Neutral Citation Number: [2023] EWHC 661 (Admin)

Case No: CO/2283/2020

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 24/03/2023

Before :

BEFORE THE HONOURABLE MR JUSTICE HENSHAW

- -

Between :

THE KING
on the Application of

REKHA RANI PHOTAY **Claimant**

- and –

GENERAL DENTAL COUNCIL **Defendant**

- -
- -

Julia Furley (instructed by **JFH Law**) for the **Claimant**
Tom Stevens (instructed by **General Dental Council**) for the **Defendant**

Hearing date: 23 January 2023
Draft judgment circulated to the parties: 13 March 2023

- -

JUDGMENT

This judgment was handed down by the Judge remotely by circulation to the parties' representatives by email and release to The National Archives. The date and time for hand-down is deemed to be 10:00 on Friday 24th March 2023.

Mr Justice Henshaw:

(A) INTRODUCTION

1. The Appellant, Rekha Rani Photay, is a dentist registered under s15(1)(ba) of the Dentists Act 1984. She appeals pursuant to section 29(1)(b) of the Act from a determination of the Professional Conduct Committee ("***PCC***") of the General Dental Council ("***GDC***") notified to her on 31 May 2022.

2. The Appellant challenges the PCC's findings of fact considered below, its findings of misconduct and impairment, and the sanction of erasure which the PCC imposed.

(B) CHARGES AND EVIDENCE

3. The Appellant was first registered as a dentist with the GDC on 6 May 2015. She was summoned to appear before the PCC at a hearing between 16 May and 25 May 2022, following an investigation into her treatment of various patients between 2017 and 2020. The charges were divided into three separate referrals.

(1) Referral 1

4. Between 20 March 2017 and December 2018, the Appellant worked as an associate dentist at the Hebburn Dental Clinic ("***Hebburn***"). She also worked at the Westmount Dental Practice between September and December 2018. Concerns were raised regarding her clinical practice at both practices and a GDC investigation ensued.

5. Referral 1 comprised Charges 1 to 18. Charges 1 to 16 were allegations concerning the Appellant's clinical practice and note taking. The Appellant admitted eleven of these in whole or in part. The remaining charges and parts of charges were withdrawn, fell away or found not proven.

6. Charges 17 and 18 related to an allegation, which the Appellant admitted, that she had dishonestly informed the practice manager at Hebburn that she had been "work shadowing" at a practice in Darlington for two days in December 2017, which the Darlington practice confirmed she had not.

7. During the investigation for Referral 1 the Appellant was made subject to an interim order with conditions requiring among other things that she be supervised. She then worked as an associate dentist at the Harrowgate Hill Dental Practice ("***Harrowgate***") from 25 February 2019 to 4 December 2020. She was supervised by Dr Jaghdeep Ladhar ("***Principal Dentist 2***"), one of the owners of the practice.

(2) Referral 2

8. Referral 2 comprised Charges 19 to 39, which related mainly to the Appellant's record keeping practices, such as failure to properly use and adapt templates and the grading of radiographs. The Appellant admitted all of these apart from part of Charge 30, which was found not proven.

(3) Referral 3

9. Referral 3 comprised Charges 40 to 42, which related to an incident that took place whilst the Appellant was working at Harrowgate. They are the most serious of the allegations of misconduct and were the main basis upon which the PCC determined that the Appellant's fitness to practise was impaired and that the sanction of erasure was necessary.

10. The clinical records indicated that between 30 April and 31 May 2019 the Appellant completed a root canal treatment ("***RCT***") on the LR5 (lower right 5 tooth) of Patient LT. The records indicate that the RCT was completed on 31 May and that the root canal had been filled with gutta percha (referred to in the notes as "*GP*"). Gutta percha is a plant-based dental substance used for this purpose. The Appellant's clinical note, as quoted in the PCC's decision stated:

> "…LR5 previous temporary restoration, cotton pellet removed, canal located and accessed again, WL confirmed at 21mm, rubber dam applied, copious amounts of chlorhexidine used to irrigate single canal, dried with paper points and GP inserted to length, condensed laterally well, excess removed using heated plugger and condensed well, amalgam placed and condensed well in increments, articulation paper used to check bite and sound, smoothened using burnisher, pt felt happy…"

The records show, and it was admitted, that no post-operative radiograph was taken at the conclusion of the RCT (that omission being the subject of charge 40.e).

11. Patient LT returned to the surgery on 5 June 2019, complaining of pain and saw another dentist ("***JH***"). JH took a radiograph, which showed that there was in fact no gutta percha root filling in the tooth. JH removed the amalgam filling and placed a temporary dressing into the tooth. He recorded that no gutta percha was present under the amalgam and that caries (decay) remained in the tooth: "*amalgam removed, revealing existing pulpal exposure/ opening - bleeding present, caries removed from cavity*". JH said in his witness statement to the PCC: *"There was still decay in the tooth and it looked more like a bleeding exposure rather than a completed root canal so I cleaned the decay as much as I could, dressed the tooth and placed the temporary filling in there"*.

12. The clinical notes disclose that the Patient LT was referred back to the Appellant for the completion of the of the RCT. JH told the PCC that he explained to the patient that the gutta percha might have been removed from the tooth during the appointment on 31 May 2019, when the gutta percha was being condensed with a plugger (that being, he said, the only explanation he could think of for the absence of the root filling). Following the appointment on 5 June 2019, dentist JH used his mobile telephone to take a photograph of the radiograph showing that no gutta percha was present in the tooth. In his witness statement he explained that he did so "*because we only had wet film x-rays, not digital. I was concerned by what I had seen because the x-ray did not match the Patient's clinical notes from when the Registrant had seen the Patient the week before. As we only had wet film x-rays, sometimes they could go missing so I wanted to be sure there was a copy of this x-ray*."

13. On 9 July 2019 the clinical notes indicate that the patient attended an appointment with the Appellant, as follows:

> "Patient attended today for review of LR5 post initial RCT, explained to patient symptoms suggest failure of RCT, pt admitted to understanding this being the case and informed us was aware prior to beginning process symptoms may worse. Pt would prefer to leave temporary restoration…"

14. Due to cancelled appointments and closures during the Covid-19 pandemic, the patient did not attend the practice again in person until 8 October 2020. The Appellant's clinical notes of a telephone consultation on 3 August 2020 refer to the LR5 RCT having failed and to it being likely that the patient required continuation of the RCT.

