Warning: this report includes sensitive data about dental professionals and references to suicide.

General Dental Council

Report on the dental professionals who died while fitness to practise concerns were investigated or remediated

Reporting period: 2019 to 2022

Dated: 4 November 2024

Warning: this report includes sensitive data about dental professionals and references to suicide.

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Foreword

The death of a dental professional that occurs while fitness to practise concerns are investigated or remediated is the death of a person who was still very much in their working life, leaving behind loved ones, friends and colleagues. These are people who have died too young, which is in itself deeply sad.

As well as reporting such deaths, this report also makes clear that some individuals took their own life while fitness to practise concerns were being investigated or remediated. Any death by suicide is a tragedy. The impact on the health and wellbeing of dental professionals during what we know can be a difficult and stressful process is of deep concern to us.

This is a very important topic. Undertaking this work has helped us to begin to understand the prevalence of death and suicide while concerns are investigated or remediated, and the complexities of the issues involved. Understanding where we are is one thing, but as Chair of the GDC I am committed to learning and doing whatever we, and others in the system, can do to support people. We understand that when a concern is raised and investigated, there is also a considerable impact on the dental professional's health, and on their family, friends and colleagues. All of these can only make the situation more difficult.

The report seeks to build on our understanding of what we know, what we have done and are doing to reduce the negative impact of Fitness to Practise (FtP) on health and wellbeing. I hope that it also serves as a beacon for the dental sector as a whole to reflect on the environment, systems and processes involved in being a dental professional. It is clear that excessive pressure and expectations are harming some of the people in it, and we should all pause to consider how we must respond to that.

We are not, in this report, going to make connections out to the wider issues. Without a shadow of a doubt, FtP is a cause of stress for many people, but also the cause of FtP may itself be a challenging and complex set of factors. In continuing to work with stakeholders with expertise in such matters, I am confident that we will learn and improve our understanding of the situation and the data.

This report contains some detail about the process we have undertaken to prepare this report. This has been a slower process than we would have liked, but we are now confident that the data is as robust as we can make it for this period, and also maintains the privacy of the individuals and families concerned.

We have heard the calls for the GDC to provide this data, and I understand the issues of trust and confidence in regulation that lie behind them. However, when the data and what we are doing to improve FtP are put aside, what is left is the death of people, some in tragic circumstances, all too young, and in our language, tone and discourse we must consider the families, loved ones and colleagues for whom the pain and hurt is still very raw.

Lord Toby Harris
GDC Chair

1. About the report

1.1. We are reporting on the dental professionals who died while fitness to practise concerns were being investigated or remediated. We are the UK regulator of dental professionals and are responsible for investigating serious public protection concerns about the health, clinical practice or behaviour of registrants.

1.2. The reporting period is 1 January 2019 to 31 December 2022. We are using a four-year reporting period to help ensure that individuals cannot be identified.

1.3. We are also reporting on the cause of death by category. We have adopted a reporting lag for this report and excluded any death that occurred on or after 1 January 2023. We have taken this approach because in some cases, it takes time for the cause of a person's death to be determined[1].

1.4. We are committed to reducing the negative health and wellbeing impacts of our investigations where we can, and have provided some details about the work we are doing to improve our understanding of the issues, and the support provided.

1.5. We understand that people may be affected by the issues and details included in this report. We have taken some steps to help ensure individuals cannot be identified, but we recognise that the family, friends of colleagues of any dental professional who has died during this period may be able to identify loved ones, and that this may cause some upset or distress.

1.6. If you are affected by the information reported or the issues set out in this report, Samaritans are available, day or night, 365 days a year. Whoever you are and whatever you're facing, the Samaritans will not judge you or tell you what to do. They are available to listen, so you don't have to face it alone. You can call the Samaritans free on 116 123 or email them at jo@samaritans.org.

1.7. We adhere to the Samaritans' guidance on how to post online safely and would urge others to do so too, to avoid the potential to cause upset or distress.

