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Case No: AC-2023-LON-002171
CO/2635/2023

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 31/01/2024

Before :

THE HONOURABLE MRS JUSTICE HEATHER WILLIAMS DBE

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Between :

Dr SHALA IMANI	**Appellant**
- and -	
GENERAL DENTAL COUNCIL	**Respondent**

- -
- -

Mr Jamas Hodivala KC (instructed by **Gunner Cooke LLP**) for the **Appellant**
Ms Lydia Barnfather (instructed by **General Dental Council**) for the **Respondent**

Hearing dates: 21 November 2023

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Approved Judgment

This judgment was handed down remotely at 10.30am on 31 January 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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MRS JUSTICE HEATHER WILLIAMS

MRS JUSTICE HEATHER WILLIAMS

Introduction

1. This is an appeal by Dr Shala Imani from the decision of the General Dental Council Professional Conduct Committee ("PCC") of 16 June 2023 suspending her registration as a dentist with the General Dental Council ("GDC") for 12 months. The appeal is brought under section 29(3) of the Dentists Act 1984. Pursuant to CPR 52.21(3), the court will allow the appeal if the decision was wrong or unjust because of a serious procedural or other irregularity in the proceedings below.

2. The allegations faced by Dr Imani concerned the period 2012 – 2018. During that time she undertook private and National Health Service ("NHS") dental work from her two dental practices in Peacehaven and in Hove. As part of her NHS contract for each practice, she had a yearly target to submit a certain amount of Units of Dental Activity ("UDAs").

3. In summary, the PCC found that Dr Imani had caused or permitted claims to be made for UDAs relating to treatments that had not in fact been provided as claimed. This included claiming for treatments that had not taken place and submitting claims with incorrect premature dates of completion. In total, the PCC found that in 23 instances her conduct was inappropriate and misleading and that in nine of those instances, including all of the charges relating to claims with incorrect premature dates of completion, her conduct was dishonest, as she sought to obtain UDAs to which she was not entitled. In addition, the PCC found that in one instance she had acted dishonestly in failing to offer a patient treatment under the NHS, as opposed to exclusively under a private contract. The PCC also determined that Dr Imani failed to provide an adequate standard of care in relation to ten patients and that she failed to provide an adequate standard of record keeping in relation to 12 patients. In turn, the PCC found that the proven allegations amounted to misconduct and that her fitness to practice was impaired by virtue of the proven dishonesty.

4. The Appellant appeals the ten findings of dishonesty. Her Grounds of Appeal are that the PCC was wrong and erred in:

> "1. Admitting or failing to exclude, multiple hearsay evidence regarding Treatment Acceptance Dates and Treatment Completion Dates contained in Schedule C;
>
> 2. Finding dishonesty proved in relation to the allegations 5(g), 6(f), 7(a) – (g) and 17(b);
>
> 3. Determining a sanction of suspension for a period of 12 months."

5. Mr Hodivala KC confirmed at the outset of the hearing that: (a) Ground 1 is only relied on in respect of the ten dishonesty findings, and that none of the other findings made by the PCC are challenged; and (b) Ground 3 only arises if the appeal succeeds in relation to Grounds 1 and/or 2; it does not raise any free-standing issue regarding the sanction imposed.

6. As I explain in para 38 below, Schedule C (the subject of Ground 1), was prepared by Dr Julian Scott, a former Chief Probity Officer of the Dental Practice Board for England and Wales and the GDC's probity expert. The document set out in tabular form data relating to 45 claims made by the Appellant in respect of treatment concerning 20 patients (each of which was assigned a number). The columns of data indicated the Treatment Acceptance Date ("TAD"), the Treatment Completion Date ("TCD"), the date the claim was received, the Band of treatment claimed and the UDAs relating to it. The data in Schedule C was based on records provided by Mr Andy Lee, Senior Operations Lead for the NHS Business Services Authority ("BSA"), in particular in exhibit NHS4. The provenance of this data is described at paras 41 – 45 below. In short, Mr Hodivala submits that it was hearsay evidence that in fairness to Dr Imani should not have been admitted or should have been excluded by the PCC.

7. The Appellant's contentions in relation to Ground 2 are detailed at paras 104 – 111 below. In summary, Dr Imani submitted that the PCC failed to focus on or make sufficient findings in respect of her subjective state of mind, as required by the first stage of the test identified in *Ivey v Genting Casinos* [2017] UKSC 67, [2018] AC 391 ("*Ivey*"); arrived at inconsistent findings between the allegations of dishonesty that were and were not found proven; and made specific errors of reasoning in relation to some of the charges.

8. The structure of this judgment is as follows:

   i) Facts and circumstances and the PCC's findings: paras 9 – 81;

   ii) The legal framework: paras 82 – 102;

   iii) The Appellant's submissions: paras 103 – 111;

   iv) Discussion and conclusions, Ground 1: paras 112 – 129;

   v) Discussion and conclusions, Ground 2: paras 130 – 157; and

   vi) Outcome: paras 158 – 159.

<u>Facts and circumstances and the PCC's findings</u>

Background

9. The Appellant graduated with a degree in dentistry whilst living in Sweden. She came to the United Kingdom in 1998 and has been registered with the GDC since 25 March 1998. In 2000 Dr Imani purchased her first dental practice, which was based in Peacehaven. When the NHS General Dental Services Contract ("GDS Contract") came into existence in April 2006, Peacehaven was allocated over 19,000 UDAs per annum (a relatively large figure). The contract year runs from 1 April to 31 March. The allocation of UDAs remained at this level during the period that the PCC was concerned with. Over the years, the Appellant engaged a number of full time, part-time and locum dentists to assist her in the practice. She also had a practice manager and a receptionist.

10. In May 2005 Dr Imani purchased a second practice, this time in Hove. This was a much smaller operation. Initially the patients were all private, but Dr Imani expanded into NHS work and from 2006 this practice was awarded 600 UDAs annually under the

GDS Contract. From the year 2016/2017 the Appellant was able to sub-contract around 2000 UDAs from the larger Peacehaven contract to be undertaken at Hove.

11. The charges faced by the Appellant arose from reviews of randomly selected records of her patients that were undertaken in August 2014, October 2015 and March 2017.

The GDS contract and FP17

12. By the time of the hearing before the PCC, the correct approach to making claims for dental treatment under the GDS contract was not in dispute. The contested issues concerned Dr Imani's state of mind at the time when the claims were made.

13. The GDS Contract was introduced by the National Health Service (General Dental Services Contracts) Regulations 2005 ("the GDS Regulations") and the National Health Service (Dental Charges) Regulations 2005 ("the Charges Regulations"). A dentist who contracts to work for the NHS agrees to deliver an annual number of UDAs. The dentist is then paid monthly pro rata the value of the annual contract. There is no additional payment made for extra UDAs undertaken, but, in the circumstances that I indicate below, the NHS can clawback funds which have been overpaid if UDA targets are not met. Every dental provider is required by their contract to furnish details of the clinical activity undertaken by the contractor's performers. The notification has to be given within two months of the completion of a course of treatment. From 2013 this is given to NHS England.

14. Clinical activity is measured in terms of UDAs with respect to a completed course of treatment. There are three main charging Bands: Band 1 attracts 1 UDA and covers, for example, examination, diagnosis and preventive care; Band 2 work attracts three UDAs and includes treatment covered by Band 1 with additional treatment such as filings, root canal treatment and extractions; and Band 3 is assigned 12 UDAs and includes treatment that is covered by Bands 1 and 2 plus more complex dental work such as the provisions of crowns and dentures. The provider is expected to know, and to indicate on the FP17 form (para 16 below), the correct Band for the treatment that they provide.

15. The contractor is expected to use their best endeavours to ensure that the course of treatment is completed within a reasonable time: clause 41 of the GDS Contract and Sch 3 Part 2, para 6(2) of the GDS Regulations. A course of treatment encompasses: examination of a patient, assessment of their oral health, the planning of any treatment to be provided and the provision of the planned treatment up to the date on which every component has been provided to the patient (or they voluntarily withdraw or are withdrawn from the treatment): regulation 2(1) of the Charges Regulations. UDAs are attributable when the course of treatment is complete: regulation 2(1) of the GDS Regulations. Accordingly, the accrual of UDAs for a GDS Contract is directly related to the course of treatment completed during a particular contract year, or, to put it another way, the date of completion of a course of treatment determines the contract year to which the relevant UDAs will be attributed.

16. The contractor is required to notify NHS England on the prescribed form ("the FP17") within two months of the date of completion of each course of treatment. At the relevant time, the FP17 could be submitted in paper format or electronically. Its contents provide the basis upon which UDAs are attributed under the contract. If a contractor fails to provide the prescribed number of UDAs in a contract year, pursuant to

regulation 19 of the GDS Regulations, NHS England may seek to recover the shortfall if it exceeds 4% of the contracted total.

17. Dentists were issued with the "NHS Dental Services – Completion of form guidance FP17 – England" ("the Guidance"). The version considered by the PCC was published by the BSA in July 2017. I understand that the contents are not materially different from earlier iterations. Part 1 of the form requires details relating to the patient's NHS number, the provider and the performer. Part 2 relates to the patient's basic information in terms of their name, address, date of birth and so forth.

18. Part 3 of the FP17 is headed "Incomplete Treatment and Treatment Dates". By the words "Incomplete Treatment" the form indicates that the "Band for ACTUAL treatment provided" (emphasis in original) is to be indicated by placing a cross in either Box 1, 2 or 3 (to denote Band 1, 2 or 3). Further boxes in this section of the form, require insertion of the TAD and an indication of whether the TCD is the same as the date of acceptance or, where it is not, the date of completion or the patient's last visit. The Guidance in relation to Part 3 included the following:

> "**Incomplete treatment** – For banded courses of treatment commenced but not completed, cross one of the boxes 1, 2 or 3 to show the work that has been completed. The patient charge will be calculated against whichever of these boxes is crossed. A charge band must also be present in part 5, showing the treatment that has been started, so the band crossed in part 5 must be the same as, or higher than, the band crossed in part 3.
>
> .....
>
> **Completion or Last Visit** – Enter date of completion if the course was completed, or the date of last visit if it was not completed. All forms should be submitted within 2 months of the date of completion. If a decision is made to mark the form as incomplete, it should be submitted as quickly as possible."

19. Part 4 of the FP17 concerns patient exemptions and remissions. Part 5 is headed "Treatment Category". The various bands are then set out with a box by each so that a cross can be placed to denote the correct band. The Guidance notes indicate that only one of the boxes can be crossed on each form. The notes also include the following:

> "**Band 1** – Cross this box for a course of treatment that falls into charge band 1.
>
> **Band 2** – Cross this box for a course of treatment that falls into charge band 2.
>
> **Band 3** – Cross this box for a course of treatment that falls into charge band 3."

20. In Part 5A of the form "the Clinical Data Set" (the nature of the treatment provided) is indicated by placing a cross by the appropriate options.

21. Part 9 of the form contains the declarations. In the paper version of the form, the declaration must be signed by the performer. The Guidance indicates that the first declaration must be signed and dated by a qualified dentist, who would usually be the "Performer responsible for the course of treatment". The declaration includes the statement that "the information I have given on this form is correct and complete". There are two boxes in which a cross may be placed by the declaration. The text by the first box says: "All the necessary care and treatment that the patient is willing to undergo will be provided.". The text by the second box states: "All the currently necessary care and treatment that the patient is willing to undergo has been carried out". The Guidance says that both boxes should be crossed save for instances where the performer decides to discontinue the course of treatment. Part 9 also contains the patient declaration. The Guidance indicates that the patient is to sign this part of the form before NHS dental services are provided. The declaration conveys the patient's consent to examination and to the provision of any necessary care and treatment that they are willing to undergo and their agreement to pay the statutory charges for NHS dental services, if applicable. There is then a section which the patient can complete to claim free or reduced cost NHS dental services.

22. Performers are expected to report on the FP17 Form when a planned course of treatment has been terminated by either the dentist or the patient: clauses 45 and 46 of the GDS Contract and Schedule 3, Part 2 para 8 of the GDS Regulations. A patient may terminate a course of treatment at any time, but the contractor may only do so in certain prescribed circumstances.

23. Under the GDS arrangements, dentists must provide patients with a treatment plan, known as the FP17 DC form. This is a two-party form of which the top copy is given to the patient and the carbon copy retained by the practice with the patient's records. The FP17 DC indicates both private and NHS treatment.

The charges and the outcomes

24. The PCC heard evidence at Stage 1 of the proceedings between 23 May and 17 June 2022. Counsels' speeches were given on 13 October 2022. Stage 2 was heard between 8 – 16 June 2023. It is unnecessary to refer to the detail of Stage 2, save to note that on 9 June 2023 the PCC announced its Stage 1 findings of fact.

25. By the time of the Stage 1 hearing, a number of the charges had been deleted and some had been admitted. Further admissions were made during the course of that hearing. In so far as the Appellant admitted some of the probity charges, this was done on the assumption, "there has been no error in capturing the data". The charges used the same numbering as that deployed in Schedule C to identify particular patients and the particular FP17 claims made in respect of them. Charge 3 said:

> "Between January 2012 and December 2017 you caused or permitted claims to be made in your name for...UDAs...under the provisions of the NHS as set out in Schedule C."

26. Charges 4 – 9 contained the probity allegations. Charge 9 alleged that the conduct set out in charges 4, 5, 6, 7 and/or 8 was: (a) inappropriate; (b) misleading; and (c) "was dishonest in that you sought to obtain additional UDAs to which you knew you were not entitled".

27. Charge 4 concerned "claims you caused or permitted...to be made for treatment that had not been provided as claimed". Charge 4(c) related to Patient 15 and Claim 73. The Appellant admitted and the PCC found that the conduct in charges 4(c) and 4(e)(1) was proved and that Dr Imani had thereby made inappropriate claims. The PCC found that her actions were misleading, but that dishonesty was not proven. The latter finding in respect of charge 4(c) is one of the alleged inconsistencies that Mr Hodivala relies upon. The PCC found that charges 4(f) and 4(g)(2) were not proved.

