Case No: CO-2261-2021

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

ON APPEAL FROM A DECISION OF THE PROFESSIONAL CONDUCT COMMITTEE OF THE GENERAL DENTAL COUNCIL

Neutral Citation Number: [2022] EWHC 175 (Admin)

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 28 January 2022

Before:

The Honourable Mrs Justice Hill DBE

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Between:

ABRAHAM JOHANNES HENNING	**Appellant**
- and -	
THE GENERAL DENTAL COUNCIL	**Respondent**

- -
- -

James Buchanan (instructed by **The Medical Protection Society**) for the **Appellant**
Peter Mant (instructed by **The General Dental Council**) for the **Respondent**

Hearing date: 19 January 2022

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JUDGMENT

This judgment was handed down remotely by circulation to the parties' representatives by email. It will also be released for publication on BAILII and other websites. The date and time for hand-down is deemed to be 10.30 am on 28 January 2022.

Mrs Justice Hill:

Introduction

1. This is an appeal under section 29 of the Dentists Act 1984 ("the Act"). The Appellant is an orthodontist who retired in 2018 but who continued to be registered with the General Dental Council ("the GDC"), the regulatory body for dentists. On 27 May 2021 the GDC's Professional Conduct Committee ("the Committee") determined that his fitness to practise was impaired by reason of misconduct and imposed a sanction of suspension for six months with review. The Appellant appeals the Committee's findings of fact in relation to four of the heads of charge, its decision that his fitness to practise as a dentist was impaired and the sanction imposed.

The facts

2. The Appellant has been in practice as a dentist for over 30 years. No allegations of poor performance had been made against him before the complaints that underpin this appeal. All the allegations relate to one patient, known for the purposes of these proceedings as 'Patient A'. The Appellant provided orthodontic treatment to Patient A between January 2015 and July 2017. She had sought treatment in order to straighten her bottom teeth and for the widening and straightening of the definition on her top arch. The treatment that was provided included the placing of brackets on Patient A's teeth using the 'Damon' technique.

3. The Committee is one of the Practice Committees responsible under section 27B(1) of the Act for determining whether a dentist's fitness to practise is impaired. The Committee's procedure is governed by The General Dental Council (Fitness to Practise) Rules 2006 ("the Rules"), made under the General Dental Council (Fitness to Practise) Rules Order of Council 2006 (SI 2006/1663).

4. The charge of misconduct against the Appellant was particularised as follows:

> **Head of charge 1(a)** alleged that the Appellant did not carry out sufficient diagnostic assessments prior to commencing treatment of Patient A on 16 January 2015, in that he did not carry out a general dental assessment adequately or at all;
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> **Heads of charge 1(b)(i)-(ix)** alleged that the Appellant provided a poor standard of orthodontic treatment to Patient A in nine different respects from 16 January 2015 to 3 July 2017;
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> **Heads of charge 1(c)(i)-(vii)** alleged that the Appellant did not adequately respond to the concerns which Patient A expressed about her treatment on seven different occasions;
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> **Head of charge 1(d)** alleged a failure to manage Patient A's pain effectively on 11 January 2017;
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> **Head of charge 2** alleged a failure to maintain adequate professional boundaries with Patient A;

> **Heads of charge 3(a)-(c)** alleged a failure to treat Patient A with dignity and respect in respect of three comments made on 3 April 2017; and
>
> **Heads of charge 4(a)-(d)** alleged failures to maintain an adequate standard of record keeping in respect of Patient A's appointments.

5. The hearing before the Committee lasted 9 days between 17 and 27 May 2021.

6. Under the Rules, the Committee first determines which of the facts alleged it finds proved (Stage 1) and then determines whether, in the light of the facts found, the dentist's fitness to practise is impaired and, if so, whether to give any direction as to sanction under section 27B(6) of the Act (Rule 21). The latter two determinations are made in a single stage (Stage 2).

7. The Committee heard oral evidence from Patient A and Professor Derrick Willmot (on behalf of the GDC) and from the Appellant, Dr Gerry Bellman and a number of colleagues (on behalf of the Appellant). The Committee also considered the reports from each expert, their joint statement and various other witness statements and documents.

8. The Appellant admitted heads of charge 1(a)(i),1(c)(v), 4(a), 4(b), 4(c) and 4(d). He admitted, as fact, the individual clinical matters set out in heads of charge 1(b)(i) to 1(b)(vii) but denied that they reflected a poor standard of orthodontic treatment. During the course of the hearing, he made a full admission to head of charge 1(b)(viii), which he had initially denied. All the remaining allegations contained within the charge were denied.

9. The Committee found charges 1(b)(i), 1(b)(iv), 1(b)(v), 1(b)(vi)), 1(b)(viii), 1(b)(ix), 1(c)(ii), 1(c)(iv), 1(c)(vii) and 1(d)) proved.

10. In considering whether the facts found proved against the Appellant amounted to misconduct, the Committee had regard to the following GDC Standards which it considered to be engaged:

> *2.1 Communicate effectively with patients – listen to them, give them time to consider information and take their individual views and communication needs into account.*
>
> *4.1 Make and keep contemporaneous, complete and accurate patient records.*
>
> *7.1 Provide good quality care based on current evidence and authoritative guidance.*
>
> *7.3 Update and develop your professional knowledge and skills throughout your working life.*

11. The Committee made the following observations about the elements of the misconduct found: (i) the failure to carry out a general dental assessment prior to commencing treatment on Patient A represented "a serious breach of the standards expected of a competent dental practitioner" and a "failing in a basic and fundamental aspect of dentistry about which both experts...were critical"; (ii) the individual failings in the standard of treatment the Appellant provided to Patient A were "not necessarily, in and

of themselves, failings that fell far below the standard expected", but "when viewed together, the clinical failings...did reflect a pattern and course of treatment that fell far short of what was proper in the circumstances"; (iii) the Appellant's failure to adequately respond to Patient A's concerns on the four occasions highlighted was "conduct that amounted to a serious departure from the standards" which "persisted over a period of time" which "other dental professionals would find deplorable"; and (iv) the deficiencies in the Appellant's record keeping "persisted throughout the entire period of Patient A's treatment" and "record keeping is a basic and fundamental aspect of general dental practice."

12. The Committee noted that the Appellant had been unaware of his obligations in relation to general dental assessments and record keeping and concluded that he should have been aware of both requirements.

