HEARING HEARD IN PUBLIC

KIRKUP, Stephen

Registration No: 61174

PROFESSIONAL CONDUCT COMMITTEE

MARCH 2018

Outcome: Erased with Immediate Suspension

Stephen KIRKUP, a dentist, BDS Ncle 1986, was summoned to appear before the Professional Conduct Committee on 19 March 2018 for an inquiry into the following charge:

Charge (as amended on 19 and 20 March 2018)

"That being registered as a dentist under the Dentists Act 1984:

Patient A (A2)

1. Between around 2 February 2013 and around 24 November 2014 you failed to provide an adequate standard of care in that you did not take any bitewings radiographs when it was indicated to do so.

Patient B (A6)

2. You did not, adequately or at all, report on the bitewings radiographs taken on or around 9 January 2014.

Patient C (A9)

3. You did not, adequately or at all, report on the bitewings radiographs taken on or around 20 February 2014.

4. On or around 8 December 2014 you failed to provide an adequate standard of care in that you used 'Chemfil' glass ionomer to restore UL5.

5. On or around 24 March 2014 you failed to take an adequate record in that you did not record the local anaesthetic used when carrying out the extraction of LR8.

Patient D (A11)

6. You did not, adequately or at all, report on the bitewings radiographs taken on or around 25 May 2015.

Patient E (A14)

7. You did not, adequately or at all, report on the bitewings radiographs taken on or around 19 August 2013.

8. You failed to provide an adequate standard of care in that:

   a. Between on or around 19 August 2013 and 8 July 2016 you failed to diagnose and/or treat:

      i. caries at LR6;

ii. bone loss around LR6.

b. Between on or around 19 August 2013 and 13 July 2015 you failed to diagnose and/or treat:

i. caries at LL6;

ii. caries at LL5;

c. On or around 29 August 2013 you failed, adequately or at all, to give oral hygiene instruction.

d. On or around 13 July 2015 you failed to, adequately or at all, assess the periodontal condition.

Patient F (A15)

9. On or around 8 January 2015 you failed to provide an adequate standard of care in that:

a. You failed to take a periapical radiograph when it was indicated to do so;

b. You failed to diagnose the cause of the sinus present in the upper left quadrant;

c. You prescribed antibiotics when it was not clinically indicated.

Patient G (A16)

10. You did not, adequately or at all, report on the bitewings radiographs taken on or around 4 June 2015.

11. You failed to provide an adequate standard of care in that:

a. On or around 4 June 2015 you failed to take a periapical radiograph when it was indicated to do so;

b. On or around 11 June 2015 you prescribed antibiotics when it was not clinically indicated.

Patient H (A17)

12. On or around 5 June 2015 you failed to provide an adequate standard of care in that you prescribed antibiotics when it was not clinically indicated.

Patient I (A21)

13. You did not, adequately or at all, report on the bitewings radiographs taken on or around 29 June 2015.

14. On or around 29 June 2015 you failed to provide an adequate standard of care in that:

a. You failed to diagnose and/or treat:

i. WITHDRAWN;

ii. caries at UL7;

iii. caries at LL7;

iv. caries at UR7

v. WITHDRAWN;

vi. WITHDRAWN;

vii. caries at LR6.

b. You prescribed antibiotics when it was not clinically indicated.

Patient J (A22)

15. On or around 25 June 2015 you failed to provide an adequate standard of care in that:

a. You failed, adequately, or at all, to diagnose the extent of the periodontal disease;

b. You failed, adequately or at all, to treat the periodontal disease which was present;

c. You failed, adequately or at all, to provide smoking cessation advice.

Patient K (B4)

16. On or around 17 August 2015 you failed to provide an adequate standard of care in that you failed to provide any, or any adequate, oral hygiene advice.

Patient L (B12)

17. You did not, adequately or at all, report on the bitewings radiographs taken on or around 20 September 2013.

18. Between on or around 20 September 2013 and on or around 8 November 2016 you failed to provide an adequate standard of care in that you failed to treat, adequately or at all, a retained root in the lower right quadrant.

Patient M (B13)

19. On or around 26 October 2015 you failed to provide an adequate standard of care in that you failed to:

a. carry out an adequate intraoral examination and/or periodontal assessment;

b. diagnose, adequately or at all, the periodontal condition;

c. advise, adequately, or at all, as to treatment.

Patient N (A30)

20. On or around 8 May 2014 you failed to provide an adequate standard of care in that you prescribed antibiotics when it was not clinically indicated.

Patient O (A1)

21. On or around 13 August 2015 you failed to provide an adequate standard of care in that you failed to provide any, or any adequate, oral hygiene advice.

