Dental Professionals Hearings Service

PUBLIC DETERMINATION

PUBLIC HEARING
Professional Conduct Committee
Initial Hearing

26-30 October 2026

Name:	TREURNICHT, Danie
Registration number:	51082
Case number:	CAS-211059-S8H4K5

General Dental Council:	Ms Rebecca Vanstone, Counsel Instructed by Jack Garden, Kingsley Napley LLP
Registrant:	Not present Tamsin Thomas, MDU (Instructed but not present)

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

Committee members:	Andrew Waite	(Chair and Lay Member)
	Hemash Shah	(Dentist Member)
	Christopher Parker	(Dental Care Professional Member)
Legal adviser:	Helen Gower	
Committee Secretary:	Kate Anderson	

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1. This is a Professional Conduct Committee (PCC) inquiry into the facts which formed the basis of the allegation against Mr Treurnicht that his fitness to practise is impaired by reason of misconduct.

2. Mr Treurnicht was neither present nor represented at the hearing.

3. Ms Vanstone, Counsel, appeared on behalf of the General Dental Council (GDC).

4. The hearing was held remotely on Microsoft Teams.

Preliminary matters

Service and Proceeding in absence

5. The Committee first considered the issues of service and whether to proceed with the hearing in the absence of Mr Treurnicht. The Committee heard submissions from Ms Vanstone. It heard and accepted the advice of the Legal Adviser as to the provisions of the Rules and the approach it should take to its decision.

Decision on Service of the Notice of Hearing

6. The Committee considered whether notice of the hearing had been served on Mr Treurnicht in accordance with Rule 13 and 65 of the GDC (Fitness to Practise) Rules Order of Council 2006 ('the Rules') and Section 50A of the Dentists Act 1984 (as amended) ('the Act'). The Committee heard submissions from Ms Vanstone and accepted the advice of the Legal Adviser.

7. The Committee received from the GDC an indexed hearing bundle, which contained a copy of the Notice of Hearing ('the notice'), dated 14 September 2026. The hearing bundle also contained a Royal Mail 'Track and Trace' receipt confirming that the notice was sent to Mr Treurnicht's registered address by Special Delivery. The Committee took into account that there is no requirement within the Rules for the GDC to prove delivery of the notice, only that it was sent. However, it noted that there was proof of delivery on 15 September 2026. A copy of the notice was also sent by first class post and emailed to Mr Treurnicht and his legal representative on 14 September 2026.

8. The Committee was satisfied that the notice sent to Mr Treurnicht contained proper notification of today's hearing, including its time, date and that it will be conducted remotely, as well as notification that the Committee had the power to proceed with the hearing in Mr Treurnicht's absence.

9. On the basis of the information provided, the Committee was satisfied that notice of the hearing had been served on Mr Treurnicht in accordance with the Rules and the Act.

Decision on Proceeding in the Registrant's Absence

10. The Committee next considered whether to exercise its discretion under Rule 54 to proceed with the hearing in the absence of Mr Treurnicht. It approached this issue with the utmost care and caution. The Committee took into account the factors to be considered in reaching its decision, as set out in the case of R v Jones [2002] UKHL 5 and GMC v Adeogba & Visvardis [2016] EWCA Civ 162, and as affirmed in subsequent regulatory cases. It took into account that fairness to Mr Treurnicht was an important consideration, but also bore in mind the need to be fair to the GDC. The Committee also remained mindful of the overarching statutory objective of the GDC, which is the protection of the public and the wider public interest, and its duty to act expeditiously in the public interest.

11. The Committee was satisfied that all reasonable efforts had been made by the GDC to notify Mr Treurnicht of the hearing. It noted that his representatives had been in contact with the GDC in relation to the hearing and had acknowledged that it would be proceeding and that neither Mr Treurnicht nor they would be attending. The Committee noted that Mr Treurnicht had provided a clear reason for his non-attendance, this being that he has retired and requested a voluntary removal, but that this was rejected by the GDC. He therefore requested that all correspondence be undertaken by his solicitor. The Committee therefore was satisfied that Mr Treurnicht had voluntarily absented himself from today's hearing.

12. It was the conclusion of the Committee that adjourning the hearing would serve no meaningful purpose in the circumstances. It noted that Mr Treurnicht had not requested an adjournment and there was no information before it to suggest that deferring the hearing would secure Mr Treurnicht's attendance in future.

13. The Committee was satisfied, having balanced the public interest and fairness to the regulator, with fairness to Mr Treurnicht, that the balance weighed in favour of proceeding with the hearing in Mr Treurnicht's absence.

Rule 18 application to amend the charge

14. Ms Vanstone made an application under Rule 18 of the Rules to amend the charges at this hearing. She submitted that there was an error in the date at head of charge 4(a) that stems from an error in the date used by the expert in his report. Ms Vanstone submitted that amending charge 4(a) would reflect the accuracy of the records. She submitted that the amendment could be made without unfairness, and reminded the Committee that Mr Treurnicht has made the decision not to attend the hearing.

Committee Decisions on Rule 18 application to amend the charge

15. The Committee heard and accepted legal advice in relation to amending the charge at this hearing.

16. The Committee was satisfied that the amendment to the date at charge 4(a) could be made without causing injustice. The Committee determined that the incorrect date appeared to be a typographical error and that the amendment would ensure that the charges accurately reflect the evidence. The Committee considered fairness, and

determined that no unfairness would be caused to the GDC nor Mr Treurnicht in making the amendment.

17. The Committee therefore acceded to the application.

The Charges

18. The charges in this case, as amended, are as follows:

"That being a registered dentist;

Patient 1

1. *On 13 October 2023 you failed to maintain an adequate standard of radiographic practice for Patient 1 in that you did not make any, or any adequate radiographic report.*

Patient 2

2. *On 26 April 2024 you failed to maintain an adequate standard of care for Patient 2 in that you did not:*
    a. *Carry out a Basic Periodontal Examination ('BPE');*
    b. *Undertake a caries risk assessment;*
    c. *Take any or any adequate radiographs;*
    d. *Spend sufficient time on the examination.*

Patient 4

3. *Between 22 May 2024 and 20 July 2024 you failed to maintain an adequate standard of care for Patient 4 in that you did not:*
    a. *Make any or any adequate report on radiographs taken on 23 May 2024;*
    b. *Take bitewing radiographs when required on 19 July 2024.*

Patient 5

4. *Between 26 April 2023 and 05 April 2024 you failed to maintain an adequate standard of care for Patient 5 in that you did not:*
    a. *Carry out any or any adequate BPE on 27 April 2023 and / or 25 May 2023 and / or 14 December 2023 and / or 11 January 2024;*
    b. *Provide any or any adequate oral hygiene instruction on 25 May 2023 and/or 14 December 2023 and/or 11 January 2024;*
    c. *Diagnose periodontitis present on 27 April 2023;*
    d. *Undertake a full periodontal evaluation on 04 April 2024;*
    e. *Take any or any adequate radiographs on 04 April 2024;*
    f. *Inform the patient of her periodontal disease;*
    g. *Provide adequate periodontal treatment;*
5. *As a result of your conduct at 4(a) and / or 4(c) and / or 4(e) above, you did not*

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diagnose the cause of the patient's bone loss.

Patient 6

6. *Between 18 April 2024 and 18 May 2024 you failed to maintain an adequate standard of care for Patient 6 in that you did not:*
    a. *Carry out any or any adequate BPEs;*
    b. *Make any or any adequate report on the radiographs taken on 19 April 2024.*
7. *On 17 May 2024 you failed to maintain an adequate standard of record keeping for Patient 6 in that you did not make any or any adequate records of the scaling appointment.*

Patient 7

8. *On 23 May 2024 you failed to maintain an adequate standard of care for Patient 7 in that you did not:*
    a. *Carry out an adequate BPE;*
    b. *Review radiographs taken on 03 February 2023;*
    c. *Take any or any adequate radiographs;*
    d. *Provide adequate oral hygiene advice*
9. *As a result of your conduct at 8(a) / (b) and / or (c) above, you failed to:*
    a. *Diagnose periodontal disease;*
    b. *Diagnose bone loss;*
    c. *Formulate an adequate treatment plan for periodontal therapy.*

Patient 8

10. *Between 29 August 2022 and 21 August 2024 you failed to maintain an adequate standard of care for Patient 8 in that you did not:*
    a. *Take any or any adequate radiographic examinations in 2024;*
    b. *Undertake an analysis of the occlusion;*
    c. *Carry out adequate diagnostic assessments to establish the underlying cause of restoration failures at the upper anterior teeth;*
    d. *Adequately plan treatment for the UL1 and / or UL2 and / or UR1 and / or UR2 and / or UR 3;*
    e. *Carry out diagnostic assessments to establish the cause of swelling on 18 June 2024;*
    f. *Prescribed antibiotics on 18 June 2024 when this was not clinically indicated;*
    g. *Did not discuss adequately or at all, risks and benefits of treatment prior to crown preparation on 11 June 2024;*
    h. *Undertake vitality testing of the UR2 on 25 June 2024.*
11. *As a result of your conduct at 10(g) above, you failed to obtain the patient's valid*

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consent for treatment.

