General Dental Council

HEARING HEARD IN PUBLIC

AZIMOVA, Kamila

Registration No: 261465

PROFESSIONAL CONDUCT COMMITTEE

JANUARY 2020

Outcome: Conditions for 12 months with immediate conditions (with a review)

Kamila AZIMOVA, a dentist, Registered under s15(1)(ba) of the Dentist Act 1984 2015, D Stom Belarusian State Medical University 2010, was summoned to appear before the Professional Conduct Committee on 20 January 2020 for an inquiry into the following charge:

Charge (as amended on 21 and 22 January 2020)

"That being a dentist registered under the Dentists Act 1984 under registration number 261465:

Patient A

1. On or around 29 March 2018 you failed to provide an adequate standard of care to Patient A in that you:
    a. Did not take any, or any adequate, history of the complaint; and/or
    b. Did not carry out adequate investigations into the complaint; and/or
    c. Diagnosed root canal treatment at UR3 and/or UR4 without adequate information to support this diagnosis.
2. On or around 29 March 2018 you failed to maintain an adequate standard of record keeping in respect of Patient A in that you:
    a. Did not record any, or any adequate, history of the complaint; and/or
    b. Did not record any questions asked to aid diagnosis; and/or
    c. Did not record, adequately or at all, the diagnostic tests undertaken.
3. On or around 29 March 2018 you failed to maintain an adequate standard of record keeping in relation to radiographs in respect of Patient A in that you did not:
    a. Record the justification for the radiograph taken; and/or
    b. Grade the radiograph taken; and/or
    c. Adequately, or at all, report on the radiograph taken.

Patient B

4. On or around 23 December 2017 you failed to provide an adequate standard of care to Patient B in that you:
    a. Prescribed antibiotics without any, or any adequate, justification; and/or
    b. WITHDRAWN

5. You failed to maintain an adequate standard of record keeping in respect of Patient B in that you:

    a. On or around 23 December 2017 did not record, adequately or at all, the history of the complaint; and/or

    b. On or around 23 December 2017 did not record any advice provided in relation to the risk of delayed healing caused by smoking; and/or

    c. On or around 23 December 2017 used pre entered text; and/or

    d. On or around 14 January 2018 made an entry into the electronic record retrospectively.

6. On or around 23 December 2017 you failed to maintain an adequate standard of record keeping in relation to radiographs in respect of Patient B in that you did not report adequately on the radiograph taken.

Patient C

7. **Amended to:** On or around 11 December 2017 you failed to provide an adequate standard of care to Patient C in that you did not carry out a basic periodontal examination.

8. **Amended to:** On or around 11 December 2017 you failed to maintain an adequate standard of record keeping in respect of Patient C in that you:

    a. did not record any detail of the care provided;

    b. did not make a record of the basic periodontal examination.

Patient D

9. On or around 5 January 2018 you failed to provide an adequate standard of care to Patient D in that you used Alveogyl as a post extraction dressing when it was inappropriate to do so.

10. **Amended to:** On or around the 5 January 2018 you failed to maintain an adequate standard of record keeping in respect of Patient D in that you did not make any clinical notes.

Patient E

11. On or around 5 January 2018 you failed to maintain an adequate standard of record keeping in respect of Patient E in that you did not make any clinical notes.

Patient F

12. On or around 10 January 2018 you failed to provide an adequate standard of care to Patient F in that you:

    a. Prescribed antibiotics without any, or any adequate, justification; and/or

    b. Failed to make any, or any adequate, enquiries as to the treatment Patient F was receiving from another dentist; and/or

    c. WITHDRAWN

    d. Used Alveogyl as a post extraction dressing when it was inappropriate to do so.

13. On or around 10 January 2018 you failed to maintain an adequate standard of record keeping in respect of Patient F in that you:

    a. Did not make any, or any adequate, record of your examination of Patient F; and/or

    b. Did not make any, or any adequate, record of any enquiries as to the treatment Patient F was receiving from another dentist; and/or

    c. Did not make any adequate record of any enquiries into Patient F's medical history; and/or

    d. Used pre entered text.

14. On or around 10 January 2018 you failed to maintain an adequate standard of record keeping in relation to radiographs in respect of Patient F in that you:

    a. Incorrectly recorded that an OPG rather than a periapical radiograph had been taken; and/or

    b. Did not record, adequately or at all, the justification for the radiograph taken; and/or

    c. Did not, adequately, or at all, report on the radiograph taken.

Patient G

15. On or around 11 December 2017 you failed to provide an adequate standard of care to Patient G in that you prescribed antibiotics without any, or any adequate, justification.

16. On or around 11 December 2017 you failed to maintain an adequate standard of record keeping in respect of Patient G in that you did not record adequate information about the presenting complaint.

17. On or around 11 December 2017 you failed to maintain an adequate standard of record keeping in relation to radiographs in respect of Patient G in that you did not:

    a. Record the justification for the radiograph taken; and/or

    b. Grade the radiograph taken; and/or

    c. Adequately, or at all, report on the radiograph taken.

Patient H

18. On or around 2 December 2017 you failed to provide an adequate standard of care to Patient H in that you:

    a. Did not carry out a basic periodontal examination; and/or

    b. You prescribed antibiotics without any, or any adequate, justification.

19. You failed to maintain an adequate standard of record keeping in respect of Patient H in that you:

    a. On or around 2 December 2017 did not record adequate detail in the clinical notes; and/or

    b. On or around 2 December 2017 used pre entered text; and/or

c. On or around 14 January 2018 made an entry into the electronic record retrospectively.

20. On or around 2 December 2017 you failed to maintain an adequate standard of record keeping in relation to radiographs in respect of Patient H in that you did not:

    a. Record the justification for the radiograph taken; and/or

    b. Grade the radiograph taken; and/or

    c. Report on the radiograph taken.

Patient I

21. Between around 12 February and 26 February 2018 you failed to provide an adequate standard of care to Patient I in that you:

    a. WITHDRAWN

    b. WITHDRAWN

22. On or around 12 February 2018 you failed to maintain and adequate standard of record keeping in respect of Patient I in that you:

    a. Did not record any, or any adequate, history of the complaint; and/or

    b. Did not record any discussion of the aesthetic treatment provided; and/or

    c. Duplicated sections of the records.

23. On or around the 12 February 2018 you failed to maintain an adequate standard of record keeping in relation to radiographs in respect of Patient I in that you did not:

    a. Record the justification for the radiograph taken; and/or

    b. Grade the radiograph taken; and/or

    c. Report on the radiograph taken.

Patient J

24. On or around 22 January 2018 you failed to provide an adequate standard of care to Patient J in that you:

    a. You prescribed amoxicillin to a patient with an allergy to penicillin; and/or

    b. You prescribed antibiotics without any, or any adequate, justification; and/or

    c. Used Alveogyl as a post extraction dressing when it was inappropriate to do so.

25. On or around 22 January 2018 you failed to maintain an adequate standard of record keeping in respect of Patient J in that you:

    a. Did not make an adequate record of the history of the presenting complaint; and/or

    b. WITHDRAWN

    c. Used pre entered text.

