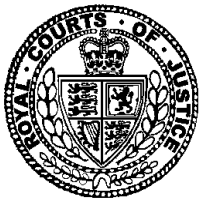

Neutral Citation Number: [2022] EWHC 1380 (Admin)

Case No: CO/552/2022

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT
On appeal from the Professional Conduct Committee of the General Dental Council's decisions made on 5th November 2021 and on 19th January 2022

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 7 June 2022

Before:

MR JUSTICE RITCHIE

- -

Between:

LUCY JANE WILLIAMS	**Claimant**
- and -	
THE GENERAL DENTAL COUNCIL	**Defendant**

- -
- -

Robert Kellar QC (instructed by **Hempsons Solicitors**) for the Appellant
Rebecca Harris instructed by the Respondent

Hearing dates: 18 and 19 May 2022

- -

Approved Judgment

Mr Justice Ritchie:

Parts of the hearing below were heard in private pursuant to Rule 53 of the *General Dental Council (Fitness to Practise) Rules* 2006 on the basis that reference was made to the Appellant's private life at the date of the index events. On that basis parts of the PCC's determination are redacted and are contained in a confidential private determination. That includes parts of the determination that are subject to this appeal. The Appellant also relies upon material that was received into evidence in private session for the purposes of this appeal.

At the outset of the hearing an application was made by the Appellant, which was supported by the Respondent, for non-disclosure. The Appellant sought an order that there shall not be reported, disseminated or otherwise disclosed to the public any copy of the private determination (or transcript of the private hearing) of the Professional Conduct Committee or the contents of the expert evidence referred to exclusively therein whether or not mentioned in court or contained in a document referred to in court, without the permission of the court or the written agreement of both parties (or their solicitors). I made an order in those terms.

It follows that that the public version of this judgment has been redacted as appropriate where I refer to material that was referred to in private session below.

The Parties

1. At the time of the relevant events the Appellant was a qualified dentist working in England and Wales.

2. The Respondent is the regulatory body for dentists.

Bundles

3. For the appeal there were 6 lever arch bundles and skeleton arguments from each party.

4. I was also provided with supplementary bundles containing the relevant NHS (General Dental Services Contracts) Regulations 2005 (hereinafter called the *Contracts Regulations)* and the NHS (Dental Charges) Regulations 2005 (hereinafter called the *Charges Regulations*) and the guidance thereon and the General Dental Services Contract held by the relevant practice (the Practice).

Terminology

5. I shall use the following terminology in this judgment:

   (1) PCC: Professional Conduct Committee.

   (2) UR4: upper right 4th tooth.

   (3) LR4: lower right 4th tooth.

   (4) GDC: General Dental Council.

   (5) COT: course of treatment.

(6) TP: treatment plan.

(7) UDA: unit of dental activity.

Introduction

6. The Appellant was charged with a long list of professional misconduct allegations by the Respondent. The PCC hearing lasted 27 days and 16 witnesses gave evidence. The fact findings were made by the PCC on 5th November 2021. The sanction decision was made on 19 January 2022. The PCC decided to erase the Appellant from the register of Dentists thereby banning her from practicing in the field for which she qualified and trained.

7. The Appellant does not appeal all of the PCC's findings. The list of those which are not appealed and so are left standing is included in the table below and includes one finding relating to dishonesty. However, she does appeal all of the other findings of dishonesty made against her and the decision to erase her from the register of dentists.

The Issues

8. Whether there was a failure in cross examination of the Appellant by the Respondent at the hearing to put the necessary assertions of fundamental facts to the Appellant so as to permit her a fair opportunity to answer the allegations of dishonesty such that the findings of the PCC on dishonesty were achieved without due or fair process.

9. Whether the appealed findings of dishonesty are wrongly made on the evidence or otherwise unfair.

10. Whether imposing the sanction of erasure was inappropriate, disproportionate, wrong or not in accordance with the relevant guidance.

Charges and chronology of the regulatory proceedings

11. The factual background to the regulatory issues is set out below. It is not in dispute.

12. The Appellant is the daughter of two dentists. She worked as a dentist's assistant in her mother's dental practice between 2000 and 2010. Whilst she did that she gained a certificate in dental nursing (2002), a certificate in oral health education (2003) and one in dental radiography (2005). She gained a qualification in pre-clinical science in Bratislava in 2009. She was a sales representative for a German dental products company for a short period between 2009 and 2010. She trained dental nurses between 2012 and 2013. She achieved a BDS degree from Peninsular Dental School in July 2016. She achieved a qualification in advance veneer restorations in Vienna in 2016. Between 2016 and 2017 she worked 4 days pw in foundation training with W, a dentist in the Glamorgan area. Whilst W did NHS and private dental work, the Appellant only did NHS dental work.

13. The Appellant became pregnant in late 2016 and gave birth on 8 June 2017 to a son. She returned to work on 24 July 2017.

14. In the background, whilst this was going on, in around 2014, her mother sold her practice to PRD who took it over. The Appellant took her first job in September 2017

at PRD's practice, the Practice, in effect taking over her mother's old role, 3 days per week.

15. No contract was provided to the Appellant by PRD. She was an independent associate dentist working at the Practice. She was set UDA targets. I am unclear as to precisely how she was paid. She had to pay a percentage of the lab fees incurred for her clinical work, the Practice paid the rest. The Practice had a contract with the NHS to provide NHS dental work to patients amounting to 18,000 UDAs pa. That work is paid for by the NHS after claims are made in four bands: numbered 1-4. The patient pays a fixed sum contribution to the cost of the work in each band, which is low. Some patients are exempt from paying anything at all. No copy of the NHS contract with the Practice governing the work in the relevant period was put before the PCC.

16. The Practice was busy. The Appellant often saw 40-60 patients per day over a 9 hour shift with 30 minutes allocated for lunch and one 10 minute coffee break. She often took no lunch. A daily list from late July 2018 was in evidence. It looks exhausting. Assuming an average of 50 patients per day over 8 hours and 20 minutes, each appointment would be 10 minutes long. The daily list evidenced this, most patients were indeed listed at 10 minute intervals with handover time included in that 10 minutes. The practice often saw 150 patients per day. A full complement of dental staff was 3 dentists but in October, the month after the Appellant joined, the other associate dentist left and her space was not filled for 3 months so the Practice was down to two dentists. The Appellant would often work late. Some of the nurses were not so happy about having to assist her after hours.

17. By all accounts the Appellant's relationship with PRD was difficult. After working for him for 11 months, on 24 August 2018, he threw her out because the Appellant advised one of the patients whom he had treated in the past to make a complaint to the practice manager (who was PRD's wife) because PRD had failed to spot a high number of diseased teeth over the course of quite a few years. He came to hear of this, perhaps through a nurse and that very day required the Appellant to leave work.

18. After being expelled, between September 2018 and March 2019 the Appellant worked as a locum dentist at various dental practices. Whilst she did so she made various complaints to NHS England about PRD (her mother complained about PRD too) and he made complaints back about her to the GDC. She of course had no access to his practice clinical records. He had full access to all of her clinical records.

19. In September 2018 the Appellant started an MSC at Bristol Dental School and in 2019 the Appellant became a clinical supervisor at Peninsular Dental school.

20. From May 2019 to March 2020 the Appellant worked as a locum at SPA dental group.

21. By July 2019 the Appellant and her mother had set up a new dental practice providing private dental care. The Appellant was a partner. According to her CV she was working there and also working as a locum at SPA dental (for a period of 8 months).

22. In 2020 she obtained a diploma in dental implantology and in 2021 she was working towards an MSC in implantology (the CV ends there).

23. On this evidence no one could or did assert at the hearing that the Appellant was a slacker. She was clearly a committed and hard working dentist with wide ranging qualifications. However, she has been erased due to the PCC findings of dishonesty, inappropriate practice events and failures of integrity arising in the first 11 months of her working life.

24. Two complaints were made against PRD involving 12 patients and the allegations were wide ranging. Some clinical failings were admitted. The result of the investigation is not relevant to this judgment.

The Legal structure for dental professional Standards

Guidance

25. S.26B of the *Dentists Act 1984* states:

> "**26B.— Guidance**
>
> (1) The Council shall prepare and from time to time issue guidance as to the standards of conduct, performance and practice expected of registered dentists.
>
> (2) Such guidance may make different provision in relation to different cases or classes of case.
>
> (3) The Council shall keep such guidance under review and may vary or withdraw it whenever they consider it appropriate to do so.
>
> (4) The Council shall from time to time publish guidance issued under this section.
>
> (5) Before issuing such guidance or varying or withdrawing it, the Council shall consult—
>
> (a) such persons to whom subsection (6) applies as the Council consider appropriate;
>
> (b) the bodies within subsection (8); and
>
> (c) such bodies to which subsection (9) applies as the Council consider appropriate."

I was shown no guidance from the Council on the matters in dispute.

Allegations

26. Under S.27 of the Act:

> "**27.— Allegations**

> (1) This section applies where an allegation is made to the Council against a registered dentist that his fitness to practise as a dentist is impaired.
>
> (2) A person's fitness to practise as a dentist shall be regarded as "impaired" for the purposes of this Act by reason only of—
>
> (a) misconduct;
>
> (b) deficient professional performance;
>
> (c) adverse physical or mental health;
>
> (d) a conviction or caution in the United Kingdom for a criminal offence, or a conviction elsewhere for an offence which, if committed in England and Wales, would constitute a criminal offence;"

27. After an allegation is made a case examiner or the investigating committee may be asked by the registrar to investigate. The case examiner or investigating committee may refer the allegation to the Practice Committee (PC) who must investigate any allegation so referred, see S.27B of the Act. The *General Dental Council (Fitness to Practice) Rules 2006* set out the procedure for the PC which in this case was the PCC and the hearing which they hold.

Charges

28. By S.13 of the *Rules:*

> "**13.— Notification of hearing**
>
> (1) The registrar shall send to the respondent a notification of hearing, and that notification shall—
>
> (a) inform the respondent of the date, time and venue of the hearing;
>
> (b) inform the respondent of his right to attend and to be represented at the hearing;
>
> (c) inform the respondent of a Practice Committee's power to proceed with the hearing in his absence;
>
> (d) inform the respondent of his right to adduce evidence;
>
> (e) contain a charge setting out the grounds by reason of which it is alleged that the respondent's fitness to practise as a dentist or as a member of a profession complementary to dentistry is impaired, and particularising the facts alleged against the respondent in support of the allegation;

(f) be accompanied by a copy of these Rules where they have not previously been sent to the respondent; and

(g) require the respondent to inform the registrar whether he intends to attend the hearing and to be represented at the hearing."

Hearings

29. The PCC proceedings involve a hearing which has 4 stages. The preliminary stage, the factual inquiry, the submissions and the determination. Under S. 21 of the *Rules*:

"**21. Determination**

(1) A Practice Committee shall, on conclusion of the address and submissions by the respondent or the respondent's representative, withdraw to deliberate in private, and shall determine—

(a) whether the respondent's fitness to practise as a dentist or as a member of a profession complementary to dentistry is impaired; and

(b) if the Practice Committee determine that the respondent's fitness to practise as a dentist or as a member of a profession complementary to dentistry is impaired, whether to give any direction under section 27B(6) or 36P(7) of the Act (the Practice Committees)."

30. There is no set format for the findings delivered by the PCC set out in the Act. I shall comment more on this below.

Sanctions

31. By S.27B(6):

"(5) If a Practice Committee determine that a person's fitness to practise as a dentist is not impaired, they—

(a) shall publish at his request a statement to that effect; or

(b) may publish such a statement if he consents.

(6) If a Practice Committee determine that a person's fitness to practise as a dentist is impaired, they may, if they consider it appropriate, direct—

(a) (subject to subsection (7)) that the person's name shall be erased from the register;

(b) that his registration in the register shall be suspended during such period not exceeding twelve months as may be specified in the direction;

(c) that his registration in the register shall be conditional on his compliance, during such period not exceeding three years as may be specified in the direction, with such conditions specified in the direction as the Practice Committee think fit to impose for the protection of the public or in his interests; or

(d) that he shall be reprimanded in connection with any conduct or action of his which was the subject of the allegation.

(7) The direction specified in subsection (6)(a) shall not be given following a determination that a person's fitness to practise as a dentist is impaired solely on the ground mentioned in section 27(2)(c) (adverse physical or mental health)."

