Dental Professionals Hearings Service

PUBLIC DETERMINATION

PUBLIC HEARING

Professional Conduct Committee
Initial Hearing

8-22 September 2025

Name:	ALI, Samina Jameel
Registration number:	177215
Case number:	CAS-204322-X2Z1Q9

General Dental Council:	Scott Smith of Capsticks
Registrant:	Present Represented by Michael Rawlinson, counsel Instructed by Tamsin Thomas of the MDU

Fitness to practise:	Impaired by reason of misconduct
Outcome:	Suspension
Duration:	12 months

Committee members:	Jill Crawford Janhvi Amin Lisa Shaw	(Lay)(Chair) (Dentist) (DCP)
Legal adviser:	Megan Ashworth	
Committee Secretary:	Paul Carson	

CHARGE (as amended)

ALI, Samina Jameel, a dentist, Statutory Exam 2008 is summoned to appear before the Professional Conduct Committee on 08 September 2025 for an inquiry into the following charge:

"That, being a registered dentist, whilst in practice as a dentist at the Practice (identified in Schedule A below[1]):

Patient 1

1. You failed to provide an adequate standard of care to Patient 1 (identified in Schedule B below) from 28 October 2014 to 27 November 2020, including by:

   (a) On 6 June 2016, you failed in the technical execution of the filling at UL4, in that:

      i. You failed to adequately treat caries;

      ii. You placed a filling with an overhang.

   (b) Providing a poor standard of root canal treatment at UL4, in that:

      i. On 6 June 2016 you failed to use and/or record the use of a rubber dam;

      ii. On 6 June 2016 you did not treat all canals present;

      iii. On 6 June 2016 you did not control the apical extent of the root canal filling;

      iv. Between 1 June 2016 and 30 October 2018, you failed to adequately restore the tooth.

   (c) On 19 July 2016, you failed in the technical execution of a filling at UL4, in that you placed a filling with an overhang.

   (d) On 29 November 2017, you failed in the technical execution of a filling at UR4, in that you placed a filling with an overhang.

2. You failed to maintain an adequate standard of record keeping in respect of Patient 1's appointments from 28 October 2014 to 27 November 2020, in that:

   (a) You did not record an entry for the appointment on 30 June 2016;

   (b) You did not record an entry for the appointment on 29 April 2019.

Patient 3

3. You failed to provide an adequate standard of care to Patient 3 (identified in Schedule B below) from 30 September 2014 to 12 January 2022, including by:

   (a) At UL4:

      i. You failed to carry out sufficient treatment planning from 12 May 2016 to 2 August 2018, in that you failed to plan a filling;

[1] Schedule A and [2] B are a private document that cannot be disclosed.

ii. On 2 August 2018, you failed in the technical execution of a filling in that you failed to diagnose and/or treat caries;

iii. On 2 August 2018, you failed in the technical execution of a filling in that you placed a filling with an overhang.

(b) At UL5:

i. Not carrying out sufficient treatment planning from 21 May 2018 to 20 October 2021, in that you:

a. failed to plan a filling;

b. failed to provide Patient 3 with all treatment options, including the risks and benefits of each;

c. failed to adequately restore the tooth by treating caries.

(c) At LL7:

i. Not carrying out sufficient treatment planning from 21 May 2018, in that you:

a. failed to plan a filling;

b. failed to provide Patient 3 with all treatment options, including the risks and benefits of each;

c. failed to adequately restore the tooth by treating caries.

(d) Your radiographic practice, in that you did not take and/or record bitewing radiographs on 21 April 2021, or at an appropriate interval.

4. You failed to maintain an adequate standard of record keeping in respect of Patient 3's appointments between 30 September 2014 and 12 January 2022, in that:

(a) You did not record an entry for the appointment on 16 April 2021;

(b) You did not record an entry for the appointment on 28 April 2021;

(c) You did not record an entry for the appointment on 15 December 2021.

Patient 4

5. You failed to provide an adequate standard of care to Patient 4 (identified in Schedule B below) from 23 September 2016 to 17 December 2021, including:

(a) by not carrying out sufficient treatment planning, in that you did not set in place a definitive plan for treating the caries present at UR4 between 27 November 2019 and 22 September 2020;

(b) in relation to your radiographic practice, in that no radiographic report was made on 3 September 2021.