26. **Amended to:** On or around the 22 January 2018 you failed to maintain an adequate standard of record keeping in relation to radiographs in respect of Patient J in that you did not:

a. Record the justification for the radiograph taken; and/or

b. Grade the radiograph taken; and/or

c. Report on the radiograph taken.

Patient K

27. On or around 30 November 2017 you failed to provide an adequate standard of care to Patient K in that:

a. You prescribed antibiotics without any, or any adequate, justification; and/or

b. **Amended to:** You took a radiograph without any, or any adequate, justification; and/or

c. WITHDRAWN.

28. You failed to maintain an adequate standard of record keeping in respect of Patient K in that you:

a. On or around 30 November 2017 recorded inadequate detail of the extraction; and/or

b. On or around 30 November 2017 used pre entered text; and/or

c. On or around 14 January 2018 made an entry into the electronic record retrospectively.

29. On or around 30 November 2017 you failed to maintain an adequate standard of record keeping in relation to radiographs in respect of Patient K in that you did not:

a. Record the justification for two of the radiographs taken; and/or

b. Grade two of the radiographs taken; and/or

c. Report on two of the radiographs taken.

Patient L

30. On or around 7 January 2018 you failed to maintain an adequate standard of record keeping in respect of Patient L in that you made a retrospective entry in the records without making it clear that it related to an appointment on 6 January 2018.

Patient M

31. On or around the 15 February 2018 you failed to maintain an adequate standard of record keeping in respect of Patient M in that you did not make any clinical notes.

Patient N

32. On or around 20 February 2018 you failed to provide an adequate standard of care to Patient N in that you:

a. WITHDRAWN

b. WITHDRAWN

c. WITHDRAWN

33. On or around 20 February 2018 you failed to maintain an adequate standard of record keeping in respect of Patient N in that you:

a. Failed to record, adequately or at all, the history of the complaint; and/or

b. Failed to record, adequately or at all, any discussion of the treatment proposed; and/or

c. Failed to record, adequately or at all, an updated medical history.

34. On or around the 20 February 2018 you failed to maintain an adequate standard of record keeping in relation to radiographs in respect of Patient N in that you did not:

a. Record the justification for the radiograph taken; and/or

b. Grade the radiograph taken; and/or

c. Report on the radiograph taken.

Patient O

35. On or around 30 November 2017 you failed to provide an adequate standard of care to Patient O in that you:

a. Prescribed antibiotics without any, or any adequate justification; and/or

b. Used Alveogyl as a post extraction dressing when it was inappropriate to do so; and/or

c. **Amended to:** You took a radiograph without any, or any adequate, justification.

36. You failed to maintain an adequate standard of record keeping in respect of Patient O in that you:

a. On or around 30 November 2017 did not record, adequately or at all, a history of the complaint; and/or

b. On or around 30 November 2017 did not record, adequately or at all, what post operative advice was provided; and/or

c. On or around 30 November 2017 did not record that antibiotics had been prescribed;

d. Made the entry into the electronic record retrospectively on 9 January 2018.

As a result of the matters set out above your fitness to practise is impaired by reason of your misconduct and/or deficient professional performance."

On 27 January 2020 the Chairman made the following statement regarding the finding of facts:

"Ms Azimova,

This is the Professional Conduct Committee's inquiry into the facts which form the basis of the allegation against you that your fitness to practise is impaired by reason of misconduct and/or deficient professional performance. You attended the hearing and you were represented by Mr Richard Partridge of Counsel. Mr Matthew Corrie of Counsel presented the General Dental Council's (GDC) case.

Preliminary Matters

Admissions

At the start of the hearing, Mr Partridge on your behalf, made admissions to the following charges: 2(a) – (c), 3(a) – (c), 4(a), 5(a) – (c), 6, 12(a), 13(a) – (d), 14(a) – (c), 15, 16, 17(a) – (c), 18(b), 19(a) & (b), 20(a) – (c), 22(b) & (c), 23(a) – (c), 24(a) & (b), 25(a) – (c), 26(a) – (c), 27(a), 28(a) & (b), 29(a) – (c), 33(a) – (c), 34(a) – (c), 35(a), and 36(a) – (c). The Committee decided to defer making a finding on your admissions until all the evidence had been adduced.

Application to Amend the Charge:

Mr Corrie made an application under Rule 18 of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules") to amend the charge. He submitted that there was an error in the dates mentioned in charges 10 and 26. The date in charge 10 should be '5 January 2018' and not '1 June 2017', and the date in charge 26 should be '22 January 2018' and not '12 February 2018'. The amendments were accepted by Mr Partridge on your behalf.

During the course of the hearing Mr Corrie made a further application to amend the charge by way of further amendments and withdrawals. He applied to withdraw the following charges:

- Charge 4(b) and 27(c) – on the basis that both expert witnesses are of the opinion that the post-operative instructions held at the practice contain sufficient information on smoking and its effects on healing. There is a record within the dental notes that these post-operative instructions were given to Patient B. Mr Corrie submitted that the Council is of the view that in light of the opinion of the experts, it would not be able to prove that you did not provide advice in relation to delay in healing caused by smoking.
- Charge 12(c) – on the basis that you gave a positive account in your witness statement in respect of the record which was made for Patient F. Mr Corrie submitted that the Council does not consider that it will be able to rebut your account merely on the basis of an absence of the record.
- Charges 21(a) & (b) – on the basis that you gave a positive account in your witness statement in respect of the record which was made for Patient I. Mr Corrie submitted that both expert witnesses agreed that the entry made in the dental records indicate that the patient had been advised to have 6 monthly check-ups which is acceptable. He submitted that the same applied for the tooth whitening process. The Council does not consider that a mere absence of the record is sufficient to prove the charge.
- Charge 25(b) – on the basis that there is no evidence in Mr Morris' report that supports the allegation that a basic periodontal examination (BPE) was required.
- Charges 32(a), (b), (c) – on the basis that you gave a positive account in your witness statement in respect of the record which was made for Patient N. Mr Corrie submitted that the Council is of the view that it cannot rebut the account given based on absence of a record alone.

Mr Corrie applied to amend the following charges:

- Charges 7 & 8 – the date should be amended from '19 January 2018' to '11 December 2017' on the basis that the appointment history shows that the relevant appointment was on '11 December 2017'.

- Charge 27(b) – 'You took two radiographs without any, or any adequate, justification; and/or' should be amended to read 'You took a radiograph without any, or any adequate, justification; and/or' on the basis that the joint expert report is not critical in relation to two of the three radiographs taken of this patient on or around 30 November 2017. Mr Corrie submitted that it is necessary to amend the charge to reflect the expert evidence.
- Charge 35(c) – 'You took two radiographs without any, or any adequate, justification' should be amended to read 'You took a radiograph without any, or any adequate, justification' on the basis that the Council's expert witness is of the view that of the three radiographs taken, there may be a reasonable body of dentists who would take a second radiograph in the case of Patient O but not a third.

Mr Partridge did not object to the proposed amendments and withdrawals.

During the course of the hearing Mr Partridge made further admissions: 5(d), 19(c), 22(a), 28(c), 30 and 36(d).

The Committee accepted the advice of the Legal Adviser on the Rule 18 applications. It was of the view that the amendments could be made without injustice to you. It therefore granted the applications.

