General
Dental
Council

HEARING HEARD IN PUBLIC

FAZIL, Muhammad Bilal Ilyas

Registration No: 246045

PROFESSIONAL CONDUCT COMMITTEE

FEBRUARY 2020

Outcome: Conditions imposed for 12 months (with a review)

Muhammad Bilal Ilyas FAZIL, a dentist, Statutory Exam 2015 BDS Karachi 2000, was summoned to appear before the Professional Conduct Committee on 3 February 2020 for an inquiry into the following charge:

Charge (as amended on 10 February 2020)

"That being registered as a dentist,

1. **Amended to:** On 27 September 2017 you used derogatory language in relation to Patient A, by referring to him as a retard and/or demented or words to that effect.

2. **Amended to:** You failed to provide an adequate standard of care to Patient B on 6 March 2017, in that you extracted Patient B's LR8 tooth when:

    a. You had not planned to do so;

    b. The extraction was not clinically indicated;

    c. **Amended to:** Patient B had not given prior consent for the extraction.

3. **Amended to:** On 18 October 2017, in the course of an investigation interview conducted on behalf of Wye Valley NHS Trust, in respect of the extraction of Patient B's LR 8 tooth on 6 March 2017, you asserted that:

    a. You had planned to extract the LR8 tooth on that date;

    b. The extraction of the LR8 tooth had been clinically indicated in your judgment;

    c. The references to the extraction of the LL8 tooth on this date in the clinical records and/or consent form and/or correspondence had all been record keeping errors by you.

4. Your conduct in respect of charge 3a above was:

    a. Misleading;

    b. Dishonest.

5. Your conduct in respect of charge 3b above was:

a. Misleading;

b. Dishonest.

6. Your conduct in respect of charge 3c above was:

a. Misleading;

b. Dishonest.

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

On 10 February 2020 the Chairman made the following statement regarding the finding of facts:

"Dr Fazil,

This is the Professional Conduct Committee's inquiry into the facts which form the basis of the allegation against you that your fitness to practise is impaired by reason of misconduct. You attended this hearing and you were represented by Mr Simon Cridland of Counsel. Mr David Patience of Counsel presented the General Dental Council's (GDC) case.

Preliminary Matters

Admissions

At the start of the hearing, Mr Cridland on your behalf, made admissions to charges 2 and 3 in their entirety. The Committee noted your admissions but deferred making a finding on them until all the evidence had been adduced.

The Committee noted that the charge refers to the patients' initials. In order to ensure complete anonymity of the patients involved the Committee adopted the naming convention used by the expert in this case, Mr Stafford. The Committee accepted the advice of the Legal Adviser. It replaced 'Patient DP' with 'Patient A' in charge 1 and replaced 'Patient CL' in charges 2 and 3 with 'Patient B'.

Prior to announcing this decision, the Committee invited Mr Patience to consider amending the charge to reflect the above. Mr Patience then applied to amend the charge. Mr Cridland did not oppose the amendment and submitted that it was a common sense amendment which would cause no injustice to you. The Committee therefore amended the charge.

Background

The case relates to a complaint against you by Wye Valley NHS Trust regarding two separate incidents. The first incident involves Patient A, a male adult with learning difficulties who attended you on 27 September 2017 for elective extraction of two teeth. He was accompanied by his mother. It is alleged that on the day of the appointment you used derogatory language in relation to Patient A by referring to him as a 'retard' and/or 'demented' or words to that effect.

The second incident involves Patient B who was referred to the hospital where you worked by her General Dental Practitioner (GDP) regarding symptoms of recurrent pericoronitis associated with the lower left eight (LL8) and the impaction of the lower right eight (LR8). The referral requested the removal of both LR8 and LL8. Patient B attended a consultation with you on 11 January 2017 and a written consent was noted for the extraction of the LL8.

A letter was dictated by you on 11 January 2017 to the patient's GDP. The letter stated that the patient had never had symptoms from the LR8 and there was therefore a lack of justification in removing it but that the LL8 would be extracted. On 6 March 2017 Patient B attended you for treatment and the LR8 was removed under local anaesthetic. It is alleged that you mistakenly removed the LR8 for Patient B when the patient had attended for the removal of the LL8.

There was an investigatory meeting of the Wye Valley NHS Trust on 18 October 2017. It is alleged that at this meeting you asserted that you had planned to extract the LR8 on the day, and that the references to the LL8 were record keeping errors.

Evidence Received and Assessment of Oral Evidence

By way of factual evidence, the Committee was provided with a signed witness statement dated 6 September 2019 from Witness 1, a signed witness statement dated 5 September 2019 from Witness 2, a signed witness statement dated 8 September 2019 from Witness 3, a signed witness statement dated 4 October 2019 from Witness 4, a signed witness statement dated 20 September 2019 from Witness 5 and a signed witness statement dated 9 September 2019 from Witness 6. The Committee also received a witness statement dated 9 September 2019 from the subsequent treating oral surgical consultant. His written statement was admitted in evidence without the need for formal proof. The Committee accepted his evidence regarding the tooth that was extracted. It was also provided with the patient records for Patients A and B.

