconsistent to allow you to continue to practise during the 28 day appeal period or, if an appeal is lodged, until it has been disposed of.

The effect of this direction is that your registration will be suspended immediately. Should you exercise your right of appeal, this immediate order for suspension will remain in place until the resolution of any appeal.

That concludes the case."

At a review hearing on 2 October 2018 the Chairman announced the determination as follows:

"Ms Elston

You are present at this hearing of the Professional Conduct Committee (PCC) and are represented by Ms Vivienne Tanchel of Counsel, instructed by Dental Protection. Ms Vanya Headley of the GDC's Legal Team appears for the General Dental Council (GDC).

Purpose of hearing

The purpose of today's hearing is to review an order of suspended registration imposed by the PCC for a period of eight months on 23 January 2018. The suspension came into effect following the end of the appeal period on 20 February 2018. Your suspension is due to expire on 19 October 2018.

Existing order

In May 2017 and January 2018 the PCC considered a number of allegations about your conduct. The PCC heard, and subsequently found proved, a number of allegations relating to the standard of care and treatment that you provided to a patient, referred to for the purposes of its proceedings as Patient A, in the period of 2005 to 2013. The Committee made specific factual findings in relation to a number of aspects of your care and treatment of the patient. These findings concerned failings in the excessive administration of local anaesthetic to the patient, the omission of medical histories, the absence of proper treatment planning, shortcomings in your radiographic practice, failures in obtaining informed consent and poor record-keeping.

The PCC went on to find that these failings amounted to misconduct, consisting as they did of multiple and repeated failings over a considerable period of time. Despite the remediation and insight that you had demonstrated, your fitness to practise was impaired as a result of that misconduct. The Committee identified an ongoing risk to patient safety, as well as to the public interest, with particular regard to the misconduct that had been found in relation to your administration of excessive local anaesthetic. That Committee decided that the appropriate and proportionate sanction to impose was a period of suspended registration for eight months, with a review to take place prior to the expiry of that period.

Submissions and evidence

The Committee has been provided with a number of documentary exhibits in relation to this matter, including copies of your personal development plans (PDPs), details of continuing professional development (CPD) that you have undertaken and which you plan to undertake, reflective statements, and template documents, practice protocols and policies for use in specific areas of your practice.

The Committee has also heard oral evidence from you. Although Ms Tanchel submitted that Ms Headley should make her submissions on the matters of impairment and sanction prior to you giving your evidence, the Committee, having accepted the advice of the Legal Adviser, considered that it would be fair and in the interests of justice for you to give your evidence before hearing Ms Headley's submissions.

On behalf of the GDC, Ms Headley submitted that there is no suggestion that you have practised whilst subject to a direction of suspended registration. Ms Headley submitted that

the onus is on you to demonstrate that your fitness to practise is no longer impaired. Ms Headley submitted that, although you have worked to remedy the shortcomings that precipitated the finding of impairment, your fitness to practise continues to be impaired. Ms Headley submitted that the Committee may wish to consider replacing the extant suspension with an order for conditional registration for a period of 12 months.

Ms Tanchel on your behalf submitted that you have provided evidence of the extensive remediation and insight that you have developed over a considerable period of time, including the targeted CPD and reflections presented to this Committee. Ms Tanchel submitted that you have remedied each of the specific deficiencies that had been identified in your practice, that you have not become de-skilled during the period of your suspension, and that your fitness to practise is no longer impaired. Ms Tanchel therefore invited the Committee to revoke the suspension.

Committee's determination

The Committee has carefully considered all the information presented to it, including the written documentation and oral submissions provided by Ms Headley on behalf of the GDC and those provided by Ms Tanchel on your behalf.

The Committee has accepted the advice of the Legal Adviser. In its deliberations the Committee has had regard to the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016).

