General
Dental
Council

HEARING PARTLY HEARD IN PRIVATE*

***** The Committee has made a determination in this case that includes some private information.

That information has been omitted from the text.

JOHNSTON, Jeffrey Thomas

Registration No: 59471

PROFESSIONAL CONDUCT COMMITTEE

MARCH 2020

Outcome: Erased with immediate suspension

Jeffrey Thomas JOHNSTON, a dentist, LDS Royal College of Surgeons of England 1986, BDS University of Manchester 1984, was summoned to appear before the Professional Conduct Committee on 2 March 2020 for an inquiry into the following charge:

Charge (as amended on 2 March 2020)

"That being a registered dentist,

1. Between January 2016 and August 2018, you were the principal dentist at the dental practice referred to in Schedule 1[1] below ["the Practice"].

Clinical Practice

2. In or around February 2018, you put patient safety at risk in that:
   (a) Your radiographic equipment had not been checked and re-certified since December 2017;
   (b) You did not have the requisite checks in place to validate your decontamination process;
   (c) You provided dental treatment without adequate chairside support.
3. In or around February 2018, you failed to maintain adequate standards of clinical practise in that:
   (a) You failed to ensure that your emergency medications were all present and/ or in date;
   (b) Your matrix bands were not single-use.
4. In or around February 2018, you did not fulfil your professional obligations in that you failed to maintain up-to-date written policies in respect of the following:
   (a) Complaints Procedure;
   (b) Environmental Cleaning and Maintenance;
   (c) Personal Protective Equipment;

[1] The schedules are private documents and cannot be disclosed

(d) Storage Application and Disposal of Disinfectants.

5. In or around February 2018, you failed to maintain adequate standards of contamination control in that:

   (a) Between March 2016 and February 2018, you failed to arrange for a specialist contractor to undertake an appropriate legionella risk assessment;

   (b) You failed to maintain an up-to-date written policy in relation to blood borne viruses.

6. On closing the practice on 20 July 2018, you failed to make appropriate arrangements for the continuing care of your patients:

   (a) As soon as reasonably practicable after 20 July 2018; and/ or

   (b) At any time before 27 February 2019.

CPD

7. You failed to complete your required CPD hours in the cycle 01/01/2013 - 31/12/2017.

Health

8. You suffer from one or more adverse health conditions in that:

   (a) [private information removed]

   (b) [private information removed]

   (c) [private information removed]

   (d) [private information removed]

   (e) [private information removed]

   (f) [private information removed]

9. By letter dated 25 August 2019, you indicated that you did not consent to undergo a Health Assessment.

GDC Investigation

10. Between March 2018 and September 2019, you failed to co-operate with the GDC's investigation into your fitness to practise in that:

    (a) You failed to respond to an email dated 20 March 2018, requesting that you facilitate a GP report [Sender A];

    (b) You failed to respond to an email dated 19 April 2018, requesting that you facilitate a GP report [Sender A];

    (c) You failed to respond to an email and/or letter dated 17 July 2018, notifying you of concerns and requesting information [Sender B];

    (d) You failed to respond to an email and/or letter dated 23 July 2018, notifying you of allegations and inviting a response [Sender C];

    (e) You failed to respond to an email dated 30 July 2018, notifying you of a hearing [Sender D];

(f) You failed to respond to an email dated 1 August 2018, requesting a response to letter of 17 July 2018 [Sender B];

(g) You failed to respond to an email dated 20 August 2018, notifying you of a review [Sender E];

(h) You failed to respond to an email dated 17 January 2019, notifying you of a review [Sender D];

(i) You failed to respond to an email dated 8 April 2019, notifying you of referral to Case Examiners [Sender F].

11. You have failed to maintain a correct and up-to-date registered address.

12. From 19 June 2018 to 20 July 2018, you failed to have indemnity insurance.

13. On 28 February 2019, at Hasting Magistrates' Court, you were made subject of a non-molestation order in accordance with section 42 of the Family Law Act 1996.

14. On 13 March 2019, at Hastings Magistrates' Court, you were convicted of an offence of breaching the non-molestation order at 2 above, contrary to sections 42A(1) and (5) of the Family Law Act 1996.

15. On 15 March 2019, at Hastings Magistrates' Court, the following sentence was imposed upon you in respect of the offence at 3 above:

a) Community Order of 12 months' duration with a [private information removed] Requirement (as set out at Schedule A) to be completed by 14 March 2020;

b) An order to pay £85 to victim services;

c) An order to pay £40 towards prosecution costs.

16. You failed to inform the General Dental Council of your conviction.

AND, by reason of the facts stated, your fitness to practise as a Dentist is impaired by reason of your Misconduct and/or Adverse Health and/or Conviction"

As Mr Johnston did not attend and was not represented at the hearing, the Chairman made the following statement regarding proof of service. He addressed this to the Counsel for the GDC.

"Mr Johnston is neither present nor represented at this Professional Conduct Committee (PCC) hearing of his case. Ms Rebecca Harris, Counsel, represents the General Dental Council (GDC).

At the outset, Ms Harris made an application under Rule 54 of the *GDC (Fitness to Practise) Rules Order of Council 2006* ('the Rules'), to proceed with the hearing notwithstanding Mr Johnston's absence. The Committee took into account Ms Harris' submissions in respect of the application and had regard to the supporting documentation provided. It accepted the advice of the Legal Adviser.

Decision on service

The Committee first considered whether notice of the hearing had been served on Mr Johnston in accordance with Rules 13 and 65 of the Rules. It received a bundle of documents containing a copy of the Notice of Hearing ('the notice'), dated 20 January 2020, which was sent to Mr Johnston's registered address, as is required, by First Class post and

Special Delivery. A copy was also sent to Mr Johnston by email to an email address given by him to the GDC. The Committee further saw that a copy of the notice was sent by the same postal methods to an alternative address for Mr Johnston, although this was not a formal requirement.

The Committee noted from the Royal Mail Track and Trace information within the bundle, that the copies of the notice sent by Special Delivery to Mr Johnston at his registered address and his alternative address, were both 'returned to sender' on 22 January 2020. The Committee took into account that there is no requirement within the Rules for the GDC to prove delivery of the notice, only that it was sent. However, it did receive evidence to indicate that Mr Johnston received the copy of the notice that was sent to his alternative address. The Committee saw a transcript of a voicemail message received by the GDC from Mr Johnston on 22 January 2020. In the voicemail message, Mr Johnston quoted the reference number from the copy of the notice sent to his alternative address.

The Committee was satisfied that the notice sent to Mr Johnston contained proper notification of today's hearing, including its time, date and venue, as well as notification that the PCC had the power to proceed with the hearing in his absence. On the basis of all the information provided, the Committee was satisfied that notice of the hearing had been served on Mr Johnston in accordance with the Rules.

Decision on whether the hearing should proceed in the absence of the registrant

The Committee next considered whether to exercise its discretion under Rule 54 to proceed with the hearing in the absence of Mr Johnston. It approached this issue with the utmost care and caution. The Committee took into account the factors to be considered in reaching its decision, as set out in the case of *R v Jones [2003] 1 AC 1HL*. The Committee remained mindful of the need to be fair to both Mr Johnston and the GDC, taking into account the public interest in the expeditious disposal of this case.