Application for restoration

32. Pursuant to S.28 the erased dentist can apply for restoration to the register after 5 years from the erasure. Both parties submitted to me that this process was not easy to pass.

Appeal

33. Pursuant to S.29 the erased dentist can appeal to the High Court from a PCC decision by giving notice within 28 days of the decision.

34. Under S.29(3):

"(3) On an appeal under this section, the court may—

(a) dismiss the appeal,

(b) allow the appeal and quash the decision appealed against,

(c) substitute for the decision appealed against any other decision which could have been made by the Professional Conduct Committee, the Professional Performance Committee or (as the case may be) the Health Committee, or

(d) remit the case to the Professional Conduct Committee, the Professional Performance Committee or (as the case may be) the Health Committee to dispose of the case under section 24, 27B, 27C or 28 in accordance with the directions of the court, and may make such

> order as to costs (or, in Scotland, expenses) as it thinks fit."

Legal structure of the appeal

35. This appeal is brought under S.29(3) of the *Dentists Act 1984.* The procedure is governed by CPR PD52D, in particular at para 19(1)(c). This is a rehearing not a review. The power which this Court has to change the PCC's rulings and findings is also set out in CPR r.52.21(3). If this Court considers the PCC ruling to be wrong or unjust due to serious procedural irregularity or other irregularity this Court can allow the appeal, substitute any decision which the PCC could have made or remit to the PCC for further consideration.

36. The correct approach to findings of fact in appeals by way of rehearing was considered by Sharp LJ and Dingemans J in the Divisional Court in *General Medical Council v. Jagjivan* [2017] 1 WLR 4438. The following principles were expounded (at para. 40):

    1) It is not appropriate to add any qualification to the test in CPR Part 52, for instance that decisions are 'clearly wrong': see *Fatnani v GMC* [2007] EWCA Civ 46, at paragraph 21 and *Meadow v GMC* [2007] 1 WLR 1460 at paragraphs 125 to 128.

    2) The court will correct material errors of fact and of law: see *Fatnani* at paragraph 20.

    3) The appeal court must be extremely cautious about upsetting findings of primary fact, particularly where the findings depended upon the assessment of the credibility of the witnesses, who the Tribunal, unlike the appellate court, has had the advantage of seeing and hearing, see *Assicurazioni Generali SpA v Arab Insurance Group* (Practice Note) [2002] EWCA Civ 1642; [2003] 1 WLR 577, at paragraphs 15 to 17, cited with approval in *Datec Electronics Holdings Ltd v United Parcels Service Ltd* [2007] UKHL 23, [2007] 1 WLR 1325 at paragraph 46, and *Southall v GMC* [2010] EWCA Civ 407 at paragraph 47.

    4) Where the question is: "what inferences are to be drawn from specific facts?" an appellate court is under less of a disadvantage. The court may draw any inferences of fact which it considers are justified on the evidence: see CPR Part 52.21(4).

    5) A failure to provide adequate reasons may constitute a serious procedural irregularity which renders the Tribunal's decision unjust (see *Southall* at paragraphs 55 to 56).

The Evidence before the PCC

37. I heard no live evidence. The rehearing was on the papers and through legal argument thereon.

38. During the appeal hearing I asked the Parties to provide me with the relevant NHS dental charges and dental contracts Regulations and all relevant guidance. I was provided with some during the hearing and after a further request some more Regulations after the hearing and a copy of the NHS contract with the Practice.

Determination by the PCC

39. The PCC did not produce a narrative judgment setting out chronologically the events, their findings of fact from the evidence and their analysis of the witnesses' credibility. Instead the PCC produced a document called a "Determination" which was split up into boxes relevant to each charge and to each patient. This makes piecing together their judgment to get the full picture of their thinking tricky but of course necessary.

40. The charges were set out. Fifteen were laid relating to 15 patients with sub-charges under each main charge. The patients were given anonymisation by the use of letters. Many of the charges were withdrawn by the time of the hearing. To keep control over and to explain the charges I have set them out in a table below. For ease of reference I set out again here my shorthand lettering for the various failures:

RF: records failure, failure to make adequate clinical records.

RFA: records failure by altering records.

XRF: x-ray reporting failure, failure to report on x-rays or failure to take x-rays.

DF: discussion failure, failure to have an adequate discussion with the patient about treatment/costs etc.

FTD: failure to diagnose what should have been diagnosed.

FTT: failure to treat patient adequately or at all.

IT: inappropriate treatment.

CF: consenting failure, failure to gain informed consent from the patient.

TPF: treatment plan failure, failure to draw up an adequate treatment plan and/or obtain the patient's informed consent to it.

BF: behaviour failure, failure to act appropriately in relation to conversations with patients or staff.

IF: integrity failure or failure to act with integrity.

IA: inappropriate activity by a dentist.

IC: inappropriate claim made to NHS funding; incorrect claim made to NHS funding; incorrect COT opened preparatory to making wrong NHS claim; incorrect charging to patient – (top up payment/split COTs).

41. Here is the table of charges and findings.

Patient/ charge	Date range	Charge	Admitted	Defence	Proven despite denial	Appealed? If blank - not appealed
B	4.12.2017-15.5.2018					
3a	4.12.2017	RF			Not proven	
3b	13.12.2017	RF	Yes			
3c	13.12.2017	XRF	Yes			
3d	4.12.2017-15.5.2018	DF types of crown	Yes			
3e	"	DF costs/funding		Denied	Proven	
3f	"	TPF		Discussed it with P on 15.5.2018	Proven	
3g	"	DF costs		Denied	Proven	
3h	15.5.2018	DF in chair		Not in chair	Proven	
3i		IF discussing costs after treatment had begun		Denied	Proven	
3j		CF		Denied, discussion was had	Proven	
3k		RFA		Denied	Not proven	
3l	29.5.2018	BF "not a charity"		Denied	Proven	
3m	29.5.2018	IF		Denied	Not proven	
3n	"	BF not to treat		Denied	Not proven	
3o	"	IF		Denied	Not proven	
3p	"	BF written reason for termination		Denied	Proven	
C						
4a	31.7.2018	XRF		Denied	Not proven	
4b	"	DF		Denied	Proven	
4c		TPF		Denied	Proven	
E						
5b	3.1.2018	FTD caries	Admitted			
5c	"	FTT caries	Admitted			
5d	"	FTT caries risk			Not proven	
5e	"	FTT prevention			Not proven	
5f	"	FTT fluoride			Not proven	
F						
6a	24.10.2017	NT perforation		Denied	Not proven	
6b	"	NT failed to spot perforation	Admitted			
H						
7b	9.3.2018	XRF reporting	Admitted			
7d	9.3.2018	XRF taking	Admitted			
7e	16.8.2018	XRF reporting	Admitted			
7j	16.8.2018	IC bridge/crown	Recorded incorrect treatment	Denied	Proven	

8a	16/8/2018	IF		Denied	Not proven	
8b	"	Dishonest			Not proven	
M						
9a	?	XRF	Admitted			
9b	7.2.2018	FTD caries	Admitted			
9c	"	FTT caries	Admitted			
9d	"	FTD caries risk properly			Not proven	
9e	"	FTT prevention			Not proven	
9f	"	FTT fluoride			Not proven	
N						
10a	10.1.2018	XRF reporting			Not proven	
10b	"	FTD caries			Not proven	
10c	"	FTT prevention	Admitted			
10d	"	FTD risk caries			Proven	
10e	"	FTT prevention advice			Proven	
10f	"	FTT fluoride			Proven	
10g	"	RF caries	Admitted			
Q						
11b	17.4.2018	XRF	Admitted			
R COT splitting						
13a	7.12.2017	XRF	Admitted			
13b	20.12.2017	IT		Denied	Not proven	
13c	"	RF	Admitted			
13d	20.6.2018-19.7.2018	IC split COT	Admitted			
13e	"	DF costs	Admitted			
13f	"	DF treatment plan	Admitted			
14a	"	IF	PRD told me to do this	Denied	Proven	Appealed in respect of factual findings
14b	"	Dishonesty		Denied	Proven	
S Mates Rates						
15a	9.8.2018	RF exam	Admitted			
15b	"	RF discussion	Admitted			
15c	"	RF wrong record mouthguard	Admitted			
15d	"	IC		No claim made by me	Proven	Appealed
15e	"	RF lab report			Proven	Appealed
16a	"	IF		Not my writing on lab report	Proven	Appealed in respect of factual findings
16b	"	Dishonesty			Proven	Appealed
T Top up Fees and COT splitting						
17a	16.3.2018-2.5.2018	RF assessment	Admitted			
17b	8.5.2018	IC split COT	Admitted			
17c	16.3.2018-2.5.2018	DF costs/crowns	Admitted			
17d	"	IC pt contributions	Admitted			
17e	"	CF	Admitted			
17f(i)	26.6.2018-	IC split COT	Admitted			

	10.7.2018					
17f(ii)	"	IC regulations contravention	Admitted			
17g	"	DF	Admitted			
18a	b,d,f,g	IF COTS and Top up payments		Denied	Proven	Appealed in respect of factual findings
18b		Dishonesty split COTS		Denied	Proven	Appealed
U Top up fees						
19a	22.5.2018-22.6.2018	DF crown costs	Admitted			
19b	"	IC Top up payment	Admitted			
19c	"	IC top up payment	Admitted			
20a	"	Misleading	Admitted			
20b	"	Dishonesty		I honestly believed this was allowed	Proven	Appealed
V Top up fees						
21b	4.5.2018	TPF		Nurse's fault	Proven	
21c	"	DF crown costs	Admitted			
21d	"	IC top up payment	Admitted			
21e	"	IC NHS claim	Admitted			
22a	"	IF			Proven	
22b	"	Dishonesty			Proven	Appealed
Z COT	**Splitting**					
23a	30.8.2017-17.1.2018	IC split COT	Admitted			
23b	24.4.2018	XRF	Admitted			
23c	24.4.2018-9.5.2018	IC split COT	Admitted			
23d	"	DF bridge costs	Admitted			
24a	a,c,d	IF			Not proven	
24b	"	Dishonesty			Not proven	
BB						
25a	12.10.2017	IC band 2/4	Admitted			
STAFF						
27a	11 months	Outside hours working			Not proven	
27b	11 months	Derogatory comments		denied	Not proven	
27c	11 months	Encouraging complaints		denied	Not proven	
27d	One event	BF about hygienist job		denied	Proven	
27e	One event	Challenged dental nurse on knowledge		appropriate	Not proven	
OVERALL						
FTP impaired by misconduct			Admitted		Proven	
Remediation				Substantial	Clinical misconduct remediated with	

/insight					insight, low risk of repetition Non clinical misconduct: not remediable – attitudinal, repeated after complaint by Pt B. Conduct of defence at hearing: shifting blame to others; failure to take responsibility for conduct before fact finding decision. Not fully acknowledged the gravity of the dishonest conduct. Lack of insight. Risk of repetition of dishonesty. Public confidence requirement. Professional attitudinal problem.	
Dental work since termination at the Practice				Substantial		
Sanction	Erasure					

The grounds of appeal

42. By a notice of appeal dated 15th February 2022 the Appellant appealed some of the decisions of the PCC. The conclusions challenged are highlighted in the table.

43. Ground one is an appeal in relation to patient S against the decision that the Appellant's behaviour was dishonest: see charges 15(e) and 16(b). The Appellant also challenges the factual findings numbered 15(d), 16(a).

44. Ground two relates to patients T, U and V and is an assertion that the PCC erred in relation to small "top up payments" which were charged by the Appellant to patients for crowns which were wholly ceramic. The findings challenged are numbered 18(b), 20(b) and 22(b). The Appellant also challenges the findings of fact made in charges 18(a) and 14(a).

45. Ground three relates to patient T. The assertion is that the PCC erred in relation to their conclusion in charge 18(b) that the Appellant was dishonest when splitting one COT into two COTs. The Appellant also challenges the findings of fact in charge 18(a).

46. Ground four is an appeal against the sanction imposed, namely erasure. The Appellant submits that the sanction should have been lower and that the erasure was disproportionate or excessive. In her skeleton argument and verbally the Appellant noted that in relation to the PCC's findings of clinical failings they concluded that she had taken sufficient steps to remedy her misconduct and therefore the PCC rightly concluded that the risk of repetition of clinical failings was low. However they also found that, as a result of her dishonesty in relation to five patients, she remained impaired through lack of insight and poor attitude and went on to rule that erasure was necessary. In summary the Appellant asserted that she accepts that she had failed to act with professional integrity but denies the findings of dishonesty in relation to patients S, T, U and V and seeks to have those findings overturned.

