Professional Conduct Committee
Initial Hearing
3-4 August 2026

Name:	Arjuna, Amar Sundeep
Registration number:	225339
Case number:	CAS- 211945-H0X1Q3

General Dental Council:	Eleanor Curzon, counsel Instructed by Rosie Geddes IHLPS
Registrant:	Present and represented by Ranald Davidson, Counsel, instructed by Bridget Miles, Weightmans.

Fitness to practise:	Impaired by reason of misconduct
Outcome:	Suspended with immediate suspension (with a review)
Duration:	3 months
Immediate order:	Immediate suspension order

Committee members:	Sue Stevens (Chair, Dentist) Tara Wilmott (Lay) Emili Shatchen(Dental Care Professional)
Legal adviser:	Judith Walker
Committee Secretary:	Jamie Barge

Allegations

The allegations are as follows:

1. *You failed to provide an adequate standard of care to Patient A between 23 October 2020 and 27 March 2024 including by:*

   a) *Not carrying out bitewing radiographs.*

   b) *Providing a poor standard of treatment, including in respect of the restorations.*

   c) *Having received the specialist periodontists' letter, dated 14 October 2021, and not:*

      i) *Carrying out sufficient treatment planning; and/or*
      ii) *Providing/arranging adequate remedial care.*

2. *You failed to maintain an adequate standard of record keeping in respect of the following appointments:*

   a) *18 December 2020.*

   b) *09 January 2021.*

   c) *30 January 2021.*

   d) *13 February 2021.*

3. *You failed to respond adequately to Patient A's complaints about their dental treatment, including in the letter to Patient A, signed on 30 November 2021.*

4. *You provided information to Patient A on 30 November 2021 about the treatment you provided that was:*

   a) *Misleading and/or*

   b) *Dishonest.*

5. *Between 10 March 2022 and 5 April 2022, you failed to have indemnity insurance.*

Mr Arjuna

1. This is an initial hearing before the Professional Conduct Committee, pursuant to section 27B of the Dentists Act 1984 (as amended) ('the Act').

2. The hearing is being conducted in person at the GDC's Wimpole Street London offices.

3. You are present and represented by Mr Ranald Davidson, Counsel at these proceedings. Ms Curzon, Counsel, appears on behalf of the General Dental Council (GDC).

Preliminary Matter: Rule 18 Application to withdraw head of charge 2 (3 August 2026)

4. At the outset of the hearing, Ms Curzon made an application under Rule 18 of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules") to withdraw head of charge 2.

5. In respect of head of charge 2 , Ms Curzon submitted that following the findings of the GDC's expert, the supplementary expert report concluded that based on updated records provided by you, there was no longer any evidence to indicate that your record keeping in this respect fell far below the standards expected in respect of head of charge 2.

6. Mr Davidson, on your behalf, submitted that he had no objection to the application.

The Committee's decision on the Rule 18 application

7. The Committee accepted the advice of the Legal Adviser on the Rule 18 application. The Committee was satisfied that the proposed withdrawal of head of charge 2 would cause no prejudice to either party. It determined that it was in the interests of justice for the withdrawal to be made and it could be made without injustice to either party.

8. The Committee, therefore acceded to Ms Curzon's application to withdraw head of charge 2.

Admissions to the charges – 3 August 2026

9. At the outset of the hearing, Mr Davidson told the Committee that you admitted all of the remaining charges in its entirety, namely heads of charge 1, 3, 4 and 5. He submitted there are no factual disputes to be resolved at Stage 1.

Decision on admissions to the charges – 3 August 2026

10. Having heard your admissions, the Committee accepted the advice of the Legal Adviser, who drew its attention to Rule 17(4) of the *GDC (Fitness to Practise) Rules Order of Council 2006* ('the Rules'), which states that:

> *"A Practice Committee shall in the first instance deal with any …, admissions …, and make determinations in respect of them before the commencement of the factual inquiry."*

11. In all the circumstances, the Committee determined that it was content to accept your admissions to the remaining heads of charge. In accordance with Rule 17(5), the Chair of the Committee announced the alleged facts as proved on the basis of your admissions.