The Committee was satisfied that the GDC had made more than reasonable efforts to notify Mr Johnston of this PCC hearing, including the instruction of a search agent. A copy of the notice of 20 January 2020 and copies of other significant correspondence were sent to the alternative address for Mr Johnston identified by the search agent. Further, the Committee was satisfied from the transcript of the voicemail message received from Mr Johnston on 22 January 2020, that he is aware of these proceedings. In that voicemail message he stated that he had retired and would not be returning to dentistry, *"so I don't have to go to any of this fitness to practise stuff. I'm out of it okay. And you don't need to waste paper and money and postage on special delivery I'm not doing dentistry any more okay, and I told them but I still get Capsticks stuff…"*

In the Committee's view, Mr Johnston's absence is voluntary. It considered that an adjournment would serve no useful purpose. The Committee took into account the evidence of Mr Johnston's infrequent engagement with the GDC regarding his case, which appears to have culminated in his decision to disengage, as expressed in his voicemail message. In the circumstances, the Committee concluded that adjourning the hearing today was highly unlikely to secure Mr Johnston's attendance on a future occasion. It also noted that Mr Johnston had not requested an adjournment.

The Committee took into account the serious nature of the allegations and the potential consequences for Mr Johnston in proceeding with the hearing in his absence. However, it remained mindful of its duty to act expeditiously and fairly, and it concluded that it was in the

public interest and in the interests of justice to facilitate the timely resolution of Mr Johnston's case.

The Committee therefore determined to proceed with the hearing notwithstanding Mr Johnston's absence and the absence of any representative on his behalf.

On 2 March 2020 the Chairman made the following statement on Rule 25 application for joinder:

Following the Committee's decision to proceed with the hearing in the absence of Mr Johnston or any representative on his behalf, Ms Harris made an application for joinder under Rule 25 of the *General Dental Council (Fitness to Practise) Rules Order of Council 2006*.

Ms Harris applied to join the following additional allegations to the current charge:

That being a registered dentist:

1. *From 19 June 2018 to 20 July 2018, you failed to have indemnity insurance.*
2. *On 28 February 2019, at Hasting Magistrates' Court, you were made subject of a non-molestation order in accordance with section 42 of the Family Law Act 1996.*
3. *On 13 March 2019, at Hastings Magistrates' Court, you were convicted of an offence of breaching the non-molestation order at 2 above, contrary to sections 42A(1) and (5) of the Family Law Act 1996.*
4. *On 15 March 2019, at Hastings Magistrates' Court, the following sentence was imposed upon you in respect of the offence at 3 above:*
    a. *Community Order of 12 months' duration with a [PRIVATE] Requirement (as set out at Schedule A) to be completed by 14 Marcy 2020;*
    b. *An order to pay £85 to victim services;*
    c. *An order to pay £40 towards prosecution costs.*
5. *You failed to inform the General Dental Council of your conviction.*

AND, by reason of the matters stated, your fitness to practise as a Dentist is impaired by reason of your Conviction and/ or Misconduct.

In making the application, Ms Harris referred the Committee to the provisions of Rule 25(2), which are as follows:

(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.

Ms Harris explained the background to the additional charges and submitted that they all arise from the same alleged facts and are of a similar nature to those set out in the current charge. Ms Harris told the Committee that due to the timing of the Council's investigations into the additional allegation, they could not be considered by the Case Examiners at the same time as the allegations in the current charge.

In relation to the first additional allegation regarding Mr Johnston's alleged failure to have indemnity insurance, Ms Harris highlighted that this proposed head of charge relates to June to July 2018. She stated that around this time there were already concerns that Mr Johnston had been failing to meet his professional obligations. It was Ms Harris' submission that the additional allegation regarding indemnity insurance arises from the same factual basis as the other allegations detailed in the current charge regarding Mr Johnston's management of his professional practice.

The remaining additional allegations concern court proceedings against Mr Johnston, including a conviction. Ms Harris explained how the information relating to these matters came to light. [PRIVATE].

Decision on the application for joinder

In reaching its decision, the Committee took account of the submissions made by Ms Harris on behalf of the General Dental Council (GDC). It accepted the advice of the Legal Adviser.

Prior to deciding on the application, the Committee first satisfied itself that, in accordance with Rule 25(3)(b), Mr Johnston was afforded the opportunity to make written representations in relation to the additional allegations. It had regard to the correspondence drawn to its attention by Ms Harris, which was sent to both Mr Johnston's registered address and alternative residential address, as well as by email. The Committee was satisfied that Mr Johnston had been made aware of the GDC's intention to make the application for joinder and that he was given the opportunity to reply. There is nothing before the Committee to indicate that any response was received from Mr Johnston.

Having considered all the evidence before it, the Committee was satisfied that all the limbs of Rule 25(2) were met in this case. In relation to subparagraphs (a) and (b), it noted the existing allegations within the current charge, referred to it by the GDC Case Examiners, which it is yet to hear, given that this substantive hearing is yet to be formally opened. With regard to subparagraph (c), the Committee was satisfied that the additional allegations are linked to a number of matters alleged in the current charge, in particular those matters concerning Mr Johnston's professional practice [PRIVATE]. The Committee considered that nothing new or unexpected had been raised by the GDC's proposal to join the additional allegations to the current charge. In its view, the additional allegations appear to provide a development to the background of Mr Johnston's case and are based on documents which were provided to the Committee and which had been provided to Mr Johnston.

In the circumstances, the Committee considered that it would be more efficient and would be in the public interest for it to hear all of the allegations against Mr Johnston, together at the same hearing. Given the similar nature of the additional allegations, the Committee was satisfied that joining them to the current charge would not compromise the fairness of the proceedings.

The Committee has therefore determined to grant to the Rule 25(2) application for joinder made by Ms Harris on behalf of the GDC.

Accordingly, the additional allegations as set out above should be joined to the current charge against Mr Johnston."

On 5 March 2020 the Chairman made the following statement regarding the finding of facts:

"At the material times, Mr Johnston was a registered General Dental Practitioner working single-handedly at a mixed (NHS and private) dental practice in Kent (the Practice). The Practice provided dental services as part of the Denplan scheme. All Members of the Denplan scheme are expected to adhere to Denplan's quality programme.

Mr Johnston first came to the attention of the General Dental Council (GDC) in relation to the issues that form the subject matter of this inquiry, when concerns were raised in relation to his health in 2017. In July 2018, the GDC received concerns from Denplan, in relation to Mr Johnston's clinical practice. The GDC's case is that between 2017 and 2018 the standard of Mr Johnston's clinical practice deteriorated significantly. There are allegations relating to his failure to maintain adequate standards of clinical practice, his failure to fulfil his professional obligations, his failure to complete the required Continuing Professional Development (CPD) and his failure, between March 2018 and September 2019, to co-operate with the GDC's investigation into his fitness to practise and to update the GDC about his conviction. Finally, there are allegations relating to Mr Johnston suffering from one or more adverse health conditions.

A routine inspection by the Care Quality Commission (CQC) on 22 March 2016 raised no real concerns about Mr Johnston's practice. On 15 February 2018, Witness 1, a Dental Advisor at Simply Health Professionals (formerly Denplan) attended Mr Johnston's Practice and a Facilitated Practice Assessment (FPA) went ahead as part of Denplan's quality programme. Witness 1 identified issues of concern that fell under the essential criteria. In particular, Witness 1 identified that Mr Johnston was working entirely alone at the Practice without any other members of staff and without chairside support.