2. Preparing this report

2.1. This is the first time we have produced a report of this kind. To produce this report, we systematically explored currently available data and took an evidence-based approach to ensure the data reported is accurate. We have not previously requested or recorded information that provides details of the cause of death. For this report, we have obtained this information from the relevant registrars.

2.2. We have now established a robust methodology to ensure we can report these sensitive data accurately in future, which includes actively sourcing documentation to support reporting the cause of death by category.

[1] Death reporting research project: Evidence review, GDC, 30 May 2023.

2.3. We are reporting data on the number of registered dental professionals who died while fitness to practise concerns were being investigated, under consideration by case examiners or determined by an independent panel at the Dental Professionals Hearings Service (the Hearings Service), including any period during which the registrant was completing undertakings or had restrictions placed on their registration i.e. conditions or suspension.

2.4. We have excluded cases closed at the initial assessment stage of the FtP process because any concerns raised were not investigated and the registrant was not notified. We notify dental professionals that an investigation has been opened only when concerns are referred to the assessment stage. Where a dental professional is issued with advice following initial assessment, they are also advised that the case is closed.

2.5. We have carried out manual checks where there was a chance that the dental professional was aware of an active investigation to verify whether they had been contacted. We have included cases where there was any possibility that the dental professional was made aware of an investigation.

2.6. We are reporting the total number of deaths during the reporting period. These have been placed into three categories and one subcategory of "suicide". The categories were determined by existing literature including the World Health Organization's ICD-10 and Department of Health and Social Care guidance.

2.7. The cause of death categories used are:

- Natural (including medical): Includes deaths identified as being due to natural causes. This covers medical causes and associated complications (e.g. stroke and cerebrovascular disorders, cancers, infections, communicable diseases) and those arising from substance misuse related to *chronic* alcohol or tobacco use.
- Deaths from external causes (including a subcategory for deaths which were confirmed as suicide): Includes deaths attributed to accidents and/or violence (e.g. accidents or misadventures, alcohol/drug related, lawful/unlawful killings, road traffic collisions, suicides).
- Other/unspecified: Includes those where we were unable to ascertain a cause of death (e.g. open verdicts, death certificate or Form 111 not available), where the cause of death was recorded as a narrative conclusion or where the death occurred overseas.

2.8. We relied on the information recorded on the death certificate or "Form 111: Notification of the death of a person to a Government Department or other specified body" (Form 111) to categorise all deaths recording during the reporting period.

2.9. We have only included deaths in the subcategory of suicide when "suicide" was listed on the death certificate or Form 111. We have taken that approach to avoid the risk of introducing errors and biases in reporting, which would be likely to occur if we attempted to interpret coroner or procurator fiscal determinations. The risks and issues relating to categorisation are set out in the report of our evidence review[2].

[2] Death reporting research project: Evidence review, GDC, 30 May 2023.

2.10. By convention, in Scotland and Northern Ireland, the word suicide, or any synonym of it, is not used on death certificates. That means there is the potential for underreporting in the subcategory of suicide, as any potential suicide in Scotland and Northern Ireland has not been listed as suicide on the death certificate or Form 111.

2.11. There is further potential for underreporting of suicide where the coroner or procurator fiscal inquiry has resulted in a narrative conclusion or open verdict, although there were no such determinations made during this reporting period. All overseas deaths have been categorised as "other/unspecified" due to difficulties relating to interpretation of the cause of death in all cases, which may also contribute to an underreporting of the number of deaths by suicide.

3. Data recorded for 2019 to 2022

Table 1: Number of cases, hearings and deaths from 2019 to 2022

Description	Number
Cases referred for assessment (NB1)	3,926
Referred to a practice committee for hearing (NB1)	751
Deaths recorded (NB2)	20

NB1: Cases referred for assessment and to a practice committee for a hearing can be the same case. Cases can also span more than one year or be referred back, so figures are subject to double counting. Further, an individual dental professional may have more than one active case at the same time, so cases do not equate to the total number of dental professionals.