6. You failed to maintain an adequate standard of record keeping in respect of Patient 4 in that you did not record an entry for the appointment on 3 September 2021.

Patient 5

7. You failed to provide an adequate standard of care to Patient 5 (identified in Schedule B below) from 19 October 2018 to 8 March 2022, including by:

(a) Providing a poor standard of treatment on or around 14 February 2019, in that you placed a crown at LL6 which was poorly fitted distally, with a marginal defect.

~~(b)~~ **WITHDRAWN**

(c) Not carrying out sufficient treatment planning, in that you:

~~i.~~ **WITHDRAWN**

ii. Or around 19 August 2019, placed a crown at UR4 when it was not clinically justified;

~~iii.~~ **WITHDRAWN**

(d) Failed to provide Patient 5 with all treatment options, in that you:

i. Did not discuss the replacement of the 2-unit bridge with another 2-unit bridge, between 22 July 2019 and 19 August 2019;

ii. Did not discuss the risks, benefits and/or alternative options to including the UR4 in a 3-unit bridge, with Patient 5 between 22 July 2019 and 29 November 2019;

iii. Told Patient 5 that a crown was necessary at UR4 to ‘save’ the tooth, when this was not the case.

(e) In light of your failure to provide all treatment options to Patient 5, as particularised at Charge 7(d)(ii), you failed to obtain informed consent from Patient 5 for the preparation of the UR4.

8. You failed to maintain an adequate standard of record keeping in relation to radiographs in respect of Patient 5 in that, you exposed a radiograph on 18 October 2019 but provided no radiographic report to justify future treatment.

9. You failed to maintain an adequate standard of record keeping in respect of Patient 5's appointments from 23 September 2018 to 3 March 2022, in that:

   (a) You did not record an entry for the appointment on 6 February 2019;

   (b) You did not record an entry for the appointment on 9 July 2019;

   (c) You did not record an entry for the appointment on 22 July 2019;

   (d) You did not record an entry for the appointment on 18 October 2019;

   (e) You did not record an entry for the appointment on 8 November 2019;

   (f) You did not record an entry for the appointment on 28 November 2019;

   (g) You did not record an entry for the appointment on 9 January 2020;

   (h) You did not record an entry for the appointment on 28 January 2020;

   ~~(i)~~ **WITHDRAWN**

   ~~(j)~~ **WITHDRAWN**

10. You failed to maintain appropriate standards of behaviour towards Patient 5, including by:

    (a) Contacting Patient 5 on their personal mobile phone and asking them to join your new practice- Mydentist- Brockfield;

    (b) Instructing Patient 5 to only book appointments with you at MyDentist- Brockfield;

    (c) Informing Patient 5 that Silk Dental Practice was going to stop offering NHS care.

11. Your actions at Charge 7(d)(iii) were:

    (a) Misleading, in that placing a Crown was not necessary to save UR4; and/or

    (b) Dishonest, in that you knew placing a Crown at UR4 was not necessary to save UR4.

12. Your actions at Charge 10 (c) were misleading, in that Silk Dental Practice was continuing to offer NHS care.

13. Your actions at Charge 10 (a), and/or (b), and/or (c) were dishonest, in that you intended to conceal that you had provided a poor standard of care to Patient 5.

Patient 6

14. You failed to provide an adequate standard of care to Patient 6 (identified in Schedule B below) in that on or around 15 July 2019, you placed a crown at LL7 with a significant mesial ledge.

15. You failed to maintain an adequate standard of record keeping in respect of Patient 6's appointments from 5 December 2014 to 24 November 2020, in that:

    (a) You did not record an entry for the appointment on 21 June 2019;

    (b) You did not record an entry for the appointment on 19 July 2019;

Patient 8

16. You failed to provide an adequate standard of care to Patient 8 (identified in Schedule B below) in that you failed to adequately restore the LL7 by removing caries between 9 November 2021 and 14 February 2022.

17. You failed to maintain an adequate standard of record keeping in respect of Patient 8's appointments from 7 July 2014 to 9 November 2021, in that you did not record an entry for the appointment on 30 August 2018.

