HEARING HELD IN PUBLIC

Professional Conduct Committee
Initial Hearing

16, 17, 19 and 20 February 2026

Name:	CHAUHAN, Krishan
Registration number:	274085
Case number:	CAS-209966

General Dental Council:	Abimbola Johnson, counsel Instructed by Andrew Richardson, IHLPS
Registrant:	Not present Not represented

Fitness to practise:	Impaired by reason of misconduct
Outcome:	Suspended with immediate suspension (with a review)
Duration:	12 months
Immediate order:	Immediate suspension order

Committee members:	Martin Isherwood (Dental Care Professional) (Chair) Nicola Jordan (Dentist) Susan Parkins (Lay)
Legal adviser:	Gerard Coll
Committee Secretary:	Gareth Llewellyn

Determination on preliminary matters – 16 February 2026

Name: CHAUHAN, Krishan
Registration number: 274085

1. This is a hearing before the Professional Conduct Committee (PCC). The hearing is being held remotely using Microsoft Teams in line with the Dental Professionals Hearings Service's current practice.

2. Mr Chauhan is not present and is not represented in his absence. Abimbola Johnson of counsel, instructed by Andrew Richardson of the General Dental Council's (GDC's) In-House Legal Presentation Service (IHLPS), appears for the GDC.

The charge

3. The charge that Mr Chauhan faces at this hearing, as amended, reads as follows:

'That you, Krishan CHAUHAN (274085), being registered as a dentist:

1. Between *18 May 2021 and 6 June 2022, you failed to provide an adequate standard of care to Patient A, in that:*

a. You did not carry out sufficient diagnostic assessments, in that you did not;

i. [withdrawn]*;*

ii. Conduct a BPE;

iii. Obtain details of complaint;

iv. Obtain history of complaint;

v. Conduct intra and extra oral examination; and/or

vi. Conduct tooth examinations specific to the patient's complaint.

b. You did not carry out pre-treatment investigations, in that you did not;

i. Conduct percussion;

ii. Conduct palpation;

iii. Conduct sensitivity test; and/or

iv. Obtain a radiograph prior to preparation of UR5.

c. You provided a poor standard of treatment in relation to the bridge at UR1;

d. You did not discuss the full risks and benefits of the proposed treatment; and/or

e. You failed to take adequate radiographs prior to preparation for a bridge.

2. You failed to maintain an adequate standard of record keeping in respect of Patient A's appointments between 18 May 2021 and 6 June 2022, in that you did not record:

a. A formal diagnosis;

b. A discussion of risks and benefits;

c. A justification and/or a report in respect of the radiograph taken on 30 March 2021; and/or

d. Any clinical notes in respect of appointments on 27 April 2021, 1 June 2021, 2 June 2021, 21 June 2021, 10 November 2021, 30 November 2021, 11 January 2022, 7 March 2022, 17 May 2022, and 6 June 2022.

3. You failed to respond adequately or at all to Patient A's complaint of 28 June 2022.

AND that by reason of the matters alleged above your fitness to practise is impaired by reasons of misconduct.'

Service of notice of hearing

4. On behalf of the GDC Ms Johnson submitted that service of notice of this hearing has been properly effected in accordance with Rules 13 and 65 of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules'). On 15 January 2026 a notice of hearing was sent to the address that Mr Chauhan has registered with the GDC, setting out the date and time of this hearing, as well as the fact that the hearing would be conducted remotely. The notice was sent using the Royal Mail's Special Delivery service. Copies of the notice were also sent to Mr Chauhan by first class post and email.

5. The Committee accepted the advice of the Legal Adviser. The Committee determined that service of the notice of this hearing has been properly effected in accordance with the Rules.

Proceeding in absence

6. The Committee then went on to consider whether to exercise its discretion to proceed in the absence of Mr Chauhan in accordance with Rule 54 of the Rules.

7. The Committee accepted the advice provided by the Legal Adviser concerning its powers and the principles to which it should have regard. The Committee was mindful that its discretion to conduct a hearing in the absence of a registrant should be exercised with the utmost care and caution. After careful consideration the Committee determined that it would be fair and appropriate to proceed in Mr Chauhan's absence. The Committee considered that Mr Chauhan appears to have voluntarily absented himself from this hearing, and that an adjournment, which has not been requested, would be unlikely to secure his attendance. The Committee was also mindful of the public interest in the expeditious consideration of this case.