The Committee also received the transcript of the Wye Valley NHS investigation and the initial statements given by Witness 1 and Witness 2 on the day of the alleged incident.

Witness 1

Witness 1 was a nurse who had recently commenced a new role in the department where you worked at the time of the events in question. The Committee heard oral evidence from her. She confirmed the contents of her witness statement as true and accurate to the best of her knowledge and belief. In her oral evidence Witness 1 did not elaborate past what she had written in her statement. She maintained that the word 'retard' had been used by you. Witness 1 was asked about the circumstances in which the alleged word was used. She told the Committee that whilst she was carrying out her task of setting up the room in preparation for the tooth extraction procedure, she noticed a diary on the work surface in the surgery. She said that the diary stated beside the patient's name that he may require two vials of Midazolam. Witness 1 said she had previously seen only one vial of Midazolam given to patients, so she asked you why. Witness 1 said you responded by saying "The patient is a retard". Witness 1 said that when you made this comment you were in the surgery room and the doors were closed. Witness 1 said that Witness 2, Witness 5 and Witness 6 were also in the room when this comment was made. Witness 1 does not say in her statement whether or not these other witnesses heard.

The Committee also considered the initial statement written on the day of the alleged incident, 27 September 2017, and the transcript of the Investigation meeting conducted by Witness 4 on 25 October 2017. Witness 1's account of the circumstances that led to the use of the alleged word was the same.

The Committee considered that there were parts of Witness 1's evidence that contradicted the evidence heard from the other witnesses in this case. She does not back up entirely the

account of the second complainant, Witness 2 and this suggests to the Committee that there has been no collusion between the two of them.

The Committee found Witness 1 to be a credible witness as her account was generally consistent through her contemporaneous account on the day of the alleged incident, the initial Trust investigation, her witness statement and her oral evidence.

Witness 2

Witness 2 was a trainee nurse associate at the time of the events in question. The Committee heard oral evidence from her. She confirmed the contents of her witness statement as true and accurate to the best of her knowledge and belief. Witness 2 alleged that prior to Patient A attending the treatment, you had a casual conversation with her, Witness 5 and Witness 6 about the patients coming in that day and during this conversation you passed a comment that the patient was a 'retard' and 'demented'. In her oral evidence Witness 2 maintained that the alleged words were used.

In order to establish the reliability of Witness 2's evidence the Committee assessed the initial statement she made on the day of the incident and the transcript of the investigation meeting. In her initial statement dated 27 September 2017 the day of the incident, Witness 2 said "The surgeon sat in the room where the procedure would be carried out speaking to/with the staff including myself and [Witness 1] (staff nurse) about the patient who was due in for surgery first. The surgeon went on to refer to the patient as a 'retard' and made a comment about him being 'demented'.

In the transcript of the Investigation meeting conducted by Witness 4 on 25 October 2017, Witness 2's account was that she was in the room with Witness 6 and Witness 5 when the comment was made. When asked if the comment was made in response to a question Witness 2 said "I can't remember. It wasn't a team brief, he was just talking about him. He was saying that he had treated him before. It was a passing comment. He said he was a retard and made a comment about him being demented. [Witness 1] was over the way – I'm not sure if she was in the room." When asked if the conversation was with someone in particular Witness 2 said "I'm not sure. I can't remember who he was talking to or in what context."

The Committee noted that Witness 2 was certain that both alleged words were used. However, she was unable to give details about how the words were used. The Committee found her to be broadly credible, but it noted the absence of any supporting evidence that the word 'demented' was used.

Witness 3

Witness 3 is a staff nurse who worked with you in the department where the incident relating to Patient A occurred. The Committee heard oral evidence from her. She confirmed the contents of her witness statement as true and accurate to the best of her knowledge and belief. Witness 3 was not present during the alleged incident. However, she recalled having a conversation with Witness 1 and Witness 2 in the surgery room as they were cleaning the room after the patient had left. Witness 3 recalled being told by the two nurses that they were not happy because they thought that your manner had been aggressive with the patient, vocally not physically. However, neither Witness 1 nor Witness 2 recall having this conversation with Witness 3. Witness 3 confirmed that she had nursed for you when you treated Patient A in the past.

Witness 3 did her best to assist the Committee. The Committee found her to be a credible witness. However, her evidence did not add anything towards proving or disproving the allegation relating to the use of derogatory language in relation to Patient A.

