General Dental Council | protecting patients, regulating the dental team

HEARING PARTLY HEARD IN PRIVATE

VIERU YORK, Dana Rozalia

Registration No: 143471

PROFESSIONAL CONDUCT COMMITTEE

February-September 2014

Outcome: Erasure with immediate suspension

Dana Rozalia VIERU YORK, DMD Bucharest 1999, was summoned to appear before the Professional Conduct Committee on 10 February 2014 for an inquiry into the following charge:

Charge (as amended by the agreement of both parties on 10 February 2014)

"That being registered under The Dentists Act 1984:

1. Between 19 July 2011 and 8 December 2011 you provided care and treatment to Patient A which included the replacement of Patient A's individual full upper crowns with a fixed 'bridge' based on teeth and implants opposing lower natural teeth.

   First Appointment

2. On 19 July 2011 you failed to:
   (a) take and/or record a past dental history,
   (b) enquire and/or record whether Patient A was under the care of a General Dental Practitioner ("GOP") with a view to liaising with that GOP,
   (c) record a tempera-mandibular examination,
   (d) record an examination of the occlusion,
   (e) record any issues with regard to bruxism.
3. You recorded the following charting on separate entries both dated 19 July 2011:
   (a) UR6321, UL123, LR4321, LL12345;
   (b) UR7321, UL123, LR54321, LL12345;
   (c) UR7321, UL123, LR54321, LL12345.
4. You recorded the following Basic Periodontal Examination ("BPE") scores on separate entries both dated 19 July 2011:
   (a) 2/1/2-2/1/2,
   (b) 7/4/- -4/4/4.
5. Following a BPE score of 2/1/2-2/1/2 or similar you ought not to,
   (a) have referred Patient A for blood tests,
   (b) have provided what you have transcribed for an entry dated 8 October 2011 as "subgingival curettage with addition of hydroxyl-apatite".

6. Following a BPE score of 7/4/0-4/4/4 or similar you failed to:
   (a) provide six point pocket depth charting,
   (b) give sufficient consideration to a referral to a periodontal specialist,
   (c) reassess her periodontal condition prior to providing implant treatment.

   Assessment, Treatment Planning & Consent

7. Prior to providing restorative and implant treatment you failed to:
   (a) record and/or give sufficient consideration to the lack of vertical height of the bone in the UL6 region as shown on an OPT dated 19 July 2011,
   (b) obtain a diagnostic preview such as with the use of pre-operative models,
   (c) discuss and/or adequately record discussion with Patient A regarding,
      (i) the lack of bone at UL6 region and risk of sinus penetration,
      (ii) the proposed use of single piece hybrid implants as definitive implants,
      (iii) the proposed time frame for the loading of implants,
      (iv) post-operative recovery,
      (v) the provisional nature of composite bridgework.

8. A document titled 'Treatment Plan' and dated 3 August 2011 was inadequate in that it:
   (a) referred to two implants not three,
   (b) provided insufficient information as to risks and benefits of treatment,
   (c) provided insufficient information as to the proposed timing and stages of treatment.

9. The 'Treatment Plan' was not provided to Patient A.

10. You failed to obtain Patient A's informed consent to treatment in that you did not provide her with sufficient information regarding:
   (a) options and alternative treatments,
   (b) the proposed treatment,
   (c) the risks and benefits of the proposed treatment,
   (d) the costs and stages involved.

   Treatment

11. Between 24 September 2011 and a date unknown but before 1 November 2011 you provided Patient A with:
   (a) two hybrid implants in the UL region,
   (b) one hybrid implant in the UR region.

12. Your records concerning the provision of implants in the UL region failed to detail:
   (a) written consent from Patient A;

(b) the use of a surgical guide,

(c) assessment of insertion torque,

(d) surgical technique,

(e) provision of written post operative instructions,

(f) oral hygiene and dietary advice relating to implants.

13. You failed to record the provision of the implant in the UR region.

14. You failed to take immediate post-operative radiographs.

15. A post treatment OPT dated 26 September 2011 shows the implant in the ULS/6 region penetrated and extended into the left maxillary sinus.

16. You failed to inform Patient A that the implant in the ULS/6 region had penetrated and extended into the left maxillary sinus.

17. You ought not to have placed an implant in the UL6 region given the vertical lack of bone.

18. On or about 1 October 2011 you provided Patient A with a temporary bridge and recorded "poor prognostic" without detailing,

(a) the extent of the temporary bridge,

(b) what the prognosis was referring to.

19. You failed to provide an adequate written prescription and/or record of the design of the definitive crown and bridgework.

20. On or about 18 October 2011 you provided Patient A with what she was informed was a definitive 'bridge'.

21. The 'bridge' you provided was substandard in that:

(a) it was poorly fitting,

(b) poorly contoured,

(c) was made of composite,

(d) was difficult to clean.

IRMER failings

22. In respect of your OPTs dated 19 July 2011 and/or 26 September 2011 you failed to record:

(a) justification for the exposure,

(b) quality assessment,

(c) clinical evaluation.

Falsification of Records

23. Your records for Patient A,

(a) contain duplication of dates,

(b) contain incompatible data,

(c) are not in chronological order,

(d) are incorrect as to the dates of a number of appointments and/or appointments have been omitted,

(e) do not accurately reflect the treatment provided and/or communications with Patient A.

24. Your records for Patient A are in full or in part,

(a) not contemporaneous,

(b) not accurate,

(c) misleading,

(d) false.

25. Your conduct in creating false records was dishonest. Referrals to GMP and SS

26. On 13 December 2011 Patient A sent you an email headed "formal complaint".

27. On or about 28 December 2011 you wrote to Patient A's General Medical Practitioner ("GP"") and Social Services stating,

(a) Patient A was "claiming she is suicidal because of her dental treatment",

(b) Patient A had "lashed out with emails and telephone calls of severe hostility."

28. On 3 January 2012 you telephoned Patient A's GP practice and received confirmation your letter had arrived.

29. On 6 January 2012 you telephoned Patient A's GP practice and spoke to a receptionist and stated words to the effect that,

(a) Patient A was unstable,

(b) Patient A was trying to sue you for no reason,

(c) Patient A had lied about her age,

(d) you had googled Patient A and Patient A had several law suits pending,

(e) Patient A was only after your money,

(f) the GP should check Patient A's passport.

