Neutral Citation Number: [2024] EWHC 18 (Admin)

Case No: CO/831/2023; AC-2023-LON-000940

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 10th January 2024

Before :

MR JUSTICE RITCHIE

- -

Between :

MANORI BALACHANDRA — **Claimant**

- and -

Defendant

THE GENERAL DENTAL COUNCIL

- -
- -

Simon Butler (instructed by **BSG Solicitors LLP**) for the **Appellant**
Sandesh Singh (instructed by **GDC Legal Department**) for the **Respondent**

Hearing dates: 15th and 19th December 2023

- -

Approved Judgment

This judgment was handed down remotely at 10.30am on Wednesday 10th January 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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Mr Justice Ritchie:

The Parties and organisations involved

1. The Appellant was a dentist providing mainly NHS services in Fareham, Hampshire from her own practice with 3-4 other dentists and support staff.

2. The Respondent is the professional conduct regulator for dentists in England and Wales.

3. NHS England has a Business Services Authority [NHSE] which provides services to dentists and the NHS. Dentists who work for the NHS make claims for payment for their work to NHSE. These were either made on paper or online. The NHSE also carries out quality control reviews of NHS dentists providing NHS services.

The Appeal

4. In February 2023 the Professional Conduct Committee [PCC] of the General Dental Council [GDC] erased the Appellant's name from the register of dentists so she cannot practice dentistry any longer in England and Wales. The main reason for that decision was that the PCC found that the Appellant had made handwritten clinical notes about 11 patients [The 11] long after the treatments were provided and then sought to persuade the PCC that the notes were contemporaneous. The Appellant denies the assertion of post event note fraud and seeks to overturn the findings made by the PCC on that alleged wrongdoing and the decision on erasure as the appropriate sanction. There were less serious charges relating to some clinical failings and poor or withdrawn billing which the parties agreed were not central to the appeal. There were charges found proved which are not appealed.

Bundles

5. For the hearing I was provided with 7 lever arch bundles of evidence and documents, a core bundle of skeleton arguments, the PCC decision and an authorities bundle. Near the end of day 2 of the appeal I was provided with 2 supplementary bundles which contained 90% duplicates of many of the documents in the main bundles, some additional documents and a case relied upon by the GDC.

Statutory Appeals

The right to appeal

6. Under S.29 of the Dentists Act 1984 [DA84] the Appellant had the right to appeal the decision of the PCC directing her erasure by notice delivered within 28 days:

> "**Appeals**
> S.29 (1) The following decisions are appealable decisions for the purposes of this section—
> (a) a decision of the Professional Conduct Committee under section 24—

(i) giving a direction for erasure of a person's name from the register under subsection (3) of that section, or

(ii) refusing an application to restore a person's name to the register, or refusing to restore his name until the end of a specified period, under subsection (6) of that section;

(b) a decision of a Practice Committee under section 27B or 27C giving a direction for erasure, for suspension, for conditional registration or for varying or adding to the conditions imposed by a direction for conditional registration;

(c) a decision of the Professional Conduct Committee under section 28—

…

(iii) giving a direction under subsection (9) of that section suspending indefinitely the right to make further applications under that section.

(1A) In subsection (1)—

(a) a reference to a direction for suspension includes a reference to a direction extending a period of suspension and a direction for indefinite suspension; and

(b) …

(1B) Subject to subsection (1C), a person in respect of whom an appealable decision has been made may, before the end of the period of **28 days** beginning with the date on which notification of the decision was served under section 24(7), 27B(8), 27C(6) or 28(7), (8) or (10) , [...] 5 appeal against the decision to the relevant court."

The powers on appeal

7. On appeal this Court has the following powers under S.29 DA84:

"29 (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."

The CPR

8. CPR Part 52 governs this type of statutory appeal. CPR PD52D applies, in particular para 19(1)(c). This is a "rehearing" not a review. However, in my judgment the word "rehearing" is misleading. The appellate Court does not re-hear or re-see any live witnesses. Instead, what the appellate Court does is re-analyse the transcript of the evidence and the bundles of evidence put before the PCC. So, it is actually an appeal by way of reanalysis, not a full rehearing.

9. The power which this Court has to set aside the PCC's rulings and findings is set out in CPR r.52.21(3). If this Court considers the PCC findings or rulings to be wrong or unjust due to serious procedural 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.

10. Under CPR r.52.21(4) the appeal Court may draw any inference of fact which it considers justified on the evidence.

Case Law guidance

11. The correct approach to findings of fact and PCC reasoning in appeals by way of reanalysis 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 set out (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 charges

12. Set out below is a table of the charges laid against the Appellant and the PCC's findings. NAR means "no adequate record". "Brown Card" means the handwritten records which were made on NHS standard brown cards.

Number of charge and Patient	**Date**	**Charge**	**PCC finding/Admission P = Proven NO = not proven A = admitted**	**Appeal**
BACKDATED CLINICAL RECORDS AND SUB-STANDARD CARE				
1a	2.2.16	NAR: Prescription without justification	P	A
1b	"	NAR: prescription justification	P	A
1c	9.2.16	Prescription without justification, alternatively NAR and inappropriate dose	P	A
1d	11.2.16	NAR: exam, oral health risks, diagnosis, treat plan, recall interval.	P	A
1e	2.3.16	Prescription without justification; NAR: justification, exam, oral health risks, med history, BEP, duration of pill taking, capsules and sachets together or separate.	P	A
2a	16.3.16	NAR of exam, BPE, assessment of radiographs	P	A
2b	17.3.16	NAR of material used for Crown	P	A
2c	31.3.16	Inappropriate treatment installing crown	P	A
3b	26.1.16	NAR: oral health risks; recall interval.	P	A
3c	1.4.17	NAR: Pt concerns re orthodontic appliance	P	A
4a	8.1.16	NAR: exam; oral health risks; recall interval	P	A
4b	"	Prescription without justification; alternatively NAR and wrong dose.	P	A
4c	15&19.4.16	Wrong record of risk of periodontal disease	P	A
4d	"	NAR as above	P	A

4f	"	NAR: exam and advice given 18.4.16	P	A
5a	12.2.16	NAR: providing partial denture	P	A
5b	2.3.16	NAR: med history; prescription without justification; NAR: justification for pills or sachets, duration of taking prescription, number of sachets prescribed	P	A
5c	15.4.16	NAR: BPE	P	A
5d	11.5.16	NAR: Failure to provide treatment or make treatment plan	P	A
5e	26.5.16	Failure to review or NAR of review	P	A
6a	25.1.16	NAR: Prescription justification, oral health risk, recall interval, radiograph quality	P	A
7a	17.3.16	NAR: exam, med history, treatment plan, oral health risk, recall interval, quality of radiographs	Part proved	A
8a	16.3.16	NAR: exam, presenting condition, med history	P	A
9a	8.4.16	NAR: exam, treatment plan, oral health risks, the treatment provided	P	A
10a	26.1.16	Prescription without justification; alternatively NAR: duration, exam, diagnosis, treatment plan, oral risk, recall interval	P	A
11a	14.1.16	Prescription without justification; alternatively NAR, wrong diagnosis	P	A
11b	8.2.16	Prescription without justification; alternatively NAR, and wrong dose	P	A
11c	24.3.16	NAR: diagnosis, treatment plan, med history, oral risks, recall interval	P	A
INAPPROPRIATE CLAIMS FOR PAYMENT BY THE NHS				
12a	Wrong band claim	P3 claim 6	P	
12b	"	P9 claims 26	P	
13b	Wrongly split course claims	P7 claims 20&21	A	-
14	Wrong urgent claim	Claim 17	P	
15a	Misleading conduct	Covering 12-14 above	NO	-
15b	Dishonest	Ditto		

	conduct			
BACKDATING BROWN CARDS – first fraud				
16a	After 19.6.17	Retrospective handwritten entries on Brown Cards wrong date: P1: 9.2.16 & 3.16	P	A
16b	"	P2: 16.3.16	P	A
16c	"	P3: 21.3.16	P	A
16d	"	P5: 2.3.16	P	A
16e	"	P6: 25.1.16	P	A
16f	"	P7: 17.3.16	P	A
16g	"	P8: 16.3.16	P	A
16h	"	P9: 8.4.16	P	A
16i	"	P10: 26.1.16	P	A
16j	"	P11: 8.2.16 and/or 24.3.16	P	A
17a	After 19.6.17	Inaccurate caries records on Brown Cards: P3: 21.3.16	P	A
17b	"	Ditto P9: 8.4.16	P	A
WITHDRAWING OR DELETING CLAIMS				
18a	After 19.6.17	Backdated letters requesting NHSE to withdraw or delete claims. P2: claim 3, 7.5.16 letter	P	
18b	"	P5: claim 14, 30.5.16 letter	P	
18c	"	P7: claim 21, 27.5.16 letter	P	
18d	"	P8: claim 23, 31.5.16 letter	P	
18e	"	P11: claim 27 letter 2.4.16	P	
19a	After 19.6.17	Retrospective changes to ER re withdraw or deletion of claims. P2: claim 3, back dated to 31.3.16	P	
19b	"	P5: claim 14, backdated to 23.6.16	P	
19c	"	P11: claim 27, backdated to 11.4.16	P	
20a	2018-2019	Sent the retrospectively dated letters in charges 16 and 17 to NHSE	P	
20b	Overall	Ditto to GDC	P	
21a	Overall	**MISLEADING** in doing charges 16,17,18,19,20	P	
21b	Overall	**DISHONESTY** in doing charges 16,17,18,19,20	P	
BACKDATED CLINICAL RECORDS 2nd fraud				
22a	Overall	Causing retrospective handwritten Brown Cards with wrong dates. P1 9.2.16	P	A
22b	"	P2: 16.3.16	P	A
22c	"	P4: 8.1.16; 15.4.16; 19.4.16; 24.4.16; 13.5.16	P	A
22d	"	P6: 25.1.16; Jan 2016	P	A
22e	"	P7: 17.3.16	P	A
22f	"	P10: 26.1.16	P	A
22g	"	P11: 14.1.16; 8.2.16; 24.3.16	P	A

23	"	Causing the Brown Cards at 22 to be sent to GDC	P	A
24a	"	**MISLEADING** in relation to charges 22 and 23	P	A
24b	"	**DISHONESTY** in relation to charges 22 & 23	P	A

Summary: The findings in relation to the Brown Cards are appealed. These are numbered 1-11, 16-17, 21 in part and 22-24 [the Appealed Findings].
The findings in relation to the withdrawal or deletion of claims and inappropriate claims for payment are not appealed. These are numbered 12-15, 18, 19, 20 and 21 in part [the Unappealed Findings].

The Grounds of Appeal

13. **Ground 1:** The PCC were wrong to refuse to stay the proceedings in relation to the Brown Cards charges.

14. **Ground 2:** The PCC were wrong to find as a fact that the CQC report in 2013 did not refer to the Brown Cards.

15. **Ground 3:** The PCC were wrong to conclude that each (Brown Card) charge was proven.

16. **Ground 4 and 5:** The PCC were wrong to find as a fact that the Appellant made backdated Brown Cards and submitted them to the NHSE and GDC.

17. **Ground 6:** The PCC were wrong to conclude that the admission of Doctor Pal's evidence in respect of record keeping prior to and at the time of the charges would be prejudicial to the GDC's case. His evidence was admitted at stage 2.

18. **Ground 7:** Sanction. The PCC were wrong to erase the Appellant from the register. Suspension would have been the appropriate sanction.

19. **Ground 8:** The PCC were wrong to impose an immediate suspension order to cover the appeal period.

The Issues

20. The first issue in the appeal was whether the Appellant's application to stay the hearing or dismiss the charges in relation to the Brown Cards for abuse of process should have been granted. If this is decided in the Appellant's favour then the Appealed Findings will be set aside, but not the Unappealed Findings.

21. The second issue is whether the PCC were wrong, on the evidence before them, or whether it was procedurally seriously irregular and/or unjust to make the Appealed

Findings relating to dishonestly back dating the handwritten Brown Cards under the asserted frauds 1 and 2 (which I shall explain below) at all or for the reasons given.

22. The third issue is whether the sanction of erasure was wrongly imposed taking into account the Appellant's 7 years of safe practise from 2016 to 2023; her otherwise good character; her CQC reports and other mitigating evidence.

The Evidence

23. I have carefully read the witness statements and expert reports of the following witnesses and I have read the transcript of evidence and bundles.

GDC witnesses

24. Professor Morganstein, dentistry expert.
Julian Scott, dental practice probity expert.
Andy Lee, service development lead, NHSE.
David Akuoko [DA], dentist, dental practice clinical adviser [CA].
Deborah Ward, NHSE.
Jennison Baskerville, NHSE.
Moira Philpott, NHSE.
Teresa Hobbs, NHSE.
Victoria Brazier, GDC.
Anna Holdsworth, Capsticks.
Charlotte Stevens-Mulroe.
Nayla Djemal.
Jozelle Patterson, the Appellant's practice deputy manager.

Appellant's witnesses

25. The Appellant.
Jamie Baker, Software of Excellence.
Mr Grant, of BSG solicitors.
John Renshaw, dentistry expert.
Abhijit Pal, dentistry expert.

The Chronology

26. I set out this factual chronology from the evidence. The PCC decision contained only a short chronology. For all findings of fact I apply the civil standard of proof.

The Appellant

27. The Appellant qualified in 2000 with a BD from KCS in London. She qualified as a dentist in 2001. She worked at various dental practices until she set up her own, mainly NHS practice, in Fareham in 2007. She started as a sole practitioner but built up the practice so that by 2023 she had 3-4 other dentists working with her, 3 - 4 full time dental assistants, a practice manager and an admin clerk. The Appellant gave evidence that the practice turned over around £543,000 pa in NHS dental work,

representing around 21,000 UDAs pa (units of dental activity) and 80% of the practice was NHS work. She asserted in her live evidence that she had used Brown Cards to make handwritten notes ever since she had started work. Her practice started using a computerised system in 2009. She gave evidence that her usual practice after 2009 was to have the Brown Card in her hand with the patient as they interacted and the computer was behind her. She made all her own notes on the Cards and the computer, no one else did. Her dental assistants put the Brown Cards in her room each day for her for each patient on her day list.

The early inspections

28. The CQC inspected the Appellant's practice on 17.10.2013 and reported in November 2013. They concluded that the practice respected and involved the patients, provided care and welfare to patients, had appropriate cleanliness, infection control, assessment and monitoring of the quality of its services. They noted that the four patients they spoke to were happy with the services they received. The staff were noted as helpful and welcoming. The complaints procedure was recorded as robust. At the time of the visit there were four dentists working in the practice together with two hygienists and three dental nurses. One patient described the practice this way: "*all the staff are lovely and the atmosphere is very relaxed here*".

29. In April 2015 the Appellant had an appraisal by the Wessex NHS health education team. The Appellant was described as a caring practitioner who works hard to ensure her patients receive the best possible care. There were no areas of concern in the report of the review which covered patient's interests, patient communication, obtaining valid consent, maintaining and protecting patients' information, having a clear and effective complaints procedure, working with colleagues in the patients' best interests, maintaining and developing professional knowledge and skills, raising concerns if patients are at risk and making sure personal behaviour maintains patients' confidence in the Appellant and the dental profession. The reviewer concluded (Manori is the Appellant's first name):

> "I am sure that Manori's personal behaviour maintains patient confidence not only in her but also in our profession. She has gained trust and confidence from her patients since setting up the practice in 2007 and over the years she has built patient list (sic) through personal recommendation. Manori comes across to me as a consummate professional dedicated to her patience and a caring and competent definition."