Witness 1 provided a copy of his report to Mr Johnston on 22 March 2018, along with a covering letter highlighting the concerns that had been raised. The letter offered further support from Witness 1 along with assistance from Denplan's business development consultant if required. The letter requested a response from Mr Johnston by 20 April 2018. No response was received.

Thereafter, a consultant from Denplan attended the Practice on 25 April 2018. Mr Johnston told the consultant that he would respond to the report within the next two weeks. No response was forthcoming and on 4 June 2018 Denplan decided to terminate Mr Johnston's membership, giving him 3 months' notice. Mr Johnston was informed that Denplan would inform the GDC if the clinical concerns were not addressed. By 26 June 2018 Denplan had not received anything from Mr Johnston and so began cancellation proceedings. Mr Johnston was notified of this decision by letter dated 27 June 2018. In July 2018 Denplan received information from Denplan patients that the Practice had been closed prior to the formal cancellation date.

On 27 July 2018 there was a telephone call between Mr Johnston and a member of staff from Denplan. Mr Johnston informed that member of staff that he had closed the Practice on 20 July 2018. Around July 2018 Denplan contacted the CQC and informed them that Mr Johnston had been working without a nurse and that they had reported their concerns to the GDC. Denplan made further contact with the CQC in January 2019.

On 27 February 2019, a CQC staff member attended the Practice for an unannounced visit. The Practice was completely empty and no longer in business.

The GDC's case is that between 2017 and 2018 there appears to have been a period when Mr Johnston withdrew from the proper provision of dental services, [PRIVATE].

In support of the clinical matters, the GDC relies on the evidence of Witness 1. He produced a witness statement dated 16 October 2019 which set out the categories that are assessed as part of an FPA. He provided a report dated 22 March 2018 in which he set out his detailed findings. Witness 1 identified a number of shortcomings, which were contrary to the requirements set out in the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) (for radiographic equipment). He also found that Mr Johnston had not been testing and validating all decontamination equipment at recommended intervals as required by the Department of Health Decontamination Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05). There were further areas where Mr Johnston had failed to comply with HTM 01-05. Witness 1 raised concerns that Mr Johnston was practising without a dental nurse or any other chairside support.

Witness 1, in his report, acknowledged that he found Mr Johnston receptive during the course of the assessment and that he seemed to want to improve. However, Witness 1's overall impression was that Mr Johnston was struggling in general practice.

Witness 1 gave oral evidence via telephone. He reiterated his view that Mr Johnston wanted to make improvements to his practice, but he was "struggling" to do so. Witness 1 confirmed that matrix bands should only be used once in accordance with HTM 01-05. It was permissible to re-use the holders, as long as they were sterilised, but Witness 1 reported that Mr Johnston was re-using the matrix bands in contravention of HTM 01-05.

The Committee found Witness 1 to be a reliable and credible witness. It noted that Mr Johnston did not challenge the conclusions reached by Witness 1 in his inspection report, dated 22 March 2018 following the visit on 15 February 2018.

The GDC also relied on the expert evidence of Ms Firestone, as set out in her report dated 16 October 2019. The Committee had sight of Ms Firestone's CV and it accepted that she is an expert on matters of dental practice, and that her report covers matters within her area of expertise. Ms Firestone referred to the relevant GDC "Standards for the Dental Team" (September 2013), as well as IR(ME)R 2017, with which Mr Johnston was required to comply. Ms Firestone echoed the concerns raised by Witness 1. She stated that in 2016, Mr Johnston had passed the CQC inspection with virtually all the domains assessed found to be satisfactory. This, she suggested, indicated that Mr Johnston was aware of what constituted a well-run practice. However, two years later, Witness 1's Denplan quality assessment produced a very different outcome for the same domains. The Committee considered that Ms Firestone's evidence was clear and measured.

Finally, in respect of the clinical matters, the Committee received the following:

- A witness statement dated 16 October 2019 from Witness 2, of Simply Health, together with exhibits (mainly correspondence from Denplan to Mr Johnston)
- A witness statement dated 16 October 2019 from Witness 3, Dental Inspector of the CQC, together with a copy of an Inspection Report dated 12 May 2016
- A screenshot of Mr Johnston's CPD record

All witnesses were available to give oral evidence to the Committee. Their evidence was not challenged by Mr Johnston, but neither was it accepted by him, as he is not engaging in the fitness to practise process. The Committee considered that the written evidence was comprehensive, was supported by documents and was coherent and sufficient to cover the matters in the charge. Therefore, no other witnesses were called to give oral evidence.

The Committee was referred to the evidence provided by the GDC as to Mr Johnston's failure to engage with the GDC's investigations, both in relation to the concerns raised about his health, and from the information provided by Denplan. This includes the witness statement dated 19 September 2019 from a GDC Caseworker and her exhibits.

The Committee also received evidence in relation to Mr Johnston's health, [PRIVATE].

The Committee has borne in mind Mr Johnston's non-engagement with the GDC in respect of its investigation that has given rise to the allegations against him. It therefore has no information from Mr Johnston as to whether or not he accepts or denies the allegations. However, it noted from Witness 1's evidence that Mr Johnston had participated in the FPA and it appears that he accepted the concerns that had been raised in Witness 1's report. The Committee has borne this factor in mind when considering the shortcomings in Mr Johnston's clinical practice.

The Committee has taken into account all the evidence presented to it. It has accepted the advice of the Legal Adviser. It has borne in mind that the burden of proof is on the GDC and that it must decide on the facts according to the civil standard of proof, namely on the balance of probabilities. Mr Johnston need not prove anything. In accordance with the Legal Adviser's advice it has considered each charge separately.

The Committee's findings are as follows

1.	*Between January 2016 and August 2018, you were the principal dentist at the dental practice referred to in Schedule 1 below ["the Practice"].* **Found proved** The Committee found this charge proved in the light of Witness 1's evidence, the evidence provided by staff working at Denplan and the CQC inspection report. This evidence establishes that Mr Johnston was the principal dentist at the Practice between January 2016 and August 2018.
	Clinical Practice *In or around February 2018, you put patient safety at risk in that:*
2.(a)	*Your radiographic equipment had not been checked and re-certified since December 2017* **Found proved** The Committee accepted Witness 1's evidence that Mr Johnston should have had his radiographic equipment checked and re-certified by a qualified person. This was a duty under IR(ME)R 2017. He explained that Mr Johnston had not had his radiographic equipment checked for over three years and that the certificate provided by Mr Johnston was out of date in December 2017. His evidence was that he gave Mr Johnston three months to get the equipment assessed in order to arrange for an engineer to come into the Practice. The Committee accepted Ms Firestone's evidence that a failure to have x-ray