Witness 4

Witness 4 is a Consultant Ear Nose and Throat Surgeon at hospital where the incident occurred. He was appointed lead investigating officer in relation to the two incidents concerning you which are also the subject of this hearing. The Committee heard oral evidence from Witness 4. He confirmed the contents of his witness statement as true and accurate to the best of his knowledge and belief. The Committee found him to be a credible witness who focussed on the issues under consideration. His oral evidence matched his written statement. He was measured and the Committee found his evidence helpful.

Witness 5

Witness 5 is a dental nurse who worked with you throughout your time at the hospital where the incident occurred. The Committee heard oral evidence from Witness 5. She confirmed the contents of her witness statement as true and accurate to the best of her knowledge and belief. The Committee noted that Witness 5 made no contemporaneous statement on the day of the incident. Witness 5 was initially consistently adamant that the alleged word 'retard' was not used. In an email responding to questions put to her as part of the investigation she said "I have no knowledge of the patient being referred to as a "retard", or of being demented." In her oral evidence to this Committee, Witness 5 said that the words were not used and if they had been used by you, she would have reported you herself. Subsequently in cross-examination by the Council's representative, after Witness 5 was shown the contents of your witness statement in which you said that you had discussed the use of appropriate language with her, Witness 5 then conceded that the word 'retard' had been used by you. The Committee considered that Witness 5's earlier account was not accurate. Witness 5 then insisted that it was a conversation between her and you only. However, the Committee noted that if it was a conversation between you and Witness 5 alone, Witness 2 would not have heard what was said.

The Committee considered that Witness 5 was inconsistent in her evidence. It did not find her evidence credible or reliable.

Witness 6

Witness 6 was a health care assistant who worked with you at the hospital where the incident occurred. The Committee heard oral evidence from him by Skype. He confirmed the contents of his witness statement as true and accurate to the best of his knowledge and belief. Witness 6 appeared to the Committee to be defensive and noncommittal. He told the Committee that he was mostly in the door-way and was busy dealing with administrative matters. He said he did not recall any conversation with regard to Midazolam and that the words 'retard' and 'demented' were not used. Subsequently in cross-examination by the Council's representative, Witness 6 said that he recalled hearing the alleged word 'retard' by a male voice and that you were the only male in the room. He also conceded that he had heard some mention of Midazolam. He maintained however that the word 'demented' was not used. Witness 6 did not assist the Committee with the context in which the alleged word 'retard', which he had previously said was not used, had been used. The Committee did not find this helpful in clarifying this matter.

The Committee found Witness 6's evidence to be inconsistent. It did not find him credible or reliable.

Expert Witness

By way of expert evidence, the Committee received a signed expert report dated 27 September 2019 from Mr James Stafford. The Committee also heard oral evidence from him. He told the Committee that in his opinion as the mesially impacted LR8 was asymptomatic, extraction was both inappropriate and against National Institute for Health and Care Excellence (NICE) Guidelines although he believed that some dentists might have thought that extraction would minimise the risk to the adjacent tooth. It found him to be a credible and reliable witness who assisted the Committee in relation to the clinical matters under consideration.

Your Oral Evidence

As part of your defence, the Committee received your witness statement, dated 9 January 2019, and it heard oral evidence from you. It noted that prior to this hearing, you are of good character with no previous adverse findings against you.

The Committee noted that in your email dated 2 October 2017 which is the most contemporaneous account from you about the 27 September 2017, you said

"The referral letter also mentioned that he had learning difficulties so [Witness 5] wondered whether it was the same as special needs to which I replied that I wasn't sure as the guidelines and rules had changed with regards to that and many terms in the previous years. We were discussing that terms used before by people such as mentioned in the past were now considered derogatory and considered offensive and should never be used as they are hurtful and even unlawful in some places. It was a normal discussion between a surgeon and a nurse and I am very surprised and concerned that a few words from an entire conversation could be taken out of context to provide material for these allegations when the conversation I believe was aimed at improving someone's knowledge and to provide insight into what was considered offensive…I can confirm, that, at no time were these terms addressed towards the patient or used in an offensive or derogatory way towards the patient.."

In your oral evidence you maintained that you had not used the alleged words 'retard' or 'demented'. However, Witness 1, Witness 2, Witness 5 and Witness 6 all confirmed in their oral evidence that the word 'retard' was used by you.

In relation to Patient B and the extraction of the wrong tooth, you told the Committee that you did not have sufficient time to review the dental records for the patient. You said that you had a cursory look at the notes during the investigation meeting. The Committee found your approach to the investigation to be less than thorough and less than what would be expected of a professional under investigation. Your evidence regarding the use of the derogatory language was unreliable. There was no clear account from you about the events of that day. The Committee found that your evidence in relation to Patient A was not credible or reliable. In relation to Patient B it found some of your evidence plausible.

The Committee's Findings of Fact

The Committee has taken into account all the evidence presented to it, both oral and documentary. It has considered the submissions made by Mr Patience on behalf of the GDC and those made by Mr Cridland on your behalf. The Committee heard and accepted the

advice of the Legal Adviser. In accordance with that advice it has considered each head of charge separately, bearing in mind that the burden of proof rests with the GDC and that the standard of proof is the civil standard, that is, whether the alleged matters are found proved on the balance of probabilities.