47. I note here that the Appellant does not appeal the finding of dishonesty in relation to patient R.

Law relating the findings of dishonesty

48. The test for dishonesty was clarified by the Supreme Court in *Ivey v. Genting Casinos UK Limited* [2017] UKSC 67. Lord Hughes JSC analysed the differences between the tests in criminal law and civil law and ruled as follows:

> "62. Dishonesty is by no means confined to the criminal law. Civil actions may also frequently raise the question whether an action was honest or dishonest. The liability of an accessory to a breach of trust is, for example, not strict, as the liability of the trustee is, but (absent an exoneration clause) is fault-based. Negligence is not sufficient. Nothing less than dishonest assistance will suffice. Successive cases at the highest level have decided that the test of dishonesty is objective. After some hesitation in *Twinsectra Ltd v Yardley* [2002] 2 AC 164, the law is settled on the objective test set out by Lord Nicholls of Birkenhead in *Royal Brunei Airlines Sdn Bhd v Tan* [1995] 2 AC 378: see *Barlow Clowes International Ltd v Eurotrust International Ltd* [2006] 1 WLR 1476, *Abou-Rahmah v Abacha* [2007] Bus LR 220 and *Starglade Properties Ltd v Nash* [2011] Lloyd's Rep FC 102. The test now clearly established was explained thus in *the Barlow Clowes* case, para 10 by Lord Hoffmann, who had been a party also to the *Twinsectra* case:
>
> > "Although a dishonest state of mind is a subjective mental state, the standard by which the law determines whether it is dishonest is objective. If by ordinary standards a Defendant's mental state would be characterised as dishonest, it is irrelevant that the Defendant judges by different standards. The Court of Appeal held this to be a correct state of the law and their Lordships agree."
>
> 63. Although the House of Lords and Privy Council were careful in these cases to confine their decisions to civil cases, there can be no logical or principled basis for the meaning of dishonesty (as distinct from the standards of proof by which it must be established) to differ according to whether it arises in a civil action or a criminal prosecution. Dishonesty is a simple, if occasionally imprecise, English word. It would be an affront to the law if its meaning differed according to the kind of proceedings in which it arose. It is easy enough to envisage cases where precisely the same behaviour, by the same person, falls to be examined in both kinds of proceeding."

He went on to rule that:

> "74. These several considerations provide convincing grounds for holding that the second leg of the test propounded in *R v Ghosh* [1982] QB 1053 does not correctly represent the

> law and that directions based upon it ought no longer to be given. The test of dishonesty is as set out by Lord Nicholls in *Royal Brunei Airlines Sdn Bhd v Tan* [1995] 2 AC 378 and by Lord Hoffmann in *Barlow Clowes International Ltd v Eurotrust International Ltd* [2006] 1 WLR 1476, para 10: see para 62 above. When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the Defendant must appreciate that what he has done is, by those standards, dishonest."

49. I take from this ruling that the test for the trial judge or the PCC to apply when considering making a finding of dishonesty is:

(a) firstly to find on the evidence as a fact what the Claimant's (1) knowledge and (2) state of mind was at the relevant time on the relevant matters; and

(b) secondly to apply an objective standard to decide whether the Claimant's conduct was dishonest as alleged;

(c) the issue of dishonesty is ultimately a "jury question" which is characterised by recognition rather than by definition [paras. 48/53].

Analysis of the evidence in relation to each ground

Patient S and the mouthguard – Ground 1

50. The root of the charges in relation to patient S had two parts. Firstly that the Appellant charged "mates rates" - NHS funding, for what should have been privately paid work. Secondly, that to do so, the Appellant dishonestly misdescribed the equipment being provided to the patient to facilitate obtaining the mates rates from the NHS.

51. I must first note that no claim was ever made on the NHS so no charge was levied by the Appellant. The charge was made on assumption that such a charge would later be made. This was uncertain. The patient was listed to attend for her second appointment when decisions were to be made on the COT she desired having heard the Appellant's advice, but the Appellant was told to leave the day of the return appointment (by PRD). So the PCC and I shall never know what would have been the true course of this patient's treatment.

52. Patient S was a close family friend as the PCC found. Her mother texted the Appellant about the proposed appointment, which is further evidence of closeness.

She asked for teeth veneers for her daughter. The Appellant arranged the first appointment, not the practice receptionist, which is further evidence of closeness. On 9.8.2018 the first appointment took place. The Appellant examined the patient's teeth and discussed alternative options. The patient indicated she wanted to go ahead with teeth veneer. The patient was a child (under 18) and permanent teeth veneer is irreversible so the Appellant advised the patient that, as an initial step, she would ask the lab to create a wax up model of the veneers and a vacuum splint/stent. These would facilitate the production of the temporary veneers and enable the patient to understand the shape and look of the permanent veneers. The plan was made for the patient to return on the 24th of August for the next step. All this is set out in the Appellant's witness statement, but not the Appellant's clinical notes.

53. It was the Appellant's case that, in view of the busy nature of her practice and the 50 or so patients that she saw per day, when she examined her patients she would say out loud the information that she wanted the nurse to record on the clinical notes on the computer and the nurse would do so.

54. The Appellant's clinical notes for S, whether written by her or her nurse, did not mention the patient's request for teeth veneers but instead stated that the patient "requested" an "upper mouthguard". In addition the notes went on to say "fit up a mouthguard" and also stated "APPLIA-0, other appliances", "impressions taken for upper mouth guard". The evidence was that the words "other appliances" relate to a category on the NHS's equipment list under which mouthguards are listed. So it was quite apparent to the PCC and is apparent to me that the Appellant's clinical notes made no mention at all of the actual equipment that the Appellant was going to provide or the temporary veneers that the patient was actually requesting. The Appellant sought, in her defence, to explain this away by suggesting that the nurse who was making the notes was mistaken or misunderstood because the Appellant may have said to the patient during the discussion part of the appointment that the vacuum formed splint that she would order is "like a mouthguard". It was agreed evidence that the equipment which the Appellant requested from the laboratory, namely the splint/stent, is a see through rubbery semi-circular item which could be fitted over the patient's top teeth. Also it was agreed that a mouthguard looks very similar. I provided to the parties images from the internet of each item and the Appellant confirmed roughly that the images were apposite. The Respondent did not demur. They do look similar. However, the Appellant's blaming of the nurse for a misunderstanding was rejected by the PCC, having heard the evidence. I am not surprised. It might explain the use of the word "mouthguard" in the notes in a different written sentence with different context but it does not explain the use of the word mouthguard in the three different lines in the clinical notes the way they actually were written. Those notes are quite clear. They say that the Appellant was obtaining a mouthguard to fit into the patient's upper mouth at the patient's express request. None of that was true.

55. Even without more I would have found on this evidence that the Appellant's notes were not correct and not honest. However the PCC were also shown the lab docket sent to the laboratory by the Appellant. That was sent on the same day as the appointment. It expressly asks for a wax up to close the spacing in the upper front teeth (UL1&2 and UR1&2) and a vacuum formed splint to make temporary veneers. I note here that "splint" and "stent" appear to be used interchangeably. It also, in what

looks like different handwriting, stated *"as discussed with Guy to bill as mouthguard.*" There was considerable evidence at the hearing in relation to who wrote the final sentence. There was wholly proper cross examination of the Appellant implying that she procured those words to be written on the lab request, but in answer she went no further than to say it was not her who wrote those words and did not explain how that could have happened.

56. I consider that the Appellant had ample opportunities: when drafting her witness statement, when deciding which evidence to put before the hearing, and when giving her evidence in chief and in cross examination, to explain how those words could have come to be on the form in view of the fact that she asserted somebody else put them there. Who did? How would that have occurred? Why would someone write on the Appellant's lab requests in a way which she did not authorise? No such explanation was given. I consider that the overwhelming likelihood was that those words were written on the lab report, which she wished to be sent to the laboratory, by somebody at her request or direction. The PCC so found.

57. The lab provided the stent/splint. There is a document from the laboratory dated 21st August 2018 addressed to the Appellant which purports to suggest that the laboratory had custom made a dental appliance namely a "transparent mouthguard". That document had on it an assertion that the appliance had been wholly manufactured in the EU to satisfy the design characteristics and properties specified by the prescriber and that it conformed to the relevant general safety and performance requirements specified in annex one of the Medical Devices Directive and the United Kingdom Medical Devices Regulations. That was clearly not true.

58. I consider that the man on the Clapham omnibus or the woman on the Balham underground would be clear in considering that this lab's document was dishonest. No such mouthguard had been provided. The lab knew very well that they had not provided a mouthguard because they were asked to provide a vacuum formed splint.

59. The lab technician who provided the stent/splint, witness A, provided a witness statement to the PCC and gave evidence. Apparently he had purchased the laboratory from the previous owner who was called "Guy". He had only worked in the laboratory for one month before the takeover and after the takeover Guy continued to work in the laboratory as an employee. His company's copy of the lab request was clearly a carbon copy of the original on a yellow sheet, which was exactly in the same form as the original lab request provided by the dental practice. It had the same words about billing for a mouthguard and asking the lab to produce a splint. The Appellant appeals on the basis that the PCC should have preferred his evidence as to why it was billed as a mouthguard. He asserted vaguely, that no request had been made by the Appellant to charge the stent as a mouthguard. He only did so because the option to charge for a stent/splint was not available on the drop down list on his computer and he did not know how manually to bill for a stent. Perhaps he should have asked Guy who still worked there. In cross examination he found enormous difficulty explaining how the words "bill as a mouthguard" could have been put on the lab request after it was received by the lab. So I am not at all surprised that the PCC (by inference from the determination) rejected his evidence. It is illogical. The absence of an express rejection in the PCC's findings is part of the problem created by the lack of a narrative judgment from the PCC.

60. It was agreed evidence that mouthguards can be provided on the NHS if they are clinically necessary. It was agreed that temporary and permanent veneer treatment, (and therefore I assume splints or stents made preparatory to permanent veneer treatment taking place) can be provided on the NHS but only if the clinician considers they are necessary for good oral health. It was agreed that veneer cannot be provided on the NHS for purely cosmetic purposes. The difference between purely cosmetic and clinical necessity may, in some cases, relate to the patient's state of distress over the appearance of their teeth but this was not fully investigated in the evidence. In any event, what was agreed by the experts, was that a clinician would have to explain and justify teeth veneer treatment to get it on the NHS but would not have to justify obtaining NHS funding for providing a mouthguard.

61. It was asserted that the PCC, in their findings, relied on three or four other lab requests which mentioned Guy, which I shall call the "Guy" documents. It was asserted that those documents had not been put to the Appellant in cross examination and therefore it was unfair for the PCC to have made their findings taking those documents into account because the Appellant had had no opportunity to give her evidence about them. The relevant documents were in the PCC bundles and the bundles before me. The first related to patient T and is a lab request by the Appellant asking for a ceramic crown "as agreed with Guy". The second is for another patient, the subject of charges, was dated the 19th of June 2018 and was for an all ceramic crown "at extra cost", which was "as discussed with Guy". The third related to patient V, was dated the 6th of June 2018 and was for a ceramic crown with an additional £60 lab fee "as discussed with Guy". The Appellant asserts that these documents, never having been put to her, should not have been used by the PCC (in part) to justify their finding that the words "as discussed with Guy" on the laboratory request for patient S were either from her or written at her direction. I have looked at the cross examinations, both of the lab technician and of the Appellant, and I consider that they were carried out professionally and fairly. There are various main methods of cross examination which are well known: insinuation, probing and confrontation are three often used methods. The heart of the Appellant's case on appeal is that confrontation is the required method for fundamental evidence being used by the "prosecution" against the "defence" in support of an allegation of dishonesty. I would find that far more persuasive were it to be in the context of a hearing at which the documents are produced for the first time in the hearing, or if the relevant key lab report document itself had not been produced and cross examined upon. But neither of these factual scenarios apply in this case. Firstly these documents were in the disclosed evidence and the hearing bundle, therefore freely available to both sides long before the hearing and available to be dealt with in served witness statements by the Appellant. Secondly the key document, the lab report relating to patient S, was cross examined upon at length.