Impairment

The Committee has considered whether your fitness to practise remains impaired. In doing so, the Committee has exercised its independent judgement. 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 determined that your fitness to practise remains impaired. It considers that the remediation evidence presented to it, whilst extensive and commendable, is not sufficient for it to conclude that you have remedied in full the failings identified in this case.

You have taken considerable steps to acknowledge, address and remedy the misconduct that the previous Committee identified. You gave honest and compelling evidence of the committed and concerted efforts that you have taken over a number of months and years to rectify the shortcomings and errors that have given rise to these proceedings, both prior to and during the course of the period of suspended registration. Your CPD is extensive and expansive and has been informed by focused and targeted PDPs. Your insight into the matters that have precipitated this case is also well developed. The Committee is in no doubt that you recognise your failings, and that you are committed to ensuring that such harmful errors will not happen again. You have approached the process of remediation in a wholehearted and systematic manner, and the Committee commends you on the commitment that you have demonstrated.

However, although it is difficult to see what more you could have done to address the identified failings whilst suspended from practice, the fact that you have not been able to practice for some months by dint of that suspension presents difficulties for your ability to demonstrate that the learning and development that you have undertaken has been put into practice and has been embedded in to your day to day work. Your remediation at the time of

the substantive PCC hearing was viewed by that Committee as incomplete, and that you 'need[ed] to provide further evidence to satisfy [that] Committee that the remediation you [had] undertaken [was] embedded into your practice'. Notwithstanding the CPD that you have undertaken in the intervening period, it remains the case that you have not shown sufficient evidence of you having put your learning in practice. The Committee therefore considers that you continue to present a risk to patients because of your unremediated failings, and that your fitness to practise remains impaired. The Committee also considers that a finding of impairment is also required for wider public interest reasons, namely to declare and uphold proper professional standards of conduct and behaviour and to maintain public trust and confidence in the profession.

For these reasons, the Committee finds that your fitness to practise is currently impaired.

Sanction

The Committee then determined what sanction, if any, would be appropriate in light of the finding of continued and current impairment of your fitness to practise that it has made. The Committee recognises that the purpose of a sanction is not punitive, although it may have that effect, but is instead imposed in order to protect patients and safeguard the wider public interest. In reaching its decision on sanction the Committee has again taken into account the GDC's Guidance for the Practice Committees, including Indicative Sanctions Guidance (October 2016). The Committee has applied the principle of proportionality, balancing the public interest with your own interests.

Having found that your fitness to practise remains impaired, the Committee determined that it would not be appropriate or proportionate to dispose of this case by terminating your suspension. To do so would permit unrestricted practice, and as set out above the Committee considers that the ongoing risk that your unremediated failings present means that some form of restriction should be in place on your registration.

After careful consideration the Committee has determined to terminate your suspension and replace it with a period of conditional registration in accordance with section 27C (1) (c) of the Dentists Act 1984 (as amended) ('the Act'). The Committee considers that these conditions will provide for you to return to practise in a safe and supported manner, and will permit you to demonstrate that your considerable learning has been put into practice. The Committee further determines that the conditions should be in place for a period of nine months, and that this period of time is required for you to demonstrate that you have made the practical changes that are necessary. The Committee further directs that the conditions be reviewed prior to their expiry.

The conditions as they will be recorded against your name in the register read as follows:

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

2. If employed, she must within 7 days provide contact details of her employer and allow the GDC to exchange information with her employer or any contracting body for which she provides dental services.

3. She must within 7 days inform the GDC of any formal disciplinary proceedings taken against her, from the date of this determination.

4. She must inform the GDC within 7 days of any complaints made against her from the date these conditions take effect.

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

6. At any time she is employed, or providing dental services, which require her to be registered with the GDC, she must place herself and remain under the supervision of a workplace supervisor nominated by her, and approved by the GDC. The workplace supervisor shall be a GDC registrant in the same category of the register as the registrant or higher.