28. Charge 5 concerned "claims you caused or permitted...to be made under Band 3 when Band 3 treatment had not been provided or had been provided but under private contract". Charge 5(g) concerned Patient 20 and Claim 95. The PCC found that the conduct set out in charges 5(b), 5(c), 5(d), 5(g) and 5(h) was proved and that Dr Imani had thereby made inappropriate claims. The conduct alleged in most of these charges was admitted, although it was not admitted in respect of charge 5(g). The PCC found that her actions were misleading, but that dishonesty was not proved in relation to these charges, save in respect of charge 5(g). The finding of dishonesty in respect of charge 5(g) is challenged in this appeal. Charge 5(f) was not proved.

29. Charge 6 concerned "claims you caused or permitted...to be made under Band 2 when Band 2 treatment had not been provided as claimed". Charge 6(f) related to Patient 22 and Claim 107. The Appellant admitted and the PCC found that the conduct set out in charges 6(a), 6(b)(1), 6(b)(2), 6(c)(2), 6(d), 6(e), 6(f) and 6(g) was proved and that Dr Imani had thereby made inappropriate claims. The PCC found that her actions were misleading, but that dishonesty was not proved, save in relation to charge 6(f). The latter finding is challenged in this appeal. In denying that she was dishonest in respect of the admitted conduct in charge 6(f), Dr Imani said in her Schedule of Admissions: "I now accept that this was an inappropriate claim and that submitting claims for incomplete treatment at the end of the contract year is not appropriate, but I did not know that at the time". She also said that she must have forgotten to put a cross against Band 1 in Part 3 of the FP17 to show that only incomplete treatment had thus far been provided. The conduct alleged at charges 6(c)(1), 6(h)(2) and 6(h)(3) was not proved. The finding that dishonesty was not proved in relation to charge 6(a) is a further alleged inconsistency that Mr Hodivala relies on.

30. Charge 7 alleged: "In respect of the following claims you caused or permitted a claim to be made with incorrect premature dates of completion: (a) Patient 1 and Claim 6; (b) Patient 2 and Claim 12; (c) Patient 6 and Claim 26; (d) Patient 8 and Claim 43; (e) Patient 11 and Claim 50; (f) Patient 22 and Claim 107; and (g) Patient 23 and Claim 109. The Appellant admitted this conduct, but she denied dishonesty on the same basis as she had indicated in respect of charge 6(f). In relation to the charge 7(c) she also said that she could not explain the dates entered and thought it to be "a mistake by whoever completed the form, which I obviously accept responsibility for". The PCC found that her conduct was inappropriate, misleading and dishonest. The findings of dishonesty in relation to these charges are appealed by Dr Imani.

31. Charge 8 related to instances where it was said that the Appellant had caused or permitted a claim to be made which split a patient's treatment into separate claims when it ought to have formed a single course of treatment. Of these, only charge 8(c) was upheld and dishonesty was not proved in relation to it.

32. Charges 10 – 34 related to clinical care and it is generally unnecessary to set out the detail. In general the charges alleged both a failure to provide an adequate standard of care and a failure to keep adequate records. It is only necessary to refer to the charges concerning Patient 5. Dr Imani admitted charge 15 which alleged that she had provided him with periodontal treatment by way of a scale and polish on 11 December 2015, and charge 16 that she did not record discussing with him the option of undergoing the periodontal treatment under the NHS or why the treatment was provided privately. Charge 17, which the PCC upheld, alleged that Dr Imani: "did not offer Patient 5 the option of undergoing periodontal treatment under the NHS and your conduct was thereby: (a) misleading; (b) dishonest in that you sought to obtain private payment for treatment to which the patient was entitled under the NHS". The finding on charge 17(b) is challenged in this appeal.

The evidence before the PCC

33. The PCC had a witness statement from the Appellant dated 16 October 2020. The GDC provided: a first statement from Mr Lee dated 12 November 2020 ("Lee 1") and his further statement served on 31 May 2022 ("Lee 2"); a statement dated 13 November 2019 from Hayley Turner, a Dental Case Manager for Professional Standards at NHS England and NHS Improvement ("Turner 1"); a statement dated 19 November 2020 from Alison Jill Graham a Dental Commissioning Manager at NHS England and NHS Improvement ("Graham 1"); and statements from Patient A and Patient 13. I refer to the contents of Mr Lee's statements from para 38 below.

34. In Turner 1, Ms Turner set out the UDA allocation for each of the relevant years in relation to the Peacehaven and the Hove dental practices and the extent to which these thresholds had been met. In relation to Peacehaven there was a shortfall each year, ranging between 76.54% of the UDA allocation being attained in 2015/2016, to achieving 95.03% of the allocation in 2016/2017 (the first year that Dr Imani could top up with the sub-contracted units from Hove). In relation to Hove, the assigned UDA level was met in most years, although 93.73% was reached in 2014/2015 and 97.53% in 2013/2014.

35. Graham 1 addressed whether a Dental Provider can claim in the first year, on the basis of incomplete treatment, for a course of treatment started in that financial year but completed in the subsequent year. Ms Graham said that if the treatment cannot be completed within the financial year (by 31 March), the Provider would be expected to continue providing that course of treatment and to submit the claim upon its completion. By contrast, an incomplete claim should be submitted when the course of treatment cannot be completed. Ms Graham also said that, given the lapse of time, she could not recall having a conversation with Dr Imani in around 2014 on how to submit claims, but she "would not have advised any NHS Dental Provider that a course of treatment started in one financial year could not be carried forward (completed) in the next financial year, or that they should submit incomplete treatment submissions on the basis of the financial year".

36. The PCC was provided with dental records for the relevant patients and Treatment Reports from BSA. As I detail from para 38 below, the FP17 forms submitted by the Appellant were no longer available. In terms of expert evidence, the GDC relied upon three expert reports: Dr Scott's report dated 11 November 2019 in relation to the probity allegations; Dr Vasiliki Karpeta's report dated 14 November 2019 in relation to the

availability of NHS treatments; and Dr Stuart Ellis' reports dated 1 November 2018 and 12 November 2019 in respect of clinical care and record keeping. Dr Imani relied upon an expert report dated 16 October 2020 prepared by Dr Abhijit Pal, which responded to each of the GDC's reports. The PCC also received joint expert reports: from Dr Scott and Dr Paul dated 25 and 26 November 2020; from Dr Pal and Dr Karpeta dated 28 November 2020; and from Dr Pal and Dr Ellis dated 28 November 2020.

37. The PCC heard oral evidence from the majority of these witnesses including from Mr Lee, Ms Graham, Dr Scott, Dr Pal and Dr Imani. I have been provided with transcripts of the evidence given by these witnesses, which I have read, in addition to considering their witness statements and their reports.

The evidence, submissions and ruling in relation to Schedule C

The evidence

38. Lee 1 exhibited claims data that was said to be drawn from the FP17s submitted by the Appellant. The statement explained that none of the paper FP17s submitted by Dr Imani were available, as the forms were only retained for a period of 14 months and then were shredded after they had been scanned by the imaging team in Newcastle. The exhibits to Lee 1 included NHS4, a spreadsheet which set out the claims data in relation to claims made by the Appellant's practices during the period January 2012 to December 2017. This data included the date when the form was received by BSA, the patient it related to and the payment schedule, the TAD, the TCD, the treatment indicated, and the UDAs claimed. NHS4 was used as the basis for the schedule prepared by Dr Scott for the purposes of his report, which in turn became Schedule C (which, as I have indicated, summarised the data in tabular form in relation to each of the claims that had given rise to a charge). Mr Lee also exhibited NHS5, which included all of the fields relating to Part 3 of the FP17 from for the period April 2014 to December 2017, so that it could be seen whether the treatment had been claimed as incomplete (which NHS4 did not show). The additional information in NHS5 was not available in respect of the period prior to April 2014.

39. In her witness statement the Appellant complained that it was unfair that she was unable to access the FP17 forms to check their contents. She said that she did not consider the BSA's data to be reliable.

40. Following concerns that were raised on Dr Imani's behalf regarding apparent discrepancies, the parties agreed that Mr Lee would provide a further statement explaining the data production and answering these specific points.

41. Lee 2 described the way that the FP17 forms were processed after they were received by BSA. They were scanned by the Scanning Operations Department, thereby creating the date of receipt. The forms were placed in a "Pouch File" with its own unique reference number. The individually scanned FP17s and the Pouch File were then transferred electronically to a branch of BSA known as NHS Dental Services and from there to a third party supplier, who was initially RR Donnelley and then Capita (who both used the same process). The third party supplier would then manually key in the information contained in each individual FP17 form from the Pouch File into an electronic file (the "raw data"). The raw data included the TAD, the TCD, whether there was an "incomplete" marking and the Band. The electronic file containing the raw data

was then transferred back to NHS Dental Services and uploaded to its system. Until February 2016 the system used to upload the electronic files was a VME mainframe and thereafter the Compass system was employed. Compass produced monthly schedules for performers and providers and fed the data into the Data Warehouse each month.

42. Mr Lee also explained that software called Business Objects was used to pull the data from the Data Warehouse for the purposes of NHS4, whereas a software system called eDEN was used in preparing NHS5.

43. Lee 2 also addressed the reliability of the data. Mr Lee said that under the service level agreement, the third party supplier was required to ensure an accuracy rate of 99.9% every month and was required to report to BSA on this on a monthly basis. The monthly reports were no longer available, but neither supplier had ever reported an accuracy of less than 99.9% during the period in question. The quality assurance was done by comparing a 10% sample of the forms in the scanned Pouch Files with the data that had been manually keyed in from the scanned paper FP17 forms to see if they matched.

44. Mr Lee also responded to the apparent discrepancies highlighted by the Appellant's solicitors. The largest number of such discrepancies had been identified in relation to the CRD shown, respectively, on NHS4 and NHS5. Mr Lee explained that this was not information taken from the FP17, but related to the date when the form was received by NHS. The Business Objects system took the date of receipt of the form by BSA as the CRD, whereas eDEN took the date of the scanning, which in most instances, but not invariably, was the same. A discrepancy between NHS4 and NHS5 in relation to the data for Patient 11 was also attributable to the different ways in which Business Objects and eDEN pulled the FP17 data when no TDC or date of last visit was shown on the form.

45. On Day 7 of the hearing (31 May 2022) Mr Lee gave evidence in accordance with Lee 2. (During the evidence NHS4 is also referred to as exhibit 8 and NHS5 as exhibit 10.) Mr Lee was asked to elaborate upon how the accuracy tests were conducted by the third party supplier. He said that the data was re-keyed by a different individual and the two compared. He said that on one occasion a BSA staff member had witnessed the data capturing process, including the quality assurance check. He said that on other occasions the monthly audit reports were taken on a trust basis by BSA. The data was inputted in Columbo and in India.

46. Mr Lee said that he believed that the schedules that were made available to dental providers and performers, against which they could check the accuracy of the inputted information, included the UDA value for the claim and both the TAD and the TCD. On 22 September 2022 the PCC was provided with an Agreed Fact that the monthly reports issued to dentists during the material period included the patient's name, the band claimed, the UDAs allocated, the patient charge and comments, but did not include the TAD or the TCD.

The submissions and the legal advice received

47. Following Mr Lee's evidence, the PCC heard submissions from Counsel. Ms Barnfather indicated that although Mr Hodivala's position was that she should make an application to admit Schedule C as it contained hearsay evidence, she declined to do as

it was already in evidence before the PCC. She added that it was "in any event admissible". Mr Hodivala then made his submissions, indicating that Schedule C was hearsay, as the data set out therein was prepared by human input and the document was relied upon for the truth of its contents, namely as to what had appeared on the submitted FP17 forms. He accepted that the document was a "business record" within the meaning of section 9(1) of the Civil Evidence Act 1995 ("CEA 1995"), but he drew attention to the disapplying power in section 9(5) of the Act. He also referred to Rule 57 of the General Dental Council (Fitness to Practice) Rules 2006 ("the FTP Rules") and to the Criminal Justice Act 2003 provisions applicable to hearsay in criminal proceedings. He then referred to the caselaw (discussed at paras 93 – 100 below).

48. In summary, Mr Hodivala submitted that NHS4, NHS5 and Schedule C should not be admitted for the following reasons: in light of the discrepancies that had been highlighted the evidence was "not demonstrably reliable"; it was unfair to admit the evidence because it was not capable of being tested because the FP17 forms had been destroyed; the allegations of dishonesty that Dr Imani faced were potentially career-ending and the contents of NHS4 and NHS5 (and, in turn, Schedule C) were effectively the sole evidence relied upon by the GDC in respect of the alleged dishonesty; and there was no good reason why the FP17s had been destroyed. In addition to the apparent discrepancies that were addressed in Lee 2, Mr Hodivala referred to some typographical errors in the data: in relation to Claim 122 the patient's year of birth was given as both 1961 and 1962; and in two instances a patient's name had been spelt differently. He acknowledged that these were "a handful of examples".

49. In response, Ms Barnfather referred to section 1(1) CEA 1995 and to rule 57(2) of the FTP Rules (paras 89 - 91 below). She said that the evidence in question related to the processing of data and that there was good reason why the courts permitted business documents to be admitted in evidence as it would be grossly disproportionate to expect all those involved in the processing of the data to give evidence in the proceedings. She submitted that it was in the interests of justice to admit the material and that there was no basis for doubting the method and manner by which BSA had collected the claims data during the relevant period and that there was no basis to doubt its reliability. Furthermore, the errors Counsel had highlighted were "trivial and insignificant and do not invalidate the claims data as a whole". It was not unfair to Dr Imani as the data had been captured from the FP17 forms before they were destroyed. She referred to Mr Lee's evidence regarding the auditing process and the monthly invoices provided to dentists in respect of which "there was no groundswell of concern leading the [BSA] to have any reason whatsoever to want to check the quality of the audit concerning the 99.9% accuracy".