Patient P (A8)

22. You did not, adequately or at all, report on the bitewings radiographs taken on or around 25 November 2014.

Patient Q (A18)

23. You did not provide an adequate standard of care in that:

    a. Between around 13 October 2011 and on or around 13 January 2015 you failed, adequately or at all, to treat and/or manage the failed crown at UL1.

    b. Between on or around 9 January 2014 and on or around 2 October 2014 you did not take a periapical radiograph of the UL1 when it was indicated to do so.

Patient R (A 24)

24. On or around 18 June 2015 you failed to provide an adequate standard of care in that:

    a. You did not provide any, or any adequate, smoking cessation advice;

    b. You did not take a bitewings radiograph when it was indicated to do so.

Patient S (B11)

25. You did not, adequately or at all, report on the bitewings radiographs taken on or around 13 August 2015.

Patient T (B1)

26. On or around 17 August 2015 you failed to provide an adequate standard of care in that you failed to carry out an adequate intraoral examination.

Patient U (B8)

27. On or around 17 August 2015 you failed to provide an adequate standard of care in that you failed to carry out an adequate intraoral examination.

Patient V (B 15)

28. On or around 26 October 2015 you failed to provide an adequate standard of care in that you failed to carry out an adequate intraoral examination.

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."

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

Service and proceeding in the absence of the registrant

"Mr Kirkup is neither present nor represented at this hearing.

The Committee saw a copy of the notification of this hearing, dated 31 January 2018, that was sent to Mr Kirkup's registered addressed by recorded delivery. The Committee noted that it was also emailed to him.

The Committee saw a printout from the Royal Mail Track and Trace website service which indicated that the notice was delivered and signed for on 1 February 2018.

The Committee was therefore satisfied that service had been effected in accordance with the Rules.

The Committee next considered whether to proceed with the hearing in Mr Kirkup's absence.

It noted a letter from Mr Kirkup's representatives at Gordon's Solicitors, dated 16 March 2018, in which they state, amongst other matters, that he will not be in attendance at this hearing due to the stress caused to him by these proceedings. They make no request for an adjournment, nor do they indicate that he would attend a rescheduled hearing on a later date. The letter also explains that Mr Kirkup has been retired '…for some time…' and that he has sought voluntary removal from the register.

Taking all of these matters into account, the Committee took the view that an adjournment would not be likely to result in Mr Kirkup's attendance at a rescheduled hearing in future. It determined that there was a public interest in the expeditious disposal of matters such as this and that the circumstances were such that proceeding in the absence of the registrant would be fair and reasonable. The Committee therefore determined so to do.

Amendments to the charge and withdrawals

During the first stage of the hearing Mr Corrie made a small number of amendments and withdrawals. The Committee heard and accepted the advice of its Legal Adviser. It was satisfied that there was no prejudice to Mr Kirkup in allowing the amendments and withdrawals, and therefore acceded to each application.

The amendments and withdrawals are reflected in an updated version of the charge sheet. The withdrawals are also indicated below."

On 21 March 2018 the Chairman made the following statement regarding the finding of facts:

"The Committee has taken into account all the evidence presented to it. It has accepted the advice of the Legal Adviser.

This case involves alleged inadequate care, treatment and record keeping on the part of Mr Kirkup in respect of a total of 22 patients. The failings are said to include not taking radiographs, not reporting on radiographs, not diagnosing and treating a variety of conditions, prescribing antibiotics when it was not clinically indicated to do so, not providing adequate intraoral assessments and not providing oral hygiene advice to patients.

The Committee received a National Clinical Assessment Service (NCAS) report and heard oral evidence from Sanhita Subramaniam and Kevin Atkinson who were both NCAS assessors at the time these matters are said to have occurred. They provided evidence in respect of care and treatment carried out by Mr Kirkup in their presence. In their professional capacity as Clinical Assessors they attended his practice and observed him whilst practising. They kept contemporaneous notes during their visit to the practice and they made reference to their written report when giving their oral evidence. The Committee found them to be credible and reliable witnesses.

The Committee received a written expert report from David Kramer on behalf of the GDC. It also heard oral evidence from him. In the Committee's judgement he gave coherent, cogent and reasonable evidence and he applied the appropriate standard when giving his opinion on Mr Kirkup's work. The Committee notes that Mr Kramer currently works in general practice and appears to have a good grasp of general dentistry. It found him to be a very credible expert witness with a high standard of expertise.