7. She must allow the GDC and the workplace supervisor to exchange information.

8. She must allow her workplace supervisor to provide reports to the GDC at intervals of not more than 3 months, and three weeks prior to any review hearing, and the GDC will make these reports available to any Postgraduate Dean/Director (or a nominated deputy) referred to in these conditions.

9. She must undertake audits of:

   - Record keeping;
   - Medical histories;
   - Treatment planning;
   - Radiography (including bitewing and pre-operative periapical radiographs); and
   - Consent.

   The audits must be signed by her workplace supervisor.

10. She must provide a copy of these audits to the GDC and the Postgraduate Dental Dean (or a nominated deputy) every three months.

11. (a) She shall maintain a log detailing every case where local anaesthetic is prescribed and where radiographs are taken and have this log and her clinical records audited on a monthly basis.

    (b) She must provide a copy of this log to the GDC prior to any review or alternatively, confirm that there have been no such cases.

12. She must work with a Postgraduate Dental Dean/Director (or a nominated deputy), to update her Personal Development Plan, specifically designed to address the deficiencies in the following areas of her practice:

    - Record keeping;
    - Medical histories;
    - Treatment planning;
    - Radiography (including bitewing and pre-operative periapical radiographs); and
    - Consent.

13. She must forward a copy of her Personal Development Plan to the GDC within 3 months of the date on which these conditions become effective and an updated copy at least one month prior to any review.

14. She must meet with the Postgraduate Dental Dean/Director (or a nominated deputy) to discuss her progress towards achieving the aims set out in her Personal Development Plan. The frequency of her meetings is to be set by the Postgraduate Dental Dean/Director (or a nominated deputy).

15. She must allow the GDC to exchange information about the standard of her professional performance and her progress towards achieving the aims set out in her Personal Development Plan with the Postgraduate Dental Dean/Director (or a nominated deputy), her workplace supervisor, and any other person involved in her training and supervision.

16. She must inform, within 7 days, the following parties that her registration is subject to the conditions, listed at (1) to (15) above:

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

17. She must permit the GDC to disclose the above conditions (1) to (16) to any person requesting information about her registration status.

Appeal

You may appeal against this decision in accordance with the provisions of section 27C (6) of the Act.

Immediate order of conditions

The Committee then invited submissions as to whether your registration should be made subject to an immediate order of conditions pending the substantive direction of conditional registration taking effect.

Decision on immediate order of conditions

Having directed that your registration be made conditional, the Committee considered whether to impose an order for immediate conditions to be placed on your registration in accordance with section 30 (2) of the Act.

The Committee has heard the submissions made by Ms Headley on behalf of the GDC, and those made by Ms Tanchel on your behalf. Ms Headley submitted that an immediate order of conditions is necessary in order to protect the public and is otherwise in the public interest in light of the findings set out in the Committee's substantive determination. Ms Tanchel submitted that an immediate order would be disproportionate and would amount to an immediate suspension.

The Committee has accepted the advice of the Legal Adviser.

The Committee has determined that it is necessary for the protection of the public and is otherwise in the public interest to impose an immediate order for your conditional

registration. The Committee has decided that, given the risks that it has identified, it would not be appropriate to permit you to practise unrestricted until the substantive direction of conditions comes into effect.

The effect of the foregoing determination and this immediate order is that your registration will be made subject to conditions from the date on which notice of this decision is deemed served upon you. Unless you exercise your right of appeal, the substantive direction of conditions will be recorded in the register 28 days from the date of deemed service. Should you exercise your right of appeal, this immediate order of conditions will remain in place until the resolution of any appeal.

That concludes this hearing."

At a review hearing on 1 July 2019, the Chairman announced the determination as follows:

"Neither party was present at today's hearing following a request by the General Dental Council (GDC) for this matter to be heard on the papers. The Committee first considered whether the notice of hearing has been served on Ms Elston.