Background

The case relates to the care you had provided to 15 patients at a dental practice in London where you worked between November 2017 and April/May 2018. You were working as a self-employed emergency dentist at the practice between November 2017 and May 2018.

At a meeting with you on 19 January 2018, the Practice raised concerns about your record keeping and documented these concerns in a letter to you dated 23 January 2018. On 9 March 2018, you were issued with a final written warning by the Practice following further concerns that you had continued not to make clinical records for the patients you had seen.

Following a negative review that had been posted on Google by Patient A regarding the treatment they had received from you on 29 March 2018, the Practice reviewed Patient A's records and could find no evidence that you had undertaken supportive tests before advising the patient that root canal treatment was required. As a result of this, you were dismissed from your post. Furthermore, the Practice referred you to the GDC in April 2018 and provided a set of records of 15 patients to evidence their concerns.

Evidence Received and Assessment of Oral Evidence

By way of factual evidence, the Committee was provided with a signed witness statement of Patient J dated 30 August 2019, a signed witness statement of Witness 1 dated 6 September 2019, a signed witness statement dated 11 September 2019 and a signed supplementary witness statement dated 21 January 2020 from Witness 2, a signed witness statement of Witness 3 dated 21 January 2020, a signed witness statement of Witness 4 dated 12 September 2019 and a signed witness statement dated 21 January 2020 from Witness 5. It was also provided with the patient records for the all the 15 patients in this case.

Witness 1

Witness 1 was the Practice Manager at the Practice at the time of these events. Witness 1 gave oral evidence in this hearing. The Committee found him credible in terms of his

administrative role at the practice. His evidence on the clinical aspects of the practice was not helpful to the Committee. He was emphatic that entering clinical records on the practice record keeping system was simple and easy but he also told the Committee that he did not know how to enter clinical records in the system, and that training in the use of the system had not been part of the induction process for new associates.

Witness 2

Witness 2 is a Practice Manager who took over from Witness 1. Witness 2 gave oral evidence in this hearing. The Committee found her evidence limited as she appeared to be concentrating on the administrative concerns. It found her credible in this regard. However the Committee was not content with her evidence about the investigations conducted prior to issuing a final written warning.

Witness 3

Witness 3 is an Assistant Manager at the Practice where you worked. She has been in this role for approximately one year and prior to this she was a receptionist at another practice in the same group of practices. The Committee found her evidence helpful. She gave clear concise information based on her knowledge. She was clear about how the record keeping system worked for the input of clinical notes. She said that she had trained dentists at the other practice on the use of the record keeping system.

Witness 4

Witness 4 is a Dentist and has been the Principal Dentist at the practice where you worked for approximately 18 years. The Committee's view is that as the Principal Dentist he had an interest in portraying a picture of a well-run practice. His evidence was that the record keeping system was simple to use but contradicted this when he subsequently told the Committee that on occasion he would 'get stuck' and would request the assistance of his nurse. Further he told the Committee that although there was a shift from the use of paper records to electronic records, paper records were still used after the transition period.

Witness 5

Witness 5 was a Practice Manager between April 2017 and April 2018 at the Practice where you worked. The Committee noted the contribution of Witness 5 and gave it due consideration. Witness 5 did not assist the Committee greatly on the issues under consideration.

Expert Witnesses

By way of expert evidence, the Committee received a signed expert report dated 5 September 2019 from Mr Michael Morris, a signed expert report dated 16 January 2020 from Mr Simon Nery, a signed joint expert report dated 22 January 2020. The Committee heard oral evidence from Mr Morris. The Committee's view is that Mr Morris is clearly an experienced dentist who did his best to assist the Committee. He was fair in his approach to the issues under consideration and made appropriate concessions where he felt necessary.

Your Oral Evidence

As part of your defence, the Committee received your witness statement, dated 16 January 2020, and it heard oral evidence from you. The Committee noted that you were unable to recall a lot of the appointments and you relied heavily on your usual practice. It noted that you demonstrated reflection on the issues, and you tried to give your best evidence. When

you could not remember you were forthcoming that you could not remember, and you did not make up answers. You made further admissions when questioned in cross-examination. The Committee found you to be a generally credible witness.

The Committee's Findings of Fact

Record Keeping

The Committee heard evidence that the Clinic used Dentsys to create and store clinical records. You accepted that it was your responsibility to ensure that both the clinical notes were made and also that they were saved and available for future reference. Having heard the evidence, the Committee concluded that the absence of notes was user error rather than system error. It noted that the absence of notes was raised with you and on one or more occasions you were able to make entries and save them appropriately. You came from a background where clinical record keeping was done differently from the standards in the UK.

The Committee has taken into account all the evidence presented to it, both oral and documentary. It has considered the submissions made by Mr Corrie on behalf of the GDC and those made by Mr Partridge on your behalf. The Committee heard and accepted the advice of the Legal Adviser. In accordance with that advice it has considered each head of charge separately, bearing in mind that the burden of proof rests with the GDC and that the standard of proof is the civil standard, that is, whether the alleged matters are found proved on the balance of probabilities.

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

	Patient A
1.	On or around 29 March 2018 you failed to provide an adequate standard of care to Patient A in that you:
1.(a)	Did not take any, or any adequate, history of the complaint; and/or **Not admitted and found not proved** In your statement you said "I believe that I did take an adequate history of Patient A's complaint. I would have undertaken my usual practice when taking a history which would have included asking details of the nature, intensity and location of the patient's pain, how long it had lasted, whether it came and went, and whether there were any aggravating factors such as hot and cold." In your oral evidence you told the Committee that you positively recall this patient because this is the patient who left a negative review on Google about their appointment with you. However, the Committee noted that you did not mention in your statement that this is the patient who left the negative review. Further your statement talks about your usual practice rather than a positive recollection of this patient. The Committee notes the undisputed evidence that you did not regularly record everything you did on several appointments for the patients in this case. The Committee could not, on the available evidence, be satisfied whether or not you took an adequate history of the patient's complaint. It notes that this is not a record keeping charge so it could not make a finding on the basis of the records alone. The Committee concluded that the GDC

	has not discharged its burden of proving, in these circumstances, given the undisputed evidence, that you did not take any or any adequate history of the complaint.
1.(b)	Did not carry out adequate investigations into the complaint; and/or **Not admitted and found not proved** The Committee notes the undisputed evidence that you did not regularly record everything you did on several appointments for the patients in this case. The Committee could not, on the available evidence, be satisfied whether or not you carried out adequate investigations into the complaint. It notes that this is not a record keeping charge so it could not make a finding on the basis of the records. The Committee concluded that the GDC has not discharged its burden of proving, in these circumstances, given the undisputed evidence, that you did not carry out adequate investigations into the complaint.
1.(c)	Diagnosed root canal treatment at UR3 and/or UR4 without adequate information to support this diagnosis. **Not admitted and found not proved** Your evidence is that you made a provisional diagnosis of possible apical pathology at UR3 and UR4 and that you advised patient A that he would need to see a specialist for further assessment as to whether these teeth required root canal treatment. Mr Morris' opinion is that the clinical record of 29/03/18 is quite clear that you diagnosed UR3 and UR4 needed root canal treatment. Mr Nery's opinion is that it is unclear whether or not you intended to start root canal treatment without seeking an endodontist opinion first regarding the diagnosis. Both experts in their joint report are of the opinion that if the Committee find that you undertook all the examination and investigations outlined by Mr Morris, a reasonable body of GDPs might have diagnosed root canal treatment being required for UR3 or UR4. However both experts think it is highly unlikely that both UR3 and UR4 would have required root canal treatment at the same time as neither had significant restorations or history of trauma. The Committee does not accept your evidence that you made a provisional diagnosis. It is of the view that you made a diagnosis of root canal treatment for UR3 and UR4. This is supported by your entry in the treatment plan which stated "Option:RCT stage 1. To see specialist. Prices given" No other option is listed in the entry you made. However, given that 1(a) and 1(b) were found not proved, the Committee could not conclude that you did not have adequate information to support your diagnosis.
2.	On or around 29 March 2018 you failed to maintain an adequate standard of record keeping in respect of Patient A in that you:

2.(a)	Did not record any, or any adequate, history of the complaint; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
2.(b)	Did not record any questions asked to aid diagnosis; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
2.(c)	Did not record, adequately or at all, the diagnostic tests undertaken. **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
3.	On or around 29 March 2018 you failed to maintain an adequate standard of record keeping in relation to radiographs in respect of Patient A in that you did not:
3.(a)	Record the justification for the radiograph taken; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
3.(b)	Grade the radiograph taken; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
3.(c)	Adequately, or at all, report on the radiograph taken. **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
	Patient B
4.	On or around 23 December 2017 you failed to provide an adequate standard of care to Patient B in that you:
4.(a)	Prescribed antibiotics without any, or any adequate, justification; and/or **Admitted and found proved**

	On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
4.(b)	WITHDRAWN
5.	You failed to maintain an adequate standard of record keeping in respect of Patient B in that you:
5.(a)	On or around 23 December 2017 did not record, adequately or at all, the history of the complaint; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
5.(b)	On or around 23 December 2017 did not record any advice provided in relation to the risk of delayed healing caused by smoking; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
5.(c)	On or around 23 December 2017 used pre entered text; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
5.(d)	On or around 14 January 2018 made an entry into the electronic record retrospectively. **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
6.	On or around 23 December 2017 you failed to maintain an adequate standard of record keeping in relation to radiographs in respect of Patient B in that you did not report adequately on the radiograph taken. **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
	Patient C
7.	**Amended to:** On or around 11 December 2017 you failed to provide an adequate standard of care to Patient C in that you did not carry out a basic

	periodontal examination. **Not admitted and found not proved** In your statement you said "I would have completed a BPE examination for all patients presenting with a hygiene appointment. I accept that it is not recorded on the disclosed record. I may have recorded this within the paper records or on the computer system but saved in a separate file. I note that the record is from a different software system and I therefore wonder whether the record may not have been transferred from the system on which it was recorded." Mr Nery's opinion is that a BPE was not mandated and that alternative forms of periodontal assessment could have been undertaken by a reasonable body of GDPs. Mr Morris' opinion is that a BPE was the minimum required according to FGDP guidelines: the starting point for all periodontal examinations should be a screening or BPE. He notes that you stated that a BPE was taken for all patients presenting with a hygiene appointment. The Committee considered whether there was a requirement to do a BPE at this appointment. It noted that both experts are in agreement that an assessment of some sort should have been done. Your evidence is that you carry out a BPE assessment for all patients which is not recorded in the electronic records. There are no paper records before the Committee for this patient. There are no contemporaneous records. There is a treatment plan. In your oral evidence you said that this patient was booked for a hygiene appointment with a dental hygienist which was cancelled but not before the patient arrived. You said you were asked to see the patient and provide information. The Committee accepted your oral evidence that you were merely providing information to this patient. The Committee considered that there are too many inconsistencies in the available evidence. For example, the record of the appointment history contains 'patient cancelled', there is a signed treatment plan and the clinical notes were made retrospectively about 5 weeks later. The Committee concluded that the GDC had not discharged its burden of proving this charge to the requisite standard.
8.	**Amended to:** On or around 11 December 2017 you failed to maintain an adequate standard of record keeping in respect of Patient C in that you:
8.(a)	did not record any detail of the care provided; **Not admitted and found not proved** In their joint report the experts state "[We] note that the appointment history shows the appointment of 11/12/17 was cancelled. However, we also note the treatment plan dated 11/12/17 which specifies hygiene and medication. The appointment history does not list 19/01/18 where there is an entry in the records. [We] note that the appointment on the 19/01/18 refers to the treatment plan of 11/12/17, and that the patient was booked for hygiene. However, there are no details of the hygiene treatment provided or any

	associated care and advice." The Committee noted that you checked the medical history and made a record about allergies and options for treatment. It found that, given that the charge alleges you did not record any detail, you did record some information.
8.(b)	did not make a record of the basic periodontal examination. **Not admitted and found not proved** Having found charge 7 not proved, this charge falls.
	Patient D
9.	On or around 5 January 2018 you failed to provide an adequate standard of care to Patient D in that you used Alveogyl as a post extraction dressing when it was inappropriate to do so. **Not admitted but found proved** In your statement you said "I note the prescription for Alveogyl and I would have used this as a post extraction dressing because the extraction was difficult and complicated. I do not routinely use Alveogyl and only do so when appropriate." Mr Morris' in his oral evidence told the Committee that this should not have been a difficult extraction. Both experts in their joint report stated "…no radiographs were taken and no comments made as to the difficulty of the extraction. [Both experts] agree that Alveogyl is indicated for the following reasons: 1. dry socket 2. in patients with a history of dry socket 3. a reasonable body of GDPs would support using it after a difficult or traumatic extraction it is NOT indicated as a routine post extraction dressing." The Committee noted that there is no record of this treatment in the dental notes and no radiographs were taken. There is no indication in the available information as to whether this patient had pain or what was going on with this tooth. There is some entry on the treatment plan about 'under gum wisdom tooth'. The Committee noted from the treatment plan that there is no charge for a radiograph. It drew an inference that a radiograph was not taken. The Committee was of the view that it was illogical for you to carry out what you considered to be a difficult extraction without taking a radiograph. In the absence of any evidence to show the difficulty of the extraction, the Committee found on the balance of probabilities that this was likely not a difficult extraction and as such the use of Alveogyl on this patient was not appropriate.
10.	**Amended to:** On or around the 5 January 2018 you failed to maintain an adequate standard of record keeping in respect of Patient D in that you did