Patient 9

12. *Between 18 April 2024 and 18 May 2024 you failed to maintain an adequate standard of care for Patient 9 in that you did not:*

    a. *Take any or any adequate radiographs;*

    b. *Provide any or any adequate oral hygiene advice.*

Patient 10

13. *Between 20 March 2024 and 26 April 2024 you failed to maintain an adequate standard of care for Patient 10 in that you did not:*

    a. *Carry out any or any adequate BPE;*

    b. *Make any or any adequate radiographic report.*

Patient 12

14 *On 04 April 2024 you failed to maintain an adequate standard of radiographic practice for Patient 12 in that you did not make any or any adequate radiographic report.*

And by reason of the matters alleged above, your fitness to practise is impaired by reason of your misconduct."

Background to the case and summary of allegations

19. In opening the case for the GDC, Ms Vanstone provided the Committee with oral submissions of the background of this case and a summary of the allegations.

20. The GDC became aware of alleged clinical failings in Mr Treurnicht's practice in June 2024, relating to multiple areas of clinical practice and multiple patients. Ms Vanstone informed the Committee that the GDC obtained all of the available records for the patients involved. Mr Quelch, the Dental Expert witness, was then instructed to make an expert report based on the clinical records of Mr Treurnicht's work.

21. Ms Vanstone took the Committee through the specific charges and failings, based upon the 10 patients whom Mr Treurnicht allegedly failed to maintain an adequate standard of care, and she took the Committee the evidential basis for these charges within the expert report and clinical records.

Evidence

22. The evidence provided to the Committee by the GDC was both documentary and oral. The documentary evidence comprised of:
    - Patient records;
    - signed witness statements and associated exhibits of Patient 5;
    - signed witness statements and associated exhibits of Patient 9;
    - signed witness statements and associated exhibits of Patient 10;

- Expert report and appendix to report of Mr Simon Quelch;
- Witness statement of Lily Matthew-Cook, Kingsley Napley Paralegal; and
- Patient medical pro formas.

23. Patient 5 and Patient 10 gave oral evidence at the hearing.

24. The Committee also heard oral evidence from the expert, Mr Quelch.

25. The evidence provided to the Committee by Mr Treurnicht's legal representatives comprised of a telephone file note of a conversation between themselves and the GDC relating to the hearing proceedings.

The Committee's findings of fact

26. The Committee considered all the evidence presented to it, both documentary and oral. It took account of the closing submissions made by Ms Vanstone on behalf of the GDC.

27. The Committee accepted the advice of the Legal Adviser, including in relation to the burden and standard of proof, the need to consider the alleged matters separately, the need to have regard to the specific wording of each allegation and how to approach the evidence.

28. In making its findings on the facts, the Committee bore in mind that the burden of proof rests with the GDC. There was no requirement for Mr Treurnicht to prove anything. Also, that the standard of proof is the civil standard, that is, whether the alleged facts are proved on the balance of probabilities. The Committee has had to decide whether it is more likely than not that the alleged matters happened.

29. The Committee considered each head of charge separately and made the following findings:

"That being a registered dentist;	
	Patient 1
1	*On 13 October 2023 you failed to maintain an adequate standard of radiographic practice for Patient 1 in that you did not make any, or any adequate radiographic report.* **Found Proved** The Committee had sight of the clinical records for Patient 1, and noted that they attended an appointment with Mr Treurnicht on 13 October 2023. The Committee noted that bitewings radiographs were taken at this appointment, but that there is no evidence of a radiographic report within the records.

	Mr Quelch's expert report states that as per the Ionising Radiation (Medical Exposure) regulations 2017 (IRMER), a dentist is legally required to report on the number of radiographs taken, provide justification for the taking, report on the radiographic findings, and evaluate any diagnosis. Mr Quelch states that *'The records do not show that a report on the radiographs has been a recorded, which is a requirement of the legislation and guidelines. Although, in my opinion the radiographs do not show any identifiable pathology, it is expected that a reasonable dentist to (sic) record this as a diagnosis within a report, in compliance with the legislation and relevant guidelines.'* Mr Quelch's opinion is that failing to report on the radiographs would fall far below the standard expected of a reasonable general dental practitioner. The Committee was satisfied that Mr Quelch is an experienced and credible expert, and was satisfied that it could accept his opinion. The Committee accordingly found this charge proved, on the basis that there was no adequate report within the clinical records and therefore Mr Treurnicht failed to maintain an adequate standard of radiographic practice.
	Patient 2
2	*On 26 April 2024 you failed to maintain an adequate standard of care for Patient 2 in that you did not:*
2a	*Carry out a Basic Periodontal Examination ('BPE');* **Found Proved** The Committee had sight of the clinical records for Patient 2, and noted that they attended an appointment with Mr Treurnicht on 26 April 2024. The Committee noted that there was no record of a BPE being carried out on this date within the clinical records. The Committee accepted the expert opinion of Mr Quelch that there is an expectation for a dentist to carry out a BPE as part of a routine dental examination, and that there is no evidence of Mr Treurnicht having done so. His expert opinion is that failing to carry out a BPE would fall far below the standard reasonably expected of a general dental practitioner. The Committee therefore determined that a BPE should have been carried out at this appointment, and given the lack of records, on the balance of probabilities, it is more likely that Mr Treurnicht did not carry out a BPE. In failing to do so, Mr Treurnicht failed to maintain an adequate standard of care for Patient 2. The Committee accordingly found this charge proved.

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2b	*Undertake a caries risk assessment;* **Found Proved** The Committee, as above in head of charge 2a, noted that there was an appointment on this date that Patient 2 attended. The Committee noted that there was no record of a caries risk assessment undertaken within the clinical records for patient 2. Mr Quelch's expert opinion is that dentists are expected to carry out risk assessments for dental diseases, including caries, as part of a dental examination. He noted that Mr Treurnicht recorded risk assessments for oral cancer and periodontal disease for Patient 2, but did not document a caries risk assessment. He opined that this falls far below the standard reasonably expected of a general dental practitioner. The Committee accepted Mr Quelch's opinion. The Committee concluded that on the balance of probabilities, the caries risk assessment was not undertaken, given the lack of a note of this within the clinical records. The Committee therefore determined that Mr Treurnicht failed to maintain an adequate standard of care and accordingly found this charge proved.
2c	*Take any or any adequate radiographs;* **Found Proved** The Committee, as above in head of charge 2a, noted that there was an appointment on this date that Patient 2 attended. The Committee first noted from the clinical records that there was no record of any radiograph being taken on this date, nor at any of the other appointments between 17 April 2014 and 24 April 2024. The Committee considered the expert opinion of Mr Quelch. He referred to The College of Dentistry (CGDent) Selection Criteria guidelines. This includes guidelines recommending that bitewing radiographs are taken every two years for patients in the low-risk category, though it is possible to deviate from this if there is long standing evidence of continuing low risk. Mr Quelch stated that a dentist should take radiographs to comply with the evidence-based guidelines above, and if not, the reasons should be clearly recorded, of which there is no evidence in this case. He therefore opined that '*There was no documented evidence as to why these were not taken and this is a deviation which is far removed than what a reasonable general practitioner would do, as so is far below the standard that is expected'.*