Decision on service

In Ms Elston's absence, the Committee first considered whether the Notice of Resumed Hearing had been served on her in accordance with Rule 28 of the General Dental Council (Fitness to Practise) (GDC) Rules Order of Council 2006 (the Rules). The Committee saw a copy of the Notice of Resumed Hearing dated 22 May 2019 addressed to Ms Elston's registered address. This letter sets out the date, time and location of today's hearing, the grounds for holding the hearing, the directions that the Committee may give and other prescribed information. Furthermore, a letter was sent to Ms Elston's representatives.

The Committee was satisfied that the Notice of Resumed Hearing sets out the information required in accordance with Rule 28 and that it was sent to Ms Elston's registered address, in accordance with Section 50A(2) of the Act and Rule 65. The Royal Mail track and trace receipt stated that the letter was delivered and signed for by the name 'ELSTON'. This is more than 28 days in advance of today's hearing. In these circumstances, the Committee is satisfied that the Notice of Resumed Hearing has been served on Ms Elston in accordance with the appropriate Rules and the Act.

Proceeding in absence

The Committee then went on to consider whether to proceed in the absence of Ms Elston, in accordance with Rule 54. Ms Elston's representatives, in a letter dated 19 June 2019, confirmed Ms Elston is aware of these proceedings and is content for the hearing to proceed in her absence. The Committee bore in mind that it was necessary for the order to be reviewed before its expiry, otherwise the GDC would lose jurisdiction, which could lead to a risk to the public.

The Committee considered the written submissions. It accepted the advice of the Legal Adviser. It noted the documentation before it and correspondence from Ms Elston's representatives with the GDC. The Committee noted that Ms Elston is content for this hearing to proceed and she has not requested an adjournment of today's hearing. The Committee concluded that Ms Elston has voluntarily absented herself from today's hearing. In addition, the Committee considered that there is a clear public interest in reviewing Ms Elston's case before the expiry of the current order, given the serious nature of the matters

found proved by the PCC. The Committee determined that it was fair to proceed with today's review hearing in

the absence of Ms Elston in accordance with Rule 54.

Background

Ms Elston's case was considered by a PCC in January 2018. The allegations found proved against Ms Elston related to failing to provide an adequate standard of care to a patient in the period from 2005 to 2013. This included Ms Elston's radiographic practice and her practice in respect of local anaesthetic. It was alleged that Ms Elston administered local anaesthetic to the patient in excess of the maximum dose that resulted in the patient experiencing Local Anaesthetic toxicity and was transferred by ambulance to hospital. It was further alleged that Ms Elston failed to maintain an adequate standard of record keeping; failed to obtain informed consent and that she provided information to the patient about the non-availability of treatment on the NHS which was misleading and dishonest. The PCC directed that Ms Elston's Conditional registration be suspended for a period of 8 months, with a review.

The first review of the order took place in October 2018. The Committee determined that Ms Elston's fitness to practise remained impaired and considered that the remediation evidence presented to it, whilst extensive and commendable, was not sufficient for it to conclude that she had remedied in full the failings identified in this case. The Committee determined to revoke the suspension and impose a period of conditional registration for a period of 9 months to allow Ms Elston to return to practise in a safe and supported manner and would allow her to demonstrate that her considerable learning has been put into practice.

Today's Review

Today this Committee has comprehensively reviewed Ms Elston's case taking account of all the evidence presented. It has also taken account of the written submissions of the GDC and the written submissions made by Ms Elston's representatives on her behalf. The Committee accepted the advice of the Legal Adviser.

In considering whether Ms Elston's fitness to practise is currently impaired, the Committee has borne in mind that this is a matter for its own independent judgement. It has also had regard to its duty to protect the public, declare and uphold proper standards of conduct and competence and maintain public confidence in the profession.

The Committee carefully considered the written submissions from the GDC and Ms Elston's representatives and acknowledged that both parties submit that the current order of conditions continue in their current form for a further period of up to 12 months with a review.