In relation to the allegation on dishonesty the Committee was referred to the recent Supreme Court judgment in the case of Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67 where the test for dishonesty was revisited.

> *"When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional 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, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) 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 burden of proving the facts alleged is on the GDC and the standard of proof is the civil standard which is “on the balance of probabilities”. You are not required to prove anything.

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

1.	**Amended to:** On 27 September 2017 you used derogatory language in relation to Patient A, by referring to him as a retard and/or demented or words to that effect. **Not admitted but found proved** The Committee is of the view that the word ‘retard’ and/or ‘demented’ or words to that effect would be derogatory if used to describe a patient. In your oral evidence you said that you may have used the words ‘simple’ to describe the patient. The Committee heard no other evidence to support this account. Witness 2’s evidence was that you used the words ‘retard’ and ‘demented’ She has maintained this position throughout her evidence. However, no other witness recalled the word ‘demented’ being used. The Committee concluded that there was insufficient evidence to find that the word ‘demented’ was used. The Committee noted that Witnesses 1, 2, 5 and 6 confirmed the use of the word ‘retard’ in their oral evidence. However, Witnesses 2, 5 and 6 were unable to provide evidence about the context in which the word was used. Witness 5 and Witness 6 initially were adamant that the word was not used but subsequently changed their mind and agreed that it was used by you. The Committee was invited to conclude that the reason for this change in position was that they were trying to cover up for you. The Committee concluded that it was more likely that they were covering up for themselves. This is because if the word ‘retard’ was used in the context of a discussion about appropriate terminology, the Committee considers that the witnesses would have been

	open and honest about it from the start. It therefore concluded that the word was most likely used in a context that was not appropriate and they were making attempts to cover it up once a report had been made. In trying to establish the context, the Committee considered the contemporaneous accounts given by Witness 1 and Witness 2. It accepted the account given by Witness 1. Part of Witness 1's role on that day was to observe the patient. This would involve monitoring a patient who had been administered Midazolam. It was plausible that she asked a question about the medication to be administered to the patient. The Committee did not accept the submission on your behalf that Witness 1 had made a complaint because she was aware that you were not satisfied with the level of competence that she demonstrated. The Committee accepted Witness 1's account of the context in which the word 'retard' was used. It found this charge proved.
2.	**Amended to:** You failed to provide an adequate standard of care to Patient B on 6 March 2017, in that you extracted Patient B's LR8 tooth when:
2. a)	You had not planned to do so; **Admitted and found proved** On the basis that your admission was made through experienced Counsel and, having reviewed the evidence, the Committee accepts that the admission was properly made.
2. b)	The extraction was not clinically indicated; **Admitted and found proved** On the basis that your admission was made through experienced Counsel and, having reviewed the evidence, the Committee accepts that the admission was properly made.
2. c)	**Amended to:** Patient B had not given prior consent for the extraction. **Admitted and found proved** On the basis that your admission was made through experienced Counsel and, having reviewed the evidence, the Committee accepts that the admission was properly made.
3.	**Amended to:** On 18 October 2017, in the course of an investigation interview conducted on behalf of Wye Valley NHS Trust, in respect of the extraction of Patient B's LR 8 tooth on 6 March 2017, you asserted that:
3. a)	You had planned to extract the LR8 tooth on that date; **Admitted and found proved** On the basis that your admission was made through experienced Counsel and, having reviewed the evidence, the Committee accepts that the admission was properly made.

3. b)	The extraction of the LR8 tooth had been clinically indicated in your judgment; **Admitted and found proved** On the basis that your admission was made through experienced Counsel and, having reviewed the evidence, the Committee accepts that the admission was properly made.
3. c)	The references to the extraction of the LL8 tooth on this date in the clinical records and/or consent form and/or correspondence had all been record keeping errors by you. **Admitted and found proved** On the basis that your admission was made through experienced Counsel and, having reviewed the evidence, the Committee accepts that the admission was properly made.
4.	Your conduct in respect of charge 3a above was:
4. a)	Misleading; **Not admitted but found proved** Your evidence was that you had not taken sufficient care when you reviewed the notes during the investigation interview with Witness 4 because you assumed that you could not have made such a mistake. You said that during the procedure you concluded that LR8 was impacted and that this was the tooth to be extracted. The Committee noted that the referral letter from Patient B's GDP requested the removal of both LR8 and LL8. Patient B attended a consultation with you on 11 January 2017. The notes of that consultation do show an inconsistency in two lines where it appears that you have reversed the LR8 and the LL8. However, the majority of the clinical notes on that day make it clear that your intention was to extract the LL8. Additionally, on that date the patient signed a consent form, confirmed by her on 6 March 2017, for the extraction of the LL8 tooth. In a letter to Patient B's GDP which was dictated by you on 11 January 2017, you said "On talking to the patient the lower right wisdom tooth [LR8] has never given her problems and she has never had symptoms from it so we will not be talking this out as it will not be justifiable. The worry for it causing caries on the distal aspect of the 7 is ok and the way to go about that is for the patient to visit you on regular basis to keep a close look on the tooth and monitor it. Should there be signs of caries in the future we will be happy to consider the extraction. She has been booked in for the extraction of the lower left wisdom tooth [LL8] under local anaesthetic in the near future and we will keep you updated of her progress." On 6 March 2017 Patient B attended you for treatment and the LR8 was removed under local anaesthetic. The Committee's view is that it was clear from the evidence before it that you had not planned to extract the LR8 on 6 March 2017. Your contemporaneous

