



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

Disciplinary Inquiry under s.18 of DRO

Defendant: Dr LAU Yuk-cheung 劉玉祥牙科醫生 (Reg. No. D02202)

Dates of hearing: 4 May 2026, 8 May 2026 and 4 August 2026

Present at the hearing

Council Members: Dr LEE Kin-man, MH, JP (Chairperson)
Dr FOO Tai-chuen
Dr CHO Shiu-yin, Rony
Ms CHOY Hok-man, Constance
Dr LEUNG Shuk-kam, Sharron

Legal Adviser: Mr Stanley NG

Defendant: Acting in person

Legal Officer representing the Secretary: Miss Linda CHAN, Government Counsel

The Charges

1. The charges against the Defendant, Dr LAU Yuk-cheung, are as follows: -

“In or about August to October 2021, 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 wear and/or change gloves in attending to patients at all necessary times;
- (ii) failed to keep your place of practice in a suitable state for your practice of dentistry; and/or
- (iii) failed to ensure proper measures for control of cross-infection;

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 9 February 1987. The name of the Defendant has never been included in the Specialist Register.
3. Briefly stated, on 23 August 2021, a Mr CHAU, the Defendant’s patient, lodged a complaint against the Defendant with the Dental Council (“Council”). The complainant raised concern in his complaint about the unhygienic condition of the Defendant’s surgery.
4. Subsequently, a Mr CHUNG Kin-shing, Lucas, Dental Inspector (“Mr CHUNG”), and a Ms HO Fung-ling (“Ms HO”), Senior Dental Surgery Assistant (Dental Regulatory and Law Enforcement) 2, both of the Department of Health (“DH”), carried out an inspection of the Defendant’s clinic named “劉玉祥牙科醫生” at M/F, 10 Fook Hong Street, Yuen Long, New Territories (“the Clinic”) on 15 October 2021 at around 11:40 a.m. (“the Inspection”). The Defendant was the sole practising dentist at the Clinic. There was no dental surgery assistant. Findings from the Visit are set out in a memo from Mr CHUNG to the Council dated 22 October 2021 (“the Memo”) with photographs (“the Photographs”) as annexures.
5. 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 HO (with annexure, including the Guide to Infection Control in Clinic Setting issued by the Infection Control Branch, Centre for Health Protection of DH (“the Guide”), and the Basic Protocol – Infection Control Guidelines for the Dental Service (2019) issued by the Infection Control Standing Committee, Dental Service of DH (“the Basic Protocol”).

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 legal officer for the Secretary offers no evidence in respect of charge (i). We will therefore acquit the Defendant of charge (i).
10. At the beginning of the inquiry, the Defendant challenged the admissibility of the Photographs in that they were taken without his consent. The Defendant told us that he was never informed that photographs would be taken, that he expressly prohibited photography and protested throughout, yet the inspectors continued taking photographs.
11. Mr CHUNG gave evidence. Mr CHUNG's role during the Inspection was to explain the purpose of the Inspection to the Defendant and take photographs. Mr CHUNG told us that all the Photographs were taken in the presence of the Defendant and with his knowledge and consent. Mr CHUNG said that had the Defendant at any stage objected to the taking of photographs, in accordance with their usual practice of inspection, he would have stopped immediately and sought instructions from the Executive Officer of the Council. Mr CHUNG confirmed that no photographs were taken covertly because the Defendant had not raised any objection at all. Mr CHUNG's testimony was not shaken upon cross-examination.
12. If it were true that the Defendant had objected to the taking of photographs, and had protested throughout the inspection, he could have raised this objection, which was very crucial to his case, in his submissions to the Preliminary Investigation Committee ("PIC") of the Council dated 12 December 2022, which was his earliest opportunity to do so. However, he had not done so. Further, the Defendant told us that he allowed the inspectors to take photograph of his dental chair only, but not photographs of the other areas. We find it illogical and unreasonable why the Defendant only allowed the taking of photograph of the dental chair, but not the other areas of the Clinic. We find it more likely the case that as some of the Photographs may appear to be unfavourable to the Defendant's case, he therefore made it up that there was no consent and that he had protested throughout. At the inquiry, the Defendant even went as far as alleging that the Secretary's witnesses had tampered with one of the Photographs, and had staged the scene for taking that photograph. However, knowing that he had no supporting basis, the Defendant at the end withdrew this serious accusation. We do not believe in what the Defendant told us. We find that all the Photographs were taken with the Defendant's consent, in his presence and with his knowledge.
13. All of the Photographs are relevant to the issues of the present proceedings. They are reliable and show us the condition of the Clinic at all material times. Even if it was the case that the Photographs were taken without the Defendant's knowledge and consent, but which we have already ruled otherwise, we do not see that this would have created any affront to public conscience or would have compromised the integrity of the inquiry. We therefore rule all of the Photographs admissible.
14. It is stipulated in the Pre-amble of the Code of Professional Discipline (2019 Edition) ("Code") that:

"All dental practitioners should ... be familiar with the provisions of the following ... guidelines:-

...