30. Your behaviour in communicating with Patient A's GP practice and/or Social Services as set out above was,

(a) inappropriate in that you did not seek Patient A's consent to do so,

(b) malicious in that in full or in part it was done with the intention of,

(i) creating a more favourable impression of your own care and conduct,

(ii) creating a less favourable impression of the conduct of Patient A.

AND, by reason of the facts stated, your fitness to practise as a Dentist is impaired by reason of your misconduct."

On 22 September 2014 the Chairman made the following statement regarding the finding of facts:

> "Dr York: The General Dental Council (GDC)'s case against you concerns the treatment you provided to Patient A between 19 July 2011 and 8 December 2011. The allegations against you fall into three broad areas: first, substandard assessment, planning and treatment, particularly in relation to the provision of implants in the upper jaw, and an upper bridge; secondly, your records for Patient A which are alleged to be in full or in part, not contemporaneous, not accurate, misleading, false and dishonest; thirdly, the GDC alleges that your conduct in communicating with Patient A's General Medical Practitioner (GP) and Social Services between December 2011 and January 2012 was inappropriate, in that you did not seek Patient A's consent and because it was malicious in full or in part as it was done with the intention of creating a more favourable impression of your own care and conduct and creating a less favourable impression of the conduct of Patient A.
>
> By way of background to this case, the Committee has heard that, following your treatment, Patient A went to see another dentist, Mrs Sritharan, for an opinion. Mrs Sritharan was unable to assist as she was not an implant specialist and referred Patient A to Mr Yerbury. Patient A saw Mr Yerbury for treatment on 5, 14 and 19 January 2012 and 2 February 2012. Thereafter, Patient A went to see a dentist in Romania, Mr Vataman, who carried out further treatment on her between February and April 2012.
>
> At the outset of the hearing, the Committee acceded to an unopposed application made by Ms Barnfather, Counsel, for the General Dental Council (GDC), pursuant to Rule 18 of the GDC (Fitness to Practise) Rules 2006, to amend the Notice of Hearing by correcting some minor typographical errors. The amendments were as follows:
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> Head of charge 1 - delete '2012' and replace it with '2011'
>
> Head of charge 4(b) – delete '0' after 7/4/ and replace it with '-'
>
> Thereafter, Mr Leonard, Counsel, on your behalf, made the following admissions: 1, 2(b) (insofar as it relates to a failure to record); 2(c), 2(d), 2(e), 3(a) - 3(c), 7(a), 7(c)(i) - 7(c)(v) (insofar as it relates to a failure to record), 11(a), 12(a) – 12(d), 12 (f), 14 (insofar as it relates to 11(a) ie in respect of the two hybrid implants in the upper left region), 15, 16, 17, 18(a) – 18(b), 19, 20, 21(c), 22(b) – 22(c), 23(a), 23(c), 26, 27(a) – 27(b) and 28.
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> In the light of your admissions, the Committee has found those facts proved.
>
> In relation to those heads of charge that have not been admitted, the Committee has considered the evidence adduced by both parties. The documentary evidence includes two sets of Patient A's dental records provided by you; copies of your transcripts of Patient A's dental records and notes in preparation of litigation; Patient A's dental records from Mrs Sritharan; Patient A's dental records from Mr Yerbury, together with a copy of his report dated 11 January 2012; Patient A's medical records from her GP; Patient A's dental records from Gentle Dental Care, as well as copies of Patient A's radiographs. The Committee has also had regard to copies of correspondence between Patient A and the GDC and between Narcissa Sombat (acting on behalf of Patient A) and you.
>
> During the course of the hearing the Committee received signed witness statements from Mr Vataman and Mr Atcha (solicitor with Hempsons Solicitors), as well as a signed statement of Mr Szekely, the proprietor of the dental laboratory.

The Committee has had regard to the evidence of Patient A. This is a case where there is a difference in recollection between Patient A and yourself as to what took place at the material times. The Committee has considered carefully Patient A's account of events as well as your own. The Committee found Patient A to be a credible witness, who gave an honest account. It noted that Patient A's account of events was supported by the correspondence she sent to you, written contemporaneously, in which she sets out her concerns regarding the treatment you provided to her.

By contrast, the Committee found your evidence to be much less credible. At times it was vague, evasive, inconsistent and contradictory. Your evidence was frequently at odds with documentary evidence, including your own notes, which you claim were written contemporaneously. Throughout your evidence you attempted to shift responsibility for apparent failures in Patient A's treatment. You also refused to accept a number of propositions that were put to you, such as dates when certain treatment were carried out, notwithstanding documentary evidence to the contrary.

You advanced a theory that Patient A by herself/in conjunction with others, was responsible for stealing money/other objects from you and that she was part of a gang that victimised and harassed you. The Committee has received no evidence to support this theory.

The Committee also had regard to the oral evidence of Mr Yerbury, Mrs Sritharan and Mrs Deanus (receptionist at Patient A's GP practice). The Committee considered that these witnesses gave a reliable and consistent account of events.

The Committee received expert evidence from Mr Nery (called by the GDC), both written and oral. Overall, the Committee found his evidence to be independent, reliable and helpful.

The Committee has also considered carefully the oral evidence of Ms Cerbu, Dental Technician, who was called to give evidence on your behalf in connection with the bridge which she made for Patient A, on your instructions. The Committee also had sight of her undated and unsigned statement produced at your request. Overall, it found her to be an honest witness but she was dependent upon her recollection.

The Committee has considered each head of charge separately, bearing in mind that the burden of proof lies with the GDC and that the standard of proof is the civil standard, namely that each matter must be proved on the balance of probabilities. The Committee has accepted the advice of the Legal Adviser. It has taken into account the submissions made by Ms Barnfather, Counsel, on behalf of the GDC and those made by Mr Leonard, Counsel, on your behalf.