62. The Appellant complains that the PCC did not expressly reject the lab technician's evidence in their decision. That is one of the reasons why I consider that the absence of a narrative judgment from the PCC is unhelpful. It makes it easier to found appeals because the PCC's reasoning on findings of fact and in relation to credibility, witness by witness, is not explained. However an objective reading of the PCC's decision shows that they did not consider that the lab technician made the choice to bill the stent as the mouthguard independently and by coincidence. Instead the PCC, in my judgment, considered that the Appellant had directed the wrong billing to take place

and Guy and the lab technician (or owner) had agreed. As for the odd evidence about whether witness A was the boss or Guy was the boss, the PCC made no findings of fact and nor do I.

63. I see no reason to overturn the PCC's findings in relation to patient S. Were I to have to make findings I would have made the same ones but also expressly stated that it was not only inappropriate to write that the patient had requested a mouthguard and that a mouthguard was going to be fitted in the clinical notes but that it was dishonest so to do. I would have found that it was not only professionally inappropriate to write that the lab should bill the stent as a mouthguard but that it was dishonest. All of that being set against the background of the NHS's charging situation which meant that a mouthguard would attract, as I understand it, 12 UDAs and NHS funded full veneers probably would attract a similar or the same rate.

64. Finally it was submitted that if the Appellant was being dishonest she would have covered her tracks better. Also that no NHS claim was made because the decision would have been taken on 24 August 2018 and that decision and the billing thereafter might have been a wholly honest one. Those are good points in relation to the scope of the dishonesty and also are mitigation points to which I shall return to below.

65. As for the relative costs, a stent costs about £27 and a mouthguard £24 so there is little difference. No claim was made to the NHS for the treatment because the Appellant left the practice before the next appointment took place and so no decision was made on the firm COT for the patient and how that would be funded. This was not a charge against the Appellant of attempted fraud on the NHS. The PCC did not find that it was such behaviour. These are mitigation points. The Appellant might well have put the temporary veneers onto the patient's teeth and then discussed private supply. We just do not know.

Top up fees for crowns

66. The second ground of appeal related to top up fees. In summary the Appellant admits that she charged top up fees to various patients: T, U and V, so that they could obtain better tooth crowns than are provided in the normal course on the NHS.

67. The agreed background facts were that the NHS provides porcelain crowns bonded onto metal bases when crowns are required. However the market also provides wholly ceramic crowns which many believe are stronger and more aesthetically pleasing. They cost more than the porcelain bonded crowns. The experts gave evidence and agreed that in the usual course porcelain bonded crowds would be offered by dentists to NHS patients who needed them for their oral health. However in some cases wholly ceramic crowns could be offered on NHS funding, where they were justifiable for the patients' oral health. It wasn't wholly clear to me in what circumstances ceramic crowns would be justifiable on those clinical grounds, other than on aesthetic grounds (which do not satisfy the oral health test), but that was the agreed evidence.

68. In relation to these three patients, quite openly and without any deception or coverup, the Appellant discussed the benefits of ceramic crowns and offered to provide ceramic crowns to the patients on the NHS but with a top up fee to be paid by the patients for the difference in price between the porcelain bonded crowns and the wholly ceramic crowns. All of the patients agreed. These agreements were written in the clinical

notes. The benefit of this arrangement for the patients was that they were receiving an NHS service and paying the normal small, fixed contribution for that service to obtain their crowns, but also paying a small top up fee to obtain the better crowns. The alternative, which would have been worse for the patients, would have been for the Appellant to have refused to provide the ceramic crowns on the NHS (because they were just needed for oral health) and to have advised the patients that they could only buy them privately from a private dentist or indeed pay for them privately at the Appellant's practice. That would have cost the patients considerably more.

69. It was said by the experts in evidence and repeated by the PCC in their decision that "the Regulations" prohibit top up fees. The Appellant's defence was that she did not know that this was prohibited by the Regulations. The Appellant submitted that to establish dishonesty the PCC needed to find that she knew that top up fees were prohibited by the Regulations. In my judgment to determine this issue the PCC should have been shown all of the Regulations allegedly broken.

The Regulations and the contract with the practice in relation to top up charges

National Health Services (General Dental Services Contracts) Regulations 2005

70. The *National Health Services (General Dental Services Contracts) Regulations 2005* (which I shall call the *Contracts Regulations)* state at Part 5, reg. 22:

> "**Fees, charges and financial interests of the contractor**
>
> 22.(1) The contract must contain terms relating to fee, (sic) charges and financial interests which have the same effect as those set out in paragraphs (2) to (4).
>
> (2) The contractor shall not, either itself or through any other person, demand or accept a fee or other remuneration for its own or another's benefit from—
>
> (a) any patient of its for the provision of any treatment under the contract, except as otherwise provided in the NHS Charges Regulations; or
>
> (b) any person who has requested services under the contract for himself or a family member, as a prerequisite to providing services under the contract to that person or his family member.
>
> (3) The contract must contain a term that—
>
> (a) only permits the contractor to collect from any patient of its any charge that that patient is required to pay by virtue of the NHS Charges Regulations, in accordance with the requirements of those Regulations; and
>
> (b) provides for obligations imposed on the contractor by virtue of the NHS Charges Regulations to be terms of the contract.

> (4) The contract must contain a term that requires the contractor in making a decision—
>
> (a) as to what services to recommend or provide to a patient who has sought services under the contract; or
>
> (b) to refer a patient for other services by another contractor, hospital or other relevant service provider under Part 1 of the Act, to do so without regard to its own financial interests."

(The underlining is mine)

71. That seems clear enough. The ban on mixed funding is subject to an exception: namely if the *Charges Regulations* permit charging. This they do by requiring a fixed charge from the patient which is different for each band of treatment.

72. However, in addition to the fixed charges in the *Charges Regulations,* Schedule 3, para. 10 the *Contracts Regulations* expressly permit voluntarily agreed mixed charging thus:

> "**Mixing of services provided under the contract with private services**
>
> 10.—(1) Subject to sub-paragraph (2) and the requirements in paragraphs 2 (referral services) and 6 (orthodontic treatment plans) of Schedule 1 and paragraph 7(1)(g) of this Schedule, a contractor may, with the consent of the patient, provide privately any part of a course of treatment or orthodontic course of treatment for that patient, including in circumstances where that patient has been referred to the contractor for a referral service.
>
> (2) A contractor may—
>
> (a) …; and
>
> (b) in the case of an orthodontic course of treatment provide—
>
> (i) the case assessment wholly privately or wholly under the contract; and
>
> (ii) the orthodontic treatment wholly privately or wholly under the contract.
>
> (3) A contractor shall not, with a view to obtaining the agreement of a patient to undergo services privately—
>
> (a) advise a patient that the services which are necessary in his case are not available from the contractor under the contract; or

> (b) seek to mislead the patient about the quality of the services available under the contract.
>
> (4) …"

(The underlining is mine)

73. The caveats to the permission in para. 10 do not apply in this case. This Regulation clearly states that mixed private and NHS funding is permitted for "any part" of dental treatment if the arrangement is agreed with the patient. Therefore I so rule. However the experts (Dr. Pal and Professor Barker) gave agreed evidence that "*there is no option to place an additional charge for a crown when provided under the NHS regulations".* Neither of them set out the details of the Regulations which they relied on to make this assertion in their reports. If the power to mix private and NHS funding for treatment by agreement is in the Regulations but prohibited by the NHS contract with the Practice or the Business Services Agency guidance, the ban does not come from the law but must be in the contractual terms imposed by the NHS organisation. The experts did not explain this in their reports. So I need to look at the contract with the Practice.

74. I was not shown the relevant contract between the NHS and the Practice at the hearing. Nor were the PCC at their hearing. I asked for the contract and was provided with the NHS contract with the Practice after the hearing. No clauses were highlighted. However at clause 241 it states:

> "241. The Contractor shall not, either itself or through any other person, demand or accept a fee or other remuneration for its own or another's benefit from-
>
> 241.1 any patient of its for the provisions of any treatment under the Contract, except as otherwise provided in the *NHS Charges Regulations;*"

75. Thus the contract recites the ban in reg. 22 of the *Contracts Regulations* and also the fixed charging permitted expressly in that paragraph by reference to the *Charges Regulations*.

76. As for para. 10 of Schedule 3 of the *Contracts Regulations,* this is incorporated in the contract by clause 58 of the NHS contract which stated that:

> "58. Subject to clause 60, the requirement on clauses 47.7, 151 to 154 and 164 to 167, the contractor may, with the consent of the patient, provide privately any part of a course of treatment or orthodontic course of treatment for that patient…"

The "subject to" clauses are not relevant, so clause 58 permits voluntary mixed charging. There is no limit placed on the power to mix. It is not stated that the power to mix does not apply to work on a single tooth.

77. The 2017 Guidance in *the Dental Handbook* issued by the NHS Business Serves Authority (which was in force pre-event) was provided to me during the appeal hearing at my request but was not before the PCC. It states at page 72:

> "**Mixing of services provided under the contract with private services**
>
> 1. If a patient needs:
>
> a) A filling on a molar tooth where an amalgam is clinically suitable and the patient wishes a white filling, can I place a white filling as an NHS item, gain the UDAs while adding some charge to the normal patient charge under Band 2?
>
> b) Transparent brackets for NHS orthodontic cases, provide them and charge an additional private fee
>
> c) Provide better quality private teeth on a NHS baseplate and charge the patient a private fee?
>
> Answer: No. The contractor shall not 'demand or accept a fee or other remuneration for its own or another's benefit from (a) any patient of its for the provision of any treatment under the contract, except as otherwise provided in the NHS Charges Regulations'. Item 22."

So the guidance summarises the ban in reg. 22 of the *Contracts Regulations* but ignores the permission to mix by agreement in Schedule 3 para. 10(1). No explanation was given to me about this guidance omitting to mention Schedule 3, para. 10(1) during the appeal. The relevant sections of the Regulations were not put before the PCC.

78. The *Charges Regulations* at Reg. 3(1) and 4(3) and (4) and Schedule 3 impose standard fixed charges on patients for the work of dentists in bands 1-3 but none of those exclude the permission for mixed charging in Schedule 3, para. 10.

79. On the evidence before me I conclude that had the Appellant read the Practice's contract and/or the *Contracts Regulations* and in particular Part 5 reg. 22 and Schedule 3, para. 10(1), she would have been entitled to conclude that she could charge top up fees for the crowns she offered if the patient/s agreed to that route and she provided proper all round advice and so long as her clinical judgment was that ceramic crowns were not necessary for her "oral health" and hence not available on the NHS.

Patient T:

80. Patient T attended the surgery on the 16th of March 2018. The clinical notes made by the Appellant or on her behalf by her nurse show she examined the patient and her diagnosis was "tca".

81. In evidence it was made clear that this patient attended for a routine dental examination and that the Appellant found LL8 to be loose and LR5 to require restoration. The treatment plan generated was for extraction of LL8 and for the placing of a crown on LR5. None of that was set out in the Appellant's clinical notes and she admitted that the omission was inappropriate note taking. What the note should have set out is the diagnosis/assessment and the course of treatment. Then the patient should have signed a treatment plan at reception, it having been passed through to reception by the nurse, usually attached to a clipboard provided to the patient, on leaving the appointment room and the Appellant.

82. On the 2nd of May 2018 the patient attended the Appellant for extraction of LL8 and that treatment was provided. The PCC received evidence to show that on the same day, the 2nd of May, the Practice made an appointment for patient T to return on the 26th of June 2018 for preparatory work for the crown, which was of course all part of the same COT.

83. The 8th of May 2018 the Appellant, and hence the Practice, made a band two claim to the NHS for the treatment she had provided between the 16th of March and the 2nd of May, namely the extraction. The expert evidence, which was agreed, was to the effect that an NHS claim can only be submitted for a COT if the COT has been completed. The experts agreed that it was not appropriate for a clinician to carry out the four steps required in a course of treatment namely examination, assessment, treatment plan and treatment, but at the same time to split the treatment up into two separate courses of treatment, thereby permitting the clinician to submit two separate claims and gain double the payment for one COT.

84. The experts pointed out that there was no clinical note made on the 2nd of May showing that the treatment plan was complete or that the COT was over and this tied in with the inadequate note taking on the 16th of March which, in itself, did not set out the diagnosis, the treatment plan and therefore the COT.

85. On the 26th of June 2018, the date for the patient's third appointment, the patient did return and the Appellant carried out preparatory work for the LR5 crown and provided a composite filling. Xrays were taken and further preparatory work was done. The Appellant specifically noted on the clinical notes "*extra lab fee for crown LR5 discussed with patient - she is happy with this*".