15. On 8 October 2020 the Appellant took two periapical radiographs which again showed there was no root filling present in the LR5. These radiographs were provided to the GDC by Harrowgate as part of the patient's clinical records. The Appellant also provided a treatment plan for the LR5, one option being to continue with the RCT, the first stage having been completed. The patient did not see the Appellant again, but saw another associate dentist on 15 October 2020. That dentist formulated a treatment plan for the patient but then ceased working at the practice.

16. On 26 November 2020 Patient LT saw Balinder Sangha ("***Principal Dentist 1***"). She took a radiograph and discussed with LT the absence of root filling. During her consultation with Patient LT, Principal Dentist 1 called the Appellant out of surgery and asked her about the case. The Appellant's evidence was that when she arrived in Principal Dentist 1's surgery, she noticed that Principal Dentist 1 was looking at the wrong patient record, and so presumably had not reviewed the clinical records for Patient LT prior to calling the Appellant into the room. Principal Dentist 1 said in evidence:

> "The Registrant's records suggested that a root canal filling had been done on the tooth in May 2019 and when I took a radiograph in November 2020, I could not see that so I wanted clarification from the Registrant of what happened and whether she could remember the Patient. The Registrant told me that if she said in the clinical records that she had done a root filling she will have done a root filling…"

17. The Appellant said in her evidence (quoted by the PCC):

"20. When I arrived, I found that [Principal Dentist 1] was with Patient LT and they were both being quite aggressive towards each other. [Principal Dentist 1] asked me whether I had carried out RCT and I explained that I had, as was recorded within the patient's notes. Patient LT seemed upset to be being told by [Principal Dentist 1] that the treatment had not been carried out.

…

24. [Principal Dentist 1] said a number of times that it would not look good for me if the record was requested by NHS England as the record was missing. I explained that record cards often went missing as they were incorrectly filed by staff and that I had raised this multiple times with the manager and [Principal Dentist 2] and that nothing had been done.

25. [Principal Dentist 1] said that the record card needed to be found, with either me or staff looking for it. I commented on several occasions that I would not jeopardise my position, having GDC interim conditions and NHS voluntary undertakings, by not carrying out treatment.

…

27. The next day, I checked with reception staff whether the record card had been located. I was told that it had not and that no one was looking for it as they were too busy with reception related matters.

28. Over the next few days, when I had some free time, I looked through the filing cabinets where records are located. I found a card for Patient LT within the archive section where record cards are kept in filing cabinets in no chronological or alphabetical order. The record card (a brown NHS record card sleeve) had the patient's name written on the front and possibly also their date of birth but I do not remember and I have not seen the record card since I handed it to [Principal Dentist 2]. The sleeve only contained the odd looking x-ray.

29. I recall that the sleeve also said "duplicate" on the front. A duplicate record card would be created in circumstances where a patient's record card could not be located. Any hard copy records, radiographs, medical history, consent forms and treatment plans along with referrals or external letters would be kept inside the duplicate record card sleeve. If the original record card was subsequently located, the original and the duplicate card would be kept together.

30. I immediately tried to give the radiograph to [Principal Dentist 2] but, on each attempt, he was busy and did not respond to my requests to speak to him. I managed to catch him at the end of the day and gave him the X-ray. He went to put the X-ray on the viewing box and I said something along the lines of "here is the card to keep it safe", as he was just walking away from the viewing box towards his computer with the x-

ray, in the wallet but without the brown card. I then gave him the brown card.

31. I emphasised to [Principal Dentist 2] that this was not my radiograph and that I just found it in the archive section. [Principal Dentist 2] commented that it was an odd looking x-ray and I agreed. He said to leave it with him. I had wanted to discuss the radiograph further but [Principal Dentist 2] just said to leave it with him. I understand from his witness statement that he was in a rush to leave that day. […] Dental Nurse, was present during our exchange."

I shall refer to this radiograph as "*the damaged radiograph*".

18. In his witness statement to the PCC, Principal Dentist 2 stated:

"6. On 4 December 2020, the Registrant came into my surgery in the daytime and gave me the post-operative radiograph which should have shown the completed root filling that the Registrant supposedly did back in May 2019. It was important because the x-ray taken by [Principal Dentist 1] did not show it had been completed.

7. I cannot recall the Registrant's exact words, but she said something to the effect of I have found the x-ray. It was right at the end of my session, and it was the day I collect my children, so I was in a rush, and I only had a brief look but straight away from my initial look it did not look right. I think I said something like that does not look quite right. I believe my nurse at the time, […] or […], might have been present, however I cannot remember who this was. I did not take a note of this conversation. I have seen thousands of radiographs and I know what one should look it. I did not have time to explore it further at that stage. Over the course of the weekend, I reviewed it further and came to the conclusion it was not correct.

8. I did not think the radiograph was genuine because the materials we use to fill in a root filling normally are rubberised material that will show up as a white line on an x-ray. The density of the x-ray was really, really white. You can only get something that white if you have metallic in the area because it will stop the x-ray going through. Secondly, it was the perfect colour and shape of the rubber in the shape of the canal. In most cases there should be a kink along the way somewhere. My initial assumption was that there must have been a metallic object placed there to fill in the root filling area. However, later it came to light that if you turned over the radiograph the section had been scratched out by a sharp knife or similar object."

19. The Appellant was dismissed from the practice on 6 December 2020 and the matter was referred to the GDC.

(4) Expert Evidence

20. Expert evidence was relied upon by both parties. The GDC called Mr Mulcahy, a specialist in prosthodontics, who provided a report and gave evidence on day 3 of the hearing. The transcript of his oral evidence is unfortunately not available. Mr Mulcahy's report concluded that several of the radiographs provided were incorrectly dated. He also confirmed that a number of hard copy documents had not been provided. However, it was not suggested that those matters have any particular significance for the issues I have to determine.

21. Mr Mulcahy was unable to provide an opinion as to the standard of the restoration of the LR5, but based on the description given by JH in the clinical notes, he concluded that the description was *"not consistent with a basic standard of endodontic access preparation"*.