	equipment checked could mean that any faults in the equipment could lead to harm for both staff and patients.
2.(b)	*You did not have the requisite checks in place to validate your decontamination process* **Found proved** Witness 1's evidence was that Mr Johnston was not testing and validating all decontamination equipment at the recommended intervals as found in HTM 01-05. He observed that Mr Johnston had an autoclave which was working but he did not have a data recorder or a printer to validate the cycle. HTM 01-05 indicates that every cycle of the autoclave should be validated – this would allow Mr Johnston to validate that he had carried out the decontamination on a certain date and time. Witness 1 explained that it was possible to record this manually but that Mr Johnston was not doing this either. Ms Firestone refers to Mr Johnston having carried out checks in 2016 and given that the CQC passed the Practice in this important area, the Committee accepted that Mr Johnston understood his obligations. The Committee places weight on Witness 1's evidence. It finds that Mr Johnston had a duty to have the requisite checks in place, in accordance with HTM 01-05. It considers that his failure to have the requisite checks in place could place patients at risk. It therefore found this charge proved.
2.(c)	*You provided dental treatment without adequate chairside support*. **Found proved** Standard 6.2 of the GDC's Standards states *"You must be appropriately supported when treating patients."* Standard 6.2.2. states *"You should work with another appropriately trained member of the dental team at all times when treating patients in a dental setting"*. Witness 1's evidence was that Mr Johnston did not have a dental nurse or any other member of staff in the practice. He explained that he spoke to Mr Johnston *"at length"* about this. His evidence was that he advised Mr Johnston to recruit a dental nurse *"as a matter of urgency"* and gave him a deadline of 3 months in which to implement this. Witness 1 confirmed in his oral evidence that he had discussed this matter with Mr Johnston at the inspection visit. The Committee notes that the Chief Dental Officer sent a letter dated 5 June 2018 reiterating these concerns *"…we highlight our concerns regarding the high numbers of outstanding essential items that were raised following your practice assessment on 15 February 2018, in particular your lack of adequate chairside support…patient safety could be place at risk as a result of you practicing without a nurse."* The Chief Dental Officer wrote again on 27 June 2018 confirming Mr Johnston's position was that he was still practicing without chairside support. The Committee found that Mr Johnston had a duty to ensure that he was appropriately supported when providing dental treatment. He continued to work single-handedly without chairside support. The Committee accepted the evidence of Ms Firestone that to work without a dental nurse for a protracted period of time placed Mr Johnston and his patients at risk of harm. Accordingly, the Committee found this charge proved.
3.	*In or around February 2018, you failed to maintain adequate standards of clinical*

	practice in that:
3.(a)	*You failed to ensure that your emergency medications were all present and/ or in date* **Found proved** Witness 1's evidence was that there was no record system showing that availability of oxygen had been checked. He considered that the oxygen should have been checked and recorded weekly, as recommended in the Resuscitation Patient Council Guidelines of 2013. Ms Firestone opined that *"checking the oxygen level of the cylinder should be a weekly task, as it is often of paramount importance for patient safety."* Witness 1 referred to the Midazolam in Mr Johnston's emergency drugs kit being out of date. Ms Firestone concluded that it was important for Mr Johnston to ensure that the emergency drugs kit was fully stocked and could function if necessary. Mr Johnston did not disagree with the conclusions of Witness 1. The Committee accepted Witness 1's evidence and that of Ms Firestone. Accordingly, it found this charge proved.
3.(b)	*Your matrix bands were not single-use* **Found proved** Witness 1's oral evidence was that Mr Johnston was re-using matrix bands. This, he said, was contrary to HTM 01-05. He explained that matrix bands are disposable and should not be re-used because they potentially come into contact with gingival tissue. Ms Firestone's evidence was that in accordance with HTM 01-05, matrix bands were single use. The Committee accepted Witness 1's evidence and that of Ms Firestone.
4.	*In or around February 2018, you did not fulfil your professional obligations in that you failed to maintain up-to-date written policies in respect of the following:*
4.(a)	*Complaints Procedure* **Found proved** Standard 5.1 of the GDC's Standards states: *"You must make sure that there is an effective complaints procedure readily available for patients to use, and follow that procedure at all times."* Given that this standard is mandatory, the Committee is satisfied that Mr Johnston had a duty to ensure that he had an up-to-date written complaints procedure. Witness 1's evidence was that Mr Johnston had downloaded the Denplan template, but it had not been amended to be relevant or specific to his practice. The Committee accepted the evidence of Witness 1 and the evidence of Ms Firestone that Mr Johnston an appropriate policy in place in March 2016, but by February 2018, the policy was not effective or specific and not readily available for patients. Accordingly, the Committee found this charge proved.
4.(b)	*Environmental Cleaning and Maintenance* **Found proved**
4.(c)	*Personal Protective Equipment*

	Found proved
4.(d)	*Storage Application and Disposal of Disinfectants* **Found proved** The Committee considered separately heads of charge 4(b) to 4(d) above and it made the same finding in respect of each head of charge. Standard 1.5 of the GDC's Standards states: *"You must treat patients in a hygienic and safe environment".* Witness 1's evidence was that Mr Johnston did not have implemented policies in place for Environmental Cleaning and Maintenance, Personal Protective Equipment and Storage Application and Disposal of Disinfectants. Witness 1 referred to HTM 01-05 Essential Quality Standards, which states that all practices must have up-to-date, detailed written local policies. The Committee is satisfied that Mr Johnston had a duty to ensure that he had up-to-date written policies in respect of the matters set out at 4(b) to 4(d). The Committee accepted the evidence of Witness 1 that Mr Johnston was asked to provide the policies and did not have them in place. Accordingly, it found these heads of charge proved.
5.	*In or around February 2018, you failed to maintain adequate standards of contamination control in that:*
5.(a)	*Between March 2016 and February 2018, you failed to arrange for a specialist contractor to undertake an appropriate legionella risk assessment* **Found proved** Standard 1.5 of the GDC's Standards states: *"You must treat patients in a hygienic and safe environment".* The CQC report identified that Mr Johnston needed to *"review the current legionella risk assessment and implement the required action including the monitoring and recording of water temperatures…no records were available to show that a specialist contractor had carried out a formal legionella risk assessment."* The Committee is satisfied that Mr Johnston had a duty to ensure that a Legionella Risk Assessment was carried out by an external contractor. The Committee accepted the evidence of Witness 1 that Mr Johnston had not arranged for this assessment to be carried out between the CQC inspection in 2016 and the date of his inspection in February 2018. Ms Firestone accepted Witness 1's observation. The Committee, relying on their conclusions, found this allegation proved.
5.(b)	*You failed to maintain an up-to-date written policy in relation to blood borne viruses.* **Found proved** Witness 1's evidence was that there was no written policy on minimising the risk of blood-borne viruses with particular regard to needlestick injuries. The Committee accepted that Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR), HTM 01-05 and GDC Standard 1.5.2, all create a duty to have such a policy. Ms Firestone concluded that this was a failure. Mr Johnston did not challenge the conclusion in Witness 1's report. On the basis of this evidence, the Committee found this head of charge

