General
Dental
Council

HEARING HEARD IN PUBLIC

TEODORESCU, Ana-Maria

Registration No: 161869

PROFESSIONAL CONDUCT COMMITTEE

MARCH 2021 – MAY 2021

Outcome: Conditions imposed for 18 months with immediate conditions (with a review)

TEODORESCU, Ana-Maria, a dentist, DMD Iasi 2003, was summoned to appear before the Professional Conduct Committee on 8 March 2021 for an inquiry into the following charge:

Charge (as amended 09 March 2021)

"That, being a registered dentist:

1. You practised at the dental practice identified in Schedule 1[1] below, and treated the patients identified in Schedule 2 below between October 2016 and October 2018.
2. You failed to provide an adequate standard of care to Patient A, in that you:
   (a) did not carry out an adequate assessment of the patient's presenting dental condition on:
      (i) 31 May 2017;
      (ii) 23 June 2017;
   (b) did not accurately diagnose the cause of the patient's pain on:
      (i) 31 May 2017;
      (ii) 23 June 2017;
   (c) did not take radiographs on:
      (i) 31 May 2017;
      (ii) 23 June 2017;
   (d) provided a poor standard of treatment on 31 May 2017, namely fillings at:
      (i) UR6;
      (ii) UR7.
3. You failed to record adequate details of examinations between 21 October 2016 and 19 September 2018 in respect of the patients and dates in Schedule 3.
4. You provided a poor standard of radiographic practice between 21 October 2016 and 1 October 2018 in respect of the patients and dates in Schedule 4.
5. You failed to adequately diagnose the need for treatment between 21 October 2016 and 1 October 2018 in respect of the patients and dates in Schedule 5.

[1] Please note the Schedules are private documents that cannot be disclosed.

6. You failed to obtain informed consent:
    a. from Patient 25 for the extraction of the UR2 on 28 April 2017;
    b. from Patient 9 for the extraction of the LR5 on 2 July 2018.
7. You provided a poor standard of treatment between 6 March 2017 and 14 September 2018 in respect of the patients, treatments and dates in Schedule 6.
8. You failed to provide individual recommendations on recall intervals between 28 October 2016 and 1 October 2018 in respect of the patients and dates in Schedule 7.
9. You failed to treat Patient 25 with kindness and compassion on or around 28 April 2017, when extracting UR2.

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

On 23 March 2021 the Chairman made the following statement regarding the finding of facts:

"Ms Teodorescu

This is the Professional Conduct Committee's ("PCC") inquiry into the charges which form the basis of the allegations against Ms Teodorescu that her fitness to practise is impaired by reason of misconduct. Ms Teodorescu attended the hearing and represented herself. The General Dental Council's (GDC) case was presented by Ms Tahta. The entire hearing was conducted via video link in line with the GDC's current practice.

Preliminary Matters

Decision on Application to join additional allegations – 8 March 2021

Ms Tahta made an application under Rule 25(2) of the General Dental Council (Fitness to Practise) Rules 2006 ("the Rules") to join additional allegations to the existing charge. She submitted that Ms Teodorescu was notified via letter dated 5 February 2021 of the GDC's intention to make an application to join further allegations and sub allegations listed within the notice. Ms Tahta submitted that the additional allegations are founded on the same facts which form the basis of the existing charge.

Ms Teodorescu did not object to the application.

The Committee accepted the advice of the Legal Adviser. Rule 25(2) provides that:

"(2) Where—

(a) an allegation against a respondent has been referred to a Practice Committee,

(b) that allegation has not yet been heard, and

(c) a new allegation against the respondent which is of a similar kind or is founded on the same alleged facts is received by the Council, the Practice Committee may consider the new allegation at the same time as the original allegation, notwithstanding that the new allegation has not been included in the notification of hearing."

The Committee was satisfied that Ms Teodorescu had been notified of the additional charges in the letter dated 5 February 2021. It was also satisfied that the new allegations against Ms Teodorescu are founded on the same alleged facts as the current allegations in the charge. The Committee concluded that it was just and fair to join the new charges to those already

before it and for all the matters to be dealt with at the same time. It noted that Ms Teodorescu did not object to the application. The Committee therefore granted the application to join the new allegations.

Decision on Application to Amend the Charge – 11, 12 and 15 March 2021

On 12 March 2021, Ms Tahta applied to amend the charge by withdrawing the allegations relating to Patient 3 of failing to diagnose caries at LR5, UL7 and UL6. Ms Tahta submitted that this was on the basis that the radiographs, on which the expert witness, Professor Morganstein, based his opinion of misdiagnosed caries, were no longer available. Professor Morganstein during his oral evidence was unable to demonstrate the basis of his criticisms from the copies of the radiographs that were before the Committee. Ms Tahta submitted that it was in Ms Teodorescu's interest to withdraw the allegations in the absence of any evidence to support the allegations.

Ms Teodorescu did not object to the application.

Rule 18 provides that:

> *"(1) At any stage before making their findings of fact in accordance with rule 19, a Practice Committee may amend the charge set out in the notification of hearing unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.*
>
> *(2) Before making any amendment under paragraph (1), a Practice Committee shall consider any representations from the parties."*

The Committee accepted the advice of the Legal Adviser that if no evidence was presented to support a charge, then that charge could not proceed any further. The Committee accepted this advice. It was satisfied that the amendment could be made without injustice and therefore acceded to the application.

On 11 March 2021, during the course of Professor Morganstein's oral evidence, Ms Tahta applied to amend the allegation of "failure to retake bitewing radiographs" in relation to Patient 2 as set out within schedule 4 to read "failure to retake right bitewing". She submitted that this was in accordance with Professor Morganstein's evidence. Further, she submitted that making the amendment posed no unfairness to Ms Teodorescu and did not affect the gravamen of the charge as it reduced the number of radiographs under criticism in relation to this patient. Ms Teodorescu did not object to the application. The Committee accepted the advice of the Legal Adviser and acceded to the application.

On 15 March 2021, Ms Tahta applied to amend the charge further by withdrawing the allegation relating to the inadequate reporting on radiographs taken on 21 October 2016 of Patient 3. She submitted that as she had withdrawn the charges relating to Patient 3 and the failure to diagnose caries because the radiographs available were not sufficient for Professor Morganstein to identify his criticism for the Committee, the allegation of an inadequate report could now no longer be supported in the absence of adequate radiographs. Ms Teodorescu did not object to the application. The Committee accepted the advice of the Legal Adviser and acceded to the application.

Admissions

Ms Teodorescu made admissions to the following allegations within the charge: 1, 2(d), 2(d)(i), 2(d)(ii), and 7 in relation to Patient 19. The rest of the allegations were contested by Ms

Teodorescu. However, during the course of the evidence, particularly in her oral evidence, she made further admissions which are reflected in the table below within this determination.

The Committee decided to defer making a finding on the admissions made by Ms Teodorescu until all the evidence had been adduced.

Background

This case involves criticisms made of Ms Teodorescu's treatment of 15 patients between October 2016 and October 2018. On 4 April 2018, Patient A made a complaint to the GDC regarding the treatment he received from Ms Teodorescu. He attended Ms Teodorescu in late May 2017 in severe pain. He alleged that Ms Teodorescu informed him, without taking a radiograph, that the pain was coming from his lower left wisdom tooth. Ms Teodorescu also carried out two fillings on Patient A's teeth. Patient A reported that one of the fillings fell out several hours after the treatment by Ms Teodorescu. Patient A returned to the practice on the same day to have the filling replaced.

Patient A complained that his pain continued to be severe, and he attended another appointment with Ms Teodorescu. Patient A alleges that he was informed by Ms Teodorescu that the extractions of his upper left and lower left wisdom teeth could not be done at the practice, they would need to be surgically removed and that there was a 16-week waiting time on the NHS. After 9 weeks, Patient A contacted the hospital where he had been referred and was informed that the waiting time was likely to be 22 weeks to have the procedure. Patient A remained in pain during this time. Patient A subsequently had his upper left wisdom tooth extracted by another dentist at the practice where Ms Teodorescu worked.

In May 2018 the GDC received another complaint from a dentist regarding the dental care provided by Ms Teodorescu at the practice that they both worked at. The complaint highlighted areas in Ms Teodorescu's practice that caused concern. The complaint was investigated and the issues arising involved alleged failures to provide an adequate standard of care to several patients, including in respect of diagnosis, radiographic practice, consent and record keeping and a failure to treat one particular patient with kindness and compassion.

Evidence Received

By way of factual evidence from the GDC, the Committee was provided with the following:

- Signed witness statement and supplementary statement of Patient A dated 26 June 2019 and 8 November 2019, including exhibits;
- Signed witness statement of Patient 9 dated 6 February 2020, including exhibits;
- Signed witness statement of Patient 25 dated 28 February 2020, including exhibits;
- Patient records for the 15 patients in this case;
- Signed expert report of Mr Ward dated 9 August 2019, including appendices;
- Signed expert report of Professor Morganstein dated 30 March 2020, including appendices.

In addition, the Committee also received documentary evidence from Ms Teodorescu which included her responses to the allegations before the Committee.

Assessment of Oral Evidence

The Committee heard oral evidence from Patient A, Patient 9, Patient 25, Mr Ward, Professor Morganstein and Ms Teodorescu.

Patient A

The Committee noted that Patient A was clear on his reason for attending Ms Teodorescu which was because of pain in the left side of his mouth. He was willing to accept when his recollection was not clear. He was straight forward in his evidence and attempted to assist the Committee. The Committee found him to be a credible witness.

Patient 9

She was very sure of the events at the appointment with Ms Teodorescu on 2 July 2018. She was clear throughout that her complaint was regarding pain in her back tooth. She was also clear that although her LR5 had caused some pain in the past when she saw Ms Teodorescu, it had cleared up and was not the source of the pain she was complaining of to Ms Teodorescu on this occasion. Patient 9 accepted that she had signed the treatment plan within the records which indicated that the tooth to be extracted was the LR5. However, she explained to the Committee that, at that time, she did not understand the teeth annotations. The Committee found her to be a credible and compelling witness who was assertive but balanced in her account. Her oral evidence was consistent with her written statement.

Patient 25

Whilst doing her best to assist the Committee, she was unclear in her recollection. For example, regarding the reason for attending Ms Teodorescu on 28 April 2017, Patient 25 said that she attended the appointment because of a chipped tooth but the evidence before the Committee showed that she had a broken crown. Patient 25 also said that she did not recall the discussion that Ms Teodorescu had with her on this appointment. However, there was evidence showing that the appointment lasted for 45 minutes and Patient 25 signed a treatment plan which detailed the treatment options of extraction and dentures or implants. Furthermore, the records also show that the subsequent treating dentist noted in the records that Patient 25 was aware of implants as an option from her previous dentist, Ms Teodorescu.

The Committee considered that Patient 25's recollection of events was likely coloured because she left Ms Teodorescu's surgery feeling that she had been treated poorly. She did her best to assist the Committee but given that some of her recollection was unclear, the Committee could not rely on the entirety of her evidence.

Expert Witness – Mr Ward

Mr Ward gave very clear, concise and balanced opinion evidence on the allegations relating to Ms Teodorescu's clinical treatment of Patient A. The Committee found him to be knowledgeable and credible.

Expert Witness – Professor Morganstein

Professor Morganstein gave detailed opinion evidence on the allegations relating to Ms Teodorescu's clinical treatment of the remaining 14 patients in this case. He sometimes prevaricated in his assessments of whether a failing was below or far below the standard expected. The Committee considered that, on occasion, his opinion was based on a gold standard rather than what a reasonable practitioner would do. On the whole however, the Committee found his evidence to be proportionate and fair, with a willingness to review his criticisms where appropriate.

Ms Teodorescu

The Committee noted that as English is not Ms Teodorescu's first language, this created difficulties for her, particularly as she represented herself in the hearing. On the whole she did her best to assist the Committee with the charges by putting her case forward. The Committee did not consider that Ms Teodorescu was being disingenuous although it found it difficult to accept her account of being able to remember specific patients from four years ago when some of the treatment provided to those patients was unremarkable, given the number of patients she treated daily. The Committee gave some weight to her evidence.

The Committee's Findings of Fact

The Committee has considered all the evidence presented to it, both oral and documentary. It took account of the submissions made by Ms Tahta. Ms Teodorescu made no closing submissions at this stage, but the Committee took account of her oral and documentary evidence. The Committee heard and accepted the advice of the Legal Adviser.