Specifically in relation to patient records it was recorded that:

"Manori has a clear understanding of the need for practice protocols to protect patient information. She keeps all her records on the

> computer which are secure and password protected. All staff are trained appropriately in patient confidentiality."

For the reasons set out below, I find as a fact that the Appellant used handwritten notes as well as computer notes, so this comment was inaccurate in relation to her.

The relevant NHSE investigation started in 2017

30. As a result of a complaint letter received by NHSE dated 18.10.2016, on 23.1.2017 the NHSE informed the GDC that they were investigating the Appellant under their framework and in May 2017 informed the GDC of a proposed record card review. In May 2017 Miss Philpott of NHSE asked DA to review the clinical records of the Appellant. DA was briefed to assess the quality of record keeping, the quality of dental care, the standard of NHS administration and whether the claims for payment were appropriate. He went through the thousands of claims for payment made by the Appellant to the NHSE and chose 11 patients. It was not a random choice. There was logic to it. He chose a cross section of different types of work in different payments bands. Claims for payment are made by her by filling in FP17 forms and sending them to the NHSE. On 8.5.2017 he wrote to the Appellant asking for the clinical records for the chosen 11 patients [The 11] for work done between January 2014 and April 2017. He specifically asked for the digital records (on her computers) to be printed out in hard copy and put with the handwritten records and given to NHSE. This was followed up by Moira Philpott of NHSE calling the Appellant on 12.5.2017 and then emailing her for the same clinical records.

The Appellant's original NHS clinical records

31. I find as a fact that in the Appellant's practice she made clinical notes in two ways: firstly, on her computer system, which, on her evidence, she had personally developed. This system had template spaces serving as a checklist for all aspects of her dental care. I will call these electronic records [ERs]. In addition to the ERs the Appellant made handwritten records on NHS standard forms supplied free to her by NHSE for clinical notes. These are called "Brown Cards", or more specifically FP25 cards. These were stored in the NHS provided "Brown Envelopes", more specifically called the FP25A envelopes. These are A5 in size (smaller than A4). I was given a Brown Envelope during the appeal. It fits the Brown Card inside very snugly and could not hold an A4 sheet unless the latter was folded. In her evidence the Appellant asserted that most of the time the Brown Cards were filled in contemporaneously (same day), but the entries were sometimes made later if there were either IT issues or she was too busy to do them with the patient in the room.

Delivering the records in 2017 and the scanning by Capita

32. The Appellant gave evidence and the GDC accepted that she delivered the original records for The 11 to NHSE in Southampton on 29.5.2017 by recorded delivery. An unknown person then sent them to Darlington and an unknown person working for or

with Capita scanned them into the NHSE's system. This set of scanned copies was called Set A. As I shall explain below the GDC did not put before the PCC any protocol for the scanning/copying of original clinical records by permanent or temporary staff working for Capita, despite the serious nature of the disciplinary proceedings which might result from analysis of the medical records. Nor did they explain in a witness statement whether the NHSE's sub-contractor, Capita scanned the records for them. As to the involvement of Capita, in scanning or returning the original records, no evidence from them was provided to the PCC. However, in an email from David Akuoko (the clinical adviser to the NHSE) to Yamsin Khaira, dated 10.3.2020 he said this:

> "I have queried your request with our applications manager who has since yesterday been sending emails to get to the bottom of this. He has confirmed that Capita would have scanned the records in 2017 in Darlington, until the process was brought in house (NHSESA) recently and now scanned in Newcastle, and so Newcastle do not have any information on this."

33. An email dated 12.3.2020, Malcolm Apted, of NHSE responded thus:

> "These records would have been returned by Capita at Darlington to the practice. The Capita scanning section no longer exists, it was transferred to the BSA in 2017. When the scanning duties were transferred back to the BSA I do recall double checking that there were no records outstanding for any cases that should be returned. Any records held by that Capita department would have been destroyed long ago. I have checked this with Mark Yarnton, who was my manager in Capita at the time, and he confirms the same."

34. I find, from this evidence, that Capita probably did the scanning in Darlington. The records must have been transported up to Darlington by NHSE. The PCC made no findings on this.

DA's report

35. Set A was then sent to DA in a digital format. DA worked from home and provided his report on the records dated 19.6.2017. In the report he described the records as having come from a period between April 2015 and April 2017 (different from the requested period). He noted that lab dockets had not been provided to him and he was missing 2 patients' clinical entry records. He noted that there were 11 patients' records and for these patients the practice had made claims for 28 courses of treatment. In brief summary he raised concerns about: the standard of records keeping for all the 11 patients reviewed; radiography for some patients and some quality of care concerns. In relation to record keeping he noted that: there were no medical history checks for patients: 2,5,7,8,10 and 11; BPE scores were not noted for patients

2,5,7,8 and 10; for patient 3 the name of the dentist in the record was different from the performer in the FP17; there was a lack of detail of recall times and oral health risk assessments for patients 1,2,6,7,9 and 10; clinical records for claims 1 and 2 were not provided for patient 4; prescription records for antibiotics (justification and duration) were not satisfactory, or for extractions (no history check or update) for patients 1,5,10 and 11. He made no criticism of any lack of analysis of X-rays. Of the 28 claims for payment made to NHSE, 16 were satisfactory, 2 had no clinical records to back them up, 6 were considered inappropriate due to failure to meet the standard of care required to claim and 4 had no evidence of full mouth examinations. In his conclusion DA stated he had only been able to review what was provided, namely the scanned records. He recommended further information gathering and consideration thereafter of disciplinary proceedings. He then deleted his digital copy of the records and informed NHSE that they could return the original records to the Appellant. In his third witness statement DA was asked whether he had seen the Brown Cards for the 11 patients when he provided his report. He asserted that he had not.

36. The original records were returned by NHSE to the Appellant by "Capita", on her evidence, in July/August 2017.

37. Then in December 2017 DA's report was sent to the Appellant by NHSE. As a result, the Appellant instructed lawyers and notified her insurers.

The key factual issue in the case

38. The key factual issue in the case, identified in the PCC's decision, was whether the Brown Cards were provided to NHSE on 29 June 2017 by the Appellant when she hand delivered the original records to the Post Office and sent them by recorded delivery. However, in my judgment the key issue was whether any Brown Cards were actually written contemporaneously for The 11 patients. The root of the GDC's case on fraud 1 was that all or most of the Brown Cards were "faked" at some time between December 2017, when the Appellant was sent DA's report and June 2018 when the original records were again requested by NHSE and given back to them. On fraud 2 the GDC's case was that further Brown Cards were made after Professional Morganstein's report and then disclosed in 2021.

The Appellant's evidence on the scanning

39. In her witness statement the Appellant commented as follows. Set A was not a complete copy of the papers that she sent to NHSE in 2017. She asserted that she had sent the Brown Cards in their Brown Envelopes for all The 11. However, NHSE/Capita had only scanned and copied the Brown Envelopes and had overlooked the cards inside. She raised, in particular, two scanned copies which showed the Envelopes with the middle of the top of the Brown Cards poking out but inside them. No Brown Card was copied. These copies were shown to me during the appeal hearing and both do indeed show a Brown Card inside. One had "2010" written in handwriting at the top of it. In addition, the Appellant criticised the scanning because

she asserted that for numerous documents only one side of double-sided documents had been scanned. The Appellant set out in her witness statement examples of the scanning errors for each of The 11. So, for instance, for patient 1 only the front side of the Brown Envelope had been scanned, not the rear and only the front side of the FP17 PR form had been scanned.

2018

40. Either in December 2017 or on 25.1.2018 the NHSE sent a letter to the Appellant. I have not seen the letter. I understand it contained DA's allegations of conduct and records failures for The 11. The deadline for reply was 4 weeks. The Appellant asked for more time.

41. According to Victoria Brazier's evidence, (she worked at the GDC) the NHSE informed her in February 2018 that the NHSE had closed its case because there was "no evidence of fraud" found. The date for this evidence from Ms. Brazier was probably not correct. I suspect the date was mistyped. This probably occurred in 2019. The GDC requested a summary of the NHSE's report.

42. On 22.5.2018 the CQC reported on their face to face regulatory inspection of the Appellant's practice which took place on 25.4.2018. They found that the provision of care was safe and in accordance with the relevant regulations. They found that the practice was providing caring services, responsive care, was well led and concluded that:

> "the practice had arrangements to ensure the smooth running of the service. These included systems for the practice team to discuss the quality and safety of the care and treatment provided. There was a clearly defined management structure and staff felt supported and appreciated. **The practice team kept complete patient dental care records which were, clearly written or typed and stored securely.** The practice monitored clinical and non clinical areas of their work to help them improve and learn. This included asking for and listening to the views of patients and staff. ... We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at a sample of dental care records to confirm our findings and noted that individual records were written and managed in a way that kept patients safe. Dental care records we saw were accurate, complete, and legible and were kept securely and complied with data protection requirements. ... The practice kept detailed dental care records containing information about the patient's current dental needs, past treatment and medical histories. The dentists assessed patients' treatment needs in line with recognised guidance. We saw that the practice audited patients dental care records to check that the dentists recorded the necessary information." (My emboldening).

43. A plain reading of that report would suggest that the Brown Cards were included in the review but the PCC found they were not. The Appellant sent her substantive response to the NHSE via her solicitors on 27.6.2018. Mr Grant, her solicitor, drafted the response letter which pointed out to NHSE that they had overlooked the Brown Cards when instructing DA to report. Mr Grant also enclosed the CQC reports and a report from Mr Renshaw, an expert, in which he expressed the opinion that when looking at the ERs and the Brown Card records for each of The 11, the Appellants' clinical records were adequate and DA's report was therefore based on a false premise. Mr Grant re-sent the original patients' clinical records, including the Brown Cards inside the Brown Envelopes, to NHSE on the same day.

44. **Mr Renshaw'**s report dealt with each of The 11. The report is unsigned and undated. His CV is impressive. For each charge in relation to The 11, Mr Renshaw advised that the appropriate notes were set out in the Brown Cards. Mr Renshaw rejected each of the allegations of clinical lack of care made by DA and gave explanations given as to why. It is noteworthy that he supported some of the criticisms of the inappropriate claims which the NHSE had raised.

45. **Miss Ward** was working at the NHSE on a temporary contract from January to July 2018. She received the original patients' records from Mr Grant in late June 2018. On the evidence I find by then that the Capita contract had ended and the NHSE did its own scanning and copying. She asserted that she recalled (in her November 2020 witness statement) that the records were received in one large lever arch file *"and a separate envelope for further records. ... pieces of paper of all different sizes*". She recalled having difficulties scanning them. She could not recall if they were all originals or some copies but could not contradict what Mr Grant said in his witness statement that they were all originals. She did not attempt to scan all the documents in the lever arch file *"they were mainly radiographs"* or any documents which were *"the incorrect size*". She asserted that, "*therefore I scanned what I could"* and the scans, together with the lever arch file, were later put before the NHSE PAG (Performance Advisory Group). She stopped working for NHSE on 28.6.2018 because it was her last day working there. So, she must have scanned the documents either on 27th or 28th June 2018. Ms Ward makes no assertion that the NHSE had any protocol for how she should scan original notes or which she should scan or not scan or for indexing the originals received.

46. The NHSE PAG meeting took place on 5.7.2018. I have read the resulting letter dated 11.7.2018 which explains why the case was referred on to the PLDP. The allegations concerned the lack of record keeping and some inadequate care.

47. The original clinical records for The 11 were returned to Mr Grant in August 2018. I interject here some very strange evidence from Miss Philpott, the deputy director for re-validation, in her witness statement dated 28.10.2020. She sets out two requests by

Mr Grant, one dated 18th and the other dated 24th July 2018 for the return of the original clinical records. She explained that she arranged for a colleague to do so. She then went on to assert that:

> "I would like to clarify that my use of the words "records" is used as a generic term for documentation or files. I had assumed that Mr Grant was referring to the bundle of documents sent by the registrant as part of her responses to Mr Akuoko's report. These are the only documents which I received from the registrant and Mr Grant which contained patient records. You will see from MP4 that these patient records are photocopies of paper records and not original records. … I can confirm that for this matter I did not receive any original patient records."

This was clearly not true. The NHSE had the original records. She was not called to give evidence to the PCC. The GDC accepted the NHSE had the originals at this time.

48. Within less than a month the NHSE asked again for the original clinical notes to be returned to them. This was the third time. I have not seen that correspondence. Mr Grant gave evidence that on 12.9.2018 he couriered the originals of the 11 patients' clinical records to them. The receipt of these was confirmed by Miss Philpott of NHSE by email which undermines her evidence that she never had originals.

49. It is agreed that the originals were never returned to Mr Grant or the Appellant thereafter. They were shredded (according to the findings of the PCC) or lost. No direct evidence was put before the PCC as to how that loss occurred. It is unimpressive that this should have been allowed to occur by a regulator.

2019

50. Miss Philpott asserted in her witness statement that the NHSE PLDP (Performers List Decision Panel) met on 17.1.2019 and decided a further clinical review of the Appellant's practice was needed.

51. In parallel with the NHSE regulatory investigation and separate from it, on 22nd February 2019 the GDC wrote to the Appellant asking for the dental records of the same 11 patients. They requested digital records in digital format and all paper records. A report had been received from the NHSE by the GDC in early 2019 and used to form part of a Rule 4 letter according to V Brazier. I have not seen that report. On 25.3.2019 the GDC sent the Rule 4 letter to the Appellant asking for comments on the detailed allegations DA had raised in 2017 for The 11 which the GDC had finessed.

52. Only 16th of April 2019 Elizabeth Tyler, a dentist and clinical adviser to the NHSE, alongside Ms Philpott, the Appellant and his solicitor, carried out a record card audit

on behalf of NHSE at the practice in Fareham. Miss Tyler considered the computerised clinical notes of the practice but did not ask for, so was not given, the handwritten records on Brown Cards. She also considered the FP17DC and FP17 PR forms and radiographs. The objective was to assess whether the information required to comply with record keeping guidelines was recorded. Her methodology was to look at the dental records of 25 patients seen by the Appellant on the 19th of March 2019. Miss Tyler considered specifically whether the records recorded: the medical history; the patient complaints; dental charting; soft tissue examination; basic periodontal examination; radiographs; diagnosis; discussion of treatment options; type, amount and batch number of local anaesthetic administered; oral hygiene instructions; smoking cessation advice; diet advice; fluoride advice; recall interval; appropriate referrals for secondary care; hygienist referrals and the NHSE payment claim forms. Miss Tyler concluded that all 25 patients had appropriate records. She also noted that:

> "the PR forms and FP17DC forms are filed in a separate location (in date order) to ensure that the brown paper files do not become too bulky."

She was clearly aware that there were Brown Card files. She recommended that the Appellant could copy what she saw in another practice she had visited, the receptionist there scanned cards and documents into the computer using a portable scanner and then shredded the original Brown Cards. The PCC found she did not look at any Brown Cards but did not analyse the evidence set out above.

53. In June 2019 Mr Grant received a full set of copy clinical records for The 11 from the Appellant.

54. On 4.7.2019 Mr Grant sent to the GDC by email (16 separate ones) digital copies of the records of 10 of The 11 (missing patient 4) which the GDC had asked for.