Amendment to charge

8. Ms Johnson then applied to amend the charge pursuant to Rule 18 of the Rules. Ms Johnson sought to correct the numbering of the heads of charge so that the first set of allegations are properly numbered. Ms Johnson described this proposed amendment as 'cosmetic' with no substantive change being sought. The Committee, having accepted the advice of the Legal Adviser, determined to accede to the application on the basis that the amendments could be made without causing injustice to Mr Chauhan. The schedule of charge was duly amended.

9. At the conclusion of the GDC's case Ms Johnson invited the Committee to further amend the charge. Ms Johnson invited the Committee to withdraw sub-head of charge 1 (a) (i), which relates to whether a medical history was obtained. Ms Johnson also applied to amend sub-head of charge 2 (d) by withdrawing the references to two dates, namely 14 February 2022 and 30 May 2022, and to amend two other dates at that same sub-head of charge, namely by changing the reference to 24 April 2021 so that it now refers to 27 April 2021, and to change the reference to 7 May 2022 so that it now refers to 17 May 2022. The Committee, having accepted the advice of the Legal Adviser, determined to accede to the application on the basis that the amendments could be made without causing injustice to Mr Chauhan. The schedule of charge was once more amended.

Findings of fact – 19 February 2026

Background to the case and summary of allegations

10. The allegations giving rise to this hearing arise out of the care and treatment that Mr Chauhan provided to a patient, who is referred to for the purposes of these proceedings as Patient A, in the period of 18 May 2021 to 6 June 2022.

11. Patient A is understood to have attended an appointment with Mr Chauhan on 30 March 2021 on an emergency basis in relation to an infected UR1. A radiograph was taken at that appointment. The UR1 is understood to have been extracted at an appointment that the patient attended with Mr Chauhan on 6 April 2021. On 18 May 2021 impressions were taken for a flexi-denture to replace the missing UR1. Subsequently a multi-unit bridge was fitted in the patient's upper right quadrant at an appointment on 11 January 2022.

12. The GDC alleges that Mr Chauhan failed to provide an adequate standard of care to Patient A in a number of respects. The GDC contends that Mr Chauhan did not carry out sufficient diagnostic assessments and pre-treatment investigations, that he provided a poor standard of treatment in relation to a bridge at the patient's UR1, that he did not discuss the full risks and benefits of the proposed treatment, and that he failed to take adequate radiographs before bridge preparation.

13. It is further alleged that Mr Chauhan failed to maintain an adequate standard of record-keeping in respect of the appointments that Patient A attended with him, in that he did not record a formal diagnosis, a discussion of risks and benefits, a justification and/or a report for the radiograph taken on 30 March 2021, and any clinical notes for 10 specific appointments.

14. The GDC also brings a head of charge against Mr Chauhan in respect of his alleged failure to respond, adequately or at all, to Patient A's complaint of 28 June 2022.

Evidence

15. The Committee has been provided with documentary material in relation to the heads of charge that Mr Chauhan faces, including the witness statement, documentary exhibits and patient records of Patient A; the witness statement and documentary exhibits of the current practice manager of the practice at which the events giving rise to these proceedings occurred, who is referred to for the purposes of these proceedings as Witness 1; and the report of the GDC's expert witness, namely Jennifer Ward.

16. The Committee heard oral evidence from Witness 1, Patient A, and Dr Ward.

Committee's findings of fact

17. The Committee has taken into account all the evidence presented to it, both written and oral. It has considered the submissions made by Ms Johnson on behalf of the GDC. The Committee has had regard to the GDC's *Fitness to Practise: Guidance for the practice committees* (January 2026).

18. The Committee has accepted the advice of the Legal Adviser concerning its powers and the principles to which it should have regard. The Committee is mindful that the burden of proof lies with the GDC, and has considered the heads of charge against the civil standard of proof, that is to say, the balance of probabilities. The Committee has considered each head and sub-head of charge separately, although some of its findings will be announced together.

19. I will now announce the Committee's findings in relation to each head of charge:

1.	Between *18 May 2021 and 6 June 2022, you failed to provide an adequate standard of care to Patient A, in that:*
1. (a)	*You did not carry out sufficient diagnostic assessments, in that you did not;*