50. The Legal Adviser then gave advice to the Committee. It is unnecessary to refer to the majority of that advice, as Mr Hodivala does not take issue with it. However, I will set out the passages that bear on his complaints of misdirection:

> "The question for you, therefore, is whether you should make a ruling that a particular document or group of documents should not be received in evidence.
>
> I realise that these documents are already in evidence, but that does not seem to me that that makes much difference to the right of Mr Hodivala to make this application because if he can

> persuade you that the documents should not be received in evidence then of course you must make a ruling that notwithstanding the fact that you have already seen them, you won't take them into consideration.
>
> ......
>
> This is not a case where there is an individual witness statement, this is a case concerning a business record. Nevertheless, it seems to me as your Legal Adviser, that you ought to seize the opportunity of considering the admissibility of this evidence with, as it were, open arms, since if the registrant is complaining that this evidence should not have been received you should certainly deal with it.
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> .....
>
> Clearly, Mr Hodivala is making a case here that you should consider at this juncture whether to admit this hearsay evidence, effectively, as it is in front of you, you should determine whether to exclude it, if Ms Barnfather is not actually making an application to admit it.
>
> When you consider whether or not you should exclude it or putting it the other way, whether you should admit it, what you are considering is effectively fairness. The statutory provision and the authorities that I have referred to demonstrate that you have a discretion. The question for you is how you should exercise that discretion.
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> .....
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> ...You should make a determination, whether in those circumstances it is fair to admit this evidence.
>
> ...broadly the position is that as Ms Barnfather indicated that in civil proceedings business record evidence is normally admitted but it can be excluded, and it is right to say that under section [sic] 57(2) other evidence can be admitted after consultation with the Legal Adviser, and you consider that is it in the interests of justice for that evidence to be admissible. Essentially that means fairness."

51. The Committee then asked Mr Hodivala if he had any comments on the legal advice that had been given. He responded that there was one matter, namely the relevance of Dr Imani's inability to challenge the hearsay evidence. The Legal Adviser indicated that this was "clearly a factor which Mr Hodivala can advance". His additional advice included the following:

> "On the one hand [Mr Hodivala] is able to say, 'Well my client cannot challenge this evidence' which is true of course of any

> hearsay evidence, that is the problem with hearsay. But on the other hand, it seems to me that as a committee you are entitled to consider the provenances of this hearsay evidence when considering whether or not it should be admitted. You will have to weigh...the two matters in the balance and then decide which way you are going to come down, I would suggest."

52. Ms Barnfather then said that not only was the data "demonstrably reliable" but that it was not right that the registrant was unable to challenge it because she could and did do so by refence to the patient records, her own recollection and with the support of her own expert. The Legal Adviser then said:

> "Ms Barnfather's observation fits nicely into the way in which Mr Hodivala has expressed himself, it must either be demonstrably reliable or capable of being tested...She makes the point that it is capable of being tested and is indeed challenged by Dr Imani in her evidence."

53. Counsel then indicated that they had no further comments to make on the legal advice that had been given.

The PCC's ruling

54. The Chairman of the PCC made a statement conveying the decision later the same day (31 May 2022). It is reproduced within the PCC's Determination. No criticism is made of the way that Counsels' submissions were summarised. The PCC's decision was expressed as follows:

> "The Committee took into account the submissions made by both parties and accepted the advice of the Legal Adviser.
>
> In making its decision, the Committee acknowledged the importance and the significance of the evidence it was being asked to consider. It noted that it may be the sole evidence with regard to the allegation of dishonesty. However it noted that that was not in itself a reason to exclude the evidence. The Committee was of the view the collation of information from the FP17 forms amounted to a business record, and, as such was generally admissible in regulatory proceedings. The GDC also considered that the information came from a reliable source, namely the NHS. Furthermore, the Committee noted Mr Lee's oral evidence regarding the auditing of the claims data and that out of 10 per cent of the data audited, 99.9 per cent was found to be accurate. The Committee consider that a 10 per cent sample was a reasonable amount to show that the data was reliable. The Committee also considered that you will have the opportunity to present your own evidence with reference to the relevant dental records and the evidence of your expert.
>
> The Committee considered carefully the fact that the FP17 forms were no longer available. The Committee also had regarding to

> Hayley Turner's witness statement...in which she stated that concerns were initially raised about your claiming in 2013. However, the Committee noted that there was no further information contained in her witness statement about what those concerns specifically involved.
>
> The Committee, therefore, do not accept that the evidence is demonstrably unreliable and determined that it should not be excluded."

The PCC's reasoning in respect of the material charges

General directions

55. When setting out its findings of fact, the PCC began by indicating that it had holistically considered all of the evidence presented to it and had considered each head of charge separately, bearing in mind that the burden of proof rested with the GDC to prove the allegations on a balance of probabilities. The PCC indicated that it had kept in mind "the more serious the allegation the less likely it is to have occurred on the balance of probabilities" and "the more serious the allegation the more cogent is the evidence required to prove it". The PCC said that it had made allowance for the passage of time and that if "there was any doubt about what had taken place owing the passage of time, then this should be decided in your favour". The PCC indicated that it rejected Ms Barnfather's submission that Dr Imani's recollection had been selective; the Committee accepted that where there was an absence of documentation, she had genuinely done her best to assist it in giving her evidence.

56. When the PCC came to focus on charge 9 and dishonesty it set out some further self-directions. The PCC reminded itself that this was not a case where the GDC relied upon "blind eye dishonesty". It noted that: "by signing the Part 9 declaration of the FP17 form you '*caused or permitted*' the relevant claims to be made...It is not disputed that dentists/performers are expected to ensure that any claim made in their name is an accurate representation of the treatment, including the date the treatment was provided, under the NHS". The PCC accepted Mr Hodivala's submission that charge 9(c) "requires the GDC to prove, on a balance of probabilities, that you knew you were not entitled to claim the UDAs claimed for". In relation to the test of dishonesty, the PCC said:

> "When determining whether your conduct amounts to dishonesty, it should apply the test set out in the case of [*Ivey*]. It should first consider the actual state of your knowledge or belief as to the facts at the time. It should then go on to consider whether your conduct would be viewed as dishonest by the objective standards of ordinary and decent people. There is no requirement that you must appreciate that what you have done was dishonest by those standards..."

Charge 3

57. As I have already indicated, the PCC found charge 3 proved, namely that Dr Imani had caused or permitted claims to be made in her name for the UDAs set out in Schedule C. In giving its reasoning, the PCC addressed the reliability of the raw data, saying:

> "...the Committee gave careful and detailed consideration to Mr Hodivala's closing submissions about the weight that the Committee should attach to the evidence contained in Schedule C. Mr Hodivala made reference to the non-exhaustive list of considerations identified in Section 4 of the [CEA 1995] and concluded that, '*both the data contained in Schedule C and the evidence of audits involve multiple hearsay*' and '*the registrant (and the Committee) have had no opportunity to check the data because all original documents, including the audit reports, have been destroyed*'. He concluded that, '*no weight should be placed on the hearsay data contained in Schedule C*'.
>
> .....
>
> The Committee accepted Mr Lee's evidence, which is based on his experience of working for NHS Dental Services for 32 years and his knowledge of the process, including the monthly audit of the transcribed data accuracy, gained through his work..."

58. The PCC then summarised and accepted Mr Lee's evidence of the auditing process and his "clear evidence" as to the arrangements by which practitioners could check the accuracy of information about "which FP17 forms have been processed, UDA values, patient charges processed and details of payments". The PCC noted that the PF17 forms were no longer available, but rejected Mr Hodivala's submission that in these circumstances it was "impossible to assess the adequacy or the reliability of either the process or the results". Mr Lee's evidence describing the quality assurance methods and the accuracy of the process was "credible", and the PCC noted the absence of "widespread concerns from the dental profession" over the accuracy of the process of data capture. The PCC acknowledged that Schedule C contained multiple hearsay and that "there was always the potential for error in the data as it involved human input". It referred to the "minor errors drawn to its attention" such as the mis-spelt names. The PCC concluded:

> "...The Committee also accepts that the quality control process did reveal an extremely low level of error (0.1%). The Committee considered this extremely minimal level of error, identified by the quality control process, was so miniscule that it did not justify Mr Hodivala's assertion that no weight whatsoever should be placed on the data in Schedule C because that data was not reliable.
>
> In conclusion, the Committee determined that it was appropriate and fair to place weight on the information contained in Schedule C because that information was reliable."

Charge 4(c)

59. It is necessary to consider the PCC's reasoning in respect of charge 4(c) because, as I have indicated, Mr Hodivala submits that the appealed findings of dishonesty are inconsistent with the finding that dishonesty was not proven in relation to this allegation. A claim had been made for treatment provided on 31 March 2015, but there was no evidence of an appointment or of treatment being given to Patient 15 on that date. This charge did not concern an instance where a claim was made in one contract year in respect of treatment that was in fact provided in the following year.

60. The PCC considered the experts' suggestion that the claim may have related to treatment provided on 9 April 2015 to be speculative. In her evidence, Dr Imani had suggested that the claim related to emergency treatment provided on either 31 March 2015 or on 19 February 2015. Noting the absence of any supporting records for 31 March 2015, the PCC considered this suggestion to also be speculative. The Committee noted that 19 February 2015 pre-dated the date on the claim form and that there had been no claim made for treatment provided on that date, but accepted that this may have been an emergency appointment at that time. The PCC also accepted that the Appellant was attempting to assist the Committee in piecing the events together. Accordingly, on the Committee's findings this was a situation where treatment claimed for 31 March 2015 may in fact have taken place earlier in the same year on 19 February.

61. The PCC explained its conclusion on dishonesty as follows:

> "With regard to dishonesty, the Committee considered your state of mind at the time. It finds credible your evidence that you were running two practices, which were very busy, and that your main focus was on treating patients rather than dealing with the administration and paperwork involved. The Committee noted that this is reflected in the poor standard of your record keeping. Both Dr Scott and Dr Pal were critical of your record keeping. You acknowledged that your record keeping was poor.
>
> You were responsible for signing the FP17 claim forms to verify that they were correct. The Committee found your evidence that:
>
> '*I don't think we were 100% diligent about signing a paper and sending it off because I always thought if anything is wrong they send it back...*'
>
> to be consistent with the chaotic nature of you [sic] practice and your approach towards the completion of FP17 claim forms.
>
> The Committee considered that your approach to completing and submitting the FP17 claim form may have been negligent. However, it reminded itself that negligence, even gross negligence, does not amount to dishonesty.
>
> The Committee, therefore determined that when this claim was made, you were not complying with your responsibilities as a dentist/performer, but you did not submit it knowing or believing

> that you were not entitled to the UDAs claimed. The Committee then determined that your conduct would not be viewed as dishonest by the objective standards of ordinary and decent people."

Charge 4(e)(1)

62. Whilst not one of the findings that Mr Hodivala focused on, I note that in determining that dishonesty had not been proved in respect of charge 4(e)(1), the PCC concluded that the GDC had not provided cogent evidence and that, on the balance of probabilities, when this claim was made "you did not submit it knowing or believing you were not entitled to the UDAs claimed".

Charge 5(b)

63. I turn next to charge 5(b) because it is important to appreciate the nature of the Appellant's misunderstanding in respect of completion of the FP17s that the PCC accepted in relation to this allegation. Charge 5(b) concerned a claim made for Band 3 treatment in respect of Patient 8, which had not been provided. The PCC noted that the records indicated that only incomplete Band 1 treatment had been provided between 27 September - 6 December 2013 (the dates given on the claim form). Dr Imani told the PCC that she had forgotten to tick the "incomplete" box on the FP17. The Committee noted that she had explained her understanding of how the form should be completed was that she could "cross Band 3 in Part 5...because Band 3 treatment was planned, and Band 1 in Part 3 as incomplete treatment because I had only conducted Band 1 work...I thought that Part 3 was used to determine how many UDAs were allocated in those circumstances. I now accept that this was an inappropriate claim".

64. The PCC accepted Dr Pal's oral evidence that he understood why a practitioner could think that Part 5 concerned a course of treatment that they had planned (as opposed to one that they had commenced) and that Part 3 related to the UDAs being claimed for a course of treatment that was incomplete, rather than Part 3 indicating what the patient should be charged (which can only relate to treatment that has actually been undertaken). The PCC accepted Dr Imani's evidence that she had been under a misapprehension as to the inter-relationship between Part 3 and Part 5:

> "...although your interpretation of how to complete the FP17 form was incorrect, you were careless and you benefitted financially from your actions when you submitted the form, you genuinely believed that you were completing it correctly. The Committee determined that the GDC has not provided cogent evidence in support of this charge and has not satisfied the burden of proof. Therefore, it determined, on the balance of probabilities, that when this claim was made, you did not submit it knowing or believing you were not entitled to the UDAs claimed."

Charge 5(c)

65. The PCC's conclusion in respect of charge 5(c) is also of note, as the Committee found that dishonesty was not proven because they accepted that the data could be erroneous

in respect of this allegation. It was another instance where it was said that the Appellant had not provided any Band 3 treatment during the period for which she had claimed for Band 3 on the FP17. The PCC noted that the data indicated that there was no TCD on the form, Dr Imani's explanation that it must have been submitted in error and Mr Lee's suggestion that either the FP17 was sent without a date or the data inputters may have failed to enter the TCD that was in fact shown on the form. The PCC considered that this may have been "an isolated example" where the "form may have been submitted without a date or that the data inputters may have failed to input the [TCD]".

Charge 5(g)

66. Charge 5(g) is the first of the dishonesty conclusions that are appealed. This charge concerned Claim 95 in respect of Patient 20. Both Dr Scott and Dr Pal agreed that there was no evidence of any Band 3 treatment having been undertaken during 25 November – 2 December 2016, the period claimed for commencement and completion of the treatment. The patient's dental records indicated that a filling was removed from their UR6 tooth on 25 November 2016. There were no clinical entries for 2 December 2016, but the UR6 filling was listed as still pending in the appointment log for that date. A filling is a Band 2, rather than a Band 3, procedure. Dr Imani's case as set out in her witness statement was that she had placed an inlay on UR6 (a Band 3 procedure) on 2 December 2016. However, in their joint report, Dr Scott and Dr Pal observed that there was no evidence of this.