The Committee noted that due Ms Elston's ill health she has not been able to practise as a dentist and has not been in a position to demonstrate full remediation of the clinical matters identified by the PCC. In these circumstances the concerns about the safety of patients arising from the findings at the initial hearing remain unaddressed and there remains a risk of repetition. The Committee noted from the letter dated 19 June 2019 from Ms Elston's representatives that they agree an extension of the conditions for a further 12 months, with a review, would afford Ms Elston the opportunity of focusing on her treatment and recovery. In the absence of evidence to the contrary, the Committee has concluded that the risk of repetition of the clinical matters remains. The Committee therefore determined that Ms Elston's fitness to practise remains currently impaired.

Sanction

The Committee next considered what direction, if any, to make on Ms Elston's registration. It reminded itself that the purpose of these procedures is not to be punitive, but to protect the public, to uphold the reputation of the profession and to maintain public confidence in the profession. It has borne in mind the principle of proportionality. The Committee has also kept in mind the GDC's "Guidance for the Practice Committees including Indicative Sanctions Guidance" (October 2016).

The Committee first considered whether it would be appropriate to allow the current order to lapse at its expiry or to revoke it with immediate effect. The Committee considered that given all of the information before it, and for all the reasons outlined above, it would be wholly inappropriate to revoke the current order or to allow it to lapse, as this would not protect the public, nor would it be in the public interest.

In light of its finding of current impairment, the Committee is satisfied that it is necessary for the protection of patients that Ms Elston's registration remains subject to conditions. It has concluded that the current period of conditional registration should be extended for a further period. In considering the length of the extension, the Committee has taken into account the fact that Ms Elston has not been working as a dentist since the order of conditions were first imposed. The Committee noted that Ms Elston has been suffering with her health. However, it recognises that during that time she has made attempts to remediate her failings to the extent she was able, namely her PDP and she met with her workplace supervisor. The Committee determined that an order for 12 months would be appropriate to give Ms Elston an opportunity to implement the clinical changes required to satisfy the PCC's concerns.

Accordingly, the Committee directs that the period of conditional registration be extended for a period of 12 months.

The Committee considered whether a period of suspension would be appropriate. However, given Ms Elston's on-going engagement with her remediation, apparently frustrated by her health condition, the Committee considered that in the circumstances of this case suspension would be disproportionate.

Having determined that a further period of conditional registration is appropriate and proportionate, the Committee has further determined that the conditions should again be reviewed prior to their expiry.

A Committee will review Ms Elston's case at a resumed hearing to be held shortly before the end of the period of conditional registration. That Committee will consider what action it should take in relation to her registration.

That concludes the case for today."

At a review hearing on 26 June 2020 the Chairman announced the determination as follows:

"This is a resumed hearing pursuant to Section 27C of the Dentists Act 1984 (as amended) ('the Act') to review the order of conditions for 12 months which was imposed on Ms Elston's registration by the Professional Conduct Committee (PCC) on 1 July 2019.

Decision on service of notice of hearing:

This Committee has been asked to perform the statutory review of this case on the papers alone and in the absence of both parties. In light of the current COVID-19 pandemic, this review has been conducted by the Committee remotely via Skype for Business.

The Committee has first considered whether notice of this hearing has been served on Ms Elston in accordance with Rules 28 and 65 of the *General Dental Council (Fitness to Practise) Rules Order of Council* 2006 (the rules).

The Committee has received a bundle of documents which contains a copy of the notification of today's review hearing, dated 19 May 2020, that was sent to Ms Elston's registered address by special delivery and first-class post. The Committee is satisfied that the letter contains proper notification of today's hearing, including its time, date and location, as well as notification that the Committee has the power to proceed with the hearing in Ms Elston's absence.

The Committee has also had sight of the extract from the Royal Mail Track and Trace service, regarding the notice of hearing. This shows that the letter of 19 May 2020 was delivered on 3 June 2020 at 10:54am and signed for by the printed name "ELSTON". The notification of hearing was also sent to Ms Elston's legal representatives, Dental Protection, who acknowledged receipt of the notification by letter dated 22 May 2020.