13. The Committee determined that the facts found proved amounted to misconduct. It had been conceded on the Appellant's behalf that misconduct was made out.

14. The Appellant adduced extensive evidence of remediation in the form of continuing professional development which he had undertaken despite having retired from clinical practice.

15. Applying *Clarke v General Optical Council* [2018] EWCA Civ 1463, the Committee decided that it had to assess the Appellant's current fitness to practise, irrespective of his retirement. He remained on the Dentists' Register and, as such, could return to practice.

16. The Committee concluded that a finding in respect of the Appellant's impairment was necessary for the protection of the public. The Committee also considered the wider public interest. It concluded that public confidence in the dental profession would be seriously undermined if a finding of impairment were not made.

17. Section 27B(6) of the Act permits a range of sanctions spanning, in order of severity, a reprimand, conditional registration, suspension and removal. As the section is permissive, the Committee may also take no further action following a finding of impairment.

18. The Committee decided that a six-month suspension, followed by a review, was the appropriate sanction.

The grounds of appeal

19. The Appellant advances three grounds of appeal.

20. Under **Ground 1** he argues that the Committee erred in its findings of fact in respect of **heads of charge 1(c)(ii), 1(c)(iv), 1(c)(vii) and 1(d)**, in that the Committee failed to take into account adequately or at all evidence relevant to Patient A's credibility. It is submitted that such a failure was a serious irregularity in the proceedings and renders the determination of the Committee unjust.

21. Under **Ground 2** he submits that the Committee's finding on impairment was wrong because (i) it gave insufficient weight to the extensive evidence of remediation

produced by the Appellant; (ii) it placed undue weight on the fact of the Appellant's retirement from practice; and (iii) it did not take into account that the Appellant's failings related to the treatment of a single patient only.

22. Under **Ground 3** he argues that the sanction imposed was disproportionate and excessive and/or wrong on the basis that (i) the allegations found proved were in respect of a single patient and were not representative of the Appellant's general standard of treatment and/or conduct; and (ii) the order for suspension with a review was unworkable and/or one which it was impossible for the Appellant to complete successfully.

The legal framework

(i) The nature of the appeal

23. Under section 29(1) of the Act, a decision to impose suspension is appealable to this court.

24. Under section 29(3) of the Act, 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 relevant Committee, or (d) remit the case to the relevant 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.

25. Such an appeal is by way of re-hearing: PD52D paragraph 19 (displacing the general rule in CPR r 52.21(1) that "every appeal will be limited to a review of the decision of the lower court").

26. Under CPR 52.21(3) an appeal court will allow an appeal where the decision of the lower court was (a) wrong, or (b) unjust because of a serious procedural or other irregularity in the proceedings of the lower court.

27. The nature of a rehearing of this kind has been considered in a number of cases including *Fish v General Medical Council* [2012] EWHC 1269 (Admin), [28]-[32], *Yassin v General Medical Council* [2015] EWHC 2955 (Admin), [32] and *R (Dutta) v General Medical Council* [2020] EWHC 1974 (Admin). In *Dutta* at [21] Warby J (as he then was) explained that:

> "(1) The appeal is not a re-hearing in the sense that the appeal court starts afresh, without regard to what has gone before, or (save in exceptional circumstances) that it re-hears the evidence that was before the Tribunal. 'Re-hearing' is an elastic notion, but generally indicates a more intensive process than a review: *E I Dupont de Nemours & Co v S T Dupont (Note)* [2006] 1 WLR 2793 [92-98]. The test is not the "Wednesbury" test.
>
> (2) That said, the appellant has the burden of showing that the Tribunal's decision is wrong or unjust: *Yassin* [32(i)]. The Court will have regard to the decision of the lower court and give it 'the weight that it deserves': *Meadow* [128] (Auld LJ, citing *Dupont* [96] (May LJ))."

28. Morris J also addressed this issue in *Byrne v General Medical Council* [2021] EWHC 2237 (Admin) at [16], observing:

> "...whilst noting the observations of Warby J in *Dutta* at §21(1), on the balance of authority there is little or no relevant distinction to be drawn between "review" and "rehearing", when considering the degree of deference to be shown to findings of primary fact: *Assicurazioni* §§13, 15 and 23. *Du Pont* at §§94 and 98 is not clear authority to the contrary. Rather it supports the proposition that there may be a relevant difference when the court is considering findings of evaluative judgment or secondary or inferential findings of fact, where the court will show less deference on a rehearing that on a review. Nevertheless, if less deference is to be shown in a case of rehearing (such as the present case), then, again I will assume this in the Appellant's favour".

(ii) Appeals against findings of fact

29. A significant number of authorities have considered the circumstances in which an appeal court will interfere with findings of fact made by the court or decision maker below.

30. Morris J listed the cases on this issue to which he had been referred in *Byrne* at [10] as follows: *Gupta v General Medical Council* [2001] UKPC 61 [2002] 1 WLR 1691 at §10 (citing *Thomas v Thomas* [1947] AC 484 at 487-488); *E.I. Dupont de Nemours v S.T. Dupont* [203] EWCA Civ 1368 at §§84-98 esp at §84 and §98; *Assicurazioni Generali SpA v Arab Insurance Group* [2003] 1 WLR 577 at §§13-22, 197; *Chyc v General Medical Council* [2008] EWHC 1025 (Admin) at §23; *Muscat v Health Professions Council* [2008] EWHC 2798 (Admin) at §83; *Mubarak v General Medical Council* [2008] EWHC 2830 (Admin) at §§5, 20; *Southall v General Medical Council* [2010] EWCA Civ 407 at §47 and §§50-62 (citing *Libman v General Medical Council* [1972] AC 217 at 221F); *Casey v General Medical Council* [2011] NIQB 95 at §6; *O v Secretary of State for Education* [2014] EWHC 22 (Admin) at §§58 to 64, 66; *R (Dutta)di v General Medical Council* [2020] EWHC 1974 (Admin) at §§21-22, 38-43; *Gestmin SGPS SA v Credit Suisse (UK) Ltd* [2013] EWHC 3650 (Comm); *McGraddie v McGraddie* [2013] UKSC 58; *Henderson v Foxworth* [2014] UKSC 41 at §§48 and 58-67; *Perry v Raleys Solicitors* [2019] UKSC 5 at §52, and the US case *Anderson v City of Bessemer* (1985) 470 US 564 at 574-57 and *Khan v General Medical Council* [2021] EWHC 374 (Admin).