67. When she gave oral evidence, Dr Imani said that she now believed that the inlay work she had undertaken was in respect of a different tooth, UR7. There was no documentation that supported the proposition that inlay work to UR7 took place on 2 December 2016, and, to the contrary, the documentation for that date made specific reference to the filling for UR6. Although not covered in his report, when he gave oral evidence, Dr Pal suggested that there appeared to be a change in the restoration of UR7 from composite to metal, as shown in a comparison of x-rays taken on 25 November 2016 and 10 August 2018. Dr Pal described the image of the tooth in the former as looking "a bit different" to the latter, that there was "a different opacity or degree of whiteness" so that he believed "they are two different restorations that we are seeing".

68. Dr Scott was also asked about these x-rays when he gave evidence. He said of the earlier x-ray of UR7 that "it looks like a composite inlay". When he was then shown the 2018 x-ray he said of UR7 that "this looks like a metal inlay", and he agreed with the proposition that at "some point the inlay has changed between November 2016 and August 2018, changed from a composite inlay to a metal inlay". He observed that Mr Hodivala was "testing my experience now as a clinician rather than a probity expert", but accepted that he "did feel comfortable" answering the question, referring to his 27 years of surgical experience up to 1996. When Ms Barnfather returned to this topic in re-examination, Dr Scott agreed that it was "possible" that the two x-rays were taken at different angles rather than showing different things. He said that he was venturing "into an area where I am not sure that I am completely happy" and concluded this topic by saying: "There appears to be a difference between 646 and 647 [the two images]...The 7 shows what appears to be a composite material on the 647 appears to be a metal and I think this is probably as far as I think I should go".

69. In explaining why the Committee found that no Band 3 treatment had taken place during the claimed period, the PCC summarised Dr Imani's explanation in respect of UR7 and then said:

> "Dr Pal's opinion is that the evidence from this can be seen from the x-rays and photos in the records. The Committee had sight of the x-rays and photos referred to by Dr Pal. However, it considered that the quality of these was poor and did not accept Dr Pal's explanation.
>
> The Committee considered that the records did not contain any evidence that an inlay was fitted to the UR7 during the dates claimed for...The Committee noted that there was an appointment for 2 December 2016, which is a 20-minute appointment marked 'pending' for 'filing-composite'. The Committee determined that there are no treatment notes for this appointment and no satisfactory evidence that an inlay was placed on that day.
>
> In conclusion, the Committee preferred and accepted Mr Scott's opinion that no Band 3 treatment was provided during this period."

70. Then when it came on to consider dishonesty, the PCC indicated that it found the Appellant's explanation that the claim was for an inlay to UR6 or UR7 to be "implausible". The PCC again indicated that it did not accept Dr Pal's opinion in respect of the x-rays, which were of poor quality. The PCC noted the absence of any evidence in the records that an inlay was fitted on the dates claimed for. It explained its conclusion that dishonesty was established as follows:

> "The Committee has previously accepted your explanation in relation to other charges for making an incomplete claim where treatment had been planned but not completed within the claim period. However, in relation to this charge, there is no satisfactory evidence that the treatment claimed for was planned, started, or even considered during the claim period.
>
> Considering the evidence holistically, even taking account of the passage of time and considering the chaotic and disorganised nature of your practice and reminding itself of the burden of proof, the Committee is satisfied, on the balance of probabilities, that you knew you were claiming for additional UDAs to which you were not entitled. This is not a claim for incomplete Band 3 treatment and it is inherently unbelievable that you did not know when the claim was submitted that you had not planned or started the treatment you were claiming for. The Committee also considers that you had a motive for making the claim which was you own financial gain. The Committee then determined that this conduct would be viewed as dishonest by the objective standards of ordinary and decent people."

Charge 6(a)

71. I turn next to the finding that dishonesty was not proven in respect of charge 6(a), as this is also relied upon by Mr Hodivala by way of alleged inconsistency in the PCC's conclusions. Charge 6(a) concerned a claim for Band 2 treatment in respect of Patient 3 on 6 August 2013. There was no record of Band 2 treatment having been provided on this date and the PCC found that Dr Imani had not provided any Band 2 treatment for the period claimed. The PCC explained their conclusion that dishonesty had not been proved, as follows:

> "The Committee noted that the records indicate that this patient did attend an emergency appointment at which he received treatment on 6 August 2013...but there is no evidence to persuade the Committee that Band 2 treatment was provided that day.
>
> However, looking at the evidence in the round, taking into account that treatment did take place on 6 August 2013, that your practice was chaotic, disorganised and you did not give the required attention to the completion of FP17s, the Committee concluded that the GDC had not proved to the requisite standard that you submitted this claim believing that it was for UDAs to which you were not entitled. Instead the Committee determined that you sent this claim in without properly checking the form before it was signed by you and submitted. You were careless, but your conduct would not be viewed as dishonest by the objective standards of ordinary and decent people."

Charges 6(b)(2) and 6(e)

72. I note that the PCC's finding regarding the Appellant's genuine misunderstanding regarding Box 3 and Box 5 of the FP17 that led it to find that dishonesty had not been proved under charge 5(b), was also applied by the Committee in making similar findings in respect of charges 6(b)(2) and 6(e).

Charge 6(f)

73. The conclusion of dishonesty in respect of charge 6(f) is the second finding that is challenged in this appeal. As the PCC noted, the claim was submitted for treatment undertaken between 3 – 31 March 2017 in respect of Patient 22, but that there was no record of any appointment for this patient during these dates. Dr Imani said that the claim was for fillings that were provided on 21 April 2017, that is to say after the date the claim was submitted. She admitted that she had not crossed the box on the FP17 to indicate that the treatment was "incomplete" and accepted that it was an inappropriate claim.

74. When it turned to consider whether dishonesty had been established, the PCC quoted the explanation that Dr Imani had provided in her witness statement as to her misunderstanding regarding the submission of FP17s at the end of the financial year:

> "It was my understanding that if you started a course of treatment in one contract year then you couldn't carry it forwards to the

> next year. I was reinforced in this view by a conversation I had with Jill Graham...in about 2014 in which she told me that I had to claim for the work before 31st March in each contract year.
>
> We would therefore fill in the Completion Date / Last Visit Date on the FP17 claim forms based on that understanding if we were unable to complete a patient's course of treatment within the same contract year, we would submit a claim for incomplete treatment on the FP17 claim form."

75. It is necessary to set out the PCC's reasoning for rejecting this professed misunderstanding in some detail:

> "However, the Committee did not accept your explanation as plausible for the following reasons:
>
> - In oral evidence Ms Graham stated that she could not remember this conversation with you. However, she stated, '*Although I cannot recall a conversation with Ms Imani, I would not have advised any NHS dental provider that a course of treatment that started in one financial year could not be carried forward (completed) in the next financial year, or that they should submit incomplete treatment submissions on the basis of the financial year*.' The Committee found Ms Graham's evidence credible. It considered it highly unlikely that Ms Graham would have advised you it is correct to complete FP17 forms in the way you have. Jill Graham's evidence was that she had not been able to find any correspondence from you raising any queries about the correct process for claiming;
>
> - The Committee noted that you had held an NHS contract since 2006 and Jill Graham's evidence was that the procedure on how to submit claims within financial years had not changed since then. You stated that you had realised in 2018 that it was wrong, but did not explain how you came to that conclusion.
>
> - The Committee accepted the witness statement of Hayley Turner...
>
> - Ms Turner relied on documents that had been saved to the NHSE casefile, which showed your UDA targets and performance from 2012 to 2018. The figures in these documents demonstrated that you have consistently underperformed on your Brighton contract for every year from 2012/13 to 2018/19. You agreed in your oral evidence that you knew that you were at risk of 'clawback' of NHS funds prepaid to you throughout these years.

> - The Committee accepted Dr Scott's evidence that, '*By dating a claim that in fact relates to treatment completed in April or May, as if it had been completed during March, the Contractor ensures that the UDAs are accrued during the previous Contract Year*'...The Committee also found credible Dr Scott's expert evidence that there was no misunderstanding from the dental profession at large in relation to premature claiming.
>
> In conclusion, after considering the evidence holistically and where the burden of proof lay, it determined that your explanation was implausible and inherently unbelievable. The Committee did not find it credible that you did not know that you were not entitled to claim in the financial year for work you had not yet completed. Because of this, unlike in relation to certain other allegations where the Committee has accepted that you may have been negligent and/or careless...it determined in relation to this particular allegation that it would have been your genuine belief at the time that you would not have been entitled to claim for Band 2 treatment that had not been completed in that financial year. The Committee then determined that this conduct would be viewed as dishonest by the objective standards of ordinary and decent people."

Charge 7(a)

76. The admitted conduct in charge 7(a) concerned the submission of a claim form in respect of Patient 1 indicating that the treatment dates were 27 – 31 March 2015, when in fact the claim related to the fitting of a crown which was not started until April 2015 and was fitted in May 2015. In denying that she had been dishonest, Dr Imani relied upon the explanation that the PCC considered and rejected in respect of charge 6(f). The PCC explained its finding of dishonesty in relation to the conduct in charge 7(a) as follows:

> "With regard to dishonesty, you denied this and stated that this was an example of where you forgot to cross the 'incomplete' box in Part 3 of the FP17 form. The Committee noted that the claim was submitted with a completion date of 31 March 2015, but the treatment was not completed until 15 May 2015. The Committee had previously rejected your explanation regarding your stated misunderstanding when completing the FP17 form for claims at the end of the financial year which it finds implausible (see reasoning above for charge 6(f) in relation to 9(c)).
>
> Therefore, the Committee determined that when you submitted the claim you did so despite knowing that you were not entitled to claim prematurely for incomplete work in that financial year. The Committee paid careful attention to the fact this claim had a

> completion date of 31 March 2015, which was the end of your UDA year when you underperformed on your NHS contract and were at risk of clawback. The Committee also noted that a number of UDA claims appeared to have been submitted by you on or about the end of the UDA year. Looking at the evidence in the round the Committee find that when you submitted this claim you were seeking to obtain additional UDAs to which you knew you were not entitled. The Committee then determined that this conduct would be viewed as dishonest by the objective standards of ordinary and decent people."

Charges 7(b) – 7(g)

77. Charges 7(b) – 7(g) concerned further instances where FP17s had been submitted in relation to treatment that was said to have taken place shortly before the end of the financial year, but records showed that the treatment had in fact been completed in the financial year that followed, namely on 15 May 2015 in respect of charge 7(b); on 17 April 2012 for charge 7(c); on 8 May 2015 for charge 7(d); on 1 May 2015 for charge 7(e); on 21 April 2017 for charge 7(f)); and on 19 October 2015 in respect of charge 7(g). In finding that the Appellant had been dishonest in each of these instances, the PCC's analysis was analogous to the reasoning that I have set out in relation to charge 7(a).

Charge 17(b)

78. As I explained at para 32 above, in respect of charges 15 and 16, the Appellant accepted that she had provided Patient 5 with periodontal treatment by way of a scale and polish under private contract on 11 December 2015 and that she did not record discussing the option of undergoing the treatment under the NHS or why the treatment was provided privately. The PCC accepted Dr Karpeta's evidence that Patient 5's records showed that this treatment was necessary and that it was available on the NHS.

79. Dr Imani's original case in response to this charge was that she had not provided any periodontal treatment privately. However, when she gave evidence and was cross-examined she indicated that she might have provided Airflow treatment for cosmetic stain removal (which would only be available privately), but omitted to record it.

80. However, the PCC found:

> "The Committee noted the FP17DC forms, which showed that on three separate occasions (14 November 2014, 24 July 2015 and 12 February 2016) you had provided private periodontal treatment to Patient 5. The Committee could see no evidence in the records that you offered to provide this treatment on the NHS.
>
> The Committee found your evidence that the patient had wanted this treatment privately to be vague and not based on any recorded discussion with the patient about this. Further, the Committee finds your explanation that, as Patient 5 had signed

the FP17DC forms, this in itself showed that he had decided to have private treatment implausible.

.....

The Committee is not critical of Airflow being provided as an additional cosmetic private treatment, but finds that because this patient's BPE scores indicated that periodontal disease was present the patient should have been offered the available treatment on the NHS. The Committee considers that there is no satisfactory evidence that you did this.

Accordingly, the Committee found it proved that you did not offer Patient 5 the option of undergoing periodontal treatment under the NHS."

81. After referring again to the *Ivey* test, the PCC concluded:

"...on the balance of probabilities, that as an experienced general dental practitioner, who had been working under an NHS contract since 2006, you would have been aware at the time that the treatment was available on the NHS. The Committee determined that the three separate FP17DCs, dated 14 November 2014, 24 July 2015 and 12 February 2016, evidenced that you had provided on these occasions private periodontal treatment, without the patient being offered the treatment on the NHS. The Committee considers that signing the FP17DCs evidences the patient may have been aware of the £65 charge but not that he could have had the treatment on the NHS but opted to have it privately instead.

The Committee determined that the use of Airflow was not documented in the clinical records to prompt the receptionist to charge for Airflow. The Committee finds it implausible that your receptionist, rather than you, decided that the patient should pay the £65 charge.

Looking at the evidence in the round, the Committee decided, on a balance of probabilities, that despite being aware that this patient was entitled to NHS treatment, you decided to charge him privately, without making him aware that the treatment was available on the NHS and that you did this most likely for personal gain. The Committee concluded that ordinary and decent people would view your actions of seeking to obtain private payment for this treatment, when the patient could have had the treatment provided on the NHS, as dishonest."

The legal framework

The approach on appeal

82. The appeal is brought under section 29(3) of the Dentists Act 1984 (para 1 above). The Court may dismiss the appeal or allow the appeal and quash the decision and substitute a different decision within the range that could have been imposed by the PCC or remit the case.