22. As to the absence of the GP, he said in his report that "*it is possible to inadvertently remove GP from a root canal during the obturation process and this is what JH assumed had happened*". (Obturation is the filling and sealing of the root canal.) He went on to say:

> "In my experience of the technique described, it is most likely that GP can be inadvertently removed either during the lateral condensation stage or subsequently when a heated plugger is used. If it was to be removed during lateral condensation, then the GP would either leave the canal space attached to the instrument being used or be dislodged and left lying in the access cavity. As such, it is more likely than not that it would be immediately apparent to the operator. Similarly, if it was to be removed attached to a heated plugger, it is more likely than not that it would be immediately apparent to the operator."

23. The Appellant's expert, Mr Morris, confirmed that he had seen GP being pulled out of a root canal on several occasions, adding that "*it is easy to see when it happens as either the GP is removed stuck to the instrument or it is pulled part way out of the canal*".

24. In their joint report, the experts said:

> "… from the clinical details recorded, it is more likely than not that [the Appellant] would have been aware if the gutta percha had been inadvertently removed from the canal during the obturation process.
>
> The experts also agree that the description of the access preparation as recorded by the subsequent treating dentist is not consistent with what would be expected if the canal had been prepared and obturated."

25. As to the damaged radiograph, Mr Mulcahy stated:

> "A photograph has been provided in the bundle which clearly shows an x-ray film which has been 'scratched' in order to alter the appearance … I have been provided with the original x-ray film and can confirm in my opinion the film has been 'scratched' to give the appearance as illustrated in 4.4.1 above".

26. Mr Mulcahy went on to state: *"It is my opinion that the appearance on the radiograph could not have occurred accidentally"*. He confirmed that this was not the same radiograph that was taken by JH on 5 June 2019, but was more likely than not to have been one of the x-rays that was missing from the records, taken on either 12 March or 30 April 2019. Mr Mulcahy stated in the summary (section 5) of his opinion that:

> "It is alleged that [the Appellant] 'altered' a PA radiograph to give the impression that endodontic treatment had been completed LR5 as recorded in her clinical records (31.5.19). A radiograph has been provided which has clearly been 'altered' as alleged. It is not disputed that this radiograph was provided by [the Appellant] to [Principal Dentist 2] on either the 3rd or 4th December 2020. However, [the Appellant] denies that she 'altered' it in any way. As such, any determination in relation to the central issues in this case will require a finding of fact as to: which x-ray was 'altered'; who 'altered' it; and why?"

27. Mr Morris confirmed that the damaged radiograph was "*not an image of a genuine RCT"*, noting that "*the back of the film has been modified by removal of the emulsion in the area corresponding to 'root filling'. This can be seen and felt on the original film."* In preparing his report Mr Morris had attempted to reproduce the appearance of the radiograph, using old radiographs with a variety of sharp dental instruments and a scalpel blade, but had not been able to do so.

28. A joint expert report was prepared, dated 16 May 2022, which included the following statement:

> "The experts have both examined the original radiograph and they agree that it has been 'tampered' with. The experts also agree that they are not in a position to establish how this came to be. As such, it will require a finding of fact on behalf of the Committee as to whether the Registrant did 'scratch' the radiograph as charged. If the Committee did find that the charge to be 'made out, it is the experts' opinion that this would represent a standard far below that expected. This is because it is unacceptable to alter/damage a radiograph."

(C) THE PCC'S DETERMINATION

29. The PCC, after hearing evidence and submissions, determined that the Appellant had knowingly not completed the obturation of the RCT, by not putting GP into the root canal, and had dishonestly prepared a clinical note to suggest otherwise. Thereafter, after it became apparent later in 2020 that the RCT had not in fact been completed, she had deliberately and dishonestly scratched the radiograph to give the false impression that the RCT had been successfully completed.

30. As regards the operation on 31 May 2019, the PCC reasoned as follows:

> "As a matter of fact, the LR5 had not been successfully obturated with gutta percha as no gutta percha was present in the tooth at the conclusion of the appointment on 31 May 2019. You had intentionally made a clinical note describing in detail that the LR5 had been successfully obturated with gutta percha. As admitted and found proved under charge 42(a) above, that note was misleading as a matter of fact. The issue under this

charge is whether you knew that the note was misleading at the time you made the note, or whether you genuinely but mistakenly believed that you had successfully obturated the LR5 with gutta percha.

The Committee determined that it is more likely than not that you had not in fact placed any gutta percha into the tooth to begin with. This is because [JH] found evidence of an exposed pulp and caries in the LR5 when he opened up the tooth six days later: there had not been even a basic standard of endodontic preparation in advance of the placement of gutta percha as a root filling.

In any event, the Committee determined that it would have been obvious to you if the gutta percha fallen out of the tooth during the treatment or if it had otherwise been removed from the tooth by becoming stuck to the heated plugger. The Committee accepted the expert opinion evidence that gutta percha was of a distinctive appearance to any other material which would have been used during the procedure. You accepted in evidence that you had used a rubber dam when placing the gutta percha into the tooth. The rubber dam would have isolated the tooth and this would have further increased the visibility of any gutta percha falling or being removed from the tooth.

In the Committee's judgment, there was no basis on which you could have reasonably believed that you had successfully obturated the LR5 with gutta percha. The Committee determined it was more likely than not that you knew you had not successfully obturated Patient LT's LR5 and that you knew your note in the clinical records was inaccurate."

31. In relation to the damaged radiograph, the PCC said:

"The issue for the Committee to determine under this charge is whether you had deliberately scratched the radiograph. This is an extremely serious allegation and one which the Committee considered with great care.

Both experts examined the radiograph and agreed that it had been deliberately scratched to give the impression that a root filling was present at the LR5. Both experts agreed that the way which the radiograph had been altered could not have been accidental.

The Committee accepted Mr Mulcahy's opinion that the radiograph which had been altered was likely to have been a pre-operative radiograph of LR5 taken on 12 March 2019 or 30 April 2019. One of those radiographs is missing from the records (it is not possible to tell which one) and is likely to have been the radiograph which was then deliberately scratched.

> The evidence before the Committee was that all practice staff had access to patient records and therefore any member of staff could have altered the radiograph.
>
> The Committee had regard to the content of the radiograph, the subject of the radiograph, what was altered on it, who was the treating dentist in relation to the subject matter of the alteration, the context of the investigation, the circumstances in which it came to be discovered and then presented to your supervisor and whether you would have had any motivation to have altered the radiograph."