Summary of the case

12. A webform complaint was received by the GDC on 1 April 2024 from an Informant, Patient A, raising concerns about you. Patient A had attended a first appointment on 23 October 2020 with you at the Practice, as she wanted composite bonding for a full smile upper and lower. Patient A attended a number of appointments. Patient A stated that the composite bonding treatment ended up being a crown on UL 1 and a veneer on UR1. The treatment was carried out over several appointments over several months. Patient A stated that she suffered major sensitivity, soreness, black spots and major staining for months afterwards. She alleges that you asked her to come back, however, when she did go back; there was no resolution to her issues.

13. Patient A stated that she emailed you on multiple occasions raising her concerns and you advised that she needed further veneers on her upper lateral incisors at an additional cost. Patient A stated one of the front teeth immediately 'went black' along the gumline, which you replaced with a new veneer. Patient A stated that the composite bonding felt sharp and she had to return to you for multiple appointments to get it corrected. At the time of the complaint, she still felt that they didn't fit her mouth properly. She complained of sensitivity, soreness, black spots and major staining. Following several appointments, Patient A was still complaining of sensitivity and the appearance of the restorations. You referred her to a Periodontist who, in a letter dated 14 October 2021, advised that the diagnosis was 'generalised gingivitis due to plaque retentive restorative margins'. The Periodontist recommended OHI (oral hygiene instruction), full mouth U/S (ultrasonic) debridement and reassessment. Following the appointment with the Periodontist, you sent a letter to Patient A, on 30 November 2021, stating that the Periodontist advised the diagnosis was plaque induced gingivitis and that nothing further was clinically required.

14. Patient A subsequently attended a Hygienist appointment and the Hygienist advised that they were unable to clean the teeth properly as the composites were joined together and could not be flossed.

15. It is alleged by the GDC that you failed to provide an adequate standard of care to Patient A between 23 October 2020 and 27 March 2024 by not carrying out bitewing radiographs, and providing a poor standard of treatment in respect of the restorations. In addition, it is alleged that having received the specialist periodontist's letter, dated 14 October 2021, you did not carry out sufficient treatment planning; and/or provide/arrange adequate remedial care. It is also alleged that you failed to respond adequately to Patient A's complaints about their dental treatment. The GDC also alleges you provided information to Patient A on 30 November 2021 about the treatment you provided that was misleading and/or dishonest. Finally, it is alleged that between 10 March 2022 and 5 April 2022, you failed to have indemnity insurance.

Evidence

16. The Committee has been provided with documentary material in relation to the heads of charge that you face. This material includes:

The witness statements and documentary exhibits of the following witnesses:

- Patient A, former patient dated 1 April 2026 ;
- Elizabeth Morbin, GDC Interim Senior Case Worker dated 26 March 2026

17. In addition, the Committee had sight of the patient records. Also, the expert report of Geoffrey Bateman, the GDC expert witness in this case, dated 7 April 2026, and a supplementary report dated 1 July 2026.

18. The Committee heard no oral evidence.

Findings of Fact

19. The Committee considered all the evidence presented to it. It has accepted the advice of the Legal Adviser.

20. The Committee made the following findings:

1	*You failed to provide an adequate standard of care to Patient A between 23 October 2020 and 27 March 2024 including by:*
1.a	*Not carrying out bitewing radiographs.* **Admitted and found proved.**
1.b	*Providing a poor standard of treatment, including in respect of the restorations.* **Admitted and found proved.**
1.c	*Having received the specialist periodontists' letter, dated 14 October 2021, and not:*
1.c.i	*Carrying out sufficient treatment planning; and/or* **Admitted and found proved.**
1.c.ii	*Providing/arranging adequate remedial care.* **Admitted and found proved.**
2.	**Withdrawn**
2.a	**Withdrawn**
2.b	**Withdrawn**
2.c	**Withdrawn**
2.d	**Withdrawn**
3.	*You failed to respond adequately to Patient A's complaints about their dental treatment, including in the letter to Patient A, signed on 30 November 2021.* **Admitted and found proved.**
4.	*You provided information to Patient A on 30 November 2021 about the treatment you provided that was:*
4.a	*Misleading and/or* **Admitted and found proved.**
4.b	*Dishonest.*