I will now announce the Committee's findings in relation to the heads of charge as follows:

1	Admitted and found proved
2(a)	Found not proved The notes of your consultation with Patient A on 19 July 2011 record "Patient denies tooth loss through trauma/injury. Tooth lost through neglect." It is clear from this entry that you elicited some information from Patient A regarding her past dental history.
2(b)	Found proved in its entirety

	Patient A's evidence was that you did not ascertain whether she was under the care of a General Dental Practitioner (GDP), whereas you say that you did. The Committee prefers Patient A's evidence on this matter. Further, there is no evidence in Patient A's records of this information.
2(c)	Admitted and found proved
2(d)	Admitted and found proved
2(e)	Admitted and found proved
3(a)	Admitted and found proved
3(b)	Admitted and found proved
3(c)	Admitted and found proved
4(a)	Admitted and found proved You have recorded in Patient A's records her BPE as 2/1/2 – 2/1/2.
4(b)	Found proved The Committee has seen your second entry in Patient A's records dated 19 July 2011 which states: "BPE 7/4/- – 4/4/4". You told the Committee that your second entry is a measurement of bone loss from the OPG taken on 19 July 2011. Notwithstanding your explanation, your entry states "BPE". The Committee is satisfied that this charge is proved.
5(a)	Found not proved The Committee has accepted your evidence that referring Patient A for blood tests was not related to her BPE score.
5(b)	Found not proved Notwithstanding the entry in the records, the Committee is not satisfied that you provided a subgingival curettage with the addition of hydroxyl-apatite on 8 October 2011. It accepted Patient A's evidence in this regard.
6(a), 6(b) & 6(c)	Found not proved in their entirety In your evidence you explained that your second reading, shown in the notes as BPE "7/4/- – 4/4/4" is a measurement of bone loss from the OPG taken on 19 July 2011, and not a BPE score. The Committee accepts your explanation that you erroneously recorded the letters "BPE" in front of the second entry and therefore finds this charge not proved.
7(a)	Admitted and found proved
7(b)	Found proved There is no evidence from the laboratory chits or the records to support your contention that you obtained pre-operative models prior to providing restorative and implant treatment to Patient A.
7(c)(i)	Found proved in full

	Patient A accepted that you mentioned to her that she might need a bone graft or some bone added due to a likely gap. However, she was clear in her evidence that she had no recollection of you informing her at any stage of the risk of sinus penetration. In cross examination Patient A explained that the first she heard of such a risk was when she saw Mr Yerbury in January 2012. You have accepted that you made no entry regarding the lack of bone at UL6 region and the risk of sinus penetration in Patient A's records.
7(c)(ii)	Admitted and found The Committee has accepted Patient A's evidence on this matter.
7(c)(iii)	Admitted and found proved The Committee has accepted Patient A's evidence that you did not discuss with her the timeframe involved for the loading of the implants.
7(c)(iv)	Admitted and found proved The Committee has accepted Patient A's evidence on this matter.
7(c)(v)	Found proved The Committee has accepted Patient A's evidence on this matter.
8(a)	Found proved The Committee had before it a document entitled Treatment Plan dated 3rd August 2011. It sets out a schedule of proposed treatment and prices including the following: *Composite crown and bridge £800 / tooth x m teeth* *(courtesy) - £600 / tooth - £200 / tooth* *Filling L5 – composite - £40 – (courtesy) £40- £0 to pay* At the bottom of the document, 2 boxes are ticked which read as follows: *I understand that this is an estimate treatment plan and the total cost might change with the progress of the work;* *I agree for all my treatments data and photos to be used for Conference, Research and Advertising Purposes.* The Committee has considered carefully this document. Patient A denied ever having been given it. You asserted in your evidence that you did give it to Patient A. You did say that she signed it, but later acknowledged that it was not signed. It is not referred to in the contemporaneous records for 3rd August 2011. There are references to a treatment plan in the records as follows: 19th July (C1, page 7): "the plan of treatment is given. Patient chose to have treatment. The plan is made, discussed and chosen. Patient approved to have contact her GP. Referral is made for blood tests …" 15th September (C1, page 9): "Retaken informed consent from patient…….. Treatment plan completed and signed. Patient informed about crowns,

	bridges, dentures and implants and periodontal disease." These dates are inconsistent with the date on the Treatment Plan. Moreover according to Patient A, at the date of the Treatment Plan (3rd August 2011), the plan which had then been discussed was only to have a single implant. In fact according to the patient records, Patient A did not choose the material for the crowns until 9th October. The relevant entry reads as follows: "9th October Review Option given. Patient choice to have upper crown and bridgework for upper R: 6,5,4,3,2,1 I 1,2,3,4,5. See lab doc 269598. INCIDENT option given of types of crowns. Zirconium or PFM (porcelain fused on metal). Patient choose composit". This latter entry establishes that Patient A's choice of composite was not made until 9 October 2011. By that time, as will be found in relation to charge 11(b), you had inserted an implant in the upper right region of Patient A's mouth in addition to the 2 implants in the upper left region. The Committee therefore find Charge 8(a) proved - the treatment plan must have been drawn up on after 9 October 2011 as composite is mentioned, and by that time you had inserted 3 implants into Patient A's mouth.
8(b) & 8(c)	Found proved The Committee has accepted Mr Nery's evidence that the treatment plan in a complex case should set out the risks and benefits of treatment and the proposed timing and stages of treatment. It finds in these respects the treatment plan was inadequate.
9	Found proved The Committee has accepted Patient A's evidence that she had no recollection of you providing her with a treatment plan, or of her signing such a document, at any time when you treated her. She said she first became aware of the treatment plan from Mr Atcha. Further, Patient A confirmed that she did not consent to photographs being used for conference, research and advertising purposes, although the Committee notes that the box of the treatment form has been ticked to indicate her agreement. Finally the treatment plan dated 3 August 2011 has not been signed by Patient A and in any event there was no consultation with her on that date.
10(a), 10(b), 10(c) & 10(d)	Found proved Patient A accepted that there was some discussion regarding the matters set out in the Heads of Charge and the costs involved. It accepted Mr Leonard's submission that it is not credible that no such discussion took place. However, the Committee is not satisfied that the information given to Patient A was sufficient for the consent to be valid. Moreover, the records did not support your contention that you had obtained informed consent for treatment from Patient A. Mr Nery's evidence was that, in order for consent to be valid, there must be adequate treatment planning to enable the dentist to provide a plan of treatment which the patient can understand. He explained that the treatment plan should set out in a logical sequence the proposed method for dealing with the patient's