For ease of reference for any reader, the allegations set out in the schedule have been included in the table below and highlighted in bold type for clarity.

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

1.	*You practised at the dental practice identified in Schedule 1 below, and treated the patients identified in Schedule 2 below between October 2016 and October 2018.* Admitted and found proved. This charge was found proved on the basis of Ms Teodorescu's admission and the documentary evidence before the Committee in the form of patient records.
2.	*You failed to provide an adequate standard of care to Patient A, in that you:*
2. (a)	*did not carry out an adequate assessment of the patient's presenting dental condition on:* *2. (a)(i) - 31 May 2017* *2. (a)(ii) - 23 June 2017* Admitted and found proved. Admitted by Ms Teodorescu during the course of her evidence and found proved on the basis of her admission, the expert evidence and the patient records.
2. (b)	*did not accurately diagnose the cause of the patient's pain on:* *2. (b)(i) - 31 May 2017;* *2. (b)(ii) - 23 June 2017;* Admitted and found proved.

	Admitted by Ms Teodorescu during the course of her evidence and found proved on the basis of her admission, the expert evidence and the patient records.
2. (c)	*did not take radiographs on:* *2(c)(i) - 31 May 2017;* *2(c)(ii) - 23 June 2017;* Admitted and found proved. Admitted by Ms Teodorescu during the course of her evidence and found proved on the basis of her admission, the expert evidence and the patient records.
2. (d)	*provided a poor standard of treatment on 31 May 2017, namely fillings at:* *2(d)(i) – UR6;* *2(d)(ii) – UR7* Admitted and found proved. This charge was found proved on the basis of Ms Teodorescu's admission at start of the hearing, the expert evidence and the documentary evidence before the Committee.
3.	*You failed to record adequate details of examinations between 21 October 2016 and 19 September 2018 in respect of the patients and dates in Schedule 3.* ***Patient 1*** ***29 June 2017*** ***Insufficient details of examination findings*** Not admitted but found proved. In his oral evidence, Professor Morganstein commended Ms Teodorescu for identifying that the patient's UR2 was a *'dens in dente'* (a tooth within a tooth). However, he remained critical that Ms Teodorescu did not describe anything about the tooth, for example whether it was tender to percussion, whether the soft tissue around the tooth was inflamed or not and whether the tooth had any mobility on examination. Ms Teodorescu had initially disagreed with Professor Morganstein's opinion. In her oral evidence, however, she accepted that her records contained insufficient details of her examination findings in some regard. The Committee accepted the opinion of Professor Morganstein. It noted that none of the assessments set out by the expert in his oral evidence were present within the records. The Committee therefore found this charge proved. ***Patient 1*** ***29 June 2017***

	Inaccurate Basic Periodontal Examination Not admitted but found proved. In his report, Professor Morganstein stated that: *"The Registrant obtained a BPE on 29.06.2017 recording low scores for 5 of the 6 sextants. The hygienist obtained two further BPE results on 02.05.2018 and 19.07 2018 both of which were significantly higher than that obtained by the Registrant. This could be the result of a significant deterioration in the state of the patient's periodontium, but this is not supported by the hygienist's records of plaque and calculus present in all areas of the mouth along with poor oral hygiene. I am certain that the Registrant underestimated the degree of periodontal disease present in the patient's mouth. This is far below the standards expected. When the underestimating of the BPE happens over a long period, that would be potentially harmful."* In his oral evidence, Professor Morganstein remained of the opinion that this patient's periodontal condition was unlikely to have changed significantly in the 11-month period between Ms Teodorescu's Basic Periodontal Examinations ("BPE") record in June 2017 and the BPE taken by the Hygienist in May 2018. Prof Morganstein considered that it was more likely that the Hygienists' scores were more accurate than Ms Teodorescu's scores because Hygienists are experts in dealing with all aspects of periodontal disease including carrying out BPEs. He was also of the view that the bone loss visible on the radiographs did not match the low scores recorded by Ms Teodorescu. Ms Teodorescu's position was that she had probed the patient's teeth properly, and that her BPE scores were not inaccurate. She did not agree with Professor Morganstein's opinion and she also stated that the oral health of the patient could have deteriorated in the 11-month period. The Committee noted that Ms Teodorescu recorded very low BPE scores of 1/0/1 in the upper arch and 1/2/1 in the lower arch in June 2017. On 2 May 2018, Hygienist 1 recorded BPE scores of 3/1/2-3/2/3 in the upper and lower arches. On 19 July 2018 Hygienist 2 recorded scores of 2/2/2-3/2/3. The Committee noted that the scores recorded by the Hygienists were in close proximity, 2 two months apart, and the BPE scores were similar yet markedly different from Ms Teodorescu's BPE scores. The Committee then considered the likelihood of the patient's periodontal condition changing in the 11-month gap. The Committee accepted the opinion of Professor Morganstein. It found that, on the balance of probabilities, it was more likely that the BPE scores recorded by the Hygienists in May and July 2018 were more accurate than Ms Teodorescu's BPE score recorded on 29 June 2017. It therefore found this charge is proved. ***Patient 4*** ***9 February 2018*** ***Insufficient details of examination findings.***

	Not admitted but found proved. In his report, Professor Morganstein stated that: *"An adult examination is recorded for this visit without any details of what was seen. This is far below the standards expected."* In his oral evidence, Professor Morganstein remained critical of the lack of detail in the examination findings recorded in the patient's dental records. He stated that at this visit, Ms Teodorescu recorded pain in the LR6 but there was no further mention of this tooth and no further investigations recorded. He noted that Ms Teodorescu should have recorded the occlusion on the LR6, tooth mobility, whether the patient's tooth was tender to percussion and a record should have been made that other issues such as cracks in or perforation of the roots had been eliminated. In her written response, Ms Teodorescu stated: *"I would like to challenge the affirmation from expert`s report that on the appointment from 9.02.2018 during the adult examination recorded I did not describe in that visit what was seen. I refer to patient [4] clinical notes. There is a description of what was assessed during the clinical examination performed in that course of treatment. I would also would [sic] like to mention that at soft tissue examinations, when some pathologies are found, we complete a diagram for the specific lesion and only pathologies are register [sic] and not the healthy or normal tissues. The clinical records are supposed to be concise and not to over write [sic] a description of the normal anatomy. We also register on the clinical charts all the findings and we use symbols, colours and notes to help. The patient [4] attended for three appointments in one course of treatment, first was on 5.12.2017 when treatment was an [sic] open the canals and dress LR6 to alleviate the pain, second appointment on the 2.02.2018 for RCT completion at LR6 and on the third appointment on 9.02.2018 for the filling done at LL8. I can explain this with the reference … from clinical records where you can see the dates with the treatment at the date of 02.02.2018 was LL8 an amalgam filling MO which was treated for a decay, Carious [sic] recorded in description after clinical chart and on the same date RCT at LR6 was completed. I mention that the filling on LL8 was applied in the last appointment on 9 .02.2018."* The Committee accepted the opinion of Professor Morganstein that there was a lack of detail on the tooth that was causing the patient's pain. It therefore found this charge proved. ***Patient 16*** ***On 13 September 2017*** ***Insufficient details of examination findings.*** Not admitted and found not proved. In his report, Professor Morganstein stated that:

	"The Examination did not include any observations on the retained root in the details of the examination. The Registrant has apparently decided that the retained roots, which do not show the apical part on the Bitewing Radiographs, did not warrant any treatment." Professor Morganstein stated in his oral evidence that although the computer records for this patient had been completed, in common with other patients, significant elaboration was missing from the entries. He stated for example that the patient complained of a broken tooth which was visible on the radiograph. However, there was no information recorded other than nothing found in the soft tissue, tongue cheeks, glands and floor of mouth. Ms Teodorescu stated in her written response that: *"treated patient 16(RS) during 3 appointments (2 check up and one emergency) and at the first appointment dated 13.09.2017 which was a regular 6 months check-up. I recorded as "patient complaint of broken tooth 37, not pain at all and that patient [16] wishes to keep under observation." I also want now to mention that at the first appointment when I examined the patient [16], I read the previously [sic] check-up notes from 13.03.2017 to know the previous dental history and to have a better understanding of the patient care and the previous dentist… discussed with the patient [16] a possible extraction and that patient was happy to leave it and the dentist…put a note for the next check-up "please monitor"…I always read the previous clinical records to understand and to know better the patient I have to treat. The patient [16] was a new patient for me as I was a new dentist who took over the list of patients previous treated by the dentist…and I never treated him before, so I could not remember any past history. For this reason and as per my routine practice, I reviewed the previous clinical records and also I checked some x rays from the patient [16's] file to see if they need an update."* The Committee noted that Professor Morganstein did not indicate the details of what he considered were missing from the records in terms of additional information about the retained root. Ms Teodorescu recorded that there was a retained root, there were no signs of an infection and the patient did not want it to be extracted. Having reviewed the dental records and the expert report the Committee could not identify what additional information was missing that was not recorded. Therefore, the Committee found this charge not proved. ***Patient 16*** ***13 September 2017*** ***Failure to record impact of patient's medical history on treatment.*** Not admitted and found not proved. In his report, Professor Morganstein stated that: "*the Registrant did not record any details of the patient's medical history (13.09.2017) which may have complicated care as the patient had type 2 diabetes, was taking anticoagulants and taking medication to control*

	hypertension. Not recording the impact of the patient's medical history on treatment is far below the standards expected." Professor Morganstein maintained his criticism in his oral evidence. He stated that the patient had been on anti-coagulants for some time which would have an influence on the type of invasive dental treatments that could be carried out. He criticised the fact that this was not mentioned by Ms Teodorescu within the patient's dental records. In her written response, Ms Teodorescu stated that: *"I agree that I did not record any impact of the patient's medical history because I did not do any invasive treatment. I always checked the medical history and the list of medications which was attached, I was aware of the impact of his present conditions: patient has diabetes type 2, treated with tablets, treatment for hypertension and that was under control and he was taking anti coagulants which could have an impact in case of an extraction. I review the medical history and the medication taken anytime when I examine, see or treat a patient as part of the risk assessment and to understand better and to know and to avoid some possible interactions with local anaesthetic or with other substances I may use it in his care.* *I do not agree that not recording the impact of patient's medical history in this case has had any significant impact in the patient [16] care."* The Committee noted that Ms Teodorescu did not record the impact of the patient's medical history on any decision to provide invasive treatment. However, it noted from the dental records that the patient's medical history was updated and as such it would have been taken into account. Professor Morganstein's criticism inferred that the patient's medical history did have an impact on the treatment provided on this appointment but there was no evidence presented to demonstrate any actual impact. Therefore, the Committee found this charge not proved. ***Patient 17*** ***28 October 2016*** ***Inaccurate Basic Periodontal Examination.*** Not admitted but found proved. In his report, Professor Morganstein stated that: *"On 28.10.2016 when seen by the Registrant the patient said that he had not had a checkup for a long time and the registrant recorded an examination with a BPE of 2/2/2, 2/2/2 and graded the risk factor for periodontal disease as medium despite the fact that the practice hygienist, who had seen the patient at the practice on the same day, had obtained a BPE of 4/4/4-4/4/4 (the highest in the BPE range). Accurate risk factor assessments for caries and periodontal diseases, as well as an oral cancer scan, are part of the whole oral history and examination protocols.*