	notes of the appointment of 11 January 2017 showed that it was agreed that the LR8 tooth would remain as it was asymptomatic but that the LL8 would be extracted as it was causing recurrent pericoronitis. Further you dictated a letter to the patient's GDP stating that the LR8 would not be extracted but that the LL8 would. The Committee found that stating at the investigation interview that you had planned to extract the LR8 on that date and that the confusion had been a clerical error, was misleading as it had led the investigation to believe something was true when it was not.
4. b)	Dishonest. **Not admitted and found not proved** The Committee considered whether there was an alternative explanation to dishonesty for your actions. The evidence suggests that you were adamant that you could not believe that you could make such a mistake and assumed that it must have been an administrative error. The Committee considers that if you had realised that you really had made a clinical mistake, you would have requested time to review your notes and contact your indemnity provider. If you had looked at all the notes as closely as you should have done, you would have realised that to claim that the LR8 was the correct tooth and that the records were incorrect, would not be a sufficient response. The Committee considers this to be a plausible explanation and therefore it cannot exclude the possibility that this is what you believed at the time.
5.	Your conduct in respect of charge 3b above was:
5. a)	Misleading; **Not admitted but found proved** For the same reasons as in 4a above.
5. b)	Dishonest. **Not admitted and found not proved** For the same reasons as in 4b above.
6.	Your conduct in respect of charge 3c above was:
6. a)	Misleading; **Not admitted but found proved** For the same reasons as in 4a above.
6. b)	Dishonest. **Not admitted and found not proved** For the same reasons as in 4b above.

We move to Stage Two."

On 11 February 2020 the Chairman announced the determination as follows:

"Dr Fazil,

Having announced its decision on the facts, the Committee heard submissions from Mr Patience, on behalf of the General Dental Council (GDC) and from Mr Cridland on your behalf, in accordance with Rule 20 of the Fitness to Practise Rules 2006. It received a remediation bundle from you and heard oral evidence from Mr Patel, Consultant Oral Surgeon.

The Committee has accepted the advice of the Legal Adviser.

The Committee has reminded itself that its decisions on misconduct and impairment are matters for its own independent judgement. There is no burden or standard of proof at this stage of the proceedings. It has taken account of the GDC's "Standards for the Dental Team" (September 2013). The Committee was referred to the cases of *Meadows v GMC* [2006] EWCA Civ 1319; *Cohen v GMC* [2008] EWHC 581 (Admin); and *CHRE v NMC & Grant* [2011] EWHC 927 (Admin).

Misconduct

The Committee first considered whether the facts found proved amount to misconduct. It noted that prior to this hearing you have no previous fitness to practise history with the GDC.

Mr Patience submitted that there is misconduct in this case.

Mr Cridland submitted on your behalf that you do not seek to suggest that the findings made in relation to charge 1 and the clinical mistake in charge 2 do not amount to misconduct. In relation to charges 3, 4(a), 5(a) and 6(a) he submitted that it might be said that with the benefit of hindsight you may have taken greater care in the interview and that you could have and should have requested more time to review the clinical records. He submitted that misconduct should be a serious falling short from the standards expected and to inadvertently mislead the Trust's investigation falls far short of the kind of behaviour required to fairly reach a determination of professional misconduct.

In relation to charge 1, the Committee found proved that on 27 September 2017 you used derogatory language in relation to Patient A by referring to him as a 'retard'. The Committee noted that your conduct did not negatively impact on the standard of care you provided to the patient on this date. Nevertheless, it considered that, referring to a patient as a 'retard', even in a conversation between colleagues as was the case here, is a serious falling short of what is proper in the circumstances and a serious departure from the standards of conduct expected from a dental practitioner. Furthermore, your conduct would be regarded as deplorable by fellow practitioners. Witness 1 and Witness 2 told the Committee in their oral evidence that they were shocked when you used the term. The other witnesses told the Committee in their oral evidence that they would find the use of such a word to be unacceptable.