55. The NHSE investigation of the Appellant closed in August 2019 with no disciplinary action. Miss Philpott gave evidence to the GDC in her witness statement that:

> "The Registrant had demonstrated her improvement and imbedding (sic) of the remediation requested."

56. The GDC investigation was only just getting started. On the 22nd of November 2019 Capsticks asked the Appellant's practice for 15 patient records. Jozelle Patterson (the practice manager) identified these and collected the paper dental records. She printed off the records for all 15 patients from the computer. Then, for each of the patients, Ms Patterson pulled out what she described as the blue forms, the Brown Envelopes and the purple forms. The blue forms were patient declaration forms which state whether a patient pays for their treatment or whether it is provided on the NHS. The Brown Envelopes contained the patients' hand-written medical records and X-rays.

The purple forms were the patients' treatment plans. She had some paper records for all fifteen of these patients. These also included the FP17 forms and consents for treatment forms. She sent these, by post, to Capsticks on the 11th of December 2019.

2020

57. On 20th January 2020 the practice received a further request from Capsticks to carry out urgent checks for any additional records for 10 of the 15 patients previously requested. Miss Patterson did so and found no additional records. By this time NHSE and the GDC had made at least 7 separate requests for the same patients' records having lost the originals. In my judgment this was a heavy burden to place on any NHS dentist's practice and was caused by the chaotic system the regulators had in place for handling records.

2021

58. In October 2021 the Claimant submitted her witness statement dated 25.10.2021 with copies of the records for The 11.

59. On the 2nd of November 2021 Capsticks informed the Appellant that the copies of the 11 patients medical records provided on the 25th and 27th October 2021 included additional hand-written Brown Card records which they had not previously seen which would lead to additional dishonesty charges.

The GDC case on fake Brown Cards

60. The GDC case on fraud 1 was advanced on the basis that the copy records (which I have found were scanned by Capita) in Set A did not include any Brown Cards thus they concluded that there never were any original Brown Cards in existence for the 11 patients at that time. It was advanced on the basis that the Brown Cards provided as originals to the NHSE in June 2018 were fraudulently backdated by the Appellant. In addition, the GDC alleged a second fraud, namely that some more Brown Cards for some of The 11 had been faked by the Claimant long after 2018, and these were first delivered to Capsticks in October 2021.

Lay witness evidence relied upon by the GDC

61. **Andy Lee** gave a witness statement dated September 2020. He is a service development lead for processing payments within the NHSE. He advised that claims are made for payment by NHS dentists on form FP17. From the 1st of May 2019 all claims are made online via the compass system used in dental practices. Before then claims could be made on paper or online. He advised that claims can be amended by submitting a new claim form and back referring to the old claim and this can cover deletion as well. His evidence was that a letter of withdrawal could only be effective if the original claim was made on paper rather than online. He stated that the Appellant's practice submitted digital claims in the relevant period from April 2015 through to April 2017 and therefore it was unlikely to make applications to amend

claims for payment on paper. In his second witness statement dated March 2021 he exhibited a list of withdrawn claims by the Appellant.

62. **Deborah Ward** was a programme manager for the NHSE. She was working on a temporary contract from January 2018 to 28th June 2018. I have incorporated most of her evidence above. When she left NHSE on the 28th of June 2018 she emailed Teresa Holt stating that the original documents came as a big lever arch file with plastic wallets by post and she locked them in the bottom drawer of her pedestal when she left. Mr Grant wanted them back after the PAG meeting. because they were original documents. She asked for them to be returned after the PAG meeting. In her second witness statement she described being unable to give evidence about the detail of the documents received in June 2018.

63. **Jennison Baskerville** provided a witness statement dated September 2020**.** She described the process that the NHSE used to gather information; to have it analysed by a clinical advisor; if there were concerns: to escalate those to the PAG who could in turn escalate to the PLDP. She was not in post at the time of the relevant events but summarised them and her evidence is incorporated in the chronology above.

64. **Teresa Hobbs** provided a witness statement dated October 2020. She worked for NHSE in 2018. She arranged for a colleague, Ms Russell-Manning to return the original clinical records to Mr Grant in the summer of 2018.

65. **Moira Philpott** provided 2 witness statements for the PCC, one in April and the other in October 2020. She managed the records audit in 2017 and hired David Akuoko to be the clinical advisor. I have incorporated her evidence in the chronology above.

66. **Jozelle Patterson** was the deputy practice manager at the practice in 2017. Her evidence is incorporated in the chronology above.

67. **Victoria Brazier** was employed by the GDC from April 2019. She did not have conduct of the matter before then. She reviewed the case file which had been managed by Clare Stringfellow, Dilvinder Sander and Lauren Brown.

The GDC's expert evidence

68. **Professor Morganstein** is a dental surgeon who is the head of comprehensive dental care at Barts and the Royal London dental school. He has an impressive CV. He reported on the 10th of June 2021 instructed by the GDC. In his report he stated that the allegations related to a period between the 3rd of December 2015 and the 3rd of March 2017 (which was not the original period covered by DA) and covered: inadequate standard of care and inadequate record keeping. He referred back to a case examiner's report dated the 1st of August 2019 which I have not seen. He stated his opinion was based on four sets of copy patient records. Set A was the name for the scanned records by the NHSE from what he called July 2017, but he must have been

referring to June 2017. Set B was a copy of the records sent by the practice to what he called "Clapsticks solicitors" (sic), which I assume related to those sent in December 2020. Set C was a copy of records provided by Software of Excellence. Set D was a set of copies provided by the Appellant, but he did not provide a date for those. He noted that the Appellant kept clinical records electronically using a template for treatment planning and examinations. He also noted the Brown Cards provided for the patients. He went on to conclude (I infer only in relation to the ERs) that the Appellant did not apply appropriate clinical treatment as follows: (1) related to the BPE scores obtained; (2) the automatically generated recall period of six months did not comply with NICE recommendations and (3) many of the electronic records were duplicated multiple times. He advised that there could be proper reasons why it may not have been possible to provide contemporaneous records, for instance technology failures or emergencies or time issues, however he advised that it should have been possible to put an entry in the electronic records stating this. Finally, he advised that the Appellant recorded inappropriate or inaccurate information in relation to antibiotic prescriptions in the ERs. Therefore, the Appellant's care fell far below the expected standards (I assume that he meant this applied just to the ERs). When looking at the justification for these conclusions he sought to give his "expert" opinion on whether the Brown Cards were contemporaneous. He analysed the Brown Card records and stated the notes were continuous, not split into paragraphs and there were no headings. He asserted that the Brown Cards included a summary of the issues raised in the DA report as well as denials by the Appellant and rebuttals. He asserted that the style of the records did not reflect contemporaneous records and there were no gaps or headings but instead they were in narrative format and he asserted they resembled "a commentary".

69. Having reviewed the Brown Cards provided for 10 of the 11 patients he said they were "*isolated*" to the extent that they only related to the visits identified by the case examiner and had not been provided for "*any other patient visits*". For the reasons I shall explain below I consider that that was a particularly insightful comment. He advised that there should be equivalent sheets of handwritten records for all the other appointments that the Appellant had with other patients and advised "*these brown card records should be available for inspection"*. This advice was never followed by the GDC.

70. The Professor advised that GDC standard 4.1 required dentists to make and keep contemporaneous complete and accurate patient records. The Professor then went through each allegation for each patient. In summary it was his opinion that the ERs were inadequate but when combined with the Brown Card records they were adequate. I will not go through his summary of each of the patients. However, as an example, taking patient 1, there were nine appointments, five with the Appellant and four with other dentists. The GDC clinical advisor had identified that the ERs were inadequate because the sections for diagnosis and treatment were incomplete, there was no record of oral health risk assessment for caries periodontal disease or oral

cancer and no justification was written for the prescribed antibiotics. He accepted that the Brown Card records filled those gaps but he provided the caveat that if the Brown Card records were not contemporaneous then that would be a breach of the relevant standards. In relation to some of the prescriptions of antibiotics the Appellant accepted that they were outside clinical guidelines. He did not assert the Brown cards were faked.

71. Other than having the experience of seeing lots of dentists' records through the years, I do not understand him to assert expertise in the authenticity of documents. There is no such expertise set out in his CV.

72. In his live evidence the Professor Morganstein confirmed his reports. He was not cross-examined.

73. The second expert instructed by the GDC was **Julian Scott.** He provided two reports: 6.5.2021 and 1.11.2021. His specialist field is the propriety of dental practice on claiming fees from the NHS. His CV shows he graduated dental school in 1969 and after five years in the Royal Navy moved into general dental practise for 22 years. That would mean that he stopped general dental practice 1996. Since then he has been an adviser on dental practice, a research fellow, taken a degree in philosophy, and he retired from the Dental Practice Board in 2008. By any measure, his experience in dental note making himself stopped 27 years ago. He reported on 6.5.2021. He set out the bands for claiming payment for NHS treatment and summarised the FP17 claim forms that dentists have to submit to claim payment for various courses of treatment which they have provided. He analysed 30 claims for courses of treatment looking at the computer records and the Brown Cards for The 11. He raised 4 propriety issues which he considered were significant. The first was submitting claims for a higher value band than appropriate. The second was submitting inaccurate documentation in support of the Appellant's assertion that claims had been deleted before being assessed. The third was modifying computer based clinical records to support the assertions that there were justifiable reasons to withdraw or delete claims following receipt of the GDC case advisors' report. The fourth was preparing non-contemporaneous Brown Card records to support two claims numbered 6 and 26. He also mentioned less significant propriety issues relating to splitting courses of treatment for four separate claims and one unjustified claim for Band 2 urgent treatment. He analysed the copy records which he had seen. He summarised that he was provided with five sets of copies of the patients' clinical records. Set A was printed on 28.5.2017. He noted that in addition to the printouts of the computerised records, the copies included various forms, documents and radiographs and the Brown Envelopes but no Brown Cards. As for Set B, he described these as apparently copies of those sent to NHSE on 27.6.2018 but noted that the copies for patients 6 through 11 were stamped by NHSE and were identical to those in Set A. As for record Set C, he described these as relating to patients 1 to 11 having been printed in late May and

early June 2017. However, he noted that these included copies of the Brown Cards. He also stated:

> "they did not appear to be contemporaneous records for the treatment provided on the date specified and had been notably absent from the records sent to the CA *(Clinical Advisor)* in June 2017" (my addition of the words in italics).

Stopping there, I am not aware that Mr Scott has any expertise in deciding whether copy records are authentic or contemporaneous or not. There is no such expertise set out in his CV. As for record Set D, he described this set of copies have as having been provided to Capsticks by the Appellant following a request in November 2019. As for record Set E, which he described as having been printed in September 2020, these were received from Software of Excellence and were solely in electronic format.

74. Mr. Scott asserted that a purpose of his review of the four sets of records (he had listed 5) was to establish the *authenticity* of the material. He noted that for patients 2 to 11 a claim for treatment payment was submitted and a subsequent submission had been made to reduce the allocation of units of dental activity to zero. For each claim he then considered whether the letter of deletion was likely to have been genuine or not. He then went on to consider the Brown Card records. In relation to the original clinical records sent to NHSE in May 2017 he advised *"there were no FP25 record cards sent with the records.*" I do not understand how Mr Scott could have been so sure of that fact which was wholly a matter for the PCC not him. He never provided a supplementary report after the Appellant served her evidence asserting different facts.

75. I question whether he had the expertise or sufficient information to be able fairly to determine the facts of whether the originals were or were not sent to NHSE and on to Capita just by looking at the photocopy records. He had no idea what happened internally in NHSE or Capita by way of scanning. He did not know who did the scanning or under what protocol. He saw no index of the documents received. He did not visit the practice and see what other hand-written records the Appellant made on the relevant days. I shall make findings on this below.

76. In relation to record Set B, he noted correctly that this set of copies did include the Brown Cards. He advised:

> "Each was identical in format, handwritten with the dates of treatment **purportedly** reported on. No other entries or previous or later treatments were present on these cards. In each case, the criticisms levelled by the CA were covered by the notes. **In my opinion these records appear to be non contemporaneous**, which at best note the registrant's recall of events provided the previous year. However, there was no indication within the

> records that the notes were anything but contemporaneous, and indeed appear to have been presented to the defence expert witness as though they were contemporaneous." (My emboldening).

77. None of the detail of the evidence to support those findings was laid out in the report. So not one of the Brown Card notes was extracted to evidence the opinion. Unpacking this evidence, the foundations for the opinion were: (1) the Brown Cards were in identical format, (2) they were handwritten, (3) they were dated, (4) no other before or after entries were provided, (5) the entries covered the points raised by the CA. In relation to those foundations, in my judgment none has any logical merit. As to (1), they were on NHS standard form Brown Cards so the format is irrelevant. As to (2), the expert evidence was that hand-written notes are sufficient. As to (3), the provision of a date on the note is required by the dentist's guidance. As to (4), the lack of before and after entries is highly relevant but should have been requested by the GDC who were firmly advised by Professor Morganstein to do so in his report. But the GDC failed to do so and neither did Mr Scott. In addition, no visit to the practice was carried out by Mr Scott or the GDC to look at the notes made by the Appellant on other patients' examinations and treatment on the same days. As to (5), the content included the sort of information which a dentist should write on such examinations according to all of the other dental experts. Thus, I struggle to understand how Mr Scott came to this firm conclusion on fraud on the basis of the 5 foundations he has set out based merely on photocopies.

78. In his live evidence Mr Scott explained that between 1996 and 2008 he worked as a dental officer reviewing dental records for the Dental Board. During that time he frequently visited dental practices to "challenge them". After that he worked as a privately funded expert. He had done 100 cases in the previous 6 years. The vast majority of the records he looked at were Brown Cards until into the 2000s. More recently most of the records were ERs. In chief, when asking Mr Scott about his experience of considering if records were made contemporaneously, counsel for the GDC asked this question:

> "Q: It is entirely a matter for the committee what has occurred in this case, I am not relying on your experience to prove what happened here, this stands entirely alone, I am simply interested if it is something that you had to look at over the period?
> A: Absolutely. It is true one cannot, unless you actually stand over the period *(I think the typing is wrong here and it should read "person")* who writes the record, you do not have direct evidence" (My words in italics)

That was an insightful statement considering that the GDC were relying on Mr Scott to prove fraud. He then went on to give evidence that he considered the records to be

non-contemporaneous. He accepted that Set A included copies of Brown Envelopes. He said that there were very few 100% ER practices. He explained that the reasons why he considered the Brown Card entries to be "*unusual*" was because "*They normally have more than one entry on each page*" and "*things tend to be shorthand*" not in essay fashion.

79. As was highlighted in cross examination, Mr Scott provided his opinion on the scanning in Darlington asserting that: *"whilst it is possible that one or two sheets may have been missed from the scanning exercise, it is highly unlikely that all the FP25s which were provided with this group of records would be missed."* On this point, I do not accept that it was within this expert's field of expertise or experience to advise on the likelihood or otherwise of scanning errors by Capita in Darlington. He is not expert on these factual matters. More troubling is that he was prepared to advise without knowing who did the scanning, the training (if any) of the operative, or under what protocol it was done and what the staffing issues were at the time in Capita and without seeing an index of the original documents received. He had none of this information. He then gave evidence of his general experience of the scanning team at the NHSE, but he had retired from the Dental Board in 2008 before the NHSE BSA was even set up and did not work for NHSE. In any event such facts were for the PCC to decide not Mr Scott. In my judgment, without direct evidence of what happened at Capita in Darlington in June 2017 it was inappropriate for Mr Scott to seek to give any evidence on what might have happened there and in doing so he stepped well over the boundary between being an independent expert and an advocate for the party instructing him. Mr Scott accepted under cross examination that he was in no position to advise the PCC on whether the Brown Cards had been delivered to NHSE when the original notes were scanned in 2017.