32. The PCC accepted the evidence of JH that he discussed his concerns about Patient LT's treatment about a week after the 5 June 2019 appointment; the PCC considered this to have been a highly significant event that the Appellant would have remembered. The Appellant would, the PCC also found, have recognised Patient LT when Principal Dentist 1 called the Appellant into her surgery on 26 November 2020, and would have recognised that this was the patient for whom she had recorded a completed RCT on 31 May 2019 that JH had six days later found not to have been completed. The Appellant would further have recalled that she had failed to tell Patient LT at subsequent appointments that no root filling was present in her tooth. Principal Dentist 1 had called for the post-operative radiograph of the 31 May 2019 treatment, and in the absence of any such radiograph the Appellant would have understood that her claim to have completed the treatment would appear to be false. The PCC concluded:

> "It is beyond doubt from the evidence before the Committee that the radiograph in question was deliberately altered to give the impression that a root filling had been placed at Patient LT's LR5. Whilst all practice staff had access to patient records, there is nothing to suggest to the Committee that any person other than you would have had any reason whatsoever to have altered the radiograph (whether out of malice, as a "prank" or for some other reason). The only person who had a motive to alter the radiograph was you.
>
> The Committee had regard to the principle that the more serious an allegation the less likely it is to have occurred. Here, the allegation is extremely serious. The Committee also had regard to the crude nature of the alteration to the radiograph and to the fact that, on close examination, it would have been obvious to Principal Dentist 2 and any other practitioner that the back of the radiograph had been deliberately scratched in order to alter the radiographic image. In the Committee's judgment, this does not make it less likely that you had deliberately scratched the radiograph. This is because people can act recklessly and demonstrate poor judgment when desperate or under considerable pressure.
>
> This is not a decision which the Committee reached lightly or with any enthusiasm. The Committee very carefully examined and deliberated on the evidence. From whichever angle it approached the matter it reached the irresistible inference that it could only have been you who had deliberately scratched the radiograph covering the LR5, which you then provided to your workplace supervisor, Principal Dentist 2."

33. In the light of these findings of fact, the PCC determined that the Appellant's fitness to practise was currently impaired, and that it was necessary to erase her from the register with immediate effect.

(D) LEGAL FRAMEWORK

34. Section 1ZA and section 1ZB of the Dentists Act 1984, as amended, provide:

> "(1ZA) The over-arching objective of the Council in exercising their functions under this Act is the protection of the public.
>
> (1ZB) The pursuit by the Council of their over-arching objective involves the pursuit of the following objectives --
>
> (a) to protect, promote and maintain the health, safety and well-being of the public;
>
> (b) to promote and maintain public confidence in the professions regulated under this Act; and
>
> (c) to promote and maintain proper professional standards and conduct for members of those professions."

35. Section 27B addresses the powers of Practice Committees (including the PCC):

> "(1) Subject to subsection (4), a Practice Committee must investigate an allegation or allegations against a person referred to them by the Investigating Committee under section 27A and determine whether that person's fitness to practise as a dentist is impaired.
>
> (2) In making a determination under subsection (1), the Practice Committee may take into account whether the person who is the subject of the allegation or allegations has complied with any relevant parts of the guidance issued under section 26B but that question is not of itself determinative of whether a person's fitness to practise as a dentist is impaired.
>
> (3) ...
>
> (4) ...
>
> (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.

36. Under section 29(3) of the Act, the court's powers on appeal are to dismiss the appeal, to allow the appeal and quash the decision, to substitute a different decision within the range that could have been imposed by the PCC, or to remit the case.

37. In *Wasu v GDC* [2013] EWHC 3782 (Admin) Haddon-Cave J summarised the law at §§ 16-18:

"16. The approach to an appeal pursuant to s.29 of the Dentists Act 1984 can be summarised as follows:

(1) An appeal pursuant to s.29 of the Dentists Act 1984 is by way of rehearing …

(2) The Court has the power (a) to dismiss the appeal, (b) to allow the appeal and quash the decision appealed against, (c) to substitute for the decision appealed against any other decision which could have been made by the Professional Conduct Committee or (d) remit the case to the Professional Conduct Committee to dispose of the case in accordance with the directions of the court …

(3) The Court will allow an appeal where the decision of the lower tribunal was wrong or unjust because of a serious procedural, or other irregularity, in the proceedings before the lower tribunal …

17. The general principles applicable to an appeal against a decision of professional Disciplinary Committee of this sort can be summarised as follows:

(1) The Court will give appropriate weight to the fact that the Panel is a specialist tribunal, whose understanding of what the medical profession expects of its members in matters of medical practice deserves respect;

(2) The Court will have regard to the fact that the tribunal has had the advantage of hearing the evidence from live witnesses;

(3) The Court should accordingly be slow to interfere with decisions on matters of fact taken by the first instance body;

> (4) Findings of primary fact of the first instance body, particularly if founded upon an assessment of the credibility of witnesses, are close to being unassailable, and must be shown with reasonable certainty to be wrong if they are to be departed from;
>
> (5) Where what is concerned is a matter of judgement and evaluation of evidence which relates to areas outside the immediate focus of interest and professional experience of the body, the Court will moderate the degree of deference it will be prepared to accord, and will be more willing to conclude that an error has, or may have been, made, such that a conclusion to which the Panel has come is or may be 'wrong' or procedurally unfair.
>
> 18. As regards a challenge to the sanction imposed, the Court will normally accord even more respect to the tribunal of first instance."

38. The test on appeal is whether the decision was "*wrong*".

39. Section 57 of The General Dental Council (Fitness to Practice) Rules 2006 allows the PCC to call evidence that is admissible in civil proceedings. CPR Practice Direction 35 § 2 sets out the principal obligations of an expert when giving evidence in civil proceedings:

    i) Expert evidence should be the independent product of the expert uninfluenced by the pressures of litigation.

    ii) Experts should assist the court by providing objective, unbiased opinions on matters within their expertise, and should not assume the role of an advocate.

    iii) Experts should consider all material facts, including those which might detract from their opinions.

    iv) Experts should make it clear –

        a) when a question or issue falls outside their expertise; and

        b) when they are not able to reach a definite opinion, for example because they have insufficient information.