	problems and describe the anticipated outcome of treatment. He also explained that, because of the amount of information that needed to be considered in this case, a detailed written treatment plan should have been given after the initial consultation so that the patient can read through and consider the contents. The Committee has already found that the treatment plan was inadequate in a number of respects and that you did not provide a plan to Patient A. Given these findings, and Patient A's evidence, the Committee is satisfied that Charge 10 is found proved.
11(a)	Admitted and found proved Your record for Patient A dated 24 September 2011 confirms that you placed two implants in the UL region.
11(b)	Found proved The GDC's case is that in addition to the two implants you placed in the UL region, you also placed a third implant in the UR region. Patient A's evidence was that soon after the first two implants had been placed in the UL, she saw you again, at which point an OPG was taken on 26 September 2011. She explained that you suggested that she should have a third implant, so as to give some strength to the final bridge. In cross examination, Patient A confirmed that you provided her with a third implant sometime around the end of September/beginning of October 2011. Your case is that you did not place this third implant. You contend that if there was a third implant placed in Patient A's mouth, it must have been placed there by another dentist after such time as your treatment was completed. The Committee has accepted Patient A's evidence on this matter. It found Patient A to be clear and consistent. It noted that all of the three 3 implants were of same type and model of material.
12(a)	Admitted and found proved
12(b)	Admitted and found proved
12(c)	Admitted and found proved
12(d)	Admitted and found proved
12(e)	Found proved Patient A's evidence was that following the provision of the implants in the UL region on 24 September 2011, she had no recollection of you providing her with written post operative instructions. Your entry dated 24 September 2011 states: 'post operative instructions given'. However, the Committee notes that this entry does not make any reference to the provision of written instructions and accordingly found this charge proved.
12(f)	Admitted and found proved
13	Found proved The Committee has accepted Patient A's evidence that you provided her with an

	implant in the UR region. It is not noted in Patient A's records. The Committee is therefore satisfied that you failed to record the provision of the implant in the UR region.
14	Found proved You have admitted that you failed to take immediate post operative radiographs in respect of the two implants placed at the upper left. In respect of the implant in the upper right, the Committee has found proved that you did place that implant and there is no record of any post operative radiograph.
15	Admitted and found proved
16	Admitted and found proved
17	Admitted and found proved
18(a)	Admitted and found proved
18(b)	Admitted and found proved
19	Admitted and found proved
20	Admitted and found proved
21(a)	Found proved The GDC relied upon Mr Yerbury's evidence. In his evidence, he explained that he examined a bridge which was in 2 parts and which (until he cut it immediately distal to the unit at UL5) contained 12 units. You challenged the GDC's assertion that the bridge which he examined in January 2012 was your bridge. You contended that the bridge which he examined was made/ inserted by another dentist at a later stage after the work which you had done. You relied upon the following: • Your evidence that the bridge which you provided to Patient A was a one piece bridge which spanned some 11 units, which evidence, you contend, is supported by: o the evidence of the technician, Ms Cerbu, who insisted that the bridge which she fashioned and later adapted (on 29 October) was a one piece, 11 unit bridge; o the statement of Mr Szekely dated 30 April 2012 in which he states that the laboratory constructed a twelve unit composite one piece bridge from a prescription provided by the dentist; o your prescription (C1, page 23) bearing a date of 12th October which is signed by the technician and which is for a single composite bridge with 11 units; • The dental record of Mrs Sritharan, a dentist whom Patient A visited on 15 December 2011 and who records Patient A stating that she had "implant done in Warren Street Surgery. Not happy with it." It is not clear from the copy which the Committee had whether Mrs Sritharan has

written *implant* or *implants.*

- A photograph (D2), which Ms Cerbu explained was taken at the laboratory when Patient A had the bridge adjusted by her in your presence. That photograph which is in fact dated 29 October 2011 appears to show only 5 teeth (units) on the upper left side and therefore, you contend, supports you're assertion that the bridge which Mr Yerbury examined in January 2012 (which is shown at C9) which has 6 teeth (units) is not your own.
- Patient A's evidence was that the dentist may have understood this to mean the dental surgery she used rather than the tube station Patient A used when visiting your practice at Harley Street.

The GDC relied upon Patient A's evidence. She insisted that she had not gone to another dentist and had your bridge replaced. She explained in her oral evidence that when she attended your surgery on 18 October 2011 for the bridge to be fitted by you (by which time the 3 implants were in position) she was anticipating a single bridge to span the whole of her upper mouth. To her surprise, the bridge which was ready for you to fit was in 2 parts. Patient A's evidence was consistent with the evidence that the laboratory may well have been instructed to make a one piece bridge. It is not for the Committee to speculate about the circumstances in which an original one piece bridge came to be in 2 parts by 18 October 2011. Patient A also stated that Mrs Sritharan must have misunderstood what she was saying on 15 December 2011 and suggested that she had probably been referring to Warren Street Underground Station, not a surgery.

In her evidence Ms Cerbu acknowledged that she did not have any specific recollection of the bridge, but asserted that, if the chit required her to make an 11 unit bridge, she would not have made a 12 unit bridge unless the chit was amended. She explained that she would only get paid for a bridge which was prescribed. The Committee notes that there was a discrepancy between her 11 unit bridge and Mr Szekely's 12 unit bridge. Moreover she acknowledged in her evidence that it was unlikely (but not impossible) that 5 units (teeth) could span the distance between the centre line of the mouth and the distal end of the (absent) implant in the upper left, where a suture was to be seen in photograph C10, an image taken by Mr Yerbury in January 2012 after he had removed the implant at that position. You acknowledge that you had positioned that implant into Patient A upper left jaw, that being the implant which penetrated Patient A's sinus.

The Committee noted your arguments about the photograph at D2 but did not consider that the image was sufficiently clear to be persuaded that it showed:

- only 5 teeth (units) on the upper left side.
- Teeth of a lighter colour or better appearance to the teeth shown on C9.

Moreover it notes the improbability that a fresh dentist would use composite to remake 2 bridges and also not address the implant which penetrated the sinus.