1. (a) (i)	[Withdrawn]
1. (a) (ii)	*Conduct a BPE;* **Proved**
	The Committee finds the facts alleged at sub-head of charge 1 (a) (ii) proved. The Committee had regard to the expert evidence of Dr Ward. Dr Ward's evidence is that there is no record of Mr Chauhan having conducted a basic periodontal examination (BPE) at any of the appointments in the period in question. The Committee, having had regard to the patient's records, agrees with this analysis and accepts Dr Ward's evidence. The Committee infers from the absence of a record of a BPE that no such BPE was undertaken. The Committee also accepts Dr Ward's unchallenged expert opinion that a BPE was required to assess the patient's periodontal health before using certain teeth as abutments for the proposed fixed bridge. Dr Ward opines that, as a result of the omission, diagnosis was impaired and pathology may have been overlooked. The Committee agrees that a BPE was all the more important in light of a radiograph dated on 30 March 2021. Although this radiograph was taken outside of the date range specified at the head of charge, the information yielded by the radiograph was relevant to diagnostic assessments in the operative period. The radiograph shows a degree of bone loss around UR2 in particular which in Dr Ward's opinion may indicate periodontal disease. Dr Ward opined that she would have expected further investigation in the form of a BPE to ascertain gum health and the presence or not of periodontal disease which could have risked the prognosis of the proposed bridge. As the Committee finds that Mr Chauhan was required to undertake a BPE, but did not do so, it determined that this amounts to a failure to provide an adequate standard of care to Patient A. Accordingly, the Committee finds the facts alleged at sub-head of charge 1 (a) (ii) proved
1. (a) (iii)	*Obtain details of complaint;* **Proved**
1. (a) (iv)	*Obtain history of complaint;* **Proved**
	The Committee finds the facts alleged at sub-heads of charge 1 (a) (iii) and (iv) proved. The Committee had regard to the expert evidence of Dr Ward. Dr Ward's evidence is that there is no record of Mr Chauhan having obtained any details or histories of Patient A's complaint, or complaints, at any of the appointments in the period in question. The Committee, having had regard to the patient's records, agrees with this analysis and accepts Dr Ward's evidence. The Committee infers from the absence of a record of Mr Chauhan having obtained details and histories of Patient A's complaint or complaints that no such details

	and histories were obtained. The Committee did note that, at an emergency appointment that took place on 21 February 2022 subsequent to the bridge being fitted, Mr Chauhan recorded his identification of some swelling. However, the Committee considered that this did not amount to him obtaining details and a history of the patient's complaint(s). The Committee also accepts Dr Ward's unchallenged expert opinion that Mr Chauhan was under a duty to obtain details and histories of the patient's complaint(s) so that relevant pathology could be noted, and further assessments could be identified, in order to assist with proper diagnosis. Dr Ward again opines that, as a result of these omissions, diagnosis was impaired and pathology may have been overlooked. As the Committee finds that Mr Chauhan was required to obtain such information, but did not do so, it determined that this amounts to a failure to provide an adequate standard of care to Patient A. Accordingly, the Committee finds the facts alleged at sub-heads of charge 1 (a) (iii) and (iv) proved.
1. (a) (v)	*Conduct intra and extra oral examination; and/or* **Proved**
	The Committee finds the facts alleged at sub-head of charge 1 (a) (v) proved. The Committee had regard to the expert evidence of Dr Ward. Dr Ward's evidence is that there is no record of Mr Chauhan having conducted an intraoral or extraoral examination at any of the appointments in the period in question. The Committee, having had regard to the patient's records, agrees with this analysis and accepts Dr Ward's evidence, save for it noting that there is a reference to an intraoral and extraoral examination at the appointment that took place on 4 April 2022 at which root canal treatment (RCT) was provided. The Committee does not consider that this sole examination amounts to a sufficiency of diagnostic assessments in the relevant period, and it accepts Dr Ward's evidence that such examinations should be conducted at each patient appointment. The Committee infers from the absence of a record of Mr Chauhan having undertaken sufficient intraoral and extraoral examinations that no examinations took place. The Committee also accepts Dr Ward's unchallenged expert opinion that Mr Chauhan was under a duty to conduct intraoral and extraoral examinations at each appointment so that relevant pathology could be noted, and further assessments could be identified, in order to assist with proper diagnosis. Dr Ward again opines that, as a result of these omissions, diagnosis was impaired and pathology may have been overlooked. As the Committee finds that Mr Chauhan was required to conduct sufficient intraoral and extraoral examinations, but did not do so, it determined that this amounts to a failure to provide an adequate standard of care to Patient A. Accordingly, the Committee finds the facts alleged at sub-head of charge 1 (a) (v) proved.
1. (a) (vi)	*Conduct tooth examinations specific to the patient's complaint.* **Proved**