83. In *Wasu v GDC* [2013] EWHC 3782 (Admin) ("*Wasu*") Haddon-Cave J (as he then was) identified the correct approach for this Court to take as follows:

> "16. The approach to an appeal pursuant to s.29 of the Dentists Act 1984 can be summarised as follows:
>
> (1) An appeal pursuant to s.29 of the Dentists Act 1984 is by way of rehearing...
>
> (2) ...
>
> (3) The Court will allow an appeal where the decision of the lower tribunal was wrong or unjust because of a serious procedural, or other irregularity in the proceedings before the lower tribunal...
>
> 17. The general principles applicable to an appeal against a decision of a professional Disciplinary Committee of this sort can be summarised as follows:
>
> (1) The Court will give appropriate weight to the fact that the Panel is a specialist tribunal, whose understanding of what the medical profession expects of its members in matters of medical practice deserves respect;
>
> (2) The Court will have regard to the fact that the tribunal has had the advantage of hearing the evidence from live witnesses;
>
> (3) The Court should accordingly be slow to interfere with decisions on matters of fact taken by the first instance body;
>
> (4) Findings of primary fact of the first instance body, particularly if founded upon an assessment of the credibility of witnesses, are close to being unassailable, and must be shown with reasonable certainty to be wrong if they are to be departed from;
>
> (5) Where what is concerned is a matter of judgement and evaluation of evidence which relates to areas outside the immediate focus of interest and professional experience of the body, the Court will moderate the

> degree of deference it will be prepared to accord, and will be more willing to conclude that an error has, or may have been, made, such that a conclusion to which the Panel has come is or may be 'wrong' or procedurally unfair."

84. *Sastry v General Medical Council* [2021] EWCA Civ 623, [2021] 1 WLR 5029 emphasises that the degree of deference to be accorded to the findings of the first instance body will depend upon the circumstances. Giving the judgment of the Court of Appeal, Nicola Davies LJ said:

> "103. The courts have accepted that some degree of deference will be accorded to the judgment of the tribunal but, as was observed by Lord Millett at para 14 in *Ghosh*, 'the Board will not defer to the Committee's judgment more than is warranted by the circumstances'. In *Preiss* [2001] 1 WLR 1926, at para 27, Lord Cooke stated that the appropriate degree of defence will depend upon the circumstances of the case; Laws LJ in *Raschid and Fatnam* [2007] 1 WLR 1460, in accepting that the learning of the Privy Council constituted the essential approach to be applied by the High Court on a section 40 appeal, stated that on such an appear material errors of fact and law will be corrected and the court will exercise judgment but it is a secondary judgment as to the application of the principles to the facts of the case (para 20)..."

85. In *Byrne v General Medical Council* [2021] EWHC 2237 (Admin) Morris J reviewed the circumstances in which the Court hearing the appeal would interfere with findings of primary fact (as opposed to findings of secondary fact or evaluative judgment). In the passage cited below he referred to *Thomas v Thomas* [1947] AC 484, *Libman v General Medical Council* [1972] AC 217, *Gupta v General Medical Council* [2001] UKPC 61, [2002] 1 WLR 1691, *Casey v General Medical Council* [2011] NIQB 95, *Perry v Raleys Solicitors* [2019] UKSC 5 and *R (Dutta) v General Medical Council* [2020] EWHC 1974 (Admin):

> "14. ...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 conclusion'* per Lord Thankerton in *Thomas v Thomas* approved in *Gupta*;
>
> - findings '*sufficiently out of 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'* per in *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*..."

Dishonesty

86. In I*vey* Lord Hughes explained the legal test for dishonesty as follows:

> "74. ...Where dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest."

87. This test applies to regulatory proceedings: *Photay v General Dental Council* [2023] EWHC 661 (Admin) at para 44.

88. Given the nature of the *Ivey* test, the registrant's actual state of mind is a critical issue for the first instance body to resolve in determining whether the conduct in question is honest or dishonest: see for example para 77 in *GDC v Williams* [2023] EWCA Civ 481.

Hearsay evidence

89. Rule 57 of the FTP Rules provides:

> "**57 Evidence**
>
> (1) A Practice Committee may in the course of the proceedings receive oral, documentary of other evidence that is admissible in civil proceedings in the appropriate court in the part of the United Kingdom in which the hearing takes place.
>
> (2) A Practice Committee may also, at their discretion, treat other evidence as admissible, if, after consultation with the legal adviser, they consider that it would be helpful to the Practice Committee, and in the interests of justice, for that evidence to be heard.
>
> (3) ...

(4) It shall be for the Council to prove any fact alleged in the notification of hearing, on the balance of probabilities."

90. Accordingly, the Committee has a discretion to admit hearsay evidence that would be admissible in civil proceedings pursuant to the CEA 1995; and also a broader discretion to receive evidence that would not be admissible in civil proceedings where it considers it to be "helpful to the" Committee and "in the interests of justice" to do so.

91. The material provisions of the CEA 1995 are as follows:

"**1. – Admissibility of hearsay evidence**

(1) In civil proceedings evidence shall not be excluded on the ground that it is hearsay.

(2) In this Act –

(a) 'hearsay' means a statement made otherwise than by a person whilst giving oral evidence in the proceedings which is tendered as evidence of the matters stated;

4. – Considerations relevant to weighing of hearsay evidence

(1) In estimating the weight (if any) to be given to hearsay evidence in civil proceedings the court shall have regard to any circumstances from which any inference can reasonably be drawn as to the reliability or otherwise of the evidence.

(2) Regard may be had, in particular, to the following –

(a) whether it would have been reasonable and practicable for the party by whom the evidence was adduced to have produced the maker of the original statement as a witness;

(b) whether the original statement was made contemporaneously with the occurrence or existence of the matters stated;

(c) whether the evidence involves multiple hearsay;

(d) whether any person involved had any motive to conceal or misrepresent matters;

(e) whether the original statement was an edited account, or was made in collaboration with another or for a particular purpose;

(f) whether the circumstances in which the evidence is adduced as hearsay are such as to suggest an attempt to prevent proper evaluation of its weight.

9. – Proof of records of business or public authority

(1) A document which is shown to form part of the records of a business or public authority may be received in evidence in civil proceedings without further proof.

(2) A document shall be taken to form part of the records of a business or public authority if there is produced to the court a certificate to that effect signed by an officer of the business or authority to which the records belong......

(3) .....

(4) In this section –

'*records*' means records in whatever form

'*business*' includes any activity regularly carried on over a period of time, whether for profit or not, by any body (whether corporate or not) or by an individual;

...

(5) The court may, having regard to the circumstances of the case, direct that all or any of the above provisions of this section do not apply in relation to a particular document or record, or description of documents or records."

92. Accordingly, the default position pursuant to section 9(1) of the CEA 1995 is that records of a business may be received in evidence without further proof, subject to the power contained in subsection (5) to disapply this provision. It is unnecessary to consider what amounts to the "records of a business" in any detail, as Mr Hodivala accepts that the PCC was correct in treating the contents of NHS4, NHS5 and Schedule C as the records of a business.

93. The Courts have considered a number of appeals where it was alleged that hearsay evidence was unfairly admitted, including contentions that the procedure adopted by the disciplinary committee breached the fair trial requirements of Article 6 of the European Convention on Human Rights ("ECHR"). The caselaw was reviewed by Linden J at paras 58 – 65 of *El Karout v Nursing and Midwifery Council* [2020] EWHC 3079 (QB) ("*El Karout*"), where he referred to *Nursing and Midwifery Council v Ogbonna* [2010] EWCA Civ 1216 ("*Ogbonna*"), *R (Bonhoeffer) v General Medical Council* [2011] EWHC 1585 ("*Bonhoeffer*") and *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 ("*Thorneycroft*"). Mr Hodivala relies upon these authorities.

94. Article 6(1) provides that: "In the determination of his civil rights and obligations or of any criminal charges against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law". Article 6(3)(d) provides that everyone charged with a criminal offence has the right to

"examine or have examined witnesses against him and to obtain the attendance and examination of witnesses on his behalf under the same conditions as witnesses against him".

95. In *Ogbonna* the Court of Appeal refused to grant permission to appeal to the Nursing and Midwifery Council ("NMC") from the High Court's finding that the Committee had misdirected itself in deciding to admit a witness statement from a Ms Pilgrim, the registrant's team leader. The NMC's case was centrally dependent upon this evidence; her account was disputed and it was accepted that there had been a difficult relationship between the two women. The NMC had made no effort to arrange for Ms Pilgrim to be available to attend the hearing for cross-examination. Rule 31(1) of the NMC (Fitness to Practice) Rules Order of Council 2002 was similar to rule 57(2) of the FTP Rules, save that the text referred to "the requirements of relevance and fairness" rather than to admission of the evidence being "helpful" to the Committee and "in the interests of justice". As Linden J summarised in *El Karout*:

> "58. ...the Court of Appeal emphasised that the issue of fairness under r.31 goes to the admissibility of the evidence rather than merely to its weight. It therefore is not open to the [Committee] to adopt an approach which involves admitting the evidence and then giving such weight to it as the Committee thinks fair: see, in particular, paras 23 and 25 of the judgment of the Court of Appeal.
>
> 59. In *Ogbonna*, the NMC had placed reliance on the statement of a Ms Pligrim without calling her. At para 23, Rimer LJ, with whom Pill and Black LJ agreed, said this:
>
>> '...the criterion of fairness referred to in 31(1) is relevant to whether a statement should be admitted at all; the rule expressly requires decisions as to the admission or exclusion of a hearsay statement to be governed by considerations, *inter alia*, of fairness. In that context, the NMC should perhaps be reminded that it was seeking to adduce Ms Pilgrim's statement as the sole evidence supporting the material parts of Charge 1, when it knew that the evidence was roundly disputed and could not be tested by cross-examination. It was, moreover, seeking to adduce it in support of a case that it was promoting, whose outcome could be (and in the event was) the wrecking of Mrs Ogbonna's career as a midwife, a career which had lasted over 30 years. I should have thought it was obvious that, in the circumstances fairness to Mrs Ogbonna demanded that in principle the statement ought only to be admitted if she had the opportunity of cross-examining Ms Pilgrim upon it.'"

96. Rule 34 of the General Medical Council (Fitness to Practice) Rules Order of Council 2004 provided that where evidence would not be admissible in criminal proceedings in England, the Committee or Panel should not admit such evidence unless satisfied after due enquiry that its admission was "desirable". In *Bonhoeffer* the High Court allowed the registrant's application for judicial review, finding that the Panel's decision to admit

the hearsay evidence in question had been irrational and a breach of his Article 6(1) right to a fair hearing. The evidence concerned video-taped police interviews with a young man who lived abroad, who was the single source of most of the allegations of sexual misconduct faced by the claimant. The young man had indicated he was willing to travel to attend the hearing in person, but the GMC decided not to call him. The principles relating to the right to cross examine were summarised by Stadlen J at para 109 as follows:

> "i) Even in criminal proceedings the right conferred by Article 6(3)(d) to cross-examine is not absolute. It is subject to exceptions referrable to the absence of the witness sought to be cross-examined, whether by reason of death, absence abroad or the impracticability of securing his attendance.
>
> ii) In criminal proceedings there is no 'sole or decisive' rule prohibiting in all circumstances the admissibility of hearsay evidence where the evidence sought to be admitted is the sole or decisive evidence relied on against the defendant.
>
> iii) In proceedings other than criminal proceedings there is no absolute entitlement to the right to cross-examine pursuant to Article 6(3)(d).
>
> iv) However, disciplinary proceedings against a professional man or woman, although not classified as criminal, may still bring into play some of the requirements of a fair trial spelt out in Article 6(2) and (3) including in particular the right to cross-examine witnesses whose evidence is relied on against them.
>
> v) The issue of what is entailed by the requirement of a fair trial in disciplinary proceedings is one that must be considered in the round having regard to all relevant factors.
>
> vi) Relevant factors to which particular weight should be attached in the ordinary course include the seriousness and nature of the allegations and the gravity of the adverse consequences to the accused person in the event of the allegations being found to be true. The principal driver of the reach of the rights which Article 6 confers is the gravity of the issue in the case rather than the case's classification as civil or criminal.
>
> vii) The ultimate question is what protection is required for a fair trial. Broadly speaking, the more serious the allegation or charge, the more astute should the courts be to ensure that the trial process is a fair one.
>
> viii) In disciplinary proceedings which raise serious charges amounting in effect to criminal offences which, if proved, are likely to have grave adverse effects on the career and reputation

> of the accused party, if reliance is sought to be placed on the evidence of an accuser between whom and the accused party there is an important conflict of evidence as to whether the misconduct alleged took place, there would, if that evidence constituted a critical part of the evidence against the accused party and if there were no problems associated with securing the attendance of the accuser, need to be compelling reasons why the requirement of fairness and the right to a fair hearing did not entitle the accused party to cross-examiner the accuser."

97. In *Thorneycroft* the High Court quashed the Panel's decision that the registrant's fitness to practice was impaired by reason of misconduct, finding that there were a number of irregularities that had a material bearing on the findings of fact that were made. Neither of the two principal complainants had attended the hearing to give oral evidence and there were suggestions that they had personal antipathy towards the registrant. Mr Andrew Thomas QC sitting as a Deputy High Court Judge ("DHCJ") found that the Panel had erred in deciding to admit their statements as evidence, in particular as it had done so without having first undertaken a careful balancing exercise in respect of the relevant matters.

98. The DHCJ summarised the principles at para 45 of his judgment as follows:

> "1.1 The admission of the statement of an absent witness should not be regarded as a routine matter. The FTP rules require the Panel to consider the issue of fairness *before* determining the evidence.
>
> 1.2 The fact that the absence of the witness can be reflected in the weight to be attached to their evidence is a factor to weigh in the balance, but it will not always be a sufficient answer to objection to admissibility.
>
> 1.3 The existence or otherwise of a good and cogent reason for the non-attendance of the witness is an important factor. However, the absence of a good reasons does not automatically result in the exclusion of the evidence.
>
> 1.4 Where such evidence is the sole or decision evidence in relation to the charges, the decision whether or not admit it requires the Panel to make a careful assessment, weighing up the competing factors. To do so, the Panel must considers the issues in the case, the other evidence which is to be called and the potential consequences of admitting the evidence. The Panel must be satisfied either than the evidence is demonstrably reliable, or alternatively that there will be some means of testing its reliability."