(viii) Relevant guidelines on infections and infection control.

...

Guidelines on infections and infection control may be found at the website of the Centre for Health Protection ...”

15. Paragraph 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.”

16. On the day of inspection, the Defendant had patients’ appointments. The Clinic therefore functioned as a dental clinic on that day. The practice of the Clinic had to be in a suitable state, notwithstanding the Defendant alleged that he had been packing up on that day.
17. During the inspection, Ms HO and Mr CHUNG were brought by the Defendant to the sterilization room. The photographs of the sterilization room show used instruments soaked in liquid in a sink. The sink was not physically or clearly separated from the rest of the sterilization room. There were numerous items scattering all over the L-shaped bench. Dirty items including extracted teeth were seen near the sink and non-sterilized used medical devices were seen on the trays above the dental vibrator and near the sink. The surface of the dental vibrator, which was placed near the sink, showed that it was used and left with uncleaned residues. Between the dental vibrator and the autoclave, there lied many dental impressions, broken denture, x-ray films (inner paper wrap), and some instruments and handpieces. There was also a purple bag immediately placed in front of the autoclave.
18. Ms HO told us that there was no identifiable delineation between clean and dirty zones in the sterilization room because the items were all mixed up on the bench, making it difficult to ascertain whether particulars items were clean or contaminated. She also considered that items of indeterminate status placed immediately adjacent to the autoclave created a risk of contaminating sterilized instruments upon removal from the autoclave.
19. At the inquiry, the Defendant told us that the purple bag immediately in front of the door of the autoclave contained used gloves and extracted teeth awaiting collection by the clinical waste collector. There is no doubt that the purple bag and what was inside it were dirty items, and should not have been placed immediately in front of the door of the autoclave because that would create a risk of contaminating sterilized instruments upon removal from the autoclave.
20. On cross-examination, the Defendant told us that he intended to preserve some of the impressions, models and fractured dentures placed near the autoclave, but they first had to be disinfected, but he had no time to do so. This must mean that some of these impressions, models and fractured dentures were at the time dirty items, and should not have been placed near to the autoclave for the same reason that dirty items would create a risk of contaminating sterilized instruments upon removal from the autoclave. There should not be any doubt that the x-ray films (inner paper wraps) were dirty items, and should not have been placed near the autoclave.
21. The Defendant further accepted that he should not have placed the tray of used instruments on top of the dental vibrator.

22. When further cross-examined on whether there were any clean items on the L-shaped bench, the Defendant answered “*nothing*”, and said that “*the whole region I would consider as a dirty zone at that moment.*” In our view, if it was the case that everything on the L-shaped bench was dirty, then that would have created an even more serious risk of contaminating sterilized instruments upon removal from the autoclave.
23. The Defendant further said that a clean zone could from time to time become a dirty zone and vice versa. The Defendant suggested that a zone assumed the character of whatever items happened to be placed there, such that a clean zone could become a dirty zone during work, and revert to a clean zone after cleaning.
24. Paragraph 3 of the Guide provides that:

“3.1.1 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.

3.1.2 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.”
25. Paragraph 2.5.1 of the Basic Protocol provides that:

*“The area for cleaning and processing used instruments (**Dirty Zone**), the area for holding sterilized and clean instruments (**Clean Zone**), and the area for patient treatment (**Working Zone**) must be clearly delineated from one another. It is essential to ensure a unidirectional flow of items from the Clean Zone to the Dirty Zone.”*
26. In our view, the Defendant clearly misunderstood the concept of zoning under the Guide and the Basic Protocol, which contemplate designated areas with fixed and identifiable functions, and do not contemplate that the boundaries of a zone fluctuate according to the dentist’s activities.
27. The evidence clearly demonstrates the absence of any objectively identifiable separation between clean and dirty areas. Dirty items were placed everywhere and some near the autoclave and on top of the dental vibrator.
28. The condition in the sterilization room was a clear violation of paragraph 3 of the Guide and paragraph 2.5.1 of the Basic Protocol.
29. In his oral closing submissions, the Defendant argued that the dirty zone in the sterilization room only confined to the sink and the adjacent bench in which he placed used instruments. He further said that the bench in front of the autoclave was neither a clean zone nor a dirty zone. He further said that the Basic Protocol on zoning is only concerned with unidirectional flow of instruments, and he never placed instruments on the bench in front of the autoclave. When asked about which zone the autoclave should be placed, the Defendant answered that the autoclave should be placed in the clean zone. The area or the bench in front of or adjacent to the autoclave was clearly dirty. Instruments would go in the autoclave for cleaning and come

out after cleaning, and this was a flow of instruments. Sterilized instruments coming out from the autoclave would risk contamination by the dirty items placed on the bench in front of it. It matters not that he had not placed the instruments on that bench.