	There is no justification in grading the patient as medium risk for both caries and periodontal disease. It would be more accurate to record caries as low and periodontal as high. *Mis-grading the risk factors indicates either a lack of understanding of the risk analysis or more likely there was an automatic acceptance of the computer-generated default position. It would be more accurate to record caries as low and* *periodontal as high. Therefore, failing to record accurate and appropriate risk factors is far below the standards expected."* In his oral evidence, Professor Morganstein remained critical of the accuracy of the BPE recorded on this appointment by Ms Teodorescu. He stated that the BPE scores of 4s in all quadrants recorded by the Hygienist including record of gingival inflammation, generalised 7-8mm pocketing, plaque and bleeding on probing with staining anterially indicated a completely different picture to what was recorded by Ms Teodorescu. He was of the opinion that the Hygienist's BPE scores were likely to be more accurate than the scores recorded by Ms Teodorescu. In her written response, Ms Teodorescu stated that: *"I deny the allegation that I failed to record adequate details of examination for patient 17 as my BPE was a true reflection of my findings, as evidence see BPE and also x rays. I gave enough details of my clinical examinations, I have done teeth charting of the mouth, and if subsequent dentist will need to see that he will understand what it was done and also will look for new findings."* The Committee noted that there was a direct conflict in the BPE scores recorded by Ms Teodorescu and the practice Hygienist on the same day. It accepted the opinion of Professor Morganstein that, on the balance of probabilities, the Hygienist's scores were more accurate due to their expertise in this area. This was also supported by the radiographic evidence of bone loss in this patient. The Committee therefore found this charge proved. ***Patient 17*** ***15 May 2017*** ***Inaccurate Basic Periodontal Examination.*** Not admitted but found proved. In his report, Professor Morganstein stated that: *"On 15.05.2017 the Registrant saw the patient for an examination and recorded a diagnosis of acute gingivitis without any descriptive evidence to justify this diagnosis nor any treatment related to the disease. The BPE recorded as 1/2/1-1/2/1. A diagnosis of acute gingivitis and the patient was scaled and polished. No further assessments, such as recording pocket depths were in the records.*

	The BPE obtained by the Registrant on 15.05.2017 is unlikely to be accurate when the previous BPE, taken 6 months previously, by the practice hygienist, had very high scores." In her written response, Ms Teodorescu stated that: *"In the second appointment, I assessed the patient 17 … from 15.05.2017, I identified acute gingivitis and the BPE discovered was 1 2 2, 1 2 1. The score factors were unchanged: medium for caries, medium for periodontal disease and cancer risk was low and according with those scores a recall interval of 6 months was agreed, during this appointment from 15.05.2017 treatments options were discussed and performed. Patient was consenting to have NHS treatment this time scaling and in the clinical notes…could read that patient has had an ultrasonic scaling (TX plan as charted us scaling today) which was the same procedure performed 6 months ago by the hygienist. As part of treatment, I instructed again and reinforced patient's SJ oral hygiene and I gave him dietary advices.* *I will mention that the expert overall comment is taking into consideration the other registrant clinical records only, and they are not justified and are not proved and doubled with clinical evidence, like x rays, pocket charts, plaque scores or other evidences that there was a certain diagnosis of severe periodontal disease with BPE 4 in each sextant. I am not sure if those scores are not related to false pocketing, due maybe a hyperplasia of the gums as he was having acute gingivitis."* The Committee noted that Ms Teodorescu carried out a basic periodontal examination of the patient on this appointment and recorded low scores of 1/2/1-1/2/1. It also noted that no treatment was carried out in the interval between this appointment and the previous appointment of 28 October 2016. The Committee had already accepted that the Hygienist's record of the patient's periodontal condition was more likely to be accurate. It accepted Professor Morganstein's opinion that the condition would not have improved significantly following one treatment provided by the Hygienist on 28 October 2016. It therefore found this charge proved.
4.	*You provided a poor standard of radiographic practice between 21 October 2016 and 1 October 2018 in respect of the patients and dates in Schedule 4.* ***Patient 1*** ***29 June 2017*** ***No report on bitewings.*** Not admitted and found not proved. In his report, Professor Morganstein stated that: *"Caries and periodontal risks were assessed as medium. A periapical radiograph is recorded as being taken to assess interproximal spaces and bone levels and graded as 1. The report, which was shared with the patient, states that there was*

	moderate horizontal bone loss, no decay seen (very poor spelling!). The record contains copies of bitewing radiographs which are not recorded or graded or reported on… *The record contains copies of bitewing radiographs which are not recorded or graded or reported on…* *The bitewing radiographs (taken on 29.06.2017) are of a poor quality and have very little clinical value. It is not clear from the records when these were taken or even if they relate to this patient."* In his oral evidence, Professor Morganstein maintained his criticism stating that there was nothing in the entries made by Ms Teodorescu within the records which constituted any kind of report on the bitewing radiograph taken on 29 June 2017. Ms Teodorescu's position was that she reported on the bitewing within the patient's records, but she incorrectly referred to the radiograph as a periapical radiograph rather than a bitewing radiograph. She stated that any dentist reading her records would note that her report although referring to a periapical radiograph would understand that the report was on a bitewing radiograph because bitewings are usually taken to check for interproximal decay and bone levels in the interproximal regions. Her report stated, *"moderate bone loss and decay"*. The Committee accepted Ms Teodorescu's evidence that the report within the patient records was for a bitewing radiograph and not a periapical radiograph. It accepted that she had made an error in labelling the report. It could not find this charge proved because what is alleged is that Ms Teodorescu did not report on the bitewing radiograph rather than a record keeping criticism. The Committee therefore found this charge not proved. ***Patient 1*** ***29 June 2017*** ***Failure to retake bitewings.*** Admitted by Ms Teodorescu during the course of her evidence and found proved on the basis of her admission, the expert evidence and the patient records. ***Patient 1*** ***30 June 2017*** ***Failure to retake periapical.*** Admitted by Ms Teodorescu during the course of her evidence and found proved on the basis of her admission, the expert evidence and the patient records. ***Patient 2*** ***19 February 2018*** ***Amended to: Failure to retake right bitewing.***

	Not admitted and found not proved. In his report, Professor Morganstein stated that: *"The bitewing radiographs, undated, have overlaps and coning off at the edges but there are several teeth with deep carious lesions present…* *The bitewing radiographs are poor and are not of the standard expected especially as these appeared to be graded 1. There is overlap, coned off at the edges and poor exposure. These should have been retaken but even these poor films showed extensive caries."* In his oral evidence, Professor Morganstein maintained his criticism of Ms Teodorescu in this regard. He was of the opinion that due to the overlap on the radiograph in the upper right six and seven region it was difficult to see if there was caries present in those two teeth. He added that because of the amount of caries in such a young patient (15 years old at this appointment), not being able to see all the upper teeth on the radiograph in order to check for caries in that area was below standard and therefore the radiograph should have been repeated. Ms Teodorescu stated in her written response that: *"I also want to challenge the criticism that bite wings taken should be repeated as they were fit for purpose and benefit the patient AD for his treatment [sic], The expert did not said [sic] that the bite wings were grade 3 but he accepted that I could identified [sic] gross deep dentine decay, so he said they were acceptable meaning grade 2. The report of the bite wings taken on 28.02.2018 indicated clear signs of deep dentine decay see page 27 from patient AN [sic] clinical records: 37 deep dentine decays, 38 dentine decay present, 35 distal interproximal decay. The justification of the x rays [sic] for assessment of interproximal spaces and was [sic] taken as Patient AN has a high risk of caries, fact which was identified in the appointment as I also discovered a cavity, so his caries risk now was higher than previously, and it was enhanced with an entry dated 16.02.2018 (AT) x-rays need it."* The Committee accepted Ms Teodorescu's evidence that she had no clinical justification to retake the radiographs as she could see the decays clinically and had planned to treat the patient as set out in the signed treatment plan. The Committee was not convinced that there was sufficient justification to repeat the radiograph in these circumstances. It therefore found this charge not proved. ***Patient 3*** ***21 October 2016*** ***Inadequate report on bitewings.*** WITHDRAWN ***Patient 3*** ***20 March 2017***

	Failure to take periapical of LR7. Admitted by Ms Teodorescu during the course of her evidence and found proved on the basis of her admission, the expert evidence and the patient records. ***Patient 4*** ***2 February 2018*** ***Failure to take post-operative radiograph of root canal treatment to LR6.*** Admitted by Ms Teodorescu during the course of her evidence and found proved on the basis of her admission, the expert evidence and the patient records. ***Patient 13*** ***6 March 2017*** ***Inadequate report on Panoral.*** Admitted by Ms Teodorescu during the course of her evidence and found proved on the basis of her admission, the expert evidence and the patient records. ***Patient 13*** ***6 March 2017*** ***Failure to take left bitewing.*** Admitted by Ms Teodorescu during the course of her evidence and found proved on the basis of her admission, the expert evidence and the patient records. ***Patient 16*** ***13 September 2017*** ***Failure to take periapical of retained root at LL7.*** Not admitted but found proved. In his report, Professor Morganstein stated that: *"The Examination on 13.09.2017 did not include any observations on the retained root in the details of the examination. The Registrant has apparently decided that the retained roots, which do not show the apical part on the Bitewing Radiographs, did not warrant any treatment. It would have been appropriate to have taken a periapical radiograph LL to see the length of the retained root and if there was any periapical or periodontal pathology related to the retained roots. In this circumstance the Registrant should be aware of the following: i. the patient has the right to not follow the dentist's advice about crowning teeth but the retention of retained roots must be a positive decision, requiring appropriate radiographs and informed consent from the patient; and ii. it is probable that for a patient of 75 years of age that leaving the root was the correct decision, but it is far from clear if this was an informed consent on the part of the patient.*

	Not taking a periapical radiograph to confirm the extent of the retained root and that the retained root is disease free is far below the standards expected." In his oral evidence, Professor Morganstein stated that the available radiographs showed a portion of a retained root. However, they did not show how many roots were present and did not show the apical region. He stated that the dentist should be aware of any pathology associated with the roots so that a completely informed decision could be made by the patient. Ms Teodorescu's position was that she had no clinical justification for a periapical radiograph because the patient did not want to consider an extraction. In her written response she stated: *"I would like to make a reference that in the first appointment on 13.09.2017, after updating the medical history and completing the extra oral and intra-oral exam, I decided to take some bite wings X rays to assess the interproximal spaces and bone level as according with FGDP (UK) guidance of radiography Selection Criteria for Dental Radiography and because there were not recent x rays in the patient file. I was satisfied with the results of bite wings which were optimal at the time (gr1), and I now could see even the mesial root of LL7 with no obvious pathology. I recognise that I did not report and document this finding from left bite wing regarding the presence of mesial root of LL7 but following my clinical judgment at the time of examination from 13.09.2017, I did not consider a peri- apical x ray on LL7 as patient was not interested to have an extraction and also the results of x rays would not have had an impact of his decision related with this tooth as this tooth has had not any pain and at the clinical examination performed at the time, there were no signs of infection, abscesses or sinus tracts in relation with LL7 which could indicate that this tooth would be better to be extracted and it was at the risk."* The Committee accepted the opinion of Professor Morganstein that Ms Teodorescu should have taken a periapical radiograph in order to assess the apex of the tooth in order to provide the patient with a full picture and enable them to make an informed decision. ***Patient 20*** ***6 March 2017*** ***Failure to take bitewings.*** Admitted by Ms Teodorescu during the course of her evidence and found proved on the basis of her admission, the expert evidence and the patient records. ***Patient 21*** ***31 May 2017*** ***Failure to retake left bitewing.***

	Admitted by Ms Teodorescu during the course of her evidence and found proved on the basis of her admission, the expert evidence and the patient records. ***Patient 23*** ***17 August 2017*** ***Failure to retake periapical.*** Admitted by Ms Teodorescu during the course of her evidence and found proved on the basis of her admission, the expert evidence and the patient records. ***Patient 24*** ***19 July 2017*** ***Inadequate report on bitewings.*** Admitted by Ms Teodorescu during the course of her evidence and found proved on the basis of her admission, the expert evidence and the patient records.
5.	*You failed to adequately diagnose the need for treatment between 21 October 2016 and 1 October 2018 in respect of the patients and dates in Schedule 5.* ***Patient 1*** ***29 June 2017*** ***Cause of pain to UR2 inadequately diagnosed.*** Not admitted and found not proved. In his report, Professor Morganstein stated that: *"Also, in relation to UR2, the use of cold as a means of testing vitality in a tooth is effective but a negative response may not be definitive, and another test should be applied such as heat or an electric pulp tester which delivers a small charge to the tooth…* *The diagnosis of the cause of the patient's pain UR2 (29.06.2017) was not recorded nor were any other attempts to confirm the result of the initial 'cold' vitality tests."* In his oral evidence, Professor Morganstein remained critical that Ms Teodorescu should have conducted additional tests such as tapping the tooth. He stated that Ms Teodorescu made the right diagnosis but without the correct information. In her written response to the allegations, Ms Teodorescu stated: *"I recognise that I tested the vitality of UR2 with etilen chloride [sic] which is a spray with a very low temperature, but I was not able to use an additional method as suggested to check vitality, as I did not have any other methods like Pulp test or heat test at the practice at the time."* Professor Morganstein considered Ms Teodorescu's response during his oral evidence. He was of the opinion that if it was the case that Ms Teodorescu

had no other means of checking the vitality of the tooth, then that was all she could do.

