Case No: CO/6654/2015

Neutral Citation Number: [2016] EWHC 1539 (Admin)
IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 30 June 2016

Before:

MR JUSTICE JEREMY BAKER

- -

Between:

The Professional Standards Authority for Health and Social Care	**Appellant**
- and -	
(1) The General Dental Council	
(2) AB	**Respondents**

- -
- -

Miss Fenella Morris QC (instructed by **Browne Jacobsen LLP**) for the **Applicant**
Miss Nicola Greaney (instructed by **Clyde & Co**) for the **First Respondent**
Mr Andrew Hockton (instructed by **BLM London**) for the **Second Respondent**

Hearing date: 11 May 2016

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Judgment

Mr Justice Jeremy Baker:

Introduction

1. AB is a dentist registered with the General Dental Council, ("the GDC"), which has a duty, under section 1(2) of the Dentists Act 1984, ("the 1984 Act"), to promote high standards of professional conduct among dentists within the UK. On 30th October 2015, following a disciplinary hearing at which AB was found guilty of professional misconduct, the GDC's Health Committee, ("the Committee"), imposed a Conditions of Practice Order upon him. The Professional Standards Authority for Health and Social Care, ("the Authority"), which is responsible for promoting the interests of patients by reviewing the work of the various professional health bodies, seeks to appeal against the Committee's determinations pursuant to section 29 of the National Health Service Reform and Health Care Professional Act 2002, ("the 2002 Act").

The Investigation

2. The disciplinary proceedings arose from a visit by NHS England to the dental practice of which AB was a principal, which took place on 22nd November 2013, when it was found that a previous written request, dated 14th February 2013, for evidence of adequate hepatitis (HbSAg) antibody titre for its staff had not been fulfilled. NHS England notified AB of this failure in an interim report dated 6th December 2013. However, it would appear that it was not until 25th April 2014 that blood tests were carried out upon AB, which revealed that he had the hepatitis B virus, and the GDC was informed of the results on 12th June 2014.

3. In the course of the subsequent investigation by the GDC it was discovered that a liver biopsy, carried out upon AB in Denmark in June 1998, revealed that he had changes which were consistent with chronic hepatitis B. Moreover, it was found that not only had these findings not been revealed by AB, either to the GDC or to other health professionals who had been treating him, but that he had not complied with the appropriate guidance relating to hepatitis B infected healthcare workers.

4. As a result of these revelations, on 25th September 2015, the GDC notified AB that he was to be the subject of fitness to practise proceedings.

The Charges

5. The charges brought by the GDC against AB were,

> "That being a registered dentist:
>
> 1. You have an adverse mental or physical health condition as specified in Schedule A.
>
> 2. You were diagnosed with Condition A as specified in Schedule A on or before 26 June 1998.

3. You did not disclose Condition A to the General Dental Council when applying for registration with the General Dental Council on or around 17 April 2000.

4. You did not disclose Condition A to medical practitioners when:

a) You underwent a new patient screen on 27 August 2003; and/or,

b) You were diagnosed with Condition B on 1 December 2012; and/or,

c) You were diagnosed with Condition C on 16 April 2013; and/or,

d) You suffered an episode of Condition D in 2006; and/or,

e) You completed a pre-admission health questionnaire on 8 November 2007, signed by yourself, in which you ticked the 'No' box in response the question: 'question A'

[NB: Conditions B, C and D and question A are specified in Schedule A.]

5. For a period of time between 17 April 2000 and 23 June 2014 you:

a) Failed to make yourself aware of appropriate guidance relating to Condition A infected Healthcare Workers; and/or,

b) Failed to comply with appropriate guidance and/or Standards in that you:

i. Failed to be the subject of regular medical supervision; and/or,

ii. Failed to undergo a course of treatment for Condition A; and/or,

iii. Failed to undergo testing of your viral load at 12 monthly intervals; and/or,

iv. Failed to ensure that all relevant staff including yourself were tested for viral load when you worked as a Principal Dentist; and/or,

v. Continued to undertake Exposure Prone Procedures whilst suffering from Condition A.

6. Your conduct in relation to the following was dishonest:

a) Allegation 3; and/or,

b) Allegation 4a; and/or,

c) Allegation 4b; and/or,

d) Allegation 4c; and/or,

e) Allegation 4d; and/or,

f) Allegation 4e; and/or,

g) Allegation 5a; and/or,

h) Allegation 5b(i); and/or,

i) Allegation 5b(ii); and/or,

j) Allegation 5b(iii); and/or,

k) Allegation 5b(iv); and/or,

l) Allegation 5b(v).

7. Your conduct in relation to the following allegations was deliberately misleading:

a) Allegation 3; and/or,

b) Allegation 4a; and/or,

c) Allegation 4b; and/or,

d) Allegation 4c; and/or,

e) Allegation 4d; and/or,

f) Allegation 4e; and/or,

g) Allegation 5a; and/or,

h) Allegation 5b(i); and/or,

i) Allegation 5b(ii); and/or,

j) Allegation 5b(iii); and/or,

k) Allegation 5b(iv); and/or,

l) Allegation 5b(v).

8. Your conduct in relation to the following allegations was recklessly misleading:

a) Allegation 3; and/or,

b) Allegation 4a; and/or,

c) Allegation 4b; and/or,

d) Allegation 4c; and/or,

e) Allegation 4d; and/or,

f) Allegation 4e; and/or,

g) Allegation 5a; and/or,

h) Allegation 5b(i); and/or,

i) Allegation 5b(ii); and/or,

j) Allegation 5b(iii); and/or,

k) Allegation 5b(iv); and/or,

l) Allegation 5b(v).

AND that by reason of the facts alleged your fitness to practise as a dentist is impaired by reason of your misconduct and/or your adverse physical or mental health."

The various conditions and question referred to were set out in Schedule A, which read as follows,

"Condition A – Hepatitis B

Condition B – fatty liver

Condition C – abnormal liver function

Condition D – jaundice

Question A – 'Have you ever had a liver disease or been jaundiced?'"

6. The case presented on behalf of the GDC was that not only had AB been diagnosed as having the hepatitis B virus in 1998, but that thereafter he had dishonestly or recklessly failed to disclose this either to the GDC upon applying for registration in 2000, or to any of the health professionals who treated him between 2003 and 2013. Moreover, that he had dishonestly or recklessly failed to comply with the relevant Department of Health Guidance, which not only required him to undergo regular medical supervision for the condition, but prohibited him from undertaking "exposure prone procedures."

7. At the commencement of the hearing before the Committee on 26th October 2015, Mr Hockton, appearing on behalf of AB, indicated that charges 1 and 2 were admitted, albeit that AB's case was that, "he was told he had the virus but not infected." He indicated that charge 3 was admitted, albeit AB's case was that, "there was no requirement to disclose." In relation to charge 4 Mr Hockton indicated that AB denied that any lack of disclosure on his part was culpable, but that the facts underlying paragraphs 4a) – 4c) were admitted, (albeit AB's case was that, he had no recollection of having been informed that he had been diagnosed with "fatty liver", and that "abnormal liver function" was a symptom, rather than a condition), paragraph 4d) was denied, but paragraph 4e) was admitted. In relation to charge 5, once again Mr Hockton indicated that AB denied any failure by him was culpable, but that the facts underlying its subparagraphs were admitted, albeit AB's case was that he was unaware that he was suffering from hepatitis B. In these circumstances, it was denied that any of AB's failures amounted to evidence of dishonesty, or were either deliberately or recklessly misleading.

The Evidence

8. In addition to witness statements concerning the history of the investigation, and documentary evidence relating both to AB's medical records and the relevant Department of Health Guidance, the Committee also heard from two medical experts; on behalf of the GDC,

the Consultant Haematologist, Dr Belinda Smith, and, on behalf of AB, the Consultant in Occupational Medicine, Dr Gordon Parker. In addition AB gave evidence, as did his wife.

