Central and South East Kent Coroners
Oakwood House
Oakwood Park
Maidstone
Kent
ME16 8AE
[redacted]

Date: 15 August 2023
[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: The General Dental Council

1. CORONER

I am Katrina Hepburn HM Area Coroner for Central & South East Kent

2. CORONER'S LEGAL POWERS

I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

3. INVESTIGATION and INQUEST

On 18 May 2023 I commenced an investigation into the death of Barry Anthony LALL. The investigation concluded at the end of the inquest which was held on 14th August 2023 . The conclusion of the inquest was

Suicide

1a Suspension

1b

1c

II

4. CIRCUMSTANCES OF THE DEATH

Barry Lall was a dentist. I understand that concerns were raised with the General Dental Council (GDC) in relation to his dental work and fitness to practise as a dentist, and that such

concerns were being investigated.

His case was referred to the Interim Orders Committee by the Registrar of the GDC on 4 August 2022. This led to a initial hearing taking place on 13th September 2022. The IOC decision was that interim conditions be placed on Mr Lall's ability to practise for a period of 18 months, and a 7 page report being published on the GDC website. Within that report the complaints/concerns regarding Mr Lall's working practices were set out in detail.

There was evidence provided by the Family that Mr Lall's mental health, affected by the GDC investigation in the first instance, then deteriorated after the detail of the complaints/concerns of his work practices entered the public domain via the GDC Website.

In November 2022 Mr Lall was formally dismissed from his employment. In December 2022 he approached his GP reporting anxiety and depression with fleeting thoughts of suicide since the loss of his job and the fitness to practice enquiries.

On Friday 12th May and again on Monday 15th May 2023, Mr Lall received email notifications from his legal team regarding an upcoming meeting with the said team and the GDC scheduled for 18th May 2023. [redacted]. He died of suspension.

5. CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. ha

The **MATTERS OF CONCERN** are as follows. –

Whilst it is accepted that the public should have knowledge of concerns raised with regards to a registered dental practitioner, my concern is regarding the *level of detail* placed on the GDC website in respect of those concerns, particularly when a case is at a stage where the proceedings have not been concluded and the issues not yet determined one way or another. In this case the report ran to 7 pages and set out in detail the allegations made under the 'background section' and then further detail of the allegations by way of documenting the submissions made by the Counsel acting on behalf of the GDC.

Whilst I accept that the report states in its preamble that "*It is not the role of the IOC to make findings of fact in relation to any charge*" the report detailed significant allegations, (which Mr Lall contested) which were undetermined by the GDC at that time. The report was then made available to the public via the GDC website.

Given that this was an interim order only, my concern is whether the the level of detail provided to the public at that stage of proceedings, was necessary or required. The family gave evidence at the inquest of Mr Lall that he was "*an extremely private individual so the impact this had on his mental health was tremendous*." By putting detailed allegations into the public domain via the GDC website, at a stage before any final determination has taken place, I am concerned that others going through a similar process may also suffer a detrimental effect to their mental health. Consequently, in my view, there exists a risk that future deaths will occur.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you,the General Dental Council, have the power to take such action.

7. YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by Wednesday 11th October 2023.

I, the coroner, may extend the period.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

8. COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons family representative.

I am also under a duty to send the Chief Coroner a copy of your response.

The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

15 August 2023

Signature 

Katrina Hepburn Area Coroner for Central and South East Kent