The Committee noted Ms Teodorescu's evidence that ethyl chloride was the only test she had available. It also noted that she diagnosed, correctly, that the UR2 was a *'dens in dente'* which Professor Morganstein commended. In addition, Ms Teodorescu also diagnosed that the tooth was non-vital. The Committee did not accept Prof Morganstein's opinion, who was not critical of the diagnosis, that failing to carry out a percussive test was a major failure. It therefore found this charge not proved.

Patient 3

21 October 2016

Failure to diagnose caries at LR5, UL7 and UL6.

WITHDRAWN

Patient 3

20 March 2017

Inadequate diagnosis of need for root canal treatment or extraction of LR7.

Not admitted but found proved.

In his report, Professor Morganstein stated that:

> *"On 20.03.2017 the patient complained of pain lower right side. Tooth 47 extremely TTP. The patient was already taking unidentified antibiotics that were left over from a previous visit to the General Medical Practitioner. The Registrant provided the patient with a prescription for metronidazole 400 mg for 5 days. The patient was told that if the antibiotics were ineffective then the patient was to return for extraction… The patient was not given a follow up appointment, according to the records, to either extract the tooth or offer a root canal treatment…The Registrant did not take a radiograph of LR7 which would have help identify if a Root Canal Treatment would have been an option for this patient."*

In his oral evidence, Professor Morganstein stated that without a periapical radiograph being taken, Ms Teodorescu could not reach an accurate diagnosis. He did not accept that the presence of deep decay removed root canal treatment as an option particularly in the absence of a periapical radiograph to inform that conclusion.

Ms Teodorescu accepted that she should have taken a periapical radiograph. However, she did not consider it to be a failure. She said that root canal treatment was not viable in this case because of the deep decay to the LR7.

The Committee accepted the opinion of Professor Morganstein that in the absence of a periapical radiograph, it was not possible to reach the correct diagnosis for the LR7. It therefore found this charge proved.

Patient 4

	6 June 2017 – 12 February 2018 ***Failure to adequately assess periodontal status.*** Not admitted and found not proved. In his report, Professor Morganstein stated that: *"No BPE recorded at any of the visits by the Registrant… There was no assessment of the periodontal status, by recording BPE, nor periodontal treatment provided at any of the visits conducted by the Registrant. This is far below the standards expected."* In her written response, Ms Teodorescu stated that: *"I deny that I did not asses the periodontal status of the patient GH as BPE and the oral hygiene instructions were discussed with the patient 4 in according with the British periodontal society and with BPE guidance…"* In her oral evidence, Ms Teodorescu reiterated that she had carried out a BPE examination on this patient as was her usual practice at the time and was evident from the patient records before the Committee. Ms Teodorescu suggested that the absence of the BPE records for this patient may be a printing error. The Committee noted that the patient's record state 'BPE taken'. However, the BPE scores do not appear in the printed records. The Committee also noted that the records before it contained BPE scores taken by Ms Teodorescu for most of the other patients in this case. In addition, Ms Teodorescu made a diagnosis of 'all soft tissues fine at this exam' which could only be arrived at as a result of including a soft tissue examination such as a BPE. These supported Ms Teodorescu's evidence that it was her usual practice to routinely carry out basic periodontal examinations. The absence of the BPE scores for this patient was not sufficient to satisfy the Committee that it was not done. It found, on the evidence before it, that it was more likely than not that Ms Teodorescu carried out a basic periodontal examination on this patient as was her usual practice, evident from the patient records. ***Patient 4*** ***5 December 2017*** ***Failure to diagnose large amalgam overhang at LR5.*** Admitted by Ms Teodorescu during the course of her evidence and found proved on the basis of her admission, the expert evidence and the patient records. ***Patient 4*** ***9 February 2018*** ***Failure to diagnose caries at LL6 and LL7.*** Not admitted and found not proved. In his report, Professor Morganstein stated that:

	"The Registrant had not provided the patient with an appropriate and adequate standard of care by not recognizing the extent of caries in several teeth. This is far below the standards expected." Ms Teodorescu's position was that she inspected the teeth visually and she did not identify caries at the time. Professor Morganstein conceded in his oral evidence that it was not always possible to identify caries clinically with the naked eye. Although another dentist who saw this patient identified caries, it was unclear from the records whether this was identified clinically or radiographically. The Committee was not satisfied from the expert evidence that Ms Teodorescu should have diagnosed the caries clinically. The Committee did not consider this a failure and therefore it did not find this charge proved. **Patient 17** **28 October 2016** **Failure to diagnose severe periodontal disease.** Not admitted but found proved. In his report, Professor Morganstein stated that: *"The Registrant obtained a BPE of 2/2/2-2/2/2 at the same time as the hygienist saw the patient and obtained much higher BPE scores. The BPE obtained by the Hygienist is much more likely to reflect the true severe level of periodontal disease Including deep pocketing. The pan-oral was enough to assess both the periodontal and caries status."* In his oral evidence, Professor Morganstein referred the Committee to the Panoral radiograph which showed generalised bone loss and the Hygienist's description of deep pocketing recorded in the dental notes. Ms Teodorescu stated in her oral evidence that if the Committee accepted the opinion of Professor Morganstein that the Hygienist's BPE scores were more likely to be correct, then she would accept that she failed to diagnose severe periodontal disease. Having found that the Hygienist's BPE scores were more likely to be accurate than the scores recorded by Ms Teodorescu, the Committee found this charge proved. ***Patient 20*** ***6 March 2017*** ***Failure to diagnose caries at LR7, UL6 and UR6.*** Not admitted but found proved. In his expert report, Professor Morganstein stated: *"The failure to obtain bitewing radiographs at this visit may have led to small carious lesions in LR7, UR6 and UL6 being missed. At this visit, had they been identified on the radiographs, the use of topical fluoride varnish may have slowed the progression of the disease in these teeth.*

The failure to obtain bitewing radiographs for this patient at this visit is far below the standards expected."

In his oral evidence, Professor Morganstein noted that at a subsequent appointment on 13 November 2017 another dentist in the practice took radiographs and noted the presence of decay in the UR6, UL6 and LR7. He further stated that it was likely that this decay would have been present at the appointment with Ms Teodorescu on 6 March 2017.

In her written response, Ms Teodorescu stated that:

> *"According with my clinical notes, the rest of the teeth were clear of decay at that exam, during inspection and visual examination with the aid of dental probe, there were any signs of decay (the probe did not catch any broken enamel).I advised the patient VR (20) in that appointment to brush better and I showed areas where plaque is present. I also advised the parent-the mother to bring patient VR in 3 months to monitor how the brushing improves…*
>
> *I admit that I did not consider to obtain bitewings radiograph to accurately diagnose extend of those carries, including proximity with the pulp. I treated Patient…(patient 20) during the appointment from 6.03.2017as there was enough time booked, around 30 minutes and I was listening to the mother request and I diagnosed those teeth with simple decay, relining on the clinical findings and symptoms found and described during anamnesis with patient and his mum. During the clinical examination performed on 6.03.2017, I remember that patient VR was very anxious of dental treatment and especially of the local anaesthetic and, when I put the question to him if he will have an injection I remember that he refused to, and jumped out from the dental chair. His mother insisted to return in the dental chair and to have the fillings done and then patient [20] allowed me to have the fillings done but without local anaesthetic. I explained him what I am going to do, and I advised him to ift his left arm if he needed to stop me. I discussed all the findings of the clinical assessment with the child and with the mother, enhancing on the inadequate oral hygiene and the high scoring plaque present in his mouth. I was addressing the cause of decay for patient VR which was in this case inadequate brushing, knowing that for the success of the treatment is very important to eliminate the cause of those decay which was the bacteria from his mouth and from his plaque. I was trying to educate the patient and the parent so further treatment could be avoided and patient himself should have been treated himself for potential decay. We all know that in the beginning every decay can be reversed with a very good oral hygiene, fluoridated toothpaste and with the correct diet."*

The Committee noted the diagnosis of decay by a subsequent treating dentist and accepted the opinion of Professor Morganstein that it would likely have been present at the visit on 6 March 2017. It therefore found this charge proved.

Patient 21

31 May 2017

Failure to adequately diagnose the periodontal risk factor.

Not admitted but found proved.

In his expert report, Professor Morganstein stated:

> *"On 31.05.2017 the patient was seen for a recall visit 6 months after her last checkup. (The Registrant recorded that the patient had caries and periodontal risk factors of medium despite the fact that the patient had not had any caries diagnosed for several years and had consistent low BPE scores.)…The Registrant did not assess the risk factors correctly when despite the recession and the calculus the more likely assessment would be low for both caries and periodontal disease. Not correctly assessing the risk factors for the patient is far below the standards expected."*

In her written response, Ms Teodorescu stated that:

> *"With regard to my risk assessment factors from the appointment from 18.02.2018, I could say that it was my rationale who concluded this was the risk, and now, when I read the previous notes from the other check-up I can see that the previous dentist has the same rationale assessment in grading the carious, periodontal risk, as medium. I was guided in putting the risk as medium on the clinical findings, as gross tartar was registered at every 6 months appointment, for a long time and also, that there was no indications that she would start to brush better, so I could not put a low risk as knowing that if one don't brush correctly or effectively, then caries or gum disease can happened. This risk assessment is just an exercise and it help us to set a recall time and not an interval for scaling. From my experience, when I try to suggest a longer interval to some patients and to indicate to see the hygienist for in between the appointments, patient refuses as they don't want to pay private as it is known that this service is not covered by NHS charges."*

The Committee noted that the clinical record on this date contained an entry of 'periodontal risk factor medium'. It also noted that this appeared to be the default entry within the 'proforma' in the patients' records. It accepted the opinion of Professor Morganstein that in this case the periodontal risk factor was low. It therefore found this charge proved.

Patient 23

17 August 2017 – 19 September 2017

Failure to test the vitality of the LR6.

Not admitted and found not proved.

In his expert report, Professor Morganstein stated:

> *"There is no record of any testing of the LR6 to confirm it was vital. With the radiograph showing that the pulp was very close to the pulp and probable caries present, it is possible that the tooth had reduced vitality…*

	There was no attempt to check the vitality of tooth LR6 before or after the making of the onlay until the visit on 01.10.2018 when it is recorded that the tooth was vital but the method used was not recorded. It might have helped with the diagnosis of pain had vitality been checked before the onlay was prepared and fitted." In her written response, Ms Teodorescu stated that: *"I recognise that according with patient … (23) clinical notes there are no evidence that I attempted to do any vitality test for the LR6 before placing an onlay. I omitted to do this test as patient indicated that, after she lost the filling her tooth was quite* *sensitive to cold and I considered this was a sign of vitality and also I did not want to produce any harm to the pulp. I normally use to check vitality for teeth with symptoms of pain only. I also would like to mention that I could not use any electric test as no pulp test was available in the surgery. So, I considered that the thermal test was not appropriate in this case as did not want ethylene chloride on the tooth which would have caused more pain to the patient. After the patient [23] lost the filling, more than three quarters of the tooth was missing. I used three in one airspray to dry the cavity and tooth (LR6) was sensitive, so I presumed that this is a sign of vitality. I offered this option only to save the tooth and to conserve more of the healthy tissue as much as possible as it was not enough retention for another filling and to prolong the life of the tooth. I do not think I have to give a patient the option not to have a treatment as my clinical recommendation as a professional, is to offer the most indicated and long term and cost effective solution to save the patient of pain and discomfort and to secure his oral health. As I stated, I did not offered the option of a new filling as it won't be guaranteed that it will last, as there were no retention and it failed several times in the past dental history of this tooth."* The Committee was of the view that Ms Teodorescu gave a clear rationale on how she reached the conclusion that the LR6 was vital. The Committee accepted Ms Teodorescu's evidence. It therefore found this charge not proved. ***Patient 24*** ***19 July 2017*** ***Failure to diagnose caries at UR5, LR5 and LR7.*** Admitted by Ms Teodorescu during the course of her evidence and found proved on the basis of her admission, the expert evidence and the patient records. ***Patient 24*** ***19 July 2017*** ***Failure to diagnose large overhang at UL6.***