40. In *Kennedy LLP v Cordia (Services) LLP* [2016] UKSC 6, Lords Reed and Hodge gave guidance as to the admissibility of expert evidence in civil cases at § 44:

> "As we have said, a skilled person can give expert factual evidence either by itself or in combination with opinion evidence. There are in our view four considerations which govern the admissibility of skilled evidence:
>
> (i) whether the proposed skilled evidence will assist the court in its task;
>
> (ii) whether the witness has the necessary knowledge and experience;

> (iii) whether the witness is impartial in his or her presentation and assessment of the evidence; and
>
> (iv) whether there is a reliable body of knowledge or experience to underpin the expert's evidence.
>
> All four considerations apply to opinion evidence, although, as we state below, when the first consideration is applied to opinion evidence the threshold is the necessity of such evidence. The four considerations also apply to skilled evidence of fact, where the skilled witness draws on the knowledge and experience of others rather than or in addition to personal observation or its equivalent."

41. At § 48 of *Kennedy*, Lords Reed and Hodge state: *"An expert must explain the basis of his or her evidence when it is not personal observation or sensation; mere assertion or "bare ipse dixit" carries little weight."*. An expert witness should not usurp the function of the tribunal/judge when it comes to findings of fact.

42. As regards the expert's knowledge and expertise, § 50 of *Kennedy* states;

> "The skilled witness must demonstrate to the court that he or she has relevant knowledge and experience to Page 17 give either factual evidence, which is not based exclusively on personal observation or sensation, or opinion evidence. Where the skilled witness establishes such knowledge and experience, he or she can draw on the general body of knowledge and understanding of the relevant expertise: Myers, Brangman and Cox (above) at para 63."

43. Lord Hughes in *Ivey v Genting Casinos* [2017] UKSC 67 set out the legal test for dishonesty:

> "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." (§ 74)

44. It was confirmed in *GMC v Krishnan* [2017] EWHC 2892 (Admin) that *Ivey* applies to regulatory proceedings.

45. Where dishonesty is made out, combined with a lack of insight, it will very frequently lead to the conclusion that nothing short of erasure is likely to be appropriate: see, e.g., *Khan v GMC* [2015] EWHC 301 (Admin) § 6 per Mostyn J; and *R (Farah) v GMC* [2008] EWHC 731 (Admin) § 21 per Sullivan J (theft and forgery of prescription forms to obtain drugs).

(E) GROUND 1: PCC APPROACH TO EXPERT EVIDENCE: DAMAGED RADIOGRAPH

46. The Appellant makes, to begin with, a number of points about expertise.

47. Mr Mulcahy's expert report was commissioned following the decision of the Case Examiners on 7 October 2021 to refer this matter to the PCC. A redacted copy was provided to the PCC for their consideration. He was asked to provide an opinion on whether the clinical care provided by the Appellant met the relevant professional standards.

48. Mr Mulcahy is a registered specialist in Prosthodontics, with, the Appellant submits, no particular expertise in radiography beyond that which is presumably taught to all dentists, or in the production or maintenance of the wet-film radiographs used at Harrowgate. The Appellant submits that Mr Mulcahy does not possess any particular qualification, skill, knowledge or experience that would allow him to comment upon what caused the damage to the radiograph. His report did not give any reasons for his view that the radiograph had been "scratched" to alter its appearance, or why accident or manufacturing error could not be responsible for the damage. The Appellants submits that this evidence was '*mere assertion*' (*Kennedy* § 48), which should have carried little weight, whereas the PCC relied upon it as the cornerstone of the case against the Appellant and the finding of dishonesty.

49. The Appellant submits that Mr Morris also has no particular expertise in radiography or the production/maintenance of wet-film radiographs. In his original report, he uses the neutral term "modified" to refer to the damage to the radiograph, and (as noted earlier) said he could not replicate the removal of the emulsion from its rear. The Appellant submits that the latter fact points away from the PCC's determination that it was done deliberately by the Appellant.

50. In the joint report, the experts agreed that the radiograph had been "'*tampered' with*", albeit they agreed that they were unable to "*establish how this came to be"*. The Appellant submits that that conclusion fell far outside of the knowledge and expertise of either expert, and clearly encroached upon the jurisdiction of the fact finding tribunal.

51. The PCC stated:

> "both experts examined the radiograph and agreed that it had been deliberately scratched to give the impression that a root filling was present at the LR5. Both experts agreed that the way which the radiograph had been altered could not have been accidental."

52. However, the Appellant points out that:

    i) the experts did not agree that the radiograph had been deliberately scratched to give the impression that a root filling was present at the LR5. The Mulcahy said it had been 'scratched' "*in order to alter the image*". Mr Morris's evidence was that "*the most cursory glance at this radiograph would indicate that this was not an image of a genuine RCT*", and the joint report stated merely that the radiograph had been *"'tampered' with"*;

    ii) neither expert was able to reproduce the damage;

    iii) neither expert provided any basis upon which accidental damage could be ruled out; and

iv) neither expert set out any particular qualification that would allow him to express an 'expert' opinion on how the damage had been caused.

53. The Appellant submits that the PCC's conclusion that "*the radiograph was deliberately altered to give the impression that a root filling had been placed in Patient LT's LR5"* could only have been based on the expert evidence and their misreading of it; and that the PCC failed to examine the radiograph themselves.

54. In assessing these submissions, it is relevant to bear in mind that the Appellant's advanced no positive case before the PCC that the radiograph might have been accidentally damaged. Had it been, then the GDC might have wished to seek evidence from, for example, a manufacturer. In her witness statement, the Appellant said "*I did not deliberately (or otherwise) scratch the radiograph. I am unable to explain how the appearance of the radiograph came about as I was not responsible for this"*. In cross-examination, the Appellant agreed that the scratch did not appear accidental:

> "Q. Because you've accepted allegation 41B. In terms of the radiograph that you handed over, again, just to that we're clear in terms of what's in dispute and what's not, you accept it's a scratched radiograph?
>
> A. Yes, it was.
>
> Q. And do you accept that whoever scratched that radiograph would have done so deliberately?
>
> A. Yes, I would have guessed so.
>
> Q. Yes. This is not an accidental scratch, is it?
>
> A. No.
>
> Q. This is something that whoever has done it, has done it very consciously and deliberately; do you accept that?
>
> A. Yes.
>
> Q. And in terms of dealing with the location of the scratch, do you accept that it's designed to cover the root of that particular tooth, the lower right 5?
>
> A. Yeah.
>
> Q. Of Patient LT?
>
> A. A very poor attempt to cover the ---
>
> Q. Well, quite crude.
>
> A. Yeah.
>
> Q. A poor attempt but an attempt nonetheless?
>
> A. Yes.
>
> Q. Do you accept that?