31. Morris J distilled the relevant principles from these cases in *Byrne* as follows:

> "12. First, the degree of deference shown to the court below will differ depending on the nature of the issue below; namely whether the issue is one of primary fact, of secondary fact, or rather an evaluative judgment of many factors: *Assicurazioni Generali* at §§16 to 20. The present case concerns findings of primary fact: did the events described by the Patient A happen?
>
> 13. Secondly, the governing principle remains that set out in *Gupta* §10 referring to *Thomas v Thomas*. The starting point is that the appeal court will be very slow to interfere with findings of primary fact of the court

below. The reasons for this are that the court below has had the advantage of having seen and heard the witnesses, and more generally has total familiarity with the evidence in the case. A further reason for this approach is the trial judge's more general expertise in making determinations of fact: see *Gupta*, and *McGraddie v McGraddie* at §§3 to 4. I accept that the most recent Supreme Court cases interpreting *Thomas v Thomas* (namely *McGraddie* and *Henderson v Foxworth*) are relevant. Even though they were cases of "review" rather than "rehearing", there is little distinction between the two types of cases for present purposes (see paragraph 16...).

14. Thirdly, in exceptional circumstances, the appeal court will interfere with findings of primary fact below. (However the reference to "virtually unassailable" in *Southall* at §47 is not to be read as meaning "practically impossible", for the reasons given in *Dutta* at §22.)

15. Fourthly, the circumstances in which the appeal court will interfere with primary findings of fact have been formulated in a number of different ways, as follows:

- where "any advantage enjoyed by the trial judge by reason of having seen and heard the witnesses could not be sufficient to explain or justify the trial judge's conclusions": per Lord Thankerton in *Thomas v Thomas* approved in *Gupta*;

- findings "sufficiently out of the tune with the evidence to indicate with reasonable certainty that the evidence had been misread" per Lord Hailsham in *Libman*;

- findings "plainly wrong or so out of tune with the evidence properly read as to be unreasonable"...*Casey* at §6 and Warby J (as he then was) in *Dutta* at §21(7);

- where there is "no evidence to support a ... finding of fact or the trial judge's finding was one which no reasonable judge could have reached": per Lord Briggs in *Perry* after analysis of *McGraddie* and *Henderson*.

In my judgment, the distinction between these last two formulations is a fine one. To the extent that there is a difference, I will adopt, in the Appellant's favour, the former....".

(iii) <u>The judicial determination of facts</u>

32. In *Dutta* at [39] Warby J observed that there is now a considerable body of authority setting out the lessons of experience and of science in relation to the judicial determination of facts. He cited Stewart J's distillation of the key aspects of this learning in *Kimathi v Foreign and Commonwealth Office* [2018] EWHC 2066 (QB) [96].

33. The Appellant relied on this element of Stewart J's summary of *Gestmin SGPS SA v Credit Suisse (UK) Ltd* [2013] EWHC 3650 (Comm) (Leggatt J, as he then was), as set out in *Dutta* at [39]:

"i) *Gestmin*:

We believe memories to be more faithful than they are. Two common errors are to suppose (1) that the stronger and more vivid the recollection, the more likely it is to be accurate; (2) the more confident another person is in their recollection, the more likely it is to be accurate.

Memories are fluid and malleable, being constantly rewritten whenever they are retrieved. This is even true of "flash bulb" memories (a misleading term), i.e. memories of experiencing or learning of a particularly shocking or traumatic event.

Events can come to be recalled as memories which did not happen at all of which happened to somebody else...

The best approach from a judge is to base factual findings on inferences drawn from documentary evidence and known or probable facts. "This does not mean that oral testimony serves no useful purpose... But its value lies largely... in the opportunity which cross-examination affords to subject the documentary record to critical scrutiny and to gauge the personality, motivations and working practices of a witness, rather than in testimony of what the witness recalls of particular conversations and events. Above all, it is important to avoid the fallacy of supposing that, because a witness has confidence in his or her recollection and is honest, evidence based on that recollection provides any reliable guide to the truth".

34. The Appellant relied on Warby J's observation in *Dutta* at [47] to the effect that what is appropriate is "*a rounded assessment of the witness's reliability, rather than approaching each charge in isolation from the others*".

35. The Respondent drew support from Morris J's summary of the applicable principles in *Byrne*:

"17. First, the credibility of witnesses must take account of the unreliability of memory and should be considered and tested by reference to objective facts, and in particular as shown in contemporaneous documents. Where possible, factual findings should be based on objective facts as shown by contemporaneous documents: *Dutta* §§39 to 42 citing, in particular, *Gestmin* and *Lachaux*.

18. Secondly, nevertheless, in assessing the reliability and credibility of witnesses, whilst there are different schools of thought, I consider that, if relevant, demeanour might in an appropriate case be a significant factor and the lower court is best placed to assess demeanour: Despite the doubts expressed in *Dutta* §42 and *Khan* §110, the balance of authority supports this view: *Gupta* §18 and *Southall* at §59.

19. Thirdly, corroborating documentary evidence is not always required or indeed available. There may not be much or any such documentary evidence. In a case where the evidence consists of conflicting oral accounts, the court may properly place substantial reliance upon the oral evidence of

the complainant (in preference to that of the defendant/appellant): *Chyc* at §23. There is no rule that corroboration of a patient complainant's evidence is required.

20. Fourthly, in a case where the complainant provides an oral account, and there is a flat denial from the other person concerned, and little or no independent evidence, it is commonplace for there to be inconsistency and confusion in some of the detail. Nevertheless, the task of the court below is to consider whether the core allegations are true: *Mubarak* at §20".

36. The Respondent also relied on this observation of Morris J in *Byrne* at [26(2)]:

> "...whilst...it is a common practice in Tribunal decisions on fact, there is no requirement for the disciplinary body to make, at the outset of its determination, a general comparative assessment of the credibility of the principal witnesses. Indeed, such a practice, undertaken without reference to the specific allegations, has been the subject of recent criticism in *Dutta* at §42 and *Khan* at §§106 and 107. In my judgment, consideration of credibility by reference to the specific allegations made is an approach which is, at least, equally appropriate".

(iv) Appeals against findings of misconduct, impairment and sanction

37. The importance of deferring to the professional expertise and judgment of the first instance body on whether the practitioner's failings amount to serious professional misconduct and what sanction is called for in order to provide adequate protection to the public is a "well-established" principle: see *Dutta* at [19]-[20] and the cases cited therein.