NB2: There is no possibility of double counting in the number of deaths recorded.

Table 2: Deaths categorised by cause of death from 2019 to 2022

Cause of death category (NB3)	Range (NB4)
Natural (including medical)	7-10
Deaths from external causes	7-10
Number of which were confirmed as suicide	*1-3*
Other/unspecified	1-3

NB3: Descriptions of cause of death categories are provided at paragraph 2.7.

NB4: We have replaced exact numbers within number ranges (i.e. 1-3, 4-6, 7-10), to minimise the risk of individuals being identified through calculations of the reported data.

4. Improving processes and support for dental professionals

4.1. We know that our FtP processes can take too long, and that investigations can adversely affect the health and wellbeing of dental professionals[3]. We also know that some groups of dental professionals are overrepresented in our fitness to practise data when compared to the registrant population[4]. We know there is much more to do and that we must collaborate with others to address the underlying issues.

[3] Experiences of GDC fitness to practise participants 2015-2021: A realist study, GDC, 30 November 2022.
[4] Unlocking the potential of GDC fitness to practise data, GDC, 23 April 2024.

4.2. While we are committed to making improvements, delivering all the changes is likely to take some time. We are prioritising work to ensure that dental professionals are supported appropriately during the process, and that the process is fair and proportionate to the issues raised. We are also prioritising work to ensure we identify learning from any serious incidents that occur.

4.3. We have been making changes to our processes that aim to reduce the impact of investigations on all those involved, particularly those who have existing health issues or other vulnerabilities. Our improvement programme is underpinned by research, which is helping us to build a more complete picture of the impacts of investigations on individuals, and the changes we need to make to ensure risks to health and wellbeing are reduced where practicable.

4.4. Below we provide some details about:

- Our recent work aimed at reducing health and wellbeing impacts of our investigations on dental professionals.
- Improvements we plan to deliver over the next few months.
- Areas where we need further research to improve our understanding.
- Plans to ensure learning is identified.

4.5. We have recently delivered the following changes:

- Amended our publications and disclosures policy to ensure that untested allegations presented to the Interim Orders Committee are not shared publicly before there has been a determination by a practice committee[5].
- Provided clearer information and signposting to support services on our website.
- Improved the skills of our caseworkers and managers through training with a specialist mental health charity, helping them identify those who may be in distress and signposting them to support earlier and more effectively.
- Ensured our standard communications have a more empathetic tone and highlight the potential health and wellbeing impacts of investigations.
- Given additional weight to the impact of investigations on health and wellbeing when considering requests for voluntary removal from the register[6].

4.6. The Hearings Service has made the following changes:

- Updated case management procedures to reduce administrative delays to the listing of hearings and ensure timely proceedings.
- Delivered training to independent panellists and their legal advisers to help them to support vulnerable individuals during hearings.
- Introduced a Participant Support Officer to support individuals, particularly unrepresented dental professionals, throughout the proceedings and during the hearing when asked to do so.

[5] GDC Disclosures and Publication Policy, Version 4, 2 July 2024.

[6] GDC Guidance for the Registrar when considering voluntary removal applications from registrants who are subject to fitness to practise proceedings, Version 1, 28 August 2024.

4.7. We also have work in progress that we expect to complete within 12 months, we are:

- Piloting the use of initial inquiries to enable the assessment of clinical practice concerns earlier in the process and improve timeliness[7].
- Reviewing our processes where there are sexual misconduct allegations and identifying opportunities for reducing impact on participants in such cases.
- Continuing to explore, understand and evaluate the experiences of those who have participated in an investigation over the last two years through research commissioned from the University of Manchester and Newcastle University.
- Reviewing decision-making guidance to improve proportionality, fairness and consistency in fitness to practise outcomes. The consultation on guidance for practice committees was issued in September, and guidance for the Interim Orders Committee was published last year[8,9].