80. Under further cross-examination Mr Scott withdrew the implication in his report that the Brown Cards were created after the event:

> "Q. But use of the words "appeared to cover" would suggest, if you don't mind me saying so, that what you are suggesting to the committee is they appear to cover them because they have been created after the event. Do you want to just be frank with the committee that that is what you insinuated?
> A. I am not saying that. You are making a statement from me which I haven't said. I haven't said that they were made after this. It is for the Committee to decide about."

81. At the end of cross-examination it was put to Mr Scott that if the copy of the records held by Mr Grant from 2019 onwards contained all the Brown Cards, his opinion that the Brown Cards disclosed in 2021 were backdated to answer Professor Morganstein's report from 2021 would be unsustainable. He accepted that he would have to withdraw his opinion that the second fraud occurred. In answer to questions

from the PCC Mr Scott stated that it was unusual for dental practices to keep handwritten and ER records save when they were changing over from the old way to the new way. He was also asked his opinion on the copy of a scan of a Brown Envelope for patient 4, and what he made of its "*condition*". The PCC panel member had calculated that 10 Brown Cards would have been inside it if they had been delivered in 2017 with it:

> "Q. I have been through the FP25s and there are a number of FP25s for each patient but this one in our bundle, I believe we have got ten FP25s that would go into this FP25A, and I presume there would be other things going in there as well, the FP17, the FP17DC et cetera, perhaps x-rays, my comment is what do you make of the condition of this FP25A?
> A. I am sorry, just let me have a look again. It doesn't look as though it contains more than one card at the most. I assume, as you so rightly suggest, that a card which contains a number of FP25s usually begins to look swollen, the edges look a bit worn because they are swollen. In my view that particular record card, that FP25A doesn't seem to have contained any FP25s, that I can't be certain about, but I would say it is possible that when an FP25A does get a little bit full another FP25A could be brought into existence. The suggestion that this one contained all the material relating to this patient would suggest there aren't other ones and as I say I would be very, very surprised if that would contain more than at the most a couple of FP25s."

In my judgment, not only was Mr Scott unqualified to give that evidence but the very question shows that the absence of the original records was polluting the PCC's ability to hold a fair hearing as they were asking him to comment on a two-dimensional copy and to expand it to three dimensions and advise on what was inside.

The Appellant's evidence

82. The Appellant's evidence in chief to the PCC was contained in four witness statements. The first three were dated 25.10.2021, 28.10.2021 and 2.11.2021. These witness statements were unhelpful in that they substantially duplicated the contents of each other. Starting with the first the Appellant asserted that when she read DA's report she saw that he had not been provided with the Brown Cards so she arranged for the originals to be sent to NHSE in June 2018 with her response letter. She asserted that in 2017 NHSE only scanned the Brown Envelopes and pointed specifically to one Brown Envelope which showed that it had a Brown Card inside which had not been copied. During the hearing two examples of copies of envelopes from the notes in Set A were highlighted to show scans of the Brown Envelopes which clearly showed Brown Cards inside. The first is in appeal bundle one at page 178 for patient one and the second is in bundle 1 at page 762 for patient five. I should say that the photocopying of these records was so bad in some of the Sets that it was

almost impossible to distinguish whether the card is inside but it was possible to distinguish that the Card was inside on others. This evidence is direct and incontrovertible factual proof that Capita failed to scan at least two Brown Cards. It is relevant because the GDC and Mr. Scott stated that no Brown Cards were scanned or copied by Capita in June 2017, only the envelopes and the GDC used that as a justification to allege that none existed. This piece of evidence has been overlooked by the PCC in its decision.

83. The Appellant also explained, in relation to the scans taken in June 2017 by Capita, that for many of the documents only one side had been copied. She provided a full list of incorrect scans. She then set out in her witness statement, patient by patient, date by date, her response to each of the allegations made by DA, referring to the contents of her notes in the Brown Cards.

84. In her second witness statement the Appellant dealt with a second set of charges which had been raised against her on the 8th of October 2021 in relation to additional Brown Cards which had been provided to the GDC by the Appellant's solicitors. The Appellant answered the new charges. She challenged Professor Morganstein's opinion and the conclusion that it was implausible for her practice to keep both electronic and hand-written records simultaneously. She relied on the CQC inspection in April 2018 to refute that suggestion and on the words "*written or typed*" and "*stored paper records securely"*. She also relied on the CQC report dated October 2013 and the words *"we saw that records were updated during or immediately following an appointment. This ensured that chronological records were maintained"*. She asserted that it was not plausible that she would fraudulently construct records after the event when she could merely have admitted a lack of handwritten records and had that remedied through training and reflection, in which event she would not have faced any serious risk of erasure. I regret to say that the rest of the responses for each new charge were word processed copies of the response for patient one and therefore were unhelpful and bulky. I do not deal with the responses on the matters which are Unappealed.

85. In her third witness statement the Appellant again recited swathes of her previous witness statements. She helpfully set out details of the defective scanning carried out in June 2017 patient by patient and then once again set out her responses to each of the charges.

86. In her live evidence in chief the Appellant explained that she had always used Brown Cards to make clinical records and continued to do so after computerisation came into the practice in 2009. She was sure she delivered the original records with the Brown Envelopes and Cards to NHSE in June 2017. She put everything together herself. She printed the ERs and collected the FP17s, the FP17DC forms, X-rays, lab dockets etc. She went to the Post office and sent them recorded delivery. For each patient there was one Brown Envelope included with the other documents. The Appellant's case

was that she took a master copy of all the records before she posted them out [the Master Copy]. The originals were sent back by recorded delivery and the Appellant opened the bag. The Brown Cards were all there. When the Appellant received DA's report in December 2017 she read it. She instructed Mr Grant. She handed the Maser Copy to Mr Grant in June 2019. She had written contemporaneous Brown Cards for each patient visit. She had hand-written cards for every patient. She started that this would be obvious on any spot examination of the practice by the GDC should they have visited. She stated that when Ms Tyler did her inspection in April 2019 she only inspected the computer records not the Brown Cards.

87. Before cross-examination the GDC applied for disclosure of the Master Copy. This was directed on 9.11.2021 and a bundle of copies was delivered to Capsticks on 12.11.2021 with a witness statement from Mr Grant and the hearing resumed on that day. Mr Grant could not confirm that he had provided the exact Master Copy but did confirm all the documents were delivered to him in June 2019.

88. At the resumed hearing in February the Appellant was cross-examined. She was not challenged on her evidence that she stored the Brown Envelopes in the garage at the practice. During questioning on the Set A this exchange took place:

> "Q. I am going to come on to the 2010 one, do not worry. I will rephrase. It does not contain a single FP25 record card which relates to the period 2014-2017, what they scanned?
> A. Yes.
> Q. Yes. It is not an issue, for example, that they scanned one side and missed off the back, or one side and missed another one ----
> A. It is. They have -- they have ----"

89. The GDC accepted the Appellant's evidence that the scanning was defective in that it did not cover all of the original documents delivered to NHSE. The Appellant then pointed out that Brown Cards were visible when inside the Brown Envelopes. I note that this is because of the semi-circular finger "cut out" at the top of the front of the Envelope. She hand-wrote the year at the top of some of the Brown Cards. The Appellant was asked about the scans which showed Brown Cards inside the Envelopes which Mr Scott conceded in his evidence showed that. It had "2010" on it which the Appellant conceded was outside the date range requested by DA. The Appellant was not challenged when she gave evidence that there were 70 copies of one side of documents which the scanner had failed to copy (other than the Brown Cards). The Appellant was then asked about patient 4 and she explained that this patient had been coming so long to the practice there there were 2 or 3 Brown Envelopes for him. Not all were provided to the GDC being outside the date range. One was provided which was outside the date range but had no Brown Cards in it. For patient 4 the Appellant explained that she sent everything on this patient who had been with her from early days, to her solicitors. In submissions in the appeal the GDC

relied on this passage of answers to show the lack of credibility of the Appellant's evidence:

> "Q. How many FP25's did you send to the NHSBSA at the start, then? I mean, approximately.
> A. Erm, approximately, I ----
> Q. Because we have about 60-something here.
> A. You have got about 60, but this is just relating to this period, so when my solicitor pulled this out, they just related -- they just took out the FP25's ----
> Q. Ms Balachandra, I am sorry to interrupt you. I have understood that is what you are saying. I am asking how many FP25's, what is your evidence, did you send to the NHSBSA at the beginning?
> A. I would have sent however many was relating to this so, er, I don't know, the 11 patient record cards along with all the FP25's that were relating to this.
> Q. We have 60-odd here, you are saying that there was more than that but, for whatever reason, they have not been included within the bundle which has been provided to the Committee, okay, so there is a load more FP25's somewhere, copies of them, and so what I am asking is how many more did you send over and above this, approximately?
> A. I am sorry, I don't know. I don't know the answer to that.
> Q. You do not know, fine. Your evidence, and this is obviously something which you will have the chance to support with documents if you wish to, if you do not wish to it is a matter for you, but your evidence is that the reason there are no FP25's for Patient 4 for those courses of treatment with you in 2009-10, your evidence is there would have been handwritten records on FP25's, those are not in the records of the practice because they were sent to the NHS and your solicitor will have copies?
> A. Erm, yes, I think that is correct. I think -- I am just trying to think over what would have happened here. I have sent everything to the NHSBSA, yes, and then afterwards I had to go to the solicitor and take my original records with me and at that point, yes, there are -- there are records in there that would relate to this time period, absolutely.
> Q. Either there are records for this patient for that period, that is one potential, okay?
> A. Yes.
> Q. The other potential is that there are none, there are no handwritten records for this patient, that is why they are not in the practice, because they do not exist. If it is that second one, that would be,

> would it not, completely at odds with your evidence that you have always kept handwritten records?
> A. Right."

This line of questioning implied that the Appellant did not keep prior handwritten records for patient 4 for 2009-2010, but she had never been asked to disclose those being outside the date range specified by DA in 2017. She was then asked about when she wrote her notes and described the busy day of a dental practitioner and how she fitted the handwritten notes in at some time during the day or at the end of the day. Every patient of hers had a handwritten record. After lunch on 15th the Appellant explained as follows:

> "A. Thank you very much. Thank you, I appreciate it. It was -- well, it was brought to my attention that Exhibit 20, I am correct in thinking that you had thought that these were the only record cards relating to Patients 1-11, but they are not, and I just want to make sure that the Panel and yourself are clear on that. There are more record cards for Patients 1-11, but the only ones that are exhibited are the ones that are relating to this period and that is why there is no more in, I believe, Exhibit 20, which is the better copy of the FP25's, which was why I was -- replied to that, and also there was a second question in relation to 2009, was there a record card sent to the BSA relating to 2009 or any of those years where I have seen patients prior to 2014-17. Yes, absolutely they would have been sent to the BSA with my records and, on top of that, my solicitors would have also had a copy of all the originals of that, which were later sent again to the NHS in 2018, in June, which was confirmed as received by the NHS, and again in September 2018, which was received by the NHS but, of course, after that has been advised as lost. So I just wanted to make sure that those two points were clearly said. Thank you very much.
> MR SINGH: Yes. I think that is all in line with what I understood you said earlier.
> A. Thank you, thank you".

90. The Appellant was asked how many days per week she worked and how many patients per day she saw and it was suggested that she would have been producing a lot of Brown Cards. She agreed. That was why they were stored in the garage. She had to store the notes for 11 years. The Cards were provided free by the NHS. She started a new card for each appointment. In what I regard as a key passage in her evidence the Appellant was asked this:

> "Q. Why write a new page for every day? One line, two lines, five lines, why would you do that, rather than writing it on a record card

that is already available? I want to be clear, what I am asking is what is the benefit of doing it that way?

A. Erm, so I would just like to explain that I do write a record card for whenever I see a patient, but I just want to make it very clear, we don't -- these record cards are provided to us free. They come from the NHS branch to the practice, so I suppose in -- we are not cutting back on records or writing of records, and I have never seen it that way. The first time when I actually saw it, I thought: "Oh, okay, I suppose they could be condensed," but there is no reason behind the practice's way for writing them one after the other, and if that is recommended after this hearing, then fine, I will write them one after the other, but it has never been said that a dentist has to write it a specific way, and neither do the records that you write have to be a specific way.

Q. No, sure, I would have to accept, there is no specific guidance saying you have to write it on one card, but I can think of a number of disadvantages of writing it on separate card every day. I mean, it makes the records bulkier, it wastes paper, there is more chance of a page getting lost if have you 30 rather than three, it is more difficult for people to find a record, it is more difficult for people to get an overview of what has happened over the course of a month or weeks if it is all spread out. There are a number of disadvantages of doing it your way, but what is the advantage? What is the benefit that you saw in doing it this way, or was there not one?

A. The benefit is that I feel happier when I am writing record cards, that is what I have done, and so it just -- it is not something I have questioned and thought: "Oh, I will change it at this point," and if I use that same mindset, well, I suppose you could also say, well, what would be the benefit of storing FP17DC and PR forms in the garage and not scanning them? Or what would be the benefit of storing actual records in a filing cabinet? I mean, you could go on for everything like that and I understand, yes, there are pros and cons of it all.

…

Q. Sure, or is the reason you are doing this, and the reason that it is done here, because if you are going to write up records retrospectively, it is going to be a lot easier to try, at least, and pass them off as contemporaneous if they are individual, self-contained records cards and then you do not have to worry about how the records for X date and Y date, which are supposedly written months or weeks apart but are actually all written in one go, look on one piece of paper when they are all side by side. Is that the reason that this very unusual way of recording one entry per date, whether it is

> one line or ten lines, is apparent from the records you have submitted?
> A. No."

She explained she would see 15-20 patients per day. When shown pages 1 and 2 (the flow backwards issue) for patient 6 she agreed that the presence of the word "continued" meant that page 1 had that word and page two was written after page 1. It was put to her that page 1 should have been written after page 2 note before. This was the Appellant's explanation:

> "Q. Surely, what you are saying in the second page is how you would start the record on the first page. Why would you start your note reporting on bitewings and then come back to the reason the patient attended in the middle of it?
> A. I had probably just taken bitewings and wrote them down straightaway. Erm, that is normal, that is probably what happened right then and there. I don't think I'm -- there's a problem with the way that I am writing it and, as I said, there is no specific way that things have to be written. But, yes, in reply to your question, I would have imagined that I would have taken the bitewings and written something down about them as soon as they were taken so I could record what was present."

91. It was put to the Appellant that the Brown Cards were not contemporaneous because the pages did not fit together or flow and because of their format and content addressing the criticisms of DA and she denied that assertion.

92. The PCC asked various questions about her modus operandi at the end. She was asked about repetition in her notes relating to patient 4. She was asked why she had no nurse to write the notes. She responded that nurses might miss something of chart incorrectly.