38. The Respondent also relied on *Council for the Regulation of Healthcare Professionals v General Medical Council and Southall* [2005] EWHC 579 (Admin) at [11] and *Khan v General Pharmaceutical Council* [2016] UKSC 64, [2017] 1 WLR 169 at [36(c)] for the proposition that the weight to be attached to the expertise of the first instance body will depend on all the circumstances of the case. This means that where there is misconduct constituted by a failure to reach proper standards in treating patients, the expertise of the first instance body in deciding what is needed in the interests of the public is likely to carry greater weight than in matters such as dishonesty or sexual misconduct.

39. That said, the court is entitled to substitute its own judgment for that of the first instance body and it must not abrogate its responsibility to determine whether the decision appealed against was wrong. The test to be applied is whether the sanction imposed was "appropriate and necessary in the public interest or was excessive and disproportionate" (*Sastry v General Medical Council* [2021] EWCA Civ 623 at [101], [105] and [112]).

(v) The requirement to give reasons

40. The Rules require the Committee to announce its findings of fact, by reference to the matters mentioned in the notification of hearing, in the presence of the parties (Rule 19(12)).

41. The Respondent highlighted *Southall v General Medical Council* [2010] EWCA Civ 407 at [51]-[56] and cases cited therein as indicating that the practitioner must be able to understand why they won or lost, but this does not necessarily require full reasons: in a straightforward case, where the central issue is one of credibility or reliability of witnesses, this may be achieved by setting out the facts to be proved and finding them proved or not.

42. The need for reasons was again considered by Morris J in *Byrne*:

> "26. As regards reasons concerning the credibility of witnesses
>
> (1) Where there is a dispute of fact involving a choice as to the credibility of competing accounts of two witnesses, the adequacy of reasons given will vary. In *English v Emery*, Lord Phillips stated that "it may be enough to say that one witness was preferred to another, because the one manifestly had a clearer recollection of the material facts or the other give answers which demonstrated that his recollection could not be relied upon". On the other hand, *Southall* at §55, and *Gupta* at §13 and 14 suggest that even such limited reasons are not necessarily required in every case...
>
> 27....an appeal court will not allow an appeal on grounds of inadequacy of reasons, unless, even with the benefit of knowledge of the evidence and submissions made below, it is not possible for the appeal court to understand why the judge below had reached the decision it did reach. It is appropriate for the appeal court to look at the underlying material before the judge to seek to understand the judge's reasoning and to "identify reasons for the judge's conclusions which cogently justify" the judge's decision, even if the judge did not himself clearly identify all those reasons: see *English v Emery Reimbold* §§89 and 11".

Ground 1: Findings of fact

The Appellant's case

43. The Appellant's first ground argues that the Committee erred in its factual findings in respect of **heads of charge 1(c)(ii), 1(c)(iv), 1(c)(vii) and 1(d)**.

44. The Appellant points to the following alleged issues with Patient A's credibility. These issues are said to permeate and vitiate the Committee's factual findings on each of these heads of charge to varying degrees, as the Committee has failed to deal with them adequately or at all.

45. First, the Appellant relies on the fact that although Patient A had initially said that a particular member of staff (known for the purposes of these proceedings as Witness 4) had been present at the consultations on 6 March 2017 and 3 July 2017, it was proved during the hearing that Witness 4 had in fact been on maternity leave from mid-January 2017 to 24 November 2017. When this was pointed out to Patient A in cross-examination, she said that two weeks before the hearing, she had identified from the practice's website that the individual in a photograph alongside the name of Witness 4 was not the person she knew as Witness 4. She had not drawn this to the GDC's attention, though she had corrected other parts of her witness statement. The

Appellant's counsel describes this course of events as "*extraordinary*" and a "*bolt out of the blue*", which raised a serious credibility issue for Patient A that the Committee has failed to address.

46. Second, the Appellant refers to Patient A's allegation that the insertion of the titanium wire on 11 January 2017 was an intentional and premeditated assault by the Appellant, to "*punish*" her for making a complaint, and one to which one of his colleagues had been a party. Although this allegation did not feature in the heads of charge against the Appellant, he argues that it gives a good indication into Patient A's motivations and it was incumbent on the Committee to factor this into its assessment of her credibility.

47. Third, the Appellant points to the fact that in relation to the events of 6 March 2017 (**head of charge 1(c)(vi)**) the Committee did find that there had been a conflict between Patient A's oral and written evidence and found this charge not proved. The Appellant argues that the conflict being referred to by the Committee here was in respect of Patient A's evidence relating to Witness 4 and that the Committee erred in that it did not state, how if, at all, it had applied this finding to its determination of the other heads of charge.

The Respondent's case

48. The Respondent's overarching response to this ground of appeal is that the Committee was entitled to reach the factual findings it did on each head of charge. Further, it is argued that although the Appellant criticises the Committee for not taking into account all the evidence in relation to Patient A, the Committee was not required to set out every factor that it took into account. Rather what was required was the identification and recording of those matters which were "critical" to the decision: *English v Emery Reimbold & Strick Ltd* [2002] 1 W.L.R. 2409 (2002) at [17] and [19]. The fact that certain matters were not expressly addressed in the Committee's written reasons does not mean they were not taken into account.

49. In respect of the Witness 4 issue, the Respondent argues that nothing in head of charge 1(c)(vii) turned on whether Witness 4 was present during the consultation or not, and it was not necessarily the case that Patient A's evidence about Witness 4 seriously undermined her credibility: the Committee could easily have concluded that she was simply mistaken and had accepted as much when the maternity leave issue was put to her.

50. On the second alleged credibility issue, the Respondent submits that even if the Committee had concluded that the pain had not in fact been inflicted in an intentional and premeditated way, it was not necessarily undermining of her credibility if Patient A perceived it in that way, especially given her dissatisfaction with the Appellant.

51. On the third issue, Respondent argues that the conflict of evidence in the Committee's finding in relation to 6 March 2017 (**head of charge 1(c)(vi)**) did not relate to a conflict in respect of Patient A's evidence relating to Witness 4 but to another issue, namely the manner in which the Appellant asked her for a 'shopping list' in response to a concern she raised. In her witness statement, Patient A had referred to the Appellant as having been "sarcastic, rude, placatory and condescending" but in oral evidence had conceded that he had said "shopping list" in a "cordial and jovial" manner (Determination, p.13).