9. Although AB was born in Iran, he completed his academic and professional dental qualifications in Denmark. Whilst there he and his wife, who also qualified as a dentist, were immunised against hepatitis B. In 1998 AB underwent subsequent blood tests and a liver biopsy, the respective results of which were, as translated into English,

> "Discharge summary: 24 year old ….male is admitted from outpatient to liver biopsy. This is completed without complications and for the present the patient is discharged with continued monitoring as an outpatient.
>
> At present has increased ALAT of around 100 – 150. He is HVS-antigen [positive], but HBE-antigen and anti-HBe [positive]. We have also received results to HBV DNA, which is negative. It is therefore doubtful whether it is a chronic HBV-infection. At present Hepatitis C antibody is also negative so it is therefore not a chronic HCV infection.
>
> For the present the plan is continued outpatient report."
>
> "Diagnosis
>
> [01] Liver parenchyma with changes consistent with chronic hepatitis B, minimally active, with light lobular involvement and Steatosis."

10. As both the experts at the hearing explained, whilst these results meant that AB was HVS-antigen positive, which was consistent with the diagnosis of hepatitis B, he was also, at that time, HBE-antigen negative.

11. In the course of the hearing these findings became of some significance, because although the experts agreed that, over time, an individual's HBE-antigen status may alter from negative to positive, generally speaking, being HBE-antigen negative tends to show that the degree of the individual's hepatitis B infection is likely to be towards the lower end. Moreover, historically, the medical profession had regarded those who were HBE-antigen negative, as being unlikely to infect others with the hepatitis B virus.

12. Indeed this view was reflected in the various iterations of Department of Health Guidance which were issued during the course of the relevant period between 1996 and 2007; the purpose of which was, inter alia, to seek to prevent hepatitis B transmission from health care workers to patients.

13. The original guidance, HSG(93)40, was issued in 1993, and provided that,

> "The new guidance recommends that carriers of the hepatitis B virus who are known to be e-antigen positive must not carry out procedures where there is a risk that injury to themselves will result in their blood contaminating a patient's open tissues. Such procedures are termed 'exposure prone procedures'…."

14. The addendum to HSG(93)40, which was issued in September 1996 was as follows,

> "All health care workers who are hepatitis B surface antigen positive must cease 'exposure prone procedures' until their e-antigen status has been established."

15. However, due to the fact that in the intervening period there had been some reported cases in the medical literature of hepatitis B transmission to patients from e-antigen negative health care workers, as from 23rd June 2000, HSC2000/020 provided that health care workers who were HBE-antigen negative were required to undergo an annual viral load test, and that those with a viral load of 1 000 or more were prohibited from carrying out exposure prone procedures.

16. Thereafter, because of the introduction of new antiviral treatments for hepatitis B, further guidance was provided in 2007, which provided that health care workers with hepatitis B who were undergoing antiviral treatment could continue to carry out exposure prone procedures, provided that they underwent quarterly viral load testing, and their viral load remained below 1 000; albeit that anyone who had tested with a viral load in excess of 100 000 was ineligible to carry out such procedures.

17. In this regard, AB is currently ineligible from carrying out exposure prone procedures, due to the fact that in 2014 his viral load was tested and found to be in excess of 100 000. However, both experts agreed that with the introduction of new drugs, it is possible that this prohibition may be removed.

18. In cross-examination Dr Belinda Smith accepted that the effect of the guidance, historically, was that during the 1990s it had been assumed by the medical profession that there was no risk of hepatitis B infection from health care workers who were HBE-antigen negative, such that there was no prohibition upon them performing any exposure prone procedures. Moreover, that this only changed in 2000, and even then they could continue to perform such procedures provided that their viral load did not exceed 1 000.

19. Dr Gordon Parker stated that in the 1990s individuals who had hepatitis B, but who were HBE-antigen negative, were considered to be low risk carriers, and pointed out that the 1993 guidance expressly stated that there was no restriction upon health care workers in such a position carrying out exposure prone procedures, unless they had been shown to have been associated with the transmission of the virus to a patient.

20. AB's evidence was to the effect that when he had first been diagnosed with hepatitis B in 1998, he had been told that, whereas he was surface antigen positive, he was e-antigen negative, such that he was not infectious, there being no risk of transmission of the virus either to his patients or his family. Moreover that it was for him to decide whether he required to disclose his condition to anyone. He stated that as a result of being provided with this information, which he accepted, he thereafter believed that he was not infectious to anyone, and did not believe that it was necessary to disclose his condition to anyone. Moreover, that this state of mind continued up until the more recent blood tests in 2014, when it was established that he was HBE-antigen positive. He accepted that, in hindsight, he had been naïve, but that he hadn't appreciated that the viral load could fluctuate over time.

21. AB's wife gave supporting evidence, and Dr Parker stated that, because of the historical understanding of the lack of infectivity by those who were HBE-antigen negative, AB's account of what he had been told by the Danish doctors in 1998 was plausible.

22. It was pointed out to AB in cross-examination that whilst in Denmark, during the period between 1998 and 2000, he had undergone a series of further blood tests relating to the condition of his liver, which established that there was significant fluctuation in his ALT levels, a common liver enzyme. He said that he did not recall having these tests, and was unaware as to the significance, if any, of their results, which Dr Smith said are likely to have been caused by the fact that he had hepatitis B.

23. The documentary evidence before the Committee included an extract from the GDC's November 1997 Maintaining Standards guidance which provided,

> "4.2 A dentist who is aware of being infected with a blood borne virus or any other transmissible disease or infection which might jeopardise the well-being of patients and takes no action is behaving unethically. The Council would take the same view if a dentist took no action when having reason to believe that such infection may be present.
>
> It is the responsibility of a dentist in either situation to obtain medical advice which may result in appropriate testing and, if a dentist is found to be infected regular medical supervision. The medical advice may include the necessity to cease the practice of dentistry altogether, to exclude exposure prone procedures or to modify practice in some other way.
>
> Failure to obtain such advice or to act upon it would almost certainly lead to a charge of serious professional misconduct."

24. In relation to AB's failure to inform the GDC that he had hepatitis B when applying for registration on 17th April 2000, AB stated that he was unaware that there had been any such requirement, and both experts agreed that they could find no documentary requirement for such disclosure.

25. In relation to the new patient screen on 27th August 2003, the GP had recorded that AB had no significant past medical history. Dr Smith stated that, in her opinion, even if AB had been informed that he was not infectious, the fact that he had been diagnosed with hepatitis B in 1998 meant that he had a past medical history. However, AB stated that because he had been informed that he wasn't infectious in 1998, he had not considered it necessary to mention his diagnosis with hepatitis B to his GP in 2003. Moreover, as he did not have any sclerosis, he didn't consider that he had any problem with his liver.

26. In relation to the diagnosis of jaundice in 2006, mention was made of this in a letter from AB's GP to his treating diabetes Consultant, in a letter dated 15th November 2011. AB said that he had never been informed of the diagnosis and didn't believe that he had ever had the condition.

27. In relation to the completion of the pre-admission health questionnaire on 8th November 2007, which AB completed prior to undergoing surgery relating to his hearing, AB had ticked the "No" box in response to the question, "Have you ever had a liver disease or been

jaundiced?" Both experts agreed that hepatitis B is a liver disease; a matter which was admitted by AB. However, AB said that in his own mind he did not consider that he had a liver disease, as the biopsy carried out in 1998 confirmed that he did not have any sclerosis, and that although the blood tests confirmed he had the virus, they also confirmed that he was not a carrier, such that he didn't consider that he had had hepatitis B.

28. In relation to the diagnosis of fatty liver on 1st December 2012, AB said that he had been unaware that he had been diagnosed with this condition, as neither the ultrasonographer nor his GP had discussed this with him.

29. In relation to the tests which revealed that AB had abnormal liver function on 16th April 2013, Dr Smith said that there was again evidence of significantly abnormal ALT levels, which would not normally be accounted for by the fact that AB was also suffering from diabetes. However, AB said that the letter from the consultant, in which these results were recorded, had been provided to his GP, rather than himself, and he had been unaware of them.

