香港牙醫管理委員會
The Dental Council of Hong Kong

Disciplinary Inquiry under s.18 of DRO

Defendant: Dr LIU Wing-hong 廖穎康牙科醫生 (Reg. No. D02030)

Date of hearing: 2 April 2026

Present at the hearing

Council Members: Dr LEE Kin-man, MH, JP (Chairperson)
Dr HSE Mei-yin, Kitty, JP
Dr FOO Tai-chuen
Dr ZHANG Chen
Ms CHOY Hok-man, Constance
Ms NG Wai-ping, Charlotte

Legal Adviser: Mr Stanley NG

Defendant: Represented by Mr Chris HOWSE of Messrs. Howse Williams, Solicitors

Legal Officers representing the Secretary: Ms Liesl LAI, Assistant Law Officer
Ms Molly WONG, Senior Government Counsel,
Ms Nova TANG, Government Counsel

The Charges

1. The charges against the Defendant, Dr LIU Wing-hong, are as follows: -

"In or about May to July 2023, you, being a registered dentist, disregarded your professional responsibility to adequately treat and care for your patients or otherwise neglected your professional duties to them in that, you –

(i) failed to adequately or at all ensure proper measures were carried out for control of cross-infection;
(ii) failed to adequately or at all ensure proper sterilization of dental instruments to prevent cross-infection; and/or
(iii) failed to keep your place of practice in a suitable state for your practice of dentistry;

and that in relation to the facts alleged, either singularly or cumulatively, you have been guilty of unprofessional conduct."

Facts of the Case

2. The name of the Defendant has been included in the General Register ("GR") since 29 January 1986. The name of the Defendant has never been included in the Specialist Register.

3. Briefly stated, on 18 May 2023, [redacted], the Defendant's patient, lodged a complaint against the Defendant with the Dental Council ("Council"). The complainant raised concern in her complaint of whether or not the clinic's tools were sterilized.

4. Subsequently, a Mr CHUNG Kin-shing, Lucas, Dental Inspector ("Mr CHUNG"), and a Ms CHEUNG Ka-lam ("Ms CHEUNG"), Acting Senior Dental Surgery Assistant (Dental Regulatory and Law Enforcement) 1, both of the Department of Health ("DH"), carried out an inspection of the Defendant's clinic at Shop 3, G/F, Shek Jing House, Chun Shek Estate, Shatin, New Territories ("the Clinic") on 27 July 2023 ("the Visit"). The Defendant was the sole practising dentist at the Clinic. Findings from the Visit are set out in a memo from Mr CHUNG to the Council dated 2 August 2023 ("the Memo") with photographs as annexures.

5. All the charges in the present case are referable to the findings from the Visit. At the inquiry, the Legal Officer adduced the Secretary's bundle, consisting of, *inter alia*, the Memo, the witness statement of Mr CHUNG and the witness statement of Ms CHEUNG (with annexure of the Guide of Infection Control In Clinic Setting issued by the Infection Control Branch, Centre for Health Protection of DH ("the Guide")).

Burden and Standard of Proof

6. The Council bears in mind that the burden of proof is always on the Legal Officer and the Defendant does not have to prove his innocence. The Council also bears in mind that the standard of proof for disciplinary proceedings is the preponderance of probability. However, the more serious the act or omission alleged, the more inherently improbable must it be regarded. Therefore, the more inherently improbable it is regarded, the more compelling the evidence is required to prove it on the balance of probabilities.

7. There is no doubt that the allegations against the Defendant here are serious. Indeed, it is always a serious matter to accuse a registered dentist of unprofessional conduct. Therefore, we need to look at all the evidence and to consider and determine each of the disciplinary charges against him separately and carefully.

Unprofessional Conduct

8. According to section 2 of the Dentists Registration Ordinance, Cap. 156, "unprofessional conduct", in relation to a person, means an act or omission of the person that would reasonably be regarded as disgraceful or dishonourable by registrants of good repute and competency.

Findings of Council

9. The Defendant admits the factual particulars of all the disciplinary charges against him but it remains for us to consider and determine on the evidence whether he has been guilty of unprofessional conduct.

10. At the Visit, inspection was conducted at the Defendant's surgery room at the Clinic. The Defendant and a Dental Surgery Assistant ("DSA") were inside. Inspection revealed the following:

(i) Clean and dirty items (including but not limited to a mobile phone, a pair of gloves, spray bottles and the ultrasonic cleaner) were not separated on the benchtop. The benchtop areas were not divided or clearly delineated from each other.