52. Finally, the Respondent argues that ground 1 is, at its highest, a 'reasons' challenge. It is said that the Committee has provided sufficient reasoning for its decisions and that its determination read as a whole alongside the parties' submissions make clear why it reached the decisions that it did.

Discussion and conclusion

53. The parties agree that for the Appellant to succeed in any element of Ground 1, he would need to show that the factual finding in question was "plainly wrong or so out of tune with the evidence properly read as to be unreasonable": *Byrne* at [15].

54. I have approached the Appellant's appeal on this and all the other grounds on the basis that a 're-hearing' indicates a more intensive process than a review: *Dutta* at [21](1). That said, there is little or no distinction when considering the degree of deference to be shown to findings of primary fact: *Byrne at* [16].

55. In oral argument, the Appellant placed particular emphasis on his grounds in respect of heads of charge 1(c)(vii) and 1(d). Accordingly, I address those first.

<u>(1): Head of charge 1(c)(vii)</u>

56. This head of charge alleged that the Appellant did not adequately respond to the concerns about her treatment which Patient A raised on 3 July 2017. The Committee's findings were as follows:

> "The Committee was satisfied from the evidence of Patient A that she did raise concerns with you at this appointment regarding the orientation of two of her front teeth, which she considered were slanting. It was Patient A's evidence that you responded by saying "that's how they were to start with dear". Patient A stated that she recalled being "furious" and saying, "so after 2 and a half years and four thousand pounds they are no better, they are actually worse".
>
> You stated in your evidence that you did not recall the precise details of the conversation that you had with Patient A on this date, but you referred to a follow-up letter that you sent to her, dated 19 July 2017 which, you stated, set out a summary of your discussions with Patient A at the appointment on 3 July 2017.
>
> The Committee had regard to that letter of 19 July 2017, which it found did set out in details responses to Patient A's concerns, including her concerns about the occlusal slant. However, the Committee considered the wording of this head of charge as its [sic] stands, which is whether you responded adequately to the patient's concerns on the date in question, namely 3 July 2017.
>
> In addition to Patient A's account, the Committee had regard to the clinical records. It noted that there was no evidence within them to indicate that there had been any discussion regarding the concerns raised by the patient on that day. In all the circumstances, the Committee was satisfied on the balance of

probabilities, that you did not respond adequately to the patient's concerns at the time she raised them" (Determination, pp.13-14).

57. It was accepted that Patient A had raised concerns about the orientation of her teeth during the consultation on 3 July 2017. The main area of dispute on this head of charge was whether, once Patient A had expressed her concerns, the Appellant said, "that's how they were to start with dear". Patient A recollected this comment. The Appellant did not, but gave an account based on his "general recollection" and a letter sent to Patient A after the consultation. The member of staff in the room was not said to have played any specific part in this consultation other than 'wrist-flicking' some photographs at Patient A. In those circumstances I share the Respondent's view that the identity of that member of staff was not a "critical" or "core" issue for the Committee to determine *English* at [17] and [19]; *Byrne* at [20].

58. In addition, Patient A's evidence about the consultations on 6 March 2017 and 3 July 2017 has to be seen in the context of the number of other issues in the case. She had given a witness statement for the Committee which ran to some 40 pages of single-spaced text and she gave evidence for over a day. Her evidence traversed a large number of consultations and other contacts with the Appellant and his staff.

59. It is also relevant that while Patient A had been confident about the member of staff's identity in some parts of her evidence, in others she had been less categorical. At paragraph 103 of her witness statement, she had initially given three possibilities for who the additional member of staff present at the 3 July 2017 consultation was (Committee's bundle, p.34). When first asked about it at the hearing, she was referred to paragraph 103 of her witness statement and then said "Yes, I can't remember who" the member of staff was (Transcript of 18 May 2021, p.9).

60. In light of this context, I accept the Respondent's submission that Patient A's evidence with respect to Witness 4's identity did not necessarily undermine her credibility to the extent relied upon by the Appellant: it could well indicate a witness who was confused about some points of detail, who accepted as much when the maternity leave issue was put to her, and who had not appreciated the need to volunteer earlier that she had checked the practice's website before giving evidence. I consider that Patient A's evidence on the Witness 4 issue could properly be regarded as "inconsistency and confusion in some of the detail" which did not vitiate the Committee's approach to the "core" issue of what the Appellant has said at the consultation: *Byrne* at [20]).

61. The 'deliberate pain' allegation was said to have taken place on 11 January 2017. Even if the Committee concluded that the Appellant had not in fact done this (and they could well have reached this conclusion in light of the fact that the Respondent had chosen not to pursue a specific head of charge in relation to it), I agree with the Respondent that it was not necessarily as damaging to Patient A's credibility as the Appellant asserts, given the overall breakdown of their relationship.

62. Even if it did raise a question about her credibility, *Byrne* at [26(2)] indicates that the Committee was not required to conduct a general assessment of Patient A's credibility and "map over" issues in relation to her credibility on one issue to other issues in the case.

63. On the third alleged credibility issue, there is a dispute between the parties as to what 'conflict' the Committee was referring to in its finding in relation to 6 March 2017 (**head of charge 1(c)(vi)**). Read in context, I consider that the Respondent's interpretation of the Committee's determination is correct and that this passage refers to Patient A's differing accounts of the 'shopping list' comment.

64. Again, I consider that *Byrne* at [26(2)] applies, and the Committee was not required to address this conflict in the context of a different charge.

65. In light of all these factors, and generally bearing in mind the deference to be afforded to the Committee which heard the witnesses in person, I conclude that it cannot be said that its decision to accept Patient A's evidence about what the Appellant said on 3 July 2017 was plainly wrong or so out of tune with the evidence properly read as to be unreasonable.

66. Finally, to the extent that this ground of appeal is, in reality, a challenge to the Committee's reasons, it is relevant that both parties had referred to the Witness 4 issue in their closing submissions. The Respondent argued that it did not seriously undermine her credibility and the Appellant argued that it did. Each party also pointed to other factors which it was said impacted positively or negatively on the Patient A's credibility. In the Respondent's case, this included the fact that many of the concerns about her treatment which Patient A had expressed had later proved vindicated by the expert evidence (Transcript of 24 May 2021, pp.2-3 and 8-9).