The Committee's findings in relation to each head of charge follow:

1.	Proved. Patient A attended Mr Kirkup's surgery regularly during the requisite time period and the preceding two years. There is no note within Patient A's records of any bitewing radiographs having been taken between February 2013 and November 2014, or the preceding two years. Mr Kramer told the Committee that despite Patient A having been assessed as being at low caries risk, bitewing radiographs should nevertheless have been taken in order to determine whether there was caries present that could not be detected by clinical examination alone. He also stated that Faculty of General Dental Practice (FGDP) guidelines require radiographs to be taken at least at two yearly intervals. The Committee concurs with Mr Kramer's view that radiographs should have been taken by Mr Kirkup.
2.	Proved. Patient B attended on 9 January 2014 and bitewing radiographs were taken. However, no report on the radiographs appears within the patient's record other than 'OK'. Mr Kramer stated that the radiographs indicate that there was caries present and that a report of 'OK' was therefore inadequate. The Committee concurs with Mr Kramer that Mr Kirkup failed to report adequately on the radiographs in the light of the caries that was present.
3.	Proved. Bitewing radiographs were taken on 22 February 2014, however there is no report in respect of these radiographs in the record. Mr Kramer describes Mr Kirkup's failure to make a report on the radiographs as a breach of IR(ME)R 2000. The Committee concurs.
4.	Not proved. Mr Kramer told the Committee that the use of 'Chemfil' glass ionomer to restore patient C's UL5 on 20 February 2014 was inappropriate because it is not designed for use as a definitive filling material on the occlusal surface of a tooth. The notes within Patient C's record state that the restoration was placed on the palatal surface. There is no mention of the occlusal. Furthermore Mr Kirkup has recorded that he would 'try to pin fill' and that there is 'very little tooth left'. This leads the Committee to conclude that this may not have been intended by Mr Kirkup to be a definitive restoration. In the light of this, the Committee was not satisfied that this head of charge was proved.

5.	Proved. There is no note of the local anaesthetic used by Mr Kirkup when extracting the LR8, within Patient C's record. Mr Kramer stated that this failure placed the patient at risk of harm in that if they were to suffer an adverse reaction to the local anaesthetic another practitioner would not know what had caused it and could not avoid it happening again. The Committee concurs with Mr Kramer.
6.	Proved. Bitewing radiographs were taken that indicated caries to UL6 and UL5, however there is no report in respect of these radiographs in the record. Mr Kramer describes Mr Kirkup's failure to make a report on the radiographs as a breach of IR(ME)R 2000. The Committee concurs.
7.	Proved. Bitewing radiographs were taken on 19 August 2013. However, no report on the radiographs appears within the patient's record other than 'nad'. Mr Kramer stated that the radiographs indicate that there was caries present, bone loss and calculus. A report of 'nad' was therefore inadequate. The Committee concurs with Mr Kramer that Mr Kirkup failed to report adequately on the radiographs in the light of the caries, bone loss and calculus that was present.
8. a) i)	Proved. Mr Kirkup has made no note in respect of diagnosis or treatment of Patient E's caries at LR6 and the Committee has inferred from this absence of a record that no diagnosis or treatment occurred. Mr Kramer has had sight of the radiograph and is satisfied that there is caries present in respect of this tooth. The Committee concurs and finds that Mr Kirkup failed to provide an adequate standard of care.
8. a) ii)	Proved. Mr Kirkup has made no note in respect of diagnosis or treatment of Patient E's bone loss at LR6 and the Committee has inferred from this absence of a record that no diagnosis or treatment occurred. Mr Kramer has had sight of the radiograph and is satisfied that there is caries present in respect of this tooth. The Committee concurs and finds that Mr Kirkup failed to provide an adequate standard of care.
8. b) i)	Proved. Mr Kirkup has made no note in respect of diagnosis or treatment of Patient E's caries at LL6 and the Committee has inferred from this absence of a record that no diagnosis or treatment occurred.