	Admitted and found proved.
5.	*Between 10 March 2022 and 5 April 2022, you failed to have indemnity insurance.* **Admitted and found proved.**

21. The hearing moves to Stage Two.

Proceedings at stage two – 4 August 2026

22. The Committee received the following documents at this stage of the proceedings:

- Your oral evidence;
- A number of testimonials.

23. In accordance with Rule 20, the Committee heard submissions from Ms Curzon on behalf of the GDC and those made by Mr Davidson on your behalf.

24. Ms Curzon submitted that the facts found proved are serious and fell short of what would be judged to be proper in the circumstances and amounted to misconduct. She stated that you admitted to multiple and serious clinical failures in respect of Patient A. She highlighted that it has been found proved that your standard of care to Patient A was inadequate. In addition, there was a failure in respect of handling of Patient A's complaint as well as failing to have indemnity insurance.

25. Ms Curzon asked the Committee to take into account the written evidence of Mr Bateman, the GDC's expert witness, who identified that the heads of charge found proved fell far below the standards expected, some of which placed Patient A at risk of harm. In addition, she submitted a failure to have indemnity insurance would deprive patients from making a claim. It was Ms Curzon's submission that any member of the dental profession would find your conduct deplorable and that these matters alone would warrant a finding of misconduct. She referred to the Committee's additional finding that you acted dishonestly in respect of the information you provided to Patient A. She submitted that taking all these matters into account, this is a serious departure from the standards expected and constitutes a finding of misconduct.

26. Ms Curzon cited relevant case law and a number of the GDC's "*Standards For the Dental Team*" (September 2013) which, she submitted, may apply in this case. In short, the GDC's position is that the findings against you fell short of what would be expected of a registered dentist and would be regarded as deplorable by fellow practitioners. They therefore amount to misconduct.

27. In respect of current impairment, Ms Curzon invited the Committee to take into account your past misconduct, the steps you have taken to remedy it and whether it is highly unlikely to be repeated. She submitted that the conduct which directly relates to your clinical practice is remediable. However, there is misleading and dishonest conduct which is harder to remediate. Ms Curzon acknowledged the work you have undertaken to improve your practice in areas such as your record keeping and treatment planning. You have provided Continuing Professional Development (CPD) certificates in probity and ethics, a written statement and reflections. Ms Curzon submitted that there have been no concerns or complaints made since these events. However, she reminded the Committee that they need to be satisfied that there is no risk of repetition. She submitted that the Committee may consider based on the evidence you have provided so far, that you may not have demonstrated adequate insight into your dishonesty conduct. Ms Curzon submitted that you have not mentioned in your written statement your understanding of the harm caused, nor is there

recognition of any reflections of the impact your conduct has had on the dental profession and the wider public. In addition, there is a lack of information on the courses you have completed and how they have been embedded in your current practice. In addition, Ms Curzon submitted there appears to be a lack of understanding of how not having indemnity insurance has impacted on others. You have failed to provide evidence of protocols being implemented to ensure there is no risk of repetition should you be faced with similar circumstances. She submitted that you have referred to peer review/mentorship, but this looks like a normal discussion between colleagues about shared caseloads rather than a formal reflective practice set up to address the underlying conduct.

28. It was Ms Curzon's submission that given the lack of insight demonstrated in this case, there remains a risk of repetition. In short, the GDC's position is that the Committee cannot be satisfied as of today that you have addressed the areas of concern. Ms Curzon submitted that a finding of current impairment is necessary for the protection of the public. She further submitted that a finding of current impairment is necessary on the grounds of the public interest given the serious nature of findings against you.