(ii) 3-in-1 syringe and dental handpieces mounted in the dental unit were not wrapped by any barrier sleeves. When enquired about how to disinfect 3-in-1 syringe and dental handpieces as they were not covered by barriers, the Defendant said that 70% alcohol would be used for disinfecting the contact surfaces contaminated by saliva while both 70% alcohol and antiseptic solution would be used in case of blood contamination. The DSA added that 1 in 49 diluted bleach would also be used for disinfection when the contact surfaces were contaminated by blood. The Defendant said that the tip of 3-in-1 syringe and the handpieces would only be replaced after a half-day session. The Defendant said that all the used instruments would be cleaned by an ultrasonic cleaner.

(iii) An autoclave was used for sterilization. According to the Defendant, it would be set at 134°C and it took about 90 minutes to complete one sterilization cycle. The Defendant said that they did not use any internal or external chemical indicators but they used biological indicator every four to five months.

(iv) Critical instruments such as probes and hand scalers stored inside a drawer were not pouched and some sterilized pouches were found opened or damaged. When asked about why some sterilized products were opened, the Defendant explained that this could dry the dental instruments faster.

(vi) When asked about the disinfection of laboratory items, suction and filter, the Defendant replied that 1 in 49 diluted bleach was used for disinfecting laboratory items while dental evacuation system cleaner was used for cleaning the suction and filters.

11. Section 1 of the Guide provides as follows:

> *"All healthcare settings, regardless of the level of care provided, must make infection prevention and control a priority. The [Guide] serves to provide guidance to healthcare personnel on prevention and control of infection in clinic settings. In this document, "clinic" refers to any facility providing medical and dental services to outpatients."*

12. At all material times, the Guide was accessible to the public. According to the Pre-amble of the Council's Code of Professional Discipline (2019 Edition) ("Code"), *"All dental*

practitioners should ... be familiar with ...(viii) Relevant guidelines on infections and infection control."

13. Section 6.3.4 of the Guide provides under the heading "Surface Asepsis":

> *"All clinical contact surfaces (e.g. ultrasonic scaler handle, 3-in-1 syringe handle, light handle) should be barrier-protected or disinfected for each patient."*

14. Since the 3-in-1 syringe and dental handpieces mounted in the dental unit were found not to be wrapped by barrier sleeves, they should be disinfected and sterilized as appropriate.

15. Section 5.6.3 of the Guide provides examples of disinfection:

> *"If places are contaminated by secretions, vomitus or excreta, use 1 part of household bleach containing 5.25% sodium hypochlorite to 49 parts of water, leave for 15-30 minutes, rinse with water and wipe dry afterwards.*
>
> *If the places are contaminated by blood, use 1 part of household bleach containing 5.25% sodium hypochlorite to 4 parts of water, leave for 10 minutes, rinse with water and wipe dry afterwards..."*

16. However, according to the Defendant, 70% alcohol would be used for disinfecting the contact surfaces contaminated by saliva while both 70% alcohol and antiseptic solution would be used for disinfecting the contact surfaces contaminated by blood. The DSA added that 1 in 49 diluted bleach would also be used for disinfection when contact surfaces were contaminated by blood.

17. One photograph annexed to the Memo shows that "Chlorhexidine* 0.05% w/v Antiseptic Solution" was the antiseptic solution used. However, "Chlorhexidine* 0.05% w/v Antiseptic Solution" is used as a general antiseptic, for the cleaning and disinfecting of wounds and the antiseptic treatment of burns.

18. According to the views of Ms CHEUNG, which we agree, the solution used at the Clinic did not meet the relevant requirements under the Guide.

19. It is stipulated in section 5.7.1 of the Guide that *"... Reusable medical devices must not be used in another patient before it has been properly cleaned and reprocessed."* Further, sections 6.3.1 ii and 6.3.1 iii state that *"All dental handpieces (including ultrasonic scalers), which are very difficult to be thoroughly disinfected, must be sterilized after use"* and *"3-in-1 syringe tips (disposable or sterilizable) must be changed between patients"* respectively.

20. Clearly, replacing 3-in-1 syringe tip and dental handpieces only after a half-day session did not meet the relevant requirements under the Guide.

21. Section 5.7.5 xi a) of the Guide states that *"... Unwrapped critical medical devices must be used at point-of-care after autoclaving..."*

22. Besides, given that some sterilized pouches of the packed instruments in the drawer were found opened and/or damaged, the Defendant was in violation of the requirement stated in

Section 5.7.6 x of the Guide, i.e. *"All packages containing sterile items should be inspected before use to verify barrier integrity and dryness. Any package that is wet, torn, damaged or beyond the expiry date should not be used. The instruments should be reprocessed, packaged in new wrap, and sterilized again."*

23. The measures for control of cross-infection at the surgery room of the Clinic was clearly deficient in areas relating to the lack of barrier sleeves, the substandard processing of dental equipment and pouching of dental instruments. The Defendant had failed to adequately or at all ensure proper measures were carried out for control of cross-infection.