	Bearing in mind all these matters the Committee reached the conclusion that the bridge which Mr Yerbury examined was your bridge. Mr Yerbury stated that the bridge which he found would be reasonable for a short term temporary restoration. By implication he was asserting that it would not be reasonable for a definitive bridge. You have admitted under charge 20 that you informed Patient A that the bridge which you fitted was a definitive bridge. The Committee therefore finds charge 21(a) proved.
21(b)	Found proved The Committee has accepted Mr Yerbury's evidence that he considered the bridge to be "unduly bulbous".
21(c)	Admitted and found proved You have accepted that the bridge was made of composite. Mr Nery's evidence, which the Committee has accepted, was that composite was not an appropriate material to use for a definitive bridge because it was not a durable material.
21(d)	Found proved Mr Yerbury explained in his evidence that he was concerned about the lack of access for adequate oral hygiene. In his letter to Patient A dated 11 January 2012, he stated that he was concerned that she was unable to clean between the teeth of the bridge due its shape.
22(a)	Found proved Mr Nery's evidence was that you had made no record of the justification associated with the OPT of 19 July 2011 and 26 September 2011. However, he accepted that the x-ray and ultrasound request forms presented on your behalf, which record the words "dental assessment" on one and "dental assessment post implants" on the other constituted justifications, albeit basic. However, the Committee is not satisfied that the information contained on the request forms is sufficient and accordingly, it has found that you failed to record justification for the exposure on each occasion.
22(b)	Admitted and found proved
22(c)	Admitted and found proved
23(a)	Admitted and found proved
23(b)	Found proved The GDC relied on 3 matters: • Inconsistent BPE scores (set out in head of charge 4) recorded on 19 July 2011; • Inconsistent charting on 19 July 2011. There were 2 charts made on that day which are inconsistent. It would appear that the charting on C1, page 5 followed the OPGs which were taken shortly after the charting at C1, page 3,and represent a second attempt at accurate charting;

	• Inconsistent Medical History: there is no record of depression in the series of notes which begin at page 5 for 19 July 2011. The Committee accepts that the first two of these matters represent "incompatible data" and on that basis find the charge proved. It does not accept that the third represents "incompatible data" as it accepts broadly that the notes which begin at C1, page 5 are a supplement to the notes which begin on C1, page 3.
23(c)	Admitted and found proved
23(d)	Found proved The GDC relied on the following: • There is no record of the appointment: o when the 3rd implant was inserted; o when Patient A attended the surgery on 21st October, the day after she had attended the technician for her bridge to be adjusted. D1, 40 The Committee finds charge 23(d) proved in relation to these matters.
23(e)	Found proved in relation to the following matters: • Failure to record the 3rd implant. • The references to treatment plans in the records as follows: o 19th July (C1, page 7): the plan of treatment is given. Patient chose to have treatment. The plan is made, discussed and chosen. o 15th September (C1, page 9): Treatment plan completed and signed. Patient informed about crowns, bridges, dentures and implants and periodontal disease. The treatment plan was not given, completed and/ or signed as stated in the records by Patient A. • The alleged poor prognosis communications: o Proposed procedure or course of treatment document dated 23rd September 2011(C1, 32) in relation to the composite bridge and ……. and implants lower denture. The document states that the patient is informed that ……. of the quality of bone and ……. structure, the prognosis is not of the best. The document asserts that this information was given on 23rd September 2011. The patient did not attend on 23rd September. She may have attended on: o 15th September 2011 (C1, 9), when the records state that "informed consent was retaken". o 24th September 2011 (C1, 10), when the records state Patient A is

	informed about her "poor prognostic". ○ 1st October 2011 (C1, 12), when the records state Patient A is informed of the "poor prognostic". but it could not have been in respect of the composite bridge as this was not approved by Patient A until 9 October 2011. Moreover the Committee accepts Patient A's evidence that she was never warned about a poor prognosis. • The alleged treatment on 8 October 2011 recorded in the records at (C1, 12) "Option given, patient to have gum treatment, deep clean. Informed consent given. … Sub-gingival curettage with addition of hydroxyl-apatite. Post intervention instructions given. Haemostasis made". Proved. The Committee accept Patient A's evidence that she never had this treatment.
24(a)	Found proved This has been found proved in respect of the Treatment Plan.
24(b)	Found proved in respect of the following: • BPEs. You intended the 2nd BPE to be a record of measurement of bone loss. That was not accurate • Charting. The first chart on C1, page 3 was inaccurate. • Treatment Plan • Poor prognosis warnings. The warnings were not made. • There is no record of the appointment: ○ when the 3rd implant was inserted; ○ when Patient A attended the surgery on 21st October, the day after she had attended the technician for her bridge to be adjusted. • The alleged treatment on 8 October 2011 noted in the records at (C1, 12) "Option given, patient to have gum treatment, deep clean. Informed consent given. ... Sub-gingival curettage with addition of hydroxyl-apatite. Post intervention instructions given. Haemostasis made". Proved. The Committee accepts Patient A's evidence that she never had this treatment.
24(c)	Found proved The Committee found proved all the matters set out in 24(b) except for those relating to the charting.
24(d)	Found proved The Committee found proved all the matters set out in 24(b) except for those relating to BPEs, the charting and missing records of appointments.
25	Found proved The Committee has considered carefully the records which it has found proved

	in charge 24(d). It has found that the following matters were inserted into the records and/or left in the record in order to deceive any person perusing those records for whatever reason: The Treatment Plan; The poor prognosis warnings; The alleged treatment on 8th October 2011. It follows that it does not find that those items were left in the records as a result of chaotic record keeping. It does not find that the failures to record the 3rd implant and the appointment the day after Patient A attended the technician were dishonest.
26	Admitted and found proved
27(a) & 27(b)	Admitted and found proved The Committee has seen the letter, and you have accepted, that on or about 28 December 2011 you wrote to Patient A's General Medical Practitioner (GP), copied to Social Services, Harrow. The letter, which was received by the GP on 30 December 2011, states that Patient A was "claiming she is suicidal because of her dental treatment" and Patient A "lashed out with emails and telephone calls of severe hostility."
28	Admitted and found proved The Committee had regard to the note in Patient A's GP notes dated 3 January 2012. The note, which was taken by the receptionist, states as follows: "[Telephone] call from Prof Dana asking if letter received. Informed her yes it was."
29(a), 29(b), 29(c), 29(d), 29(e) & 29(f)	Found proved A further entry in Patient A's GP notes dated 6 January 2012 records the following: "Pt's dentist rang from Harley Street, claims pt is very unstable, and is trying to sue her for no reason. She claims the patient is older than she says as her teeth are that of a 44 year old, she has googled the ppt and the pt has several law suits pending, she thinks the pt is only after money… Dentist recommends we …check the pt's passport". In your evidence in chief you said that you had no recollection of having telephoned Patient A's GP practice on that occasion. You maintained that position when you were cross examined on this matter. The Committee found that you did telephone the GP as recorded by the receptionist. It did not find your explanation satisfactory or convincing. It was not credible that another person would have telephoned Patient A's GP practice and made a conversation along the same lines as that recorded in the note. Moreover the receptionist's note was consistent with the letter which you sent to the GP and Social Services on 28 December 2011.
30(a)	Found proved