93. **Mr Paul Grant** was the solicitor from BSG solicitors who acted for the Appellant. In his first witness statement he gave evidence which I have summarised above in the chronology about him sending the original records to NHSE on the 12th of September 2018 and that they were never returned to his firm. In his second witness statement dated 7.11.2021 he gave evidence that he had prepared the Appellant's main response dated 27.6.2018 by looking at the original records for The 11, including the Brown Cards. He sent those with the letter and received a receipt from NHSE. He received the original records back in August 2018 but again had to return them to NHSE on the 12th of September 2018 and the documents were never again returned to his firm. He also dealt with the photocopies of the originals. The Appellant delivered a set of copies to him in June 2019. His evidence was that the Appellant had not changed those copies or delivered any additional copies since that date apart from one Brown

Card on the 1st of November 2021. He explained that if any of the later sets of copies of the clinical records of The 11 did not include all of the relevant pages that could have been an oversight by a member of his team. However, he stated that it would have been helpful if NHSE had returned the original records rather than having to rely on photocopies. In his third witness statement Mr Grant stated that the Appellant did not deliver any X-rays to his office, she did deliver laboratory dockets for certain patients and did not deliver any photographs to his office in June 2019. He also repeated that the Appellant had delivered copies of all relevant clinical notes for The 11 in June 2019. Finally in his fourth witness statement Mr Grant answered a question posed by the GDC's barrister at the hearing only 12th of November 2021 to the effect that the copies of the Brown Card records were taken from the bundle of copy documents which his firm held and sent to the GDC and he did not return copies of these to the main bundle. That is why they were not included in the disclosure on the 12th of December 2021 (by which I assume he meant the 12th of November 2021).

Further GDC evidence

94. Further evidence was served by the GDC in between the first part of the hearing in November 2021 and the second part of the hearing in February 2022. Anna Holdsworth, a solicitor from Capsticks, gave a witness statement explaining that during the November hearing the Appellant mentioned that she had kept a copy of the records originally sent to NHSE at the outset of the case. The PCC made a direction for that set of copies to be provided to the GDC by 12th November 2021. A black lever arch folder was Couriered to Capsticks by Mr Grant on the 12th of November. She checked the copies and found no copies of Brown Cards. She handed the folder to a member of intelligent office docu-centre team to whom Capsticks subcontracted photocopying. By the 6th of December 2021 the subcontractors had shredded it by mistake.

95. The evidence of Miss Holdsworth was corroborated by a witness statement from Charlotte Stevens-Mulroe updated January 2022 and a witness statement from Miss Djemal dated January 2022.

Further evidence from the Appellant at stage 2

96. Doctor Pal wrote an expert report on 17.6.2022. He had been asked to carry out a random check on the records of the practice for the years 2015-2021 in particular to check whether Brown Cards were used and to look at the style of writing on different pages. On 11 May 2022 he was granted access to the practice computer and shown 250 Brown Cards. He was told the rest were being scanned into the computer. He selected 20 sample patients and another 11 paper records. On 24th May he went to the practice. By then 50% of the Brown Cards had been scanned into the computer. By 16th June all the Brown Cards were on the computer system. He then selected another 15 patients. In total he examined the records of 68 patients. 53 of 57 patients had Brown Cards. He discovered that the Appellant was the only dentist at the practice using handwritten records. He considered that the computer records were below the

standard required being formulaic and lacking in detail. When he looked at the Brown Cards, he found that each Card had only one date on it (not two or more). They were mainly "full-mouth examinations" and oral health reviews. There were no procedures in them. The quality was high however the records for procedures were below the standard expected.

97. Doctor Pal's evidence was not put before the PCC at stage 1. It was used at stage 2. The Appellant put in a further witness statement at stage 2 disclosing how the CQC had criticised her for keeping handwritten records and how she had taken the advice and scanned them all into her system using Proscan. They scanned 27,000 Brown Cards.

The Hearing

98. The GDC's evidence was served in March and May 2021 and the expert evidence in 11th June 2021 with further documentation in August 2021. Additional dishonesty charges were added in early October 2021. Mr Scott provided a short addended report dated 1st November 2021. The hearing took place between 1st and 12th November and then 14th February and 2nd March 2022. In opening there was discussion by the GDC of the need for handwriting experts and last minute instructions to them. The PCC were provided with the bundles on 4th November 2021.

99. The sets of copies were as follows:
Set A, June 2017, copied in Darlington by Capita (no scanned copies of Brown Cards but copies of Brown Envelopes) from the originals.
Set B, copied by NHSE in June 2018, from the originals (with copies of Brown Cards).
Set C, copies provided by the Appellant to the GDC (with copies of Brown Cards).
There were other sets.

100. In opening the GDC gave an example of the asserted dishonestly backdated Brown Cards for patient 6 and the detailed handwritten entries on the Brown Cards about the visit, asserting that it was *"exceptionally detailed*", and "*the style of entry does not resemble, a contemporaneous record of an appointment*" and it was written as *"a piece of prose*", with no gaps or headings in the narrative. "*It addresses neatly and comprehensively the concerns raised by the clinical adviser*". For patient 7 the case was put that the clinical adviser raised the concern that there was *"no record of oral health risk assessment including periodontal caries and oral cancer as part of the examination, no record of interval."* The Brown Card entry for patient 7 was as follows:

> "Patient is generally well, however arrived today with abscess associated with lower right second pre-molar. Patient was offered options on examination offered extractions or root canal treatment and possible immediate denture. Procedure of extraction and root

> canal treatment advised and explained in full detail. Patient requested for extraction of upper right and upper left wisdom teeth as many previous episodes of previous pericoronitis with previous practice. PDH at previous dental practice. Agreed with consent of patient to take radiographs of right and left wisdom teeth. Patient requested for extraction under sedation, therefore offered referral. Patient is generally not anxious.
> Medical history checked, ? today, TMJ NAD, lymph notes NAD, BPE carried through, OH homecare brushes daily mouthwash daily interdental clearing daily x 1 using floss tepe. Occlusion NAD. Diet sugar intake low. Patient aware of smoking and alcohol cessation advice clinic offered free by NHS. Caries risk is low, acid erosion risk is low, periodontal risk is low, oral cancer risk is low, special investigations patient consents to radiographs. Discussed and treatment plan involves OHI given and preventative treatment advised on interdental cleaning daily, fluoride mouthwash daily, and scale and polish. Radiographs sent with referral. Recall 6/12".

The GDC submitted that this Brown Card comprehensively addressed the points raised by the clinical adviser which did not *"resemble a contemporaneous clinical record*".

101. The GDC then focussed on the (fraud 2) recent charges of fraudulently produced Brown Cards which rested on the page 1/ page 2 case put against the Appellant. It was suggested in opening that the reason why the Appellant had fabricated more Brown Cards in a second batch long after the asserted first fabrication of Brown Cards delivered in 2018, was to answer the Professor's concerns. It was submitted that:

> "If you cross reference what is in this newly provided record, with what Professor Morganstein said in his report but that the Clinical Adviser did not say in his report, the new record neatly addresses everything from Professor Morgantstein's report."

Professor Morgantstein had identified that although x-rays had been taken the results had not been graded or reported upon. The "new" Brown Cards contained the results, the grading and reporting. Patients 6 and 7 were used as examples. The use on page 1 of the word "continued" indicated it was written first and contained the X-ray report. Page 2 contained the general notes of the appointment. So, for patient 6, page 1, which was supplied in 2021, said:

> "Bitewings right and left taken for patient justification caries graded 1. On radiographic assessment advice caries present, upper right, second molar. Bone levels are moderate. Discussed radiographs with patient stated there is caries. Discussed the aetiology of caries and

> risk assessment to be carried through in…" then something I cannot quite make out.
> Perhaps caries risk is medium. However, will collectively look at all factors and full risk assessment here. Recall suggestion 3/12. Patient declined and said she prefers 6/12 recall …. Gums generalised slightly red perhaps inflammation… radiographs showed bone levels are moderate. Advise patient of periodontal condition and advised and referred to NHS perio RSC Band 2 or private referral to hygienist. Patient declined rsd. Patient accepted for hygienist and booked this and will go ahead with scaling I think patient prefers to have this. contd"

Whereas Page 2 (which is very difficult to read, and this Court was not provided with a typed copy) and was copied in 2018 said this (as far as I can interpret the copy:

> "pt attended today for a dental check up last dental check up MP S 6/2 amorb nil. P/O nil, MH checked no change, EDP TMJ NAD, lymph nodes NAD, OH ! Home care brushes daily mouthwash daily and enter dental cleaning recommended daily. Conclusion NAD. Diet sugar intake Low carries risk is low acid erosion risk is low periodontal risk is low oral cancer risk low diagnosis dash acute generalised gingivitis and carries at upper right second molar discussion today involved explanation to Pt understand that she needs to floss and brush to avoid progression of gum disease Pt understands she can lose her teeth going to gum disease and decay if she doesn't comply Advised on low sugar intake and restrict only to meal times... (I cannot read the rest of the right hand column down to) … recall 6/12"

102. The GDC submitted that if these were written at the same time they made very little sense. The order of the pages was the wrong way around. Then it was submitted that:

> "The way the pages are written are quite different. I am not asking you to be handwriting experts, this is nothing to do with analysing the handwriting itself but what is quite obvious from looking at this page on the left and this page on the right, is that the layout of the pages is markedly different."

This point can only be considered by pasting the entries into this judgment and I do so below:

Page 1:

DATE	TREATMENT	DATE	TREATMENT
25.1.16	Bitewings right and left taken for patient justification caries grading 1 On radiographic assessment advised caries present upper right second molar Bone levels are moderate Discussed radiographs with patient stated there is caries discussed the aetiology of caries and risk assessment to be carried through in free perhaps caries not is medium however will collectively look at all factors and form risk assessment here recall surgeon		3/12, pt declined and says she prefers 6/12 recall (for financial reasons) Gums generalised slightly red pt gingival inflammation generalised, radiographs shows bone levels are moderate advised Patient of periodontal condition and advised and offered a nhs perio - rsd band 2 or private referral to hygienist Pt declined rsd Patient opted for hygienist and will book this and will go ahead with scaling session wants pt prefers to have this Contd

DENTAL RECORD - NATIONAL HEALTH SERVICE

Printed for The Astron Group J249485 01/2007 FP25 (02/03)

Page 2:

DATE | TREATMENT

15-1-16 Pt attended today
for a dental check
up last dental
check up MOS 6/12
anticipated, Pt and
MH checked no change,
EOE TMJ NAD, lymph
nodes NAD, OH
home care brushes
daily mouthwash
daily and interdental
cleaning recommended
daily. Cheeks on NAD.
Diet sugar intake on
consumption is low
and erosion risk is low,
periodontal risk is low,
oral cancer risk low.
Diagnosis - acute generalised
gingivitis and caries
upper right second
molar. Discussion on
today involved
explanation to pt of
the x the pt understands
that she needs to floss
and brush to avoid
progressive gum
disease. Pt understands
she can loose her teeth
owing to gum disease
and decay if she
doesn't comply. Continuing

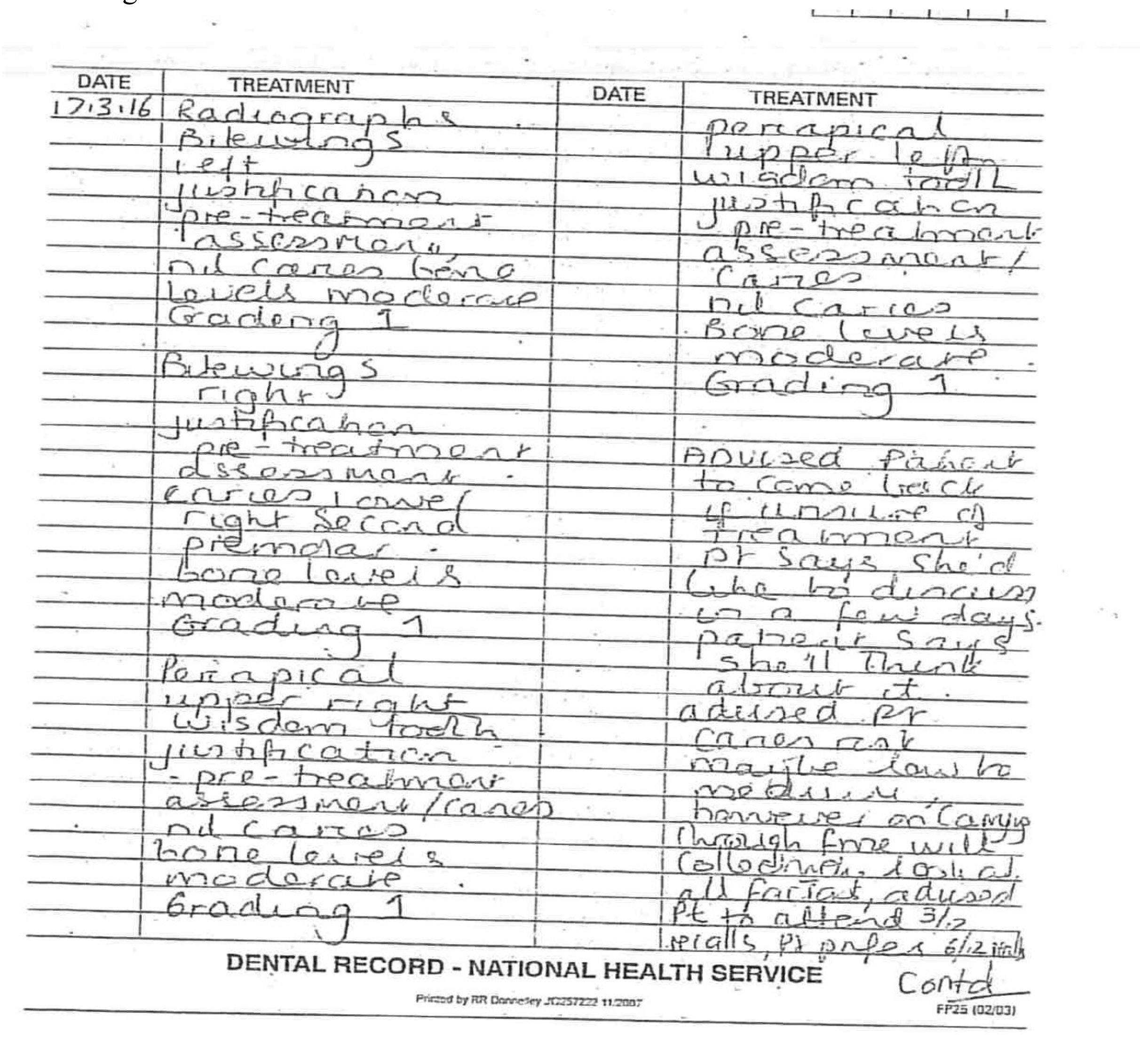
DATE | TREATMENT

advised on low
sugar intake
restrict only to
meal times [illegible]
of periodontal [illegible]
and its complications
and aetiology.
Advised on [illegible]
[illegible] Pt made
aware of [illegible]
[illegible]
[illegible]
treatment plan
[illegible]
with Pt with [illegible]
[illegible]
filling [illegible] and
[illegible]
[illegible]
[illegible]
[illegible]
Pt regards [illegible]
course of treatment
[illegible]
filling
recall 6/12

DENTAL RECORD - NATIONAL HEALTH SERVICE

103. The same point was made in opening about patient 7 and I paste those records into the judgment here:

Page 1:



DATE | TREATMENT

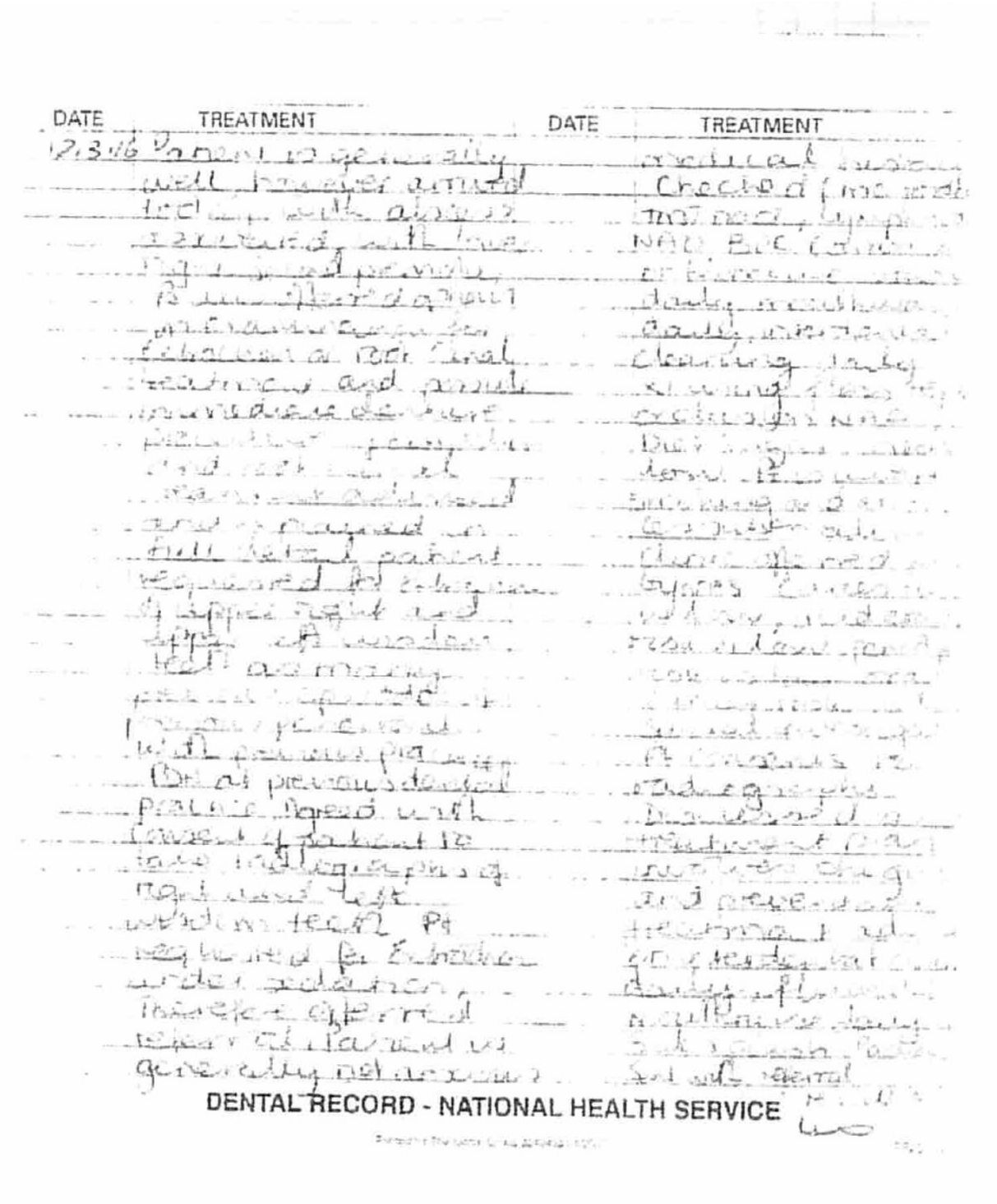
17.3.16 Radiographs
Bitewings
left
justification
pre-treatment
assessment,
nil caries bone
levels moderate
Grading 1
Bitewings
right
justification
pre-treatment
assessment.
caries lower
right second
premolar.
bone levels
moderate
Grading 1
Periapical
upper right
wisdom tooth
justification
- pre-treatment
assessment/caries
nil caries
bone levels
moderate
Grading 1

DATE | TREATMENT

periapical
upper left
wisdom tooth
justification
pre-treatment
assessment/
caries
nil caries
Bone levels
moderate.
Grading 1
Advised patient
to come back
if unsure of
treatment
Pt says she'd
like to discuss
in a few days.
patient says
she'll think
about it.
advised pt
caries risk
maybe low to
medium,
however on carrying
through free will
collection, looked
all factors, advised
Pt to attend 3/12
recalls, Pt prefers 6/12 recalls
Contd

DENTAL RECORD - NATIONAL HEALTH SERVICE
Printed by RR Donnelley 11/2007
FP25 (02/03)

Page 2 (again a very poor copy indeed, I could find no better one):


DATE TREATMENT DATE TREATMENT

DENTAL RECORD - NATIONAL HEALTH SERVICE

104. The GDC case had been closed and the Appellant was part way through her evidence when the hearing was adjourned on 12.11.2021. At that time the Appellant notified the PCC that she would be making an abuse of process application. Directions as to further evidence were made.

105. On 14.2.2022 the Appellant made her abuse of process application based on (1) the destruction or loss of the original clinical records; (2) the destruction by Capsticks' agents of the copies sent to them in November 2021; (3) the failure by the GDC to call evidence about the Darlington scanning of the copies in Set A; and (4) the

evidence of Mr Grant which resulted in the undisputed fact and he had in his possession since 2019 included all of the Brown Cards so none could have been fraudulently produced in answer to the Professor's 2021 report. It was submitted that it would be an abuse to allow the case to continue in relation to the Brown Cards in those circumstances. The GDC apologised for Capsticks' agents shredding the documents delivered by Mr Grant. They submitted that a fair hearing could still be achieved despite the shredding and loss of originals and copies. They asserted that the disadvantage to the Appellant could be "accommodated" by the PCC. They submitted that it was too late to make a no case to answer submission.

106. In reply the Appellant raised the issue of the inability to rely on a handwriting expert in the absence of the originals.

107. After the application was dismissed the Appellant continued her evidence.

The Tribunal's Judgment

108. The tribunal's decision is undated. The charges are laid out at the start. There are no paragraph numbers and there is no full chronological recitation of the findings of fact or the assessment of the evidence of each of the witnesses. The decision records a preliminary ruling to permit the GDC to add further charges relating to further handwritten Brown Cards provided as part of the defence case in the week before the hearing. Addendum report from the expert Julian Scott dated 1.11.2021 expressed a concern that the further written records were not contemporaneous. No objection was taken and the additional charges were permitted. Those are reflected in the table above as charges 22, 23 and 24. The next matter the PCC dealt with was the Appellant's application made at the start of the resumed hearing that the Brown Card assertions should be stayed or dismissed because the process was an abuse or unfair. The PCC noted that the Appellant had said in evidence at the November 2021 part of the hearing that before she had delivered the original patient records for The 11 to the NHSE in 2017 she had made a copy of everything. As a result, an order for directions had been made on the 9th of November 2021 to disclose those copies. The Appellant had made those copies available to the GDC by delivering them to Capsticks whose subcontractors had copied them onto their system and then shredded the original copies. Therefore, the PCC would have to work with scanned copies of the delivered copies. The Appellant justified the submission on the basis that the GDC's case was that when the original patient records for The 11 were delivered to NHSE in June 2017 there were no Brown Cards with the original records. The originals had been lost or shredded and then more recently the original copies made by the Appellant in June 2017 had been destroyed by Capsticks. The Appellant asserted that the GDC had no evidence to support their assertion that the original records contained no Brown Cards because the NHSE had destroyed the evidence. The GDC were relatively neutral on the application regarding it as a hybrid application partly being on the basis of a submission of no case to answer but they opposed the abuse of process part of the application. The GDC relied on *P v PR* [2019] EWCA Crim. 1225, for the

submissions that copies of the Brown Cards were sufficient for the PCC to determine the charges. The GDC submitted that the Appellant had not evidenced any substantial prejudice from the destruction of the original records. The PCC decided to go ahead stating that "*the central issue in this case remains the same. The issue is whether the original FP25 record cards were sent by you to the NHSESA in 2017*." The PCC ruled that in law a stay would only take place has an exceptional course. It was not satisfied that the absence of the original copies or original notes meant that the Appellant could not have a fair hearing. They considered that any perceived unfairness could be addressed by the hearing process.

109. The PCC's findings in relation to the background chronology were that the Appellant sent the records to NHSE for each of The 11 and these were scanned. The clinical advisor reported in June 2017 setting out his concerns. The concerns led to a PAG meeting in mid 2018 and a full disciplinary panel meeting of NHSE in 2019. The PCC did not go on to mention that NHSE then ended their investigation with no disciplinary or penalty decision whatsoever in August 2019 and no finding of fraud. The PCC appear not to have taken that fact into consideration.

110. The PCC's chronology continued by jumping to the GDC investigation and summarising the Appellant's June 2018 response alleging defective scanning of the original records. The PCC summarised the GDC's case, that the copy records sent by the Appellant to the GDC in June 2018 included non-contemporaneous Brown Cards. In the chronology the PCC noted the original Brown Cards were "unavailable" and noted that there was no evidence to indicate exactly what material the Appellant had provided to the NHSE in June 2017. The PCC noted *"in the circumstances of the original record cards not being available, the GDC's assertion is based on circumstantial evidence."* The GDC submitted that the circumstantial evidence was sufficient to sustain an inference by the PCC that the Brown Cards were created retrospectively.

111. The PCC stated they had read all of the documents and the witness statements and had heard live evidence from Professor Morganstein, Julian Scott and the Appellant. No live evidence was heard from Mr Renshaw or any other witness. The key reasoning of the PCC, which is challenged in this appeal, is set out at pages 17 to 20. The PCC accepted the expert evidence of Professor Morganstein and Mr. Scott to the effect that the Brown Cards were created at a time long after the relevant treatment was provided. However, they did not state when the fraud was effected by the Appellant in their findings. They cited the reasoning of Professor Morganstein that: (1) the style of the notes was not, in his opinion, contemporaneous; (2) there were no gaps or headings and (3) that they resembled a commentary of the visits that were criticised. They accepted Mr Scott's justification for alleging the notes were not contemporaneous as follows: (1) there were many duplicate entries for the same treatment dates. (2) Mr Scott had never before seen clinical records written in the way the Brown Cards had been written. (3) All of the notes were written in long-hand

prose which the PCC considered to be an exceptional way to record clinical information. (4) For some patients the notes were the wrong way round so that page one which had the word "continued" on it led on to page 2, but the information on page 2 would be more likely to have been taken at the start of the consultation than the information on page one. They relied on the notes for patient 5 and 6 for this. There was a lack of flow between the first and second pages. (5) There was a different style of writing between pages one and pages two. The PCC gave examples. (6) The Brown Cards directly addressed the concerns of the clinical advisor, DA, which was particularly overt for patient 3 charge 16 (c) which the committee found to be more like a response to the concerns than a clinical record. The same applied to patient 5's antibiotics prescription. (7) The PCC relied on the difference between the substantial information in the handwritten Brown Cards and the brief shorthand notes in the ER. (8) The PCC also relied on the absence of scanned Brown Cards in June 2017 doubting that if Brown Cards had been delivered to NHSE in the Brown Envelopes the photocopier would have missed every single one for 11 patients.

112. The PCC then went on to consider whether coexisting circumstances could weaken the GDC's circumstantial evidence. They found the Appellant's evidence of little assistance. They considered her evidence evasive, defensive and neither helpful nor credible. They did not provide reasons for that finding. They dismissed the relevance of the CQC summaries of their examination of the Appellant's records because they failed specifically to refer to Brown Cards in their reports. They dismissed the NHS appraisal in April 2015 because that stated that the Appellant kept all her records on computer and they dismissed Miss Tyler's April 2019 NHSE examination of the records in the Appellants practice because she noted on the report that no hand-written Brown Cards were examined. The committee went further and stated:

> "in the committee's view the comments made about your record keeping in both documents raised a question about whether handwritten records have always been your primary method of note taking, as you have maintained."

The PCC concluded there were no coexisting circumstances which undermined the GDC's circumstantial case. The PCC then disregarded the evidence of Mr Grant that he had copy records in his possession from 2019 stating:

> "the information he provided did not assist the committee with what you sent to the NHSBSA in 2017."

The PCC accepted there was a strong inference that the Appellant did not send Brown Cards to the NHSE in June 2017 and therefore the Brown Cards relied on in 2018 were written retrospectively. The PCC concluded:

> "the committee found nothing in the FP25 records to indicate that they were not made contemporaneously rather than being retrospective." (sic)

I raised this at the appeal hearing because this conclusion acquits the Appellant of all Brown Card charges. The parties agreed that this was a typing error by the PCC. Accordingly, the Appellant was found to have committed each of the charged items of wrongful conduct in relation to the Brown Cards for The 11. The PCC then went through each charge finding it proven. No analysis of dishonesty was set out.

The Law

113. In addition to the guidance set out above in *General Medical Council v. Jagjivan,* I refer to *Sastry v General Medical Council* [2021] EWCA Civ. 623, in which Nicola Davies LJ summarised the approach to re-hearings relating to findings by PCCs thus:

> "102. Derived from *Ghosh* are the following points as to the nature and extent of the section 40 appeal and the approach of the appellate court:
>
> i) an unqualified statutory right of appeal by medical practitioners pursuant to section 40 of the 1983 Act;
>
> ii) the jurisdiction of the court is appellate, not supervisory;
>
> iii) the appeal is by way of a rehearing in which the court is fully entitled to substitute its own decision for that of the Tribunal;
>
> iv) the appellate court will not defer to the judgment of the Tribunal more than is warranted by the circumstances;
>
> v) the appellate court must decide whether the sanction imposed was appropriate and necessary in the public interest or was excessive and disproportionate;
>
> vi) in the latter event, the appellate court should substitute some other penalty or remit the case to the Tribunal for reconsideration.
>
> 103. The courts have accepted that some degree of deference will be accorded to the judgment of the Tribunal but, as was observed by Lord Millett at [34] in *Ghosh* , *"the Board will not defer to the Committee's judgment more than is warranted by the circumstances*". In *Preiss*, at [27], Lord Cooke stated that the appropriate degree of deference will depend on the circumstances of the case. Laws LJ in *Raschid* and *Fatnani*, in accepting that the learning of the Privy Council constituted the essential approach to be applied by the High Court on a section 40 appeal, stated that on such an appeal material errors of fact and law will be corrected and the court will exercise judgment but it is a secondary judgment as to the application of the principles to the facts of the case ([20]). In *Cheatle* Cranston J

> accepted that the degree of deference to be accorded to the Tribunal would depend on the circumstances, one factor being the composition of the Tribunal. He accepted the appellant's submission that he could not be "completely blind" to a composition which comprised three lay members and two medical members."