	Admitted by Ms Teodorescu during the course of her evidence and found proved on the basis of her admission, the expert evidence and the patient records.
6.	*You failed to obtain informed consent:*
6. (a)	*from Patient 25 for the extraction of the UR2 on 28 April 2017;* Not admitted and found not proved. Patient 25 stated in her witness statement that: *"During my appointment, Miss Teodorescu reviewed my mouth and informed me that I needed an extraction of my tooth. She informed me that the tooth would need to be extracted straight away. I asked Miss Teodorescu if my tooth could be saved, but she was very abrupt in her answers. She told me "no" and that she could not save the tooth, and did not explain why the tooth could not be saved. I told her that I did not want to lose the tooth and asked to make another appointment for a different day, but she refused this request and said that "the tooth needs to come out today". I did not get a chance to refuse the treatment. Miss Teodorescu began injecting my mouth with local anaesthetic and extracting the tooth before I had a chance to say no. I did not expect Miss Teodorescu to take out the tooth as I had said that I did not wanted [sic] to lose the tooth".* The Committee noted that Patient 25 confirmed during her oral evidence that she had signed the Personal Dental Treatment Plan dated 28 April 2017. It was clear to the Committee from the detailed treatment plan that there had been discussions with the patient on this appointment about the extraction and the options for treating the gap. The Committee concluded from Patient 25's evidence that she did understand that her tooth was going to be extracted at this appointment. However, Patient 25 may have felt rushed into undergoing the treatment as she said that she had expected to come back for the extraction on another date. On the basis of the evidence before it, the Committee was not satisfied that this was an issue of a lack of consent but rather related to Patient 25's perception of Ms Teodorescu's manner. It therefore found this charge not proved.
6. (b)	*from Patient 9 for the extraction of the LR5 on 2 July 2018.* Not admitted but found proved. Patient 9 stated in her witness statement that: *"I remember seeing Miss Teodorescu on 24 May 2018. I went to see her for chronic toothache in my lower right molar and she prescribed antibiotics for the pain. After this initial appointment, the toothache did not settle and I went for a follow up appointment, which I recall took place on 26 June 2018. Miss Teodorescu told me that the tooth needed to be extracted. During this appointment Miss Teodorescu kept repeating 'L5', however this meant nothing to me as I did not know the teeth by letters and numbers…Following the appointment, I was booked in to see again on 2 July 2018 for an extraction of the tooth. At the appointment on 2 July 2018, as before, she kept calling the tooth by numbers and therefore at*

	the time I could not understand what she meant. She did not explain to me that it was a molar. But I told her several times that it was the lower back tooth. She did not say much at all during the whole appointment. Miss Teodorescu just said she was going to numb my mouth. When she numbed mu mouth, I was told to return to the reception area, and when I returned to her room, she extracted a tooth. However, she took the wrong tooth out. ..I told her that she had taken out the wrong tooth because as soon as she extracted the tooth, I could still feel the pain from the molar that was causing the toothache and when I placed my tongue on it, it was still there." In her oral evidence, Patient 9 maintained that the source of the pain she was experiencing was from her molar tooth, the LR7 and not the LR5. She maintained that Ms Teodorescu did not explain properly which tooth was to be extracted although she acknowledged that she should have read the Personal Dental Treatment Plan which was signed by her and which clearly indicated the tooth to be extracted as the LR5. In her oral evidence, Ms Teodorescu explained that she followed the Personal Dental Treatment Plan which was signed by the patient. She explained that this was the first time that she had extracted the wrong tooth and she apologised to the patient at the time. The Committee was of the view that given that Patient 9 had signed the Personal Dental Treatment Plan which clearly indicated the LR5 as the tooth to be extracted, it was difficult to criticise Ms Teodorescu in light of such clear evidence. On the other hand, Patient 9 said that Ms Teodorescu constantly referred to the tooth to be extracted as 'L5' which meant nothing to her. The Committee was of the view that Ms Teodorescu had made an assumption that the source of the patient's pain was the LR5 based on the patient's history of root canal treatment in the tooth and the fact that the tooth had not settled despite repeated courses of antibiotics. Ms Teodorescu did not take sufficient steps to check with the patient that the LR5 was the correct tooth causing the pain on that day. The Committee noted that the radiograph of the LR5 did not show any definitive apical pathology that would have suggested that the LR5 needed extraction and therefore there was no clinical justification for extracting the LR5. The Committee concluded that Ms Teodorescu did not listen properly to the patient neither did she explain clearly the treatment to be carried out. It therefore found this charge proved.
7.	*You provided a poor standard of treatment between 6 March 2017 and 14 September 2018 in respect of the patients, treatments and dates in Schedule 6.* ***Patient 1*** ***29 June 2017*** ***Inappropriate prescribing of antibiotics***

	Admitted by Ms Teodorescu during the course of her evidence and found proved on the basis of her admission, the expert evidence and the patient records. ***Patient 1*** ***30 June 2017*** ***Poor standard of Root Canal Treatment to UR2*** Not admitted but found proved. In his report, Professor Morganstein stated that: *"The tooth had an anatomic anomaly that meant the root canal was wider than the norm.* *Root canal treatment cleans the walls of the canals removing soft and potentially infected dentine from the walls of the canal. The presence of the anomaly would require the instrumenting to leave a wider than normal root canal. Once completes the canal is washed and dried and Gutta Percha points are placed into the canal with a sealant cement. When the points and sealant do not fill and seal the canal to produce an impervious seal tissue fluid, from the tissue surrounding the apex of the tooth will go into the spaces created within the canal and be a potential source of recurrent infection. The recorded size of the point placed is far too small and without the lateral pressure of well-fitting points sealant cannot fill the voids.* *The completed Root Canal Treatment is far below the standards expected because the canals have been inadequately instrumented and poorly filled.* *The anatomical anomaly known as 'dens in dente' has a wider canal than normal and therefore needs to be root filled so that the canal is completely blocked with condensed gutta percha. The techniques used by the Registrant have not provided a satisfactory RCT and the procedure should have been repeated by a practitioner more proficient in endodontics."* In her oral evidence, Ms Teodorescu accepted that the root canal treatment *"could be better…if I had different instruments/tools/ it would be different result but under the specific circumstances in that contract it was the best standard I could produce. I also informed the patient that they could go to a private endodontic specialist elsewhere who could provide a good standard."* The Committee accepted the opinion of Professor Morganstein. It was clear from the radiograph of the tooth which showed voids that this was a poorly treated root canal. The Committee therefore found this charge proved. ***Patient 3*** ***20 March 2017*** ***No follow up after prescribing antibiotics.***

	Admitted by Ms Teodorescu during the course of her evidence and found proved on the basis of her admission, the expert evidence and the patient records. ***Patient 4*** ***6 June 2017 – 12 February 2018*** ***Failure to provide adequate periodontal treatment.*** Not admitted and found not proved. In his report, Professor Morganstein stated that: *"There was no assessment of the periodontal status, by recording BPE, nor periodontal treatment provided at any of the visits conducted by the Registrant."* In his oral evidence, Professor Morganstein maintained his criticism in relation to this patient. He was of the opinion that not providing even a scale and polish in this period amounted to a failure to provide adequate periodontal treatment. Professor Morganstein conceded when questioned that there was no requirement for treatment in circumstances where the BPE scores were 1/1/1-1/1/1. The Committee noted that the subsequent treating dentist found low BPE scores. It concluded on that basis that there was no evidence that periodontal treatment was required. Professor Morganstein's criticism was that periodontal treatment was not provided but the GDC had produced no evidence that periodontal treatment was necessary or required. The Committee concluded that there was insufficient evidence to find that there was a failure to provide adequate periodontal treatment. It therefore found this charge not proved. ***Patient 4*** ***5 December 2017 – 2 February 2018*** ***Failure to adequately remove caries from LR6 prior to root canal treatment.*** Not admitted but found proved. In his report, Professor Morganstein stated that: *"The Registrant identified the mesial caries and planned a mesial-occlusal restoration but did not include the distal caries which is seen on the radiographs taken on 02.02.18… On 02.02.2018 The patient returned for Root Canal Treatment LR6 under rubber dam… The placement of poor restorations, inadequate root canal treatment and leaving caries in the LR6 prior to completing the RCT (02.02.2018) are far below the standards expected."* In his oral evidence, Professor Morganstein stated that the intra-operative radiograph of the LR6 showed caries on the mesial and distal aspects of the

tooth. He maintained the opinion that to leave the caries fell far below standard as it posed a serious risk to the longevity of the tooth.

In her written response, Ms Teodorescu stated:

> *"I deny that I did not remove the caries from LR6 prior to root canal treatment."*

The Committee accepted the opinion of Professor Morganstein that there was caries visible on the radiograph and therefore Ms Teodorescu had not, as she stated, removed the caries from LR6 prior to carrying out the root canal treatment. It therefore found this charge proved.

Patient 4

2 February 2018

Poor standard of Root Canal Treatment to LR6.

Not admitted but found proved.

In his report, Professor Morganstein stated that:

> *"On 02.02.2018 The patient returned for Root Canal Treatment LR6 under rubber dam. The record indicates that the Registrant identified 2 distal canals and there are measurements for 3 canals. These are quite short and the pre and post filling radiographs shows all three canals are not filled to the appropriate length. The record indicates that rubber dam was applied but the radiographs do not show any rubber dam clamps on the lower teeth. The post filling radiograph does show apical radioluscencies that are mentioned in the patient records.*
>
> *The RCT as completed is unsatisfactory. It was appropriate to carry out a RCT for this patient but the Gutta Percha points in all canals are short either because the original instrumentation was poor or the filling was not to the filed lengths. It is not possible to see unfiled but instrumented canals. The only radiograph taken was of the trial positioning of the GP points and there should have been a radiograph of the completed procedure. This RCT should have been repeated by a practitioner more proficient in endodontics.*
>
> *The very poor standard of root canal treatment is far below the standards expected and the accepting poor radiographs is far below the standards expected."*

Ms Teodorescu stated in her oral evidence that she recognised that the root canal treatment was not as good as it should have been. She explained that it was her capability at the time. She also told the Committee that it was not a simple root canal because four canals were identified. She said that she did her best to carry out the treatment to a good standard. However, she stated that if the standard she provided was not acceptable, she would accept the criticism.

The Committee was of the view that the radiograph showed that the root filling was clearly short. It noted that the tooth was subsequently re-root filled on 5

April 2018 by the subsequent treating dentist. The Committee accepted Professor Morganstein's opinion. It therefore found this charge proved.

Patient 4

9 February 2018

Poor standard of restoration to LL8

Admitted by Ms Teodorescu during the course of her evidence and found proved on the basis of her admission, the expert evidence and the patient records.

Patient 9

26 June 2018 – 2 July 2018

Failure to provide adequate periodontal treatment.

Not admitted and found not proved.