30. Dr Smith had reviewed AB's medical notes from which it was clear that there had been a significant number of occasions upon which health care professionals had indicated some reluctance and failure by AB to comply with recommended treatment for his various disorders, including the monitoring of his diabetes, and treatment for blood pressure. However, she accepted that in so far as his post 2014 treatment for hepatitis B is concerned, AB appears to have complied with his medical monitoring and treatment; a matter which was confirmed by his treating doctor, Dr Timms. AB denied that he had failed to comply with any medical treatments for his other conditions, save that he had been reluctant to take blood pressure and cholesterol medications, as he did not consider that these were required and was concerned as to their side effects.

31. AB stated that since coming to the UK in 2000 he has practised as a dentist at a number of locations, the last being at a dental practice in West Sussex which, until 2014, was owned by himself and his wife, and of which he was one of the principals. He said that he had not been aware of any guidance concerning health care workers suffering from hepatitis B. However, AB accepted, in cross-examination, that, as a principal dentist in charge of his practice, he should have made himself aware of such guidance, and had failed to do so.

32. AB said that he was unaware that his dental practice had received the letter dated 14th February 2013 addressed to him, concerning the request for evidence of hepatitis B (HbSAg) antibody titre in respect of their staff. He said that his wife dealt with it, and that, in any event, as it involved his staff, it hadn't applied to him. In cross-examination it was pointed out to AB that there was a request for documents concerning his own hepatitis B status, to which he responded that this was not something which he had dealt with, rather it was his wife's responsibility. AB agreed that, during the visit by NHS England, the request for adequate antibody titre for the staff had been repeated, and that his wife had arranged for this to be provided in relation to the other members of staff, albeit not himself until after he had attended occupational health for blood tests on 25th April 2014, which were subsequently reported in May 2014, and provided to the GDC in June 2014.

33. At the conclusion of the evidence the Committee received legal advice as to the definitions of both dishonesty and recklessness, neither of which are criticised. The Committee was also provided with a direction in relation to the relevance of AB's good character, and the burden and standard of proof.

The Decisions of the Committee

34. On 29th October 2015 the Committee announced its findings of facts. In relation to those charges relating to AB's lack of disclosure, in addition to finding proved those charges which had been admitted by AB, the Committee also found proved, under paragraph d) of charge 4, that he had suffered from jaundice, albeit the Committee accepted that, as it may have been a mild episode and may have not have produced noticeable symptoms, AB may not have been aware of it.

35. More significant however were the Committee's findings in relation to the issue of AB's culpability regarding the non-disclosure of hepatitis B, in that, with the exception of charge 4e), the Committee did not find proved that AB's non-disclosure was either dishonest, deliberately misleading or recklessly misleading.

36. In relation to the non-disclosure to the GDC in 2000, the reasons given by the Committee for not finding dishonesty, were that there was no evidence that the GDC required disclosure of hepatitis B, whilst in relation to the issue of recklessness, the Committee stated that it accepted AB's evidence as to his understanding of the nature of his condition, and that the relevant Department of Health Guidance in 2000 did not classify him as presenting a risk.

37. In relation to the non-disclosure to his GP in 2003, the reasons given by the Committee for not finding dishonesty, were that there was no evidence of the questions which AB had been asked, whilst in relation to the issue of recklessness, the Committee stated that bearing in mind who may have been misled by the non-disclosure, it wasn't satisfied that recklessness had been established.

38. In relation to the non-disclosure to other medical personnel when he had been diagnosed as suffering from other conditions or symptoms, the reasons given by the Committee for not finding dishonesty, were that there was no evidence that AB had been informed of any of these diagnoses, whilst in relation to the issue of recklessness, the Committee repeated that, bearing in mind who may have been misled by the non-disclosure, it wasn't satisfied that recklessness had been satisfied.

39. By way of contrast, in relation to the fact that in 2007 AB had indicated that he had never had liver disease or jaundice, the Committee determined that he had been dishonest when he provided this indication. The reasons given by the Committee for this finding were that,

> "You ticked the box 'No' to the question 'have you ever suffered from liver disease or jaundice?' (Question A) when you knew that you were or had been affected by Condition A. It was clear from other entries that you had carefully completed the form. By the standards of other practitioners that would be regarded as dishonest; and you must have known it would be regarded as dishonest."

40. In relation to those charges concerning AB's alleged failure to make himself aware of the relevant Department of Health Guidance and GDC Guidance, and/or failure to comply with it, the Committee found those charges proved. The Committee stated that,

> "…. 'Failed to' means there was an obligation on your part to do something. The GDC's standards create obligations for all registrants to discover and to maintain an up-to-date understanding of the various requirements made of them, both by the GDC itself and by other relevant organisations. These would include guidance relating to the protection of patients and staff against blood borne diseases, and those relating to staff suffering from blood borne diseases. The committee is satisfied that there was therefore a duty on you to make yourself aware of the appropriate guidance and that you failed to comply with that duty."

Moreover, that

> "There is a general obligation on you to comply with the requirements of the GDC and other relevant organisations. The committee accepts that you were not aware that you should undergo these interventions; however, it is of the opinion that this does not absolve you from that obligation."

41. Although the Committee did not find that any of these failures amounted to sufficient evidence of dishonesty by AB, it did consider that some of the failures provided evidence of recklessness by him. In regard to the issue of dishonesty, the Committee stated that whilst these failures were,

> "undoubtedly wrong",

they did not meet the test for dishonesty. However, in relation to the issue of recklessness relating to AB's failure to make himself aware of the relevant guidance, the Committee stated that,

> "During this 14 year period, you cannot have failed to have become aware of the existence of guidance relating to the risks of blood borne diseases and of the requirements for testing and immunisation of healthcare workers. You did not acquaint yourself with that guidance. Patients would have expected you to be aware of all relevant guidance and accordingly they would have been misled. All health professionals must know the risks attached to failing to be aware of relevant guidance."

Moreover, although the Committee didn't find that AB's failure to comply with the relevant guidance was in general reckless because it couldn't find that any party would have been misled, it did find that the continuation of his undertaking of exposure prone procedures whilst suffering from hepatitis B, was reckless. The reasons given by the Committee for this were that,

> "Had you acquainted yourself with and then complied with the appropriate guidance you would have known that you were no longer permitted to undertake exposure prone procedures. The committee has already found that you were reckless in not knowing of and complying with the guidance, and it considers that patients would have been misled in this regard."

42. On 30th October 2015 the Committee, having heard further submissions and been provided with a report from AB's treating Consultant confirming his compliance with medical treatment for hepatitis B, announced its decisions concerning health, misconduct, impairment and sanction.

43. In relation to AB's health, the Committee stated that because the seriousness of his infection with hepatitis B resulted in him being precluded from carrying out exposure prone procedures, it was satisfied that his fitness to practise was impaired on grounds of his health.

44. In relation to misconduct, the Committee had regard to the GDC's "Standards for Dental Professionals (May 2005)", and in particular the imperative of protecting patients' health. The Committee stated that it,

> "…. did not find that all the allegations found proved were serious. Unusually, the Committee did not consider that the single finding of dishonesty was serious. It was a single incident, and did not involve loss to anyone or gain to yourself and was not in the context of dentistry. The Committee found that your misconduct in relation to not making yourself aware of appropriate guidance and/or standards over a period of 13 years was serious and, although there is no evidence of actual patient harm, this failure exposed patients to the risk of serious harm. The Committee has found that your actions in this respect were reckless. However, the Committee accepted that you did not know throughout this period that you were placing patients at risk, and it noted that those patients included your own family members. In all the circumstances, the Committee is satisfied that the serious findings amounted to misconduct."