4.8. Analysis of our FtP data has indicated that some groups of professionals have been overrepresented in the number of concerns raised, relative to their proportion of the register. For example, some minority ethnic groups have had a disproportionately high number of concerns raised, although the data has also shown that these cases progressed in broadly the same proportions that we received them.

4.9. Further research is needed to improve our understanding of the different ways that investigations can affect those with protected characteristics. We are particularly interested in knowing more about the factors that may influence behaviour or increase health and wellbeing risks, such as cultural differences linked to stigma or affect decisions on accessing health and wellbeing support services.

4.10. We have some further work to do, and the immediate steps we are taking are:

- Procuring a data maturity assessment to provide recommendations for improving the quality of casework data to enable more detailed analysis.
- Collecting and recorded data about the protected characteristics of those who raise public protection concerns.

4.11. We have also recently agreed new work for next year that aims to improve the communication and practical support offered to those who participate in investigations and hearings. We are currently developing our plans and are mindful of the need to consider the wider context and impacts of investigations, including:

- Adjustments are needed to ensure inclusion.
- Additional stressors and pressures are experienced by dental professionals when concerns are raised, for example, issues relating to employment.
- Feelings of stress and anxiety are likely to be experienced from the moment a dental professional has been notified that an investigation has been opened.

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[7] Trends in Fitness to Practise: We are seeing fewer concerns and closing more cases at the early stages of the process, GDC, 19 June 2024.
[8] Consultation on revisions to the guidance and conditions bank for practice committees, GDC, 3 September 2024.
[9] GDC Fitness to Practise: Guidance for the Interim Orders Committee, Version 1, 18 December 2023.

- Health and wellbeing impacts can permeate to those around the dental professional involved, which can also be an additional stressor.

4.12. We are committed to learning from any death that occurs while concerns are being investigated or remediated. We are developing our thinking in this area and are exploring serious incident review processes. We want to be able to identify any opportunities for learning quickly, and have a process in place that ensures any resulting recommendations are implemented and reviewed.

4.13. Any review process needs to have the family, friends and colleagues of the dental professionals involved at the centre. The aim is to listen to those who have been affected and take steps to reduce the risk of harm.

4.14. We acknowledge that there is more for us to do to reduce the negative health and wellbeing impacts of investigations and hearings on dental professionals. Our ongoing work will be informed by research findings, feedback from stakeholders and registrants and the results of any serious incident reviews.

5. Others involved in the preparation of this report

5.1. We have engaged with stakeholders with relevant expertise to provide oversight of our work before finalising this report. We particularly asked for comments on our approach, language used and scope of the reported data. We also invited views on any further actions we should consider taking. Stakeholders are listed in Appendix A.

5.2. We have also sought the advice of Sir Louis Appleby, Chair of the National Suicide Prevention Strategy Advisory Group, in the production and reporting of these data, including how we can identify any learning to enable the mitigation of risks and to reduce the negative impacts on health and wellbeing.

5.3. We would like to thank those who provided their views for their supportive and thoughtful engagement on these important and sensitive issues. We remain responsible for the content and presentation of this report.

Appendix A

Professor Sir Louis Appleby, Professor of Psychiatry, Division of Psychology and Mental Health, The University of Manchester.

Janine Brooks, Dental Mentors UK.

Laura Cross, Chair of the Education, Ethics and the Dental Team Working Group, British Dental Association.

Fiona Ellwood BEM, Society of British Dental Nurses, Mentor.

Laura Hannon, Chief Executive Officer, BDA Benevolent Fund.

Dr Marina Harris, Senior Lecturer and Periodontology, Lead in the University of Portsmouth Dental Academy.

Shareena Ilyas, British Dental Association, Mentor.

Roz McMullan, Chair of Probing Stress in Dentistry in Northern Ireland.

Professor Tim Newton, Professor of Psychology as Applied to Dentistry at King's College London.

Anastasios Plessas, Honorary University Fellow, Faculty of Health, University of Plymouth.