In relation to Patient B, the Committee found proved that you failed to provide an adequate standard of care to the patient on 6 March 2017 in that you extracted the wrong tooth, LR8, when you had not planned to do so, the extraction was not clinically indicated and Patient B had not given prior consent for the extraction. On 18 October 2017 in the course of an investigation interview conducted on behalf of the Wye Valley NHS trust in respect of the extraction of Patient B's LR8 tooth on 6 March 2017 you asserted that you had planned to extract the LR8 tooth on that date, that the extraction of the LR8 had been clinically indicated

in your judgment and that references to the extraction of the LL8 tooth on this date in the clinical records and consent form and correspondence had all been record keeping errors by you. The Committee found your actions on 18 October 2017 to be misleading. It did not find you to be dishonest.

The Committee considers that extracting the wrong tooth from Patient B, although a single act, was a serious error by you. The Committee considers that your failure was elemental in that it involved basic dental skills which should be achieved through effective pre-operative checks. This was a never event that should not have occurred. Once the error was flagged, you did not treat the matter with the seriousness that it deserved to ensure that it was properly investigated and addressed. You had clinical records of your consultation with the patient, including a consent form and correspondence with the patient's GDP all of which should have been carefully reviewed prior to carrying out the extraction procedure and prior to attending the investigatory interview. You led the investigation to believe something was true when it was not.

The Committee's view is that your conduct in relation to Patient A and your failure in relation to Patient B were serious departures from expected standards, particularly the *Standards for the Dental Team* (September 2013):

1.2 Treat every patient with dignity and respect at all times.

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

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

The Committee noted that you engaged with the Trust investigations, but it is of the view that once the possibility of a never event had been raised with you, you had a professional duty proactively to aid the investigations. The Committee considered that failing to do so given the seriousness of the situation was conduct that fell far short of the standards expected.

The Committee noted that the expert, Mr Stafford was of the opinion that your conduct in relation to Patient A fell below and in relation to Patient B fell far below the required standards of care.

The Committee, having found serious breaches and falling short of the standards, was in no doubt that the facts found proved in relation to Patient A and charge 1, and in relation to Patient B and charge 2 in its entirety, charge 3 in its entirety, and charges 4(a), 5(a) and 6(a) are all 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 carrying out this assessment the Committee considered whether the adverse findings made in this case are remediable, whether they have been remedied and the likelihood of repetition. It also assessed the level of your insight into the findings made and the impact of these findings on the public interest.

The Committee is of the view is that the facts found proved are all remediable. The Committee considered your remediation in relation to each patient separately. Regarding

Patient A and the use of derogatory language, the Committee noted from the evidence before it that you had treated Patient A in the past and developed a good rapport with him. It concluded that the way in which you acted on this occasion was out of character and not consistent with your previous dealings with the patient. The Committee did not consider this finding to represent a serious attitudinal issue on your part. The Committee noted from your remediation bundle that you have attended Continuing Professional Development (CPD) courses on 'Communicating with Patients', 'Safeguarding Level 2 and Level 3 including elements concerning vulnerable adults and autism', 'Mental Capacity Act and Consent', amongst others. The Committee noted that there has been no further evidence to suggest that you have used such language since the incident in September 2017. The Committee concluded that the likelihood of repetition of such behaviour in the future was low.

In relation to Patient B, the Committee noted that you apologised for your mistake in extracting the wrong tooth. You also admitted to this charge at the start of the hearing. The Committee noted from your remediation bundle that you have undertaken LocSSip training in order to address the issues relating to the standard of care you provided to Patient B. In a letter dated 27 March 2019 a consultant Oral Surgeon with whom you work with at Guy's and St Thomas' NHS Foundation Trust stated:

> "I am aware of the allegations made against him, regarding wrong sight (sic) surgery and the issues related to consent, made against him. I am aware of his undertaking in further training within these areas, in particular the use of LocSSip training, which he has undertaken. He has also demonstrated further study and training in relation to the issues of informed consent and I am content that Dr Fazil is fully conversant with the appropriate protocol in relations to these areas of clinical governance and professionalism."

The Committee noted, however, that there is no evidence from you demonstrating how the LocSSip protocol has been embedded in your practice in order to reduce the risk of repetition of a similar failing in the future.

Regarding the findings that you misled an investigation into your extraction of the wrong tooth, although the Committee found that you did not deliberately mislead the investigation, it found that you were less than thorough in dealing with the investigation. The Committee has seen no reflection from you on the implications of your behaviour and the outcome for the patient. There is no evidence from you on how you would approach a similar situation were it to occur in the future. The Committee is of the view that you have some insight into your failings by your admissions to the relevant charges. The Committee concluded that your remediation is not yet complete and your insight is not yet sufficient to provide the assurance that the failings found proved in relation to Patient B will not be repeated. As such there remains a risk of repetition and a need to protect patients.