86. It can be seen from the above clinical note that if the Appellant had known or thought that offering and agreeing a top up fee was in breach of the Regulations or the NHS's business contract terms with the Practice her clinical notes were a full and frank confession to that breach. There was no deception in the notes about charging top up fees. I find this directly relevant to the decision on whether the Appellant knew this was dishonest. It seems to me to weigh against such a finding. I shall return to this later in because it is also relevant to mitigation.

87. On the 10th of July 2018 the patient returned, the temporary crown was removed and the permanent, all ceramic, crown was put in place. The patient paid the top up fee of £65. Again this was all done openly. PRD's wife, the practice manager, did not come through and say to the Appellant: "*I deal with payments. This £65 charge is not allowed. You cannot do this!".*

88. I have carefully read the "guidance sheet" which the Practice issued to patients and dentists. It provides no guidance on charging for crowns or top up fees.

89. On the 11th of July 2018 the Practice and therefore the Appellant, made a band three claim for the crown under the second course of treatment.

90. The Appellant left the Practice in August 2018 and in October 2018 the £65 top up fee was repaid to the patient.

91. It was the Appellant's defence to the charges of dishonesty in relation to top up fees that she was not happy with the NHS porcelain crowns and that she had a discussion with the technician Guy about top up costs. He had a long business relationship with the Appellant's mother and agreed to provide ceramic crowns at a small extra charge. The Appellant asserted she did not appreciate that she could not charge a top up fee to patients. She went on to assert that some time after this she spoke to her supervisor, W, and was told by her that it was not allowed and she should stop immediately. I note that the Appellant did not ask PRD or his wife the practice manager and that is indicative to me of the lack of availability of freely encouraged supervision and guidance within the practice to back up and guide her on NHS claiming and top up fees. The Appellant did stop charging top up fees after W told her to. The defence was partly that she had misunderstood the Regulations as a result of the technician's suggestion. It was her defence that she genuinely held the belief that she could offer a more aesthetically pleasing crown for a small additional agreed cost.

92. In relation to the reason why dentists do not always supply wholly ceramic crowns on the NHS Dr.Pal said this:

> "Q…. If it is permissible under the NHS and it looks better, why would a dentist not go for that option? Sorry, I am a lay panel member, so maybe I am asking something that I do not know is maybe customary to do. I do not know. If it is permissible to provide it under the NHS, why would you not?
>
> A. I think the fact is that it is usually on a financial basis that dentists would not. I think the way the NHS contract is operated, and the I suppose one could say auditory and financial constraints that practices have, would mean that it would be I think usually on financial grounds. I am sorry, there is one other thing I should add, madam, I am sorry. There is a small clause in the NHS contract that they are sometimes cited which says that in terms of provision of appliances the duty is to – sorry, I paraphrased the wording, it is essentially saying that the practitioner has an obligation to ensure cost effectiveness within the use of NHS funds. There are some practitioners who cite that as a reason to say that there is no obligation for me to provide anything above what would reasonably secure the oral health of the patient"

93. In one answer in cross examination on top up fees in relation to gaining a patient's consent Dr. Pal said this:

"A. Yes, if the dentist was willing to provide that on the NHS. If the dentist was willing to provide that ceramic crown on the NHS, which they are of course entitled to do, many dentists do not, if that is the case, if that is what you are saying is that a dentist would have provided that ceramic crown completely under the NHS then, yes, I can see most of the parameters for informed consent, bar the inaccurate information on the charges, was met.

….

Q. Okay. The all-ceramic crown has higher lab costs.

A. Yes, they do.

Q. However, the dentist gets paid the same, so the lab costs are paid by the dental surgery.

A. Correct.

Q. But the UDAs that they can claim is the same.

A. Correct, yes

Q. If you are talking about accounting terms, they get less of a margin then, so they make less money out of an all-ceramic crown.

A. Yes, essentially that would be the case.

Q. Okay, sorry.

A. Clearly, if it was possible for the dentist to negotiate with some lab and they are having it at the same price, which is very unusual, that would negate that advantage.

Q. Thank you. Just one minute. Sorry, I am labouring this point. If it is the same UDAs that the NHS pays to the dentist, why does the NHS care whether it is an all-ceramic or a bonded crown then if they pay the same to the dentist?

A. I think really in terms of that question, one might need to talk to the bodies that formulated the current contract. I think much of this would – I suppose from an historical basis before 2006, the contract we operated upon had items of service, so you are paying for specific items of treatment, and within the schedule that contained those items there was different costings of different crowns. Therefore, in the pre-2006 contract, there was a difference in fees paid for different types of crown. I believe that when they created the 2006 contract, and it is by no means something that was universally accepted by the profession, it was decided that they would amalgamate all those types of crowns into one band, and the purpose of the current

> contract was to simplify the charging regime and the cost to the patient, so a decision was made that all those different types of crown would come under one charging umbrella which was Band 3. I am afraid that is as far as I can probably answer."

94. It can be seen that one way of satisfying the patient's need for a better crown and the "small clause" about costs saving for the NHS, would be to charge the patient a top up fee.

95. The PCC determined dishonesty in relation to top up fees on the basis of the evidence of Doctor Pal that ceramic crowns can be offered on the NHS but the dentist could not charge a top up fee privately for a crown provided on the NHS. He asserted that no "mixing" of fees was permitted by the Regulations on the same tooth. Therefore it was Doctor Pal's evidence, agreed by Professor Barker, that top up fees were not permitted. The PCC ruled that the ban on mixing private and NHS treatment on the same tooth was a fundamental tenet of the NHS Regulations. They appear to have found that all fundamental tenets would have been taught during the foundation year. They appear then to have found that if a tenet had been taught the Appellant would have known it and so did in fact know. They appear to have found that if the Appellant knew of fundamental tenets when she was taught them, then she knew of them when she charged the top up fees. Then they appear to have found she knowingly breached the Regulations.

96. I have already set out above that it is clear from the relevant Regulations, put before me by the parties in and after the appeal, that agreed voluntary mixed fees are expressly permitted by the NHS *Contracts Regulations.* Nor is there anything in the NHS contract with the Practice which bans top up fess, far from it, clause 58 permits mixed charging as does Schedule 3 para. 10 of the *Contracts Regulations.* Therefore I do not find myself able to support that finding of the PCC, whatever the experts said or agreed, that agreed voluntary "mixing" was banned by the Regulations (or the contract). It was on that basis that the PCC rejected the defence of genuine belief which the Appellant put forwards. The express finding of the PCC in relation to patient T and the apparent knowledge about top up funding was as follows:

> "however the committee was satisfied from the expert evidence that the non mixing of NHS and private treatment on the same tooth is a fundamental tenet of the NHS regulations. It is therefore considered given your knowledge and experience at the time, that it was more likely than not that you were aware of this rule. The committee did not accept your evidence that you genuinely believe that you could offer patient T a crown on the NHS, with a small additional private cost."

(My underlining)

97. On this issue I consider that the PCC fell into error. I have set out above the law on findings relating of dishonesty. The first defect in this reasoning is that the Regulations do permit agreed voluntary mixing, yet the PCC was not taken to the Regulations and so found that they did not permit agreed voluntary mixing. It was not pointed out to the PCC that Schedule 3 para. 10 of the *Contracts Regulations* expressly permits agreed voluntary mixing. The second defect is that the NHS

contract with the Practice permitted agreed voluntary mixing of funding. This was not put before the PCC. It is the guidance issued by the NHS Business Service Authority, a copy of which was not before the PCC, that interpreted the Regulations as banning top up fees. It was not put to the Appellant by the Respondent in cross examination that the Dental Handbook interpreted the Regulations as banning top up fees, not the Regulations or the contract. It was not put that the Handbook omits reference to Sched. 3 para.10. These matters, it seems to me, are fundamental to the proof of dishonesty.

98. I rule that it is not fair to make a finding that a professional has breached a Regulation without stating accurately which Regulation was allegedly breached. I also rule that it is wrong for the GDC to allege or for the PCC to make a finding that a professional has breached a Regulation when in fact the Regulations expressly permit what the professional did or are at the least ambiguous.

99. Rather general evidence was given by one of the dentists who used to work in the Practice and the experts about the contents of training courses on NHS charges provided during the foundation year. No course notes were provided. No trainer was called. This general evidence was relied upon to make the finding that top up fees were banned by the "Regulations" and that such ban was a "fundamental tenet" of the NHS Regulations. On the evidence before me I consider that the PCC did not have proper evidence to make a finding of dishonesty on this issue. In addition the GDC and the PCC overlooked the NHS Regulations or mixed them up with the NHS Business Services Authority's guidance and furthermore were not informed that the guidance omitted to refer to Regulation para, 10 of Schedule 3. Both Regulations and contracts are of course important, as is guidance, but there appears to be a substantial difference between them. In any event, one is a matter of law and the other is a matter of business practice guidance. So in my judgment the foundation for the allegation and the finding of dishonesty in relation to top up fees was wholly insufficient if based on a breach of the Regulations without reference to which Regulation was breached.

100. It was the undisputed evidence from the Appellant that she had completed a foundation year with W which was spent wholly doing NHS work not a mixture of NHS and private work. PRD was a director of and the principal of the Practice and responsible to the CQC for the contract with the NHS. The contract was for 18,000 UDAs per annum. The NHS Business Services Authority carried out audits inter alia to check that COTs were not split or not split too often. PRD accepted that:

> "Q: It is right, is it not, that the NHS Business Service Authority performs audits?
>
> A: Yes.
>
> Q: Those audits are to check that claims for units of dental activity are being made in accordance with the relevant regulations.
>
> A: Yes, they do.

> Q: They perform -- you have heard of this phrase – 28 day re-attendance audits. That is something you are familiar with.
>
> A: Yes.
>
> Q: The purpose of a 28 day re-attendance audit is to verify that practices are not splitting up care which should be provided under a single course of treatment, into multiple courses of treatment.
>
> A: I would think that is the purpose of part of the audit, yes. I do not know what the entire process is.
>
> Q: So far as you understand it, if a practice is very regularly opening new courses of treatment within 28 days of another course of treatment ending, that can give rise to concerns by the NHS BSA that there is improper course of treatment splitting going on. A: Not necessarily course splitting. That could be one of the reasons, but there could be a number of reasons."

101. I take note that after PRD took over the Practice and before the Appellant joined an NHS Business Services Authority audit found he had over claimed UDAs and required a refund to the NHS and to patients.

> "Q: Do you see that what the BSA are writing to you on 3rd April is this -- I am reading from the second paragraph: "The findings of your self-audit have now been considered by a clinically led review process. This letter details the proposed action following the further actions required of you. It has been agreed to accept your findings, which identify a difference of 223.4 UDAs, associated with 28 day re-attendance claims and/or any associated claims in the review period. Based on the contract UDA value for the financial years 2015 to 2016 and then 2016/17, the UDAs identified a total value of £6498.47." Yes?
>
> A: Yes.
>
> Q: In addition, there are a number of patients who paid for treatment that you now consider to be linked to the UDAs identified above. We therefore consider that these patients are due a full or partial refund of the charges they paid. The total patient charges refunded are £1089." Do you see that?
>
> A: That is correct, yes.
>
> Q: The result of this audit process was that the practice had to repay to the BSA about £6500?
>
> A: That is correct.

> Q: And that is repaid to patients just in excess of £1000.
>
> A: Yes.
>
> Q: That was in respect of UDAs which had been overclaimed?
>
> A: Correct
>
> …
>
> Q: You were responsible for the over-claim?
>
> A: Yes, I was.
>
> …
>
> Q: Do you accept, on the basis that you were responsible for a sizeable proportion of that over-claim against NHS funds, that there was a fundamental misunderstanding on your part in respect of NHS claims and the process for that?
>
> A: Yes. Without context I would say yes.
>
> Q: Would you take the view that there was also a fundamental misunderstanding on the part of the other dentists who were working at the practice?
>
> A: Again, without context I would say yes."