	proved.
6.	*On closing the practice on 20 July 2018, you failed to make appropriate arrangements for the continuing care of your patients:*
6.(a)	*As soon as reasonably practicable after 20 July 2018; and/ or* **Found proved**
6.(b)	*At any time before 27 February 2019.* **Found proved** The Committee considered separately heads of charge 6(a) and 6(b) above and it made the same finding in respect of each head of charge. GDC Standard 1.7.8 sets out that "*Before you end a professional relationship with a patient, you must be satisfied that your decision is fair and you must be able to justify your decision. You should write to the patient to tell them your decision and your reasons for it. You should take steps to ensure that arrangements are made promptly for the continuing care of the patient."* There is no evidence before the Committee that Mr Johnston gave notice to either his NHS patients or his private patients that the Practice was closing. The Committee accepted the evidence of Ms Firestone that the obligation in the Standard is not onerous and a note on the door of the Practice might be a sufficient and appropriate arrangement. Despite evidence of adverse health conditions, the Committee was satisfied that at 20 July 2018, Mr Johnston was sufficiently well to make it reasonably practicable that he put a note on the door when he closed the Practice. The Committee noted that Mr Johnston was well enough to communicate with Denplan by telephone on 23 July 2018. The Committee accepted that in August 2018 and in October 2018 Mr Johnston [PRIVATE] would have been unable to make any arrangements at those times. However, the evidence overall led the Committee to the conclusion that both before August 2018 and after October 2018 there were periods of time when Mr Johnston could have made arrangements for the continuing care of his patients. On this basis the Committee found these heads of charge proved.
	CPD
7.	*You failed to complete your required CPD hours in the cycle 1/01/2013 - 31/12/2017.* **Found proved** The Committee had sight of the printout from an officer of the GDC exhibiting Mr Johnston's CPD record for the period 2013 to 2017. It showed that Mr Johnston did not complete the required CPD hours. The Committee was satisfied that Mr Johnston had an obligation to complete a required number of CPD hours in order to maintain his GDC registration. Standard 7.3 states that *"Update and develop your professional knowledge and skills throughout your working life."*
	HEALTH
8.	*You suffer from one or more adverse health conditions in that:*
8.(a)	*[private information removed]*

	Found proved [PRIVATE]
8.(b)	*[private information removed]* **Found proved** [PRIVATE]
8.(c)	*[private information removed]* **Found proved** [PRIVATE]
8.(d)	*[private information removed]* **Found proved** [PRIVATE]
8.(e)	*[private information removed]* **Found proved** [PRIVATE]
8.(f)	*[private information removed]* **Found proved** [PRIVATE]
9.	*By letter dated 25 August 2019, you indicated that you did not consent to undergo a Health Assessment.* **Found proved** The Committee had sight of a copy of the consent form sent to Mr Johnston by the GDC and noted his written refusal to undergo a health assessment. The form was signed by Mr Johnston and dated 25 August 2019. The Committee was therefore satisfied that this allegation is proved.
	GDC INVESTIGATION
10.	*Between March 2018 and September 2019, you failed to co-operate with the GDC's investigation into your fitness to practise in that:*
10.(a)	*You failed to respond to an email dated 20 March 2018, requesting that you facilitate a GP report [Sender A];* **Found proved**
10.(b)	*You failed to respond to an email dated 19 April 2018, requesting that you facilitate a GP report [Sender A];* **Found proved**
10.(c)	*You failed to respond to an email and/or letter dated 17 July 2018, notifying you of concerns and requesting information [Sender B];*

	Found proved
10.(d)	*You failed to respond to an email and/or letter dated 23 July 2018, notifying you of allegations and inviting a response [Sender C];* **Found proved**
10.(e)	*You failed to respond to an email dated 30 July 2018, notifying you of a hearing [Sender D];* **Found proved**
10.(f)	*You failed to respond to an email dated 1 August 2018, requesting a response to letter of 17 July 2018 [Sender B];* **Found proved**
10.(g)	*You failed to respond to an email dated 20 August 2018, notifying you of a review [Sender E];* **Found proved**
10.(h)	*You failed to respond to an email dated 17 January 2019, notifying you of a review [Sender D];* **Found proved**
10.(i)	*You failed to respond to an email dated 8 April 2019, notifying you of referral to Case Examiners [Sender F].* **Found proved** The Committee considered separately heads of charge 10(a) to 10 (i) above and it made the same finding in respect of each head of charge. In reaching its decisions, the Committee had regard to Standard 9.4.1 of the GDC's Standards, which states: *"If you receive a letter from the GDC in connection with concerns about your fitness to practise, you must respond fully within the time specified in the letter. You should also seek advice from your indemnity provider or professional association."* The Committee was therefore satisfied that Mr Johnston had an obligation to respond to the above correspondence sent to him by the GDC. Whilst it took into account that Standard 9.4.1 refers to "a letter", it considered the purpose of the obligation and was satisfied that Mr Johnston was obliged to deal with any communication from his regulator in relation to his fitness to practise. In concluding that Mr Johnston failed to respond to the correspondence listed at 10(a) – 10(i) above, the Committee determined, on the balance of probabilities, that it was more likely than not that Mr Johnston received those letters and emails from the GDC. It noted that he was engaging with the Council during the early stages of his case, when correspondence was sent to those addresses, including his email address. Further, Mr Johnston replied to other correspondence sent by the GDC to those addresses. The Committee noted that the correspondence in each of the charges requested information from Mr Johnston by a specified date and there was no evidence that he had provided a response within the time specified. Taking all of this into account, the Committee was satisfied that Mr Johnston failed to co-operate with the GDC's

	investigation into his fitness to practise.
11.	*You have failed to maintain a correct and up-to-date registered address.* **Found proved** The Committee considered that it was Mr Johnston's professional obligation as a registered dentist to ensure that his regulator knew where he could be contacted. Further, in light of the fact that he was subject to an ongoing GDC investigation, the Committee considered that the general obligation under Standard 9.4 to *"give full and truthful information"*, was of particular importance. The Committee noted that Mr Johnston's registered address with the GDC has remained the same to date, despite there being evidence that he no longer uses that address and has not done so from about the end of July 2018. The Committee was therefore satisfied that there was a failure on Mr Johnston's part to maintain a correct and up-to-date registered address.
12.	(**Previously:** *From 19 June 2018 to 20 July 2018, you failed to have indemnity insurance.)* **Amended to:** *From **20** June 2018 to 20 July 2018, you failed to have indemnity insurance.* **Found proved (as amended by the Committee)** The Committee heard closing submissions from Ms Harris, as to whether '19 June 2018 to 20 July 2018' was the correct timeframe for this allegation, taking into account the documentary evidence received from Mr Johnston's indemnifiers, Dental Protection. The information received from Dental Protection appears to suggest that Mr Johnston had professional indemnity covering the period 20 December 2017 up to and including 19 June 2018. Therefore, it could be said that the period '20 June 2018 to 20 July 2018' was more accurate when considering any alleged failure on Mr Johnston's part to have indemnity insurance. Ms Harris drew the Committee's attention to its powers under Rule 18 of the *GDC (Fitness to Practise) Rules Order of Council 2006* ('the Rules'), which allows the Committee to amend the charge prior to any findings on the facts. She invited the Committee to amend this charge, taking into account the evidence. The Committee heard and accepted the advice of the Legal Adviser on this point. Having had regard to the letter from Dental Protection, dated 9 October 2019, the Committee was satisfied that in this head of charge, the date '19 June 2018' should be amended to '20 June 2018'. The Committee was satisfied that the amendment would cause no prejudice to Mr Johnston, given that it is based on a document addressed to him from Dental Protection and which was sent to him by the GDC as part of this case. The Committee next considered the allegation itself. In doing so, it had regard to the letter, dated 9 September 2019, from Denplan Professional Support Services to Mr Johnston. The letter set out that Mr Johnston had confirmed in a prior telephone conversation that he closed his dental practice on 20 July 2018. On balance, the Committee was satisfied that Mr Johnston had been holding himself out as a practising dentist up until 20 July 2018. It also took into account that he worked single-handedly at the practice and therefore would have been the only