	The Committee finds the facts alleged at sub-head of charge 1 (a) (vi) proved. The Committee found that the matters alleged at this head of charge are averred with greater specificity at sub-heads of charge 1 (b) (i), 1 (b) (ii) and 1 (b) (iii) below. The Committee therefore finds the facts alleged at head of charge 1 (a) (vi) proved, but considers that the proven facts are the same as those established at sub-heads of charge 1 (b) (i), 1 (b) (ii) and 1 (b) (iii) below.
1. (b)	*You did not carry out pre-treatment investigations, in that you did not;*
1. (b) (i)	*Conduct percussion;* **Proved**
1. (b) (ii)	*Conduct palpation;* **Proved**
1. (b) (iii)	*Conduct sensitivity test; and/or* **Proved**
	The Committee finds the facts alleged at sub-heads of charge 1 (b) (i), 1 (b) (ii) and 1 (b) (iii) proved. The Committee had regard to the expert evidence of Dr Ward. Dr Ward's evidence is that there is no record of Mr Chauhan having conducted key pre-treatment investigations, namely percussion testing, palpation and sensitivity tests, at any of the pre-treatment appointments that Patient A attended. The Committee, having had regard to the patient's records, agrees with this analysis and accepts Dr Ward's evidence. The Committee infers from the absence of a record of Mr Chauhan having undertaken such pre-treatment investigations that no such investigations took place. The Committee also accepts Dr Ward's unchallenged expert opinion that Mr Chauhan was under a duty to conduct such key pre-treatment investigations so that relevant pathology could be noted, and further assessments could be identified, in order to assist with proper diagnosis. Dr Ward again opines that, as a result of these omissions, diagnosis was impaired and pathology may have been overlooked. Dr Ward further opined that, had such pre-treatment investigations been conducted, the treatment planning may have changed and the large bridge that was fitted may not have been provided. Dr Ward also opined that such pre-treatment investigations were all the more necessary in light of the possible periapical pathology at UR2 evident on the radiograph previously taken on 30 March 2021. As the Committee finds that Mr Chauhan was required to conduct key pre-treatment investigations, but did not do so, it determined that this amounts to a failure to provide an adequate standard of care to Patient A. Accordingly, the Committee finds the facts alleged at sub-heads of charge 1 (b) (i), 1 (b) (ii) and 1 (b) (iii) proved.
1. (b) (iv)	*Obtain a radiograph prior to preparation of UR5.*

	Proved
	The Committee finds the facts alleged at sub-head of charge 1 (b) (iv) proved. The Committee accepted the unchallenged expert evidence of Dr Ward that the radiograph referred to above which predated the period of time averred at this head of charge, namely the radiograph taken on 30 March 2021, did not adequately reveal all of the patient's UR5, which was, as well as UR2, to be used as an abutment for the proposed bridge. Accordingly, the existence and extent of periapical pathology, and with it the appropriateness of the proposed bridge, could not properly be determined. The Committee accepts Dr Ward's evidence that, for these reasons, Mr Chauhan was under a duty to obtain a radiograph prior to preparing UR5. It infers from the absence of any such radiograph in the patient's records, or any reference to any such radiograph, that no such radiograph was obtained. As the Committee finds that Mr Chauhan was required to obtain a radiograph prior to preparing the patient's UR5, but did not do so, it determined that this amounts to a failure to provide an adequate standard of care to Patient A. Accordingly, the Committee finds the facts alleged at sub-head of charge 1 (b) (iv) proved.
1. (c)	*You provided a poor standard of treatment in relation to the bridge at UR1;* **Proved**
	The Committee finds the facts alleged at sub-head of charge 1 (c) proved. The Committee considers that this finding follows from its findings at the other heads of charge which it has found proved as set out above. In summary, the identified omissions in Mr Chauhan's assessments, examinations and investigations resulted in a poor standard of treatment in relation to the bridge which appears to have been fitted at an appointment that took place on 11 January 2022. This, in turn, amounts to an inadequate standard of care as alleged at the head of charge. In reaching this conclusion the Committee also noted, and accepted, Dr Ward's unchallenged expert opinion that the bridge failed quickly, that is to say approximately one month later, which is particularly suggestive of underlying issues having not been identified and resolved before the relevant teeth were prepared in anticipation of the fitting of the bridge. The Committee also notes that RCT was required shortly after at the abutted UR5, which is further illustrative of a poor standard of treatment. The Committee also notes that Patient A continues to complain of the bridge never having properly fitted. Accordingly, the Committee finds the facts alleged at sub-head of charge 1 (c) proved.
1. (d)	*You did not discuss the full risks and benefits of the proposed treatment; and/or* **Proved**
	The Committee finds the facts alleged at sub-head of charge 1 (d) proved.