99. At para 56 of his judgment, Mr Thomas identified the considerations that the Panel should have taken into account. These included: whether the statements were the sole or decisive evidence in support of the charges; the nature and extent of the challenge to their contents; whether there was any suggestion that the witnesses had reason to

fabricate their accounts; the seriousness of the charges and the potential impact on the registrant's career; and whether there was a good reason for the non-attendance of the witnesses.

100. In *El Karout* Linden J found that the Committee had erred in determining that it was fair to admit the statement of Patient C, a significant witness who had failed to attend the hearing. The errors he identified in the Committee's reasoning included: concluding that the evidence of Patient C was not the sole or decisive evidence; failing to consider whether their account was demonstrably reliable or whether there was some means of testing its reliability (in circumstances where there were question marks over its reliability); not reading the statement before making its decision on admissibility; and failing to refer to the seriousness of the issues faced by the registrant (paras 77 and 81).

101. In *Mansaray v Nursing and Midwifery Council* [2023] EWHC 730 (Admin) ("*Mansaray*"), Stacey J dismissed the registrant's appeal from the Panel's decision upholding allegations of misconduct and finding that his fitness to practice was impaired. She concluded that the Panel was entitled to admit hearsay evidence from a witness, Patient A, regarding allegations of inappropriate sexual behaviour towards him. In summary, the Panel had conducted a careful evaluation of the relevant factors before deciding to admit the evidence (paras 48 – 56). As I return to (at paras 103(vi) and 121 below) Mr Hodivala places reliance upon the following paragraph of Stacey J's judgment:

> "55. The appellant criticises the wording of the Panel's decision that stated: 'The panel did not consider Patient A's account to be so unreliable that it should not be admitted into evidence'. This was a good point well made by Ms Ahmed. If that had been how the Panel had directed itself as to how to approach the question of the admissibility of hearsay evidence, it would be worrying as it is wrong. However, when one reads those words in the context of the Panel's overall self-direction and all its findings and reasoning, it is clear that it is just a stray phrase – merely infelicitous wording or a Homeric nod – and does not represent the test they have applied. The Panel did not consider the admission of Patient A's statement as a routine matter. It noted the good and cogent reason for the inability of Patient A to attend the hearing to give evidence...His evidence was decisive, but after careful consideration the Panel concluded that Patient A's account...was demonstrably reliable and in some respects was capable of being tested by other evidence."

102. The Court also rejected the proposition that including the evidence in the hearing bundle before admissibility had been determined was a procedural irregularity; the Panel had to consider the hearsay evidence in order to rule on its admissibility (para 64).

The Appellant's submissions

Ground 1

103. During his oral submissions, Mr Hodivala accepted that the contents of Schedule C was a business record and, as such, that it would have been admissible in civil proceedings under the CEA 1995. However, he submitted that the admission of the hearsay evidence in Schedule C was unfair and constituted a breach of Article 6(1) of the ECHR, so that the PCC was wrong to admit or to fail to exclude this evidence. He relied upon the following contentions in particular:

    i) The GDC declined to apply to admit the hearsay evidence;

    ii) In turn this led to unfairness to the Appellant, as the PCC treated the application as one to exclude the evidence, thereby placing the burden on Dr Imani to show why it should be excluded, rather than on the GDC to establish that it was fair to admit the evidence;

    iii) The evidence given by Mr Lee about the quality assurance auditing process and its outcomes involved multiple hearsay evidence. In addition, the evidence was unsatisfactory as the audits were carried out by third parties and the results simply taken on trust by the BSA. In oral submissions he added for the first time that it was irrational for the PCC to accept that an auditing process, which tested a 10% sample, provided a sufficient indicator of reliability, particularly in the absence of any expert evidence as to its statistical significance;

    iv) As the FP17 forms and the audits had been destroyed Dr Imani had no opportunity to test the accuracy of the evidence contained in Schedule C. The Legal Adviser failed to address this matter adequately in his advice to the PCC, wrongly indicating that the admission of hearsay always involved the inability to challenge the evidence (in the passage set out at para 51 above). Furthermore, the PCC was wrong to conclude that the Appellant could test its accuracy in any meaningful way;

    v) As shown by the agreed fact, the PCC relied on inaccurate evidence from Mr Lee that the TAD and TCD were included in the material that was made available to all dentists (para 46 above). As this part of the data was not sent to the dentists, there could not have been any concerns raised by them as to its accuracy and it was irrational for the PCC to have attached any weight to the absence of voiced concerns in these circumstances;

    vi) The PCC placed the onus on Dr Imani to show that the material was unreliable, rather than placing the onus on the GDC to show that it was reliable. The PCC referred in terms to whether the data was "demonstrably unreliable", and the Legal Adviser had wrongly suggested that the burden was on Dr Imani to establish this. The PCC had thereby adopted the very approach described as "wrong" in para 55 of *Mansaray* (para 101 above); and

    vii) It was particularly unfair to admit the evidence given the errors that had been shown in the data.

Ground 2

Charges 6(f) and 7(a) – (g)

104. Mr Hodivala emphasised the PCC's findings that dishonesty had not been proved in relation to a number of the charges faced by the Appellant and that the Committee's reasoning involved an acceptance that she was very busy at the time, that her record keeping was poor and her administration chaotic and that she did not properly check the forms, for example in relation to charges 4(c) and 6(a) (paras 59 – 61 and 71 above). Furthermore, in relation to charge 5(b) the PCC had accepted that the allegations of dishonesty were not proven in light of Dr Imani's explanation as to how she had genuinely misunderstood what she was required to enter on the FP17 form. He submitted that in light of these findings it was inconsistent and wrong for the PCC to find these other allegations of dishonesty proved, particularly as they were also based on a misunderstanding regarding completion of the FP17 forms. He said that there was no evidential or rational basis for the different conclusions reached and that the circumstances were identical.

105. Mr Hodivala also criticised the PCC's reasons for rejecting Dr Imani's explanation as to why she had completed the FP17 form as she had (paras 74 - 75 above). It was unfair of the Committee to rely upon Jill Graham's evidence that she would not have advised Dr Imani to complete the form in this way (para 75 above). The Appellant's evidence was not that this was what Jill Graham had told her to do, rather her evidence was that this was how she had understood Ms Graham's advice at the time.

106. Mr Hodivala drew attention to the wording of charge 9: "you sought to obtain additional UDAs to which *you knew you were not entitled*" (emphasis added). This was not a case about blind-eyed recklessness. He submitted that the PCC failed to apply the subjective limb of the *Ivey* test, in that the Committee failed to find that the Appellant knew that the declaration on the relevant FP17 form was wrong and/or that the data submitted in the form was wrong and that she was not entitled to make a claim in the way that she had done. He said that the PCC wrongly focused on the objective limb of the *Ivey* test. In this regard, Mr Hodivala referred specifically to evidence given by the Appellant as to the extent to which others at the practices had a role in the completion of the forms.

107. Mr Hodivala indicated that he did not pursue the allegation in his skeleton argument that it was never put to Dr Imani that she was not telling the truth in relation to the misunderstanding that she described.

Charge 5(g)

108. Mr Hodivala said that the PCC had failed to have regard to Dr Scott's evidence concerning the changed appearance of the patient's UR7 (para 68 above); this clearly supported Dr Pal's opinion, but it was not referred to at all in the Committee's reasoning (para 69 above).

109. Secondly, Mr Hodivala criticised the PCC's assessment that in this instance there was no evidence of the planned treatment (para 70 above). He submitted that the PCC failed to refer to the fact that there must have been an FP17 signed and dated by the patient for this claim to have been made, and that this would have set out the treatment planned by Dr Imani. In this regard he referred to an answer given by Mr Scott when he was

being asked in cross-examination about the FP17 form and the Guidance, where he indicated that an FP17 signed by the patient was "[t]he best evidence that there is a [treatment] acceptance date".

110. An allegation that the PCC had failed to apply the subjective limb of the *Ivey* test in relation to its finding on this charge was not pursued.

Charge 17(b)

111. Firstly, Mr Hodivala submitted that the Committee proceeded on an erroneous factual basis, namely that there were three further occasions where the Appellant had provided private periodontal treatment to Patient 5 (para 80 above). The GDC had in fact withdrawn charges in relation to 14 November 2014 and 24 July 2015 and there was no allegation in relation to 12 February 2016. Secondly, he said that the PCC's reasoning showed that it reversed the burden of proof in relation to this charge in stating that: "... that patient should have been offered the available treatment on the NHS. The Committee considers that there is no satisfactory evidence that you did this". Thirdly, he contended that there was no evidence to rebut Dr Imani's case that the patient had wanted to have the treatment privately on this occasion; there was no evidence called from the patient and she had provided him with treatment on the NHS on other occasions.

Discussion and conclusions

Ground 1

Alleged misdirections by the PCC

112. As its terms make clear, Rule 57(2) of the FTP Rules confers a discretion on the PCC in relation to the admission of evidence that it considers it "helpful" and "in the interests of justice" to hear (para 89 above). I will initially consider the respects in which the Appellant contends that the PCC misdirected itself in exercising its discretion to admit / not to exclude the contents of Schedule C.

113. Firstly, it is said that the PCC wrongly placed the burden on Dr Imani to show that the evidence should be excluded, rather than on the GDC to show that it should be admitted. I reject that submission for the reasons that I now identify.

114. The advice given by the Legal Adviser, which I have set out at para 50 above, did not distinguish between whether the PCC should *admit* the Schedule C evidence or *exclude* the evidence, both phrases were used interchangeably. However, crucially, the advice made clear that the central question for the PCC in the exercise of its discretion was "what you are considering *is effectively fairness*", "You should make a determination, *whether in those circumstances it is fair to admit this evidence*", and "you consider that it is *in the interests of justice for that evidence to be admissible. Essentially that means fairness*" (emphasis added).

115. The authorities have drawn no distinction between the "interests of justice" criterion in the FTP Rules and the requirement of "fairness" in the NMC's Fitness to Practice Rules (paras 89 and 95 above) and Mr Hodivala accepts that fairness was indeed the key touchstone for the Committee when exercising this discretion. The PCC indicated that

it accepted the Legal Adviser's advice (para 54 above) and there is nothing to indicate that it failed to follow this. This approach does not involve placing an onus on the registrant to establish that evidence should be excluded. The PCC's reasoning shows that in assessing fairness it had regard to and carefully balanced the relevant considerations that Counsel had relied upon in their respective submissions. In particular the PCC addressed: the importance of the evidence; whether it was the sole evidence with regards to the allegations of dishonesty; that it was a business record and, as such, generally admissible in regulatory proceedings; the reliability of the information; whether Dr Imani would have the opportunity to challenge the evidence; and why the FP17 forms were no longer available (para 54 above).

116. As the Schedule C evidence was already before the PCC, it is unsurprising that the terminology of both admission and exclusion was used, but it made no practical difference to the PCC's examination of whether, overall, it was fair to permit the GDC to rely on this evidence. Inevitably the PCC had to consider Schedule C and the evidence from Mr Lee relating to its provenance before it could resolve this issue (*El Karout* at para 100 above and *Mansaray* at para 102 above) and so nothing turns on the fact that it was already before the Committee at this juncture.

117. During the hearing, Mr Hodivala emphasised a particular passage in the Legal Adviser's advice, which he said wrongly indicated that the burden lay with the Appellant, namely: "I realise that these documents are already in evidence, but that does not seem to me that that makes much difference to the right of Mr Hodivala to make this application because if he can persuade you that the documents should not be received in evidence then of course you must make a ruling notwithstanding the fact that you have already seen them". However, rather than taken in isolation, this one sentence needs to be considered in light of the entirety of the advice given by the Legal Adviser, which covers three and a half pages of a single line spaced transcript and includes the passages that I have set out at para 50 above. Read as a whole, I am satisfied that the Legal Adviser did not indicate that there was an onus on Dr Imani to establish that the Schedule C material should be excluded. Furthermore, the central point being made in this particular sentence was one favourable to Dr Imani, namely that the PCC should still give full consideration to the admissibility of the material, notwithstanding that it was already before the Committee. Whilst I do not place it at the centre of my reasoning, I also derive some support from the fact that Mr Hodivala raised no objection to this aspect of the Legal Adviser's advice at the time, although he was given the opportunity to comment (para 51 above); and this point was not thought to be sufficiently significant to appear in the detailed Skeleton Argument that he prepared for the hearing.

118. Mr Hodivala also submitted more specifically that the PCC wrongly placed the onus on Dr Imani to show that the Schedule C material was unreliable, rather than assessing whether the GDC had shown that it was reliable, as required by para 45 of *Thorneycroft*, in turn cited with approval in *El Karout* (paras 93 and 98 above). In considering this submission, I proceed on the basis most favourable to Dr Imani, namely that the Schedule C material was indeed the sole or decisive evidence against her in relation to the dishonesty allegations. Nonetheless, I am unpersuaded by it.

119. The PCC were given a very clear direction by the Legal Adviser in this regard, to the effect that the evidence must either be demonstrably reliable or capable of being tested (para 52 above). This direction accurately reflected the earlier authorities.

120. It is also apparent that the PCC were alive to this issue. In summarising Mr Hodivala's submissions, the PCC noted: "He submitted that you have the right to a fair trial and that the evidence should be demonstrably reliable and capable of being tested for it to be admitted". In summarising Ms Barnfather's submissions, the PCC noted: "she referred the Committee to Mr Lee's oral evidence in which he attested to the reliability of the data". Then in setting out its decision, the PCC explained why it considered that the data in Schedule C *was reliable*: "...the Committee noted Mr Lee's oral evidence regarding the auditing of the claims data and that out of 10 per cent of the date audited, 99.9 per cent was found to be accurate. The Committee considered that a 10 per cent sample was a reasonable amount to show that the data was reliable".