67. While it might have been helpful for the Committee to have made this explicit, taking the submissions and the Determination as a whole, as is required (*English* at [26]), it can be inferred that the Committee had accepted the Respondent's arguments on Witness 4 issue, and did not consider that this seriously impacted on Patient A's credibility.

68. The same point can be made about the 'deliberate pain' issue which had also featured in the Appellant's closing submissions (Transcript of 24 May 2021, p.10).

69. I consider that overall, the Committee complied with its duty in respect of reasons. It went further than the standard suggested by *English* at [19] (and even that is not said to represent a minimum standard: *Byrne* at [26(1)]), in that in addition to indicating that it preferred Patient A's evidence to the Appellant's, it also indicated its reliance on the absence of evidence in the clinical records suggesting that Patient A's concerns had been discussed on 3 July 2017. To that extent, the Committee followed the guidance in *Gestmin*: it looked to see if there was documentary evidence to assist it in reaching findings of fact and did not rely entirely on the competing memories of Patient A and the Appellant. It was entitled, in these circumstances, to rely on the absence of documentation.

70. For all these reasons I do not consider that the Committee's finding on this head of charge was wrong or unjust due to serious procedural or other irregularity. Accordingly, the appeal against the Committee's finding of fact in respect of **head of charge 1(c)(vii)** is dismissed.

<u>(2): Head of charge 1(d)</u>

71. This head of charge alleged that the Appellant did not manage Patient A's pain effectively during an appointment on 11 January 2017. The Committee's findings were as follows:

> "It was the evidence of Patient A that she "yelped" in pain when you pushed titanium wire into the bracket of her lower incisors during treatment. In your oral evidence, you initially stated that you did not recall the patient being in pain, but later accepted that she had "yelped" in pain as she described, as you mentioned this in your witness statement.
>
> It was the opinion of Professor Willmot that you did not manage Patient A's pain effectively during the procedure you undertook. He stated that he would have expected a reasonable practitioner to explain the likely sequelae and if necessary, prescribe and appropriate analgesic. The Committee also noted Mr Bellman's evidence that when placing wires on the lower incisors, it was not uncommon to cause transitory pain to a patient. He was therefore not critical in this regard.
>
> The Committee preferred the evidence of Professor Willmot. It considered that there was a continuum of care that you should have provided to the patient, which should have included setting an expectation about pain, as well an apology, advice and aftercare, including recommended painkillers if the pain persisted. The Committee noted from Patient A's witness statement, the graphic description of the pain that she said she experienced. She stated that "There was absolutely no apology" and that all you said was "I hate to have to do that to you". Whilst the Committee noted your evidence that you did apologise for the pain caused, it took into account that there is no reference to the incident in the clinical records. In all the circumstances, the Committee was satisfied on the balance of probabilities that you did not manage the patient's pain effectively at this appointment" (Determination, p.14).

72. As is clear from the above, the Appellant had conceded in cross-examination that Patient A's graphic description of having "yelped" in pain was accurate.

73. The main issue on this head of charge was whether the Appellant should have explained the likely consequence of the treatment to Patient A and suggested an appropriate analgesic. The Committee accepted the evidence of Professor Wilmott that this was the appropriate course of events. The Appellant had admitted in cross-examination that he had not followed this course.

74. There was a factual dispute between the parties as to whether the Appellant had apologised to Patient A, but I accept the Respondent's submission that this was not an essential issue: rather, the head of charge was made out by the Appellant's admitted failure to give advice to Patient A about follow up and aftercare.

75. It can therefore be seen that Patient A's credibility was not central to the Committee's determination of this head of charge.

76. To the extent that Patient A's credibility was relevant to the apology issue, as I have explained above, I do not consider that her allegation of deliberate pain was necessarily

as damaging to her credibility as the Appellant asserts. The Committee had heard closing submissions about this issue, and it can reasonably be inferred that the Committee did not accept the Appellant's arguments on this issue.

77. Consistent with *Byrne* at [26(2)], the Committee was not required to reflect its view on the Witness 4 issue, or the conflict of evidence about the 'shopping list' issue, in determining this head of charge either.

78. Again, I consider that overall, the Committee complied with its duty in respect of reasons in respect of this head of charge: it explained that it had accepted Professor Willmot's evidence, noting its consistency in part with that of Mr Bellman, and indicated that it had preferred Patient A's recollection, again partly because of the absence of reference to the appropriate incident in the clinical records.

79. I therefore do not consider that the Committee's finding on this head of charge was wrong or unjust. The appeal in respect of **head of charge 1(d)** is therefore dismissed.

<u>(3): Head of charge 1(c)(ii)</u>

<u>(4): Head of charge 1(c)(iv)</u>

80. I take these two heads of charge together because no separate arguments are made by the Appellant in relation to them. As such they were addressed relatively briefly in oral submissions.

81. **Head of charge 1(c)(ii)** alleged that the Appellant did not adequately respond to the concerns about her treatment which Patient A raised on 27 June 2016. The Committee's findings were as follows:

> "This head of charge relates to Patient A's request that you consider moving some of the brackets on her upper teeth so that they would correctly align. Patient A stated that she made this request after having seen another orthodontist for a second opinion. Her evidence was that without any measurement, you declined to move the brackets stating, "they are fine where they are". Patient A stated in her oral evidence that you said this verbatim. You stated that you could not recall saying this to Patient A, but that if you did, you would have explained to her why you considered it appropriate for the brackets to remain where they were.
>
> The Committee found that Patient A's evidence on this issue was clear and compelling. It considered that it was more likely than not that she did raise this concern with you and that you responded as she said, without any explanation. In the Committee's view, your response was not adequate. Patient A was sufficiently concerned to have sought a second opinion, which was her right, and this should have been respected. The patient should have left this appointment with a full understanding as to why your professional opinion differed from the other orthodontist she had seen. The Committee was satisfied from Patient A's evidence that this was not the case. In reaching its decision the Committee also took into account the absence of any reference to such a discussion in the clinical records" (Determination, pp.11-12).