114. In relation to findings on credibility on a rehearing, this Court has been given guidance that the primary tribunal which heard and saw the witnesses was in the best position to determine that issue. In *Gupta v GMC* [2001] 1 WLR 1691, Lord Rodger in the Privy Council ruled thus:

> "10.. The decisions in Ghosh and Preiss are a reminder of the scope of the jurisdiction of this Board in appeals from professional conduct or practices committees. They do indeed emphasise that the Board's role is truly appellate, but they also draw attention to the obvious fact that the appeals are conducted on the basis of the transcript of the hearing and that, unless exceptionally, witnesses are not recalled. In this respect these appeals are similar to many other appeals in both civil and criminal cases from a judge, jury or other body who has seen and heard the witnesses. In all such cases the appeal court readily acknowledges that the first instance body enjoys an advantage which the appeal court does not have, precisely because that body is in a better position to judge the credibility and reliability of the evidence given by the witnesses. In some appeals that advantage may not be significant since the witnesses' credibility and reliability are not in issue. But in many cases the advantage is very significant and the appeal court recognises that it should accordingly be slow to interfere with the decisions on matters of fact taken by the first instance body. This reluctance to interfere is not due to any lack of jurisdiction to do so. Rather, in exercising its full jurisdiction, the appeal court acknowledges that, if the first instance body has observed the witnesses and weighed their evidence, its decision on such matters is more likely to be correct than any decision of a court which cannot deploy those factors when assessing the position. In considering appeals on matters of fact from the various professional conduct committees, the Board must inevitably
> follow the same general approach. Which means that, where acute issues arise as to the credibility or reliability of the evidence given before such a committee, the Board, duly exercising its appellate function, will tend to be unable properly to differ from the decisions as to fact reached by the committee except in the kinds of situation described by Lord Thankerton in the well known passage in *Thomas v Thomas* [1947] AC 484 , 487–488."

115. The law on staying proceedings was considered in a criminal case: *R v Maxwell* [2011] 1 WLR 1837, by Lord Dyson at para. 13:

> "13. It is well established that the court has the power to stay proceedings in two categories of case, namely (i) where it will be impossible to give the accused a fair trial, and (ii) where it offends the court's sense of justice and propriety to be asked to try the accused in the particular circumstances of the case. In the first category of case, if the court concludes that an accused cannot receive a fair trial, it will stay the proceedings without more. No question of the balancing of competing interests arises. In the second category of case, the court is concerned to protect the integrity of the criminal justice system. Here a
> stay will be granted where the court concludes that in all the circumstances a trial will "offend the court's sense of justice and propriety" (per Lord Lowry in *R v Horseferry Road Magistrates' Court, Ex p Bennett [1994] 1 AC 42* , 74G) or will "undermine public confidence in the criminal justice system and bring it into disrepute" (per Lord Steyn in *R v Latif and Shahzad [1996] 1 WLR 104* , 112F)."

116. In another criminal case the loss of documents or other evidence was considered in general terms by Fulford LJ in *PR v The Crown* [2019] EWCA Crim. 1225, at para 65 thus:

> "65. It is important to have in mind the wide variations in the evidence relied on in support of prosecutions: no two trials are the same, and the type, quantity and quality of the evidence differs greatly between cases. Fairness does not require a minimum number of witnesses to be called. Nor is it necessary for documentary, expert or forensic evidence to be available, against which the credibility and reliability of the prosecution witnesses can be evaluated. Some cases involve consideration of a vast amount of documentation or expert/forensic evidence whilst in others the jury is essentially asked to decide between the oral testimony of two or more witnesses, often simply the complainant and the accused. Furthermore, there is no rule that if material has become unavailable, that of itself means the trial is unfair because, for instance, a relevant avenue of enquiry can no longer be explored with the benefit of the missing documents or records. It follows that there is no presumption that extraneous material must be available to enable the defendant to test the reliability of the oral testimony of one or more of the prosecution's witnesses. In some instances, this opportunity exists; in others it does not. It is to be regretted if relevant records become unavailable, but

> when this happens the effect may be to put the defendant closer to the position of many accused whose trial turns on a decision by the jury as to whether they are sure of the oral evidence of the prosecution witness or witnesses, absent other substantive information by which their testimony can be tested."

117. In *R (Embrahim) v Feltham Magistrates* [2001] EWHC Admin 130, Brooke LJ in the Divisional Court considered abuse of process in criminal proceedings at para. 17-23 thus:

> "**The jurisdiction of a court to stay criminal proceedings for abuse of process**
> 17.. We think it may be helpful to restate the principles underlying this jurisdiction. The Crown is usually responsible for bringing prosecutions and, *prima facie,* it is the duty of a court to try persons who are charged before it with offences which it has power to try. Nonetheless the courts retain an inherent jurisdiction to restrain what they perceive to be an abuse of their process. This power is "of great constitutional importance and should be … preserved". per Lord Salmon in *DPP v Humphrys [1977] AC 1* at p 46C–F. It is the policy of the courts, however, to ensure that criminal proceedings are not subject to unnecessary delays through collateral challenges, and in most cases any alleged unfairness can be cured in the trial process itself. We must therefore stress from the outset that this residual (and discretionary) power of any court to stay criminal proceedings as an abuse of its process is one which ought only to be employed in exceptional circumstances, whatever the reasons submitted for invoking it. See *Attorney-General's Reference (No 1 of 1990) [1992] QB 630* , 643G.
> 18.. The two categories of cases in which the power to stay proceedings for abuse of process may be invoked in this area of the court's jurisdiction are (i) cases where the court concludes that the defendant cannot receive a fair trial, and (ii) cases where it concludes that it would be unfair for the defendant to be tried. We derive these two categories from the judgment of Neill LJ in *R v Beckford (1996) 1 Cr App R 94* at p 101. He observed that in some cases these categories may overlap. There may, of course, be other situations in which a court is entitled to protect its own process from abuse, for example where it considers that
> proceedings brought by a private prosecutor are vexatious (see *R v Belmarsh Magistrates' Court ex p Watts [1999] 2 Cr App R 188*), but we are not here attempting to carry out an exhaustive review of this jurisdiction.

> 19.. We are not at present concerned with the second of these two categories (which we will call "Category 2" cases), in which a court is not prepared to allow a prosecution to proceed because it is not being pursued in good faith, or because the prosecutors have been guilty of such serious misbehaviour that they should not be allowed to benefit from it to the defendant's detriment. In some of these cases it is this court, rather than any lower court, which possesses the requisite jurisdiction (see *ex p Watts* per Buxton LJ at p 195B–D).
> 20.. In these cases the question is not so much whether the defendant can be fairly tried, but rather whether for some reason connected with the prosecutors' conduct it would be unfair to him if the court were to permit them to proceed at all. The court's inquiry is directed more to the prosecutors' behaviour than to the fairness of any eventual trial. Although it may well be possible for the defendant to have a fair trial eventually, the court may be satisfied that it is not fair that he should be put to the trouble and inconvenience of being tried at all.
> 21.. Neill LJ gave three examples of this type of case in his judgment in *Beckford* at p 101D–102A. In all such cases — and one hopes they will be very rare — the court has to make a value judgment about the character of the prosecutor's conduct. If it is satisfied that it would not be fair to allow the proceedings to continue, the court does not then concern itself with the possibility that any ensuing trial might still be a fair one, because it will have formed the prior view that it would not be fair to the defendant if it were to take place at all.
> 22.. This, in our judgment, is the type of situation which Sir Roger Ormrod, sitting in this court with Lord Lane CJ in *R v Derby Crown Court ex p Brooks [1985] 80 Cr App R 164* had in mind when he said at p 168–9 that it may be an abuse of process if:
>
> > "the prosecution have manipulated or misused the process of the court so as to deprive a defendant of a protection provided by the law or to take unfair advantage of a technicality."
>
> 23.. In one of the unreported cases we were shown, it was said that there had to be either an element of bad faith or at the very least some serious fault on the part of the police or the prosecution authorities for this ground of challenge to succeed." (My emboldening).

Analysis: Applying the law to the facts

Stay and abuse of process

118. Applying the general rule from the case law, loss of evidence by the prosecuting authority does not necessarily mean disciplinary proceedings are to be stayed. The more specific rule is that prejudice or unfairness need to be shown by the Registrant before the threshold is crossed. But that is not enough to grant the application. It must be shown that the registrant cannot receive a fair hearing without the evidence. In the appeal before me there is no allegation that the GDC were intentionally shredding

documents. Instead, the Appellant's application was made on the basis of prejudice and unfairness. The loss of the originals deprived the Appellant of the ability to instruct a documents and handwriting authenticity expert. It also meant that the hearing was polluted by a lot of unnecessary sets of copies, some of which were poor and by many witnesses of fact simply on the copy trail not the relevant issues. The cross-examination on copies clearly made giving evidence harder for the Appellant as the transcript shows. However, the PCC considered that so long as due allowance was given for these deficiencies a fair hearing could take place. I am troubled by this because it is not possible to say what a handwriting and document authenticity expert would have said about the Brown Cards at the centre of the issue. So, it was not possible for the Appellant to flesh out the prejudice. The GDC also seriously considered obtaining authenticity expert evidence in relation to the Master Copies, before they were lost. However, on balance I do not consider that the decision to proceed was wrong. It was possible to hold a reasonably fair hearing, despite the absence of the original notes, which were lost in 2018 and so would not once and for all determine the issue of what was sent in 2017, but only if that absence was given the weight it deserved when coming to conclusions on inferences of fact.

The findings of dishonesty

119. There are some striking facts at the heart of this appeal.

Lost original notes

(1) The first is that the original clinical notes for The 11 which the GDC relied upon to make out the charges of dishonesty in this case were lost or shredded by Capita, agents of NHSE, or NHSE long before the hearing. No witness was called or proofed to give evidence to the PCC about how those notes were lost or shredded. So, at the PCC hearing the GDC relied on 5-6 different sets of copies of the patient's clinical notes.

No witness evidence about the key copies of the notes in 2017

(2) The second is that the key set of digital copies of the original notes (Set A) had been made by someone on the instructions of NHSE (probably a Capita employee in Darlington) using a scanning machine in early June 2017, but this set did not contain any scans of the handwritten clinical records for and of The 11. No scanning protocol for their working practices was put in evidence. When dealing with original patients' notes for serious professional misconduct investigations such a protocol might be expected to require the person scanning to list the originals received in an index. That index would have set out the documents received, for instance, the number of computer hard copy pages, the FP17s, the FP25A envelopes, the FP25 cards, the lab dockets, the patient treatment plans, etc, with the number of pages of each. The protocol might be expected to give clear guidance on what had to be copied by way of the front and the back of documents (for instance the FP25A envelopes and FP25 cards (which have full mouth teeth charts on them). To prove the charges laid against the Appellant the GDC compared those copies with a later set of copies made around June 2018 from the

original clinical records supplied by the Claimant's solicitors (Set B). The scanning of these was done by Miss Ward who was employed temporarily by NHSE. No protocol for NHSE scanning was produced. The same comments I have set out above in relation to Capita apply. Her evidence showed how haphazard her scanning was. She scanned some but not all of the originals. Ms Ward's scans did contain the handwritten clinical Brown Cards but she made no index of originals. No witness was proofed or called before the PCC to explain who did the scanning for Set A and how it was done or to explain how he/she could have missed the handwritten notes or to give evidence that there were no original handwritten notes to copy.

No visits to the practice by the GDC

(3) The third is that NHSE started the investigation into The 11 in May 2017 and at the end of their investigation, in August 2019, having specifically visited the practice run by the Appellant in Fareham in Hampshire, they found no evidence of the alleged wrongdoing or fraud and closed their investigation. In contrast, the GDC ran their disciplinary process on the same 11 patients but never visited the practice. The result of this failure to visit the practice was that the GDC were unable to look at the clinical notes for any of the hundreds of other patients treated by the Appellant in 2016 to see if she made similar handwritten clinical records for those either on the same days as The 11 were seen or any other day. So, the GDC charged the Appellant with failing to make any handwritten notes for The 11 without investigating whether she made handwritten notes on any of her other patients.

7 years of NHS dental practice after the alleged events

(4) The fourth is that nearly 7 years passed between the criticised note taking in 2016 and the erasure in 2023. During those years the Appellant ran her practice with 2-3 other dentists successfully, gaining generally, but not wholly, good reviews from the Care Quality Commission and no repetition of the asserted wrongdoing. But the PCC regarded her as requiring both erasure and immediate suspension after the findings they had made.

120. The central issue in this case was whether the Appellant fraudulently wrote the Brown Cards. The PCC did not define it that way but instead expressed the central issue by asking whether the Appellant delivered the Brown Cards to NHSE in June 2017. That did not quite get to the heart of the central issue. On the PCC's issue, there was no first-hand eye-witness evidence from the GDC to rebut the Appellant's evidence that she herself gathered the original notes for The 11 together and delivered them to the Post Office. There was no evidence of how these were sent to Darlington. There was no evidence from Capita's Darlington staff. No copying protocol was put in evidence. So, all the GDC had to rely on was the scans taken which, on the agreed evidence, were incomplete. Many documents, including the Brown Envelopes, had not been copied on both sides. At best all the PCC could conclude from this evidence was that Brown Cards were not scanned. In my judgment there was insufficient evidence to find as a fact that no Brown Cards existed in June 2017.

121. The next foundation for the GDC's case was the form and content of the Brown Cards which were copied by NHSE from the originals in June 2018 by Ms Ward. At the root of the GDC's case was the assertion that a busy dentist would not have had the time in the working day to write the hand-written records the way that the Appellant did. They were in prose not in shorthand format. They had no gaps and no headings. They covered the necessary matters which the ERs did not cover. The GDC used the experience of two dental experts to justify this assertion. I accept that both had considerable experience of looking at dental records made by many different dentists, so they had sufficient experience to give evidence that the Appellant's notes were unusual. But, the experts were not expert in advising on document authenticity or handwriting. What the PCC had to decide was whether they could draw an inference of fraud from the chronology and the expert evidence.

The second Brown Card Fraud findings

122. In their joint report Professor Morganstein and Mr Renshaw agreed that if the Brown Cards were contemporaneous then the charges relating to them would all be unproven save for the points raised by the Professor which did not relate to backdating. Mr Scott and Mr Renshaw met to discuss the other charges not relevant to this appeal.

123. The 2nd fraud allegations arose because in October 2021 the Appellant, through her solicitors, served her witness statement with copies of a few Brown Cards which had not been disclosed in Set B, the copies made in 2018. The GDC asserted that these focussed on analysis of X-rays, which the earlier Brown Cards did not cover and which Professor Morganstein had raised as a criticism in 2021, but DA had not raised as a criticism in 2017.

124. No findings were made by the PCC on when the Appellant faked these notes. In my judgment this was because it was not possible to make findings which implicated the Appellant on the evidence. The original clinical notes were lost or destroyed. The Darlington scanning was unevidenced. Mr Grant's evidence was that he had a full set of copies by June 2019 and any failure to send the additional copy Brown Cards lay with his staff. This evidence was not challenged and was accepted by the GDC. Professor Morganstein's report was not produced until 2021. Mr Grant received no alterations to his copies of the notes after 2019. So how did the "new" Brown Card copies get into his hands by 2021? The PCC never descended into the detail of this but instead stated Mr Grant's evidence did not assist them because it did not deal with the 2017 original notes. That misses the point.

125. The GDC initially premised their case on the 2021 Brown Cards being fakes, produced in 2021, motivated by the desire of the Appellant to answer the Professor's concerns. This motive assertion was abandoned after Mr Grant's last witness statement, because it was unsustainable.