	The Committee accepted the unchallenged evidence of Patient A, namely that Mr Chauhan did not discuss the risks and benefits of the proposed bridgework treatment with her. The Committee also infers from the absence of a record of Mr Chauhan having discussed the full risks and benefits of the proposed treatment with Patient A that no such conversations took place. The Committee also accepted the unchallenged expert evidence of Dr Ward that the risks of the proposed treatment should have been discussed with Patient A. These risks included the potential for the abutment teeth to be compromised in the future due to the apparent bone loss and potential periapical pathology, and the potential need for subsequent RCT. As the Committee finds that Mr Chauhan was required to discuss the full risks and benefits of the proposed treatment with Patient A, but did not do so, it determined that this amounts to a failure to provide an adequate standard of care to Patient A. Accordingly, the Committee finds the facts alleged at sub-head of charge 1 (d) proved.
1. (e)	*You failed to take adequate radiographs prior to preparation for a bridge.* **Proved**
	The Committee finds the facts alleged at sub-head of charge 1 (e) proved. The Committee found that the matters alleged at this head of charge are also averred at sub-head of charge 1 (b) (iv), and that there are no other matters that fall to be determined at head of charge 1 (e). The Committee therefore finds the facts alleged at head of charge 1 (e) proved, but considers that the proven facts are the same as those established at sub-head of charge 1 (b) (iv).
2.	*You failed to maintain an adequate standard of record keeping in respect of Patient A's appointments between 18 May 2021 and 6 June 2022, in that you did not record:*
2. (a)	*A formal diagnosis;* **Proved**
	The Committee finds the facts alleged at sub-head of charge 2 (a) proved. The Committee noted that Mr Chauhan did not record any formal diagnosis in Patient A's records in the period in question. As noted above, the Committee did note that, at an emergency appointment that took place on 21 February 2022, after the bridge had been fitted, Mr Chauhan recorded his identification of some swelling. However, the Committee considered that this did not amount to a formal diagnosis. The Committee accepts Dr Ward's unchallenged expert opinion that Mr Chauhan was under a duty to record a formal diagnosis in the patient's records. As he did not do so, the Committee considers that this constitutes a failure to maintain an adequate standard of record-keeping.

	Accordingly, the Committee finds the facts alleged at sub-head of charge 2 (a) proved.
2. (b)	*A discussion of risks and benefits;* **Proved**
	The Committee finds the facts alleged at sub-head of charge 2 (b) proved. As set out in respect of its findings at sub-head of charge 1 (d), the Committee noted that Mr Chauhan did not record any discussion of risks and benefits of the proposed treatment. The Committee accepts Dr Ward's unchallenged expert opinion that Mr Chauhan was under a duty to record a discussion of risks and benefits in the patient's records. As he did not do so, the Committee considers that this constitutes a failure to maintain an adequate standard of record-keeping. Accordingly, the Committee finds the facts alleged at sub-head of charge 2 (b) proved.
2. (c)	*A justification and/or a report in respect of the radiograph taken on 30 March 2021; and/or* **Not proved**
	The Committee finds the facts alleged at sub-head of charge 2 (c) not proved. The Committee noted that the date on which the radiograph was taken, namely 30 March 2021, falls outside of the time period to which the overarching head of charge relates, namely 18 May 2021 to 6 June 2022. Accordingly, any omission of a justification for, and/or a report on, a radiograph taken outside of that period of time could not amount to an inadequate standard of record-keeping in that period. Accordingly, the Committee finds the facts alleged at sub-head of charge 2 (c) not proved.
2. (d)	*Any clinical notes in respect of appointments on 27 April 2021, 1 June 2021, 2 June 2021, 21 June 2021, 10 November 2021, 30 November 2021, 11 January 2022, 7 March 2022, 17 May 2022, and 6 June 2022.* **Proved in respect of all dates apart from 27 April 2021**
	The Committee finds the facts alleged at sub-head of charge 2 (d) proved in respect of all of the specified dates, save for the specific date of 27 April 2021. The Committee again notes that the date of 27 April 2021 falls outside of the period of time to which the overarching head of charge relates, namely 18 May 2021 to 6 June 2022. Accordingly, any omission of clinical notes for an appointment that occurred quite outside of that period of time could not amount to an inadequate standard of record-keeping in that period. In respect of the other dates specified at this sub-head of charge, the Committee had regard to the unchallenged evidence of Witness A, who provides a list of