82. **Head of charge 1(c)(iv)** alleged that the Appellant did not adequately respond to the concerns about her treatment which Patient A raised on 3 October 2016. The Committee's findings were as follows:

> "This head of charge relates to Patient A's concern that she had swallowed part of the wire that had been used to secure the brackets on her teeth. It was this concern that initiated her return to see you on this date, following her visit to a hospital Accident and Emergency department. The Committee noted Patient A's evidence as contained within her witness statement that, at the appointment, she elaborated on her concerns, which included her complaints that she thought "the assessment was poor which led to no securing of the wire, which is why it slid through the brackets, dug into my cheek and eventually broke. I would not have swallowed it if it had been tightened/ secured". Patient A stated that you listened without comment or apology and then walked out of the room.
>
> The Committee took into account your denial that this happened. It was your evidence in your witness statement that you recalled being alerted by Witness 4 of Patient A's concern about swallowing the wire, and that you informed the patient that the wire was soluble in stomach acid and unlikely to be harmful. You stated that to the best of your recollection, Patient A was "content and reassured".
>
> Whilst the Committee had regard to your evidence, and the evidence of the witnesses who worked with you at the Practice that walking out on a patient would not have been in your nature, it preferred the evidence of Patient A on this matter. It considered that it would have been very clear to you at that appointment that Patient A was unhappy with a number of issues, and it was satisfied that it was more likely than not, that you did walk out when she confronted you. The Committee also took into account that, despite your evidence of Patient A being reassured, there is little or no reference to any conversation in the clinical records; just an indication that no wire was broken. In all the circumstances, the Committee found this head of charge proved" (Determination, pp.12-13).

83. The facts of these heads of charge did not involve Witness 4, the allegation of 'deliberate pain' or the 'shopping list'. Resolution of these issues was not therefore essential for determination of these heads of charge. Following *Byrne* at [26(2)], the Committee was not required to reflect its view on these issues when determining these heads of charge.

84. In respect of both these charges, the Committee was entitled to have regard to the absence of reference to the issues in question in the clinical records and provided reasons for its decisions in sufficient detail to meet the standard set out in *English* at [19].

85. I therefore do not consider that the Committee's findings on these heads of charge were wrong or unjust and the appeal in respect of **heads of charge 1(c)(ii) and 1(c)(iv)** is dismissed.

Materiality

86. The Respondent also argues that even if one or more of the grounds of appeal relating to the findings of fact succeeded, the appeal should be dismissed because it could not be said that different findings on these issues would have been material to the outcome.

87. This issue does not arise because I have dismissed this ground of appeal on its substance, so that the findings of fact stand.

88. However, if I had to decide the issue, I would have agreed with the Respondent insofar as the Committee's finding on impairment was concerned. I say this because the Committee's observations on the seriousness of the heads of charge proved as summarised at [11] above make clear that they took a serious view of the findings on heads of charge 1(a), (1)(b) and 4 which are not the subject of appeal. Further, even if all the grounds of appeal in relation to head of charge 1(c) had succeeded, this would still have left one incident of failing to respond to Patient A's concerns, given that the Appellant had admitted incident 1(c)(v).

89. The issue of whether or not success on one or more of the grounds of appeal would have led to the Committee taking a different view on sanction is more difficult to assess. However, on balance, I suspect it would not have done, because even if the Appellant's appeal had succeeded in full, all of the aggravating factors would still have been present bar one (that which related to the failure to respond to "*repeated*" attempts by Patient A to raise her concerns).

90. For these reasons if Ground 1 had not failed on its facts, I would have dismissed it on the 'materiality' ground.

Ground 2: Impairment

The Committee's Determination

91. The Committee's decision on impairment is at its Determination, pp.20-21.

92. The Committee approached the issue of impairment by noting that the misconduct "included multiple non-clinical and clinical failings" and "failings of a basic and fundamental nature". Further, there had been "resultant harm caused to Patient A". It nevertheless considered that the shortcomings identified were capable of being remedied.

93. The Committee noted that the Appellant had taken steps towards remediation and that this illustrated "a degree of insight", albeit that there had been "a late realisation...of a number of problems in the treatment of Patient A".

94. It referred to Professor Willmot's very positive view of the Appellant's efforts at remediation through Continuing Professional Development and reflection and described the Appellant's activities as "*commendable*" given his retirement. I then said the following:

> "...the Committee did regard the fact that you have been out of clinical practice for almost three years to be a matter of concern when assessing the extent of your remediation. The Committee took into account that the issues in this case relate to matters of clinical assessment, clinical technique, record

> keeping and patient communication. In its view, these are all concerns that can only be assessed as remedies, if there is evidence to indicate that they have been embedded in one's clinical practice. The Committee has received little or no independent assurance, such as peer reviews and verified audits in the areas of concern to demonstrate that the remediation he had undertaken has made any difference to your day to day clinical practice.
>
> Therefore, whilst the Committee appreciated your significant efforts towards remediation, and noted the comments of Professor Willmot's evidence in this regard, it considered that in the absence of any up to date evidence regarding the standard of your practice, there is a risk of repetition. The Committee acknowledged the fact of your retirement and the impact of this on your ability to provide such evidence. However, it had regard to the case of *Clarke* and took into account that it must assess your current fitness to practise, irrespective of your retirement. The Committee noted that you remain on the Dentists Register, and as such, have the potential to return to practice. Accordingly, the Committee determined that a finding of impairment is necessary for the protection of the public.
>
> The Committee next considered the wider public interest. It took into account that wide-ranging and serious findings have been made in this case, and there is little or no evidence of embedded learning. The Committee was of the view that public confidence in the dental profession would be seriously undermined if a finding of impairment were not made in these circumstances. It also considered that such a finding is required to promote and maintain proper professional standards".

95. On that basis the Committee determined that the Appellant's fitness to practise is currently impaired by reason of his misconduct.

The Appellant's case

96. The Appellant argues that in reaching the conclusion it did in respect of impairment, the Committee erred in placing too great an emphasis on the fact of the Appellant's retirement and insufficient weight on the Appellant's evidence of insight and remediation.

97. The Appellant highlights the very positive assessment of his remediation evidence by the Respondent's expert, Professor Willmot, and argues that he could have done no more than he did in this regard, given that he had retired: it was simply not possible for him to provide the evidence of "embedded learning" the Committee apparently required.

The Respondent's case

98. The Respondent argues that the Committee did not place any emphasis on the Appellant's retirement as such, and it gave careful consideration to all of the evidence of remediation and insight that was available to it, and that evidence was insufficient to demonstrate full remediation.

99. Overall, it is said that the Committee was best placed to assess what was required to demonstrate full remediation of its clinical concerns and its finding that evidence was required to show that learning had been "embedded" cannot be criticised.