	Your case is that you were genuinely concerned about Patient A's welfare and her risk of suicide, and that therefore you were justified in communicating with Patient A's GP and Social Services without her consent as found above. The Committee notes the reference to suicide in Patient A's email to you dated 14 December 2011. In that email Patient A states: "I am nice enough to accept my money back and not to take legal proceeding to ask for compensation for the attempted suicide, the depression, hunger and jeopardizing my job." Although Patient A gave evidence of the circumstances of an attempted suicide in November 2011, she confirmed that she had not disclosed this information to you other than in the reference in her e-mail. The Committee does not accept your assertion that your concern for Patient A's health warranted and explained your communicating as alleged in this charge without her consent. Had you been concerned, you would not have delayed some 14 days to 28th December before writing / sending the letter. Moreover the contents of the letter and the communication to the GP on 6th January 2012 belie the proposition that you had Patient A's interests at heart.
30(b)(i) & 30(b)(ii)	Found proved The Committee considered the content of the letter. It contained a number of observations as follows: • We treated the infection with periodontal surgery and antibiotics, installed two implants and had a bridge fashioned. The treatment remains unfinished; • For two months, [Patient A] booked appointments and failed to attend every one. • [Patient A] refused further care…… She booked but failed to attend any further appointment. • [Patient A] did subsequently appear in my practice, but refused treatment. She listened with flat affect, uninterested, when I spoke of a home maintenance regiment. • [Patient A] then lashed out with e-mails and telephone calls of severe hostility. The Committee finds that this letter has the characteristics alleged in charge 30(b)(i) and (ii) bearing in mind the matters set out above and the finding at 30(a). In respect of your communications with the GP, it also relies on the findings in paragraph 29.

We move to Stage Two."

On 23 September 2014 the Chairman announced the determination as follows:

"Mr Leonard: The Committee addresses these comments to you as Dr York's legal representative, noting that she is not present today. The Committee has considered whether the facts found proved amount to misconduct. In so doing, it has had regard to all the evidence before it, as well as the submissions made by Ms Barnfather, on behalf of the General Dental Council (GDC), and the submissions you have made on behalf of Dr York. The Committee has also had regard to the GDC's 'Standards for Dental Professionals' and 'Principles of Complaints Handling'. It has accepted the advice of the Legal Adviser.

Ms Barnfather has submitted that the findings against Dr York amount to misconduct. She referred to the relevant principles contained in the GDC's 'Standards for Dental Professionals' and 'Principles of Complaints Handling' which she says Dr York has breached. She confirmed that Dr York has no previous adverse finding against her by a GDC's Professional Conduct Committee.

You have invited the Committee to take into account a number of matters, including the fact that this was an isolated case in an otherwise unblemished career.

In its deliberations on the matter of misconduct, the Committee reminded itself of the extent and nature of the findings against Dr York in respect of the restorative and implant treatment she provided to Patient A between July and December 2011 and her communications with the patient's GP and Social Services. They include the following:

> Prior to providing restorative and implant treatment, a failure to record and/or give sufficient consideration to the lack of vertical height of the bone in the UL6 region as shown on an OPT dated 19 July 2011 or obtain a diagnostic preview such as with the use of pre-operative models.
>
> A failure to discuss and/or adequately record with Patient A a number of key aspects of the proposed treatment. This includes the lack of bone at the UL6 region and the risk of sinus penetration, the proposed time frame for the loading of the implants and the risks and benefits.
>
> A failure to provide Patient A with a Treatment Plan throughout the course of treatment.
>
> A failure to obtain Patient A's informed consent.
>
> A failure to take immediate post-operative radiographs following the provision of implant treatment.
>
> A failure to identify on a post treatment OPT taken on 26 September 2011 that the implant she had placed in the region UL5/UL6 had penetrated and extended into Patient A's left maxillary sinus.
>
> A failure to record justification for the exposure in respect of the OPTs dated 19 July 2011 and 26 September 2011 in accordance with IRMER guidance.
>
> The provision of a substandard bridge that was poorly fitting, poorly contoured and difficult to clean.
>
> Poor record keeping, including records which contained duplicate dates, incompatible data, incorrect dates of a number of appointments and which do not accurately reflect the treatment provided and/or communications with Patient A.

Records which in full or in part were not contemporaneous, not accurate, misleading and false.

Dishonest conduct in relation to the creation of false records.

Inappropriate behaviour in communicating with Patient A's GP practice and/or Social Services without Patient A's consent to do so; malicious behaviour in this regard in that in full or in part, it was done with the intention of creating a more favourable impression of Dr York's own care and conduct and creating a less favourable impression of the conduct of Patient A.

The Committee considers that the clinical failures identified in this case are serious, encompassing wide ranging and basic aspects of patient care. This includes, but is not limited to, Dr York's failure to recognise that the OPT dated 26 September 2011 showed that the implant in the UL region had penetrated and extended into the left maxillary sinus. In addition, Dr York failed to obtain Patient A's informed consent for complex restorative treatment. This was a serious failure of good practice.

The Committee also had grave concerns about the poor quality and accuracy of Dr York's record keeping. The provision of accurate and complete patient records is an essential and basic requirement expected of a dental professional. The Committee found in part that Dr York's records for Patient A were not contemporaneous, not accurate, misleading and false. The Committee found that Dr York's dishonest conduct in creating false records was totally unacceptable. Further, the Committee regarded Dr York's behaviour in communicating with Patient A's GP practice and/or Social Services without her consent totally unacceptable. Moreover, it found that Dr York's behaviour in this regard was malicious. Dr York used language such as "Patient A then lashed out with e-mails and telephone calls of severe hostility" in correspondence to Patient A's GP. It is clear from the documentary evidence before it that Dr York did not have Patient A's interests at heart in communicating in the way that she did with Patient A's GP. It rejected Dr York's assertion that she communicated with Patient A's GP and Social Services, without the patient's consent, because she was concerned about Patient A's health.