	The Committee accepted the opinion of Mr Quelch that a radiograph should be taken every two years, and noted that there was no evidence of a radiograph having been taken by any practitioner within the 10 year period of Patient 2's appointments. The Committee noted that 10 years was a significantly longer period than 2 years without a radiograph being taken. The Committee determined that given the lack of any evidence of a radiograph being taken on this date, on the balance of probabilities it is more likely than not that it wasn't done. The Committee accordingly found proved that Mr Treurnicht failed to maintain an adequate standard of care by failing to take any or any adequate radiographs on this date.
2d	*Spend sufficient time on the examination.* **Found Not Proved** The Committee, as above in head of charge 2a, noted that there was an appointment on this date that Patient 2 attended. The Committee noted that the informant raised concerns and provided the information that Patient 2 spent 8 minutes in the chair for their examination. The Committee, however, noted that there is no computerized record of exactly how long Mr Treurnicht spent examining the patient. Further, it accepted Mr Quelch's expert report in which he states that there is no criteria or guidance that states exactly how long an appointment should be. The Committee considered that there is no benchmark as to the sufficient time for an examination, and therefore could not conclude that 8 minutes was insufficient. The Committee concluded that the GDC has not discharged its burden of proof that Mr Treurnicht did not spend sufficient time on the examination of Patient 2. It accordingly found this charge not proved.
	Patient 4
3	*Between 22 May 2024 and 20 July 2024 you failed to maintain an adequate standard of care for Patient 4 in that you did not:*
3a	*Make any or any adequate report on radiographs taken on 25 May 2024;* **Found Proved** The Committee had sight of the clinical records for Patient 4, and noted that they were being treated by Mr Treurnicht between 22 May 2024 and 20 July 2024. It noted that there was a clinical record stating that a

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	posterior periapical radiographic view was taken on 23 May 2024, when Patient 4 presented with swelling. The Committee, however, noted that there was no evidence of a radiographic report for this periapical radiograph within the clinical records. Mr Quelch's expert report states that in line IRMER and good record keeping guidelines, Mr Treurnicht should have written a radiographic report. He opined that justification for the radiographs was reasonable with the clinical note of ''*toothache/pain',* but that a report should have followed. He opined that Mr Treurnicht is legally obliged to write a report and a failure to do so would be far below the standard expected of a reasonable general dental practitioner. The Committee accepted this opinion. The Committee therefore determined that it had no evidence of an adequate radiographic report within the clinical records, and in turn concluded that Mr Treurnicht failed to maintain an adequate standard of care for patient 4. The Committee accordingly found this charge proved
3b	*Take bitewing radiographs when required on 19 July 2024.* **Found Proved** As in 3a above, the Committee was satisfied that it had evidence before it from the clinical records that Patient 4 was being treated by Mr Treurnicht between 22 May 2024 and 20 July 2024. The Committee noted that there is a clinical record of Patient 4 attending an appointment on 19 July 2024, and no bitewings were taken at this appointment. Mr Quelch referred to the Selection Criteria guidance, that covers dental radiography and suggests an interval of 18-24 months between bitewing radiographs is appropriate for a patient with a low risk of dental caries. He stated that Patient 4 had last had bitewings radiographs taken in 2020, and therefore despite being low risk, he opined that a reasonable dentist should have updated the bitewing views, as they were overdue. The Committee accepted the opinion of Mr Quelch. It considered that 4 years appeared to be an excessive period of time without a bitewing to assess Patient 4's dental health. The Committee therefore determined that bitewing radiographs should have been taken on this date, and that failing to do so represented a failing to maintain an adequate standard of care for Patient 4. Accordingly, the Committee found this charge proved.

	Patient 5
4	*Between 26 April 2023 and 05 April 2024 you failed to maintain an adequate standard of care for Patient 5 in that you did not:*
4a	*Carry out any or any adequate BPE on 27 April 2023 and / or 25 May 2023 and / or 14 December 2023 and / or 11 January 2024;* **Found Proved** The Committee had sight of the clinical records for Patient 5, and noted that they were being treated by Mr Treurnicht between 26 April 2023 and 05 April 2024, and attended appointments on 27 April 2023, 25 May 2023, 14 December 2023, and11 January 2024. The Committee noted that there was no evidence within the clinical records of a BPE being carried out at any of the appointments at the dates above. Mr Quelch stated in his expert report that a BPE should have been carried out at these appointments for the following reasons: • Examination appointment (27/04/23): Mr Treurnicht made a note in the clinical records of '*gingivitis present LR3-LL3, extensive scaling adv'* which would equate to a diagnostic assessment, justifying treatment • *Scaling appointment 25/05/23: a BPE should be carried out (or updated) as part of a periodontal assessment, including when providing scaling, unless a recent valid BPE exists which it didn't in this case.* • *Examination appointment (14/12/23): Mr Treurnicht records that the gums were 'swollen on LL3 LL4' and in addition 'BOP' (bleeding on probing).* • *Scaling appointment (11/01/24): The records covering this appointment are very brief and just note the following 'simple scaling, bleeding, calculus, sensitivity'. There was no further periodontal diagnosis (bone levels), including a BPE.* The Committee accepted the opinion of Mr Quelch that failing to undertake a BPE at any of these appointments was far below the standards of a reasonable general dental practitioner. The Committee also considered the oral evidence of Patient 5. It bore in mind that Patient 5 stated in oral evidence that they only had a vague recollection as to the examinations that took place at their appointment. However, it noted that the patient was consistent and clear in stating that they had loose teeth, and various medical conditions including osteoporosis that leads to bone loss. The Committee therefore noted that there was evidence of 4 separate appointments for a Patient who presented with serious health issues that could affect her dental health, but that there is no record of a BPE being

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	carried out. Having accepted Mr Quelch's opinion, it concluded that a BPE should have been carried out, and that in failing to do so, Mr Treurnicht failed to maintain an adequate standard of care. The Committee accordingly found this charge proved.
4b	*Provide any or any adequate oral hygiene instruction on 25 May 2023 and/or 14 December 2023 and/or 11 January 2024;* **Found Not Proved** As in 4a above, the Committee was satisfied that it had evidence before it from the clinical records that Patient 5 was being treated by Mr Treurnicht between 22 May 2024 and 20 July 2024 by Mr Treurnicht between 26 April 2023 and 05 April 2024, and attended appointments on 27 April 2023, 25 May 2023, 14 December 2023, and11 January 2024. The Committee noted that there was a note stating "*keep good OH*" (oral hygiene), recorded at the scaling visit on 25 May 2023, and "*OHI given*" (Oral Hygiene Information) recorded at the examination on 14 December 2023. The Committee took into account the opinion of Mr Quelch and his report in which he states that '*The absence of detailed preventive advice in the records limits the ability to confirm that appropriate preventive care was provided and discussed'*. Mr Quelch also stated that it is likely that the "OHI given" appears to be a template statement as it is recorded in an identical manner for all the Registrant's patient examinations reviewed in this case. The Committee however considered that the question of whether the advice given was adequate is subjective, and that there is no benchmark or guidance for what was appropriate for this patient in particular. The Committee also considered the oral evidence of Patient 5. Patient 5 stated that they could not fully recollect what took place within their appointments and what exactly was instructed, however they did state that they received some information relating to oral hygiene from both their dentist and their hygienist. The Committee therefore accepted that the oral health advice may not have been recorded adequately within the clinical records, however it was not satisfied that the GDC had discharged its burden of proof that oral hygiene instruction was not provided either adequately or at all. Accordingly, the Committee found this charge not proved.

4c	*Diagnose periodontitis present on 27 April 2023;* **Found proved** As in 4a above, the Committee was satisfied that it had evidence before it from the clinical records that Patient 5 was being treated by Mr Treurnicht between 22 May 2024 and 20 July 2024. The Committee noted that there was a clinical record of an appointment dated 27 April 2023, which Patient 5 attended. At this appointment, Mr Treurnicht noted a diagnosis of *"Gingivitis present from the LR3-LL3"*. There is no clinical record of periodontitis at this appointment. Mr Quelch, in his report, stated that gingivitis indicates inflammation of the gingival tissues without loss of supporting bone or attachment but that a radiograph taken on 4 April 2024 demonstrates that patient 5 was actually suffering from periodontitis, with evidence of very severe bone loss. Mr Quelch opined that Mr Treurnicht's initial diagnosis of gingivitis underestimated the severity of Patient 5's periodontal disease, and that gingivitis is reversible and does not involve bone loss, while periodontitis represents active disease and requires a more comprehensive preventative and stabilisation plan. Mr Quelch's expert report stated that *'Periodontitis is a chronic condition (developing over many years), and the bone loss observed on the later radiograph would not have developed in the interval between the Registrant's initial gingivitis diagnosis and the radiographic examination'.* He opined that a failure to correctly identify and manage periodontitis at an earlier stage falls far below the standard reasonably expected of a general dental practitioner. The Committee accepted the opinion of Mr Quelch, noting that the bone loss caused by periodontitis would have taken place over a period of years and therefore should have been noticed from radiographs taken. The Committee accepted that on the balance of probabilities, periodontitis would have been present at the appointment on 27 April 2023, and not gingivitis. Mr Treurnicht therefore should have diagnosed periodontitis and in failing to do so, failed to maintain an adequate standard of care. Accordingly, the Committee found this charge proved.
4d	*Undertake a full periodontal evaluation on 04 April 2024;* **Found proved**