29. Ms Curzon referred to the mitigating and aggravating features in this case. She submitted that the appropriate sanction is to direct an order of suspension for a period of three to six months with a review to take place before the expiry of the order. She submitted that this sanction was sufficient to mark the seriousness of the misconduct and also allow you further time to reflect on your misconduct.

30. The Committee next heard submissions from Mr Davidson. He recognised, on your behalf, that the conduct matters which you have admitted and were found proved, were serious enough to amount to misconduct.

31. In addressing the Committee on the issue of impairment, Mr Davidson submitted that the clinical findings relate to your treatment of Patient A and that this is a test of current impairment. Mr Davidson highlighted that you have admitted all the clinical allegations in this case and further submitted that this demonstrates that you have insight into your clinical failings. He asked the Committee to consider the contents of your written statement and written reflections. Also, your oral evidence and engagement with the GDC. He submitted that you have provided a volume of CPD certificates and documentation since 2021, all of which has been targeted to the concerns. You have attended 3 composite courses and a master's qualification completed in 2022, all of which are relevant to the practical care you provided to Patient A. Mr Davidson submitted that you have addressed all the areas of concern. Furthermore, he submitted you have demonstrated that your learning has been embedded.

32. In relation to the dishonesty found proved, Mr Davidson said that you understand how seriously dishonesty is taken by your regulatory body. You have attended courses on ethics which illustrate your insight into your past dishonest conduct. He stated that the risk of occurrence has been reduced by virtue of your remediation and the changes in your practice. You now work with other practitioners and you plan to continue to do so, therefore, you are not subject to clinical isolation and practice ownership. Mr Davidson submitted that your conduct, coupled with your insight and remediation, demonstrates that there is a very low risk of reoccurrence. He submitted there is a spectrum of dishonesty and invited the Committee to look at the specific circumstances of this case, and that it relates to a single communication with Patient A, and there was no financial gain. He submitted this can be considered at the lower end of dishonesty. In respect of lack of indemnity insurance, Mr

Davidson submitted that you have admitted to this and you have obtained retrospective indemnity insurance. He submitted there has been no repetition of any of these shortcomings since 2022.

33. Mr Davidson submitted there have been no further complaints and no repetition of the dishonesty. It was submitted on your behalf that that dishonesty is wholly out of your character and there will be no repetition. He invited the Committee to consider that you are not impaired by your misconduct.

34. Mr Davidson submitted that were the Committee to conclude that your fitness to practise is currently impaired, then it would be sufficient and appropriate to conclude the case with a reprimand. He also submitted that you have demonstrated insight and remorse and these shortcomings are out of character and there has been no repetition before or after, and that if the Committee were minded to impose a more stringent sanction, conditions or suspension that this would be disproportionate, bearing in mind your remediation, the insight you have shown, and the period since 2022 that you have remained in practice with no further issues.

35 Mr Davidson submitted that in the event that the Committee was minded to conclude this case with an order of suspension, a shorter period of suspension would adequately address the public interest considerations in this case.

Misconduct

36 The Committee considered whether the facts found proved in this case amount to misconduct. It took into account that a finding of misconduct in the regulatory context requires a serious falling short of the standards expected of a Dentist. It also took into account that Ms Curzon on behalf of the GDC and Mr Davidson on your behalf had submitted that the conduct found proved at Stage One was serious enough to amount to misconduct. It has also accepted the advice of the Legal Adviser. Throughout its deliberations, the Committee has had regard to the GDC's Guidance.