	Mr Kramer has had sight of the radiograph and is satisfied that there is caries present in respect of this tooth. The Committee concurs and finds that Mr Kirkup failed to provide an adequate standard of care.
8. b) ii)	Proved. Mr Kirkup has made no note in respect of diagnosis or treatment of Patient E's caries at LL5 and the Committee has inferred from this absence of a record that no diagnosis or treatment occurred. Mr Kramer has had sight of the radiograph and is satisfied that there is caries present in respect of this tooth. The Committee concurs and finds that Mr Kirkup failed to provide an adequate standard of care.
8. c)	Proved. Mr Kirkup has made no note of having given Patient E oral hygiene instruction. The Committee has looked through over twenty of Mr Kirkup's patient records and has noted that there are a number of occasions when he has recorded having given oral hygiene instruction. It has therefore inferred that when he has given oral hygiene instruction he records it. The Committee has seen that Patient E had basic periodontal examination (BPE) scores of '2' – indicating the presence of calculus. It is therefore satisfied that Mr Kirkup was obliged to give oral hygiene advice in the light of those scores.
8. d)	Proved. The Committee has seen no record to indicate that a BPE occurred. It therefore infers that none occurred. The last assessment took place a year prior. Mr Kramer is critical of Mr Kirkup's failure to carry out a BPE on 13 July 2015. The Committee concurs with his view.
9. a)	Proved. A sinus is noted as present in the upper left quadrant of Patient F's mouth. Mr Kramer takes the view that a periapical radiograph should have been taken in order to investigate the cause of the infection. The Committee concurs.
9. b)	Proved. There is no diagnosis recorded within Patient E's record.
9. c)	Proved. Mr Kramer is critical of Mr Kirkup's prescribing of antibiotics on the basis that there was no evidence of spreading infection with swelling and/or raised temperature. He therefore concludes that there was no justification for the prescription. The Committee concurs.

10.	Proved. Bitewing radiographs were taken, however there is no report in respect of these radiographs in the record. Mr Kramer describes Mr Kirkup's failure to make a report on the radiographs as a breach of IR(ME)R 2000. The Committee concurs.
11. a)	Proved. Patient G saw Mr Kirkup on 4 June 2015 complaining of pain in the upper left quadrant of her mouth. A bitewing radiograph was taken that showed UL6 with a large filling present but no obvious pathology or change. Mr Kramer takes the view that a periapical radiograph should have been taken in order to properly assess the tooth, make a diagnosis and consider treatment options. The Committee concurs.
11. b)	Proved. Mr Kirkup has noted the presence of a dry socket. Mr Kramer is critical of Mr Kirkup's prescribing of antibiotics on the basis that there was no evidence of spreading infection with swelling and/or raised temperature. Furthermore, he cited in his report an extract from the FGDP guidance in respect of dry socket and the use of antimicrobials, which states that they are contraindicated in the absence of spreading infection. He therefore concludes that there was no justification for the prescription. The Committee concurs.
12.	Proved. Mr Kirkup has noted the presence of a dry socket. Mr Kramer is critical of Mr Kirkup's prescribing of antibiotics on the basis that there was no evidence of spreading infection with swelling and/or raised temperature. Furthermore, he cited in his report an extract from the FGDP guidance in respect of dry socket and the use of antimicrobials, which states that they are contraindicated in the absence of spreading infection. He therefore concludes that there was no justification for the prescription. The Committee concurs.
13.	Proved. Bitewing radiographs were taken, however there is no report in respect of these radiographs in the record. Mr Kramer describes Mr Kirkup's failure to make a report on the radiographs as a breach of IR(ME)R 2000. The Committee concurs.
14. a) i)	Withdrawn
14. a) ii)	Proved. Mr Kirkup has made no note in respect of diagnosis or treatment of Patient I's caries at UL7 and the Committee has inferred from this absence of a record that no diagnosis or treatment occurred. Mr Kramer has had sight of the radiograph and is satisfied that there is caries present in respect of this tooth. The Committee

	concurs and finds that Mr Kirkup failed to provide an adequate standard of care.
14. a) iii)	Proved. Mr Kirkup has made no note in respect of diagnosis or treatment of Patient I's caries at LL7 and the Committee has inferred from this absence of a record that no diagnosis or treatment occurred. Mr Kramer has had sight of the radiograph and is satisfied that there is caries present in respect of this tooth. The Committee concurs and finds that Mr Kirkup failed to provide an adequate standard of care.
14. a) iv)	Proved. Mr Kirkup has made no note in respect of diagnosis or treatment of Patient I's caries at UR7 and the Committee has inferred from this absence of a record that no diagnosis or treatment occurred. Mr Kramer has had sight of the radiograph and is satisfied that there is caries present in respect of this tooth. The Committee concurs and finds that Mr Kirkup failed to provide an adequate standard of care.
14. a) v)	Withdrawn
14. a) vi)	Withdrawn
14. a) vii)	Proved. Mr Kirkup has made no note in respect of diagnosis or treatment of Patient I's caries at LR6 and the Committee has inferred from this absence of a record that no diagnosis or treatment occurred. Mr Kramer has had sight of the radiograph and is satisfied that there is caries present in respect of this tooth. The Committee concurs and finds that Mr Kirkup failed to provide an adequate standard of care.
14. b)	Proved. Mr Kirkup has prescribed antibiotics but has made no note of the reason or justification for doing so. Mr Kramer is critical of Mr Kirkup's prescribing of antibiotics on the basis that there was no evidence of spreading infection with swelling and/or raised temperature. He therefore concludes that there was no justification for the prescription. The Committee concurs.
15. a)	Proved. Patient J's records indicate that a BPE was carried out by Mr Kirkup., with scores of '3' and mobility noted. There is no further assessment noted such as pocket charting and no diagnosis is made. Mr Kramer stated that in his view the radiographs also indicate a very poor periodontal condition.