In his report, Professor Morganstein stated that:

> *"On 26.06.2018 an adult examination is recorded with no abnormality detected. A BPE of 3/1/3-1/2/3 was recorded…The Registrant did not provide any treatment directed to the high scores in the patients BPE."*

In her written response, Ms Teodorescu stated:

> *"Regarding the periodontal BPE scoring found during the examination from 26.06.2018, I performed scale and polish according with the clinical findings and the diagnosed [sic] of mild generalised gingivitis which was produced by the presence of plaque and big calculus because [sic] the inefficient inter dental cleaning… I considered indicated [sic] to improve the oral hygiene first and I instructed the patient [sic] how to use inter dental cleaning for this. I did not diagnosed [sic] any periodontal disease as according with [sic] the results of her x rays there were no significant bone loss. The periodontal disease can be diagnosed following the clinical examination and after the examination of the x rays for estimation if there is advanced bone loss.*
>
> *I was [sic] intended to reassess her oral health and to address her mild generalised inflammations [sic] of the gums (gingivitis) on the long term and to review her soft tissue at the next check-up, but I did not have this opportunity as patient [9] did not return*
>
> *to my care. At the time of the last examination dated 2.07.2018, I checked the panoramic X ray taken on the 28.02.2017 where there was [sic] no signs of gingival tartar and not [sic] significant bone loss. So I could not diagnose an [sic] active periodontal disease. I also noticed from patient [3's] clinical notes that the patient [3] booked an appointment privately with the hygienist but she failed to attend her appointment."*

The Committee noted that on 26 August 2018 BPE scores of 3s were recorded in the posterior sextants (high). Professor Morganstein's opinion was that there should have been further investigation of the BPE scores of three. Ms Teodorescu carried out a scaling of the patient's lower anterior

	teeth. However, she carried out no further treatment at subsequent appointments with Patient 9. Ms Teodorescu's evidence was that she had referred the patient to the Hygienist. Patient 9 attended a Hygienist appointment on 23 July 2018. The Committee accepted Ms Teodorescu's evidence that she had referred the patient to a Hygienist. It was of the view that in those circumstances, the provision of a scaling treatment alone at that stage was sufficient. It therefore found this charge not proved. ***Patient 16*** ***17 May 2018*** ***Failure to provide adequate periodontal treatment.*** Not admitted but found proved. In his report, Professor Morganstein stated that: *"On 17.05.2018 after obtaining verbal consent an examination is recorded with no extra detail. A BPE of 1/3/3-3/2/3 was obtained...The patient's lower incisors were hand scaled by the Registrant. There was no cleaning of the areas in the mouth with high BPE scores. The patient should have been seen for further appointments by the Registrant or the practice hygienist for further periodontal care so leaving this for another 6 months without any treatment having a 6/12 recall interval is Far Below the Standards Expected…"* Ms Teodorescu stated in her written response that: *"In regards with the BPE standards found at the first appointment which were 1/1/1-1/2/1, I acted in according with the BPE findings and with BSP recommendation 1992 of acting: oral hygiene instructions were given (see page 241 from patient [16]) and as treatment options was advised both NHS/Private option hygienist with prices and patient option was NHS scaling and polishing which was performed at the time of the appointment 13.09.2017 in according with patient informed consent. Also, I could identify in the same clinical notes that patient has a mild gingivitis present, which is a condition which can be found in almost 90% of examination and for this I advised to increase the brushing and to floss in between his teeth."* The Committee accepted the opinion of Professor Morganstein that given the high BPE scores on this date, the patient should have received further periodontal treatment from Ms Teodorescu particularly in the sextants where she had recorded BPE scores of 3 or should have been referred to the Hygienist. Ms Teodorescu did neither of these things. The Committee therefore found this charge proved. ***Patient 17*** ***15 May 2017*** ***Failure to adequately treat periodontal disease.*** Not admitted but found proved.

	In his report, Professor Morganstein stated that: *"There regular visits to the hygienist as well as 6-point pocket charts was no treatment proposed for the peri odontal tissues described by the Registrant in the record for that visit. This young patient has severe periodontal disease that went untreated by the Registrant. This patient should have been having to monitor progress of the treatment. A referral to a specialist would have been appropriate after this appointment had the Registrant recognized the serious nature of the patient's condition."* In his oral evidence Professor Morganstein maintained his criticism of Ms Teodorescu. He stated that as there was no referral to the hygienist and if the patient had acute gingivitis recorded by Ms Teodorescu, it needed to be treated at that stage but there was no treatment plan for this within the records. He acknowledged that Ms Teodorescu carried out scaling of the patient's teeth on this date, but he was of the opinion that it would have been insufficient as treatment for genuine acute gingivitis. He stated that Ms Teodorescu should have done a 6-point pocket chart which would have given her enough information to determine what treatment was required. Further, he was of the opinion that a single episode of scaling was not adequate to treat disease that was present since October 2016. In her written response, Ms Teodorescu stated that: *"In the second appointment, I assessed the patient 17 SJ from 15.05.2017, I identified acute gingivitis and the BPE discovered was 1 2 2, 1 2 1. The score factors were unchanged: medium for caries, medium for periodontal disease and cancer risk was low and according with those scores a recall interval of 6 months was agreed, during this appointment from 15.05.2017 treatments options were discussed and performed. Patient was consenting to have NHS treatment this time scaling and in the clinical notes at page 287 could read that patient has had an ultrasonic scaling (TX plan as charted us scaling today) which was the same procedure performed 6 months ago by the hygienist. As part of treatment, I instructed again and reinforced patient's SJ oral hygiene and I gave him dietary advices.* *I will mention that the expert overall comment is taking into consideration the other registrant clinical records only, and they are not justified and are not proved and doubled with clinical evidences, like x rays, pocket charts, plaque scores or other evidences that there was a certain diagnosis of severe periodontal disease with BPE 4 in each sextant. I am not sure if those scores are not related to false pocketing, due maybe a hyperplasia of the gums as he was having acute gingivitis."* The Committee accepted the opinion of Professor Morganstein that there was severe periodontal disease present in this patient and the scaling offered by Ms Teodorescu was insufficient to address the condition. It therefore found this charge proved. ***Patient 17*** ***15 May 2017***

	Failure to refer patient for specialist periodontal care. Not admitted and found not proved. In his report, Professor Morganstein stated that: *"There was no treatment proposed for the periodontal tissues described by the Registrant in the record for that visit. This young patient has severe periodontal disease that went untreated by the Registrant. This patient should have been having regular visits to the hygienist as well as 6-point pocket charts to monitor progress of the treatment. A referral to a specialist would have been appropriate after this appointment had the Registrant recognized the serious nature of the patient's condition…Not referring this 27-year-old patient with severe periodontal disease for specialist care after either of the appointments is far below the standards expected."* In her written response, Ms Teodorescu stated that: *"As response to the Overall Comment of the expert page 66, I can confirm that I registered an accurate and appropriate risks factors assessment for the patient [17] in accordance with my findings and my evidences from both appointments (clinical findings and x rays) and that the BPE scoring was correct and reflected in the image from Panoramic X ray taken at the time, and on visual clinical examination. I also can add that I could not anticipate a further periodontal assessment such as periodontal pocket depth charting as this procedure is indicated only after you diagnosed severe active periodontal disease and score 4 which it was not my case and was not justified by my clinical opinion. Also, the referral to the specialist periodontologist for a patient with severe periodontal disease I could not be expected to do a referral for this, if it was not my diagnosis and my findings. I have not acknowledged the presence of the advanced periodontal disease for patient…17 in any of the appointments he attended with me."* The Committee noted that in this case, Professor Morganstein has referred to Hygienists as 'specialists'. It accepted that Hygienists are specifically trained to carry out periodontal treatment and that constitutes a major part of the work they carry out on a daily basis. The patient's records indicate that Ms Teodorescu did offer a referral to a Hygienist. The Committee therefore found this charge not proved. ***Patient 19*** ***14 July 2017*** ***Failure to adequately remove caries from UL3.*** Admitted and found proved. ***Patient 19*** ***14 July 2017*** ***Poor standard of restoration to UL3.*** Admitted and found proved.

	Patient 20 ***6 March 2017*** ***Failure to adequately remove caries from LR6 and LL6.*** Admitted by Ms Teodorescu during the course of her evidence and found proved on the basis of her admission, the expert evidence and the patient records. ***Patient 24*** ***9 August 2017*** ***Stoning UL7 without clinical justification.*** Not admitted and found not proved. In his report, Professor Morganstein stated that: *"On 09.08.2017 the UR4 was restored with composite, after removal of caries mesially. The record also says that the UL7 was 'stoned' (probably ground), at the patient's request. There is no clinical justification recorded for this procedure… Stoning UL7 on 9.08.2017 without identifying why this tooth tissue removal was justified is far below the standards expected."* Professor Morganstein was invited during his oral evidence to consider Ms Teodorescu's response to this allegation that the patient was complaining that the filling was sharp and the stoning was done to smoothen the filling. He was of the opinion that this was sufficient justification. In her written response, Ms Teodorescu stated that: *"I also confirm that I smoothed the UR7 because patient 24(FW) was complaining that something was sharp and when I looked it was the filling which was done previously by previous dentist, and she told me it was sharp and was catching her cheek and tongue. I was empathic towards my patient as this was my clinical justification knowing that this was disturbing. My assistant put the additional note and I did not pay attention to describe more but I advised my assistant to be charted on the clinical chart of the patient."* The Committee accepted Ms Teodorescu's evidence. It therefore found this charge not proved.
8.	*You failed to provide individual recommendations on recall intervals between 28 October 2016 and 1 October 2018 in respect of the patients and dates in Schedule 7.* ***Patient 3*** ***20 March 2017*** ***None*** Not admitted but found proved. In his report, Professor Morganstein stated that:

	"The Registrant did not recognize or identify and record the presence of large carious lesions. In view of the patients previous history the proposed recall interval is not compliant with NICE guidelines." Ms Teodorescu's position was that there were no NICE guidelines for recalls following emergency appointments. The Committee considered that 'recall interval' had a broad meaning. In this case, Ms Teodorescu prescribed antibiotics to the patient and did not offer a follow up appointment. The Committee accepted the opinion of Professor Morganstein that Ms Teodorescu had an obligation to arrange for the recall of this patient having prescribed antibiotics. It therefore found this charge proved. ***Patient 4*** ***9 February 2018*** ***6/12*** Not admitted and found not proved. In his report, Professor Morganstein stated that: *"The visit on 09.02.2018 it is recorded twice that the recall interval will be 6 monthly without any detail why that was decided upon. This is below the standards expected.* *However, the patient was placed onto recall (09.02.2018) when there was still active disease present. This is far below the standards expected.* *The recall interval proposed is not compliant with NICE guidelines. This is below the standards expected."* In her written response, Ms Teodorescu stated: *"I deny that the recall interval after the examination from the 9 02.2018 was not appropriate and in accordance with the NICE guidance and I can only emphasise and refer to the same 6 months interval which was agreed in the following examination during the appointment from 8.03.2018 which was an appointment with a different dentist…"* The Committee was of the view that the premise of his opinion that a shorter recall was required because there was active disease, was insufficient to find this charge proved. It noted that Ms Teodorescu was not aware that there was still active decay remaining in the tooth following the treatment she provided. She therefore could not have known to recall the patient earlier than the six-monthly interval following the conclusion of a course of treatment. On that basis the Committee did not find this charge proved. ***Patient 16*** ***13 September 2017*** ***6/12*** Not admitted and found not proved.

	In his report, Professor Morganstein stated that: *"The proposed recall interval proposed on 13.09.2017 is not appropriate without clarifying the status of the retained root, is also not compliant with NICE guidelines. Both proposed recall periods, as recorded on 13.09.2017 and 17.05.2018, are inappropriate and therefore are far below the standards expected."* In his oral evidence Professor Morganstein told the Committee that NICE guidelines indicated that recall periods should be based on disease level and/or patient cooperation and does not stay the same throughout the patient's time with the dentist. He was of the opinion that the recall intervals that appeared in the patient records was a computer-generated recall which had not been modified to the individual patient given that the patient had a retained root and the decision to do nothing was made without complete information. Ms Teodorescu stated in her written response that: *"As comments to the intervals advised by myself between check-up, I think that 6 months was appropriate to the needs of patient RS and in his best interest to secure his oral health."* The Committee noted that Ms Teodorescu made the decision not to extract the LL7 which had no signs or symptoms. In addition, the patient was content to leave the root. Given that there were no ongoing concerns regarding the LL7, and the retained root was under observation, Ms Teodorescu decided on the recall interval as 6 months. On this basis, the Committee was not satisfied that this recall period for this patient should have been shorter than what was recorded. It therefore found this charge not proved. ***Patient 16*** ***17 May 2018*** ***6/12*** Not admitted and found not proved for the same reasons as above on 13 September 2017 for the same patient. ***Patient 20*** ***6 March 2017*** ***6/12*** Not admitted and found not proved. In his expert report, Professor Morganstein stated: *"The proposed recall interval is not compliant with NICE guidelines as the level of caries in the two teeth could have benefited from the application of topical fluoride varnish at 3 monthly intervals and not 6 monthly. This is far below the standard expected."* Professor Morganstein stated in his oral evidence that Ms Teodorescu's entries in the dental records within the 'free form' section indicated the patient