121. Mr Hodivala drew attention to a subsequent passage in its reasoning, where the PCC said: "The Committee, therefore, do not accept that the evidence is demonstrably unreliable..." (para 54 above). However, again, the PCC's reasoning needs to be read as a whole; importantly it is clear from its earlier reasoning, referred to in my previous paragraph, that the PCC was satisfied by the evidence led by the GDC that the data was indeed reliable. I regard the sentence highlighted by the Appellant as no more than an isolated example of loose language. This position is further reinforced by the Committee's subsequent reasoning in respect of charge 3, when it came on to consider the *weight* to be attached to the Schedule C evidence. I have set out the material parts of this reasoning at paras 57 - 58 above. It is quite apparent from this that the Committee was fully satisfied as to the reliability of the evidence, for the reasons that it identified. In the circumstances the PCC did not apply the approach that Stacey J described as "wrong" in *Mansaray* (para 101 above).

122. For the reasons I have explained, I do not consider that the PCC did place an onus on Dr Imani to satisfy the Committee that the evidence should be excluded, however, I note for completeness that the issue of admissibility arose in a context where the material was accepted to be a record of a business and that, accordingly, pursuant to section 9 of the CEA 1995 it would have been admissible in civil proceedings, unless it had been shown by the party objecting to the evidence that the default position should be disapplied (paras 91 - 92 above).

123. Lastly, in terms of alleged misdirections, Mr Hodivala criticised a passage in the Legal Adviser's advice where he indicated that the admission of hearsay always involved the inability to challenge the evidence (para 51 above). I do not consider that there is anything in this point. Read in context, the Legal Adviser was clearly referring at this point to the inability to challenge hearsay evidence *directly* (by cross-examining the maker of the statement). He went on to expressly advise the Committee to take account of the extent to which the accuracy of the material in Schedule C was capable of being tested by Dr Imani (para 52 above), and the PCC duly considered this point (para 54 above). I also note that Mr Hodivala did not raise this as an issue at the time, although invited by the PCC to comment (para 53 above).

The PCC's exercise of its discretion

124. If, as I have concluded, the PCC did not misdirect itself as to the correct legal approach that it was to take to the question of admissibility, Dr Imani faces an uphill struggle in challenging the Committee's decision. As Mr Hodivala accepted during the hearing, absent any misdirection, the exercise of a discretion is not open to challenge on the basis that a party disagrees with the conclusion reached or with the weight that the

decision-maker attached to particular factors. It is not suggested here that irrelevant factors were considered or that relevant factors were left out of account. Accordingly, Dr Imani would have to show that the PCC reached a conclusion as to the fairness of admitting the evidence that a reasonable Committee in their position could not have arrived at. Furthermore, in so far as the PCC's conclusion was based in part on an assessment of the credibility of Mr Lee's evidence, for the reasons I have identified at paras 83 – 85 above, it is very difficult to challenge such a conclusion of primary fact on appeal, save in the limited circumstances identified in those authorities.

125. Accordingly, whilst Mr Hodivala developed various criticisms of Mr Lee's evidence and of the auditing process itself, it was for the PCC to evaluate this and it was plainly open to it to accept his evidence and to conclude that his description of the auditing process and its outcomes satisfied the Committee that the data was reliable. The additional suggestion that it was irrational for the Committee to accept that an auditing process which tested a 10% sample was a sufficient indicator of reliability, is hopeless. The point was not raised at all in Mr Hodivala's detailed written and oral submissions to the PCC; and at this late stage he provided no foundation, statistical or otherwise, for the proposition that it was outside the bounds of reasonableness for the Committee to be satisfied by this evidence.

126. Mr Hodivala also submitted that the PCC was wrong to conclude that the Appellant could test the accuracy of the Schedule C data in any meaningful way without the FP17 forms. I am also unpersuaded by this submission. Firstly, the ability to test the evidence was characterised in *Thorneycroft* as an *alternative* basis for admitting the evidence, if the Panel was not satisfied of its reliability; here, as I have already addressed, the PCC was satisfied as to the reliability of the data. Secondly, in any event, the PCC was entitled to take into account, as it did, that this was a situation where Dr Imani was still able to present her own detailed evidence about each of the patients and treatments, that she was able to rely upon their relevant dental records and that she was assisted by the detailed reports and evidence of Dr Pal. The present case is quite different from the situations in *Ogbonna*, *Bonhoeffer* and in *Thorneycroft* where heavily contested witness evidence, central to the case and whose reliability (and in some instances, honesty) was seriously in question, was admitted in documentary form.

127. I also accept that it was rational for the PCC to rely upon the fact that other dentists had not raised concerns over the accuracy of the inputted data. For present purposes I will assume that this formed part of the PCC's reasoning on admissibility (although it is only referred to in relation to charge 3 and the weight to accord to Schedule C: para 58 above). Whilst the schedules that were circulated to the dentists did not include the TAD and the TCD (para 46 above), it was still significant that dentists had not raised concerns about the accuracy of the data that was shown on the schedules, given that this reflected material from the FP17 forms that was inputted at the same time as the TAD and TCD and as part of the same process (paras 41 - 45 above).

128. Finally, the PCC was entitled to regard the errors in the data as "minor" (para 58 above), given they amounted to a few instances of misspelt names and the like (para 48 above) and Mr Lee had provided an explanation for the earlier apparent discrepancies raised on behalf of Dr Imani (para 44 above).

129. Accordingly, I am satisfied that the PCC's decision to admit the Schedule C evidence was one that was open to it and involved no error of law, procedural irregularity or any

other basis for characterising it as wrong. I have already noted that the way the Committee approached charge 3 underscores the careful conclusion that it arrived at that the material was reliable (paras 57 - 58 above) and I also note that in the isolated instance of charge 5(c), where the data did appear to be unsatisfactory, in that there was no TCD entered for the relevant claim, the PCC was, rightly, willing to give Dr Imani the benefit of the doubt (para 65 above).

Ground 2

Charges 6(f) and 7(a) – (g)

130. I will first address the alleged inconsistency in the PCC's conclusions regarding the dishonesty charges (para 104 above).

131. I am satisfied that the PCC's reasoning shows that there was a clear distinction between the findings that it made in respect of charges 4(c) and 6(a) (on the one hand) and its findings on charges 6(f) and 7(a) – (g) (on the other). It is also clear that the misunderstanding concerning the completion of the FP17 forms that Dr Imani relied upon in relation to charge 5(b) (and charges 6(b)(2) and 6(c)) was distinct from her alleged misunderstanding that was rejected by the PCC in respect of charges 6(f) and 7(a) – (g). Accordingly, the inconsistency complaint is without foundation.

132. As I explained at paras 59 – 61 above, in relation to charge 4(c), the PCC accepted that the treatment that was claimed for 31 March 2015 may have taken place on 19 February 2015 and the fact that it was not recorded as having occurred on the February date may have been due to the Appellant's chaotic record keeping. Accordingly, this was not an instance where it was established that treatment that had been claimed had never in fact been provided, nor was it an instance where a claim was made before the end of the contract year in relation to treatment that was only provided in a later year. Similarly, charge 6(a) involved an instance where the PCC was satisfied that dental treatment had taken place on 6 August 2013 (the date stated in the claim), albeit the records did not show that it was Band 2 treatment, as claimed (para 71 above).

133. By contrast, in respect of charges 6(f) and 7(a) – (g), Dr Imani accepted that she had not provided the claimed treatment during the relevant contract year, but said that she believed that unless she claimed for it by 31 March in the year that the course of treatment had been started, she would be unable to do so. Accordingly, this was a specific scenario in which the focus was, necessarily, upon whether or not the PCC accepted Dr Imani's explanation (as I further address from para 135 below). Moreover, the PCC was fully aware of its earlier findings that certain dishonesty allegations had not been proved and the basis of the same. Indeed, in finding that dishonesty was established in respect of charge 6(f), the Committee referred to this expressly, clearly distinguishing the position (para 75 above); as it had also already done in respect of charge 5(g) (para 70 above).

134. I have explained at para 63 – 64 above, that the misunderstanding that Dr Imani relied upon in respect of charge 5(b) related to the inter-relationship between Part 3 and Part 5 of the FP17 form and whether she could insert in Part 5 treatment that was only at the planning stage and treatment in Part 3 that had not actually been undertaken. The PCC was prepared to accept that whilst she had been careless, Dr Imani genuinely held the belief that she described and thus was not dishonest. By contrast, as I discuss in more

detail below, the PCC did not believe the explanation that Dr Imani advanced in respect of charges 6(f) and 7(a) – (g), that although she had not provided the claimed treatment during the relevant contract year, she believed that as the course of treatment had started, unless she claimed for it at that stage, she would be unable to do so. These were two distinct alleged misunderstandings and the PCC was perfectly entitled to arrive at differing conclusions in respect of them. Mr Hodivala is simply incorrect to say that the evidential position was "identical" in respect of all these charges.

135. Secondly, I address the contention that the PCC unfairly or wrongly rejected Dr Imani's explanation as to the misunderstanding that she was under in respect of these charges (para 105 above). I begin by highlighting that although Mr Hodivala's submission focused upon the Committee's reliance upon the evidence of Ms Graham, it is apparent that this was just one of a number of factors that undermined the credibility of the Appellant's explanation, as I discuss below. I also remind myself again of the limited circumstances in which a finding as to credibility made by the first instance tribunal, who had the benefit of seeing and hearing the relevant witnesses giving their evidence, can be overturned on appeal (paras 83 – 85 above).

136. Ms Graham gave evidence on Day 6 of the hearing and was cross-examined by Mr Hodivala. The following exchanges took place at pages 106H – 107B of the hearing transcript:

> "Q A suggestion I am going to put to you...that there was a discussion between yourself and Dr Imani about the fact that there are all these late submitted claims *and that if she wanted to get paid for the work, then she had to put the claim in by the end of the year.*
>
> A. On the late submitted claims?
>
> Q. ...there was discussion *about the fact that claims had to be submitted by the year end if they were to be paid.*
>
> A. If they were completed claims, then they would have to be submitted by the end – completed by 31 March to ensure that they were included on that year end information.
>
> Q. Yes, but I am going to suggest to you that there was not any discussion about completed or incompleted, just that there *was a discussion about the fact that claims had to be submitted by the end of the year if she was to be paid for those UDAs.*
>
> A. And if the treatment had been completed on or before 31 March of that financial year." (Emphasis added.)

137. In her witness statement the Appellant had said: "It was my understanding that if you started a course of treatment in one contract year then you couldn't carry it forwards to the next year. I was reinforced in this view by a conversation I had with Jill Graham...in about 2014 *in which she told me that I had to claim for the work before 31st March in each contract year*" (para 74 above; emphasis added).

138. In her evidence-in-chief on Day 11 of the hearing, Dr Imani elaborated on her account of the alleged conversation with Ms Graham as follows (page 384D-H of the transcript):

> "...And I remembered that time Jill came and showed me a – like a bundle of paper and said – and she had highlighted with yellow/pink...and said 'These are not paid' because they were submitted late...
>
> ....And so I asked her, I said 'So you are telling me all this claim that we sent for last year it hasn't been paid for or UDA hasn't been given...She said – this was exactly what she said, 'As long as you sent your claim form before 31 March, you will be paid, or UDA will be claimed for that financial year. Anything that goes to the new financial year is for new financial year'. I don't think she did anything – said anything wrong. I think the misunderstanding for me what that I thought the late submitted claim that she showed me belongs to those ones that I started the treatment but didn't finish it in the same financial years. So that's why she is saying that this hasn't been paid...So my understanding was that if you don't finish your UDAs on the previous financial year, you are not going to be paid for them."

139. She was cross-examined about this aspect of her account by Ms Barnfather on Day 14 of the hearing, where the following exchanges occurred (pages 474D – 475B of the transcript):

> "Q. Did you look at the bundle of papers you say she [Ms Graham] brought highlighted in pink and yellow to see what are those claims she is telling you were late submitted and I have not been paid for?
>
> A. She just brought that example to show me. I don't know if she left it with me of she took it with her. I don't remember. She specifically came and said that these claims that she highlighted there hasn't been paid because they're late submitted claims.
>
> Q. Yes, meaning submitted later than two months since the last date of completion.
>
> A. I know. I know, but I didn't think the late submitted claim meant that way.
>
> Q. But she brought with you on your account the documents to show you, to show you if you like, where you had been short changed UDAs.
>
> A. Because she thought I knew what late submitted claim meant to be...She just said to me, 'These are late submitted claims'.

Q. Why did you not look at the documents she had brought to show you?

A. I had looked at the highlighted one. I didn't go specifically to every single one and look at them, no, I didn't. There were many so I didn't.

Q. So you took from those documents she had brought you, highlighting late submitted claims, so submitted after the two month window...

...to mean all UDAs have to be claimed by 31 March – yes?

A. Yes, if they have started in that year.

Q. And a course of treatment started in one year could not continue to the next year?

A. I didn't think it could. No.

Q. But, Dr Imani, not least from a clinical perspective, that is totally illogical is it not?

A. I know, but -"

140. It was plainly appropriate for the PCC to consider whether it accepted Ms Graham's evidence as to what she would and would not have said to Dr Imani, and then to evaluate the Appellant's account in light of that and the other relevant evidence. I also note that there was at least a shift in emphasis in Dr Imani's accounts. In her witness statement and in the version put in cross-examination by Mr Hodivala, it was said that Dr Imani had been specifically told by Ms Graham that she had to claim before the end of the financial year (31 March) in order to be paid and to obtain the UDAs. It was therefore pertinent for the PCC to consider whether it accepted Ms Graham's evidence that she would only have said this in relation to claims that were completed by 31 March. By the time she gave evidence Dr Imani was suggesting that Ms Graham simply referred to late submitted claims that would not be paid and that she, Dr Imani, had taken from this that all claims had to be made before 31 March, the end of the financial year.