Accordingly, the Committee has concluded that the notification of this review hearing has been served on Ms Elston in accordance with the rules.

Decision on proceeding with the hearing on the papers:

Having been satisfied that all reasonable efforts have been taken to serve Ms Elston with notification of this hearing, the Committee has then considered whether to proceed to review this case in the absence of the parties and on the basis of the papers only. The Committee has borne in mind that its discretion to proceed with a hearing in the absence of a respondent should be exercised with the utmost care and caution. In making its decision on whether to proceed in Ms Elston's absence the Committee has taken account of the principles set out in *GMC v Adeogba & Visvardis [2016] EWCA Civ 162.*

The Committee notes the emails dated 4 and 18 June 2020 from Ms Elston's legal representatives to the GDC. In their email of 12 June 2020, they stated that Ms Elston agrees to the hearing being "conducted on the papers to obviate the need for the parties' attendance. This was confirmed in their letter with submissions dated 23 June 2020 in which they stated "I can confirm that the Notice of Hearing has been appropriately served and that Ms Elston is content for the hearing to proceed in her absence on the papers in accordance with the Council's submissions. No disrespect is intended to the Committee by virtue that Ms Elston does not propose to attend the hearing in person as a consequence of ill health." The Committee is satisfied that Ms Elston is aware of this hearing and has voluntarily waived her right to attend.

The Committee is satisfied that it is appropriate to review the case on the basis of the papers before it and in the absence of both parties.

Application to proceed in private

The Committee has also considered an application made pursuant to Rule 53 that this hearing should be conducted in private. Rule 53(1) provides that "a hearing before a Committee shall be conducted in public except where paragraph (2) applies." It is submitted by the Council that the matters to be considered in this hearing relate solely to Ms Elston's health which fall within the provisions of Rule 53(2) that provides that "all or part of a hearing may be held in private (a) where … the protection of the private and family life of the respondent … so requires." The Committee has accepted the advice of the Legal Adviser on this matter. It is determined that given that this review is being conducted on the papers, in

the absence of the parties, where matters relating to Ms Elston's health are addressed in its determination, a public version of the determination will be created and all such matters will be redacted from the public version.

Background

In May 2017 and January 2018 the PCC considered a number of allegations about Ms Elston's conduct. The PCC heard, and subsequently found proved, a number of allegations relating to the standard of care and treatment that Ms Elston provided to a patient, referred to for the purposes of its proceedings as Patient A, in the period of 2005 to 2013. The Committee

made specific factual findings in relation to a number of aspects of Ms Elston's care and treatment of Patient A. These findings concerned failings in the excessive administration of local anaesthetic to the patient, the omission of medical histories, the absence of proper treatment planning, shortcomings in radiographic practice, failures in obtaining informed consent and poor record-keeping. The PCC went on to find that these failings amounted to misconduct, which consisted of multiple and repeated failings over a considerable period of time. Ms Elston's fitness to practise was found to be impaired as a result of that misconduct. The PCC identified an ongoing risk to patient safety, as well as to the public interest, with particular regard to the misconduct that had been found in relation to Ms Elston's administration of excessive local anaesthetic. The PCC decided that the appropriate and proportionate sanction to impose was a period of suspended registration for eight months, with a review to take place prior to the expiry of that period.

First PCC Review

On 2 October 2018, the PCC reviewed the case. The PCC had evidence of Ms Elston's remediation which included evidence of PDP, CPD, reflective statements, templates, practice policies and protocols. Ms Elston attended that review hearing and gave oral evidence. The PCC was of the view that Ms Elston had not shown sufficient evidence of having put her learning into practice. It determined that Ms Elston's fitness to practise remained impaired. The PCC revoked the suspension order and imposed a period of conditional registration. It considered that conditions would provide for Ms Elston's return to practise in a safe and supported manner and would allow her to demonstrate that her considerable learning had been put into practice. The order for conditional registration on Ms Elston's registration was imposed for a period of nine months and a review hearing ordered to be held prior to the expiry of the order.