45. The Committee proceeded to consider the issue of impairment of fitness to practise, and bore in mind its duty to act in the public interest. It found that,

> "…your conduct is easily remediable. However it has not been provided with any evidence that you have taken steps to

> remedy your failings, other than a statement from your counsel that you have now read the relevant guidance. The Committee has not been satisfied that you have full insight into the potential seriousness of your failings nor that you take sufficient responsibility for them. The Committee is therefore not satisfied that you would not fall into the same errors in the future. It therefore finds that your fitness to practice is currently impaired by reason of your misconduct."

46. In relation to the Committee's determination as to the appropriate sanction to be imposed upon AB, it stated that it had borne in mind,

> "….that the purpose of a sanction is not to be punitive, although it may have that effect, but is to protect patients and the wider public interest. It has taken into account the "Guidance for the Professional Conduct Committee (Oct 2015)". It considered the range of sanctions available to it, starting with the least serious. The Committee applied the principle of proportionality, balancing the public interest with your own interests. The Committee considered that taking no action would not reflect the serious nature of your failings and would not protect the public. It reached the same conclusion in respect of a reprimand. The Committee considered whether to impose conditions on your registration and determined that an appropriately constructed set of conditions could serve to protect the public and meet the public interest in upholding high standards in the profession. Before deciding upon conditions the Committee considered suspending your registration, but decided that this would be purely punitive and would serve no useful purpose."

Thereafter the Committee set out the conditions it imposed, which included conditions designed to provide a supervised course of education to improve his understanding of GDC guidance, the continuation of his treatment for hepatitis B with disclosure of the state of his condition to the GDC, together with restrictions upon his practice of dentistry, including a prohibition upon undertaking exposure prone procedures. The Committee determined that these conditions should apply to his registration for a period of 18 months, with a review to be held before the expiry of that period.

The Authority's Grounds of Appeal

47. The Authority's original grounds of appeal were fivefold. It submitted that:

> 1. The Committee's decision was unlawful and irrational in that, having decided that AB had been dishonest in 2007 concerning his answer to the pre-admission questionnaire, their decision that this did not amount to professional misconduct was unduly lenient. In this regard the Authority submitted that there was either no evidence that the dishonesty was not related to AB's practice of dentistry, or, that the Committee took an inconsistent approach to

it, and, even if it was not related to his practise of dentistry, this may still amount to evidence of professional misconduct.

2. The Committee took an inconsistent approach to AB's evidence, in that having found that he had been dishonest in 2007, a matter which he denied in evidence, and, bearing in mind the evidence that AB had undergone post-diagnosis blood tests in Denmark, the Committee was not entitled to find that he was a credible witness in relation to the issue of his belief that he was not infectious.
3. The Committee failed to have regard to relevant factors, including the GDC's Indicative Sanctions Guidance, which suggests that dishonesty is so damaging to a registrant's fitness to practice and to public confidence in the profession, that erasure should generally be considered the appropriate sanction. Moreover that the Committee's decisions failed to have regard to the fact that AB's hepatitis B status only came to light as a result of an NHS England inspection, and also failed to take into account the potential psychological harm to patients who learnt that they had been treated by an individual with hepatitis B.
4. That bearing in mind its finding that AB had been dishonest, the maintenance of his lack of admission to dishonesty, the level of risk to patients borne of AB's reckless attitude to making himself aware of relevant guidance and his undertaking exposure prone procedures over a significant period of time, the Committee's decision to impose Conditions of Practice, failed to sufficiently protect the public and/or maintain public confidence in the profession.
5. The Committee failed to provide adequate reasons for its decisions, in particular its departure from the GDC's Indicative Sanctions Guidance.

48. In its original grounds the Authority had submitted that, absent exceptional circumstances, dishonesty should lead to erasure. However, in the light of Leggatt J's observations in *Hassan v General Optical Council* [2013] EWCA 1887 (Admin), this submission was withdrawn.

49. By the conclusion of the hearing of the appeal the Authority had refined some of its submissions. In relation to ground 1, it was submitted that there had been little exploration, and therefore evidence, of the circumstances in which AB provided the false answer in the pre-admission health questionnaire in 2007, such that the Committee was not entitled to determine that it was not of such seriousness as to amount to misconduct. Moreover, that the Committee was in error in treating dishonesty which is unrelated to the profession as, automatically, not amounting to misconduct. In relation to ground 2, it was submitted that, in the absence of sufficient reasons, which were not provided by the Committee, it was aberrant for it to find dishonesty established in only one of a series of similar incidents of non-disclosure. In relation to ground 3, it was submitted that the Committee failed to provide any or adequate reasons why it departed from the GDC's Indicative Sanctions Guidance, where the circumstances of the instant case indicated suspension, rather than the imposition of Conditions of Practice. Moreover, the Committee failed to have any regard to the fact that AB had not taken any action after the initial report by NHS England in 2013. In relation to ground 4, it was submitted that the Committee had overlooked or underestimated the significance of the lack of insight exhibited by AB regarding the impact of his condition on his professional work.

The GDC's Response

50. The GDC in its original grounds of response was generally supportive of the Authority's appeal, in that, bearing in mind the circumstances of the case, the imposition of Conditions of Practice was an unduly lenient sanction. It submitted that the Committee's approach to the issue of dishonesty was flawed, in that without an exploration of the reasons why AB gave a false answer in the 2007 pre-admission health questionnaire, neither its gravity nor its potential link to his professional work could be properly assessed. Moreover, that bearing in mind the finding of recklessness in regard to AB's failure to acquaint himself with the relevant guidance, which denoted an awareness of the risk of infecting others, it was inconsistent to find that he was a generally credible witness, and, in particular, was unaware that he was infectious. It was submitted that the sanction imposed, bearing in mind AB's lack of insight regarding the impact of his condition on his professional work, failed to have sufficient regard either to the safety of the public, and/or the imperative to maintain public confidence in the profession. Overall there was a lack of sufficient reasons for the decisions which the Committee had reached.

51. At the conclusion of the appeal hearing, the GDC maintained its submissions, albeit its primary position was that, bearing in mind the level of patient risk arising from the reckless nature of AB's failure either to acquaint himself with the relevant guidance or to cease exposure prone procedures, the sanction imposed was unduly lenient. In reaching this view the GDC took into account the lack of insight shown by AB, his lack of apology and the lack of evidence of remedial steps taken by him, together with the need to protect the public and maintain public confidence in the profession.

AB's response

52. In the grounds of response it was submitted on behalf of AB that the Committee was entitled to and made clear findings that AB was a credible witness, and that he believed that he was non-infectious. Moreover, the Committee, in the light of this finding, having rejected all of the allegations of dishonesty bar one, which was of a minor nature and not related to his professional practice, was entitled to maintain its finding upon credibility, and in these circumstances there was no irrationality. Moreover, the Committee had provided clear reasons for its conclusions.

53. It was submitted that the Committee had had due regard to the GDC's Indicative Sanctions Guidance, and that its decision was in accordance with it. The Committee was entitled to take into account that its finding of dishonesty involved a single event and was not designed to conceal that AB was infectious, as this was a matter of which the Committee had found he was unaware. Moreover, there was no evidence of psychological harm caused to any of AB's patients, and no specific allegation in relating to any delay in reporting his condition to the GDC. The finding of recklessness was of limited scope. In any event, when considering continuing risk to the public, AB is currently ineligible from carrying out exposure prone procedures, which is the main part of any dentist's work. Moreover, he is currently complying both with his treatment for his condition, and the Conditions of Practice. Overall the Committee was entitled to determine that Conditions of Practice was the appropriate sanction in this case and provided sufficient reasons for reaching this view.

Legal principles

54. In relation to the jurisdiction of the Committee, Section 27(2) of the Dentists Act 1984 Act, as amended, provides that,

> "A person's fitness to practise as a dentist shall be regarded as "impaired" for the purposes of this Act by reason only of –
>
> Misconduct;
>
> ……."

Section 27B(1) of the 1984 Act, as amended, provides that,

> "Subject to subsection (4), a Practice Committee must investigate an allegation or allegations against a person referred to them by the Investigating Committee under section 27A and determine whether that person's fitness to practise as a dentist is impaired."