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	As in 4a above, the Committee was satisfied that it had evidence before it from the clinical records that Patient 5 was being treated by Mr Treurnicht between 22 May 2024 and 20 July 2024. The Committee noted that within the clinical records, it is noted that Patient 5 attended an appointment on 4 April 2024 complaining of loose teeth in the lower anterior region. A radiograph was taken, included in the clinical records, that Mr Quelch states revealed that there was a large amount of bone loss and chronic periodontitis. Mr Quelch states that '*When radiographs show significant bone loss, a dentist is expected to carry out a comprehensive periodontal assessment, including six-point pocket charting, attachment loss measurement, bleeding on probing, and mobility assessment, and further radiographic review. Risk factors and findings should then assist in getting an overall diagnosis which leads to a treatment plan.'* He opined that failing to perform these assessments limited accurate diagnosis and treatment planning and falls far below the standard reasonably expected of a general dental practitioner. The Committee accepted the opinion of Mr Quelch. The Committee noted that there was no record within the clinical records of a full periodontal evaluation carried out on 4 April 2024. Having accepted Mr Quelch's opinion that this should have been done, the Committee determined that this was a failure to maintain an adequate standard of care. Accordingly, the Committee found this charge proved.
4e	*Take any or any adequate radiographs on 04 April 2024;* **Found Proved** The Committee noted that there is no evidence within the clinical records of further radiographs being taken at these appointments that Patient 5 attended, nor of a reason why not. The Committee considered the expert report of Mr Quelch, where he opined that *'when dentist diagnoses mobility of anterior teeth due to periodontitis, further radiographs are indicated to assess the extent, pattern, and severity of alveolar bone loss in other areas of the mouth. Radiographs can assist in identifying the prognosis of all the teeth, which is essential for accurate diagnosis, and treatment planning'.* Mr Quelch therefore opined that patient should have had further radiographs taken within this period of appointments as in failing to do so, Mr Treurnicht's ability to make an overall diagnosis and treatment plan was limited and this falls far below the standard expected. The Committee accepted this opinion.

	The Committee determined therefore that further adequate radiographs should have been taken during this time period, and in failing to do so Mr Treurnicht failed to maintain an adequate standard of care. Accordingly, the Committee found this charge proved.
4f	*Inform the patient of her periodontal disease;* **Found Not Proved** As in 4a above, the Committee was satisfied that it had evidence before it from the clinical records that Patient 5 was being treated by Mr Treurnicht between 22 May 2024 and 20 July 2024. The Committee noted that there was no explicit note within the clinical record that Patient 5 was informed of their periodontal disease. The Committee considered the oral evidence of Patient 5, and noted that they stated that they did not remember much about their appointments. Patient 5 appeared to believe that any issues with the loosening of their teeth were due to their osteoporosis, and it was not clear whether they were informed by Mr Treurnicht of their periodontal disease. The Committee noted that when Patient 5 was asked whether Mr Treurnicht informed them of their periodontal disease, they answered 'it vaguely rings a bell'. Given the lack of clarity within the evidence, the Committee was not satisfied that the GDC had discharged its burden of proof that Mr Treurnicht did not inform Patient 5 of their periodontal disease. Whilst it has not been recorded in the clinical records, the Committee was not satisfied that it had sufficient evidence before it to be persuaded that on the balance of probabilities it did not happen. The Committee accordingly found this charge not proved.
4g	*Provide adequate periodontal treatmen*t; **Found Proved** As in 4a above, the Committee was satisfied that it had evidence before it from the clinical records that Patient 5 was being treated by Mr Treurnicht between 22 May 2024 and 20 July 2024. The Committee turned to the expert report provided by Mr Quelch, and noted that his opinion was that Mr Treurnicht did not provide adequate periodontal treatment for the patient. Mr Quelch stated that '*Appropriate periodontal care would require a full assessment, targeted scaling and root surface debridement, evaluation and management of occlusal forces, risk factor modification, and ongoing preventive advice. Limiting treatment to*

	superficial scaling and splinting fails to control the disease, reduce risk factors, and address the underlying disease.' He opined that the limiting treatment provided by Mr Treurnicht falls far below the standard reasonably expected of a general dental practitioner. The Committee accepted the opinion of Mr Quelch. The Committee therefore determined that given the discrepancy between what is adequate treatment and the treatment that Mr Treurnicht carried out, this charge is found proved.
5	*As a result of your conduct at 4(a) and / or 4(c) and / or 4(e) above, you did not diagnose the cause of the patient's bone loss.* **Found Proved** The Committee having found proved charges 4(a), 4(c) and 4(e), considered whether this conduct led to a failing by Mr Treurnicht to diagnose the cause of patient's bone loss. The Committee accepted the report of Mr Quelch in which he summarised Mr Treurnicht's failings in respect to diagnosing the patient's bone loss. This included; failing to carry out a BPE on 27 April 2023 and 14 December 2023 and as a result, not assessing or diagnosing the full extent of the underlying bone loss apparent in the lower anterior region, misdiagnosing the patient with gingivitis on 27 April 2024, and no overall periodontal diagnosis as additional radiographs and periodontal charting were not obtained. The Committee accepted the opinion of Mr Quelch that failing to identify the cause of the bone loss would be far below the standard of a reasonable dentist. Taking all of the factors above, the Committee considered that bone loss should and could have been identified and diagnosed earlier. It therefore determined that Mr Treurnicht's conduct at 4(a) and / or 4(c) and / or 4(e) above, led to him not diagnosing the cause of the patient's bone loss. Accordingly, it found this charge proved.
	Patient 6
6	*Between 18 April 2024 and 18 May 2024 you failed to maintain an adequate standard of care for Patient 6 in that you did not:*
6a	*Carry out any or any adequate BPEs;* **Found Proved** The Committee had sight of the clinical records for Patient 6, and noted that they were being treated by Mr Treurnicht between 8 April 2024 and 18 May 2024.

	The Committee noted that there was no record of any BPE being carried out at the examination appointment on 19 April 2024, nor at the scaling appointment on 17 May 2024. The Committee accepted the opinion of Mr Quelch that a BPE is a key element of the dental examination process, serving as a screening tool to assess the patient's periodontal health and informs further treatment and care of the patient. He stated that failing to undertake a BPE falls far below the standard reasonably expected of a general dental practitioner. The Committee therefore determined that given the lack of any record of a BPE, on the balance of probabilities it was not carried out and this amounted to a failure to maintain an adequate standard of care. The Committee accordingly found this charge proved.
6b	*Make any or any adequate report on the radiographs taken on 19 April 2024.* **Found Proved** As in charge 6(a), the Committee had sight of the clinical records for Patient 6, and noted that they were being treated by Mr Treurnicht between 8 April 2024 and 18 May 2024. It noted that there was a clinical record stating that right bitewing and left bitewing radiographs were taken on 19 April 2024. The Committee, however, noted that there was no evidence of a radiographic report for these bitewings within the clinical records. Mr Quelch's expert report states that in line with IRMER and good record keeping guidelines, Mr Treurnicht should have written a radiographic report. He stated that *'Even in the absence of visible pathology, a contemporaneous note confirming that the images were reviewed and no abnormalities were identified is required.'* He opined that failing to do so falls far below the standard reasonably expected. The Committee accepted this opinion. On the basis that there was no adequate radiographic report within the clinical records, the Committee determined that Mr Treurnicht failed to maintain an adequate standard of care. The Committee accordingly found this charge proved
7	*On 17 May 2024 you failed to maintain an adequate standard of record keeping for Patient 6 in that you did not make any or any adequate records of the scaling appointment*. **Found Proved**