141. It is also important to appreciate that the question of what was or was not said by Ms Graham was only one part of the factual matrix for the PCC to evaluate when considering the credibility of the explanation given by Dr Imani. I note the following, in particular:

i) The PCC also accepted the credibility of Ms Graham's evidence that she had found no correspondence from Dr Imani raising any queries about the correct process for claiming (para 75 above);

ii) As Ms Barnfather put to her in cross-examination in the passage set out above, it strains credulity to believe that if Ms Graham had presented Dr Imani with late claims that could not be paid with the relevant parts of the documents

highlighted, she would not have looked at the documents and in turn appreciated that they were "late" in the sense that they had been made beyond the two month period for claiming (para 16 above);

iii) The PCC were entitled to conclude from this evidence that Dr Imani had not explained how the fairly brief discussion with Ms Graham and being shown some claims that had been made outside of the two month limit for making claims, had led her to believe that *all courses of treatment* embarked upon in a contract year had to be claimed for in full before the end of that year;

iv) As the PCC pointed out, Dr Imani had held an NHS contract since 2006 and the process for submitting claims had not changed since that time, yet she claimed to rely upon a misunderstanding based upon a conversation that occurred in 2014;

v) As shown by the passage I have cited from her cross-examination, Dr Imani was unable to counter the proposition that her stated belief was "totally illogical", given that the treatment in question had yet to take place. (In an additional answer to Ms Barnfather during Day 14 at page 472G of the transcript, she said: "I understand it's not logical and it's not now when I know it. It was a stupid way of thinking but at the time that was my understanding".) The PCC was entitled to take into account that this was something that Dr Imani could not really explain;

vi) As the PCC also noted (para 75 above), Dr Imani was unable to describe how she came to realise her misunderstanding. She told Ms Barnfather, when pressed on the point, that this occurred in "about 2018" (Day 14, transcript at pages 472H – 473B). But she was then unable to say how she discovered that her understanding was wrong ("I don't remember", transcript at 473B). Ms Barnfather pressed her on how she had come to realise that this important misunderstanding which had affected the way she had claimed for the previous four years was incorrect, but Dr Imani gave no clear response, eventually saying when pressed again: "I'm not going to say anything" (transcript at page 473B-H). It was also put to her by Ms Barnfather that if she had held this misunderstanding until 2018, her pattern of claiming, with a spike in March, would have been the same in each of 2015, 2016 and 2017, which was not the case. To this Dr Imani replied: "I don't know" (Day 14, transcript at page 482H);

vii) To be consistent with her professed belief, Dr Imani should have indicated in relation to each of these claims in Part 3 of the FP17 that the treatment was "incomplete", but in fact each of these claims were wrongly submitted as having been completed by 31 March;

viii) Absent the suggested misunderstanding of the conversation with Ms Graham there was nothing identified by Dr Imani to explain why she thought that she had to claim by 31 March for treatment that had not yet been undertaken. The concept of a "course of treatment" and the contents of the FP17 form and the related Guidance (summarised at paras 15 – 19 above), do not support such an interpretation and the Appellant did not suggest otherwise;

ix) Dr Imani claimed that everyone who had worked in her two practices, irrespective of their role and the time when they had worked there, was under the same misunderstanding (Day 14, transcript at page 475F). This assertion did not sit easily with the evidence of Dr Scott, accepted by the PCC, that there was no equivalent misunderstanding from the dental profession at large in relation to premature claiming (para 75 above); and

x) The PCC was satisfied that there was a motive for Dr Imani to make these claims, namely in order to try and meet her UDA allocation for the contract year and avoid a clawback of payments (para 75 above).

142. In short, there was ample basis to support the PCC's conclusion that Dr Imani's explanation was "implausible and inherently unbelievable" (para 75 above). Whilst its decision referred to the majority of these points, it was unnecessary for the PCC to list every reason why it did not accept the Appellant's credibility in relation to this aspect of her case. The PCC was entitled to form an overall view and the view that it formed is unassailable.

143. Thirdly, I turn to the Appellant's contention that the PCC failed to apply the subjective limb of the *Ivey* test. For the reasons given below, I reject that contention as well.

144. It is accepted that the PCC gave itself a correct self-direction as to the *Ivey* test (para 56 above). It is also clear that when the PCC came to consider each of the dishonesty allegations, it focused upon Dr Imani's subjective state of belief. During the hearing, Mr Hodivala accepted that the Committee had applied the subjective limb of the *Ivey* test in making its findings of dishonesty in respect of charges 5(g) and 17(b). It is also quite clear that where the PCC concluded that dishonesty had not been established, this was arrived at after considering the evidence as to the Appellant's subjective state of mind, as I have summarised in relation to charge 4(c) at para 61 above, charge 4(e)(1) at para 62 above, charge 5(b) at para 64 above and charge 6(a) at para 71 above.

145. Furthermore, the PCC's stated reasoning in finding dishonesty proved in respect of charge 6(f) shows that the Committee correctly applied the first limb of *Ivey*, ascertaining the Appellant's subjective belief, rather than simply focusing on the objective limb of the test, as Mr Hodivala suggests. As I have already discussed, Dr Imani advanced a positive explanation as to why she had made claims with incorrect premature dates of completion (showing a TCD by 31 March, when in fact the treatment was outstanding at the time), actions which she now acknowledged were wrong. She relied upon a particular misunderstanding, which she claimed that she held at the time. The PCC examined this alleged misunderstanding, but rejected Dr Imani's account, finding that her professed belief was "inherently unbelievable". It therefore followed that Dr Imani had not told the truth about the belief that she held at the time when she made the claim. In these circumstances, the PCC, unsurprisingly, went on to conclude that it: "did not find it credible that you did not know that you were not entitled to claim in the financial year for the work you had not yet completed". In other words, the PCC were satisfied that the Appellant had submitted the claim on a false basis and that she did know that she was not entitled to make the claim in question at the time that it was made. The PCC further reinforced this in indicating it had determined that: "it would have been your genuine belief at the time that you would not have been entitled to claim for Band 2 treatment that had not been completed in that financial year" (para 75 above). It was only after making this finding as to the belief held by the Appellant at the time

of making the claim, that it went on to consider the objective limb of the test, namely whether this conduct would be considered dishonest by the standards of ordinary and decent people (para 75 above).

146. I have discussed the PCC's reasoning in respect of charge 6(f). It is clear from the decision that the same line of reasoning was then employed in a shorter form in respect of charges 7(a) – (g), with cross reference to the Committee's reasoning on charge 6(f) (paras 76 – 77 above). It is apparent, for example, from the PCC's reasoning in respect of charge 7(a), that its focus was again upon Dr Imani's subjective state of knowledge, and that the Committee found that she knew when she submitted the claim that she did so: "despite knowing that you were not entitled to claim prematurely for incomplete work in that financial year" (para 76 above).

Charge 5(g)

147. I have summarised the allegation and the PCC's findings in respect of charge 5(g) at paras 66 – 70 above. The Appellant contends that the PCC failed to have regard to Dr Scott's evidence concerning the changed appearance of the patient's UR7 (para 108 above). The basis for this submission is that the PCC did not refer to it expressly in the reasons that it gave in respect of this charge.

148. However, it is trite law, as Mr Hodivala accepts, that a first instance decision-maker is not to be taken to have overlooked a particular piece of evidence, simply because it is not referred to in the decision. Moreover, in this instance there was a logical reason for the PCC to refer to Dr Pal's evidence in respect of the appearance of UR7 (rather than Dr Scott's evidence), given that Dr Pal was the originator of the proposition that there was an alteration to the restoration to the UR7 and it was this that provided the justification for the Band 3 claim. Additionally, Dr Scott caveated his assessment (para 68 above). In other words, Dr Pal's evidence in relation to the appearance of the patient's UR7 was the high point from Dr Imani's point of view.

149. In any event, it was for the PCC to assess the evidence it had heard from the experts and, importantly, Mr Hodivala accepted during the hearing that the Committee was entitled to form its own view as to the quality of the x-rays. It therefore follows that the PCC was entitled to concluded, as it did, that their quality was too poor for the Committee to accept Dr Pal's explanation (para 69 above).

150. In the circumstances there is no basis for this Court to infer that the PCC failed to have regard to Dr Scott's evidence in respect of the x-rays or that it reached an unfair or impermissible conclusion in rejecting Dr Pal's evidence on this point. Furthermore, I remind myself that the most that the experts could say from the comparison of the appearance of the UR7 in the x-rays was that there had been an apparent change from a composition inlay to a metal inlay at *some point* between November 2016 and August 2018 (para 68 above). Accordingly, even if the PCC had accepted this evidence from Dr Pal and Dr Scott, it did not follow that the inlay work had taken place on 2 December 2016 (the date when Dr Imani said the Band 3 treatment had been undertaken and the TCD given in the claim), as opposed to at some later point before the August 2018 x-ray. Furthermore, the other evidence did not support the proposition that Band 3 work was undertaken to the UR7 on 2 December 2016. Dr Imani had changed her account between her witness statement and her evidence as to the tooth in question and the work that had been undertaken (paras 66 – 67 above); there was no documentation supporting

the proposition that inlay work to the UR7 was undertaken on 2 December 2016; and the documentation that did exist for that date indicated an appointment for a filling for the UR6 (paras 67 and 69 above). In all the circumstances, the PCC was fully entitled to reject the Appellant's explanation regarding inlay work to UR7 as "implausible" (para 70 above).

151. Mr Hodivala's second point was that in concluding that there was no evidence that the Band 3 treatment had been considered, planned or started during the claim period, the PCC had ignored the fact that the FP17 form would have been signed by the patient, thereby, it is said, indicating their agreement to the treatment referred to on the form. I also reject this contention.

152. The PCC concluded that there was: "*no satisfactory evidence* that the treatment claimed for was planned, started or even considered during the claim period" (para 70 above, emphasis added). This was an assessment that the Committee was entitled to make, having heard and considered all the evidence and taken into account the points that I have referred to in the previous paragraph. As I have already indicated, the fact that the PCC did not mention the patient's signature on the FP17 does not mean that it was not taken into account. The PCC was entitled to give that aspect the weight that it saw fit. It did not follow from this that Band 3 treatment of the kind that the Appellant now claimed, had been discussed and agreed with the patient. Moreover, in their Joint Expert Report, both experts had agreed that there was no evidence of Band 3 treatment having been undertaken during the dates of the claim. After rejecting the suggestion subsequently raised in oral evidence regarding the x-rays and alleged work in December 2016 to UR7, the PCC were entitled to proceed on the basis that this was indeed the position.

153. In turn, the absence of any satisfactory evidence that Band 3 treatment had been planned, started or even considered at the material time, led the PCC to permissibly conclude that Dr Imani knew that she was claiming for additional UDAs to which she was not entitled and to distinguish this situation from the findings that dishonesty had not been proved in respect of charges 4(c) and 6(a) (para 70 above).

Charge 17(b)

154. I have summarised the allegation and the PCC's findings in respect of charge 17(b) at paras 78 - 81 above.

155. Ms Barnfather accepted that the PCC was in error in saying that the Appellant had *provided* private periodontal treatment to Patient 5 on the three other occasions that it listed. However, she submitted that this made no material difference to the Committee's conclusion, for reasons that I accept. The correct evidential position was that the documentation indicated that private periodontal treatment had been *planned* (rather than undertaken) on the dates referred to. Accordingly, this position also undermined Dr Imani's original case that she had only ever provided this patient with treatment on the NHS (para 79 above). There was no indication in the documentation that the option of NHS treatment had been offered on these three other occasions either.

156. I also reject the contention that the PCC placed the burden of proof on Dr Imani to disprove the allegation of dishonesty. The Committee was well aware where the burden of proof lay and referred to it on numerous occasions throughout its decision as it set

out its findings on the various charges. In this instance, the PCC rejected the suggestion that Dr Imani raised in her evidence, that only Airflow treatment was provided and, as such, the work could only have been done privately. The PCC found that the patient's BPE scores indicated that periodontal disease was present and that accordingly this was treatment that should have been offered on the NHS (paras 79 – 80 above). Having rejected Dr Imani's explanation, the PCC then considered whether there was any evidence that the treatment was indeed offered on the NHS, concluding that there was no evidence to that effect. Indeed Dr Imani had admitted charge 16, namely that she did not record discussing with Patient 5 the option of undergoing the treatment under the NHS. After reminding itself of the *Ivey* test and further explaining why it rejected the Appellant's Airflow explanation as "implausible", the PCC concluded: "on a balance of probabilities, that despite being aware that this patient was entitled to NHS treatment, you decided to charge him privately, without making him aware that the treatment was available on the NHS and that you did this most likely for personal gain". This chain of reasoning did not involve placing the burden of proof on Dr Imani at any stage. Moreover, the PCC referred in terms to being satisfied on the balance of probabilities that the allegation was established in setting out its conclusion. Inevitably the Committee analysed the explanation that Dr Imani had put forward, but that did not involve any reversal of the burden of proof; the Committee rejected her explanation and explained why.

157. As to Mr Hodivala's third point (para 110 above), the Committee arrived at a legitimate conclusion, having evaluated the evidence overall and having explained its reasoning, as I have already described. The absence of a direct account from Patient 5 did not preclude the conclusion that was reached. Having heard the evidence, including Dr Imani's account, the PCC was entitled to reject her claim that the patient had wanted to pay privately for this treatment, which was available on the NHS, characterising this assertion as "vague and not based on any recorded discussion" and as "implausible" (para 80 above).

Outcome

158. For the reasons that I have set out above, I do not consider that the PCC's decision was wrong, unjust or that it involved any procedural or other irregularity. I have explained why I reject both Ground 1, concerning the Committee's decision to admit the hearsay evidence in Schedule C, and Ground 2, relating to the dishonesty allegations that were found proved. In the circumstances, Ground 3, regarding the sanction imposed, does not arise. This was a careful and detailed decision; charges were considered individually, the evidence in respect of each was evaluated and the PCC's reasoning was clear and thorough.

159. It follows that I dismiss the appeal.