The Committee then considered whether a finding of impairment is required in the public interest to maintain public confidence in the profession and declare and uphold proper standards. It is of the view that a reasonable and informed member of the public, fully aware of the findings made regarding the use of derogatory language in relation to Patient A, the extraction of the wrong tooth in Patient B, misleading an investigation into the extraction of the wrong tooth, and the concerns regarding incomplete remediation and limited insight, would lose confidence in the profession and the dental regulator if a finding of impairment is not made in the circumstances of this case.

The Committee has therefore 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. The Committee has applied the principle of proportionality. It has taken account of the *Guidance for the Practice Committees including Indicative Sanctions Guidance, October 2016 (updated May 2019), ("PCC Guidance")*.

The Committee considered the testimonials presented on your behalf. It noted that the testimonials are written by people who have worked with you for a number of years at your current place of work as well as at the hospital where the incidents occurred in 2017. The writers are positive and speak to your clinical competence and rapport with patients. The Committee also noted the positive patient feedback given by patients you treated. The Committee gave the testimonials and patient feedback due weight.

The Committee considered the mitigating and aggravating factors in this case. In mitigation it took account of:

- evidence of good conduct following the incident in question, particularly any remedial action;
- evidence of previous good character; and
- time elapsed since the incident.

The aggravating features of this case include:

- … risk of harm to a patient…
- Limited insight.

The Committee considers that although you have undertaken CPD courses to address the findings made against you, as identified when assessing current impairment, you are yet to demonstrate through personal reflection that you have reviewed your conduct and performance, recognised how you should have behaved differently and identified and put in place measures that will prevent a recurrence of such circumstances in the future. As your remediation and insight remain incomplete the Committee considers that there remains a risk of repetition. However, it recognises that you have made efforts towards reducing the risk.

The Committee considered whether to conclude this case with no further action. It noted the submissions made by Mr Cridland that if the Committee concludes that a finding of impairment is required to mark the seriousness of the facts found proved, this case is one of those relatively rare cases where a finding of current impairment is sufficient and a sanction would be neither necessary nor proportionate. However, having concluded that further remediation and the development of insight are required, the Committee determined that it would be inappropriate to conclude this case with no further action.

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

In relation to a reprimand it noted paragraph 7.9 of the PCC Guidance which states:

"A reprimand may be suitable where most of the following factors are present (this list should not be taken to be exhaustive):

- there is no evidence to suggest that the dental professional poses any danger to the public;
- the dental professional has shown insight into his/her failings;
- the behaviour was an isolated incident;
- the behaviour was not deliberate;
- the dental professional acted under duress;
- the dental professional has genuinely expressed remorse;
- there is evidence that the dental professional has taken rehabilitative/corrective steps; and
- the dental professional has no previous history."

The Committee acknowledged that some of the factors listed are present in this case. However, given that there remains a risk of repetition, a reprimand would not be appropriate to address all the concerns or sufficient to safeguard the public interest.

The Committee then considered whether it would be appropriate to apply conditions to your registration. It noted paragraph 7.18 of the PCC Guidance which states:

"Conditions may be appropriate when all or most of the following factors are present (this list is not exhaustive):

- there are discrete aspects of the registrant's practice that are problematic;
- any deficiencies are not so significant that patients will be put at risk directly or indirectly as a result of continued – albeit restricted – registration;
- the registrant has shown evidence of insight and willingness to respond positively to conditions;
- it is possible to formulate conditions that will protect the public during the period they are in force;
- it is possible to formulate conditions that satisfy the requirements set out at 7.19."

Paragraph 7.19 of the PCC Guidance states:

"The Committee must ensure that the conditions they impose are:

- necessary in order to protect patients, the public or the interests of the profession;
- clear;
- relevant to the identified shortcomings;
- proportionate to the identified impairment;
- workable (conditions must not be such that in reality they amount to suspension); capable of being monitored for compliance by the executive and/or at a review hearing;
- addressed only to the registrant and not to a third party."

The Committee's view is that the outstanding concerns highlighted above can be properly addressed with the imposition of conditions. You have demonstrated a willingness to remedy your failings by engaging in remedial action. The Committee considered whether a suspension would be more appropriate in this case. It noted paragraph 7.28 of the PCC Guidance which states:

"Suspension is appropriate for more serious cases and may be appropriate when all or some of the following factors are present (this list is not exhaustive):

- there is evidence of repetition of the behaviour;
- the registrant has not shown insight and/or poses a significant risk of repeating the behaviour;
- patients' interests would be insufficiently protected by a lesser sanction;
- public confidence in the profession would be insufficiently protected by a lesser sanction;
- there is no evidence of harmful deep-seated personality or professional attitudinal problems (which might make erasure the appropriate order).

The Committee considered that the factors set out at 7.28 above did not apply in this case. It was of the view that the evidence before it showed that you are well regarded amongst colleagues and that with sufficient remediation, you can be returned to safe and unrestricted practice in the future following a successful period of conditional registration.