In the light of the findings against Dr York, the Committee has concluded that she breached the following paragraphs of the GDC's 'Standards for Dental Professionals':

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

1.2: Follow these principles when handling questions and complaints from patients and in all other aspects of non-clinical professional service.

1.3: Work within your knowledge, professional competence and physical abilities. Refer patients for a second opinion and for further advice when it is necessary, or if the patient asks. Refer patients for further treatment when it is necessary to do so.

1.4: Make and keep accurate and complete patient records, including a medical history, at the time you treat them. Make sure that patients have easy access to their records.

1.10: Do not make any claims which could mislead patients.

2.1: Treat patients politely and with respect, in recognition of their dignity and rights as individuals.

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

2.3: Treat patients fairly and in line with the law… Do not discriminate against patients or groups of patients because of … lifestyle, beliefs or any other irrelevant consideration.

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

- communicating effectively with patients;

- explaining options (including risks and benefits);

- and giving full information on proposed treatment and possible costs.

5.1: Recognise that your qualification for registration was the first stage in your professional education. Develop and update your knowledge and skills throughout your working life.

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

6.1: Justify the trust that your patients, the public and your colleagues have in you by always acting honestly and fairly.

6.2 Apply these principles to clinical and professional relationships, and any business or educational activities you are involved in.

The Committee has also had regard to Dr York's breaches in the GDC's guidance in Principles of Complaint Handling as follows:

1.1: It is part of your responsibility as a dental professional to deal properly and professionally with complaints.

1.2: If you get a complaint from a patient, deal with it calmly and in line with your complaints procedure.

The Committee, having regard to the extent, nature and gravity of the findings against Dr York, as well as her breaches of relevant guidance, is satisfied that these amount to a falling short of what would be proper in the circumstances. Accordingly, the Committee is satisfied that the findings against Dr York are serious and amount to misconduct.

The Committee then went on to consider whether Dr York's fitness to practise is currently impaired by reason of her misconduct. In so doing, it has had regard to all the documents before it, as well as the submissions made by both parties. The documents presented on behalf of Dr York at this stage of the proceedings included the following: copies of her Personal Development Plan (PDP), which address some of the shortcomings in Dr York's practice identified in this case, such as implants, records, IRMER regulations. The Committee has had regard to the certificates of Dr York's Continuing Professional Development (CPD) through her completion of E-wisdom courses and her attendance at

relevant courses such as the Oral Implantology World Congress in July 2014. In addition, the Committee's attention has been drawn to the correspondence from Raj Majithia (Associate Dean of Postgraduate Dentistry, London Deanery) to Dr York and also to RadcliffesLeBrasseur Solicitors (acting on behalf of Dr York).

The Committee has also noted the bundle of testimonials from Dr York's colleagues, patients and former students. The authors of these letters comment favourably on Dr York's skills as a dentist.

The Committee notes the letter dated 29 August 2014 from Raj Majithia to RadcliffesLeBrasseur Solicitors in which he confirms that Dr York has attended the Deanery for remediation on two occasions in 2013 and on two occasions (23 January and 30 June) in 2014.

Ms Barnfather referred to the serious nature of the findings against Dr York and submitted that there is no evidence to satisfy this Committee that the shortcomings have been remedied. She invited the Committee to conclude that Dr York has demonstrated a startling lack of insight and while acknowledging that there is some evidence to demonstrate that Dr York has undertaken remedial work, the steps undertaken thus far have not been fruitful. In summary, Ms Barnfather submitted that there is a high risk of repetition of the clinical lapses in this case. Furthermore, the behavioural and attitudinal matters found proved in this case demand a finding of current impairment in the public interest.

You, on behalf of the Registrant, have referred the Committee to Dr York's commitment to dentistry, as shown by her extensive remediation. You have referred to the documentary evidence, including Dr York's PDP, her CPD and the information concerning the audits of Dr York's record keeping, which, you say, demonstrates an improvement in the standard of practice. You have conceded that this is a case where the Committee might conclude that the findings against Dr York necessitate a finding of current impairment.

In reaching its decision on the issue of current impairment, the Committee has borne in mind that its duty is to consider the public interest, which includes the protection of patients, the maintenance of public confidence in the profession and the declaring and upholding of proper standards of conduct and behaviour. The Committee has also had regard to the principles and guidance set out in the relevant case law, including the case of CHRE v NMC and Paula Grant [2011] EWHC 927 (Admin).

The Committee first considered the nature of Dr York's misconduct in respect of the clinical shortcomings identified in this case. It has borne in mind that these failings are multiple, wide ranging and relate to basic aspects of dentistry which were woefully lacking. Dr York failed to provide Patient A with a good standard of care. Whilst accepting that in principle Dr York's clinical shortcomings are capable of remediation, the Committee is concerned that the evidence provided falls well short of addressing fully the extensive failings in her care of Patient A. Dr Raj Majithia, in his letter of August 2014 acknowledged that Dr York was engaging with the Deanery and that some progress had been made, including improvements in Dr York's record keeping. However, he considered that Dr York found the "remediation process difficult and so progress has been slow."

In addition, the Committee has grave concerns about Dr York's lack of insight into the shortcomings identified in this case. The Committee is not satisfied that Dr York has a real understanding of the mistakes she has made in respect of Patient A. In its judgement, given

the Committee's concerns about the extent of Dr York's remediation, as well as her lack of insight, it has concluded that there is a significant risk of repetition. Dr York therefore continues to present a risk to members of the public in her current role as a dentist.

In addition, the Committee takes a serious view of Dr York's dishonesty, which goes to the heart of public confidence in the profession and the need to uphold proper standards. Furthermore, Dr York's inappropriate conduct in communicating with Patient A's GP and Social Services without obtaining her consent to do so was serious. This was compounded by Dr York's malicious behaviour in her communications in this regard.