37 The Committee first considered the facts found proved in relation to your treatment of Patient A, including the matters of your dishonesty. The Committee had regard to the individual clinical failings that led to your overall provision of a poor standard of care to Patient A. The Committee also noted the expert opinion of Mr Bateman, as set out in his report, that the overall standard of your care of Patient A fell far below that expected of a reasonably competent dentist, such as failure to take radiographs, poor treatment planning and the inadequate restorations provided. The Committee also noted that actual harm was caused to the patient on account of your clinical shortcomings. The Committee was satisfied that your standard of care provided to Patient A fell far below the standards expected and constitutes a finding of misconduct.

38 In respect of your failure to deal adequately with Patient A's concerns, the Committee considers that as a Registered Dentist it was part of your responsibility to deal with complaints properly and professionally. The Committee considered that you failed to address the letter from the Periodontist adequately. There was no attempt to resolve the matter in a constructive manner. The Committee takes a serious view of the way in which you dealt with Patient A's concerns. It is satisfied that your conduct in this regard would be regarded as deplorable by fellow practitioners and amounts to misconduct.

39 The Committee next considered your dishonesty associated with Patient A's treatment. You admitted, as matters of fact, that you provided information to Patient A on 30 November 2021 about the treatment you provided that was both misleading and dishonest. In addition, you did not directly apologise for your errors to Patient A. It found that the comments were inaccurate and untrue and was dishonest in the course of your clinical practice. Your dishonesty represented a significant breach of a fundamental tenet of the dental profession, namely the requirement to act honestly and with integrity. It was clear to the Committee that by any measure your dishonesty was unacceptable. Notwithstanding that this was a single incident and there was no direct financial gain, the Committee is satisfied that its finding of dishonesty would be regarded as deplorable by fellow practitioners and amounts to misconduct.

40 The Committee also found proved that you failed to have indemnity insurance whilst practising. The Committee considers that this placed patients in your care at risk of not being able to make a claim for negligence. The Committee is satisfied that such conduct would be viewed as deplorable by colleagues.

41 The Committee was satisfied, taking into account the expert evidence regarding your clinical failings and the matters of your dishonesty towards Patient A, that your conduct in relation to each charge found proved represented a significant departure from the following GDC Standards:

1.2 You must treat every patient with dignity and respect at all times

1.3 Be honest and act with integrity.

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...

1.7 You must put patients' interests before your own or those of any colleague, business or organization.

1.7.8 In rare circumstances, the trust between you and a patient may break down, and you may find it necessary to end the professional relationship. You should not stop providing a service to a patient solely because of a complaint the patient has made about you or your team. Before you end a professional relationship with a patient, you must be satisfied that your decision is fair and you must be able to justify your decision. You should write to the patient to tell them your decision and your reasons for it. You should take steps to ensure that arrangements are made promptly for the continuing care of the patient.

1.8 You must have appropriate arrangements in place for patients to seek compensation if they have suffered harm.

42 The Committee has accepted Mr Bateman's opinion that these matters amounted to a falling far below acceptable standard. It considers that you failed to meet the standards expected of a Dentist and that this is sufficiently serious to amount to misconduct.

Committee's decision and reasons on impairment

43 The Committee next considered whether your fitness to practise is impaired by reason of misconduct on the grounds of the protection of patients and/or in the wider public interest. The Committee considered that clinical failings are usually remediable with further training. It considered that behavioural issues, such as dishonesty, are more difficult to remedy, although not impossible.

44 The Committee notes with regard to the issue of indemnity insurance, you have put measures in place, monthly reminders on your calendar to ensure that you renew your indemnity insurance each year. It is therefore satisfied that you have remediated these concerns and that a risk of repetition no longer remains.

45 The Committee then considered whether your clinical failings, as identified in its findings, have been remedied. In doing so, it had regard to the evidence of the steps you have taken to address the matters raised regarding your clinical practice. The Committee took into account the evidence of your CPD and your MSc. The Committee heard your oral evidence where you stated the changes you have made to your clinical practice.

46 However, the Committee was not reassured that there is evidence before it to show that your learning has been sufficiently embedded into your clinical practice. It noted the dates when you completed some of your composite CPD courses and your master's degree, were during the actual time of these events. It notes that there were no written reflections attached to your CPD.