30. We are satisfied that the absence of a properly delineated system of clean and dirty zones in the sterilization room rendered the Clinic unsuitable for the practice of dentistry. 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).
31. Paragraph 5.7.5(xi)(a) of the Guide provides that “... *Unwrapped critical medical devices must be used at point-of-care after autoclaving...*”
32. Paragraph 2.8 of the Basic Protocol provides that “[c]ritical items are those which are used to penetrate soft tissues or bone. The risk of disease transmission is high. They must be sterilized before and after use. These include forceps, surgical instruments and scalers.”
33. Paragraph 2.8.1 of the Basic Protocol provides that “... [c]ritical instruments not for immediate use should be packaged to prevent recontamination after sterilization...”
34. During the inspection of the dental surgery, sterilized instruments were found to be kept in open trays inside the drawers. All instruments were not wrapped, including critical instruments such as fissure burs, round burs, needle holders, scissors, scalpel handles, scalers and extraction forceps.
35. The Defendant told us that at the material times, he did not use pouches to pouch the critical instruments although he claimed that he possessed pouches. He explained that the reason he did not pouch the critical instruments was because surgical appointments were pre-arranged and the required instruments would be sterilized about one hour beforehand. He also said that the critical instruments would be sterilized twice daily at the beginning of each session. On the day of inspection, he said that (i) all critical instruments were sterilized at 8:50 a.m.; (ii) the sterilized tray was removed at about 9:30 a.m. and placed in the drawer; (iii) he used one extraction forceps from the tray for a “Patient (2)”; and (iv) the remaining instruments stayed unwrapped in the drawer.
36. On the Defendant’s own account, on the day of inspection, he had only used one extraction forcep from the tray of sterilized instruments on Patient (2). The fact remained that all the other sterilized instruments on the tray were not pouched and the longer they remained not pouched on the tray, the higher the risks that they would be contaminated. The failure to package critical medical devices was a clear violation of paragraph 2.8.1 of the Basic Protocol.
37. The Defendant argued that he only sterilized the critical instruments at the point of care, in other words, shortly before an appointment, and therefore there was no need for pouching. However, there could always be situations where certain unsterilized critical instruments would be suddenly needed to deal with the urgent clinical condition of a particular patient, such as an urgent extraction. The Defendant told us that in these situations, he would not perform extraction and would ask the patient to come back at next appointment or would just leave it. In our view, such an arrangement would deprive the patient of immediate treatment and was definitely not appropriate. The Defendant’s argument that he only sterilized critical instruments at the point of care is not credible.

38. Paragraph 5.7.2 of the Guide provides that *"Before disinfection or sterilization, thorough cleaning is essential because inorganic and organic materials that remain on the surfaces of medical devices would interfere the effectiveness of these processes."*
39. Paragraph 5.7.6 (iv) of the Guide provides that *"[s]terilized items are recommended being stored in the enclosed cabinets/drawers, well separated from other non-sterilized items and away from potential source of contamination and with limited access."*
40. One of the Photographs shows that substantial amount of fragments and powder, which could be dental stones, were found accumulating in the corner of one of the said open trays of sterilized instruments in the dental surgery. There also appears to have residual cement remained on the surface of some of the instruments.
41. At the inquiry, the Defendant claimed that he did not know what the residues were and he did not know how they came about. However, in his PIC submissions, the Defendant stated that *"[s]ome cements were found at the corner of a instrument tray and one of the flat plastic. They were glass ionomer or zinc phosphate cement..."*. The Defendant's evidence at the inquiry was plainly inconsistent with what he said in his PIC submissions. We do not find the Defendant credible.
42. From that photograph, the fact remains that there were substantial amount of fragments, powders and cements accumulated at the corner of one of the open trays of sterilized instruments inside the drawer of the dental surgery. Not only were these instruments not pouched, they were either not properly cleaned or were exposed to recontamination. This was a clear violation of paragraphs 5.7.2, 5.7.3 and 5.7.6 (iv) of the Guide.
43. We are satisfied that the Defendant had failed to ensure proper measures for control of cross-infection. 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

44. The Defendant has no previous disciplinary records.
45. 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.
46. The Defendant told us in mitigation that he had thought of admitting to the charges, but in view of the inspectors' integrity, he therefore defended his case. Despite our verdict which we did not find that there was any integrity issue with the inspectors, the Defendant still maintained this view in his mitigation. This shows that the Defendant is not remorseful.
47. The offences committed by the Defendant in this case were very serious. It shows that the Defendant had never kept up with the contemporary concept of infection control, which is critically important for practice of dentistry.

48. The Defendant has not shown us in mitigation that he has taken any remedial measure to equip himself with knowledge of infection control. What raises grave concern to us is that the Defendant even told us that since he was close to retirement, he could practise dentistry differently from other dentists.
49. Infection control, particularly in dentistry, is of fundamental importance for the protection of the public. The Defendant has no insight in the importance of infection control.
50. Having regard to the gravity of the case and the mitigation submitted by the Defendant, we make an order in respect of charges (ii) and (iii) that the name of the Defendant be removed from the General Register permanently.
51. We have considered whether we should impose a suspension order. For the reasons stated above, we do not find suspension appropriate.



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