	dentist available to provide treatment. In the circumstances, the Committee found that he should have had indemnity insurance which the evidence indicates, lapsed after 19 June 2018. It therefore found this allegation proved as amended.
13.	*On 28 February 2019, at Hasting Magistrates' Court, you were made subject of a non-molestation order in accordance with section 42 of the Family Law Act 1996.* **Found proved** The Committee noted that it did not receive a copy of the non-molestation order. However, it was provided with a copy of the Memorandum of Conviction in relation to the offence at head of charge 14, which refers to there having been such an order. The Committee was therefore satisfied this head of charge is proved.
14.	*On 13 March 2019, at Hastings Magistrates' Court, you were convicted of an offence of breaching the non-molestation order at 2 above, contrary to sections 42A(1) and (5) of the Family Law Act 1996.* **Found proved** Rule 57(5) of the Rules states as follows: *"Where a respondent has been convicted of a criminal offence—* *(a) a copy of the certificate of conviction, certified by a competent officer of a court in the* *United Kingdom (or, in Scotland, an extract conviction) shall be conclusive proof of the* *conviction; and* *(b) the findings of fact upon which the conviction is based shall be admissible as proof of* *those facts."* Having received a copy of the Memorandum of Conviction, the Committee was satisfied that this head of charge is proved.
15.	*On 15 March 2019, at Hastings Magistrates' Court, the following sentence was imposed upon you in respect of the offence at 3 above:*
15(a).	*Community Order of 12 months' duration with a [PRIVATE] Requirement (as set out at Schedule A) to be completed by 14 March 2020* **Found proved**
15(b).	*An order to pay £85 to victim services;* **Found proved**
15(c).	*An order to pay £40 towards prosecution costs.* **Found proved** The information set out at heads of charge 15(a) to 15(c) above are all matters

	of fact set out in the Memorandum of conviction.
16.	*You failed to inform the General Dental Council of your conviction.* **Found proved** The Committee had regard to the witness statement prepared by an officer of the GDC, which is dated 27 January 2020. The officer exhibits with her statement a copy of the GDC's 'Guidance on reporting criminal proceedings (Effective from 30 September 2013)' The Committee was satisfied from this evidence that Mr Johnston had a duty to inform the GDC of his conviction under Standard 9.3, which states *"Inform the GDC if you are subject to criminal proceedings or a regulatory finding is made against you anywhere in the world."* The evidence of the officer of the GDC, which the Committee accepted, is that there is no record of Mr Johnston having declared his conviction to the Council. Accordingly, this allegation is proved.

We move to Stage Two."

On 6 March 2020 the Chairman announced the determination as follows:

"Mr Johnston is neither present nor represented at this Professional Conduct Committee hearing of his case. Ms Rebecca Harris, Counsel, represents the General Dental Council (GDC).

The Committee's tasks at this stage of the hearing have been to consider whether the relevant facts found proved amount to misconduct and, if so, whether Mr Johnston's fitness to practise is currently impaired by reason of that misconduct. The Committee also considered whether Mr Johnston's fitness to practise is impaired by reason of his conviction and his adverse health. The Committee noted that if it found current impairment on one or more of these grounds, it would need to consider the issue of sanction.

In reaching its decisions, the Committee considered all the evidence presented to it. It took account of the submissions made by Ms Harris on behalf of the GDC. She submitted that misconduct was made out on the relevant facts of this case and that Mr Johnston's fitness to practise was currently impaired on all three grounds, misconduct, conviction and by reason of his health. The GDC acknowledged that matters are complicated by Mr Johnston's adverse health and that this fact may provide some mitigation. However, it was Ms Harris' primary submission that an order for erasure would be both proportionate and appropriate in this case.

The Committee accepted the advice of the Legal Adviser. It reminded itself that misconduct and current impairment are matters for its own independent judgement. There is no burden or standard of proof at this stage of the proceedings.

Summary of the facts found proved

At the material times, Mr Johnston was a registered General Dental Practitioner working single-handedly at a mixed (NHS and private) dental practice in Kent (the Practice). The Practice provided dental services as part of the Denplan scheme. The Committee made a number of findings in this case relating to Mr Johnston's professional and personal life.

In relation to Mr Johnston's clinical practice, the Committee found proved that in or around February 2018, he put patient safety at risk in that:

- his radiographic equipment had not been checked and re-certified since December 2017;
- he did not have the requisite checks in place to validate his decontamination process; and
- he provided dental treatment without adequate chairside support.

The Committee found that around the same time, Mr Johnston failed to maintain adequate standards of clinical practice in that he failed to ensure that his emergency medications were all present and/or in date. Further, Mr Johnston's matrix bands were not single-use.

It was further found that around that period, Mr Johnston did not fulfil his professional obligations in that he failed to maintain up-to-date written policies. He also failed to maintain adequate standards of contamination control.

Mr Johnston closed the Practice unexpectedly on 20 July 2018 and when he did so, he failed to make appropriate arrangements for the continuing care of his patients.

In addition to the clinical matters, the Committee found that there were failings on Mr Johnston part in respect of a number of other matters, namely his failure to:

- complete his required Continuing Professional development hours in the cycle 2013 to 2017;
- to co-operate with the GDC's investigation into his fitness to practise and to maintain a correct and up-to-date registered address;
- have indemnity insurance from 20 June 2018 to 20 July 2018.

Findings were also made in relation to the fact that Mr Johnston received a conviction on 15 March 2019 for breaching a non-molestation order dated 28 February 2019. Mr Johnston failed to inform the GDC of his conviction.

The Committee also made a number of findings in relation to Mr Johnston's adverse health.

Decision on misconduct

The Committee took into account that a finding of misconduct in the regulatory context requires a serious falling short of the professional standards expected of a registered dental professional. It therefore had regard to the standards that were applicable at the time of the events in this case, as set out in the GDC's publication '*Standards for the Dental Team (September 2013)'.* In particular, the Committee considered the following Standards:

1.4 Take a holistic and preventative approach to patient care which is appropriate to the individual patient.

1.5 Treat patients in a hygienic and safe environment.

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

1.8 Have appropriate arrangements in place for patients to seek compensation if they suffer harm.

1.9 Find out about laws and regulations that affect your work and follow them.

5.1 Make sure that there is an effective complaints procedure readily available for patients to use, and follow that procedure at all times.

6.2 Be appropriately supported when treating patients.

7.3 Update and develop your professional knowledge and skills throughout your working life.

9.1 Ensure that your conduct, both at work and in your personal life, justifies patients trust in you and the public's trust in the dental profession.

9.2 Protect patients and colleagues from risks posed by your health, conduct or performance.

9.3 Inform the GDC if you are subject to criminal proceedings or a regulatory finding is made against you anywhere in the world.

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

The Committee considered the facts found proved relevant to the issue of misconduct, namely its findings in relation to: the serious clinical matters in this case, Mr Johnston's unexpected closure of the Practice, his failure to comply with CPD requirements, his failure to co-operate with the GDC's investigation and to maintain a correct and up-to-date registered address, his failure have indemnity insurance over a specified period and his failure to inform the GDC of his conviction.