102. I also bear in mind that the Appellant had no induction course at the Practice when she started in September 2017. The evidence of the practice manager (PRD's wife) on continuing training and induction was telling. She said that there was none. They did not even issue contracts. PRD gave evidence thus:

> "Q: No formal training then in relation to, for example, the NHS claims procedure within the practice?
>
> A: Formal training, she had -- yes. I gather she was given -- it depend what you call formal. Sorry, my words I elude me. She was given the rules and regulations of claiming.
>
> Q: You are talking here about the sheet that was passed around by your wife?
>
> A: I do not know whether it was a sheet or a booklet or what. I believe -- you would have to ask my wife.
>
> Q: You do not have any recollection of her receiving any training?
>
> A: Not formal. Formal training, no."

103. PRD went on to assert that his wife, Helen, sent round a sheet on NHS claims and charging as follows:

> "Q: Well, let us forget about auditing. She would it not be responsible for advising dentists about how to claim under the NHS scheme, would she?
>
> A: Given the rules and regulations, she would have given out the booklet. I do not know if it is a booklet or a sheet. She would have given that out.
>
> Q: Yes, she told us she put a sheet together with some regulations on it. Your wife has also given evidence that she has never been responsible for advising on claims. Do you agree with that?
>
> A: I do not know what she has done, to be fair. I do not know if she has given advice or not. I do not know whether she gave any advice or not.
>
> …
>
> Q: I am suggesting that you provided advice to Ms. Williams about how to claim within the system in the way that you yourself and others had been doing for years.
>
> A: Well, no, we had not been doing it for years. There was a year, but no. No, I was not advising anybody to do that. I think we had all learnt our lesson and learnt the rules a lot better. To be honest, I had one previously about I was not giving enough fluoride and you learn from your lessons. That is what you do. So, no, I was not going to give advice -- I am not going to give advice to somebody which is clearly wrong. We had been told that is clearly wrong. Again, as I said, the whole profession -- I am not going to discuss all that, but the whole profession felt that what the Business Services Authority did was a bit strange but, no, I am not going to give advice to carry on trying to do stuff within 28 days. Of course not."

(My underlining).

104. I agree that the NHS Business Services Authority's interpretation of the mixed funding provisions in the *Contracts Regulations* was a bit strange. I bear in mind that no direct evidence was given as to the contents of the one day of training on NHS charging that the experts considered the Appellant would have undergone during her education. Nor was there any evidence produced that the 10 years of work the Appellant did as a dental nurse/assistant would have provided her with the information about mixed funding which is clearly permitted under the Regulations but not under the NHS Business Services Authority's Guidance. As the Appellant said in her evidence in cross examination *"at the time I genuinely thought that that was an entirely permissible way to work and I was just naively thinking I was providing a*

much better quality material and looking the restoration, without incurring the very much larger private fee for the patient". The Appellant admitted in cross examination that she did not look up the Regulations. The PCC found that this was part of her inadequacy, but they themselves did not look up the Regulations or ask for them or see the NHS contract with the Practice and neither did the experts or the Respondents who prosecuted the charges. It was when, during the appeal hearing, I asked counsel to provide the Regulations, the contract and all relevant guidance, that this was disclosed: that paragraph 10(1) of schedule 3 specifically allows voluntary agreed mixed charging if the ceramic crowns are not necessary for the patent's oral health in the dentist's clinical judgment.

105. The Appellant's defence on top up fees was tied up with her undisputed evidence about her very busy working days and the lack of time that she had available. In cross examination the date of W's advice was suggested as approximately June of 2018 and the Appellant agreed with that. There was no suggestion of finding that after that date the Appellant continued providing full ceramic crowns with top up fees.

106. There was no direct evidence that the Appellant knew that top up fees were not permitted. The PCC's finding was therefore a matter of inference. I do not consider that dishonesty was an inference that could properly be drawn on the evidence provided.

107. One point made against the Appellant was that she did not instigate refunds of the top up fees in patients T, U and V after W informed her of her error. I see some merit in that but I do not consider that it justifies the finding by inference of dishonesty made by the PCC in relation to top up fees. It simply highlights again the unsupportive relationship with the Practice and PRD.

108. I have looked at the evidence in relation to patients U and V and nothing in their chronologies or the evidence relating to their treatment changes my view on the finding of dishonesty in relation to top up fees.

Conclusion on the finding of dishonesty relating to top up fees

109. This appeal is a rehearing. There was no ground of appeal stating that the PCC or the experts were in error, or misinformed about the NHS Regulations or the NHS contract with the Practice or the NHS Business Service Authority's guidance on them. But because this is a rehearing I consider that this Court is duty bound to consider issues raised which affect the validity of the foundations for the PCC's decisions on dishonesty.

110. For all of the reasons set out above I consider that the decisions of the PCC on the Appellant's honesty in relation to voluntary agreed top up fees were wrong, were procedurally unfair and were not inferences which could properly be made in relation to patient T and in the absence of the Regulations and the Practice contract or at all. It follows, and I so find, that the dishonesty findings in relation to patients U and V were likewise wrong and I overturn them. This decision also affects part of charge 18(a) relating to top up payments.

111. In relation to patient T the Appellant submitted that the further alternative ground that the PCC put forwards in support of their finding of dishonesty, namely that the

laboratory did not charge for the fully ceramic crown and therefore that was further evidence of dishonesty, was internally contradictory with their other finding that the evidence in relation to whether the laboratory did charge was "unclear". I asked the Respondent whether they maintained that that was a proper ground for a finding of dishonesty on its own in view of the internal contradiction in the PCC's own finding of the evidence in support and, quite rightly, the Respondent accepted that this would not be a proper finding for them to seek to uphold. Therefore I overturn that finding as well.

Splitting COTS

112. In relation to patient T and the third ground of appeal, the relevant charge was that the Appellant split a course of treatment (COT). The PCC found that under the NHS dental contract a dentist has to carry out his or her professional work by taking four general steps:

a. the first is examination;

b. the second is assessment;

c. the third is providing a treatment plan (TP) to the patient, and getting consent to it;

d. the fourth is providing the full course of treatment in the TP.

After that, of course, the dentist will send a claim to the NHS for payment. After the claim is submitted the NHS will pay it under various bands. Those bands are numbered one to four. As set out above, the way the system is set up the dental treatment is not completely free. Patients are required to make a fixed contribution for dental treatment paid for by the NHS at a different fixed sum for each band. The sum is small for band one and rises through the bands up to the largest sum in band four. However the expert evidence was that it is a basic tenet of NHS dental treatment that once the clinician has been through the first 3 stages and constructed a TP the clinician is not allowed to do anything other than see that treatment plan through and bill after it is certified as completed. So the term "course of treatment" (COT) which is a term of art, covers all four stages. Only when the COT is done can the subsequent claim be made to the NHS. There are exceptions to this rule if the patient decides to stop the COT part way through or fails to attend.

113. It was the agreed expert evidence that clinicians are not permitted to make more than one NHS claim for a single COT. They are not committed to split a COT up into two COTs or indeed 3 COTs. They are not permitted to charge the NHS twice or three times for one COT. Herein, when I use the term "split COT", what I mean is a clinician splitting a course of treatment into two or more courses of treatment.

114. No Regulations were put before me which support the experts' agreed opinions on the ban on splitting COTs during the hearing but after the hearing the following Regulations were provided.

115. A Course of Treatment (COT) is defined within the *Contracts Regulations* at paragraph 2 of Part 1:

> "course of treatment" means—
>
> (a) an examination of a patient, an assessment of that patient's oral health, and the planning of any treatment to be provided to that patient as a result of that examination and assessment; and
>
> (b) the provision of any planned treatment (including any treatment planned at a time other than the time of the initial examination) to that patient up to the date on which—
>
> (i) each and every component of the planned treatment has been provided to the patient, or
>
> (ii) the patient either voluntarily withdraws from, or is withdrawn by the provider from, treatment, by, **unless the context otherwise requires**, one or more providers of primary dental services, **except that it does not include** the provision of orthodontic services or dental public health services **and,** [where the course of treatment is an interim care course of treatment provided under a prototype agreement or a Capitation and Quality Scheme 2 Agreement in the context of regulation 12A of the NHS Charges Regulations (charges in respect of primary dental services provided under a prototype agreement or under a Capitation and Quality Scheme 2 Agreement)], **it does not include the treatment mentioned in sub-paragraph (a)".**

(The underlining and bold emphasis is mine)

116. A COT is deemed to be "complete" as defined by paragraph 2 of Part 1 of the *Contracts Regulations* as follows:

> "complete", in relation to—
>
> (a) a course of treatment, means that—
>
> (i) where no treatment plan has to be provided in respect of a course of treatment pursuant to paragraph 7(5) of Schedule 3 (treatment plans), all the treatment recommended to, and agreed with, the patient by the contractor at the initial examination and assessment of that patient has been provided to the patient; or
>
> (ii) where a treatment plan has to be provided to the patient pursuant to paragraph 7 of Schedule 3, all the treatment specified on that plan by the contractor (or that plan as revised in accordance with paragraph 7(3) of that Schedule) has been provided to the patient; and …"

117. Paragraph 4 (6) of the *Charges Regulations* sets out that:

> "(6) For the purposes of paragraphs (1) to (3) and (5) above, only one charge may be made for any one course of treatment or urgent course of treatment provided, notwithstanding that a number of individual treatments may be provided or dental appliances or orthodontic appliances supplied during that course of treatment and a number of individual treatments may be provided during that urgent course of treatment."

118. On this the *Dental Handbook* (Managing dental services (v1.0) 04.201771) says at page 70 that:

> "**Requirements for a course of treatment / splitting courses of treatment**
>
> The term ''splitting" is not defined within the regulations but the term is generally used to describe the deliberate intention not to deliver all necessary treatment in a single course of treatment, i.e. the treatment required by a patient is unreasonably or un-necessarily split across a number of courses of treatment.
>
> If a dentist is repeatedly splitting treatment across several courses of treatment, this will be highlighted in the activity monitoring reports from NHS Dental Services."

(The underlining is mine)

119. The wording in the guidance is interesting as an insight into practice. It implies that splitting COTs happens quite a lot, either necessarily or unnecessarily and is "monitored". This acknowledges that there are necessary circumstances where splitting COTs occurs or alternatively that there may be some widespread confusion about it.

120. I have to admit that interpreting Part 1 paragraph 2 part (b)(ii) appears to be fiendishly tricky. I understand that a COT is defined as the work ongoing until the treatment is done or the patient "withdraws". I am clear and understand that a COT will also end if the patient "is withdrawn" by the provider. A dentist would need expert assistance on when and how that is permitted. Then there are 3 caveats which are drafted in a really complex manner. The first uses the words "**unless the context otherwise requires**," I struggle to know what that means. A dentist would need expert assistance on that. Then there is a further exception which states: "**except that it does not include** the provision of "orthodontic services" or "dental public health services". This case does not concern orthodontic services (roughly: teeth straightening) but may concern dental public health services. Those are defined in the *Contracts Regulations* as: "*services provided by the contractor by virtue of section 16CB(4)(C) of the Act."* I searched for that and it was repealed in March 2007 by the *National Health Service (Consequential Provisions) Act 2006.* The repealed provisions described sub-contractors to primary care trusts. Without further assistance this exception is a bit of

a dead end, at least to me. But the tricky maze does not stop there because a third exception is set out in the final words of the sub-paragraph which are: **"and […] it does not include the treatment mentioned in sub-paragraph (a)".** Sub paragraph (a) covers the assessment and the whole treatment plan. So it would appear that a dentist cannot withdraw a patient from the treatment plan which undermines the whole purpose of Part 1 para. 2 (b)(ii). Quite how a young dentist could be expected to understand this legislation whilst engaging in a busy dental practice and without good quality senior support is beyond me on the evidence put before me.

121. I heard argument on the "swings and roundabout" principles of the sums paid for band 1-4 claims. Fixed fees for lump sum work cover a range of scenarios. So a COT covering one crown would be a band 3 payment. A COT covering 5 crowns would also be a band 3 payment. A dentist would therefore be paid the same fee by the NHS for 5 times the work. That fee disadvantage would be a considerable incentive to split the COT.

Patient R

122. The PCC heard and determined a hard fought issue between the Appellant and PRD, the owner of the Practice, over whether PRD had in fact directed the Appellant to stick to easy work and avoid band 3 work and avoid overloaded COTs and to split COTs. They determined that issue against the Appellant.