	The Committee had sight of the clinical records, which state that Patient 6 attended a scaling appointment on 17 May 2024 and was treated by Mr Treurnicht. The Committee accepted and agreed with the opinion of Mr Quelch that the record of this appointment appeared to be a computerised template, naming the treatment and describing the procedure and the cost. Mr Quelch opined that further details should have been incorporated into this clinical record including a BPE, oral hygiene review, diagnosis and justification for treatment, what instruments were used (hand or ultrasonic), where the scale was removed, any local anaesthetic used, oral hygiene advice including plaque control aids, recall and maintenance, any post-operative warnings for example soreness or sensitivity. The Committee accepted this opinion. The Committee considered that the GDC standards are clear that there is a professional duty upon dentists to make accurate, contemporaneous, and comprehensive records. The Committee having accepted Mr Quelch's opinion that there was more information that should have been included, determined that Mr Treurnicht failed to maintain an adequate standard of record keeping. The Committee accordingly found this charge proved.
	Patient 7
8	*On 23 May 2024 you failed to maintain an adequate standard of care for Patient 7 in that you did not:*
8a	*Carry out an adequate BPE;* **Found proved** The Committee had sight of the clinical records, which state that Patient 7 attended an appointment on 23 May 2024 and was treated by Mr Treurnicht. The Committee noted that a BPE was carried out and recorded within the clinical records on this date, with scores of 222/222. Mr Quelch however opined that he would have expected scores of 3 or 4, given the radiograph taken on 7 July 2024 showing significant bone loss, just 2 months after the examination where significant bone loss is recorded. Mr Quelch stated that periodontal disease is a chronic condition and that the bone loss would not have arisen in this case in the space of 2 months. The Committee accepted Mr Quelch's opinion. The Committee determined that the BPE carried out on 23 May 2024 could not be deemed as adequate as its inaccuracy led to a failure to conduct

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	further investigations that may have picked up the significant levels of attachment loss. The Committee accepted Mr Quelch's opinion that the BPE was not accurate and therefore found that it was not adequate. The Committee accordingly found this charge proved.
8b	*Review radiographs taken on 03 February 2023;* **Found Not Proved** As in head of charge 8a above, the Committee was satisfied that it had evidence from the clinical records that Patient 7 attended an appointment on 23 May 2024 and was treated by Mr Treurnicht. The Committee noted from the clinical records that Mr Treurnicht recorded '*BWs taken in , no need to take today*'. The Committee observed that whilst the computerised record does not reference a specified date, it is a note that suggests that Mr Treurnicht had seen a previous radiograph and reviewed this, and was satisfied that he need not take another. The Committee considered that the extent of the review may be questionable, however with this note in place it was not satisfied that the GDC had discharged its burden of proof that Mr Treurnicht did not review the radiographs taken on 3 February 2023. Accordingly, it found this charge not proved.
8c	*Take any or any adequate radiographs;* **Found Not Proved** As in head of charge 8a above, the Committee was satisfied that it had evidence from the clinical records that Patient 7 attended an appointment on 23 May 2024 and was treated by Mr Treurnicht. The Committee noted that it was previously advised by Selection Criteria guidelines that 18 months to 24 months is not an abnormal gap to have between bitewings, if the risk has been deemed as low. The Committee noted that MR Quelch's expert report states that *'The Registrant risk rated the patient as low for caries and medium for periodontal disease and based on the information within the records those evaluations can be roughly supported.'* The Committee noted from the clinical records that the last right bitewing was taken on 3 February 2023 and therefore it was not necessary to take another on the date of this appointment, while the risk remained to be deemed as low.

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	In relation to the left bitewing, the Committee noted Mr Quelch's opinion that a bitewing or periapical views were due to be taken on this date as Mr Treurnicht did not have any radiographic information available. The Committee has previously determined that Mr Treurnicht did review the radiographs at charge 8(b) and therefore was in possession of radiographic information. The Committee therefore determined that Mr Treurnicht did not fail to maintain an adequate standard of care by not taking any or any adequate radiographs. This was due to its finding that it was not proved that Mr Treurnicht did not review radiographs from 3 February. Accordingly this charge was found not proved.
8d	*Provide adequate oral hygiene advice* **Found Not Proved** As in head of charge 8a above, the Committee was satisfied that it had evidence from the clinical records that Patient 7 attended an appointment on 23 May 2024 and was treated by Mr Treurnicht. The Committee noted that "*OHI given*" (Oral Hygiene Instruction) was recorded in the clinical records on this date. Mr Quelch's opinion is that it is likely that the "OHI given" is a template statement as it is recorded in an identical manner for all the Registrant's patient examinations reviewed in this case. His subsequent opinion was that this therefore fell below the standard expected. The Committee however found that this note indicated that oral hygiene instruction was given, but that there is no specific information on what that advice was. It could not find it proved therefore that the advice given was inadequate. The Committee accepted that the oral health advice may not have been recorded adequately within the clinical records, however it was not satisfied that the GDC had discharged its burden of proof that oral hygiene instruction was not provided adequately. Accordingly, the Committee found this charge not proved as it did not have evidence before it to be persuaded that Mr Treurnicht did not provide adequate hygiene advice.
9	*As a result of your conduct at 8(a) / (b) and / or (c) above, you failed to:*
9a	*Diagnose periodontal disease;*

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	Found proved The Committee found proved above that a BPE is essential to diagnose periodontal disease. The Committee accepted the opinion of Mr Quelch that had Mr Treurnicht carried out an accurate BPE, this would have led to the periodontal disease and bone loss being identified. The Committee therefore found this charge proved, on the basis that failing to carry out a BPE led to a failing to diagnose periodontal disease.
9b	*Diagnose bone loss;* **Found proved** Having found charges 8(b) and 8(c) not proved, the Committee did not consider their impact on this charge. The Committee considered its finding at 8(a) that Mr Treurnicht failed to carry out an adequate BPE. The Committee considered that had 8(a) been conducted correctly, this would have led to more detailed radiographic and other investigations, which is likely to have led to a diagnosis of bone loss. Accordingly the Committee found this charge proved.
9c	*Formulate an adequate treatment plan for periodontal therapy.* **Found proved** The Committee once again accepted Mr Quelch's opinion that a BPE was essential to diagnose periodontal disease. The Committee noted that in failing to carry out a BPE, Mr Treurnicht failed to diagnose periodontal disease. Therefore, the Committee determined that Mr Treurnicht could not make an adequate treatment plan for periodontal therapy as he had failed to diagnose the periodontal disease present in the first place. Accordingly, the Committee found this charge proved.
	Patient 8
10	*Between 29 August 2022 and 21 August 2024 you failed to maintain an adequate standard of care for Patient 8 in that you did not:*
10a	*Take any or any adequate radiographic examinations in 2024;* **Found Proved**

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	The Committee had sight of the clinical records, which evidence that Patient 8 attended appointments between 29 August 2022 and 21 August 2024 and was treated by Mr Treurnicht. The Committee noted that there is nothing in the clinical records to indicate that any radiographic examinations were taken in 2024. The Committee accepted the opinion of Mr Quelch, that radiographs were necessary during the period following Patient 8's diagnosis of inflammation and as part of the diagnostic and treatment planning process for crown restoration. Having regard to all the evidence, the Committee accepted Mr Quelch's opinion that radiographs should have been taken, and determined that failing to do so was a failure to maintain an adequate standard of care. It therefore found this charge proved.
10b	*Undertake an analysis of the occlusion;* **Found Proved** The Committee had sight of the clinical records, and as above, was satisfied that Patient 8 attended appointments between 29 August 2022 and 21 August 2024 and was treated by Mr Treurnicht. The Committee noted that there is nothing in the clinical records to indicate that any analysis of the occlusion took place within the appointments. The Committee accepted the opinion of Mr Quelch, that a reasonable dentist should carry out a diagnostic assessment to identify the underlying cause rather than simply just continually replacing the fillings. It accepted Mr Quelch's opinion that failing to undertake any analysis of the patient's occlusion or any other reason, to understand why the fillings were continually breaking, was far below the standard expected. Having regard to all the evidence, the Committee accepted Mr Quelch's opinion that an analysis of the occlusion should have been done, and determined that failing to do so was a failure to maintain an adequate standard of care. It therefore found this charge proved.
10c	*Carry out adequate diagnostic assessments to establish the underlying cause of restoration failures at the upper anterior teeth;* **Found Proved** The Committee had sight of the clinical records, and as above, was satisfied that Patient 8 attended appointments between 29 August 2022 and 21 August 2024 and was treated by Mr Treurnicht.