	not make any clinical notes. **Not admitted but found proved** You accepted in your oral evidence that this appointment took place. You accepted that there are no records available for this patient. You said that you could not recall if you made a handwritten record or an electronic record however your usual practice is to write your notes after the patients leave. You said that you would have made clinical notes for this patient and it was possible that you did not save the notes correctly as you found it difficult to use the record keeping system at that practice. Both experts in their joint report stated "there are no clinical notes for this single appointment". Furthermore the Committee concluded that ensuring that clinical entries are saved is a fundamental aspect of record keeping. The Committee accepted the opinion of the experts. It found that you failed to maintain an adequate standard of record keeping for this patient in that you did not make any clinical notes.
	Patient E
11.	On or around 5 January 2018 you failed to maintain an adequate standard of record keeping in respect of Patient E in that you did not make any clinical notes. **Not admitted but found proved** In your statement you said "I did record clinical notes for all my of patients, and I cannot understand why this has not been disclosed. I believe this may be one of those patients where I have made a paper note similar to the paper note I have made for the treatment plan estimate and I do not understand why those notes are not present…I believe I did make a clinical note for Patient E as I would for all my patients." Both experts in their joint report stated "the appointment history shows Patient E saw [you] on 05/01/2018. There is a handwritten treatment plan dated 05/01/18 and undated handwritten notes about a cracked tooth on the upper left side". The Committee noted that both of these documents were unsigned and undated. The handwritten notes could not be assigned to anybody. The Committee notes the comments of the joint experts. It has itself reviewed the relevant documentation and concludes that there are not any clinical records in respect of this appointment.
	Patient F
12.	On or around 10 January 2018 you failed to provide an adequate standard of care to Patient F in that you:
12.(a)	Prescribed antibiotics without any, or any adequate, justification; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel

	and having reviewed the evidence, the Committee accepts that the admission was properly made.
12.(b)	Failed to make any, or any adequate, enquiries as to the treatment Patient F was receiving from another dentist; and/or **Not admitted and found not proved** In your statement you said "My note was not meant to mean that she was receiving a specific course of treatment from her dentist." Mr Morris' opinion is that the note referred to the patient having treatment at that time with another dentist. Mr Nery's opinion is that it is a matter for the Committee to consider the meaning of the text entered by [you]. The Committee notes from the clinical record that this patient attended in pain and had an extraction of the UR7. The Committee accepts your evidence that the patient was seeing a regular dentist. It was of the view that this was an emergency appointment and you had done what was necessary prior to carrying out the extraction of the UR7. It found that there is no evidence to support the allegation that you failed to make adequate enquiries.
12.(c)	WITHDRAWN
12.(d)	Used Alveogyl as a post extraction dressing when it was inappropriate to do so. **Not admitted but found proved** In your statement you said "I would have used Alveogyl as a post extraction dressing only if necessary. This was when the extraction was difficult or there was a history of post extraction dry socket." Both experts in their joint report stated "having examined the original peri-apical radiograph of 10/01/18, [we] agree there is nothing to suggest this would be a difficult extraction of UR7." In his oral evidence Mr Morris said that the tooth appeared to be loose from the available radiograph. He accepted that care was needed in carrying out the extraction as the tooth was behind two implants, but his opinion was that this did not make it a difficult extraction. The Committee accepted the opinion of both experts.
13.	On or around 10 January 2018 you failed to maintain an adequate standard of record keeping in respect of Patient F in that you:
13.(a)	Did not make any, or any adequate, record of your examination of Patient F; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.

13.(b)	Did not make any, or any adequate, record of any enquiries as to the treatment Patient F was receiving from another dentist; and/or **Admitted but found not proved** Having found 12(b) not proved, this charge falls.
13.(c)	Did not make any adequate record of any enquiries into Patient F's medical history; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
13.(d)	Used pre entered text. **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
14.	On or around 10 January 2018 you failed to maintain an adequate standard of record keeping in relation to radiographs in respect of Patient F in that you:
14.(a)	Incorrectly recorded that an OPG rather than a periapical radiograph had been taken; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
14.(b)	Did not record, adequately or at all, the justification for the radiograph taken; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
14.(c)	Did not, adequately, or at all, report on the radiograph taken. **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
	Patient G
15.	On or around 11 December 2017 you failed to provide an adequate standard of care to Patient G in that you prescribed antibiotics without any, or any adequate, justification.

	Admitted and found proved On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
16.	On or around 11 December 2017 you failed to maintain an adequate standard of record keeping in respect of Patient G in that you did not record adequate information about the presenting complaint. **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
17.	On or around 11 December 2017 you failed to maintain an adequate standard of record keeping in relation to radiographs in respect of Patient G in that you did not:
17.(a)	Record the justification for the radiograph taken; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
17.(b)	Grade the radiograph taken; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
17.(c)	Adequately, or at all, report on the radiograph taken. **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
	Patient H
18.	On or around 2 December 2017 you failed to provide an adequate standard of care to Patient H in that you:
18.(a)	Did not carry out a basic periodontal examination; and/or **Not admitted but found proved** In your statement you said “I would have completed a BPE examination for all patients presenting with a hygiene appointment. I accept that it is not recorded on the disclosed record. I may have recorded this within the paper records or on the computer system but saved in a separate file. I note that the record is from a different software system and I therefore wonder whether the record may not have been transferred from the system

	on which it was recorded." Mr Nery's opinion is that a BPE was not mandated and that alternative forms of periodontal assessment could have been undertaken by a reasonable body of GDPs. Mr Morris' opinion is that a BPE was the minimum required according to FGDP guidelines: the starting point for all periodontal examinations should be a screening or BPE. He notes that you stated that a BPE was taken for all patients presenting with a hygiene appointment. The Committee noted that the notes for this appointment were made retrospectively by you. It noted that you entered a detailed account of what you did but this account does not include carrying out a BPE. The Committee concluded that it was more likely that a BPE was not done at this appointment.
18.(b)	You prescribed antibiotics without any, or any adequate, justification. **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
19.	You failed to maintain an adequate standard of record keeping in respect of Patient H in that you:
19.(a)	On or around 2 December 2017 did not record adequate detail in the clinical notes; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
19.(b)	On or around 2 December 2017 used pre entered text; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
19.(c)	On or around 14 January 2018 made an entry into the electronic record retrospectively. **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
20.	On or around 2 December 2017 you failed to maintain an adequate standard of record keeping in relation to radiographs in respect of Patient H in that you did not:

20.(a)	Record the justification for the radiograph taken; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
20.(b)	Grade the radiograph taken; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
20.(c)	Report on the radiograph taken. **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
	Patient I
21.	Between around 12 February and 26 February 2018 you failed to provide an adequate standard of care to Patient I in that you:
21.(a)	WITHDRAWN
21.(b)	WITHDRAWN
22.	On or around 12 February 2018 you failed to maintain and adequate standard of record keeping in respect of Patient I in that you:
22.(a)	Did not record any, or any adequate, history of the complaint; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
22.(b)	Did not record any discussion of the aesthetic treatment provided; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
22.(c)	Duplicated sections of the records. **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.