	appointments that Patient A attended with Mr Chauhan. The Committee observed from the patient's records that Mr Chauhan made no clinical notes for any of those appointments. The Committee accepts Dr Ward's unchallenged expert opinion that Mr Chauhan was under a duty to make clinical notes of these appointments in the patient's records. As he did not do so, the Committee considers that this constitutes a failure to maintain an adequate standard of record-keeping. Accordingly, the Committee finds the facts alleged at sub-head of charge 2 (d) proved with regard to all of the dates specified, save for 27 April 2021.
3.	*You failed to respond adequately or at all to Patient A's complaint of 28 June 2022.* **Proved**
	The Committee finds the facts alleged at head of charge 3 proved. The Committee notes from her unchallenged evidence that Patient A made a complaint to the practice at which Mr Chauhan had treated her by email on 28 June 2022. The evidence of Witness A is that Mr Chauhan left the practice that same month. He exhibits exchanges of emails which demonstrate that, by 12 January 2023, Mr Chauhan had been informed of the fact and content of Patient A's complaint, and that he was asked to respond. Witness A's evidence is that Mr Chauhan did not do so, and that Mr Chauhan's sole contact was simply to confirm his current contact details by email on 22 September 2023. The Committee accepts the unchallenged expert opinion of Dr Ward that Mr Chauhan was under a duty to respond adequately to Patient A's complaint. As he did not do so, the Committee finds that this amounts to a failure on his part. Accordingly, the Committee finds the facts alleged at head of charge 3 proved.

20. We move to stage two.

Determination on misconduct, impairment and sanction – 20 February 2026

21. Following the handing down of the Committee's findings of fact on 19 February 2026, the hearing proceeded to stage two; that is to say, misconduct, impairment and sanction.

Proceedings at stage two

22. The Committee has considered all the evidence presented to it, both oral and written. It has taken into account the submissions made by Ms Johnson on behalf of the GDC. In its deliberations the Committee has had regard to the GDC's *Fitness to Practise: Guidance for the practice committees* (January 2026). The Committee has accepted the advice of the Legal Adviser concerning its powers and the principles to which it should have regard.

Evidence at stage two

23. The Committee received no further oral or documentary evidence at this stage of the hearing.

Fitness to practise history

24. Ms Johnson on behalf of the GDC addressed the Committee in accordance with Rule 20 (1) (a) of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules'). Ms Johnson stated that Mr Chauhan has no fitness to practise history with the GDC.

Summary of submissions

25. Ms Johnson invited the Committee to find that the facts that it has found proved constitute misconduct, and that Mr Chauhan's fitness to practise is currently impaired with regard to public protection and public interest factors. Ms Johnson submitted that the appropriate and proportionate sanction is one of suspension for a period of nine to 12 months, with a review hearing to take place prior to the end of that period.

Misconduct

26. The Committee first considered whether the facts that it has found proved constitute misconduct. In considering this and all other matters, the Committee has exercised its own independent judgement.

27. In its deliberations the Committee has had regard to the following paragraphs of the GDC's *Standards for the Dental Team* (September 2013) in place at the time of the incidents giving rise to the proven facts. These paragraphs state that as a dentist you must:

1.1.1 You must discuss treatment options with patients and listen carefully to what they say. Give them the opportunity to have a discussion and to ask questions.

1.4.2 You must provide patients with treatment that is in their best interests, providing appropriate oral health advice and following clinical guidelines relevant to their situation. You may need to balance their oral health needs with their desired outcomes. If their desired outcome is not achievable or is not in the best interests of their oral health, you must explain the risks, benefits and likely outcomes to help them to make a decision.

2.3 Give patients the information they need, in a way they can understand, so that they can make informed decisions.

2.3.4 You should satisfy yourself that patients have understood the information you have given them, for example by asking questions and summarising the main points of your discussion.

2.3.5 You should make sure that patients have enough information and enough time to ask questions and make a decision.

4.1 Make and keep contemporaneous, complete and accurate patient records.

4.1.1 Make and keep complete and accurate patient records, including an up-to-date medical history, each time that you treat patients. Radiographs, consent forms, photographs, models, audio or visual recordings of consultations, laboratory prescriptions, statements of conformity and referral letters all form part of patients records where they are available.

4.1.2 You should record as much detail as possible about the discussions you have with your patients, including evidence that valid consent has been obtained. You should also include details of any particular patient's treatment needs where appropriate.

4.1.4 You must ensure that all documentation that records your work, including patient records, is clear, legible, accurate, and can be readily understood by others. You must also record the name or initials of the treating clinician.

5.1.1 It is part of your responsibility as a dental professional to deal with complaints properly and professionally. You must:

• ensure that there is an effective written complaints procedure where you work;
• follow the complaints procedure at all times;
• respond to complaints within the time limits set out in the procedure; and
• provide a constructive response to the complaint

5.3 You must give patients who complain a prompt and constructive response.

5.3.3 You should aim to resolve complaints as efficiently, effectively and politely as possible.

5.3.4 You must respond to complaints within the time limits set out in your complaints procedure.

5.3.9 If a complaint is justified, you should offer a fair solution. This may include offering to put things right at your own expense if you have made a mistake.