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	The Committee accepted the opinion of Mr Quelch, who stated that *'Where anterior restorations are repeatedly failing, a reasonable general dental practitioner would be expected to undertake diagnostic assessment to identify the underlying cause. This would include an occlusal analysis, appropriate radiographs, and a review of restorative technique and material choice. Parafunctional habits such as bruxism should also be considered.'* The Committee noted that there is no record within the clinical records of any of these diagnostic assessments to establish the underlying cause of restoration failures at the upper anterior teeth. The Committee therefore determined that failing to carry out these diagnostic assessments was a failure to maintain an adequate standard of care. Accordingly, it found this charge proved.
10d	*Adequately plan treatment for the UL1 and / or UL2 and / or UR1 and / or UR2 and / or UR 3;* **Found Proved** The Committee had sight of the clinical records, and as above, was satisfied that Patient 8 attended appointments between 29 August 2022 and 21 August 2024 and was treated by Mr Treurnicht. The Committee noted that there was no evidence of a treatment plan within the clinical records for these teeth. Mr Quelch, in his report, provided a list of the pre-treatment assessments he would expect a dentist to carry out when planning a large restorative case (multiple crowns and a denture) but stated that Mr Treurnicht did not carry these out. He also opined that Mr Treurnicht's treatment planning should have included information on the way that the crowns were manufactured and planning around the management of the occlusion. Mr Quelch opined that a lack of evidence of a treatment plan is far below the standard expected. The Committee accepted the opinion of Mr Quelch. The Committee therefore determined that since it had no evidence of a treatment plan, Mr Treurnicht failed to adequately plan treatment for the UL1 and / or UL2 and / or UR1 and / or UR2 and / or UR 3 and this was a failure to maintain an adequate standard of care. Accordingly, it found this charge proved.
10e	*Carry out diagnostic assessments to establish the cause of swelling on 18 June 2024;* **Found Proved**

	The Committee had regard to the clinical records for this date, and noted that Patient 8 attended on this date with swelling and was treated by Mr Treurnicht. The Committee noted that there is nothing within the clinical records to indicate that diagnostic assessments to establish the cause of swelling were carried out. The Committee accepted the opinion of Mr Quelch, that a reasonable general dental practitioner would be expected to undertake some diagnostic assessments if a patient presented with swelling. The Committee therefore determined that failing to do carry out these diagnostic assessments was a failure to maintain an adequate standard of care. Accordingly, it found this charge proved.
10f	*Prescribed antibiotics on 18 June 2024 when this was not clinically indicated;* **Found Proved** The Committee had regard to the clinical records for this date, and noted that Patient 8 attended on this date and was treated by Mr Treurnicht. The Committee noted from the clinical records that Amoxycillin 500mg 7 days was prescribed '*due to inflammation on the gum areas'*. Mr Quelch referred to the antibiotic guidelines that state that dentists should only prescribe antibiotics when there is clear evidence of infection that cannot be adequately managed by local measures alone. He opined that Antibiotics should not be prescribed for gum inflammation, as this is usually caused by gingivitis or periodontitis, and local measures should have been prescribed instead. The Committee accepted this opinion. The Committee therefore determined that there was no clinical indication to prescribe antibiotics at this appointment and that in doing so Mr Treurnicht failed to maintain an adequate standard of care. Accordingly, it found this charge proved.
10g	*Did not discuss adequately or at all, risks and benefits of treatment prior to crown preparation on 11 June 2024;* **Found Proved** The Committee noted from the clinical records that Patient 8 attended the Practice on 11 June 2024 for crown preparation and was treated by Mr Treurnicht. The Committee, however, noted that there was no evidence within the clinical records nor any other documents that the patient had

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	seen or signed a treatment plan in which they agreed to the treatment and was aware of all of the related risks and benefits. It noted that there was a lengthy list of information within the invoice provided to Patient 8, but that this was general to restorative practice and not tailored to the treatment that Patient 8 would receive. Mr Quelch, in his expert report, provided a list of the risks and benefits of the treatment that Patient 8 should have received, and the Committee noted that these were not included within any of the documents before it. The Committee accepted the opinion of Mr Quelch that the evidence suggests that Mr Treurnicht did not cover the specific risks and benefits of the treatment proposed in this case, and that this was far below the standard expected for a reasonable dentist. Mr Quelch also referred to the GDC standards, that require a dentist to communicate effectively with patients and ensure that they understand all the risks and benefits of the treatment proposed. On the basis that there is no evidence that Mr Treurnicht adequately discussed risks and benefits of treatment prior to crown preparation, as expected of a registered dentist, the Committee determined that Mr Treurnicht failed to maintain an adequate standard of care for Patient 8. Accordingly, it found this charge proved.
10h	*Undertake vitality testing of the UR2 on 25 June 2024.* **Found Proved** The Committee has had regard to Patient 8's clinical records for this date. The Committee noted that there is no reference in the clinical records of a vitality test having been carried out on the UR2 on this date. The clinical records state that '*no vitality test was done today*'. The Committee noted that a different dentist saw the Patient on 20 June 2024, and noted '*…ur2 has been painful?? Vitality??*'. The Committee accepted Mr Quelch's opinion that this appeared to be a questioning by the other dentist as to the cause of the pain, and that as Mr Treurnicht was caring for this Patient, he had a duty to review the records and review the vitality of the tooth at the appointment. The Committee determined that on the balance of probabilities, this was not carried out despite there being a need, and that in failing to undertake vitality testing Mr Treurnicht failed to maintain an adequate standard of care. Accordingly, it found this charge proved.

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11	*As a result of your conduct at 10(g) above, you failed to obtain the patient's valid consent for treatment.* **Found Proved** The Committee considered that it had found charge 10(g) proved, that Mr Treurnicht did not discuss the risks and benefits of treatment prior to crown preparation on 11 June 2024. It noted that for valid consent to be given, the consent needs to be informed in nature. As Mr Treurnicht did not discuss the risks and benefits, the Committee considered that Patient 8 could not give valid and informed consent. Accordingly, it found this charge proved.
	Patient 9
12	*Between 18 April 2024 and 18 May 2024 you failed to maintain an adequate standard of care for Patient 9 in that you did not:*
12a	*Take any or any adequate radiographs;* **Found Proved** The Committee had sight of the clinical records for Patient 9, and noted that they were being treated by Mr Treurnicht between 18 April 2024 and 18 May 2024. The Committee noted that there is no evidence within the clinical records of a radiograph being taken at any of the appointments during this period, nor of a reason why not. The Committee considered the expert opinion of Mr Quelch, where he again made reference to The College of Dentistry (CGDent) Selection Criteria guidelines, which state that bitewing radiographs should generally be taken every 24 months. The guidance also states that any refusal by the patient should be clearly documented within the records. Mr Quelch opined that Patient 9 should have had a radiographic examination to identify potential caries and to review the periodontal bone levels, and in failing to do so Mr Treurnicht's radiographic practice is far below the standard expected for a reasonable general dental practitioner. The Committee accepted this opinion. The Committee determined that given the lack of any evidence of a radiograph being take on this date, on the balance of probabilities it is more likely than not that it was not done. The Committee accordingly found proved that Mr Treurnicht failed to maintain an adequate standard of care by failing to take any or any adequate radiographs within this time period.

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12b	*Provide any or any adequate oral hygiene advice.* **Found Proved** As above at head of charge 12a, the Committee was satisfied that there were clinical records proving that Mr Treurnicht was treating Patient 9 between these dates. The Committee noted from the clinical records that there is a note of 'OHI Given' meaning Oral Health instructions given on 19 April 2024. The Committee noted that there was no record of any note of oral hygiene advice provided at the appointment on 17 May 2024. The Committee took Mr Quelch's opinion into consideration. He stated that the British Society of Periodontology (BSP) provide guidelines for treatment indicated by BPE scores, and that having scored Patient 9 with a score of 111/111 on 19 April 2024, there was oral advice that would have preferably been recorded in the records as an individually itemised list including tooth brushing advice and the use of interproximal aids. Mr Quelch further noted that the entry of "OHI" on 19 April 2024 within the records is virtually identical in content and formatting to records of other patient examinations. He noted the possibility that "OHI" represents a pre-populated computerised template that was not amended to accurately reflect the care provided. He also noted that there was no record of advice provided at the scaling appointment on 17 May 2024. Mr Quelch opined that '*if the records are interpreted as unmodified templates that do not accurately represent the contemporaneous advice given, this allegation is supported. In that case, the Registrant's oral health advice would fall far below the standard expected of a reasonable dentist.*' The Committee had further regard to the witness statement of Patient 9, in which they stated *'I do not believe I was given any advice on personal oral hygiene'.* The Committee therefore on this occasion, accepted Mr Quelch's opinion that the records were unmodified templates and therefore it is likely that that no oral hygiene advice was given. It determined that this was supported by the Patient's account, which is unchallenged and states that no oral hygiene advice was given. The Committee therefore concluded that inadequate oral hygiene advice was given to Patient 9 and that this did not maintain an adequate standard of care. Accordingly, it found this charge proved.