Section 27B(6) of the 1984 Act, as amended, provides that,

> "If a Practice Committee determine that a person's fitness to practice as a dentist is impaired, they may, if they consider it appropriate, direct –
>
> (a) (subject to subsection (7)) that the person's name shall be erased from the register;
>
> (b) that his registration in the register shall be suspended during such period not exceeding twelve months as may be specified in the direction;
>
> (c) that his registration in the register shall be conditional on his compliance, during such period not exceeding three years as may be specified in the direction, with such conditions specified in the direction as the Practise Committee think fit to impose for the protection of the public or in his interests; or
>
> (d) that he shall be reprimanded in connection with any conduct or action of his which was the subject of the allegation."

55. The current GDC Guidance for the Professional Conduct Committee, including Indicative Sanctions Guidance, provides as follows,

> "1.1 This guidance has been developed by the General Dental Council (GDC) for use by Fitness to practise panels in cases which have been referred to them for a hearing. The aim is to provide guidance for panels on exercising their powers in relation to fitness to practise matters and on considering what sanction to impose following a finding that the registrant's fitness to practise is impaired. This guidance outlines the decision-making process and the factors which should be considered when deciding upon sanction.

…….

5.7 In deciding what sanctions to impose, the PCC must apply the principle of proportionality by weighing the interests of the public with those of the practitioner. The panel should commence their consideration of sanction with the least restrictive. If the least restrictive sanction is, in the panel's judgment, insufficient, it should move to consider the next sanction, and so on until it reaches the appropriate sanction.

…..

5.8 Any sanction, and the period for which it is imposed, must be necessary to protect the public interest (see section 7).

……

1.11 The PCC exists to protect the public interest, which includes:

The protection to patients, colleagues and the wider public from the risk of harm;

Maintain public confidence in the dental profession;

Protecting the reputation of the dental professions; and

Declaring and upholding appropriate standards of conduct and competence among dental professionals.

…….

5.12 Whilst there may be a public interest in facilitating the dentist's professional return to safe practice, and the PCC should always recognise this and promote this where appropriate when making their decisions, it should always bear in mind that its main concerns are the protection of patients and the maintenance of public confidence in the profession.

5.13 The purpose of imposing a sanction is not to punish the registrant but to protect patients and the wider public interest described above. However, the sanction imposed may be punitive in effect.

……"

5.17 Mitigation may include:

Evidence of the circumstances leading up to the incident in question;
Evidence of good conduct following the incident in question, particularly any remedial action;
Evidence of previous good character;
Evidence of remorse shown/insight/apology given;
Evidence of steps taken to avoid a repetition;
No actual harm or risk of harm to a patient or another;
No financial gain on the part of the registrant;
The fact that the incident was a single, isolated event;
Time elapsed since the incident.

5.18 Similarly, the PCC will need to consider whether there are any aggravating factors to the case. Aggravating factors may include:

Actual harm or risk of harm to a patient or another;
Dishonesty;
Premeditated misconduct;
Financial gain by the registrant;
Breach of trust;
The involvement of a vulnerable patient or other vulnerable individual;
Misconduct sustained or repeated over a period of time;
Blatant or wilful disregard of the role of the GDC and the systems regulating the profession;
Attempts to cover up wrongdoing;
Previous warnings, convictions or other adverse findings;
Lack of insight (see below).

……

5.22 In the context of a hearing, insight on the part of the dental professional is an important factor. Insight might be defined as an expectation that they will be able to:

Review their own performance or conduct;
Recognised that they should have behaved differently in the circumstances considered; and
Identify and put in place measures that will prevent a recurrence of such circumstances.

5.23 When considering whether or not a dental professional has insight, it will be necessary for a panel to consider whether or not the dental professional has demonstrated insight consistently throughout the hearing – for example in the giving of their evidence or in the accuracy of their records. The panel should also consider whether the dental professional has displayed insight prior to the hearing

– for example by putting in measures in place to prevent a repetition of the circumstances which led to the hearing (if appropriate).

……

6.1 All decisions given by the PCC should be written using clear language and vocabulary so that the dental professional, the other parties to the hearing, members of the public and any appellate court will understand the decision and the reasons for it….

……..

7.17 Conditions may be appropriate when all or most of the following factors are present (this list is not exhaustive):

There are discrete aspects of the registrant's practice that are problematic;
Any deficiencies are not so significant that patients will be put at risk directly or indirectly as a result of continued – albeit restricted – registration;
The registrant has shown evidence of insight and willingness to respond positively to conditions;
It is possible to formulate conditions that will protect the public during the period they are in force;
It is possible to formulate conditions which satisfy the requirements set out at 7.18

……

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

There is evidence of repetition of the behaviour;
The registrant has not shown insight and poses a significant risk of repeating the behaviour;
Patients' interests would be insufficiently protected by a lesser sanction;
Public confidence in the profession would be insufficiently protected by a lesser sanction;
There is no evidence of harmful or deep-seated personality or professional attitudinal problems.

……

7.33 Erasure is likely to be appropriate when the behaviour is fundamentally incompatible with being a dental professional and involves any of the following:

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

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

……..

Appendix A

……

This appendix sets out the factors which a panel should take into account when considering fitness to practise allegations and when deciding upon sanction…….

52 Patients, employers, colleagues and the public should be able to rely upon a dental professional's integrity. Dishonesty, particularly when associated with professional practice, is highly damaging to the dental professional's fitness to practise and to public confidence in the profession. Examples of dishonesty in professional practice include, but are not limited to:

……

53 Dishonesty is serious even when it does not involve direct harm to patients (for example defrauding the NHS or providing misleading information) because it can undermine public confidence in the profession. The Privy Council has emphasised that "*Health Authorities must be able to place complete reliance on the integrity of practitioners and the Committee is entitled to regard conduct which undermines that confidence as calculated to reflect on the standards and reputation of the profession as a whole*".

54 The High Court has also held that, when considering impairment, a panel is entitled to take into account the way in which a registrant has conducted his or her defence and any dishonesty therein.

……..."

56. In relation to the powers of the Authority and the consequential jurisdiction of the court, section 29(1) of the National Health Service Reform and Health Care Professional Act 2002 Act provides that,

"This section applies to –

……..

(e) a determination by the Professional Conduct Committee of the General Dental Council under section 27 of the Dentists Act

1984 (c.24) (erasure or suspension of registration for crime or misconduct),

……"

Subsection (3) provides that,

"The things to which this section applies are referred to below as "relevant decisions".

Subsection (4) provides that,

"If the Council considers that –

(a) a relevant decision falling within subsection (1) has been unduly lenient, whether as to any finding of professional misconduct or fitness to practice on the part of the practitioner concerned (or lack of such a finding), or as to any penalty imposed, or both, or

(b) ……..

and that it would be desirable for the protection of members of the public for the Council to take action under this section, the Council may refer the case to the relevant court."

Subsection (7) provides that,

"If the Council does so refer a case –

(a) The case is to be treated by the court to which it has been referred as an appeal by the Council against the relevant decision (even though the Council was not a party to the proceedings resulting in the relevant decision), and

(b) ……"

Finally subsection (8) provides that,

"The court may –

(a) dismiss the appeal,

(b) allow the appeal and quash the relevant decision,

(c) substitute for the relevant decision any other decision which could have been made by the committee or other person concerned, or

> (d) remit the case to the committee or other person concerned to dispose of the case in accordance with the directions of the court,
>
> and may make such order as to costs (or, in Scotland, expenses) as it thinks fit."

57. The extent of the duty upon a disciplinary committee to provide reasons for its decisions, was considered by Lord Roger of Earlsferry, in *Gupta v General Medical Council* [2002] 1WLR 1691 at 1699, who stated that the Privy Council was satisfied that,

> "[13]……..there is no general duty to on the committee to give reasons for its decisions on matters of fact and, more particularly, that there is no duty to do so in a case like the present where, as the appellant's solicitor was at pains to emphasise to the committee, its decision depended essentially on resolving questions of the credibility of the witnesses led before it. The committee's decision on the individual heads of the charge, when considered in the light of the transcript of the evidence, reveals sufficiently clearly the reasons for its decision. Nothing more was required in this case….."