Discussion and conclusion

100. Following *Clarke*, the Committee was required to assess the Appellant's current fitness to practise. The Committee correctly directed itself in this regard.

101. Given the Appellant's retirement from practice, this was an inevitably difficult exercise, as his counsel recognised in oral argument.

102. However, the Committee plainly grappled with – and indeed largely accepted - the points in the Appellant's favour on the impairment issue, principally his insight and his efforts at remediation, including the positive views of the Respondent's expert on the latter.

103. It is also fair to infer that the Committee was cognisant of the fact that the Appellant's failings related to the treatment of a single patient only, in the context of an otherwise lengthy and unblemished career: the Committee had heard his counsel's submissions to this effect, while addressing the impairment issue (Transcript of 26 May 2021, p.12)

104. The Committee also gave careful consideration to the points in favour of a finding of impairment: namely the serious nature of the issues underpinning the misconduct finding, the content and sufficiency of the remediation evidence and what the public interest required.

105. I accept the Respondent's submission that the Committee did not place weight on the fact of the Appellant's retirement from practice as such, but it did, fairly, recognise the fact of the impact of his retirement on his ability to provide evidence of current practice.

106. However, the Committee had to assess fitness to practise based on the evidence before it. Its assessment that the available evidence did not show that learning had been sufficiently embedded in practice is not one I consider to be wrong or unjust.

107. The Committee was best placed to determine where the balance lay between the competing positions advanced by the parties on the impairment issue, not least because the matters in issue here reflected misconduct constituted by a failure to reach proper standards in treating patients, not matters such as dishonesty or sexual misconduct, and an assessment of what the public interest required (*Southall* [2005] at [11] and *Khan* at [36(c)]).

108. Accordingly ground of appeal 2 is dismissed.

Ground 3: Sanction

The Committee's Determination

109. The Committee's decision on sanction is at its Determination, pp.21-23.

110. The Committee had regard to the Respondent's Guidance for the Practice Committees including Indicative Sanctions Guidance. It identified aggravating and mitigating factors present in the case.

111. It noted the "wide-ranging nature of the concerns raised in this case" and concluded that "addressing these concerns would require the putting in place of a structure and support network to enable [the Appellant] to engage with the remediation process and evaluate [his] progress".

112. The Committee concluded that given that the Appellant had retired from clinical practice, it "could not see how it could formulate a set of conditions that would protect the public and address wider public interest considerations", such that "conditional registration in the circumstances of this case would not be practical or workable".

113. It then decided that a six-month suspension, followed by a review, was the appropriate sanction as this marked the seriousness of the misconduct found, and would "afford [the Appellant] the opportunity to address the concerns raised by the [Committee], while ensuring that members of the public are adequately protected".

The Appellant's case

114. The Appellant argues that it is difficult to understand the rationale behind the Committee's decision as to sanction, as by imposing a period of suspension the Committee was posing the Appellant an impossible task: he was being denied the very opportunity the Committee had purported to afford him to address its concerns (i.e.. a return to practice, through which he could evidence embedded learning opportunity to address concerns identified by the Committee).

115. The Appellant relies on the fact that no questions were asked of him at the hearing about any "structure and support network", which is said to be a "construct" of the Committee's.

116. The Appellant argues that in light of the apparent thinking of the Committee, a more appropriate sanction would have been imposing conditions on his registration compelling him to demonstrate that the relevant learning had been embedded in his practice and/or compelling him to put in place the relevant structure and support network if he sought to return to practice. However, as the Committee found that conditions were not practical or workable, given the Appellant's retirement, it is hard to see how the sanction imposed was appropriate.

The Respondent's case

117. The Respondent recognises that a case of this nature (involving clinical concerns about treatment, communication and record keeping) would often be met with conditions. However, those conditions must be practical and workable and the Indicative Sanctions Guidance at [6.12] makes clear that this applies even if concerns about non-compliance with conditions are due to circumstances, rather than due to the Appellant.

118. The Committee had no evidence before it that the Appellant was (or would be) able or willing to put in place the sort of structure and support network that the Committee considered necessary to enable him to engage with remediation and evaluate progress.

It is said that the Appellant could have volunteered this, having heard the Respondent's submissions on sanction.

119. The Respondent argues that the Committee's approach was not illogical: The Appellant could take the first step to addressing the Committee's concerns by, as is apparently common in this context, identifying a potential placement and colleagues. They could provide the structure and support network that the Committee considered necessary to enable the Appellant to engage with the remediation process and evaluate progress. The Committee would then be in a position to determine, at a review hearing at the end of the six-month period of suspension, whether the arrangements identified by the Appellant could translate into conditions that are practical, workable and enforceable.

120. Alternatively, if the Appellant does not wish to return to practice, he could apply for voluntary removal at the end of the suspension period.

Discussion and conclusion

121. As with the finding on impairment, the fact of the Appellant's retirement made the Committee's decision on sanction difficult.

122. The Committee correctly directed itself to the relevant guidance on sanctions, and properly considered them in increasing order of gravity.

123. There was no argument that the Committee was entitled to reject the sanction of a reprimand, given the gravity of its findings and the ongoing risk to members of the public.

124. Moving to the next possible sanction of conditions, the Committee was required to consider whether any conditions were practical and workable. The applicable Guidance makes clear that this applies, even if – as here – difficulties with practicality or workability are due to circumstances such as retirement.

125. The Committee was entitled to conclude, based on the lack of evidence of the Appellant having the necessary structure and support network, that conditions were not, yet, practical and workable in this case.

126. The Committee was therefore entitled to consider that a suspension with review was the appropriate sanction, bearing in mind the twin purposes of protecting individual patients from risk and the wider public interest.

127. I accept the Respondent's submission as to the practical first step the Appellant could take during the period of suspension (the identification of potential placement and colleagues) if he wishes to return to practice. If he does so, conditions could be imposed at the end of the period of suspension. This has satisfied me that the sanction imposed is not internally illogical or circular in the manner advanced by the Appellant.

128. Overall, the Committee was best placed to assess what the public interest required in terms of sanction (*Southall* [2005] at [11] and *Khan* at [36(c)]).

129. In my view the sanction imposed was appropriate and necessary in the public interest and was not excessive and disproportionate such that this Court should interfere with it (*Sastry* at [101], [105] and [112]).

130. Accordingly ground of appeal 3 is also dismissed.

Conclusion

131. For the reasons set out herein, this appeal is dismissed.