123. The starting point in this issue is the fact that PCC found that the Appellant split the COT for patient R. The COT involved crowning 4 teeth: UR1 and 2 and UL1 and 2. The first appointment was on 7th December 2017. 3 teeth had been damaged in a traumatic incident. On 20 June 2018, at the fourth appointment with the Appellant, costs were discussed and it was agreed the Appellant would do two crowns first and two later, thereby splitting the treatment. The clinical notes did note the splitting of the work saying UR1 and UL1 would be done first and the other two "*on a later date".* Splitting the COT billing was not expressly put in the notes. In her witness statement the Appellant accepted that she told the patient that it would not be "cost effective" to do all the 4 crowns under one COT so the patient would understand two fixed charges would arise. It was the Appellant's defence that PRD had told her to do this very thing and she did not know it was not permitted. If the PCC had accepted that evidence then dishonesty would probably not arise without more detailed evidence of a conspiracy to defraud in the knowledge that splitting was contrary to the Regulations or the NHS contract terms.

124. The PCC found against the Appellant on dishonesty and rejected her defence that PRD told her to split COTs in relation to patient R. That finding is not appealed. Patient R's treatment ran from 7th December 2017 to 1st August 2018 and the second split COT claim was made on 6th August 2018.

Patient T

125. An appeal is brought in relation to patient T on the same split COT issue. This patient was treated between March 2018 and July 2018 during which time her COT was split and the work was done in two batches and charged under two NHS claims.

126. It is therefore a challenging task for the Appellant to succeed in proving in this appeal that she was not dishonest for splitting patient T's COT when she does not appeal the finding of dishonesty in splitting patient R's COT over pretty much the same period.

127. The appeal was based on the assertions that: the first NHS claim was made by an administrative error on 2nd May 2018 so the first part of the COT was "closed" in error; compelling evidence of pressure of work; the assertion that the opening of the 2nd COT in June 2018 was an oversight based on the way the previous records were written and the way that patient T attended on 26.6.2018 needing an urgent replacement filling which distracted the Appellant from reading into the notes and spotting it was all one COT started back in March 2018.

128. Against this defence were the facts that:

a. The COT was closed by the Appellant, nurses cannot close COTs and any person looking at the clinical notes could see that another part of the COT was still outstanding at that time;

b. the next appointment after the 2nd May appointment (made for 26th June) was listed on 2nd May 2018 (just when the first COT was closed), that would only occur if further treatment was needed under the original COT;

c. the June 2018 appointment was listed for 50 minutes, so 5 times as long as the usual 10 minute appointment, therefore the Appellant must have realised the June appointment was for substantial ongoing treatment not just a filling;

d. splitting the COT doubled the UDAs earned by the Appellant for the practice.

129. Having carefully listened to the submissions and read the evidence thereon and looked at the clinical notes I do not find any error in the PCC's approach to dishonesty on this issue. I make this decision despite my concerns about the convoluted wording of the Regulations about COTs.

The Law

Failure to put key factual issues in cross examination

130. The Appellant relied on the rule in *Browne v Dunne* (1894) 6 R67 for the submission that it is necessary to put to a party or witness in cross examination the nature of the case upon which the proponent relies, in particular if dishonesty is asserted. The case relied upon in which the rule is summarised was *Markem v Zipher* [2005] RPC 31, [2005] EWCA Civ 267, in which Jacob LJ summarised previous cases as follows at paras 58-61:

> "58. *Browne v Dunn* is only reported in a very obscure set of reports. Probably for that reason it is not as well-known to practitioners here as it should be although it is cited in *Halsbury* for the following proposition:
>
> > "Where the court is to be asked to disbelieve a witness, the witness should be cross-examined; and failure to cross-examine a witness on some material part of his

> evidence or at all, may be treated as an acceptance of the truth of that part or the whole of his evidence."

Because the decision is so difficult to lay hands on, we take the opportunity here of citing all the material passages. We do so *via* the decision of Hunt J. in *Allied Pastoral* because his judgment also contains his own valuable comments. He said (p.623):

> "It has in my experience always been a rule of professional practice that, unless notice has already clearly been given of the cross-examiner's intention to rely upon such matter, it is necessary to put to an opponent's witness in cross-examination the nature of the case upon which it is proposed to rely in contradiction of his evidence, particularly where that case relies upon inferences to be drawn from other evidence in the proceedings. Such a rule of practice is necessary both to give the witness the opportunity to deal with that other evidence, or the inferences to be drawn from it, and to allow the other party the opportunity to call evidence either to corroborate that explanation or to contradict the inference sought to be drawn. That rule of practice follows from what I have always believed to be rules of conduct which are essential to fair play at the trial and which are generally regarded as being established by the decision of the House of Lords in *Browne v Dunn* (1894) 6 R 67. No doubt because that decision is to be found only in an obscure series of law reports (called simply '*The Reports*' and published briefly between 1893 and 1895), reliance upon the rules said to be enshrined in that decision seems often to be attended more with ignorance than with understanding. The appeal was from a defamation action brought against a solicitor and based upon a document which the defendant had drawn whereby he was to be retained by a number of local residents to have the plaintiff bound over to keep the peace because of a serious annoyance which it was alleged he had caused to those residents. Six of the nine signatories to the document gave evidence on behalf of the defendant that they had genuinely retained him as their solicitor and that the document was really intended to be what it appeared on its face to be. No suggestion was made to any of these witnesses in cross-examination that this was not the case and, so far as the conduct of the defendant's case was concerned, the genuineness of the document appeared to have been accepted. However, the defence of qualified privilege relied upon by the defendant

depended in part upon whether the retainer was in truth genuine or whether it was a sham, drawn up without any honest or legitimate object but rather for the purpose of annoyance and injury to the plaintiff. This issue was left to the jury. The plaintiff submitted to the jury that the retailer was not genuine and was successful in obtaining a verdict in his favour. In support of that submission, the plaintiff asked the jury to disbelieve the evidence of the six signatories who had said that the retainer was a genuine one.

Lord Herschell LC said (at 70–71): 'Now my Lords, I cannot help saying that it seems to me to be absolutely essential to the proper conduct of a case, where it is intended to suggest that a witness is not speaking the truth on a particular point, to direct his attention to the fact by some questions put in cross-examination showing that that imputation is intended to be made, and not to take his evidence and pass it by as a matter altogether unchallenged, and then, when it is impossible for him to explain, as perhaps he might have been able to do if such questions had been put to him, the circumstances which it is suggested indicate that the story he tells ought not to be believed, to argue that he is a witness unworthy of credit. My Lords, I have always understood that if you intended to impeach a witness you are bound, whilst he is in the box, to give him an opportunity of making any explanation which is open to him; and, as it seems to me, that is not only a rule of professional practice in the conduct of a case, but is essential to fair play and fair dealing with witnesses. His Lordship conceded that there was no obligation to raise such a matter in cross-examination in circumstances where it is 'perfectly clear that (the witness) has had full notice beforehand that there is an intention to impeach the credibility of the story which he is telling'. His speech continued (at 72): 'All I am saying is that it will not do to impeach the credibility of a witness upon a matter on which he has not had any opportunity of giving an explanation by reason of there having been no suggestion whatever in the course of the case that his story is not accepted.'

Lord Halsbury said (at 76–77):

'My Lords, with regard to the manner in which the evidence was given in this case, I cannot too heartily express my concurrence with the Lord Chancellor as to the mode in which a trial should be conducted. To my

mind nothing would be more absolutely unjust than not to cross-examine witnesses upon evidence which they have given, so as to give them notice, and to give them an opportunity of explanation, and an opportunity very often to defend their own character, and, not having given them such an opportunity, to ask the jury afterwards to disbelieve what they have said, although not one question has been directed either to their credit or to the accuracy of the facts they have deposed to.'

Lord Morris (at 77–79) said that he entirely concurred with the two speeches which preceded his, although he wished (at 79) to guard himself with respect to laying down any hard-and-fast rules as regards cross-examining a witness as a necessary preliminary to impeaching his credit. The fourth member of the House of Lords, Lord Bowen, is reported (at 79–80) to have said that, on the evidence of the six signatories, it was impossible to deny that there had been a real and genuine employment of the defendant. But his Lordship made no statement of general principle. These statements by the House of Lords led to the formulation of a number of so-called 'rules'. They have been stated in various ways in the cases and by text-book writers, and it is fair to say that there is some room for debate as to their correct formulation. For example, in *Cross on Evidence* (2nd Australian ed, 1979) the authors state (at para 10.50): 'Any matter upon which it is proposed to contradict the evidence in chief given by the witness must normally be put to him so that he may have an opportunity of explaining the contradiction, and failure to do this may be held to imply acceptance of the evidence in chief.'

In *Phipson* (12th ed, 1976) the authors state the rule somewhat more discursively (at para 1593):

'As a rule a party should put to each of his opponent's witnesses in turn so much of his own case as concerns that particular witness, or in which he had a share . . . If he asks no questions he will in England, though not perhaps in Ireland, generally be taken to accept the witness's account and he will not be allowed to attack it in his closing speech, nor will he be allowed in that speech to put forward explanations where he has failed to cross-examine relevant witnesses on the point . . . Where it is intended to suggest that the witness is not speaking the truth upon a particular point his attention must first be directed to the fact by cross-examination, so that he may have an opportunity of explanation; and

> this probably applies to all cases in which it is proposed to impeach the witness's credit . . . Failure to cross-examine, however, will not always amount to an acceptance of the witness's testimony, e.g. if the witness has had notice to the contrary beforehand, or the story is itself of an incredible or romancing character'."
>
> Hunt J. concluded (p.634):
>
> "I remain of the opinion that, unless notice has already clearly been given of the cross-examiner's intention to rely upon such matters, it is necessary to put to an opponent's witness in cross-examination the nature of the case upon which it is proposed to rely in contradiction of his evidence, particularly where that case relies upon inferences to be drawn from other evidence in the proceedings."
>
> We think all that applies here. It is not necessary to explore the limits of the rule in *Browne v Dunn* for this case falls squarely within it. Indeed the position is stronger here, for the judge was not even asked to disbelieve the witnesses. Mr Watson was right not to support the judge's findings—the only puzzle is why he did not take that position earlier.""

131. This is a rule of fairness relating to the conduct of cases at hearings. The context is provided in the text. I glean from this case the following matters relevant to the issue in this case, which is proof of dishonesty:

a. If the proposer has, in advance of the hearing, given notice of the allegation of dishonesty and the main evidential foundations for it, the rule may be of less or no application, so long as the opposer has been given a reasonable opportunity to respond to the allegations and gather evidence in response to rebut the allegations.

b. If the proposer has not given notice of the nature of the allegation of dishonesty in advance and the opposer has not been given the opportunity to answer in advance then the proposer must put the allegation in cross examination so that the opposer may answer it.

c. These rules are ones of practice and are necessary both to give the opposer the opportunity to deal with the main evidence, or the inferences to be drawn from it, and to allow the opposer the opportunity to call evidence either to corroborate the defence to the allegation, to give an explanation or to contradict the inferences sought to be drawn.

d. These rules are however subject to a great deal of flexibility depending on the circumstances of the case. So there is no need for cross examination on every evidential matter in support of an allegation of dishonesty which has already been

made clear in pleadings, in opening and/or in evidence, that is a matter for the advocate's discretion and the judge.

e. In a civil matter, a party, whether through its advocate or in person, should not make a submission of dishonesty against a party or witness in closing speeches which is not founded on a pleaded case, and/or set out in the opening, and/or supported in evidence, and/ or properly put to the relevant witness or party in cross examination, so that the latter has had a reasonable and fair opportunity to answer the allegation.