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	Patient 10
13	*Between 20 March 2024 and 26 April 2024 you failed to maintain an adequate standard of care for Patient 10 in that you did not:*
13a	*Carry out any or any adequate BPE;* **Found Proved** The Committee had sight of the clinical records for Patient 10, and noted that they were being treated by Mr Treurnicht between 20 March 2024 and 26 April 2024. The Committee noted that there was no record of a BPE within the clinical records before it. The Committee accepted the expert opinion of Mr Quelch that a BPE is considered a standard part of a dental examination and that failing to provide one would be far below the standard expected for a reasonable dentist. The Committee also considered the oral evidence of Patient 10, in which they stated that they could recall a sort of percussion test being carried out but nothing else. The Committee noted that this was not a BPE test. The Committee therefore determined that given the lack of evidence within the clinical records and Patient 10's oral evidence, on the balance of probabilities it is likely that Mr Treurnicht did not carry out a BPE at the examination. The Committee concluded that in failing to do so, Mr Treurnicht failed to maintain an adequate standard of care. Accordingly it found this charge proved.
13b	*Make any or any adequate radiographic report.* **Found Proved** As above at head of charge 13a, the Committee was satisfied that there were clinical records proving that Mr Treurnicht was treating Patient 10 between these dates. It noted that there was a clinical record stating that right bitewing and left bitewing radiographs were taken on 21 March 2024. The Committee, however, noted that there was no evidence of a radiographic report for these bitewings within the clinical records. Mr Quelch's expert report states that in line IRMER and good record keeping guidelines, Mr Treurnicht should have written a radiographic report. He opined that Mr Treurnicht's record keeping in relation to radiographs was far below the standard expected. The Committee accepted this opinion.

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	On the basis that there was no adequate radiographic report within the clinical records, the Committee determined that Mr Treurnicht failed to maintain an adequate standard of care. The Committee accordingly found this charge proved.
	Patient 12
14	*On 04 April 2024 you failed to maintain an adequate standard of radiographic practice for Patient 12 in that you did not make any or any adequate radiographic report.* **Found Proved** The Committee had sight of the clinical records for Patient 12, and noted that they attended an appointment with Mr Treurnicht on 4 April 2024. It noted that there was a clinical record stating that right bitewing and left bitewing radiographs were taken at this appointment. The Committee however noted that there was no evidence of a radiographic report for these bitewings within the records. Mr Quelch's expert report states that in line with IRMER and good record keeping guidelines, Mr Treurnicht should have written a radiographic report. He opined that failing to do so this would be far below the standard expected for a reasonable general dental practitioner. The Committee accepted this opinion. On the basis that there was no adequate radiographic report within the clinical records, the Committee determined that Mr Treurnicht failed to maintain an adequate standard of radiographic practice. The Committee accordingly found this charge proved.

30. We move to stage two.

Stage 2 Determination

31. Following the Committee's announcement of its decision on the facts, the hearing moved to Stage 2. At Stage 2, the Committee considered whether the facts found proved amounted to misconduct and, if so, whether Mr Treurnicht's fitness to practise is currently impaired by reason of his misconduct. If it found that Mr Treurnicht's fitness to practise is impaired, it would consider what sanction, if any, should be imposed.

32. The Committee received one further document at stage 2 by Mr Treurnicht's legal representatives which was a testimonial.

Submissions

33. Ms Vanstone made submissions on misconduct, impairment, and sanction.

34. With regard to misconduct, Ms Vanstone referred the Committee to the relevant case law and the GDC's *Standards for the Dental Team (2013).* She submitted that to find misconduct, the Committee must find proved that Mr Treurnicht's conduct was a serious departure from the standard expected of a registered dental professional.

35. Ms Vanstone submitted that Mr Treurnicht's conduct was in breach of Standards 1.1 and 1.9 with specific reference to IRMER regulations within Principle 1 (Put patients' interests first). In relation to Principle 2 (Communicate effectively with patients), Ms Vanstone submitted that Mr Treurnicht had breached standards 2.2 and 2.3. Lastly, in relation Principle 3 (Obtain valid consent), she submitted that Mr Treurnicht had breached standard 3.1.

36. Ms Vanstone also submitted that Mr Quelch's expert report stated that Mr Treurnicht's conduct fell far below the standard expected over the 2 year period for all of the facts found proved. She referred the Committee to the table he provided which summarised the failings he had identified and his opinion on whether these fell far below the standard expected of a dental professional.

37. Ms Vanstone therefore submitted that Mr Treurnicht's conduct can be properly judged as misconduct and invited the Committee to make this finding.

38. Ms Vanstone then moved on to the issue of current impairment. She referred to the relevant case law, and submitted that impairment can be considered in two parts: the public protection component and the public interest component.

39. Ms Vanstone submitted that impairment could be found on both grounds in this matter. In respect of public protection, she submitted that although it is possible to remediate the concerns in this case, this has not been done. She submitted that there is no evidence before the Committee that Mr Treurnicht has remedied the issues nor that that he has kept up his skill set given his retirement, and therefore it is likely that the failings would be repeated. Ms Vanstone referred the Committee to the guidance in relation to the retirement of a practitioner, and submitted that this is of little relevance to impairment and that ceasing to practise does not impact the risk of repetition. Ms Vanstone therefore submitted that there was a public protection risk.

40. In respect of public interest, Ms Vanstone submitted that a finding of current impairment should be made to maintain public confidence in the dental profession. She submitted that you had breached fundamental tenets of the profession with your clinical failings and that this had the potential to damage public confidence in the profession.

41. Ms Vanstone lastly addressed the Committee on the matter of sanction. She informed the Committee that Mr Treurnicht has no previous adverse Fitness to Practise (FtP) history. Ms Vanstone confirmed that Mr Treurnicht retired in August 2025, and had applied for voluntary removal, but that this could not be done due to the outstanding FtP issues. Ms Vanstone referred to the mitigating and aggravating factors in this case.

42. Ms Vanstone submitted that the Committee must consider proportionality and consider the range of sanctions available to it, starting with the least restrictive. Ms Vanstone submitted that the matters were too serious for a reprimand to be sufficient and that conditions are inappropriate and unworkable given Mr Treurnicht's lack of engagement and retirement

from practise. Mr Vanstone therefore invited the Committee to make a direction for suspension. She referred the Committee to the guidance, and submitted that all of the factors that may make a suspension appropriate are present in this case. Ms Vanstone submitted that a suspension for 6 months, with a review, is the proportionate sanction.

43. Ms Vanstone, for completeness, informed the Committee that an Interim Order of conditions is currently in place for Mr Treurnicht, but as he is not working these have not been acted on.

Committee's Decision

44. The Committee has borne in mind that its decisions on misconduct, impairment and sanction are matters for its own independent judgment. There is no burden or standard of proof at this stage of the proceedings. The Committee had regard to the *GDC's* Guidance document, *'Fitness to Practise: Guidance for the practice committees' (6 January 2026)* (the GDC's Guidance) and the relevant case law. The Committee also received advice from the Legal Adviser which it accepted.

Misconduct

45. The Committee first considered whether the facts found proved amounted to misconduct. In doing so, the Committee had regard to the GDC's publication, *Standards for the dental team* (September 2013).

46. The Committee noted that the conduct proved in this case related to multiple clinical failings in the care and treatment provided to 10 patients, over a 2 year period. This included repetitive issues relating to radiographic practice and BPE issues that had the potential to cause actual harm to patients. The Committee further considered that the failures in relation to diagnosing bone loss for some of these patients could have caused actual harm as periodontal diseases is a progressive disease that could have worsened as a result of Mr Treurnicht's non-diagnosis.

47. The Committee determined that based on the facts it had found proved, Mr Treurnicht breached the following standards:

- Standard 1.1: You must listen to your patients
- Standard 1.9: You must find out about laws and regulations that affect your work and follow them
- Standard 2.2: You must recognise and promote patients' rights to and responsibilities for making decisions about their health priorities and care
- Standard 2.3: You must give patients the information they need, in a way they can understand, so that they can make informed decisions
- Standard 3.1: You must obtain valid consent before starting treatment, explaining all the relevant options and the possible costs.
- Standard 4.1: You must make and keep contemporaneous, complete and accurate patient records
- Standard 7.1: You must provide good quality care based on current evidence and authoritative guidance

48. The Committee further considered that Mr Quelch opined that the standard of care provided by Mr Treurnicht fell far below the standard expected for all of the charges found proved by this Committee. The Committee determined that this was sufficiently serious for a finding of misconduct to be made.