23.	On or around the 12 February 2018 you failed to maintain an adequate standard of record keeping in relation to radiographs in respect of Patient I in that you did not:
23.(a)	Record the justification for the radiograph taken; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
23.(b)	Grade the radiograph taken; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
23.(c)	Report on the radiograph taken. **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
	Patient J
24.	On or around 22 January 2018 you failed to provide an adequate standard of care to Patient J in that you:
24.(a)	You prescribed amoxicillin to a patient with an allergy to penicillin; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
24.(b)	You prescribed antibiotics without any, or any adequate, justification; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
24.(c)	WITHDRAWN
25.	On or around 22 January 2018 you failed to maintain an adequate standard of record keeping in respect of Patient J in that you:
25.(a)	Did not make an adequate record of the history of the presenting complaint; and/or **Admitted and found proved**

	On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
25.(b)	WITHDRAWN
25.(c)	Used pre entered text. **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
26.	**Amended to:** On or around the 22 January 2018 you failed to maintain an adequate standard of record keeping in relation to radiographs in respect of Patient J in that you did not:
26.(a)	Record the justification for the radiograph taken; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
26.(b)	Grade the radiograph taken; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
26.(c)	Report on the radiograph taken. **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
	Patient K
27.	On or around 30 November 2017 you failed to provide an adequate standard of care to Patient K in that:
27.(a)	You prescribed antibiotics without any, or any adequate, justification; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
27.(b)	**Amended to:** You took a radiograph without any, or any adequate, justification; and/or

	Not admitted but found proved In your statement you said "I believe that I was justified in taking two radiographs during the extraction procedure in order to identify the shape and position of the retained root and to then check that it had been completely removed." In their joint expert report the experts said "[We] agree that the shape and position of the fractured root was clear from the pre-operative radiograph, and that the second radiograph was therefore not justified on this basis. [We] agree that if the retained root had been removed in multiple pieces a third radiograph may have been justified." The Committee accepted the opinion of both experts.
27.(c)	WITHDRAWN
28.	You failed to maintain an adequate standard of record keeping in respect of Patient K in that you:
28.(a)	On or around 30 November 2017 recorded inadequate detail of the extraction; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
28.(b)	On or around 30 November 2017 used pre entered text; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
28.(c)	On or around 14 January 2018 made an entry into the electronic record retrospectively. **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
29.	On or around 30 November 2017 you failed to maintain an adequate standard of record keeping in relation to radiographs in respect of Patient K in that you did not:
29.(a)	Record the justification for two of the radiographs taken; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.

29.(b)	Grade two of the radiographs taken; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
29.(c)	Report on two of the radiographs taken. **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
	Patient L
30.	On or around 7 January 2018 you failed to maintain an adequate standard of record keeping in respect of Patient L in that you made a retrospective entry in the records without making it clear that it related to an appointment on 6 January 2018. **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
	Patient M
31.	On or around the 15 February 2018 you failed to maintain an adequate standard of record keeping in respect of Patient M in that you did not make any clinical notes. **Not admitted but found proved** In your statement you said “I always made clinical notes for all patients I treated. I can only assume that my record has not been disclosed or it was not correctly saved on the system.” The Committee notes the comments of the joint experts. It has itself reviewed the relevant documentation and concludes that there are not any clinical records in respect of this appointment. The Committee was of the view that there was no explanation for the absence of records for this patient on this date. It noted that you said that it was either the records were not disclosed or that they were not saved properly. There is no evidence before the Committee to indicate that notes were not disclosed. The Committee noted the entry on the record card for this patient which says “Notes on PC Dr KA”. The Committee could not rely on the fact that this actually meant that the notes were on the computer system. It is of the view that it is your responsibility is to make the clinical notes and to ensure that the notes are saved particularly given that this was after the issue of a lack of records had been raised with you and you had successfully made

	retrospective entries on 14 January 2018.
	Patient N
32.	On or around 20 February 2018 you failed to provide an adequate standard of care to Patient N in that you:
32.(a)	WITHDRAWN
32.(b)	WITHDRAWN
32.(c)	WITHDRAWN
33.	On or around 20 February 2018 you failed to maintain an adequate standard of record keeping in respect of Patient N in that you:
33.(a)	Failed to record, adequately or at all, the history of the complaint; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
33.(b)	Failed to record, adequately or at all, any discussion of the treatment proposed; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
33.(c)	Failed to record, adequately or at all, an updated medical history. **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
34.	On or around the 20 February 2018 you failed to maintain an adequate standard of record keeping in relation to radiographs in respect of Patient N in that you did not:
34.(a)	Record the justification for the radiograph taken; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
34.(b)	Grade the radiograph taken; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.

34.(c)	Report on the radiograph taken. **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
	Patient O
35.	On or around 30 November 2017 you failed to provide an adequate standard of care to Patient O in that you:
35.(a)	Prescribed antibiotics without any, or any adequate justification; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
35.(b)	Used Alveogyl as a post extraction dressing when it was inappropriate to do so; and/or **Not admitted but found proved** In your statement you said "I believe placing Alveogyl as a post extraction dressing was appropriate as the extraction was complicated." Mr Morris' opinion is that this should not have been a difficult extraction. [Both experts] agree that Alveogyl is indicated for the following reasons: 1. dry socket 2. in patients with a history of dry socket 3. a reasonable body of GDPs would support using it after a difficult or traumatic extraction it is NOT indicated as a routine post extraction dressing." The experts both written and oral evidence indicate that this was not a difficult extraction. The Committee accepted their opinion. In the absence of any evidence to show the difficulty of the extraction, the Committee found on the balance of probabilities that this was likely not a difficult extraction and as such the use of Alveogyl on this patient was not appropriate.
35.(c)	**Amended to:** You took a radiograph without any, or any adequate, justification. **Not admitted but found proved** In your statement you said "I also believe it was appropriate to take two further radiographs during the extraction in order to assess the size and position of the retained root and to then confirm its removal." Both experts saw the original radiographs.

	Mr Nery's opinion is that there would be a body of responsible GDPs who would have taken the three radiographs in this instance depending on how difficult it was to remove the lower half of the mesial root. Mr Morris' opinion is that he agrees there might be a reasonable body of GDPs that would have taken the second radiograph. However, it was unlikely that the third would be needed. The Committee prefers Mr Morris' evidence that this was not a difficult extraction. In the absence of any evidence to suggest that the extraction had been difficult, the Committee could find no justification for taking the third radiograph.
36.	You failed to maintain an adequate standard of record keeping in respect of Patient O in that you:
36.(a)	On or around 30 November 2017 did not record, adequately or at all, a history of the complaint; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
36.(b)	On or around 30 November 2017 did not record, adequately or at all, what post operative advice was provided; and/or **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
36.(c)	On or around 30 November 2017 did not record that antibiotics had been prescribed; **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.
36.(d)	Made the entry into the electronic record retrospectively on 9 January 2018. **Admitted and found proved** On the basis that your admission was made through experienced Counsel and having reviewed the evidence, the Committee accepts that the admission was properly made.

We move to Stage Two."

On 28 January 2020 the Chairman announced the determination as follows:

> "Having announced its decision on the facts, the Committee heard submissions from Mr Corrie, on behalf of the General Dental Council (GDC) and from Mr Partridge on your behalf, in accordance with Rule 20 of the Fitness to Practise Rules 2006. It has received a remediation bundle from you.
>
> The Committee has accepted the advice of the Legal Adviser.
>
> The allegation against you is that your fitness to practise is impaired by reason of misconduct and/or deficient professional performance. The Committee has reminded itself that its decisions on misconduct/and or deficient professional performance and impairment are matters for its own independent judgement. There is no burden or standard of proof at this stage of the proceedings. It has taken account of the GDC's "Standards for the Dental Team" (September 2013). The Committee was referred to the cases of *Roylance v GMC* (no.2) [2000] 1 A.C. 311; *Remedy UK v General Medical Council* [2010] EWHC 1245; *Nandi v General Medical Council* [2004] EWHC (Admin); *Calhaem v GMC* [2007] EWHC 2606 (Admin); *Vali v GOC* [2011] EWHC 310 (Admin); *Cohen v GMC* [2008] EWHC 581 (Admin); *Zygmunt v GMC* [2008] EWHC 2643 (Admin); *Cheatle v GMC* [2009] EWHC 645 (Admin); *CHRE v NMC & Grant* [2011] EWHC 927 (Admin).
>
> Mr Corrie submitted that in considering misconduct and deficient professional performance, the Committee should adopt the approach as set out in paragraph 9 of his submissions:
>
> > "it is clear that the same fact or facts cannot be both misconduct and deficient professional performance. The suggested approach is to consider first whether an allegation amounts to misconduct. If it does there is no need to consider whether it amounts to deficient professional performance."
>
> Mr Partridge did not object to the Committee adopting this approach.
>
> **Misconduct**
>
> The Committee first considered whether the facts found proved amount to misconduct. It found proved a wide range of failings across a significant number of patients. These failings fall into a number of categories – record keeping, radiographic practice, antibiotic prescribing and the use of Alveogyl, and within each category there are a range of consistent and multiple failures. There appeared to be a less than conscientious approach in your clinical practice in relation to areas of basic dentistry. The Committee heard that this was your first role as a dentist in England. From the evidence before the Committee it is obvious that you found yourself in unfamiliar territory and you were unfamiliar with the practices and standards expected. You were not aware of the GDC's Standards, the Ionising Radiation (Medical Exposure) Regulations 2018, or guidelines issued by the Faculty of General Dental Practice (FGDP) on antimicrobial prescribing, clinical examination and record keeping, and selection criteria for dental radiography. It is your responsibility to ensure that you have the competence to fulfil your role as a dentist by keeping up to date with relevant regulations, standards and guidance. The facts found proved show that you did not do this. As a consequence, your failures transgressed across many areas of basic dentistry some of which had the potential to harm patients. Examples include over exposure of two patients to radiation by taking more radiographs than necessary and prescribing amoxycillin to a patient with an allergy to penicillin. There is no evidence before the Committee that any patient was harmed by your failures, but the Committee's view is that there was an increased risk of harm to patients and this cut across all areas of your practice.

The Committee is of the view that your omissions fell short of what was proper and breached the GDC's Standards, particularly the *Standards for the Dental Team* (September 2013):

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

4.1 Make and keep contemporaneous, complete and accurate patient records.

4.4 Ensure that patients can have access to their records.

4.5 Keep patients' information secure at all times, whether your records are held on paper or electronically.

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

7.2 Work within your knowledge, skills, professional competence and abilities.

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

Your failures as found proved and breaches of the standards of the profession are a serious departure and would be regarded as deplorable by fellow practitioners. The Committee noted that both experts were of the opinion that many of your failures fall far below the standards expected of a reasonable general dental practitioner whilst others fall below and not far below the standards expected.

The Committee having found these serious failures and breaches was in no doubt that the facts found proved individually in respect of those that fall far below and cumulatively in respect of those that fall below the standards expected are all serious and amount to misconduct. Having made a finding that all the facts found proved individually and cumulatively amount to misconduct, the Committee did not consider deficient professional performance.

Current impairment

The Committee next considered whether your fitness to practise is currently impaired by reason of your misconduct.

The Committee is of the view that all the failings found in this case are capable of being remedied.

In considering whether there has been remediation in this case, the Committee took account of your remediation bundle which includes your CV, Continued Professional Development (CPD) certificates, copies of audits on medical history forms and record keeping, Professional Development Plan (PDP) and reflections, and testimonials. The Committee noted that most of the CPD courses you completed, relevant to the areas found proved, were online courses. It noted that the CPD certificates contain sections on 'Reflective Account', 'What have you learnt?', 'How will this influence your current daily practice?', 'Do you need to adjust your PDP to reflect any areas of weakness highlighted by this learning activity?' The Committee has seen no evidence of your reflection on each of these courses or indeed your responses to the questions posed on the certificates. It also noted that a high number of the CPD certificates presented were of courses completed in 2018.

In relation to your PDP the Committee's view is that it appears to be more of a check list rather than an actual personal development plan which should be forward looking in nature, contain information on future learning with set goals and targets, dated and constantly

updated. Your PDP lists courses as done with no indication on how you intend to embed your learning into your practice and maintain standards.

In relation to the evidence of audits presented, the Committee is of the view that they have been of little assistance to it. The audit of medical history forms was an audit of multiple practitioners and dated June 2018. The audit showed that of the seven patients seen by you, four had previous medical history forms completed within the current course of treatment and 1 patient had not had a medical history form updated since 2009. The record keeping audit presented is dated 2 July 2018 and it is unclear if this was an audit of your patients alone or a practice wide audit. The Committee also noted the record keeping audits of your records at another dental practice where you also work part-time. The audits were carried out in July 2019, December 2019 and January 2020.

The audit conducted in January 2020 was commissioned to assess your current standards of care, record keeping and Radiographic practice. The audit report states:

> "From a review of the appointment diary it appeared that the scope of clinical care provided by Miss Azimova was broadly confined to the following areas: short term orthodontic using the 'Invisalign' system of treatment; tooth whitening treatment using products containing 16% carbamide peroxide normally releasing less that 6% hydrogen peroxide which is in accordance with current regulations; routine restorative and preventative care including the use of composite bonding techniques to improve patient aesthetics."

The report concluded that "the quality of the clinical record keeping was judged to be of the "reasonable standard" when judged again the criteria used for an ordinary general dental practitioner. Radiographic practice appeared to be in line with current IR(ME)R 2018 Regulations (justified, reported, quality assessed)." The Committee noted from the learning points section of the report that there was advice on the use of pre-populated templates which could undermine the integrity of a dentist's clinical record. The report gave an example of radiographs being graded as 'Grade 1' whereas the actual review of the radiographs in question showed 'coning' which would push them into a Grade 2. The Committee noted from your reflective statement dated 15 January 2020 that you acknowledged the learning points and stated that the templates served as a foundation for your clinical notes which were customised and tailored to each individual patient.

In your reflective statement you accepted that your standard of care was far below that required and that many aspects of your record keeping and clinical notes were substandard. You also acknowledged that your level of knowledge regarding antibiotic prescribing was of a substandard level. You said:

> "I now fully understand the importance of patient records that are: meaningful, intelligible, chronological and contemporaneous…Any radiograph that is taken is justified on my clinical records, I will write up a radiographic report to compliment this…My daily practice now is to take the necessary steps to carry out appropriate radiographs without the need for unnecessary or repeat radiographs and to reduce dosage so far as it reasonably achieved. I have been auditing my quality of radiographs taken, to ensure they are in-line with NRPB (National Radiological Protection board) guidelines…I have taken further CPD courses to ensure I understand the latest guidelines regarding justification for prescribing antibiotics…I have also taken necessary steps to always confirm antibiotic allergies with patients, and I will confirm with them again before handing over the prescription. Over the last

> 12 months, I have not prescribed any antibiotics. Currently in my practice, I am focussed on doing mainly cosmetic treatments such as Invisalign and composite bonding. Over the last 12 month, I have carried out extractions on one occasion. After any extraction, I ensure that I provide my patients with postoperative written instructions. I will now always re-check the medical history to check the smoking status of the patient, and ensure I start my instructions by explaining the risk of smoking within the first 24-48 hours. This is also documented in my clinical records. Regarding the use of Alveogyl…I am no longer using any Alvogyl [sic] following extractions in practice…I am truly sorry that my previous practice between November 2017 and April 2018 fell below the standards expected of me as a dental professional. I feel great remorse and felt like I have let my patients down, but also my profession."