A. Yes, yes.

Q. And also at the top of it, we can see the scratch, it stands out, to give the appearance of an amalgam as well?

A. Yes.

Q. Yeah. So be it crudely, not particularly good, but it's clear that whoever scratched that tooth is trying to give the impression of an amalgam and root fill; do you accept that?

A. Yes."

albeit later in the cross-examination the Appellant said:

> "But I don't know how it - how that radiograph came to look like how it does, I don't know how it's possible to do it, if it was scratched or not. I don't know."

55. In closing submissions before the PCC, the Appellant's counsel submitted that it was for the GDC to prove that it was the Appellant who scratched the radiograph, and that she had no motive to do so because the alteration to it was so crude that it was obvious no-one would ever be fooled by it. Counsel continued:

> "So it is not contested that somebody scratched this radiograph and if Ms. Photay did not then somebody else must have, and that in my submission is where the relevance of the other dentist and the chaos around radiographs and the misdated wallets do have their relevance because if this record card had been all the time in Ms. Photay's possession or in a locked bag of hers or in a locked cabinet to which nobody else had access, well then it would have to be but no one else would even physically have had the opportunity to do this and so it is relevant to ask questions and to seek around where opportunities might have been, how well and carefully radiographs were looked after and where they were kept and so on and so forth. …
>
> The relevance is that whatever else was going on in the practice at this time. There are some very odd things about the radiographs for this patient. …
>
> …
>
> How would anyone else, it might be asked, know to mark that radiograph in that particular way? Well, the issue with the missing radiograph was widely known among the staff who were tasked to look for it so there were plenty of people in the practice who knew that there was a missing post-operative radiograph and that the notes were being called into question. Whether the records drawer was locked or not and Ms. Sangha confirmed that all the staff had access to the records, the tampered radiograph was found by Ms. Photay in the archive section where record cards were stored chaotically in no particular order. Ms. Photay has been criticised to some degree for not, as it were, nominating a candidate for who did it. She does not know who did it, she can only know whether she did

> or not. She does not know whether it was produced for a prank, someone who knew she had had this difficulty, done for some kind of laugh, or whether it was done more maliciously. She has no idea how, when, where it was done or who did it, and all she can do is give her evidence to you that it was not her who did it and that it would have been completely pointless for her to do it. …"

It was not submitted to the PCC that the alteration could have been a manufacturing or handling error and that the GDC had failed to adduce evidence to rule out that possibility. Nor, the Appellant's counsel accepted in submissions to me, were the experts cross-examined to that effect, or to the effect that they lacked the expertise to give the evidence set out in their reports.

56. Moreover, it would have been a remarkable coincidence had a manufacturing error or other accident led to the alteration in question, which, although crude, was located precisely over the body and root of the tooth in question, as is clear from the images of the radiograph in Mr Mulcahy's report and as the experts described.

57. Although the experts were not in a position to state how, or by whom, the alteration had been done, they were properly able to give an opinion on its location on the radiograph vis a vis the location of the tooth on which the Appellant had operated. They would both have had experience of the taking, handling and interpretation of radiographs as a basic and vital aspect of dentistry. The coincidence of locations of the alteration and the tooth was highly material to the question of whether the radiograph had been deliberately scratched in some way, which was a matter for the PCC to decide.

58. The GDC accepts that the PCC was wrong to state, in the first paragraph quoted in § 31. above, that the experts had agreed that the radiograph had been scratched to give the impression that the root filling was present in the tooth. In fact, they agreed only that it had been *"'tampered' with"* (the inverted commas round the word *"tampered"* being the experts'), and that they could not say how that came about or who did it, those being matters for the PCC. By refraining from commenting on those matters, the experts recognised that to do so would exceed their role.

59. However, as indicated in last paragraph quoted in § 31. above, in considering who altered the radiograph the PCC then had regard to:

> "the content of the radiograph, the subject of the radiograph, what was altered on it, who was the treating dentist in relation to the subject matter of the alteration, the context of the investigation, the circumstances in which it came to be discovered and then presented to your supervisor and whether you would have had any motivation to have altered the radiograph"

Having considered those matters, the PCC reached its own conclusions, in the light of the evidence as a whole, that the Appellant had a motive to alter the radiograph, and that the Appellant had done so.

60. As to whether the PCC examined the radiograph itself, counsel for the Appellant was not present at the PCC hearing but was instructed that the radiograph was not handed up. It was not listed in the exhibits list, or mentioned in the transcripts or decision that the PCC had reviewed it. Counsel for the GDC told me, also on instructions, that the original of the radiograph was made available to the PCC for examination during

their deliberations. I consider it likely that the PCC did look at the radiograph itself, but in any event as the PCC had clear images and descriptions of it from the experts' reports, it ultimately makes no difference in any view.

61. For these reasons, I do not consider that the PCC allowed the experts to usurp its functions; and, although it erred at one point in its characterisation of the expert evidence, I consider that the conclusions it reached about how the radiograph came to be damaged were based on its assessment of the evidence as a whole, were consistent with that evidence, and cannot be said to have been wrong. I therefore do not accept the Appellant's Ground 1.