126. The PCC did not provide reasons as to why they accepted Mr Scott's evidence. The PCC did not make findings as to how the 2nd set of allegedly fraudulent documents came into existence and into Mr Grant's hands. In addition, none of the steps necessary in the *Ivey v Genting* [2016] EWCA Civ 1093 test were applied:

> "138. If as I think it is, dishonesty is an essential ingredient of the criminal offence of cheating, then in my view, there is no difficulty in determining the correct test to be applied by the trier of fact in any case
> where it is necessary to give a dishonesty direction. It is that identified in *R v Ghosh* [1982] QB, namely "… Whether according to the ordinary standards of reasonable and honest people what was done was dishonest. If it was not dishonest by those standards, that is the end of the matter and the prosecution fails." If but only if the defendant's conduct was dishonest by those standards, then the jury must go on to consider: "…whether the defendant himself must have realised that what he was doing was [by the standards of or reasonable and honest people] dishonest."

127. Julian Scott retired from dental note making long before he wrote his report. Further, he stopped working for the Dental Board in 2008. In my judgment he is not an expert in handwriting or the authenticity of documents generally or in identifying fraudulently backdated Brown Cards in the circumstances of this case which involved a fully qualified dentist working in her own practice. He did not visit the practice to assess comparable Brown Cards and the GDC did not ask for a range of comparable Brown Cards from 2016 for comparison. So, he had nothing to compare them with. Equally worryingly, he was not given the original Brown Cards because they were lost or shredded by Capita. The colour of the ink was therefore not visible to him nor the age and state of the Envelopes and the Cards.

128. Importantly, Mr Scott withdrew his allegations in relation to backdating the Brown Cards in cross examination, a fact that the PCC wholly ignored in their findings. He accepted in cross-examination that he made no reference to the Darlington scanning issues and changed his evidence on the implication that the Brown Cards were not delivered to NHSE in 2017 in his reports.

129. In addition, Capsticks' agents inappropriately shredded a key set of copies Mr Grant delivered to them. All that was left was the scanned set that Capsticks' agents produced.

130. Professor Morganstein was no better qualified to opine as a handwriting or document authenticity expert on fraudulently backdated notes on the facts of this case than Mr Scott. Certainly, he had expertise in the necessary content of clinical notes but not on whether their form, layout, handwriting, headings, prose and gaps indicate fraud.

These were matters of pure fact for the tribunal and an expert in handwriting and document authenticity.

131. Crucially, Professor Morganstein specifically caveated his opinion on the authenticity point by advising the GDC to get comparable Brown Cards from the practice from before and after for The 11 and for other patients. The GDC ignored that advice. They never went to the practice. They never asked for comparable cards. By failing to do this they deprived the Professor and Mr Scott of the ability to assess whether the Appellant wrote similar long-hand Brown Cards for other patients. I was informed in submissions that the GDC never visit the practice which they are making charges against. This, if correct, is a self-limiting approach to the quality and scope of their investigations, for which they take responsibility.

132. Although the GDC seriously considered the idea of instructing a handwriting expert, as their counsel stated before the PCC, they never did. Perhaps because they only had copies to examine or perhaps because Capsticks' agents had destroyed the Master Copies. So, the hole at the heart of the GDC's prosecution of these charges was exposed.

133. In my judgment, in relation to the alleged second fraud, the findings of dishonest creation of non-contemporaneous clinical Brown Cards in the later sets of copies disclosed in 2021, long after Set A and long after the 2018 copies (Set B), the PCC did not make the necessary findings of fact to justify their conclusion of dishonest back dating. Nor did the evidence support such a finding. For those reasons, in my judgment the PCC's findings on the assertion that the Appellant made a second set of fraudulently backdated cards, after the Professor's report, or in anticipation of it (before seeing it), were wrong for lack of evidence and procedurally unjust for lack of the necessary reasoning.

The first Brown Card fraud findings

134. In relation to the first alleged Brown Card fraud, which can only have taken place between December 2017 and June 2018, the PCC's findings of post treatment creation were premised wholly on circumstantial evidence and their expert evidence about what they usually saw in handwritten notes from other dentists. Once Mr Scott had abandoned his assertions in cross-examination, which I have already ruled lay outside the expert's true fields of expertise, that left only his evidence on what he usually saw in handwritten notes and Professor Morganstein's similar but caveatted opinion.

135. The dishonesty charges relied on legal argument and opinions from the two experts based on their assessment of what they thought a dentist would have written contemporaneously in a busy practice, compared with what the Appellant did write. They advised that the copy Brown Cards were not contemporaneous because they were in long-hand prose, had no gaps, had no headings, were repetitious, covered

relevant matters (which were not on the ER and so were identified as missing by DA) and a few appeared back to front.

136. Without being given the opportunity, which he advised specifically that he needed, to compare the Appellants' garage full of Brown Cards (27,000 by 2022) with the Cards of The 11, the Professor was deprived of the comparable evidence necessary to enable him to make any comment on how the Appellant usually wrote her notes. I have already set out above how the Professor's opinion on authenticity or unusualness was undermined by his own insightful caveat, which the GDC did not fulfil. As a result, much time was spent in the hearing with the Appellant giving evidence about how she wrote Brown Cards from straight after her qualification up to 2016 for every patient. In response, the GDC suggested she did not, with little to back up the suggestion other than an empty envelope from 2014 for one patient. Furthermore, without having bothered to attend the Appellant's practice to see the asserted garage full of notes, the GDC instead focussed on interpreting Ms Tyler's April 2016 practice visit as excluding Brown Cards and the NHSE investigation as overlooking the Brown Card issue. In my judgment because David Akuoko's June 2017 report raised the very issue that there were no Brown Cards and because NHSE specifically investigated that, the fact that they took no further action and found no fraud is evidence which the PCC should have found weighed in the Appellant's favour. In the decision the PCC failed to mention the NHSE terminating their investigation in August 2019 having found no fraud.

137. The Appellant's evidence was not analysed by the PCC. It was criticised as evasive and defensive but no foundation for those findings was provided. I take, as an example, one of the key paperwork justifications relied upon by the GDC's experts: the lack of flow of the records for patients 6 and 7 (the page 1/page 2 point). The Appellant's explanation for that was simple: she did the X-rays, analysed them, then wrote her findings down in detail. Then she wrote "continued", started a new sheet because she had run out of space on Page 1, and summarised the appointment from start to finish on Page 2. The logic of that answer is readily apparent, but the PCC did not engage with it or even mention it.

138. I do not consider that it was safe or right for the PCC to rely on what they called the circumstantial evidence of the style of writing in prose; the comprehensive detailed notes; the lack of spaces or headings or the repetitions. Each dentist no doubt has his or her own style and none is set out as mandatory in the Guidance, so long as the notes cover what is needed. This evidence would only have had some weight if the PCC had been shown, by the GDC, other Brown Cards written by the Appellant in 2016 which were wholly different. But the GDC chose not to do so. So, for example, if on the same days when the Appellant wrote notes for patients 5 and 6 she wrote ER notes for 10 other patients, all of whom had no Brown Cards, or all of whom had Brown Cards with shorthand notes with gaps, headings and acronyms, that would have been some evidence. Nor do I place any weight on the fact that the Appellant's

ER notes were short-hand and her Brown Card notes were long-hand. The style was wholly for her own choice, so long as she covered the matters required. I accept that the PCC were entitled to find that the longhand notes were unusual in the factual experience of the two GDC experts, but that is not enough to prove fraud.

139. Whilst this evidence was not put before the PCC at stage one, I am fortified in my judgment by the evidence that Doctor Pal did investigate the other Brown Cards. There were 27,000 of them. This evidence could have been provided to the PCC at stage 1 by the GDC through a simple visit to the practice or a written request. It undermines the finding the PCC impliedly made questioning whether the Appellant had a longstanding practice of writing handwritten notes. True it is that the Appellant failed to serve such evidence herself at stage one. But the prosecution had the burden of proof.

140. The PCC's reasoning for finding that the Appellant fraudulently back dated non-contemporaneous notes was partly based on format and partly on content. As to format in my judgment there is little or no probative weight to be gained from the GDC's submissions based on their experts' opinions. Gaps, headings, prose and repetition may or may not be incorporated by dentists in handwritten notes. These are matters of style not substance. Some practices are busier than others. By depriving their own experts of the opportunity to compare the 27,000 other Brown Cards with The 11, the GDC hollowed out any force from the opinions on format. They were comparing apples with pears: the Appellant's format to other dentist's formats. Not apples and apples: the Appellant's format for The 11 compared to her format for other patients at a similar time in 2016.

141. As to content, for instance the Brown Cards on prescriptions and all the Cards for The 11, the finding that fraud was indicated because the hand-written notes dealt with the clinical matters not set out in the ER, and hence identified as missing by DA, has a slight undercurrent of the 17th century practice of witch swimming. Witch swimming was the practice of tying up and dunking the accused into a lake to determine whether she sinks or floats. Sinking to the bottom indicated that the accused was innocent, while floating indicated a guilty verdict. In my judgment, without clear evidence of fraud, it is not a fair and balanced approach to say, on the facts of this case, in the absence of the originals, that if the Appellant does not have notes she is guilty of misconduct, but if she does have them, she is guilty of fraud.

142. The PCC highlighted what they regarded as a powerful content finding in relation to the page 1, page 2 evidence. It was found that it was obvious for patients 5 and 6 that the two Brown Cards appeared to be the wrong way round based on the word "continued". It was submitted to the PCC and accepted by them that the second page appears more likely to have been written first because it deals with the general examination and then the decision to take X-rays. The first page sets out the analysis of the X-rays. One would expect the words continued to be on page 2. This was

another style or format issue. However, it must be remembered that all the Cards were separate sheets. They were not bound together. The Appellant gave evidence in cross examination that for patient 5, page 1 was the first written page because it had "continued" on it. She explained that meant nothing more than that it was written straight after the X-rays were taken. She analysed them and wrote page 1. Then the Appellant wrote the general stuff about the appointment on the second page. This was a thoroughly logical explanation. Yet the PCC rejected her evidence and found that the flow of the notes in these cases indicated fraud. In my judgment, for these two patients, the flow of the notes indicated nothing more than the Appellant said it did. This was not a matter of credibility, it was a matter of logic.

143. Another fact overlooked by the PCC was the Set A copies of Brown Envelopes with Brown Cards visible inside them. This was indisputable evidence that Capita in Darlington failed to copy the Brown Cards inside, because they copied no Brown Cards at all. I find these copies to be a signpost supporting the Appellant's case that she wrote the Brown Cards contemporaneously and delivered them in Brown Envelopes to NHSE in 2017 but they were not copied in Darlington. It is consistent, as the GDC accepted, with Darlington not copying the rear of many documents in 2017.

144. Underlying all of the concerns I have over the PCC's findings is the loss or destruction of the original notes by Capita as agents of NHSE and the absence of any witness evidence from Capita about their scanning protocol. There was no witness evidence from the employee who scanned the notes or any manager there. The PCC did not consider the destruction in their decision. They merely noted that the originals were "unavailable". This made the hearing much longer and more difficult. Lots of witnesses gave evidence about when sets of copies were received, returned and copied. The PCC were assessing 5-6 sets of photocopies. Some were poor copies. This deprived the Appellant of the ability to instruct a handwriting and authenticity expert to report on the original Brown Cards. I cannot speculate on what such an expert might have opined. The GDC submitted at the appeal that such an expert would have added very little and there was no serious prejudice, but that was rather undermined by their own desire to instruct an expert to examine the Master Copy notes which were held by the Appellant and delivered on 12.11.2021. It was of course frustrated by those being shredded. In my judgment the destruction of the originals probably prejudiced the Appellant's ability to defend herself against allegations of fraudulent note making through expert evidence on handwriting and authenticity and the PCC did not make any proper allowances for that but simply recorded that the originals were unavailable. I find that the PCC failed adequately to take this properly into account.

Each Ground

145. **Ground 1:** Taking into account that law in relation to stay and abuse of process I do not consider that the PCC were wrong to dismiss these applications for the reasons set

out above in the analysis.

146. **Ground 2:** (That the PCC were wrong to find as a fact that the CQC report in 2013 did not refer to the Brown Cards). There was no sufficient evidence one way or the other to uphold this ground of appeal.

147. **Ground 3:** (That the PCC were wrong to conclude that each (Brown Card) charge was proven). In my judgment this ground was made out in the appeal for the reasons set out in the analysis. There was inadequate evidence to draw the inferences the PCC drew. In addition, the PCCs stated reasoning was flawed and no adequate reasoning was provided to justify the findings.

148. **Grounds 4 and 5:** In my judgment the PCC were wrong to find as a fact that the Appellant fraudulently made back dated Brown Cards and submitted them to the NHSE and GDC. There was inadequate evidence to draw the inferences the PCC drew. Further, I find that the PCCs stated reasoning was flawed and there was no adequate reasoning provided to justify the findings. I will be setting aside the findings on the following charges with all of the sub-charges: 1-11, 16, 17, those parts of 21 relating to Brown Cards and 22-24.

149. **Ground 6:** (Doctor Pal's expert evidence as to the Appellant's record keeping at stage 1.) His evidence was admitted at stage 2. I have read the transcript and there was no application to rely on his evidence at stage 1. His report was dated June 2022 so did not exist when Stage 1 took place. The Appellant did not proceed with this ground at the hearing.

150. **Ground 7: Sanction.** (That the PCC were wrong to erase the Appellant from the register. Suspension would have been the appropriate sanction). Because I have set aside many of the most serious charges, I consider that this case should be remitted to the PCC for reconsideration of the sanction.

151. **Ground 8:** (That the PCC were wrong to impose an immediate suspension order to cover the appeal period). Immediate suspension is only imposed if it is considered necessary. S.30 of the Dentists Act 1984 states as follows:

> ""30.— **Orders for immediate suspension…**
> (1) On giving a direction for erasure or for suspension under section … in respect of any person, the Practice Committee giving the direction, **if satisfied that to do so is necessary for the protection of the public or is otherwise in the public interest, or is in the interests of that person,** may **order** that his registration shall be **suspended forthwith** in accordance with this section.
> (2) ….

> (3) Where, **on the giving of a direction, an order** under subsection (1) … is made in respect of a person, his registration in the register shall, subject to subsection (6), **be suspended** …, **from the time when the order is made until** the time when—
>
> (a) the direction takes effect in accordance with section 29A;
>
> (b) **an appeal** under section 29 against the decision giving the direction **is determined** under section 29(3)(b) or (c); or
>
> (c) following a decision on appeal to **remit** the case to a Practice Committee, the Practice Committee dispose of the case.
>
> (4) …
>
> (5) ...
>
> (6) …
>
> (7) A person in respect of whom an order under subsection (1) or (2) is made may apply to the court for an order terminating any suspension imposed under subsection (1) or any conditional registration imposed under subsection (2), and the decision of the court on any such application shall be final." (My emboldening)

Therefore, the immediate suspension ceases from this determination of the appeal. I consider it is determined by the handing down of this judgment. If I am wrong about the date of the automatic ending under S30, then I specifically terminate the order for immediate suspension on the date of handing down pending the remission to the PCC for sanction because, on the evidence put before the PCC, the Appellant practiced reasonably safely for 7 years between 2016 and the sanctions hearing in 2023.

Conclusions

152. For the reasons set out above I grant the appeal and set aside the findings of the PCC in relation to the Brown Cards. The case shall be remitted to the PCC for determination of sanction.

END