24. We are satisfied that the conduct of the Defendant had seriously fallen below the standard expected amongst registered dentists. It would be reasonably regarded as disgraceful and dishonourable by registered dentists of good repute and competency. We therefore find the Defendant guilty under charge (i).

25. According to the Defendant, they monitored the sterilization process of the autoclave by using solely biological indicators every four to five months.

26. However, this would be in violation of section 5.7.5 vii a) of the Guide which provides that *"The sterilization process monitoring requires the use of mechanical indicators, external and internal chemical indicators, and biological indicators to provide a comprehensive picture to ensure the process has been effective... When dynamic air removal sterilizer is used, Appropriate steam penetration test such as Bowie-Dick test or Helix test should be performed before the first processed load of the day."*

27. We are satisfied that the conduct of the Defendant had seriously fallen below the standard expected amongst registered dentists. It would be reasonably regarded as disgraceful and dishonourable by registered dentists of good repute and competency. We therefore find the Defendant guilty under charge (ii).

28. According to section 3.1.1 of the Guide, *"All areas should be designed, constructed, furnished and equipped to minimize the risk of transmitting infection, and facilitate implementation of infection prevention and control measures."* Section 3.1.2 of the Guide also stipulates that *"The principles of separation of clean and dirty items and unidirectional flow maintaining all items from dirty to clean zone should be observed. The following areas should be divided and clearly delineated from each other: cleaning, preparation and packaging, sterilization, storage."*

29. The Defendant's failure to delineate clean zone and dirty zone was in violation of the sections 3.1.1 and 3.1.2 of the Guide.

30. We are satisfied that the conduct of the Defendant had seriously fallen below the standard expected amongst registered dentists. It would be reasonably regarded as disgraceful and dishonourable by registered dentists of good repute and competency. We therefore find the Defendant guilty under charge (iii).

Sentencing

31. The Defendant has no previous disciplinary records.

32. The Council gives credit to the Defendant's cooperation and admission to the facts of the charges.

33. The Council bears in mind that the purpose of a disciplinary order is not to punish the Defendant, but to protect the public and maintain public confidence in the dental profession.

34. We have considered the Defendant's CPD record, the survey of summary of patients, and the commendation letters as submitted.

35. The Defendant told us that since the incident, he has taken remedial steps to improve his knowledge of hygiene in the clinic. He attended seminars concerning infection control requirement of healthcare facilities and infection control practice. He has shown us photographs that he has been using barrier sleeves for dental instruments, using proper solution for disinfection and sterilization, disposable 3-in-1 syringe tip, using external and internal chemical indicators to monitor sterilization, and proper pouching of dental instruments. In mitigation, the Defendant has provided to us a sterilization log of the autoclave. This is only a summary of the log, but not the individual logs *per se*. We have concern about the reliability of these log documents submitted. In any event, with the remedial steps in place, we accept that the risk of repetition is low.

36. The Defendant told us in mitigation that he would accept an order to be made that his dental practice be subject to monitoring by a dental monitor according to terms as seen appropriate by the Council.

37. The offences committed by the Defendant in the present case are very serious. Dental hygiene of a proper dental practice is always fundamental for the protection of the public.

38. Having regard to the gravity of the case and the mitigation submitted by the Defendant, the Council makes the following orders:-

(a) In respect of charges (i) to (iii), that the name of the Defendant be removed from the General Register for a period of 3 months.

(b) The operation of our removal order be suspended and shall not take effect for a period of 24 months subject to the conditions in paragraph (c) below.

(c) The conditions are in the following terms –

(i) The Defendant's practice during the suspension period be subject to inspection by a Practice Monitor to be appointed by the Council.

(ii) The Practice Monitor shall conduct inspection visits to the Defendant's clinic at least once in every 4 months during the suspension period.

(iii) The inspection visits shall be conducted without advance notice to the Defendant.

(iv) The Practice Monitor shall be given unrestricted access to all parts of the Defendant's clinic and all documents (including clinical records) which in the opinion of the Practice Monitor are necessary for proper inspection of the Defendant's dental practice. In particular, the Defendant shall prove to the satisfaction of the Practice Monitor that the practice at his dental clinic is in compliance with the Guide issued by Centre for Health Protection of DH.

(v) The Practice Monitor shall report to the Council the progress of the inspection at the end of the 4th, 8th, 12th, 16th, 20th and 24th month during the suspension period. If any irregularity is detected, the irregularity should be reported as soon as possible.

(d) Our order of suspension above shall be uplifted if the Defendant is found by the Council to be in breach of any of the conditions as set out in paragraph (c) above, or if a finding is made against the Defendant during the said suspension period under section 18(1) of the Dentists Registration Ordinance, Cap.156.

(e) The orders in paragraphs (a) to (d) above shall be published in the Gazette.

Dr LEE Kin-man, MH, JP
Chairperson
The Dental Council of Hong Kong