47 The Committee notes that you stated that you have set up peer reviews/mentorship. However, the Committee noted that you have not provided any evidence of this. Based on your oral evidence, the Committee is not satisfied this is a formal arrangement focusing on your development.

48 Given the Committee's concerns regarding the limitations of your insight, reflection and your remediation, it could not be confident that the risk of repetition in relation to the clinical matters is low.

49 The Committee went on to consider the behavioural aspects of your misconduct, namely your dishonesty associated with head of charge 4. It notes the specific wording made by the periodontist letter to you. It notes the dishonesty is clinically based. It took into account you have completed a number of targeted CPD courses in relation to probity, however these were completed recently and did not include written reflections. The Committee notes that you have had over two years to demonstrate insight and to reflect on the impact on Patient A and on public confidence, and to explain how you would ensure there would be no repetition of your dishonesty. It was the conclusion of the Committee that there remains a risk of repetition in respect of your dishonesty.

50 In light of the identified risk of repetition in relation to the aspects of your misconduct, clinical and behavioural, the Committee determined that a finding of impairment is necessary on public protection grounds.

51 The Committee went on to consider the wider public interest. It was the view of the Committee that a reasonable and well-informed member of the public would be shocked and dismayed, if a finding of impairment were not made in respect of your misconduct, clinical and behavioural. Accordingly, the Committee determined that a finding of impairment is required in the public interest, to promote and maintain public confidence in the dental profession and to uphold proper professional standards and conduct.

52 Accordingly, the Committee has determined that your fitness to practise is currently impaired by reason of your misconduct on the grounds of the protection of the public and in the public interest.

Committee's decision and reasons on sanction

53 The Committee then determined what sanction, if any, would be appropriate in light of the findings of facts, misconduct and current impairment that it has made. The Committee recognises that the purpose of a sanction is not punitive, although it may have that effect, but is instead imposed in order to protect patients and safeguard the wider public interest. In reaching its decision the Committee has again taken into account the GDC's Guidance. It has applied the principle of proportionality, balancing the public interest with your own interests.

54 The Committee has considered the mitigating and aggravating factors present in this case. In terms of mitigating factors, the Committee has noted the following:

- Previous good character;
- You have no fitness to practise history;
- You have undertaken some remedial action;
- There is no evidence of repetition;
- Admissions made at the outset of this hearing;
- No financial gain.

55 In relation to aggravating factors, the Committee has borne in mind the following:

- Actual harm caused to Patient A;
- Abuse of trust;
- Misconduct sustained over a period of time;
- Lack of full insight.

56 The Committee has had regard to its previous findings on misconduct and impairment in coming to its decision and considered each sanction in ascending order of severity.

57 The Committee first considered whether to impose no order or to issue a reprimand. However, it rejected these courses of action on the basis that they would not be sufficient to protect the public, nor would it be in the public interest, to allow you to continue to practice without some form of restriction in place, given its finding that there is a risk of repetition of your clinical conduct and dishonesty.

58 The Committee then considered whether placing conditions on your registration would be a sufficient and appropriate response to address the risks identified in this case. Any conditions that may be formulated must be workable, measurable, enforceable and address the risks that have been identified. While noting the progress you have made, the Committee considers that you currently lack sufficient insight into the importance of being honest and have not demonstrated that your learning in respect of the concerns about your clinical practice has been embedded in your current practice. The Committee considers that the clinical concerns could be addressed by conditions but considers that conditions could not address your current level of insight into your dishonest conduct. It is therefore satisfied that conditions would be insufficient to meet the public interest.

59 In addition, given the finding of dishonesty in this case, the Committee concluded that conditions would not adequately address the public interest in this case and would not adequately uphold public confidence in the profession.