Albeit, he went on to state that,

> "[14]……..the committee can always give reasons, if it considers it appropriate to do so in a particular case. Their Lordships would go further: there may indeed be cases where the principle of fairness may require the committee to give reasons for their decision even on matters of fact……."

58. This duty was considered further by the Court of Appeal in *Phipps v GMC* [2006] EWCA Civ 397, where Wall LJ said at that,

> "[77] ……there is, in my judgment, considerable force in Mr. Pennock's submission that there is no reason why doctors sitting in judgment on their peers should be exempt from the general rules which apply to all other tribunals. Plainly, the need to give reasons for findings of fact will vary from case to case, and will depend on the subject matter under consideration. There may be cases where such reasons are unnecessary because they emerge clearly from the court's findings; there may be cases where the expression of such reasons is essential. The test in every case, it seems to me, is the same, and finds its expression in many places in the books, most succinctly in paragraph 16 of this court's judgment in English v Emery Reimbold & Strick [2002] 1 WLR 2409 at 2417, to which I have already referred, namely:

> "[16] We would put the matter at its simplest by saying that justice will not be done if it is not apparent to the parties why one has won and the other has lost."

This approach finding an echo in the judgment of Leveson LJ in *Southall v GMC* [2010] EWCA Civ 407, at paragraph 55.

59. The task of the High Court when considering appeals under section 29 of the 2002 Act was considered by the Court of Appeal in *Council for the Regulation of Health Care Professionals v GMC and Ruscillo* [2004] EWCA Civ 1356, where Lord Phillips of Worth Maltravers MR stated,

> "69. We have concluded that the concerns of the Council which can entitle it to refer a case to the High Court are (i) that the decision in relation to the imposition of a penalty is unduly lenient and (ii) that it is desirable in the interests of the public to take action under the section. Where a reference is made, what is the task of the Court when considering the reference? The Act does not deal with this, save for the important provision that the reference is to be treated as an appeal by the Council *against the relevant decision.* Thus the Court is concerned with the decision as to the penalty.
>
> 70. If the Court decides that the decision as to the penalty was correct it must dismiss the appeal, even if it concludes that some of the findings that led to the imposition of the penalty were inadequate. No doubt any comments made by the Court about those findings will receive due consideration by the disciplinary tribunal if, at a later stage, it has occasion to review the standing of the practitioner.
>
> 71. If the Court decides that the decision as to penalty was 'wrong', it must allow the appeal and quash the relevant decision, in accordance with CPR 52.11(3)(a) and section 29(8)(b) of the Act. It can then substitute its own decision under section 29(8)(c) or remit the case under section 29(8)(d).
>
> 72. It may be that the Court will find that there has been a serious procedural or other irregularity in the proceedings before the disciplinary tribunal. In those circumstances it may be unable to decide whether the decision as to penalty was appropriate or not. In such circumstances the Court can allow the appeal and remit the case to the disciplinary tribunal with directions as to how to proceed, pursuant to CPR 52.11(3)(b) and section 29(8)(d) of the Act.
>
> 73. What are the criteria to be applied by the Court when deciding whether a relevant decision was 'wrong'? The task of the disciplinary tribunal is to consider whether the relevant facts demonstrate that the practitioner has been guilty of the defined professional misconduct that gives rise to the right or duty to impose a penalty and, where they do, to impose the penalty that is appropriate, having regard to the safety of the public and the reputation of the profession. The role of the Court when a case is referred is to consider whether the disciplinary tribunal has properly performed that task so as to reach a correct decision as to the imposition of a penalty. Is that any different from the role of the Council in considering whether a relevant decision has been 'unduly lenient'? We do not consider that it is. The test of undue leniency in this context must, we think,

involve considering whether, having regard to the material facts, the decision reached has due regard for the safety of the public and the reputation of the profession.

74. Collins J in *Truscott* held that the approach to 'undue leniency' should be that applied in *Lomas v Parle* [2003] EWCA Civ 1804. That was a case concerned with the power of the court to increase, on appeal, a sentence of imprisonment for contempt of Court. In that case Thorpe LJ, giving the judgment of the Court of Appeal held that it was appropriate to adopt the same approach as that applied by the Criminal Division of this Court to the reference of a sentence by the Attorney General under the Criminal Justice Act 1988. As to that approach, Thorpe LJ cited this passage from the judgment of Judge LJ in *Neil v Ryan* [1998] 2 FLR 1068, 1069:

> "… but a sentence should not be increased under that Act unless the court is satisfied that it is not merely lenient, but 'unduly' lenient. And, what is more, if the court reaches that conclusion, when deciding the appropriate level of sentence the court must also reflect the element of what is sometimes described as double jeopardy."

75. The reference to having regard to double jeopardy when considering whether a sentence is unduly lenient is not, as we have already indicated, really apposite where the primary concern is for the protection of the public. More pertinent is this passage in the judgment of the Lord Chief Justice in *Attorney General's Reference (No 4 of 1989)*(1990) 90 Cr App 266:

> "The first thing to be observed is that it is implicit in the section that this Court may only increase sentences which it concludes were unduly lenient. It cannot, we are confident, have been the intention of Parliament to subject defendants to the risk of having their sentences increased – with all the anxiety that this naturally gives rise to – merely because in the opinion of this Court the sentence was less than this Court would have imposed. A sentence is unduly lenient, we would hold, where it falls outside the range of sentences which the judge, applying his mind to all the relevant factors, could reasonably consider appropriate. In that connection regard must of course be had to reported cases, and in particular to the guidance given by this court from time to time in so-called guidelines cases. However it must always be remembered that sentencing is an art rather than a science; that the trial judge is particularly well-placed to assess the weight to be given to various competing considerations; and that leniency is not in itself a vice. That mercy should season justice is a proposition as soundly based in law as it is in literature."

76. This passage was cited with approval by Leveson J in *Solanke*. As he observed, not all of it is appropriate in a case where the primary object of imposing a penalty is the protection of the public. We consider that the test of whether a penalty is unduly lenient in the context of section 29 is whether it is one

which a disciplinary tribunal, having regard to the relevant facts and to the object of the disciplinary proceedings, could reasonably have imposed.

77. Leveson J in *Solanke* referred to 'the range of sanctions which the tribunal could reasonably consider appropriate' and accepted that an unduly lenient sentence was one which 'departed by a substantial extent from the norms of sentencing generally applied'. We have reservations as to whether this language is helpful in relation to the types of disciplinary sanction that are available in relation to the regulation of health care professionals. These range from a reprimand to sanctions that prevent the practitioner from continuing to practise. In any particular case under section 29 the issue is likely to be whether the disciplinary tribunal has reached a decision as to penalty that is manifestly inappropriate having regard to the practitioner's conduct and the interests of the public.

78. The question was raised in argument as to the extent to which the Council and the Court should defer to the expertise of the disciplinary tribunal. That expertise is one of the most cogent arguments for self-regulation. At the same time Part 2 of the Act has been introduced because of concern as to the reliability of self-regulation. Where all material evidence has been placed before the disciplinary tribunal and it has given due consideration to the relevant factors, the Council and the Court should place weight on the expertise brought to bear in evaluating how best the needs of the public and the profession should be protected. Where, however, there has been a failure of process, or evidence is taken into account on appeal that was not placed before the disciplinary tribunal, the decision reached by that tribunal will inevitably need to be reassessed."