The Committee considered together Mr Johnston's shortcomings in a number of important clinical areas. It noted that these were all failings relating to basic rules of safety and hygiene at the Practice which, by their very nature, put patients at risk of harm. Among other things, Mr Johnston failed to check and re-certify his radiographic equipment in over a year, he did not have the required checks in place to validate his decontamination process, he provided dental treatment without adequate chairside support and he failed to ensure that all emergency medicines were present and/or in date. The Committee noted that in February 2018, Mr Johnston was offered support in addressing all the identified clinical issues at the Practice by Witness 1, a Dental Advisor at Simply Health (formerly Denplan), along with the assistance of a Denplan consultant. However, Mr Johnston did not take up this offer of support, despite being made aware of his duty to address the concerns in compliance with mandatory regulations. The evidence indicates that Mr Johnston continued to work at the Practice up until July 2018, without having taken any necessary action. In the Committee's view, Mr Johnston compounded the seriousness of the clinical concerns by continuing to offer dental services in an environment that was far from what was expected of a dental practice.

Accepting the evidence of Ms Firestone, the expert witness for the GDC, and in all the circumstances, the Committee was satisfied that the clinical matters found proved in this case represented a serious departure from the requisite Standards.

The Committee also took into account Mr Johnston's unexpected closure of the Practice. It's finding was that Mr Johnston's obligation in this regard was not onerous one. It accepted the evidence of Ms Firestone that a note on the door of the Practice might have been a sufficient and appropriate arrangement in the circumstances. However, Mr Johnston made no arrangements for the continuing care of his patients and therefore contrary to the Standards, he failed in his duty put their interests first.

The Committee also concluded that Mr Johnston's failure in relation to his CPD requirements, was a serious breach of the expected Standards. In its view, Mr Johnston had a professional obligation, as a registered dentist, to complete his CPD hours in the 2013 to 2017 cycle. In deciding that this was conduct that fell far below what was required, the Committee accepted the evidence of Ms Firestone and considered the risk Mr Johnston posed to patient safety by not keeping his professional knowledge and skills up to date.

The Committee next considered Mr Johnston's failure to co-operate with the GDC's investigation into his fitness to practise. The Committee found that he failed on several occasions to respond to correspondence from the GDC and it was in no doubt as to the seriousness of his behaviour in not dealing with the requests for information from his regulatory body. Mr Johnston also failed to keep the GDC informed of where he could be contacted. These omissions demonstrated a complete disregard by Mr Johnston for the rules governing his registration and for the role of the GDC as the regulator of his profession. The Committee was satisfied that Mr Johnston's conduct in this respect was a serious departure from the expected Standards.

It was also found proved that Mr Johnston failed to have indemnity cover from 20 June 2018 to 20 July 2018. The Committee noted that in the absence of indemnity cover, patients are unable to seek compensation should anything go wrong with their dental treatment. The Committee considered that Mr Johnston's conduct in not ensuring that he was appropriately indemnified over the period in question, has put his patients at a serious disadvantage. It therefore concluded that it was conduct that fell far below the requisite Standards.

Finally, in relation to the issue of misconduct, the Committee had regard to Mr Johnston's failure to inform the GDC of his conviction. It considered that Mr Johnston's failure to disclose his conviction seriously undermined the GDC's statutory functions in safeguarding the public and maintaining standards. Mr Johnston's omission again demonstrated his flagrant disregard for his regulatory body.

Having identified serious departures from the Standards in relation to all of the matters outlined above, the Committee determined that those findings amount to misconduct.

Impairment

The Committee went on to consider the issue of current impairment in relation to Mr Johnston's misconduct, his conviction and his health. In doing so, it exercised its own independent judgement. It had regard to the over-arching objective of the GDC, which involves: the protection, promotion and maintenance of the health, safety and well-being of the public; the promotion and maintenance of public confidence in the dental profession; and the promotion and maintenance of proper professional standards and conduct for the members of the dental profession.

Decision on impairment by reason of misconduct

The Committee was satisfied that at the time of the events that formed the basis of Mr Johnston's misconduct, his fitness to practise was impaired. It has found that Mr Johnston's misconduct included past behaviour that put patients at unwarranted risk of harm, as well as past behaviour that brought the dental profession into disrepute.

Whilst the Committee was of the view that Mr Johnston's misconduct is capable of being remedied, there is no evidence of any remediation before it. Mr Johnston has not engaged with the fitness to practice process in any meaningful way. The Committee took into account the evidence of his most recent communication with the GDC, as set out in a transcript of a

voicemail message left by him on 22 January 2020. In the voicemail message Mr Johnston stated that *"…I've retired and I'm not going back to dentistry so I don't have to go to any of this fitness to practise stuff…"* In the Committee's view, this comment made by Mr Johnston demonstrates an ongoing lack of insight into the seriousness of the concerns that have been raised. [PRIVATE]. However, in the absence of any relevant evidence from Mr Johnston, a more detailed assessment of his current attitude and understanding was not possible.

The Committee considered that Mr Johnston was given ample opportunity to engage effectively with the regulatory process, but he appears to have chosen not to do so. In the circumstances, given the absence of any evidence of remediation or insight, the Committee remained concerned about the risk of repetition and the risk of harm to patients. A finding of impairment is therefore necessary for the protection of the public.

The Committee also had regard to the wider public interest. It was of the view that a reasonable, well-informed member of the public would expect that Mr Johnston, as a registered professional would be held to account for his misconduct. He has demonstrated a disregard for the GDC, both by failing to engage with required training and by not engaging with these regulatory proceedings. The Committee therefore considered that a finding of impairment was also required to maintain public confidence in the profession and to declare and uphold proper standards.

In all the circumstances, the Committee determined that Mr Johnston's fitness to practise is impaired by reason of his misconduct.

Decision on impairment by reason of conviction

The Committee considered whether Mr Johnston's fitness to practice is also impaired by reason of his conviction in March 2019. In doing so, it had regard to the serious nature of the circumstances that led to the offence. In particular, the Committee noted that the non-molestation order was imposed on 28 February 2019 and the very next day, 1 March 2019, Mr Johnston breached the order which had been designed to protect the complainant from his unwanted contact. Between 1 March 2019 and 10 March 2019, Mr Johnston is said to have persistently intimidated, harassed and pestered the complainant in her own home. The complainant eventually reported the matter to the police. The Committee had sight of the witness statement relating to Mr Johnston's arrest and noted the distressing history of Mr Johnston's degrading, threatening and aggressive conduct towards the complainant.

It was the view of the Committee that Mr Johnston's conviction for breach of the non-molestation order demonstrated a flagrant disregard for the authority of the court. It also noted from the evidence relating to his arrest that he appeared to show no insight, at that time, into the seriousness of his wrongdoing. The Committee considered whether it had any evidence of Mr Johnston's current insight into his conviction, however, given his lack of engagement there is no such evidence before it.

The Committee considered the ongoing risk in relation to the issue regarding Mr Johnston's conviction and questioned whether there are any public protection concerns arising from the matter. In doing so, it had regard to the specific circumstances of Mr Johnston's offence, including his relationship to the complainant. Taking these factors into account, the Committee concluded that it had no evidence of a wider risk to the public arising out of Mr Johnston's conviction. It therefore decided that there are no public protection concerns in this regard.

However, the Committee was mindful of the wider public interest, in particular the need to maintain public confidence in the dental profession and to uphold standards. It considered that Mr Johnston's indifference to the authority of the court and defiance of a court order put in place for the protection of another person, represent serious attitudinal concerns. Mr Johnston demonstrated a pattern of anti-social behaviour which, in the Committee's view, was inconsistent with the standing of a registered dentist. Whilst the conviction did include a rehabilitation activity component, there is no evidence to indicate that Mr Johnston completed any programme of rehabilitation or that this has been sufficient remediation. The Committee therefore considered that public confidence in the dental profession would be undermined if a finding of impairment were not made in the circumstances. It also considered that such a finding is necessary to declare and uphold proper standards.