	In the light of the BPE scoring, mobility and the radiographs Mr Kirkup should have carried out, and made a record of, further assessments in order to determine the extent of Patient J's periodontal disease.
15. b)	Proved. The notes indicate that a scale and polish was carried out and that oral hygiene advice was given to the patient. A six month recall period was also established. However, in the light of the extent of Patient J's periodontal disease, this treatment was inadequate.
15. c)	Proved. According to Patient J's medical history, the patient was a smoker. According to the medical history the patient smoked 20 cigarettes a day. There is no record of smoking cessation advice having been provided to Patient J and the Committee has inferred from this absence of a record that no such advice was given. Bearing in mind Patient J's poor periodontal condition, a condition that the Committee is aware is adversely affected by smoking, smoking cessation advice should have been given.
16.	Proved. The NCAS assessors were present during Mr Kirkup's treatment of Patient K. They told the Committee that although Mr Kirkup assessed the patient's oral hygiene, he failed to give oral hygiene advice. The Committee is aware that this was a child patient and accepted Mr Kramer's view that Mr Kirkup was obliged in the circumstances to provide such advice to the patient.
17.	Proved. Bitewing radiographs were taken and Mr Kirkup noted in the record 'two bitewings taken for decay, bitewings checked', 'no pain from roots, happy to leave'. Mr Kramer stated that the radiographs indicate that there are numerous retained roots and show an apical pathology. Mr Kirkup's assessment is therefore inadequate. The Committee concurs with Mr Kramer that Mr Kirkup failed to report adequately on the radiographs in the light of the pathology present.
18.	Proved. Patient L's records indicate that Mr Kirkup had discussed the retained roots with him in the past. Mr Kirkup has noted 'problem' in the record, indicating that he has identified that there is pathology present. He also noted that there was no pain in the roots and 'happy to leave until toothache', which the Committee is satisfied can reasonably be attributed to the patient.

	However, having had regard to the NCAS report, based on two assessors who were present during the relevant appointment, which states that no suitable treatment options were discussed, the Committee concurs with Mr Kramer there was no adequate justification for Mr Kirkup's failure to treat the retained root in the lower right quadrant.
19. a)	Proved. Patient M's LL1 was loose. The NCAS assessors state in their report that if Mr Kirkup had carried out an adequate intraoral assessment he would have noticed the loose LL1. There is no record of a BPE or pocket depth charting having been carried out. The Committee accepts Mr Kramer's view that this failing constitutes a failure to carry out a periodontal assessment.
19 b)	Proved. Having found that Mr Kirkup failed to carry out a periodontal assessment, the Committee also finds that he cannot have diagnosed the periodontal condition.
19. c)	Proved. Having found that Mr Kirkup failed to carry out an adequate intraoral assessment and periodontal assessment, the Committee also finds that he failed to advise adequately as to treatment.
20.	Proved. Mr Kirkup has prescribed antibiotics but has made no note of the reason or justification for doing so. Mr Kramer is critical of Mr Kirkup's prescribing of antibiotics on the basis that there was no evidence of spreading infection with swelling and/or raised temperature. Furthermore, he cited in his report an extract from the FGDP guidance in respect of dry socket and the use of antimicrobials, which states that they are contraindicated in the absence of spreading infection. He therefore concludes that there was no justification for the prescription. The Committee concurs.
21.	Proved. The NCAS assessors were present during Mr Kirkup's treatment of Patient O. They told the Committee that although Mr Kirkup assessed the patient's oral hygiene, he failed to give oral hygiene advice. The Committee is aware that this was a child patient and accepts Mr Kramer's evidence that Mr Kirkup was obliged in the circumstances to provide such advice to the patient.
22.	Proved. Bitewing radiographs were taken, however there is no report in respect of these radiographs in the record. Mr Kramer describes Mr Kirkup's failure to make a report on the radiographs as a