	was told to come back in three months, but she did not amend the computer-generated recall period to reflect the advice she gave to the patient. He was of the opinion that this was far below standard because it was damaging to the patient. The Committee noted from Ms Teodorescu's clinical entries for this patient that she recorded a recall interval of 3 months in the notes but did not amend the standard recall interval that was automatically populated in the records. It accepted her oral evidence on how recall intervals were arranged at the practice reception once a patient had been advised of when to return. It therefore found this charge not proved. ***Patient 24*** ***19 July 2017*** ***6/12*** Not admitted and found not proved. In his report, Professor Morganstein stated that: *"It is not clear if the proposed recall intervals recorded on visits dated 19.07.2017 and 09.08.2017 are compliant with NICE guidelines. This is far below the standards expected."* In her written response, Ms Teodorescu stated that: *"I recommended 6/12 as per NICE guide line and according with my clinical judgement at the time. The expert does not suggest what would be more appropriate and why?"* The Committee noted that Professor Morganstein's opinion was that as there was disease still present in this patient's teeth, a shorter recall period would have been appropriate. However, the Committee noted that Ms Teodorescu considered at that time that she had provided all necessary treatment and she was not aware that disease was present. On that basis the recall period set would have been appropriate based on the information she had at the time. Therefore, the Committee found this charge not proved. ***Patient 24*** ***9 August 2017*** ***6/12*** Not admitted and found not proved for the same reasons as above on 19 July 2017 in relation to this patient.
9.	*You failed to treat Patient 25 with kindness and compassion on or around 28 April 2017, when extracting UR2.* Not admitted and found not proved. Patient 25 confirmed in her oral evidence under cross-examination by Ms Teodorescu that she had signed the Personal Dental Treatment Plan dated 28 April 2017 which was in the dental records. Patient 25's evidence was that

	she understood from Ms Teodorescu that the tooth would have to be extracted but she did not expect that it would be extracted at this appointment. Ms Teodorescu explained that the appointment with Patient 25 lasted for 45 minutes during which she had explained to the patient that the tooth did not have sufficient structure for a crown restoration particularly as the previous crown had lasted over 10 years. Ms Teodorescu stated that she also explained to Patient 25 the options for closing the gap following extraction which included denture or implant treatment. The Committee noted that the signed Personal Dental Treatment Plan stated "UR2, UR4 2 tooth [sic] partial denture. UR2, retained root xla". The Committee also noted from the clinical entries in the patient's records that in a subsequent appointment with another dentist, it is recorded that "Pt adv she had discussed dentures and poss implants." The Committee was of the view that it was clear from Patient 25's oral evidence that she felt intimidated by Ms Teodorescu. It also considered that having heard Ms Teodorescu give evidence, she may have been perceived by Patient 25 as being abrupt. Her intonation and delivery of language at times was abrupt and direct which may be a result of English not being her first language. Regardless, it was clear from Ms Teodorescu's evidence that she was genuinely concerned about Patient 25 needing an immediate solution to her problem and she did not come across as an uncaring dentist. She was also genuinely surprised to have been perceived in this manner by the patient. The Committee was of the view that there was no evidence of any positive action by Ms Teodorescu that could be considered as unkind or lacking in compassion. It acknowledged that visiting the dentist for an appointment could be a traumatic event for some patients but on the basis of the information before it, it did not find this charge proved.

We move to Stage Two."

On 23 March 2021, the hearing was adjourned part-heard. The hearing re-opened on 4 May 2021.

On 5 May 2021, the Chair announced the determination as follows:

> "Having announced its decision on the facts, the hearing adjourned part-heard on 23 April 2021 due to insufficient time to conclude all the stages in the case. Proceedings resumed on 4 May 2021 and in accordance with Rule 20 of the Fitness to Practise Rules 2006, the Committee heard submissions in relation to the matters of misconduct, impairment and sanction from Ms Tahta, on behalf of the General Dental Council ("the GDC") and from Ms Teodorescu. The Committee also received documentary evidence from Ms Teodorescu relating to her remediation and from the GDC in relation to the matters under consideration at this stage. It heard advice from the Legal Adviser which it accepted.
>
> The Committee reminded itself that its decisions on misconduct, impairment and sanction are matters for its own independent judgement. There is no burden or standard of proof at this stage of the proceedings. The Committee also had regard to its duty to protect the public,

declare and uphold proper standards of conduct and competence, and to maintain public confidence in the profession. Where applicable, the Committee took into consideration the GDC's "*Standards for the Dental Team*", (September 2013) and the *Guidance for the Practice Committees, including Indicative Sanctions Guidance, (revised December 2020)* ("the Practice Committee Guidance"). The Committee was referred to the cases of *Roylance v GMC* [2001] AC 211; *Remedy UK v GMC* [2010] EWHC 1245 (Admin); *Cohen v GMC* [2008] EWHC 581 (Admin); *Calhaem v GMC* [2007] EWHC 2606 (Admin); *CHRE v NMC & Grant* [2011] EWHC 927 (Admin).

Fitness to Practise History

Ms Tahta addressed the Committee regarding Ms Teodorescu's previous fitness to practise history with the GDC. She informed the Committee that Ms Teodorescu was the subject of letters of advice from the Case Examiners first in December 2016 in relation to criticisms dating between 2010 and 2012, and secondly in September 2020 in relation to criticisms dating between September 2019 and March 2020.

Summary of Findings

The Committee found proved that between October 2016 and October 2018, Ms Teodorescu:

- failed to provide adequate standard of care to Patient A in that she:
  - did not carry out an adequate assessment of the patient's presenting dental condition on two occasions.
  - did not accurately diagnose the cause of the patient's pain on two occasions,
  - did not take radiographs on two occasions.
  - provided a poor standard of treatment on 31 May 2017, namely fillings at UR6 and UR7.
- failed to record adequate details of examinations on dates between 21 October 2016 and 19 September 2018 in respect of three patients in that she:
  - recorded insufficient details of examination findings on two dates in relation to Patient 1 and 4.
  - recorded inaccurate Basic Periodontal Examination on three dates in relation to Patient 1 and 17.
- provided a poor standard of radiographic practice on numerous dates between 21 October 2016 and 1 October 2018 in respect of nine patients in that she:
  - failed to report on bitewing radiographs in relation to Patient 1.
  - failed to take and retake bitewing radiographs in relation to Patient 1, 2, 13, 20, 21.
  - failed to take and retake periapical radiographs in relation to Patient 1, 3, 16, 23.
  - failed to take a post-operative radiograph of root canal treatment in relation to Patient 4.
  - made an inadequate report on a Panoral radiograph in relation to Patient 13.
  - made an inadequate report on bitewing radiographs in relation to Patient 24.

- failed to adequately diagnose the need for treatment on numerous dates between 21 October 2016 and 1 October 2018 in relation to six patients in that she:
  - made an inadequate diagnosis of need for root canal treatment or extraction in relation to Patient 3.
  - failed to diagnose large amalgam overhang at LR5 in relation to Patient 4.
  - failed to diagnose severe periodontal disease in relation to Patient 17.
  - failed to diagnose caries at LR7, UL6 and UR6 in relation to Patient 20.
  - failed to adequately diagnose the periodontal risk factor in relation to Patient 21.
  - failed to diagnose caries at UR5, LR5, LR7 and a large overhang at UL6 in relation to Patient 24.
- failed to obtain informed consent from Patient 9 for the extraction of the LR5 on 2 July 2018.
- provided a poor standard of treatment on numerous dates between 6 March 2017 and 14 September 2018 in relation to seven patients in that she:
  - inappropriately prescribed antibiotics to Patient 1.
  - provided a poor standard of Root Canal Treatment to Patient 1's UR2 and Patient 4's LR6.
  - did not follow up after prescribing antibiotics to Patient 3.
  - failed to adequately remove caries from LR6 prior to root canal treatment in relation to Patient 4.
  - provided a poor standard of restoration to Patient 4's LL8.
  - failed to provide adequate periodontal treatment in relation to Patient 16.
  - failed to adequately treat periodontal disease in relation to Patient 17.
  - failed to adequately remove caries from Patient 19's UL3.
  - provided a poor standard of restoration to Patient 19's UL3.
  - failed to adequately remove caries from Patient 20's LR6 and LL6.
- failed to provide a recall interval on 20 March 2017 in respect of Patient 3.

Misconduct

Submissions on behalf of the GDC

Ms Tahta submitted that the Committee's findings against Ms Teodorescu involve sufficiently serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practise. She submitted further that the Committee found proved failings in relation to 13 patients on numerous occasions over a 13-month period. She also submitted that Ms Teodorescu's conduct fell short of the GDC's *Standards for the Dental Team*, September 2013, in particular Principle 2, Standards 2.2, 2.3, Principle 3, Standards 3.1, 3.2, 3.3, Principle 4, Standard 4.1, Principle 7, Standard 7.1. Ms Tahta submitted that the facts found proved clearly amount to multiple breaches of the standards, are serious and constitute misconduct.

Submissions by the Registrant

Ms Teodorescu made no specific submissions on misconduct beyond admitting that she had made mistakes.

Committee decision on misconduct

The Committee found proved that Ms Teodorescu made numerous clinical failings, which spanned a considerable period of time, involved multiple patients and related to basic fundamental areas of dental practice. Some of these failings were admitted by Ms Teodorescu at the start of the hearing and also under cross-examination by Ms Tahta. The dental experts, Mr Ward and Professor Morganstein were of the opinion that Ms Teodorescu's failings in majority of the areas found proved fell far below the standard of an ordinary, reasonably competent dental professional.

The Committee was of the view that Ms Teodorescu's failings were a serious departure from the standards of conduct expected from a dental practitioner and fell short of the following provisions in the GDC's *Standards for the Dental Team*:

Principle 2 Communicate effectively with patients

Standard 2.2

You must recognise and promote patients' rights to and responsibilities for making decisions about their health priorities and care.

Standard 2.3

You must give patients the information they need, in a way they can understand, so that they can make informed decisions.

Principle 3 Obtain valid consent

Standard 3.1

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

Standard 3.2

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

Standard 3.3

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

Principle 4 Maintain and protect patients' information

Standard 4.1

You must make and keep contemporaneous, complete and accurate patient records.

Principle 7 Maintain, develop and work within your professional knowledge and skills

Standard 7.1

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

The Committee was satisfied that, considered as a whole, Ms Teodorescu's failings were serious and crossed the threshold for a finding of misconduct. It therefore concluded that the facts found proved amount to misconduct.

Current Impairment

Submissions on behalf of the GDC

Ms Tahta submitted that in considering whether Ms Teodorescu's fitness to practise is currently impaired, the Committee should take into account the need to protect patients and the wider public interest. She submitted that Ms Teodorescu's fitness to practise is currently impaired on both grounds. She invited the Committee to adopt the approach set out in the case of *Cohen* and by *Dame Janet Smith* in her fifth report to the Shipman Inquiry. She submitted that the Committee may well think that in a clinical case such as this, the failings found proved are easily remediable. However, the crux of the Committee's decision at this stage was whether it has been remedied and whether it is highly likely to be repeated. Ms Tahta made detailed submissions in relation to the remediation material provided by Ms Teodorescu and the Case Examiner letters of advice issued to Ms Teodorescu in 2016 and 2020. She drew the Committee's attention to the similarities in the failings in this case and the concerns considered by the Case Examiners for which the letters of advice were issued. Ms Tahta acknowledged that Ms Teodorescu had undertaken considerable work by engaging in online learning as well as meeting with her supervisor and Post-Graduate Dental Dean. In addition, she submitted that Ms Teodorescu had shown considerable insight by making formal admissions at the start of the hearing and further admissions during cross-examination.

However, on closer examination, Ms Tahta submitted, the Committee could not be satisfied that Ms Teodorescu had fully remedied what were extensive and basic clinical failings nor could it be satisfied that any remediation had now become embedded in clinical practice particularly as Ms Teodorescu stopped working in clinical practice in July 2020.

Ms Tahta submitted that it was the GDC's position that Ms Teodorescu had not fully remedied her failings. She submitted further that the absence of a finding of current impairment would undermine public confidence in the profession.

Submissions by the Registrant

Ms Teodorescu emphasised the fact that there had been no criticism of her practice between March and July 2020 and further that in so far as there were criticisms raised by the Case Examiner's letter of advice in September 2020, they did not consider that it would amount to misconduct.

Committee decision on current impairment

The Committee considered whether Ms Teodorescu's fitness to practise is currently impaired by reason of her misconduct.

The Committee was of the view that Ms Teodorescu's failings are remediable. It noted the considerable efforts made by Ms Teodorescu to address her failings. It noted the reports from her workplace supervisor which showed steady and positive progress with each updated report, the last report being 13 July 2020. The Committee also noted that Ms Teodorescu had been proactively engaging with her Postgraduate Dental Team since 21 May 2018. It reviewed her personal reflections, Personal Development Plan ("PDP") and action plan.