The Committee therefore directs pursuant to section 27B (6)(c) of the Dentists Act 1984, as amended ("the Act") that your registration shall be conditional on your compliance for a period of 12 months. The Committee has decided on this duration in order to give you sufficient time to devise and accomplish your Personal Development Plan and carry out audits to establish that the changes are fully embedded in your clinical practice.

The conditions as they will appear against your name in the Register are as follows:

1. He must notify the GDC promptly of any professional appointment he accepts and provide the contact details of his employer or any organisation for which he is contracted to provide dental services and the Commissioning Body on whose Dental Performers List he is included or Local Health Board if in Wales, Scotland or Northern Ireland.
2. He must allow the GDC to exchange information with his employer or any organisation for which he is contracted to provide dental services
3. He must inform the GDC of any formal disciplinary proceedings taken against him, from the date these conditions take effect.
4. He must inform the GDC within 7 days of any complaints made against him from the date these conditions take effect.
5. He must inform the GDC if he applies for dental employment outside the UK.
6. He must work with appropriate guidance to formulate a Personal Development Plan, specifically designed to address the concerns in the following areas of his practice:
   a. Pre-operative procedures and checks;

b. Equality and Diversity;

c. The role and responsibility of professionals in the course of an investigation; and

d. Reflective practice.

7. He must forward a copy of his Personal Development Plan to the GDC within 3 months of the date on which these conditions become effective.

8. At any time he is employed, or providing dental services, which require him to be registered with the GDC, he must place himself and remain under the supervision* of a workplace supervisor nominated by the Registrant, and agreed by the GDC. The workplace supervisor will be at the same level of registration or higher than the Registrant.

9. He must meet with his workplace supervisor on a regular basis to discuss his progress towards achieving the aims set out in his Personal Development Plan.

10. He must allow his workplace supervisor to provide reports to the GDC every three months and at least 14 days prior to any review hearing.

11.

a. He shall carry out clinical audit of pre-operative checks. The clinical audits must be signed by his workplace supervisor.

b. He must provide a copy of these clinical audits to the GDC on a 3 monthly basis and at least 14 days prior to any review hearing or, alternatively, confirm that there have been no such cases.

12. He must inform within one week the following parties that his registration is subject to the conditions, listed at 1 to 11, above:

a. Any organisation or person employing or contracting with him to undertake dental work,

b. Any locum agency or out-of-hours service he is registered with or applies to be registered with (at the time of application),

c. Any prospective employer (at the time of application),

d. The Commissioning Body on whose Dental Performers List he is included or seeking inclusion, or Local Health Board if in Wales, Scotland or Northern Ireland (at the time of application)

13. He must permit the GDC to disclose the above conditions, 1 to 12, to any person requesting information about his registration status.

**Supervision required is at the lowest level, namely basic supervision. Defined as, "The registrant's day to day work must be supervised by a person who is registered with the GDC in their category of the register or above. The supervisor need not work at the same practice as the registrant, but must make themselves available to provide advice or assistance should they be required. The registrant's work must be reviewed at least once monthly by the supervisor via one to one meetings and case-based discussion. These monthly meetings should normally take place face to face.*

The Committee also directs that this direction for conditional registration be reviewed prior to the end of the 12 month period pursuant to section 27C(2) of the Act.

Decision on immediate order of conditions

The Committee took account of the submissions made to it.

Mr Patience on behalf of the GDC that an immediate order should be imposed on your registration. He submitted that the substantive order of conditional registration will not come into effect until 28 days has lapsed and, given the Committee's reasoning that the substantive order is required for public protection it would be unreasonable to leave the public unprotected in the 28 day appeal period so it is appropriate to impose an immediate order today.

Mr Cridland opposed the application. He submitted that this is the case where there is no interim order in place. He submitted further that the misconduct found by this Committee relates to events that occurred over two years ago, without repetition and on the Committee's finding there has been a considerable degree of remediation by you. Mr Cridland submitted that this is not the type of case where an immediate order is required. He submitted that any concern as to the risk of repetition has to be balanced against the absence of any repetition, the changes implemented in your practice and the CPD courses you have attended. He submitted that this is not a case where it could sensibly and fairly be said that an immediate order is necessary and proportionate.

The Committee accepted the advice of the Legal Adviser.

The Committee considers that the immediate risk to the public is low and as such an immediate order is not necessary for the protection of the public. Further in relation to the public interest, although the Committee found current impairment on public interest grounds, the threshold for the imposition of an immediate order on public interest grounds has not been met in this case. The Committee has therefore determined that immediate order is not necessary for the protection of the public, otherwise in the public interest or in your own interest.

The effect of the foregoing direction and this order is that your registration will not be restricted until the substantive direction for conditional registration for 12 months takes effect.

That concludes this determination."