	breach of IR(ME)R 2000. The Committee concurs.
23. a)	Not proved. The records indicate that on 18 November 2010 when Mr Kirkup placed a new crown on UL1 he wrote 'will try new post' then 'will see if it holds'. Although this occurred outside of the period covered by this head of charge, the Committee is of the view that it is contextually relevant in that it shows that when treatment was initially undertaken there was an element of doubt in Mr Kirkup's mind regarding its success. On 15 May 2014 'may need xla…pt warned' is noted within the records. This indicates that a discussion was had with the patient about the prognosis and options in respect of the tooth. The Committee is not satisfied that the GDC has discharged its burden to prove a failing on the part of Mr Kirkup in respect of this head of charge.
23. b)	Proved. No periapical radiograph was taken in respect of Patient Q's UL. The Committee accepts Mr Kramer's evidence that Mr Kirkup should have taken a periapical in order to assess the prospects of success of refixing or replacing the crown. Furthermore, the Committee notes that a root fracture was noted in respect of the tooth.
24. a)	Proved. According to Patient R's medical history, the patient was a smoker. There is no record of smoking cessation advice having been provided to Patient R and the Committee has inferred from this absence of a record that no such advice was given. Bearing in mind Patient R's poor periodontal condition, a condition that the Committee is aware is adversely affected by smoking, smoking cessation advice should have been given.
24. b)	Proved. There is nothing in the records to indicate that bitewing radiographs were taken in respect of Patient R. Eight years had elapsed since Patient R's last attendance. Taken together with the patient's periodontal condition, bitewing radiographs were indicated.
25.	Proved. Bitewing radiographs were taken however, no report on the radiographs appears within the patient's record other than 'OK'. Mr Kramer stated that the radiographs show an absence of the LR5 and that an adequate note required this to have been recorded. A report of 'OK' was therefore inadequate.

	The Committee concurs with Mr Kramer that Mr Kirkup failed to report adequately on the radiographs in the light of the absence of the LR5.
26.	Proved. The NCAS assessors were present during Mr Kirkup's treatment of the patient. Despite his note that the 'soft tissues were okay' the NCAS assessors state that only the teeth and gums were checked, and that no soft tissue examination was conducted. In oral evidence Mr Atkinson said there was no systemic soft tissue check or palpation. As soft tissue examination is an integral part of intraoral examination, the Committee deems Mr Kirkup's standard of care to have been inadequate.
27.	Proved. The NCAS assessors were present during Mr Kirkup's treatment of the patient. Despite his note that the 'soft tissues were okay' the NCAS assessors state that only the teeth and gums were checked, and that no soft tissue examination was conducted. In oral evidence Mr Atkinson said there was no systemic soft tissue check or palpation. As soft tissue examination is an integral part of intraoral examination, the Committee deems Mr Kirkup's standard of care to have been inadequate.
28.	Proved. The NCAS assessors were present during Mr Kirkup's treatment of the patient. Despite his note that the 'soft tissues were okay' the NCAS assessors state that only the teeth and gums were checked, and that no soft tissue examination was conducted. In oral evidence Mr Atkinson said there was no systemic soft tissue check or palpation. As soft tissue examination is an integral part of intraoral examination, the Committee deems Mr Kirkup's standard of care to have been inadequate.

We move to Stage Two."

On 22 March 2018 the Chairman announced the determination as follows:

"The Committee took into account all the documentary evidence presented to it, including the stage two bundle produced on behalf of Mr Kirkup, and the submissions made at this second stage of the proceedings. It accepted the advice of the Legal Adviser.

FACTUAL BACKGROUND

The Committee found proved allegations that from 2011 to 2015 Mr Kirkup failed to provide an adequate standard of care, treatment and record keeping in respect of a total of 22 patients.

The findings against him include:

- Failing to take radiographs when indicated;
- Failing to adequately report on radiographs taken;
- Failing to make a record of local anaesthetic used during an extraction;
- Failing to diagnose caries, bone loss, periodontal disease and the cause of a sinus present in a patients ULQ;
- Failing to treat caries, bone loss, periodontal disease and a retained root in the LRQ;
- Failing to give oral hygiene instruction,
- Failing to give smoking cessation advice;
- Failing to adequately assess the periodontal condition of a number of patients;
- Prescribing antibiotics when it was not clinically indicated; and
- Failing to carry out adequate intraoral examinations.

MISCONDUCT

The Committee first considered whether any of the facts it found proved against Mr Kirkup amounted to misconduct. It bore in mind that misconduct is a word of general effect involving some act or omission which falls short of what would be proper in the circumstances, and in order to make such a finding the falling short must be serious. The Committee also bore in mind that misconduct is a matter for its own judgement.