Accordingly, the Committee determined that Mr Johnston's fitness to practise is impaired by reason of his conviction.

Decision on impairment by reason of health

In considering whether Mr Johnston's fitness to practise is currently impaired by reason of his adverse health, the Committee had regard to the relevant evidence before it. [PRIVATE]. The Committee also took into account that Mr Johnston was subject to a conditions of practice order in respect of his health, following a hearing before the Health Committee in April 2008. The Committee noted that Mr Johnston engaged with the hearing process at that time.

[PRIVATE].

[PRIVATE].

[PRIVATE].

[PRIVATE].

[PRIVATE]. It therefore determined that his fitness to practise is impaired by reason of adverse health.

Decision on sanction

Having found Mr Johnston's fitness to practise to be impaired on all three grounds, the Committee considered what sanction, if any, to impose on his registration. It noted that the purpose of a sanction is not to be punitive, although it may have that effect, but to protect patients and the wider public interest. In reaching its decision, the Committee took into account the *'Guidance for the Practice Committees including Indicative Sanctions Guidance (effective from October 2016; revised in May 2019)* ('the Guidance'). It applied the principle of proportionality, balancing the public interest with Mr Johnston's interests.

In deciding on the appropriate sanction, the Committee considered whether there are any mitigating factors in this case, and it identified the following:

- [PRIVATE].
- [PRIVATE]. and
- that he engaged with the GDC, albeit for a short period, during the initial stages of its investigation.

The Committee also found that there were a number of aggravating features in this case, which are as follows:

- actual harm or risk of harm to a patient or other;
- misconduct that was repeated and sustained;
- a blatant or wilful disregard of the role of the GDC and the systems regulating the profession;
- a blatant disregard for the authority of the court;
- lack of any evidence of remediation;
- lack of any evidence of insight;
- previous fitness to practise history with adverse findings

Taking the above factors into account, the Committee considered the available sanctions in ascending order.

Having determined that there is an ongoing risk to the safety of patients from the matters in this case, the Committee decided that it would be wholly inappropriate to conclude this case without taking any further action. Taking no action would clearly be insufficient to protect the public and such a course would not satisfy the wider public interest, as it would not mark the seriousness of the Committee's findings.

In deciding whether to issue Mr Johnston with a reprimand, the Committee had regard to paragraph 7.9 of the Guidance and was satisfied that none of the relevant factors exist in this case. There are ongoing public protection concerns and there has been no evidence of insight or remediation from Mr Johnston. The Committee therefore concluded that a reprimand would not be an appropriate or proportionate outcome.

The Committee reached the same conclusion in respect of conditions, having had regard to the relevant part of the Guidance. It noted that conditional registration was considered appropriate by the Health Committee in April 2008, when the sole matters under consideration related to Mr Johnston's health. However, the concerns highlighted in this current case are more widespread and cover areas of Mr Johnston's life outside his clinical practice. The matters found proved in respect of his conviction are serious and the Committee considered that conditional registration would not be proportionate or appropriate in the circumstances. The Committee also took into account Mr Johnston's lack of engagement with the regulatory process.

The Committee carefully considered whether the suspension of Mr Johnston's registration would be an appropriate and proportionate outcome in all the circumstances. [PRIVATE] , it considered that, notwithstanding the health matters, there is evidence that Mr Johnston has a deep-seated attitudinal problem. In reaching this conclusion, the Committee took into account Mr Johnston's lack of engagement with the GDC, which included his disregard for its rules and standards. It also had regard to the circumstances relating to his conviction, which demonstrates an apparent indifference to authority and a persistent campaign of intimidation and harassment of a vulnerable individual, despite a court order. [PRIVATE].

There has been no evidence of insight or remediation in this case, even though Mr Johnston has been given a number of opportunities to provide such evidence. The only information the Committee has received in respect of his current mindset are his comments as contained in the transcript of the voicemail of 22 January 2020. There was also the indication that Mr Johnston wished to apply for Voluntary Removal from the Dentists Register, which he set out in a handwritten note on the consent form he returned to the GDC in which he refused to

undergo a health assessment in August 2019. Taking all of these matters into account, the Committee concluded that the suspension of Mr Johnston's registration would neither be appropriate nor proportionate given its grave concerns about his attitude. Whilst the Committee took into account that a period of suspension would afford the public protection, it was not satisfied that it was a sufficient sanction to address the wider public interest. The Committee considered that the suspension of Mr Johnston's registration would serve no meaningful purpose, given his outlook.

The Committee considered that Mr Johnston's behaviour showed deep-seated professional attitudinal problems. It also had regard to the seriousness of the conviction in deciding that suspension was not an appropriate outcome. The Committee considered paragraph 7.34 of the Guidance which deals with erasure. This paragraph states:

"Erasure will be appropriate when the behaviour is fundamentally incompatible with being a dental professional: any of the following factors, or a combination of them, may point to such a conclusion:

- *serious departure(s) from the relevant professional standards;*
- *where serious harm to patients or other persons has occurred, either deliberately or through incompetence;*
- *where a continuing risk of serious harm to patients or other persons is identified;*
- *…*
- *…*
- *…*
- *a persistent lack of insight into the seriousness of actions or their consequences."*

It was the view of the Committee, taking into account the above factors, that Mr Johnston's behaviour, as demonstrated in this case, is fundamentally incompatible with being a dental professional.

In all the circumstances, the Committee has determined to erase Mr Johnston's name from the Dentists Register.

The Committee now invites submissions from Ms Harris as to whether an immediate order should be imposed on Mr Johnston's registration, pending the taking effect of its determination for erasure.

In reaching its decision on whether to impose an immediate order on Mr Johnston's registration, the Committee took account of Ms Harris' submissions that such an order should be imposed. It accepted the advice of the Legal Adviser.

The Committee has determined that it is necessary for the protection of the public, is otherwise in the public interest and is in Mr Johnston's own interests, to impose an order for the immediate suspension of Mr Johnston's registration. The Committee has identified an ongoing risk to the safety of patients should Mr Johnston continue to practice without any restriction. It considered that it would be inconsistent with its substantive determination, if an order were not imposed in these circumstances. The Committee noted its substantive direction for erasure would not come into effect until after the 28-day appeal period or

potentially longer, if Mr Johnston lodges an appeal. An immediate order is therefore necessary to ensure the public is protected. The Committee also considered an immediate order to be in the wider public interest. It has made serious findings in Mr Johnston's case, including matters relating to a serious conviction. The Committee has also concluded that Mr Johnston has a deep-seated attitudinal problem which is incompatible with continued registration as a dentist. Accordingly, the Committee concluded that the imposition of an immediate order would serve to maintain public confidence in the dental profession and the regulatory process.

In light of the findings it has made in relation to Mr Johnston's health, the Committee considered that an order suspending his registration immediately is in his own interests.

The effect of the foregoing determination and this order is that Mr Johnston's registration will be suspended from the date on which notice is deemed to have been served upon him. Unless Mr Johnston exercises his right of appeal, the substantive direction for erasure, as already announced, will take effect 28 days from the date of deemed service.

The interim order currently in place on Mr Johnston's registration is hereby revoked.

That concludes this hearing."