The Committee acknowledged that you made admissions at an early stage to a large number of the charges in this case. You have also taken steps towards remediating the criticisms highlighted by the charges. You have demonstrated remorse, apologised and shown a good level of insight. However, the Committee's view is that you are yet to fully remedy your failings. Although you have attended a number of CPD courses in areas relating to the findings made in this hearing, a large number of the courses were done online, there is an absence of your reflections on each of the courses, your PDP is more retrospective than prospective, you refer in your reflective statement to NRPB (National Radiological Protection Board) guidelines when the relevant regulation on radiographs is IR(ME)R 2018. The Committee is not looking only at what you have done towards remediation but the embedding of the new standards of your clinical practice that you have acquired. This information is currently lacking. The Committee concluded that in light of these concerns, it could not be satisfied that the failings found proved would not be repeated in future and as such there remained a risk of repetition and a need to protect patients.

The Committee then considered whether a finding of impairment is required in the public interest to maintain public confidence in the profession and declare and uphold proper standards. It is of the view that a reasonable and informed member of the public, fully aware of the range of failings found and the Committee's concerns with regards to your remediation, would lose confidence in the profession and the dental regulator if a finding of impairment is not made in the circumstances of this case.

The Committee has therefore determined that your fitness to practise is currently impaired by reason of your misconduct.

Sanction

The Committee next considered what sanction, if any, to impose on your registration. It recognises that the purpose of a sanction is not to be punitive although it may have that effect. The Committee has applied the principle of proportionality. It has also taken account of the *Guidance for the Practice Committees including Indicative Sanctions Guidance, October 2016 (updated May 2019), ("PCC Guidance")*.

The Committee considered the testimonials presented on your behalf. It noted that there are positive and are written by people who currently work with you although not directly such that they can review your work in detail. The Committee gave the testimonials due consideration.

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

- evidence of good conduct following the incident in question, particularly any remedial action;
- evidence of previous good character;
- evidence of remorse shown/insight/apology given; and
- evidence of steps taken to avoid a repetition.

The aggravating features of this case include:

- … risk of harm to a patient…
- misconduct sustained or repeated over a period of time.

The Committee noted that the misconduct relating to record keeping was repeated even after the failings were brought twice to your attention.

You have started the process of remedying your failings, prior to this hearing you were previously of good character, you have demonstrated remorse and apologised to the Committee and shown good insight. The Committee's view is that as your remediation is incomplete there remains a risk of repetition. However, you have made considerable efforts towards reducing the risk.

The Committee was of the view that to conclude this case with no further action would be inappropriate given the outstanding concerns.

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

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

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

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

The Committee acknowledged that some of the factors listed are present in this case. However given that it is not satisfied that you have fully remedied your failings and there remains a risk of repetition, a reprimand would not be appropriate to address the concerns or sufficient to safeguard the public interest.

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

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

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

The Committee's view is that the outstanding concerns highlighted above can be properly addressed with the imposition of conditions. It considered whether suspension would be more appropriate in this case. It concluded that given that you have demonstrated good insight, remorse and a willingness to remedy your failings, you can be returned to safe and unrestricted practice in the future following a successful period of conditional registration. The Committee therefore directs pursuant to section 27B (6)(c) of the Dentists Act 1984, as amended ("the Act") that your registration shall be conditional on your compliance for a period of 12 months. The Committee also directs that this direction for conditional registration be reviewed prior to the end of the 12 month period pursuant to section 27C(2) of the Act.

The Conditions that will appear against your name in the Register are as follows:

1. She must formulate with appropriate guidance an updated Personal Development Plan, that includes measures to address:
    a. Record keeping
    b. Antibiotic prescribing and use
    c. Radiographic practice
    d. Reflective practice
2. She must forward a copy of her Personal Development Plan to the GDC within 2 months of the date on which these conditions become effective.
3. She must notify the GDC promptly of any professional appointment she accepts and provide the contact details of her employer or any organisation for which she is contracted to provide dental services and the Commissioning Body on whose Dental Performers List she is included or Local Health Board if in Wales, Scotland or Northern Ireland.
4. She must allow the GDC to exchange information with her employer or any organisation for which she is contracted to provide dental services, and the reporter referred to in these conditions.
5. a. She must undertake at least 3 clinical audits of record keeping, radiographic practice, antibiotic prescribing and use within the next 11 months. The audits must be signed by her workplace reporter.

b. She must provide a copy of the audits to the GDC on a 3 monthly basis or, alternatively, confirm that there have been no such cases.

6. At any time she is providing dental services, which require her to be registered with the GDC, she must agree to the appointment of a reporter nominated by her and approved by the GDC. The reporter shall be a GDC registrant of the same level.

7. She must allow the reporter to provide reports on compliance with these conditions to the GDC at intervals of not more than 3 months.

8. She must inform the GDC of any formal disciplinary proceedings taken against her, from the date of this determination.

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

10. She must inform within one week the following parties that her registration is subject to the conditions, listed at (1) to (9), 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);

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

11. She must permit the GDC to disclose the above conditions, (1) to (10), to any person requesting information about her registration status.

The Committee will now consider whether an immediate order should be imposed in this case.

Decision on immediate order of conditions

The Committee took account of the submissions made by Mr Corrie on behalf of the GDC that an immediate order should be imposed on your registration. He submitted that based on the Committee's determination that you are yet to fully remedy your failings and the risk of repetition identified, an immediate order is necessary for the protection of the public and otherwise in the public interest.

Mr Partridge submitted that an immediate order is not necessary in this case. He referred to the Committee's observations in its substantive decision that you have shown a good level of insight and taken steps towards remedying the failings identified. He observed that the conditions imposed by the Committee do not require supervision but liaising with a reporter. Mr Partridge submitted that the 28 days should be allowed to lapse prior to the taking effect of the substantive conditions.

The Committee accepted the advice of the Legal Adviser.

The Committee has identified a potential risk to the public. It has also identified a public interest issue that a reasonable and informed member of the public fully aware of the range of failings found proved and the Committee's concerns with regards to your remediation, would lose confidence in the profession if an immediate order were not made in the circumstances of this case. The Committee notes that the conditions imposed on your registration are supportive of your development. As such it sees no reason to postpone their taking effect and supporting you back to safe practice.

The Committee considers that given its decision in its substantive determination and the reasons set out above, an immediate order is necessary for the protection of the public and is otherwise in the public interest. It therefore determined to impose an immediate order of conditions pursuant to section 30(2) of the Dentists Act 1984, as amended.

The effect of the foregoing direction and this order is that your registration will be subject to the same conditions as the substantive conditions with immediate effect and unless you exercise your right to appeal, the substantive direction of conditional registration for 12 months will take effect 28 days from when notice is deemed served on you. Should you exercise your right to appeal, this order for immediate conditions will remain in place pending the resolution of any appeal proceedings.

That concludes this determination."