(F) GROUND 2: PCC DETERMINATION AS TO MOTIVE

62. The Appellant submits that, on the evidence available to the PCC, the determination that the Appellant had a "*strong motive to produce a post-operative radiograph showing that Patient LT's LR5 had been successfully obturated"* was wrong. This motive formed the basis upon which the PCC determined that the Appellant would choose dishonestly to alter the radiograph. The Appellant highlights the following points.

    i) It was an accepted fact that the Appellant did not take a post-operative radiograph on 31 May 2019. The contemporaneous clinical notes did not suggest that a radiograph had been taken and the Appellant admitted Charge 40e which reflected this.

    ii) The clinical notes, which were available to both the Appellant and Principal Dentists 1 and 2 at all times, clearly disclosed that a radiograph had been taken by JH on 5 June 2019, which disclosed the lack of gutta percha in the root canal. Further, the notes disclosed and JH confirmed that the patient had been told that the canal did not contain the required gutta percha.

    iii) Whilst the original radiograph from 5 June 2019 was missing from the clinical records, it was clear from the Appellant's evidence and JH's witness statement that wet-film radiographs going missing was not uncommon. Further, Mr Mulcahy confirmed that several of the radiographs provided were wrongly dated and others missing, and that hard copies of treatment plans and medical questionnaires were missing despite being requested by the GDC on several occasions.

    iv) According to the clinical notes, the Appellant consistently informed the patient that the RCT had "*failed*". Whilst she may not have clearly set out that the reasons for the failure was her poor treatment and the removal of the gutta percha, it would have been clear to the patient that the RCT had failed and had to be redone. This was wrongly found by the PCC to be misleading the patient.

    v) The PCC's determination fails to acknowledge that further radiographs were taken by the Appellant on 8 October 2020. These radiographs were present in the clinical records sent to the GDC by the Harrowgate practice, and according to the GDC's expert (Mr Mulcahy) clearly showed that there was no gutta percha in the tooth. These would presumably have been available to Principal Dentist 1 during the appointment had she used the correct patient file, yet the PCC did not question why a further radiograph was taken by her at the appointment on 26 November 2020.

    vi) It was common ground between Principal Dentist 2 and Mr Morris, the Appellant's expert, that it was immediately apparent that the mark on the

damaged radiograph could not be evidence of a successfully completed RCT, as the mark was too white, too straight and too wide.

vii) The evidence did not indicate that the Appellant positively told Principal Dentist 2 that the radiograph she handed him was one she had taken on 31 May 2019.

63. The Appellant says these points undermine the determination that the Appellant had any real motivation to fabricate a post-operative radiograph. For her to have done so would have contradicted the entire clinical record, to which both Principal Dentists had access. To ignore these incongruities on the basis that the Appellant was "*desperate or under considerable pressure*" is based on poor reasoning and a lack of cogent explanation.

64. The PCC found that the Appellant would have recalled the conversation regarding this in June 2019, despite her saying that she did not. On that basis, the Appellant would have been aware not only that the gutta percha was not present, but that a radiograph had been taken and the patient informed. The PCC stated that:

> "you would have been aware at this early stage (if you were not already aware) that you had failed to take a post-operative radiograph, as it is more likely than not that you would have reviewed Patient LT's records and would have searched for a post-operative radiograph in response to [JH]'s concerns that no root filling was present when he subsequently examined her."

The Appellant says that finding contradicts the finding that she "*had a strong motivation to produce a post-operative radiograph showing that the Patient LT's LR5 had been successfully obturated by you with gutta percha on 31 May 2019, so as to corroborate what was recorded by you in the clinical notes and what Patient LT also understood to be the case".*

65. The Appellant further notes that Patient LT was not called as a witness in the case, so her understanding of what had happened was never tested. However, if the Appellant knew from reviewing the clinical notes that no post-operative radiograph was taken, that the patient had been made aware in June 2019 that the gutta percha was absent, and that the records showed her continually informing the patient that the RCT had failed, then it would make no sense for her to seek to recreate a post-operative radiograph indicating that the RCT had been successful: still less when the Appellant herself took radiographs on 8 October 2020 showing the absence of gutta percha.

66. I do not accept those submissions. Following the conversation with Principal Dentist 1 on 26 November 2020, the Appellant and others were looking for a post-operative radiograph reflecting the 31 May 2019 operation. The 31 May 2019 clinical record was silent as to the existence of such a radiograph, albeit normal practice would have been to record the fact that one had been taken, and in cross-examination the Appellant said (when asked about the November/December 2020 search for a radiograph): *"Just on the off chance that I had failed to record it, I needed to make sure."*

67. It is true that the clinical records from 5 June 2019 onwards made clear that no gutta percha was present in the tooth, and the Appellant would have known that. However, the Appellant had a motive for supporting the detailed clinical note she had made on 31 May 2019 about the operation, and may have acted in a degree of panic or, at least, without thinking matters through clearly. She may have thought that if she could

produce a radiograph that was arguably consistent with her notes – even if only to the extent that the relevant part of the image was evidently damaged and could not be said to show the *absence* of gutta percha – then it would have opened up the possibility that the gutta percha had been inserted but then accidentally removed on 5 June 2019. In addition, there is some indication in the clinical notes that the Appellant told Principal Dentist 1 on 26 November 2020 that she had taken a post-operative radiograph:

> "[Principal Dentist 1] spoke to both [the Appellant] and jh about the patient – UNABLE TO LOCATE MP [pre-operative radiograph] AND POST OP RECT PAS – [the Appellant] says she has taken altho no record in notes, JH pa not in record card either"

albeit, as the Appellant points out, that may not have been a considered response in circumstances where she was summoned into a discussion about an operation some 18 months previously.

68. Although the Appellant said in her evidence (as quoted earlier) that she emphasised to Principal Dentist 2 that it was not her radiograph and that she had just found it in the archive section, Principal Dentist 2's recollection was that the Appellant had given him to understand that the radiograph she handed him was the post-operative radiograph that people had been looking for; and, indeed, it is not easy to see why the Appellant would have handed the radiograph to him otherwise.

69. In the light of all these matters, the PCC was in my view entitled to conclude, on the evidence as a whole, that the Applicant had a motive to alter the radiograph, and its finding cannot be said to have been wrong. I therefore do not accept Ground 2.

(G) GROUND 3: PCC APPROACH TO EXPERT EVIDENCE: OUTCOME OF 31 MAY 2019 OPERATION

70. The PCC concluded that despite, the Appellant's clinical note from the 31 May 2019 appointment, the Appellant had never placed any gutta percha in the root canal. The PCC said:

> "The Committee determined that it is more likely than not that you had not in fact placed any gutta percha into the tooth to begin with. This is because [JH] found evidence of an exposed pulp and caries in the LR5 when he opened up the tooth six days later: there had not been even a basic standard of endodontic preparation in advance of the placement of gutta percha as a root filling.