7.1 Provide good quality care based on current evidence and authoritative guidance.

7.1.1 You must find out about current evidence and best practice which affect your work, premises, equipment and business and follow them.

7.1.2 If you deviate from established practice and guidance, you should record the reasons why and be able to justify your decision.

28. The Committee's findings relate to the care and treatment that Mr Chauhan provided to Patient A in the period of 18 May 2021 to 6 June 2022. The Committee found that Mr Chauhan failed to provide an adequate standard of care to Patient A in a number of respects. These were, namely, Mr Chauhan not carrying out sufficient diagnostic assessments and pre-treatment investigations, providing a poor standard of treatment in relation to a bridge at the patient's UR1, not discussing the full risks and benefits of the proposed treatment, and failing to take adequate radiographs before preparing the bridge. The Committee also found that Mr Chauhan failed to maintain an adequate standard of record-keeping in respect of the appointments that Patient A attended with him. The Committee also determined that Mr Chauhan failed to respond, adequately or at all, to Patient A's complaint about her care and treatment.

29. In light of the findings of fact that it has made, the Committee has determined that the proven facts amount to misconduct. In exercising its own independent judgement the Committee had regard to Dr Ward's expert opinion that Mr Chauhan's acts and omissions fell far below the required standards. The Committee considers that Mr Chauhan's acts and omissions were serious, and fell far short of the standards reasonably to be expected of a registered dentist, Mr Chauhan's acts and omissions relate to fundamental and wide-ranging aspects of the safe practice of dentistry. Mr Chauhan caused actual, and indeed ongoing, harm to Patient A, and otherwise placed her at unwarranted risk of harm. The Committee's concerns about Mr Chauhan's clinical practice are compounded by his proven failure to respond to Patient A's complaint about her care and treatment. The Committee considers that Mr Chauhan's conduct would be viewed as deplorable by his fellow practitioners.

30. The Committee has therefore determined that the facts that it has found proved amount to misconduct.

Impairment

31. The Committee next considered whether Mr Chauhan's fitness to practise is currently impaired by reason of the misconduct that it has found. In doing so, the Committee again exercised its own independent judgement. Throughout its deliberations, the Committee has borne in mind that its overarching objective is to protect the public, which includes the protection of patients and the wider public, the maintenance of public confidence in the profession and in the regulatory process, and the declaring and upholding of proper standards of conduct and behaviour.

32. The Committee has determined that Mr Chauhan's fitness to practise is currently impaired by reason of the misconduct that it has found. The misconduct in this case is serious, relating as it does to fundamental issues of patient safety, and engages public protection issues. The Committee has been provided with no evidence whatsoever to demonstrate that Mr Chauhan has developed any insight into his misconduct, or that he has taken any steps to remedy those failings. The Committee therefore considers that Mr Chauhan continues to pose a risk to the public on account of his wholly unremediated misconduct. The Committee therefore finds that Mr Chauhan's fitness to practise is currently impaired with reference to public protection factors.

33. Further, the Committee considers that a finding of impairment is also required to maintain public confidence in the profession and to declare and uphold proper professional standards of conduct and behaviour. In the Committee's judgement the public's trust and confidence in the profession, and in the regulatory process, would be significantly undermined if a finding of impairment was not made given the serious nature of Mr Chauhan's misconduct, and in particular the harm that he has occasioned to Patient A, and the disregard that he has shown to her.

34. Accordingly, the Committee finds that Mr Chauhan's fitness to practise is currently impaired by reason of his misconduct, with regard to both public protection and public interest considerations.

Sanction

35. The Committee then determined what sanction, if any, is appropriate in light of the findings of facts, misconduct and impairment that it has made. The Committee recognises that the purpose of a sanction is not to be punitive, although it may have such an effect, but is instead imposed to protect patients and safeguard the wider public interests mentioned above.

36. In reaching its decision the Committee has again taken into account the GDC's *Fitness to Practise: Guidance for the practice committees* (January 2026). The Committee has applied the principle of proportionality, balancing the public interest with Mr Chauhan's own interests. The Committee has once more exercised its own independent judgement.

37. The Committee has paid careful regard to the mitigating and aggravating factors present in this case.

38. In respect of the mitigating factors that are present, the Committee notes that Mr Chauhan is of previous good character with no fitness to practise history.