The facts found proved span a period of time that encompasses both the most recent standards and those that immediately preceded them. The Committee considered that Mr Kirkup's failings had breached a number of standards from both publications.

The Committee first had regard to the following sections of *Standards for Dental Professionals* (2005):

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.

1.3 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.

5.3 Find out about current best practice in the fields in which you work. Provide a good standard of care based on available up-to-date evidence and reliable guidance.

5.4 Find out about laws and regulations which affect your work, premises, equipment and business, and follow them.

The Committee then considered the following sections of *Standards for the Dental Team* (2013):

1.1.1 You must discuss treatment options with patients and listen carefully to what they say. Give them the opportunity to have a discussion and to ask questions.

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

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.

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

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

The Committee had regard to the requirements of the *Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER)*.

Mr Kirkup's failures were numerous, involved many patients, were wide ranging and related to basic and fundamental aspects of dentistry. The Committee was very concerned about the repeated and sustained nature of a number of the breaches over a lengthy period.

The Committee had particular regard to Mr Kirkup's repeated failure to carry out adequate soft tissue examinations on patients. It noted with concern that he failed to do so appropriately even whilst being observed by NCAS assessors. It took the view that he demonstrated a systemic habit of inadequacy regarding this aspect of patient care.

The examinations are important because they screen for serious pathology such as oral cancer – a disease which can be fatal and where early detection significantly affects prognosis. On multiple occasions Mr Kirkup noted 'ok' in respect of soft tissue examinations despite not undertaking important aspects of this assessment.

It determined that all of Mr Kirkup's actions and omissions as set out above were serious and fell far short of the standards expected of a reasonably competent dentist. The Committee is in no doubt that they would be deemed deplorable by his fellow professionals and therefore amount to misconduct.

DEFICIENT PROFESSIONAL PERFORMANCE

Having determined that the facts found proved amount to misconduct, the Committee had regard to the comments of Ouseley J in Vali v General Optical Council [2011] EWHC 310 (Admin). It took the view that it was unnecessary to consider whether the same matters amounted to deficient professional performance.

IMPAIRMENT

In determining whether Mr Kirkup's fitness to practise is currently impaired, the Committee remained mindful of the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession.

The Committee considered that Mr Kirkup's clinical failings although wide-ranging were potentially remediable. It was satisfied that his misconduct could be addressed by appropriate Continuing Professional Development (CPD) courses, an appropriately directed Personal Development Plan (PDP), written reflection material and evidence of insight.

The Committee considered the written material put forward on Mr Kirkup's behalf relating to his application for Voluntary Removal. It notes from a letter within that material, dated 22 December 2017, that Mr Kirkup has acknowledged his performance was deficient and has expressed remorse for his past errors. He has also stated that he is retired and intends to remain so and that he accepts his fitness to practise is impaired on the basis of deficient professional performance. In the light of the material, the Committee took the view that Mr Kirkup has a degree of insight in to his misconduct. However, Mr Kirkup has produced no material demonstrating that he has addressed his deficiencies.

Many of Mr Kirkup's failings were repeated on many occasions. The Committee is therefore concerned that his deficiencies are ingrained. Notwithstanding his decision to retire, the Committee determined that in the absence of any material demonstrating that he is now safe to practise, or making any efforts to become safe to practise, the risk of repetition of his misconduct is high.

Having determined that there is a real risk of repetition of Mr Kirkup's misconduct, the Committee further determined that public confidence in the profession would be undermined if a finding of impairment were not made. The public would expect such a finding to be made given the wide-ranging nature of Mr Kirkup's errors and their persistent and repeated nature.

The Committee therefore finds that Mr Kirkup's fitness to practise is currently impaired.

SANCTION

The Committee next considered what sanction, if any, to impose upon Mr Kirkup's registration. It bore in mind that the purpose of a sanction is not to be punitive, but rather to protect patients and the wider public interest.

In considering sanction, the Committee took into account the *Indicative Sanctions Guidance for the Practice Committees* (October 2016). It applied the principle of proportionality and balanced the public interest against Mr Kirkup's own interests.

The Committee had regard to the mitigation in Mr Kirkup's favour; namely his lack of a fitness to practise history before the GDC, the small element of insight that he has shown, the remorse he has expressed and that he was not financially motivated in his misconduct. It balanced these against the aggravating factors, including the numerous basic failings he exhibited that fell far below appropriate standards, the risk of harm posed to a number of patients and the sustained and repeated nature of his misconduct. It particularly bore in mind that Mr Kirkup purportedly carried out intraoral examinations and assessments of patient's soft tissues and periodontal conditions, yet failed to do so properly. Troublingly he would at times erroneously make a record that nothing abnormal had been detected during such examinations, despite the presence of obvious anomalies and disease. Whilst the Committee has seen no evidence of malevolence on his part, it nevertheless judges that his deficiencies in this regard would serve to undermine the trust that patients are entitled to have in dental professionals – particularly when considering the more ominous potential repercussions of his errors, such as not picking up on lesions that could be cancerous.