Second PCC Review

On 1 July 2019, the PCC reviewed the case in the absence of both parties and on the basis of the papers alone. It was the joint submission of both parties that the order of conditions should continue for a further period of 12 months and a review hearing ordered to be held prior to the expiry of the order. The PCC noted that Ms Elston had not been able to practice as a dentist due to ill health and therefore she was not able to demonstrate full remediation of the clinical matters identified at the initial hearing. The PCC concluded that there remained a risk of repetition of the unaddressed clinical matters and Ms Elston's fitness to practise remained impaired. The order for conditional registration was extended for a period of 12 months to give Ms Elston the opportunity to remedy the clinical concerns of the initial PCC.

Today's Review

This is the third review of this case. The Committee has conducted a comprehensive review based on the evidence before it. It has taken account of the written submissions made on behalf of Ms Elston and the Council. The Committee has accepted the advice of the Legal Adviser.

In considering the question of current impairment, the Committee has borne in mind that this is a matter for its own independent judgement. It has also had regard to its duty to protect the public, declare and uphold proper standards of conduct and competence and maintain public confidence in the profession.

The Committee noted the letter dated 23 June 2020 from Ms Elston's legal representative. The letter states "Regretfully, Ms Elston's position has not changed since the last review of the order in that she has been unable to return to clinical practice since the conditions were imposed on 2 October 2018." The Committee concluded that it is clear that Ms Elston has not been working due to poor health. She has not been able to update her Personal Development Plan (PDP) or report to her workplace supervisor. The Committee acknowledged that it is evident that Ms Elston's poor health has prevented her from demonstrating her remediation of the clinical concerns identified by the initial PCC in January 2018. In the absence of such remediation the Committee could not be satisfied that Ms Elston has fully remedied her failings, neither could it be assured that they would not be repeated. The Committee concluded that there remains a risk to patients. It determined that Ms Elston's fitness to practise remains currently impaired.

Sanction

The Committee next considered what sanction to impose under Section 27C of the Dentists Act, 1984 as amended. The Committee bore in mind the principle of proportionality. It carefully considered the GDC's Guidance for the Practice Committees, including Indicative Sanctions Guidance (October 2016, reviewed May 2019).

The Committee first considered whether to revoke the order for conditional registration. It was of the view that, in light of the absence of evidence of remediation from Ms Elston, it would be inappropriate to revoke the order at this stage.

The Committee then considered whether to extend the period of conditional registration for a further period of time. It noted that both parties are in agreement that the conditions should be extended. The Committee considered whether suspension would be appropriate in this case since Ms Elston's poor health has prevented her from demonstrating the appropriate remediation necessary in this case. However, having considered the case, it is of the view that conditions are workable if Ms Elston is able to return to work. It noted that Ms Elston has clearly made efforts in the past to remedy her failings. As such, conditions remain appropriate and proportionate and a suspension would be disproportionate. The Committee concluded that Ms Elston's registration will remain subject to conditions. In considering the duration of the conditions, the Committee noted the submissions made on behalf of Ms Elston that "Given Ms Elston's ongoing ill health she is considering retirement from dentistry due to ill health…In the circumstances it would be fair and reasonable for the conditions in their current format to be extended for 18 months whilst Ms Elston reaches a decision about her future in the profession." The Committee determined that 18 months would be appropriate in order to give Ms Elston the chance to focus on her poor health and implement the necessary remediation.

The Committee therefore directs that Ms Elston's registration be subject to conditions for a period of 18 months, in the same terms as were imposed on 2 October 2018. The

Committee also directs that this case should be reviewed prior to the expiry of the 18 month period.

That concludes this determination."