39. In terms of aggravating factors, the Committee notes that Mr Chauhan's acts and omissions meant that Patient A suffered actual harm and was otherwise placed at risk of harm, that Mr Chauhan's misconduct was sustained and repeated over a considerable period of time, and that he has not provided any evidence of having insight into his misconduct.

40. The Committee has considered the range of sanctions available to it, starting with the least restrictive. In the light of its findings, the Committee considers that taking no action or issuing a reprimand would not be sufficient in the particular circumstances of this case. In the Committee's judgement the safety of the public, and public trust and confidence in the profession and in the regulatory process, would be significantly undermined if no action were taken or if a reprimand were issued. No sanction, or a reprimand, would also not be sufficient to declare and uphold proper professional standards of conduct and behaviour. In the Committee's judgement a sanction that restricts Mr Chauhan's practice is required to protect the public and meet the wider public interest considerations that it has identified.

41. The Committee next considered whether it would be appropriate to conclude the case with a direction of conditional registration. The Committee considers that conditions cannot be formulated to adequately manage the risks to the public that it has identified. Although the Committee has not drawn any adverse inference from Mr Chauhan's absence at this hearing and his non-engagement with these proceedings, the Committee recognises that this has the practical effect of making it even more difficult for it to identify workable conditions with which it could be satisfied that he would comply. The Committee further considers that a direction of conditional registration would not be sufficient to declare and uphold proper professional standards of conduct and behaviour or maintain public trust and confidence in the profession.

42. The Committee next considered whether to direct a period of suspended registration. After careful consideration, the Committee has determined that it would be appropriate and proportionate to suspend Mr Chauhan's registration. The Committee again notes that Mr Chauhan has provided no evidence of his insight into, or remediation of, his misconduct, that he is at significant risk of repeating his misconduct, and that the public and the wider public interest would be insufficiently protected by a lesser sanction.

43. The Committee did consider whether the higher, and ultimate, sanction of erasure would be appropriate. It considered that no higher sanction than that of suspension is needed in order to address the public protection and public interest considerations referred to above. Although the Committee considers that the misconduct that it has found is serious, including as it does Mr Chauhan's failure to respond to the patient's complaint, it does not conclude that the misconduct that it has identified connotes a deep-seated and harmful professional attitudinal problem. The Committee also considers that the misconduct that it has identified, which largely relates to discreet, fundamental and identifiable aspects of Mr Chauhan's clinical practice, is capable of being remedied. Accordingly, a direction of erasure would be disproportionate.

44. The Committee hereby directs that Mr Chauhan's registration shall be suspended for a period of 12 months, with a review hearing to take place prior to the end of that period of suspended registration. In the Committee's judgement this period of time is likely to be required by Mr Chauhan to develop and demonstrate insight into, and remediation of, his misconduct, should he be minded to do so. The Committee considers that this period of time is commensurate with the findings that it has made.

45. Although the Committee in no way wishes to bind or fetter the Committee which will review Mr Chauhan's suspension in approximately 12 months' time, it considers that that Committee may be assisted by Mr Chauhan:

    - producing a reflective statement dealing with the Committee's findings and his observations on the impact that his conduct has had on Patient A, the profession and the wider public;

    - engaging with these proceedings;

- providing evidence of his remediation of his misconduct, including focussed and targeted ongoing learning and continuing professional development (CPD) in relation to the Committee's findings.

Immediate order

46. The Committee now invites submissions as to whether Mr Chauhan's registration should be made subject to an immediate order of suspension, pending its substantive direction of suspension taking effect.

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47. Ms Johnson on behalf of the GDC submitted that an immediate order of suspension is necessary to protect the public and is otherwise in the public interest.

48. The Committee has again had regard to the GDC's *Fitness to Practise: Guidance for the practice committees* (January 2026). The Committee accepted the advice of the Legal Adviser concerning its powers and the principles to which it should have regard.

49. In all the circumstances, the Committee considers that an immediate order of suspension is necessary to protect the public and is otherwise in the public interest. The Committee has determined that, given the risks to the public and the public interest that it has identified, it would not be appropriate to permit Mr Chauhan to practise before the substantive direction of suspension takes effect. The Committee considers that an immediate order for suspension is consistent with the findings that it has set out in its foregoing determination.

50. The effect of the foregoing determination and this immediate order is that Mr Chauhan's registration will be suspended from the date on which notice of this decision is deemed to have been served upon him. Unless Mr Chauhan exercises his right of appeal, the substantive direction of suspension will be recorded in the register 28 days from the date of deemed service. Should Mr Chauhan decide to exercise his right of appeal, this immediate order of suspension will remain in place until the resolution of any appeal.

51. That concludes this case.