The Committee considered whether it would be sufficient to conclude the case with no further action. However, it determined that in the light of the serious findings it had made, concluding the case with no further action would not be an appropriate or proportionate response.

The Committee considered the available sanctions in ascending order of seriousness, remembering that the sanction to be imposed should be the least severe sanction which deals adequately with the identified issues whilst protecting the public interest.

It next considered whether to issue Mr Kirkup with a reprimand. It determined that a reprimand would neither serve to safeguard patients, nor uphold public confidence in the profession given the identified risks.

The Committee considered whether conditions of practice could be formulated that would address Mr Kirkup's impairment. Although the Committee determined that his misconduct is remediable it bore in mind that he has not sought to do so, but rather has chosen to retire. Furthermore, this case involves numerous wide ranging and sustained clinical findings in respect of a number of patients. Taking all of these factors into account, the Committee determined that conditions could not be formulated that would address the risks to the public and preserve public confidence in the profession. It determined that due to the nature and number of failings in this case, the public interest required a higher level of sanction.

The Committee next considered whether to suspend Mr Kirkup's registration for a period of time. It noted the GDC's submission that suspension would be the appropriate sanction in this case.

It had regard to paragraph 7.28 of the *Indicative Sanctions Guidance* which states:

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

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

Mr Kirkup's departures from the standards were serious and his deficiencies were in respect of general dentistry that he should have been capable of carrying out appropriately. The risks posed to patients by his actions and omissions were serious. In the light of this the Committee took the view that his conduct may be fundamentally incompatible with being a dental professional.

The Committee had regard to paragraph 7.34 of the *Indicative Sanctions Guidance,* which states:

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

- *serious departure(s) from the relevant professional standards;*
- *where serious harm to patients or other persons has occurred, either deliberately or through incompetence;*

- *where a continuing risk of serious harm to patients or other persons is identified;*
- *the abuse of a position of trust or violation of the rights of patients, particularly if involving vulnerable persons;*
- *convictions or findings of a sexual nature, including involvement in any form of child pornography;*
- *serious dishonesty, particularly where persistent or covered up;*
- *a persistent lack of insight into the seriousness of actions or their consequences.'*

Mr Kirkup carried out inadequate examinations and regularly inaccurately recorded that things were 'ok'. His behaviour in this regard appears to the Committee to have become ingrained. This taken together with his other failures, including not taking radiographs, not reporting on radiographs, prescribing antibiotics inappropriately, failing to diagnose and treat caries, bone loss and other conditions, not giving oral hygiene advice and poor record keeping, amounts to an approach to dentistry that serves to undermine trust in the profession. Proper practice and standards were not upheld.

As the Committee has set out above, the risks to patients as a result of Mr Kirkup's repeated and persistent substandard practice are high. He has had the opportunity to demonstrate remediation and safe practice, but he has not done so.

The Committee has determined that Mr Kirkup's conduct is fundamentally incompatible with ongoing registration and that the public interest would not be satisfied by a sanction less than erasure.

The Committee must uphold and declare standards and safeguard the public. To that end it has determined that Mr Kirkup's name be erased from the Register."

IMMEDIATE ORDER

"The Committee considered the submissions made by Mr Corrie.

In his submissions Mr Corrie invited the Committee to impose an immediate order of suspension on Mr Kirkup's registration to cover the 28 day appeal period prior to the substantive sanction coming into effect. He submitted that such an order is necessary for the protection of the public and otherwise in the public interest.

The nature of the issues is very serious, and consequently the Committee has imposed a sanction of erasure. If Mr Kirkup were able to practise unrestricted at this time, he would pose a risk to patients. In the light of the Committee's reasons for its substantive decision, public confidence in the profession would be undermined. The Committee has therefore determined that an immediate order is necessary in this case for the protection of the public and is otherwise in the wider public interest for the same reasons as given for the substantive order.

The effect of the foregoing determination and this order is that Mr Kirkup's registration will be made subject to an order of suspension with immediate effect. If he chooses to appeal the substantive decision, this immediate order of suspension will remain in place until the resolution of that appeal. If no appeal is pursued, the immediate order will remain in place for 28 days, following which the substantive order will take effect.

The interim order currently in place is hereby revoked."