Discussion

60. In the course of the hearing before the Committee, it became apparent that the main thrust of AB's case was that, as a result of the diagnosis in 1998, although he appreciated that he had been diagnosed with hepatitis B, he believed that he was non-infectious, and therefore, because of the lack of risk to patients, there was no need to disclose his condition to the GDC or any health professionals, and this precluded or mitigated any culpability for his failure to make himself aware and/or comply with appropriate guidance relating to those suffering from the condition. As the Committee appears to have taken the view that the issue of AB's belief in his non-infectivity was of particular significance when considering the issue of culpability, (a matter which has not been sought to be criticised by the Authority or the GDC), it was clearly necessary for the Committee, as the fact finding body, to determine this issue, by reaching a reasoned conclusion upon it, and its implications in relation to culpability, based upon the evidence presented to it by the opposing parties

61. In large measure the determination of this issue rested upon the Committee's assessment of AB's credibility, in relation to which, as it said in terms, they found him to be a "generally credible witness." The Authority seeks to challenge this assessment upon the basis that it was inconsistent with the finding of dishonesty in relation to charge 4e), whilst the GDC also seek to do so on the basis that it is inconsistent with the finding of recklessness in relation to charge 5a) and 5b)v. The Authority also submits that the Committee was not entitled to make this assessment, bearing in mind that AB had undergone post-diagnosis blood tests in Denmark between 1998 – 2000.

62. In determining this issue, not only was the Committee entitled, as it said, to take into account the consistency of AB's evidence, but also his good character. However, over and above these expressed matters, it is apparent from the evidence of both of the experts that AB's account was consistent with the understanding of the medical profession at the time when he was informed of the results of his blood tests and liver biopsy in 1998, namely that, being HVS-antigen positive and HBE-antigen negative, whilst he had hepatitis B, he was non-infectious. As Dr Parker said in terms, bearing in mind the historical understanding of the medical profession as reflected in the contemporary health care guidance, AB's account on this issue was plausible. In these circumstances it seems to me that the Committee was entitled to reach its central determination, namely that AB was a generally credible witness, and to accept that, although AB had hepatitis B, he believed that he was non-infectious, and was therefore not a risk to his patients.

63. I accept that, having made this central determination, it was not necessarily to have been anticipated that the Committee would have proceeded to make a finding of dishonesty in relation to charge 4e). However, I am unpersuaded that this displays a sufficiently inconsistent approach to the evidence which, as the Authority argues, disentitled the Committee to find that he was a credible witness. Indeed, it seems to me that if one considers with care the Committee's finding of dishonesty in relation to charge 4e), it is explicable upon the basis that, unlike the other examples of non-disclosure, not only was there clear evidence of what information was being sought and provided, but, of particular significance was the fact that the question asked a question in the past tense, "Have you ever had a liver disease…". In this regard it is clear that not only was AB aware that hepatitis B was a liver disease, but that he knew that in 1998 he had been diagnosed with the condition. In these circumstances, I do not consider the making of a single finding of dishonesty in relation to one discrete aspect of AB's conduct concerning his knowledge about his past diagnosis negated the Committee's ability to find that he was generally a credible witness in relation to the central issue which he sought to establish in the course of his evidence.

64. Moreover, I do not consider that the issue relating to the post-diagnosis blood tests carried out in Denmark, either disentitled the Committee to determine that AB was a generally credible witness, or was a matter which had not been properly considered by the Committee. In this regard, the significance of the results of these tests, was far from clear on the evidence before the Committee. Essentially they disclosed elevated ALT levels, which, as Dr Smith explained is a common liver enzyme consistent with an individual having hepatitis B. In particular there was no definitive evidence that a rise in ALT levels necessarily indicated a rise in viral load, and/or that AB would or should have been aware of this in any event. In these circumstances either as a discrete issue, or coupled with the finding of dishonesty in relation to charge 4e), I do not consider that this matter has the effect contended for by the Authority.

65. In relation to the original submission made by the GDC that the Committee's determination of AB's credibility was inconsistent with its finding of recklessness in relation to charges 5a) and 5b)v, once again it is necessary to consider with care the basis upon which the Committee made its finding of recklessness. Although the Committee had been provided with legal advice in relation to recklessness based upon AB's subjective awareness of risk in general terms, the finding made by the Committee was on the specific basis that, as a dentist in practice over the previous 14 years, he could not have failed to have become aware of the existence of guidance relating to the risks of blood borne diseases, and had not acquainted himself with it. It is apparent therefore that this was not a finding which bore upon the

question of AB's knowledge of his risk of infectivity, but related to his knowledge of the existence of relevant guidance, and his failure to obtain and adhere to it. In these circumstances I do not consider that this finding displays any inconsistency of approach by the Committee, nor did it preclude the Committee's main conclusion in relation to AB's credibility in general.

66. In reaching these views I have taken into account that the Committee both saw and heard the evidence from the various witnesses, including AB, and was therefore in an advantageous position to make a proper assessment of the credibility of these witnesses, and the evidence which they provided. Undoubtedly the fact that AB was a dentist and had undergone further blood tests in Denmark following his diagnosis were matters of some significance, and it may be that not every Committee would necessarily have reached the same conclusion relating to AB's overall credibility. However, neither of these factors, nor those raised by the Authority or the GDC are such that, in my judgment, the Committee's determination on this issue in the present case can be said to be wrong, which it is clear is the test for intervention by this court, in order to disturb primary findings of fact by the Committee.

67. Although each case falls to be considered on the basis of its own facts, there is no doubt that a finding of dishonesty will, in general terms, justify a finding of professional misconduct, and consequential impairment of the individual's fitness to practise, which in turn, in the case of serious dishonesty, is likely to lead to the sanction of erasure. Indeed where the dishonesty is both significant and relates directly to the dentist's professional practice, it may be difficult to envisage a situation where this will not occur. Moreover, as is apparent from Appendix A of the current GDC Guidance for the Professional Conduct Committee, including Indicative Sanctions Guidance, dishonesty outside the context of the profession may also justify such a finding, based upon the public's and others' expectation of integrity within the profession in general.

68. As both the Authority and the GDC acknowledge, that does not mean that such a finding is automatic and should be made in every situation where there has been a finding of dishonesty. However, in the present case the Committee's decision that AB's dishonesty in relation to charge 4e) did not amount to professional misconduct is criticised on the basis that there was no evidence that the dishonesty was not related to his professional practice, and/or that the lack of exploration of his motivation for having failed to disclose that he had suffered from liver disease meant that the Committee was not sufficiently informed so as to reach an appropriate view of its seriousness. Overall it is submitted that the Committee failed to have due regard to the GDC's Indicative Sanctions Guidance, and that the decision of the Committee was unduly lenient.

69. It is apparent from the Committee's decision that it was well aware that its determination, that its finding of dishonesty was not serious and therefore did not amount to professional misconduct, was unusual. Moreover, it was aware of the need to provide sufficient reasons to seek to justify this decision. In that regard it relied upon three main matters. Firstly the singular nature of the incident, secondly the fact that it had not involved loss or gain to anyone, and thirdly that it was not in the context of dentistry. Taking these reasons in turn, undoubtedly the incident in question was a single event, and now of some age. Moreover, there was no evidence that it involved loss or gain to anyone. In relation to the finding that it did not take place in the context of dentistry, I consider that the Committee was entitled to reach this conclusion. The failure of disclosure related to a pre-admission health questionnaire which was completed by AB prior to undergoing an operation relating to his

hearing. Moreover, there was no evidence that those receiving the information, if it had been disclosed by AB that he had suffered from liver disease, would have been under any obligation or been likely to have disclosed this information to the GDC. In these circumstances, I am satisfied that the failure of disclosure was not related to AB's practise of dentistry, in that it was not made in response to an enquiry by the GDC, nor was his dishonesty related to his dealings with any of his patients, nor those providing funding for his dental services.

70. It may be that there could have been more exploration as to AB's motivation for this single incident of dishonesty. However, it has to be borne in mind that the Committee reached its determination as to the seriousness or otherwise of this incident against the backdrop of its overall conclusion as to AB's credibility, in which it was satisfied that, although he had been diagnosed with hepatitis B, he genuinely believed that he was non-infectious. In these circumstances I do not consider that it is likely that any further exploration as to the motivation behind this single incident of dishonesty would have been likely to have gleaned matters which would have been sufficient to have persuaded the Committee to reach a different view from the one which it expressed in this case.