60 The Committee then went on to consider whether a suspension would be the appropriate sanction. Paragraph 277 of the GDC's Guidance states that suspension may be suitable where most of the following factors are present:

- the registrant has not shown insight into the issues which led to a finding of current impairment being made, and/or poses a significant risk of repeating the behaviour;
- a lesser sanction would be insufficient to meet the public interest.

61 The Committee has had regard to the dishonesty found proved in this case. There is no evidence of repetition of similar conduct, either before or since the incident. The Committee was satisfied that the misconduct in this case was not fundamentally incompatible with remaining on the register. The Committee considered that a short period of suspension of three months would give you sufficient time to reflect on your dishonesty and to develop sufficient insight into it in order to be able to practise safely. In addition, this period would allow you to seek evidence to demonstrate that the deficiencies in your clinical practice have been addressed, and you are now competent to practise safely.

62 The Committee did go on to consider erasure but, taking into account its finding that your dishonesty was an isolated incident, it determined that it would be disproportionate and unduly punitive.

63 Balancing all these factors, the Committee directs your registration be suspended for a period of three months. The Committee is satisfied that this period of time is necessary, sufficient and proportionate in order for you to reflect further whilst sending the public and the profession a clear message about the standards of practice required of a dentist. The Committee noted the hardship the suspension may cause you, however this is outweighed by the public interest in this regard. The Committee further considers that this period of time is sufficient to protect patients and to maintain and uphold public confidence in the profession.

64 The Committee directs that this order be reviewed before its expiry, and you will be informed of the date and time in writing. The reviewing Committee will consider what action it should take in relation to your registration following an assessment of the concerns affecting your fitness to practise.

65 The reviewing Committee may be assisted to receive:

- *A detailed reflective statement demonstrating your insight into and understanding of your previous dishonest conduct. You may wish to outline what you should have done differently, the impact of your failings on Patient A and the reputation of the profession. You may wish to further outline how you will avoid a repetition of your failings in the future.*
- *Evidence of how you have embedded your clinical learning in your practice.*

66 The Committee now invites submissions as to whether the suspension should take immediate effect to cover the 28-day appeal period.

Decision on an immediate order – 4 August 2026

67 The Committee considered whether to impose an immediate order of suspension on your registration to cover the 28-day appeal period, pending the substantive direction for suspension taking effect.

68 Ms Curzon applied for the imposition of an immediate order of suspension on your registration for the same reasons set out in the Committee's substantive determination, in particular she emphasised the identified risk of repetition.

69 Mr Davidson stated that he resists the application and the circumstances of this case fall short of the statutory test for an immediate order. You are not subject to an interim order, there has been no previous FTP history, and there has been no recurrence of the matters found proved.

70 Having heard from both parties, the Committee accepted the advice of the Legal Adviser, who drew its attention to the statutory test for immediate orders and the relevant paragraphs of the Guidance.

71 The Committee determined that the imposition of an immediate order of suspension on your registration is necessary for the protection of the public and is otherwise in the public interest.

72 In finding that your fitness to practise is impaired by reason of your misconduct, the Committee has identified a continuing risk to patients on account of the insufficiency of your insight, reflection and remediation. In view of this identified risk, the Committee considered that it would be inconsistent not to impose an immediate order of suspension on your registration for the protection of the public. It took into account that in the absence of an immediate order, you could return to unrestricted practice during the appeal period, or for longer, in the event of an appeal. The Committee was therefore satisfied that an interim order is necessary for public protection.

73 The Committee was also satisfied that an immediate order is required in the wider public interest, in light of the seriousness of the matters found proved. The Committee considered that immediate action is necessary to maintain public confidence in the dental profession, the regulatory process, and to uphold proper professional standards and conduct.

74 The effect of the foregoing substantive determination and this order is that your registration will be suspended to cover the appeal period. Unless you exercise your right of appeal, the substantive direction for suspension for a period of 3 months (with a review) will take effect 28 days from the date of deemed service.

75 Should you exercise your right of appeal, this immediate order will remain in place until the resolution of the appeal.

76 That concludes this determination.