Taking all these factors into account, and also having regard to the need to maintain public confidence in the profession and to declare and uphold proper standards of conduct and behaviour, the Committee has determined that Dr York's fitness to practise is currently impaired by reason of her misconduct.

In the light of that finding, the Committee next considered what sanction, if any, should be imposed on Dr York's registration.

Ms Barnfather, on behalf of the GDC, submitted that given the serious nature of the findings against Dr York, the appropriate sanction in this case is one of erasure. She drew the Committee's attention to various sections of the GDC's 'Guidance for the Professional Conduct Committee' (November 2009), including paragraph 42 (relating to behaviours which are so damaging to a registrant's fitness to practise and to public confidence in dental professionals that erasure should be considered to be the appropriate outcome), which she said were relevant in this case.

You, on behalf of Dr York, have submitted that this is not a case where the outcome should be one of erasure and that, instead, the Committee should consider a lesser sanction. You have indicated that Dr York would be willing to abide by conditions on her registration, to include a requirement that her practise be supervised. However, you recognise that in view of the serious findings against Dr York, the Committee may conclude that a period of suspension, together with a review hearing to take place before the expiry of the order, would be appropriate. In support of that submission, you have referred to the fact that this is a one off episode in an otherwise long and unblemished career, the evidence of remediation, as well as the supportive testimonials submitted on behalf of Dr York.

The Committee has considered the submissions made by both parties. It has borne in mind the testimonials as well as the fact that there have been no GDC proceedings against Dr York in her long career.

Throughout its deliberations the Committee has kept in mind the GDC's 'Guidance for the Professional Conduct Committee' and the general principles that it must apply in considering what sanction, if any, is to be imposed. These include the need to protect patients and the public interest. The public interest includes not only the protection of patients, but also the maintenance of public confidence in, and the reputation of, the profession and its regulatory process, as well as the declaring and upholding of proper standards of conduct and behaviour. The Committee has also had regard to the principle of proportionality, weighing the interests of the public with Dr York's own interests. It has borne in mind that it should impose the least restrictive sanction which is sufficient for the protection of the public and is in the public interest. It is mindful that the purpose of a sanction is not to be punitive, although that may be its effect.

The Committee has considered the range of sanctions available to it, starting with the least serious. It first considered whether it would be sufficient to conclude this case by taking no action against Dr York's registration. Given the wide ranging and serious nature of the findings against Dr York, including a finding of dishonesty, the Committee is satisfied that such a course of action would be insufficient. For the same reasons, the Committee has determined that it would be wholly inappropriate to conclude the case with a reprimand.

The Committee next considered the sanction of a period of conditional registration. In so doing, it has taken into account the breadth of the clinical findings against Dr York, which the Committee considered were serious breaches of the basic standards of care patients are entitled to expect from dentists. The Committee is concerned that Dr York has shown no real insight into the shortcomings identified in this case. The Committee is not satisfied that Dr York has the potential to respond positively to remediation. Moreover, the Committee has had regard to the finding of dishonesty and her inappropriate and malicious behaviour in communicating with Patient A's GP practice and Social Services. The Committee considers that these findings are serious which relate to significant attitudinal problems and which could not be addressed by way of conditions. Taking these factors into account, the Committee has concluded that a period of conditional registration would not be sufficient for the protection of patients or for the maintenance of public confidence or for the upholding of proper standards in the profession.

The Committee then considered whether it should impose a period of suspension. It has found significant shortcomings in Dr York's clinical practice and she has caused harm to Patient A. It has grave concerns about Dr York's insight into the matters found proved against her. Throughout her evidence, Dr York has attempted to blacken Patient A's reputation and to shift responsibility away from herself rather than to acknowledge fault for failures in Patient A's treatment. Further, it has found Dr York to have behaved dishonestly; this is in breach of one of the fundamental tenets of the dental profession, namely to be trustworthy. She deliberately created false records. This was a serious matter.

The Committee had regard to the GDC's "Guidance for the Professional Conduct Committee". It considers that paragraphs 42(c), 42(e), 42(f), 42(g) and 42(h), are relevant in this case, under the following headings:

42(c) Deliberately or recklessly causing serious avoidable harm to patients

42(e) Dishonesty

42(f) Failure to maintain professional knowledge and competence in areas relevant to the registrant's practice.

42(g) Undertaking treatment or procedures beyond one's competence

42(h) Patterns of behaviour which are incompatible with professional registration

In conclusion the Committee is satisfied that to suspend Dr York's registration would not be sufficient to protect the public, uphold proper standards and maintain public confidence in the dental profession.

The Committee has concluded that Dr York's misconduct as a whole is so serious that it is fundamentally incompatible with her remaining on the Dentists Register. Accordingly, the Committee has determined that the only appropriate and proportionate sanction in this case is that of erasure. The Committee has taken into account the impact of such a direction on

Dr York's own interests. However, in the light of the serious nature of the findings against Dr York, the Committee considers that the need to protect patients and the public interest clearly outweighs her own interests in this matter.

The Committee now invites submissions from both parties as to whether Dr York's registration should be suspended immediately, pending the taking effect of its substantive direction of erasure."

Decision on immediate order

"Mr Leonard: Having directed that Dr York's name be erased from the Dentists Register, the Committee has considered whether to impose an order for immediate suspension in accordance with Section 30(1) of the Dentists Act 1984.

Ms Barnfather, on behalf of the General Dental Council (GDC), has submitted that such an order is necessary for the protection of the public, is otherwise in the public interest and is in Dr York's own interests in the light of the Committee's findings. You, on behalf of Dr York, have made no submission on this matter.

In all the circumstances, the Committee has determined that it is necessary for the protection of the public and is otherwise in the public interest to impose an order for the immediate suspension of Dr York's registration. The Committee has imposed the highest possible sanction in this case as it is satisfied that Dr York's conduct and behaviour are incompatible with professional registration. The Committee has therefore decided that it would be inconsistent to allow Dr York the opportunity to continue to practise during the intervening appeal period.

The effect of the foregoing determination and this immediate order is that Dr York's registration will be suspended from the date on which notice of this decision is deemed served upon her. Unless she exercises her right of appeal, her name will be erased from the Dentists Register 28 days from the date of deemed service. Should Dr York exercise her right of appeal, this immediate order for suspension will remain in place until the resolution of any appeal.

That concludes this case."