71. In my view there is no substance in the suggestion, which was made during the hearing, that the Committee considered that dishonesty, which was not related to the profession, could not amount to professional misconduct, or would not necessarily justify the sanction of erasure. As I have mentioned, it is evident that regardless of its finding that the incident of dishonesty was not in the context of dentistry, the Committee was aware that it was taking an unusual course in not treating it as amounting to professional misconduct leading to impairment of AB's fitness to practise. The Committee had been expressly referred to the GDC's Indicative Sanctions Guidance, and there is no indication that it did not take this guidance into account in relation to the treatment of dishonesty, including the provisions of Appendix A. Moreover, although it is apparent that serious dishonesty is likely to lead to erasure, and other degrees of dishonesty may also justify this sanction, each incident of dishonesty has to be considered on its own individual merits and considered within the context of the full circumstances of the case.

72. Overall, after taking these factors into account, whilst AB may consider himself fortunate that the Committee did not consider that this finding of dishonesty justified a finding of professional misconduct, bearing in mind the Committee's view as AB's credibility in general, and the fact that this was a single incident of dishonesty unrelated to his professional practise, I am ultimately unpersuaded that it reached a wrong decision or that the decision was unduly lenient.

73. In my judgment the most significant adverse findings which the Committee made were in relation to extent of AB's culpability in relation to charges 5a) and 5b)v, namely his failure to make himself aware of appropriate Department of Health Guidance relating to hepatitis B infected health care workers, and his continued undertaking of exposure prone procedures whilst suffering from the condition. In this regard the fact that, as Dr Smith suggested in evidence, relevant guidance is not infrequently a matter of which health practitioners are unaware, does not seem to me to be one which significantly ameliorates the position. Although the Committee did not find that AB had been either dishonest or deliberately misleading, it did find that he had been reckless, on the basis that during the 14 year period in which he had been practising as a dentist in the UK, he could not have failed to have become

aware of the existence of the guidance, and he failed to acquaint himself with it. Moreover, that patients would have been misled, and that all health professionals must know of the risks attached to failing to be aware of the Department of Health Guidance. On this basis the Committee was clearly justified in finding that AB's actions were serious and amounted to professional misconduct by him, especially as these failures exposed had exposed his patients to the risk of serious harm.

74. Having reached this determination the Committee proceeded to consider the question of the appropriate sanction to impose upon AB. The Committee correctly considered the range of sanctions, commencing with the least serious, and ultimately considered that Conditions of Practice was the appropriate sanction. This decision is criticised by both the Authority and the GDC on the basis that it is unduly lenient. It is also submitted that the decision discloses a lack of adherence to the GDC's Indicative Sanctions Guidance, and failed to take into account factors which aggravated AB's position and ought to have justified, at the least, the sanction of suspension.

75. I of course bear in mind that, when considering the question of sanction, a considerable degree of regard must usually be had to the fact that the Committee has significant expertise in assessing what is required in order to best protect the needs of the public and the profession. Moreover that when considering the question of undue leniency, it is necessary to consider whether the sanction imposed is one which a disciplinary tribunal, having regard to the relevant facts and the object of the disciplinary proceedings, could reasonably have imposed.

76. Although the GDC's Indicative Sanctions Guidance is just that, namely guidance, it is apparent that a significant feature, when considering the question of whether to impose conditions as opposed to suspension, is the existence and extent of any insight which the dentist may have into his misconduct. Moreover, the Committee is also required to consider the question of whether public confidence would be insufficiently protected by a lesser sanction than suspension, the Committee being specifically reminded in the guidance that one of the reasons it exists is to maintain public confidence in the profession, and to protect the reputation of the dental profession.

77. In the present case the Committee accepted that AB did not know that that he was placing his patients at risk. However, this matter apart, the only other indication as to why Conditions of Practice were selected, instead of suspension, was that it considered that AB's misconduct was "easily remediable", and that suspension would be "purely punitive." In my judgment, given the serious nature of the misconduct involved, these reasons were inadequate to explain why it was that Conditions of Practice, as opposed to suspension, was selected as the appropriate sanction in this case.

78. In this regard no sufficient consideration appears to have been given to the relevance of AB's insight into his misconduct, to the question of the appropriate sanction. This is particularly important in the present case, bearing in mind the Committee's findings that not only did AB lack full insight into the potential seriousness of his failings, but he had failed to take sufficient responsibility for them. Moreover, the Committee also stated that it had not been provided with any evidence that he had taken any steps to remedy his failings, other than a statement from his counsel that AB had now read the relevant guidance. On the face of it these are all matters which not only rendered AB's position more serious than would otherwise have been the case, but in the light of the Indicative Sanctions Guidance, indicated

that the more appropriate sanction was more likely to have been suspension, rather than the imposition of Conditions of Practice.

79. Furthermore, over and above a general expression of the need to protect the confidence of the public in the profession, there is no indication that the Committee considered whether public confidence in the profession would be insufficiently protected by Conditions of Practice, rather than suspension. Certainly there is no sufficient rationale provided as to the reasons for reaching any determination on this issue.

80. It is also apparent that the Committee does not appear to have reached any determination upon a relevant issue of potential significance, namely AB's culpability for the delay of over a year, between the initial request by NHS England for evidence of adequate hepatitis (HbSAg) antibody titre on 14th February 2013, and his undergoing a blood test on 25th April 2014. Especially bearing in mind that throughout this period AB continued to practise as a dentist, treating patients who would have been at risk of being infected with the virus. Although this issue had not been made the subject of a formal charge, it was one which clearly arose from the evidence during the course of the proceedings, and required determination by the Committee, in that if it considered that AB bore culpability for the delay, then this was a further, and potentially important, aggravating factor.

81. On any view the degree of professional misconduct which the Committee found established in this case was serious. Although, as the Committee found, AB did not know that he was infectious, he continued practising as a dentist for 14 years whilst being infected with hepatitis B, and whilst failing to acquaint himself with relevant guidance, of which he was aware, concerning the risks relating to blood borne diseases. Throughout this period patients' health was put at risk by AB's practise of exposure prone procedures. There is no evidence that this situation would have come to light had it not been for the intervention of NHS England, and there may well have been culpable delay thereafter in failing to provide the requisite blood samples for laboratory testing. Moreover, on the evidence before the Committee, and as it found, there has been a significant lack of insight by AB into his condition. Although it is right to acknowledge that, since the matter has come to light, AB appears to have complied with both his treatment and with the Conditions of Practice, and he is of course a professional man of good character, I accept the submissions made on behalf of the Authority and the GDC that the reputational damage to the profession in this case is and remains of a high order. In these circumstances not only am I satisfied that the Committee failed to provide adequate reasons for its decision upon sanction in this case, but it failed to make a determination upon a potentially significant aggravating factor. Moreover, bearing in mind the potential degree of damage to public confidence in the profession, the Committee reached an unduly lenient decision, in that Conditions of Practice was not a sanction which could reasonably have been imposed in this case.

Disposal

82. Having reached the decision that the sanction imposed by the Committee is unduly lenient I propose to quash the order for the imposition of Conditions of Practice. Although it would be open to me to decide the appropriate sanction in this case, as the primary body mandated with this task is the relevant disciplinary tribunal, I will remit the decision for further consideration by the same Committee. I have considered whether because it will be necessary for the Committee to make a further determination upon the extent of any culpability for the delay in providing the results of blood test to the GDC, it would be appropriate to remit the case back

to the Committee for it to review both impairment and sanction. However, it seems to me that in the absence of a specific charge in relation to this issue, although the Committee is entitled to make a determination upon it for the purposes of sanction, it being a potentially significant aggravating factor, it is not one which it would be appropriate to be considered under impairment. Therefore, I will remit the case back to the Committee for it to give further consideration as to the appropriate sanction in this case in the light of this judgment.