71. However, the Appellant notes, the evidence shows that the Appellant completed a "*working length radiograph*" of the tooth on 15 May 2019 (albeit Mr Mulcahy considered it to be inadequate), following the irrigation of the root canal. The evidence of JH, the only person to have looked at the tooth, was not that there had been no attempt to undertake an RCT but that the RCT had not been completed. Whilst there were clearly significant problems with the standard of the RCT, JH's evidence does not (the Applicant submits) support the determination that no RCT had taken place (either basic preparation or obturation). Indeed, his immediate assessment, contained in the clinical note was that it "*appears GP LR5 removed when condensing at RCT apt…".*

72. Both experts expressed the opinion that it is possible for gutta percha to be removed inadvertently during the condensation stage of the process; but both stated that such an event would likely have been apparent to the dentist. The Appellant's evidence was that she did not recall the procedure itself, but would as a matter of course have obturated the tooth.

73. The Appellant submits that the PCC failed to identify any motivation for the Appellant's apparent conscious decision to place an amalgam filling on an unfilled root canal, which would almost certainly fail and cause the patient significant pain (as happened), at a time that she was under direct clinical supervision as result of Referral 1. It is far more likely that the gutta percha was inadvertently removed.

74. As quoted in § 30. above, the PCC had regard both to:

    i) the fact that JH found evidence of an exposed pulp and caries in the LR5 when he opened up the tooth on 5 June, with not even a basic standard of endodontic preparation having been done (a finding which, in my view, was not inconsistent with the Appellant having previously done some preparatory work on 15 May), and

    ii) their view (based in part on the expert evidence) that the distinctive appearance of gutta percha, and the use of a rubber dam which would have isolated the tooth and further increased the visibility of any gutta percha falling or being removed from the tooth, would have made it obvious to the Appellant if the gutta percha had been placed in the root but then was removed accidentally or fell out.

75. Given those points, I do not consider that the PCC's conclusion – that there was no basis on which the Appellant could reasonably have believed that she had successfully obturated the tooth with gutta percha – was wrong. On that basis, the Committee was entitled to make the further finding that it was more likely than not that the Appellant in fact knew she had not successfully obturated the tooth and that her clinical record of the operation was wrong. In my judgment that finding too cannot be described as wrong.

(H) GROUND 4: SANCTION

76. The PCC concluded, first, that the clinical concerns in Referral 2 did not amount to an unacceptably low standard of professional performance affecting fitness to practice. The record keeping concerns in Referral 2 were largely due to the overuse of templates, the records were largely complete and patient safety was not compromised. There was no finding of impairment or misconduct for Referral 2.

77. As to Referral 1, the dishonesty to which Charges 17 and 18 related was a spontaneous and isolated act for which there was no apparent personal gain or benefit to the Appellant, other than potentially to save face. The PCC considered it to be at the lower end of the spectrum of dishonesty, though they said any dishonesty by a dental practitioner is inherently serious, and that the dishonesty here met the threshold for misconduct. The proven clinical and record keeping failings were serious enough to meet the threshold of misconduct too: they included wide-ranging errors in basic dental care, which had the potential to put patients at risk of harm, and a serious breach of a basic and fundamental record-keeping standard.

78. The PCC noted that the experts' agreement that the clinical failings found proven under Referral 3 (Charges 40(b), (c), (e) and (f)) fell far below standard, and the PCC considered these to have been serious clinical failings in relation to the provision of

RCT to Patient LT's LR5 in May 2019 and a failure to diagnose caries at LR6 at an appointment on 9 July 2019; as well as the two instances of dishonesty in relation to the RCT.

79. When considering impairment, the PCC noted that the Appellant's clinical and record keeping failings were remediable, though the Appellant (who had not practised since December 2020) had not so far shown them to have been remedied. The PCC felt that there remained a real risk of repetition (and harm to patients) should the Appellant be allowed to practise without restriction. The PCC continued:

> "Your dishonesty is more difficult to remedy, as it is a matter which goes to your character. The Committee accepts that the dishonesty in 2017 was likely to be an isolated and spontaneous act, which as the Committee has already stated, falls at the lower end of the spectrum of seriousness. Your dishonesty in 2019 and 2020 on any view falls at the higher end of the spectrum. There is no evidence before the Committee of any insight, remorse or acknowledgement of wrongdoing. You had denied as part of the factual inquiry that you had acted dishonestly in respect of the entry you had made in Patient LT's records on 31 May 2019 and in respect of altering the radiograph in 2020 (you denied that you had scratched the radiograph). The Committee could not be satisfied that there is a low risk of you acting dishonestly again, particularly when under pressure. In the Committee's judgment, your fitness to practise is clearly impaired by reason of both your clinical and record keeping failings and your dishonesty. There is a real risk of harm to patients should you be allowed to practise without restriction. Further, public confidence in the profession and this regulatory process would also be undermined if no finding of impairment were to be made. Your clinical failings involved basic errors in fundamental aspects of dental practice. Through these failings you had put patients at an unwarranted risk of harm in the past and you are liable to do so again if allowed to practise without any restriction on your registration. You have acted dishonestly and are liable to do so again. You have breached a fundamental tenet of the profession by acting dishonestly. Your misconduct has the potential to bring the profession into disrepute."

80. As to sanction, the PCC considered the available measures in ascending order of severity, concluding as follows:

> "The Committee acknowledges that your dishonesty occurred whilst you were under pressure and it appears that it may have been the result of desperation. Had your dishonesty been limited only to the inaccurate record on 31 May 2019 then suspension may be proportionate. However, your dishonesty persisted with the subsequent alteration of the radiograph. This demonstrates a deep seated underlying professional attitudinal problem which is fundamentally incompatible with continued registration. Your having engaged in such a calculated attempt to alter a dental radiograph to cover up your earlier dishonesty is so serious that the Committee does not believe that either patients or fellow members of the profession could be expected to place their trust in you not to act dishonestly in the future,

> particularly if you again felt under pressure. Furthermore, your dishonesty was so serious that public confidence in the profession and this regulatory process would be seriously undermined if you were allowed to remain on the Register."

81. I understand the Appellant realistically to accept that if the PCC's conclusions that I consider in sections (E) to (G) above are upheld, then the sanction of erasure cannot realistically be criticised. I take the same view: on the basis of those conclusions, the PCC's decision as to sanction cannot be regarded as having been wrong.

(I) CONCLUSION

82. For these reasons, I shall affirm the PCC's decision and therefore dismiss the appeal. I am grateful to both parties' counsel for their helpful written and oral submissions.