49. The Committee further considered that such conduct would be considered deplorable by fellow practitioners.

50. As a result, the Committee determined that the facts found proved, both individually and collectively, amounted to misconduct.

Impairment

51. The Committee then considered whether your fitness to practise is currently impaired by reason of your misconduct on the grounds of the protection of patients and the public and/or is in the wider public interest.

52. On public protection grounds, the Committee considered that the clinical deficiencies, whilst serious, were remediable. However, the Committee had no evidence before it of any remediation or intent to remediate the issues identified. Mr Treurnicht provided no evidence of insight into the issues. Whilst the Committee noted that Mr Treurnicht states that he has retired, it had no evidence before it that he would not return to practise. The Committee therefore determined that the likelihood of repetition in future is high and that there is a real risk of harm to patients. It determined that Mr Treurnicht's fitness to practise is currently impaired on public protection grounds.

53. The Committee next considered the wider public interest. The Committee determined that that an informed member of the public would be concerned should no impairment be found given the multiple failings in Mr Treurnicht's practice, the lack of evidence of remediation and insight into these, and the high risk of repetition of harm to patients. The Committee concluded that Mr Treurnicht's conduct had the potential to bring the profession into disrepute. The Committee also determined that an informed member of the public would expect a finding of impairment given that Mr Treurnicht is aware of the concerns but has taken the active decision not to engage with the GDC and its regulatory function. The Committee therefore determined that Mr Treurnicht's fitness to practise is also currently impaired on the wider public interest ground.

54. Accordingly, the Committee has determined that Mr Treurnicht's fitness to practise is currently impaired by reason of his misconduct on the grounds of the protection of the public and the public interest.

Sanction

55. The Committee next considered what sanction, if any, to impose on Mr Treurnicht's registration. It recognised that the purpose of a sanction is not to be punitive although it may have that effect. The Committee applied the principle of proportionality balancing Mr Treurnicht's interest with the public interest. It also took into account the *GDC's Guidance*.

56. The Committee considered the mitigating and aggravating factors in this case and took into consideration the relevant paragraphs in the *GDC's Guidance* on these matters.

57. The Committee considered that the only mitigating factors in this case was that Mr Treurnicht has evidence of good character in that he has no previous fitness to practise history.

58. The Committee noted that it had received a testimonial from a former colleague of Mr Treruniche's, however this pre-dated this substantive hearing as it was dated May 2025 and was originally provided for the Case Examiners investigation. The Committee gave limited weight to this document.

59. The aggravating factors in this case were that:

- There was a real risk of harm to the patients;
- The misconduct was sustained and repeated over a 2 year period;
- Mr Treurnicht has shown a blatant and wilful disregard of the role of the GDC and the systems regulating the professions by not engaging with the hearing proceedings other than requesting a voluntary removal; and
- Mr Treurnicht has demonstrated no insight.

60. The Committee decided that it would be inappropriate to conclude this case with no further action nor impose a reprimand. There were no exceptional circumstances, and it would not satisfy the public interest given the seriousness of the matters found proved. The Committee considered that these would both be insufficient to address the findings.

61. The Committee next considered a sanction of conditions. The Committee noted that there were defined clinical elements to the issues found proved, which could be remediated and managed by specifically formulated conditions. The Committee reminded itself however that conditions were only suitable when it could be confident that a registrant may comply. The Committee considered that Mr Treurnicht has not engaged with this process, in that he absented himself from the hearing and has provided no evidence of any insight into his conduct. The Committee therefore determined that conditions would be inappropriate and insufficient as they would be unworkable given Mr Treurnicht's disengagement.

62. The Committee next considered whether to make a direction for a suspension. The Committee had regard to paragraph 277 of the guidance, which states the following:

'Suspension may be appropriate when all, or some, of the following factors are present:

a. There is evidence of repetition of the behaviour.

b. 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.

c. A lesser sanction would be insufficient to meet the public interest.

d. There is no evidence of harmful deep-seated personality or professional attitudinal problems (which might make erasure the appropriate order).'

63. The Committee noted that all of the factors above are engaged in this case. It noted that Mr Treurnicht's conduct was serious and repeated. It caused a real risk of harm to patients and the expert had determined that his clinical failings fell far below the standard expected of a registered dental practitioner. The Committee noted that Mr Treurnicht has not provided evidence that he has remedied any of the clinical issues nor demonstrated any insight into the matters. The Committee considered that this complete lack of insight and the disregard Mr Treurnicht showed to his regulator in disengagement, was a serious matter.

64. The Committee did also consider whether an erasure would be appropriate in the circumstances of this case. The Committee considered that whilst the clinical failings alone could be proportionately sanctioned by a suspension, the Committee considered whether the utter disregard to the GDC and its regulatory function would mean that an erasure was appropriate. The Committee also considered the interests of Mr Treurnicht in that he had previously applied for voluntary removal and was disengaged from the process, and that an erasure would ensure that the matter could be concluded and no further action would have to be taken.

65. The Committee considered however that it must balance the public interest with the interests of Mr Treurnicht and that the sanction must be proportionate and not punitive, and the least restrictive that is appropriate. On this occasion, the Committee determined that a sanction of suspension was the most proportionate sanction. This would protect the public and suitably mark the seriousness of the Mr Treurnicht's misconduct by addressing the public interest concerns.

66. The Committee made a direction for a suspension for 12 months, which it determined was appropriate and proportionate to reflect the seriousness of the clinical failings, and would be sufficient to address the public interest given Mr Treurnicht's lack of insight and engagement. The Committee noted that Ms Vanstone had invited it to impose a suspension for 6 months, however the Committee decided that this period was not sufficient to satisfy the public interest in this case. The Committee also directed that a review should be held at the end of this period of suspension.

67. Unless Mr Treurnicht exercises his right of appeal, his registration will be suspended for a period of 12 months, starting 28 days from the date that notice of this Committee's direction is deemed to have been served upon him.

68. The Committee next invited submissions from Ms Vanstone, as to whether an immediate order of suspension should be imposed on Mr Treurnicht's registration to cover the 28-day appeal period, pending the taking effect of its substantive direction for suspension.

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Decision on an immediate order

69. The interim order of conditions currently in place on Mr Treurnicht's registration is hereby revoked, given the sanction imposed at this hearing.

70. The final stage at this hearing was to consider whether an immediate order should be placed upon his registration.

71. Ms Vanstone made an application for an immediate suspension order to be imposed on Mr Treurnicht's registration under Section 30 of the Dentists Act 1984. She submitted that an immediate order for suspension is necessary for the protection of the public and is otherwise in the public interest.

72. Ms Vanstone referred the Committee to the Guidance and submitted that grounds for when an immediate order may be appropriate are relevant in this case given the Committee's findings. These are that Mr Treurnicht's behaviour is considered to pose a risk, Mr Treurnicht placed patients at risk through poor clinical care, and immediate action is required to maintain public confidence in the professions.

73. Ms Vanstone submitted that it would be inconsistent with the findings at stage 2, where a suspension has been imposed, if an immediate order was not made and Mr Treurnicht was able to practise unrestricted within the appeal period.

74. Ms Vanstone submitted that the Committee determined that there was a risk of repetition, and that with this ongoing risk, members of the public would expect immediate action to uphold standards in the dental profession.

75. The Committee accepted the advice of the Legal Adviser, who drew its attention to the relevant guidance contained in the GDC's Fitness to Practise: Guidance for the practice committees (January 2026).

76. The Committee determined that the imposition of an immediate order of suspension on Mr Treurnicht's registration is necessary on public protection grounds and is otherwise in the public interest. It considered that the nature of his conduct was serious, and put patients at risk due to his poor clinical care that was deemed far below the standard expected of a dental professional. The Committee further noted that Mr Treurnicht has not demonstrated any insight or remediation. The Committee therefore determined that an immediate order is necessary to protect the public, given the risk of repetition and ongoing risk of harm to patients. The Committee also determined that it would be necessary and proportionate to impose an immediate order of suspension to maintain the public's confidence in the dental profession and its regulator.

77. The effect of this immediate order is that Mr Treurnicht's registration is now suspended. Unless he exercises his right of appeal, the substantive suspension will replace the immediate suspension upon the expiry of the 28-day appeal period. Should Mr Treurnicht exercise his right of appeal, this immediate order shall remain in force pending the resolution of the appeal.

78. That concludes this determination.

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