132. The Appellant also relied upon *Chen v Ng* [2017] UKPC 27. In the Privy Council Lord Neuberger and Lord Mance gave a joint judgment and at paras. 51 onwards stated this:

> "51. Mr Parker's argument is, as it was before the Court of Appeal, that if the two grounds cited by the Judge were to be relied on as reasons for disbelieving Mr Ng, they ought to have been put to Mr Ng in cross-examination. As neither ground was raised with him, runs the argument, it was unfair for the Judge to have relied on either of them as reasons for disbelieving Mr Ng; accordingly, it would be wrong to let the decision of the Judge stand. The Court of Appeal accepted this argument, and, albeit with some hesitation, the Board considers that they were right to do so.
>
> 52. In a perfect world, any ground for doubting the evidence of a witness ought to be put to him, and a judge should only rely on a ground for disbelieving a witness which that witness has had an opportunity of explaining. However, the world is not perfect, and, while both points remain ideals which should always be in the minds of cross-examiners and trial judges, they cannot be absolute requirements in every case. Even in a very full trial, it may often be disproportionate and unrealistic to expect a cross-examiner to put every possible reason for disbelieving a witness to that witness, especially in a complex case, and it may be particularly difficult to do so in a case such as this, where the Judge sensibly rationed the time for cross-examination and the witness concerned needed an interpreter. Once it is accepted that not every point may be put, it is inevitable that there will be cases where a point which strikes the judge as a significant reason for disbelieving some evidence when he comes to give judgment, has not been put to the witness who gave it.
>
> 53. Mr Parker relies on a general rule, namely that "*it will not do to impeach the credibility of a witness upon a matter on which he has not had any opportunity of giving an explanation by reason of there having been no suggestion whatever in the course of the case that his story is not accepted",* as Lord Herschell LC put it in *Browne v Dunn* (1893) 6 R 67, 71. In other words, where it is not made clear during (or before) a trial

> that the evidence, or a significant aspect of the evidence, of a witness (especially if he is a party in the proceedings) is challenged as inaccurate, it is not appropriate, at least in the absence of further relevant facts, for the evidence then to be challenged in closing speeches or in the subsequent judgment. A relatively recent example of the application of this rule by the English Court of Appeal can be found in *Markem Corpn v Zipher Ltd* [2005] RPC 31.
>
> 54. The Judge's rejection of Mr Ng's evidence, and his reasons for rejecting that evidence, do not infringe this general rule, because it was clear from the inception of the instant proceedings, and throughout the trial that Mr Ng's evidence as to the basis on which the Shares were transferred in October 2011 was rejected by Madam Chen. Indeed, Mr Ng was cross-examined on the basis that he was not telling the truth about this issue. The challenge is therefore more nuanced than if it was based on the general rule: it is based on an objection to the grounds for rejecting Mr Ng's evidence, rather than an objection to the rejection itself. It appears to the Board that an appellate court's decision whether to uphold a trial judge's decision to reject a witness's evidence on grounds which were not put to the witness must depend on the facts of the particular case. Ultimately, it must turn on the question whether the trial, viewed overall, was fair bearing in mind that the relevant issue was decided on the basis that a witness was disbelieved on grounds which were not put to him.
>
> 55. At a relatively high level of generality, in such a case an appellate court should have in mind two conflicting principles: the need for finality and minimising costs in litigation, on the one hand, and the even more important requirement of a fair trial, on the other. Specific factors to be taken into account would include the importance of the relevant issue both absolutely and in the context of the case; the closeness of the grounds to the points which were put to the witness; the reasonableness of the grounds not having been put, including the amount of time available for cross-examination and the amount of material to be put to the witness; whether the ground had been raised or touched on in speeches to the court, witness statements or other relevant places; and, in some cases, the plausibility"

133. I take from this judgment that the old rule must move forwards with the times. In more modern hearings, both in civil and in tribunals, the procedural rules require claims to be pleaded out or in this case for the charges to be set out in detail. Also for the evidence to be reduced into writing and served with all relevant documents. The case is opened and parties therefore know in advance most of the case which they have to meet and answer including any assertions of dishonesty. In addition proportionality and efficient use of court time is relevant. Witnesses are less often

allowed to give evidence in chief and their written witness statement are taken as that evidence. In that modern context the rule requiring cross examination to challenge the opposer over every detail of the alleged dishonesty is more flexible and dependent on the context of the allegation within the claims and the context of the main issues.

Applying the law to the facts on cross examination

134. Having read the charges, the witness statements, the opening, the Appellant's witness statements, those of PRD, the statement of her lab technician witness W and the cross examination of the Appellant and many other parts of the transcripts, it is clear in my judgment that the Appellant knew the allegations which she faced and had ample opportunity to put her defence and to gather evidence to defend herself against the allegations of dishonesty before and during the hearing in relation to every allegation except the top up fees.

135. The allegation that the 3 or 4 additional "Guy" lab requests relating to other patients were not put to the Appellant is not in any way in my judgment unfair to the Appellant. The key "Guy" lab report was put to her and her explanation for the genesis of the disputed words on the lab report was unconvincing and incomplete. The Appellant insisted that she did not write the words but never went on to explain who else would have come into her patients' files, spoken to "Guy" and then have ordered exactly the wrong article for the patient which the Appellant herself , by her nurse, had written wrongly in her own examination notes: to bill it as another item which was never being produced or delivered.

136. I consider that the cross examination carried out by the GDC's counsel, who also appeared on the appeal, was fair, robust, subtle and effective and covered the topics necessary in the time available, except for the Regulations relating to top up fees.

137. For the reasons set out above I reject the grounds of appeal based on unfair process involving the allegation that inadequate opportunity was provided to the Appellant to defend herself due to inadequate cross examination, save to the extent that the General Dental Council did not cross examine the Appellant on para. 10 of Schedule 3 of the *Contracts Regulations* or on the NHS contract with the Practice in relation to top up fees. This should have been done because it was fundamental to the allegation of dishonesty on top up fees. That failure was serious and relevant to my decisions on honesty relating to top up fees.

Sanction

138. The charges which have been proven are undoubtedly serious ones. Dishonesty in dealing with the NHS claims process and failing to communicate properly with patients over charging are serious matters. Failing to make proper clinical notes and diagnose caries likewise can be serious.

139. I agree with the PCC that all of the sanctions below suspension are not relevant to such serious charges and would not be sufficient.

140. I also agree with the PCC that the Appellant has shown remarkable endeavour in retraining herself to ensure her clinical failings including note taking, spotting caries

and reporting on x-rays which she made over her first 11 months of practice do not recur.

141. However, in my judgment in all of the circumstances of this case the sanction of erasure for this young dentist is too harsh and is unnecessary in the circumstances of this set of proven charges. My reasoning is as follows.

142. As set out above the findings of dishonesty over top up payments are quashed, so the scope of the breaches of professional standards is narrower than the PCC was considering. However even if my interpretation of the *Contracts Regulations* is wrong, what I set out below remains my judgment.

143. These misconducts were nearly all committed over a short period between December 2017 and August 2018 in the Practice which did not provide the Appellant with any induction training or any continuing training or any clear guidance on NHS claims and under a principal dentist with whom the Appellant had a difficult and unsupportive relationship. There was little if any evidence of supervisory support provided by PRD to this young dentist. I consider that I can take judicial notice that young professionals including dentists need guidance in their first job and later on as well.

144. The Appellant was very busy indeed during this first 11 months. The time available for her note taking and for discussions with her patients and for reporting on xrays was less than 10 minutes per patient on average. Patients have to come into the surgery room, sit down, take off their coats and need to be put at ease. However busy more senior and experienced dentists may be, as the PCC's professional members clearly knew, it was unchallenged evidence that this young Appellant was very busy. Also she had to stand in for the only other associate dentist who left the Practice in October 2017 and was not replaced for 3 months. Then after the 2nd associate was finally replaced, the owner took time off from January 2018, leaving the Practice at below strength again.

145. What did the Appellant do to remediate her errors? After the investigation started, the Appellant engaged in a wide and long list of effective training on the issues relevant to her admitted and later proven misconduct in a mature and insightful way. The road to redemption starts which insight and understanding and travels through remorse and learning to improvement.

146. The Appellant's reflective statement on her errors is insightful in my judgment.

147. In relation to the Appellant's refusal to admit dishonesty, I take into account the law on the inalienable right of all subjects in this country to defend themselves robustly against allegations of dishonesty and lack of integrity. This applies to professionals and non professionals alike and is not just reserved for those in the criminal courts. No harsher penalty is imposed for a not guilty plea as a result of that plea. However a guilty plea does permit a reduced penalty.

148. I take into account the guidance in the General Dental Council's Indicative Sanctions booklet. The decision process on sanctions starts, as one would expect, with the lowest sanctions and rises up through the sanctions until, in the judgment of the tribunal, or this Court, the correct one is reached. Using that process I consider that

the necessary punishment and the necessary protection of the public is achieved by a 9 month suspension of the Appellant from the date of the PCC's decision: 19 January 2022. A suspension deprives the Appellant of her profession and her income, her reputation and her status and is publicly an admonishment for her misconduct.

149. In relation to the need for protection of the public, and the public purse, I bear in mind that the Appellant's dishonest action in splitting COTs was aimed at keeping her practice viable not at depriving the public. Very little extra cost to the public purse was involved.

150. In relation to proportionality, I take into account that the patients who have been involved in the misconduct have suffered no or very little clinical damage or disadvantage. They have suffered very little additional cost – for instance a doubling of the fixed charge for treatment for patients R and T. These sums will have been refunded. I take into account that the NHS Business Services Authority has paid out via two COTs rather than one for patients R and T. These sums will or should have been refunded. The total involved may be under £2,000 but no accurate figure was ever put before me. Throughout all of this the Appellant had been working so very hard. There is no evidence that the Appellant made "profit" from her misconduct. At most she may have gained some indirect benefit from claiming a few extra UDAs under the split COTs. When assessing the seriousness of the dishonesty the sums involved are relevant. These are at the very bottom of the scale.

151. When considering NHS protection I do not consider that the PCC's approach in relation to the Appellant's attitude was correct. When the NHS Business Services Authority's guidance given on splitting COTs assumes that practitioners will split COTs (see page 70 set out above) and they monitor such occurrences, that gives the context for the issue. The PCC found the Appellant knew she should not split COTs but did so. I consider that the Appellant has learned that lesson clearly through the disciplinary process as shown in her reflective. I consider that the risk of reoffending over NHS funding is very low. I also consider that the NHS Business Services Authority's guidance on top up fees and splitting COTs could and should be made clearer and should distinguish between Regulations and business practice advice.

152. I consider that the reference from W and the Appellant's good conduct since the charges were brought and her focus on education since the events are impressive and admirable. Her hard work since is also impressive.

153. I did indicate a desire to see comparable PCC and appellate Court sanction decisions during the appeal hearing however I have not been shown any comparable sanctions passed by the PCC or the Courts and was informed that it is not common practice to provide such. For consistency of approach to sanction it is my judgment that comparables would be useful.

154. In relation to pre-meditation, I do not consider that to be of much relevance to sanction in this case. It would apply strongly in relation to stealing practice funds, supplying unworthy medical equipment from dodgy sources and other pre-planned damaging behaviour but the pre-mediation in these offences is little more than an inappropriate way to keep working hard despite knowing it was wrong.

155. In relation to breach of trust, that is all tied up with the NHS charging contract and the Regulations themselves and the guidance on them. I do not find those to be a stand out feature in these proven charges because the contract and Regulations were never put before the PCC.

156. The Appellant has shown insight. She has retrained in ethics and other relevant fields. She has worked under supervision. She has hired and learned from an expert: Dr. Janine Brooks. I consider that looking at her qualifications and determination to focus on so many aspects of dentistry, it is clear that dentistry is her professional life and she is truly horrified, embarrassed and humbled by what she has done.

157. I take into account paras. 6.28, 6.30 and 6.34 of the guidance on sanctions. When considering public confidence I consider that many members of the public who work in the NHS, or have relatives of friends who do, understand how difficult it is to work in busy public service in the NHS in many fields. The public understand how stressful, low paid and overworked many NHS staff are and how the system can be unyielding and the throughput never ending. I do not consider that members of the public would clamour for the permanent removal of a well qualified, hard working, young dentist based on these two split COTs and the other proven charges.

158. In my judgment erasure is disproportionate and unnecessary and I quash the PCC's decision on that. Suspension is enough for these proven charges for this young and repentant dentist.

Conclusions

159. For the reasons set out above I allow the appeal against the findings of the PCC in relation to the top up payment charges and the findings of dishonesty relating thereto, namely the following charges:

    a. those parts of 18(a) and (b) relating to top up fees (but not those parts relating to split COTs);

    b. all of charge 20(b);

    c. all of charge 22(b).

    So charges 20(b) and 22(b) are quashed. Parts of charges 18(a) and (b) are not proven in relation to top-up payments and likewise charges 17(d) and 17(f)(ii) and so are also quashed (but the parts relating to split COTs remain proven as the PCC found).

160. The erasure sanction of the PCC shall be quashed and in its place the Appellant's registration will be suspended for 9 months from the date of the decision of the PCC. If I am found by a higher Court to be wrong in relation to my decision to quash the findings of dishonesty relating to top up fees I should record here that I would have increased the overall suspension to one year in total for all the misconduct including those additional findings.

161. I rule that no further sanction may be imposed for the matters covered by the investigations considered by the PCC.