The Committee commended Ms Teodorescu's efforts at addressing her failings. However, it noted that she received a letter of advice from the Case Examiners dated 29 September 2020. The concerns considered by the Case Examiners involved one patient, in relation to two appointments in September 2019 and February 2020, and were similar to those found proved in this hearing. The Committee noted that the appointments post-dated some of the remediation courses undertaken by Ms Teodorescu and coincided with some of the period when her dental practise was being supervised. The Committee also noted Ms Teodorescu's submissions that regarding this Case Examiner's letter of advice, the patient saw online press reports regarding regulatory proceedings against her and made a complaint directly to the GDC. Ms Teodorescu explained that the patient did not raise their concerns directly with her or the practice where she worked at the time. The Committee also noted the Case Examiner's conclusion that, although there was a real prospect of most of the factual allegations being found proved, taking into account their *Guidance Manual (November 2016)*, the *Standards for the Dental Team (September 2013)*, and the conclusions in the Clinical Advice Report commissioned by the GDC, there was no real prospect of a Practice Committee finding the pertinent factual allegations amounted to misconduct.

Nevertheless, the Committee was concerned that Ms Teodorescu's remediation may not yet be sufficiently embedded in her clinical practice, particularly as, following the issuance of the letter of advice, Ms Teodorescu only worked for 5 months thereafter. Ms Teodorescu explained that she lost her job due to the increase in the level of supervision imposed on her GDC registration on an interim basis. The Committee noted Ms Teodorescu's submission that restrictions arising from the Covid-19 pandemic had also impacted on her ability to demonstrate that she had remedied her failings.

The Committee's view was that Ms Teodorescu had demonstrated good insight into her failings by her admissions, her expression of remorse to the witnesses and the Committee, her visible willingness to engage with those involved in her remediation process, the significant evidence of her remediation thus far, and the positive reports from her supervisor and the Postgraduate Dental Team. However, given that she received a letter of advice in September 2020 in relation to concerns similar to those found proved by this Committee and given that she has not worked as a dentist since July 2020, there was a likelihood of repetition of similar failings and therefore a risk of harm to patients. It therefore concluded that a finding of current impairment was required in order to protect the public.

In relation to the public interest, the Committee was of the view that Ms Teodorescu had in the past acted in a way that put patients at unwarranted risk of harm, breached fundamental tenets of the profession and her actions were liable to bring the dental profession into disrepute. It considered that a fully informed member of the public would be concerned about the risk of repetition given the incomplete remediation the Committee had identified. It therefore concluded that a finding of current impairment was needed in the public interest.

The Committee therefore determined that Ms Teodorescu's fitness to practise is currently impaired by reason of her misconduct.

Sanction

Submissions on behalf of the GDC

Ms Tahta submitted that the appropriate action for the Committee to take is to impose conditions on Ms Teodorescu's registration. She submitted that given Ms Teodorescu's inability to show that her academic learning had been embedded into her clinical practice, the conditions should include a period of close supervision for at least 3 months so that another

dentist can oversee Ms Teodorescu's daily work as the Committee could not currently be satisfied that she is safe to practice. Ms Tahta submitted further that overall, the period of conditions should also be sufficient in length to allow Ms Teodorescu sufficient time to find employment and demonstrate an embedding of her learning before any review hearing. Ms Tahta commended draft conditions to the Committee for consideration but submitted that they were not intended to fetter the Committee's discretion. She submitted that the conditions should be imposed for a period of 36 months.

Submissions by the Registrant

Ms Teodorescu informed the Committee that she lost her job as a dentist due to the tightening of the interim conditions currently on her registration. She stated that the conditions had made her unemployable and her career was currently on a standstill as a result. She went on to explain the difficulties she was experiencing financially and personally. Furthermore, Ms Teodorescu stated that conditions should be workable and proportionate. However, the conditions currently on her registration were tantamount to a suspension given that no employer was willing to offer her a role as a dentist. Ms Teodorescu stated that the conditions proposed by the GDC were also not practicable as they would continue to make her unemployable. She explained the significant personal difficulties that she would encounter were she unable to practise as a dentist.

Ms Teodorescu explained that she was fully aware of the gravity of her failings, she apologised for her errors and stated that she had learnt lessons from them. She stated that the fact of not having a job was sad because she could not prove that she had improved in her clinical practice. She stated that she had been working for many months with conditions, the Committee should consider issuing her with a reprimand.

Committee decision on sanction

The Committee next considered what sanction, if any, to impose on Ms Teodorescu's registration. It recognised that the purpose of a sanction is not to be punitive although it may have that effect. The Committee had regard to the principle of proportionality and the requirements of public protection and the public interest.

The Committee was of the view that Ms Teodorescu had demonstrated good insight into her failings consistently throughout the hearing. Ms Teodorescu had also started on the process of remediation of her failings although as previously indicated, her remediation was not yet sufficiently embedded into her clinical practice in light of the Case Examiner letter of advice of September 2020. The Committee therefore concluded that to conclude this case with no further action in light of the above would be inappropriate to protect patients and would not satisfy the public interest.

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

The Committee was of the view that although a reprimand may be able to deal with the public interest aspect of this case, there was an ongoing need to ensure patient safety until Ms Teodorescu was deemed to be practising safely. A reprimand was therefore not appropriate in this case.

The Committee then considered whether a conditions of practice order would be appropriate. It was satisfied from the evidence before it that conditions were the appropriate, sufficient and proportionate order to make in this case, and that workable conditions could be formulated

which would protect the public and the public interest. Furthermore, the Committee noted that the GDC's position was that conditions were the appropriate response in this case.

In considering the nature of the conditions to impose, the Committee noted that the GDC were proposing the imposition of close supervision. The Committee was of the view that this was excessive given that Ms Teodorescu had continued to engage with the process of remediation, the positive reports from her supervisor, the feedback from patients, testimonials written on her behalf, her insight and remorse. The Committee also took into account Ms Teodorescu's submissions that conditions requiring close supervision had led to the end of her employment. They were a barrier to her being currently employed and were tantamount to a suspension. The Committee concluded that although Ms Teodorescu's practice required supervision, close supervision would be disproportionate and tantamount to a suspension particularly given the current working conditions in dental practices due to Covid-19. The Committee decided that the level of supervision required in this case is supervision.

The Committee considered whether a suspension would be more appropriate. However, it was of the view that as Ms Teodorescu had demonstrated remorse, insight, produced evidence of significant steps taken towards remediation and a willingness to continue to remedy her failings, a suspension would be disproportionate and inappropriate in this case.

The Committee therefore determined pursuant to section 27B(6)(c) of the Dentists Act 1984, as amended, ("the Act") to direct that Ms Teodorescu's registration be subject to conditions.

The Committee considered how long conditions should be in place. It considered that imposing conditions for 3 years as proposed by the GDC would be disproportionate given Ms Teodorescu has already undertaken significant remediation. This was evident during her oral evidence on clinical failings and was reflected in positive patient feedback from her most recent clinical practice. The Committee considered that 18 months was sufficient time for Ms Teodorescu to embed her learning safely and demonstrate that she had remedied her previous failings. It therefore determined to impose the conditions for 18 months.

The conditions will be reviewed prior to the expiry of the 18-month period. By virtue of rule 21(3) of the Rules, the interim order currently on Ms Teodorescu's registration in relation the allegations to which this determination relates is hereby revoked pursuant to section 27B(9) of the Act.

The conditions as they will appear against the name TEODORESCU, Ana-Maria are as follows:

1. She must notify the GDC within 7 days 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 service and the Commissioning Body on whose Dental Performers List she is included.
2. She must allow the GDC to exchange information with her employer or any organisation for which she is contracted to provide dental services, and any Postgraduate Dental Dean/Director or workplace supervisor referred to in these conditions.
3. She must inform the GDC within 7 days 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 within 7 days if she applies for dental employment outside the UK.
6. She must work with a Postgraduate Dental Dean/Director (or nominated deputy) to update her Personal Development Plan (PDP) specifically designed to address the alleged deficiencies in the following areas:
    a. Compliance with GDC and FGDP (UK) Guidelines
    b. Record keeping
    c. Radiography
    d. Antibiotic prescribing
    e. Caries diagnosis and treatment
    f. Endodontics
    g. Appropriate management of periodontal care
    h. Patient communication and complaints
7. She must provide a copy of her PDP to the GDC within three months of the date on which these conditions become effective and at least 14 days prior to any review hearing.
8. She must permit the GDC to exchange information about the standard of her professional performance and her progress towards achieving the aims set out in her PDP with the Postgraduate Dental Dean/Director (or a nominated deputy), and any other person involved in her retraining and supervision.
9. At any time she is employed, or providing dental services, which requires her to be registered with the GDC:
    a. she must place herself and remain under the supervision* of a workplace supervisor;
    b. the workplace supervisor shall be a GDC registrant in the same category of the register as the Registrant or higher.
10. She must present the workplace supervisor with a copy of this determination.
11. She must meet with the workplace supervisor at least once a month to review her work via one to one meetings and case-based discussion. These meetings must be focused on all areas of concern identified in condition 6 above. Whilst Covid-19 restrictions are in place, these meetings may take place face to face remotely; otherwise they should be in person. She must act on any advice given concerning her practice.
12. She must seek reports from her workplace supervisor to the GDC every 3 months and at least 14 days prior to any review of these conditions. The report will address the following areas:
    a. Compliance with GDC and FGDP (UK) Guidelines
    b. Record keeping
    c. Radiography
    d. Antibiotic prescribing
    e. Caries diagnosis and treatment

f. Endodontics

g. Appropriate management of periodontal care

h. Patient communication and complaints

13. She must meet with the Postgraduate Dental Dean/Director (or a nominated deputy), on a regular basis to discuss her progress towards achieving the aims set out in her PDP. The frequency of the meetings is to be set by the Postgraduate Dental Dean/Director (or a nominated deputy).

14. She must inform within one week the following parties that her registration is subject to conditions, listed at (1) to (13), above:

    a. Any organisation or person employing or contracting with her to undertake dental work;

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

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

    d. The Commissioning Body in whose Dental Performers List she is included, or seeking inclusion (at the time of application).

15. She must permit the GDC to disclose the above conditions to any person requesting information about her registration status.

*****Supervised***

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 himself/herself available to provide advice or assistance should they be required. The registrant's work must be reviewed at least once fortnightly by the supervisor via one to one meetings and case-based discussion. These fortnightly meetings must be focussed on all areas of concern identified by the conditions.

The Committee now invites submissions on whether an immediate order of conditions should be imposed on Ms Teodorescu's registration."

Decision on immediate order

"Having made its decision, the Committee considered whether an immediate order is necessary for the protection of the public, otherwise in the public interest or in the interest of the registrant.

Submissions on behalf of the GDC

Ms Tahta submitted that pursuant to section 30(2) of the Dentists Act 1984, as amended, an order for immediate conditional registration should be imposed on the grounds that it is necessary for the protection of the public and otherwise in the public interest. She submitted that Ms Teodorescu would be free to practise unrestricted in the 28 days prior to the substantive decision coming into effect. Further, she submitted that having decided that Ms Teodorescu is not safe to practise without restriction, an immediate order is necessary.

Submissions by the Registrant

Ms Teodorescu submitted that as she is currently not working, she cannot be a risk to anyone. In addition, she emphasised that securing employment was not immediate and she would have to notify the GDC of any employment as required by the substantive conditions.

Decision of the Committee

The Committee considered the submissions made by Ms Tahta and Ms Teodorescu. It accepted the advice of the Legal Adviser.

The Committee was of the view that, having concluded that Ms Teodorescu's fitness to practise is impaired and she is not safe to practise unrestricted, an immediate order is necessary for the protection of the public. It determined that an immediate order is also in the public interest in order to maintain public confidence in the dental profession and standards in the profession.

The effect of the foregoing direction and this order is that Ms Teodorescu's registration will be subject to conditions in the same terms as the substantive conditions with immediate effect and unless she exercises her right to appeal, the substantive direction for conditional registration will take effect as indicated in the notice to be served on her. Should she exercise her right to appeal, this order for immediate conditional registration will remain in place pending the resolution of any appeal proceedings.

That concludes this determination."