Patient 9

18. You failed to provide an adequate standard of care to Patient 9 (identified in Schedule B below) from 8 May 2015 to 26 November 2021, including by:

    (a) Not carrying out sufficient diagnostic assessment, in that:

        i. Your recorded basic periodontal examination ('BPE') scores did not adequately reflect the presence and/or severity of periodontal disease, between 13 January 2017 and 26 November 2021;

        ii. You did not conduct detailed pocket charting between 13 January 2017 and 26 November 2021;

        iii. You failed to undertake sufficient periodontal care with root-surface debridement of pockets with adjunctive local anaesthetic, between 13 January 2017 and 26 November 2021.

19. You failed to maintain an adequate standard of record keeping in respect of Patient 9's appointments from 8 May 2015 to 9 November 2021, in that you did not record an entry for the appointment on 23 September 2016.

Patient 10

20. You failed to provide an adequate standard of care to Patient 10 (identified in Schedule B below) on or around 29 January 2020, in that you placed a crown at UL6 which was poorly fitted, with significant ledges present.

Patient 11

21. You failed to provide an adequate standard of care to Patient 11 (identified in Schedule B below) from 11 April 2018 to 16 March 2022, including by:

(a) At UR2:

i. Providing a poor standard of root canal treatment, in that the root canal filling was poorly obturated;

ii. Not carrying out sufficient treatment planning, by placing a crown notwithstanding the poor standard of root canal treatment at that tooth.

(b) At UR5:

i. Providing a poor standard of filling care, in that you:

a. Failed in the technical execution of a filling on 10 May 2019 by failing to adequately treat caries;
b. Failed in the technical execution of a filling on 10 May 2019 by placing a filling with an overhang;
c. Failed in the technical execution of a filling on 14 January 2020 by placing a filling with an overhang.

ii. Not carrying out sufficient treatment planning, by failing to replace the poor quality fillings at that tooth between 13 September 2021 and 16 March 2022.

(c) At UL6:

i. Providing a poor standard of filling care, in that you:

a. Failed in the technical execution of a filling on 12 January 2021 by failing to adequately treat caries;

b. Failed in the technical execution of a filling on 12 January 2021 in that you placed a filling with an overhang.

ii. Not carrying out sufficient treatment planning, by failing to replace the poor quality filling at that tooth between 13 September 2021 and 16 March 2022.

Patient 12

22. You failed to provide an adequate standard of care to Patient 12 (identified in Schedule B below) from 21 January 2021 to 1 March 2022, including by:

    (a) Not carrying out sufficient diagnostic assessment on 21 January 2022 by failing to appropriately assess periapical pathology at UR5 as revealed by the radiograph from the same date;

    (b) Not carrying out sufficient treatment planning, in that you:

        i. Failed to plan root canal treatment at UR5 on 21 January 2022;

        ii. In light of charge 22(b)(i), failed to provide Patient 12 with all treatment options, in that you did not offer root canal treatment at UR5 on 21 January 2022.

23. Between 21 January 2022 and 22 June 2022, you caused or permitted one or more claims to be made in your name for Units of Dental Activity ('UDA') under the provisions of the National Health Service ('NHS') when the claimed treatment had not been carried out.

24. Your conduct at paragraph 23 was misleading, as the submitted claim indicated treatment had been undertaken when it had not.

25. In the alternative to paragraph 24, your conduct at paragraph 23 was dishonest, as you submitted a claim for treatment which you knew had not been undertaken.

Patient 13

26. You failed to provide an adequate standard of care to Patient 13 (identified in Schedule B below) from 4 October 2016 to 15 February 2022, including by:

    (a) At UL6, you failed in the technical execution of a crown on or around 3 November 2021 as you failed to adequately treat caries prior to placing that crown;

    (b) At UL7, you failed in the technical execution of a filling on or around 3 November 2021 as you failed to adequately treat caries prior to placing that filling.

Patient 14

27. You failed to provide an adequate standard of care to Patient 14 from 29 July 2019 to 2 August 2019, in that:

    (a) At UL7:

i. On 2 August 2019, you failed to carry out sufficient diagnostic assessment by failing to expose a periapical radiograph to assess the restorability of the tooth and/ or prior to extraction of the tooth;

ii. On 2 August 2019, you failed to carry out sufficient diagnostic and/or risk assessment by failing to expose a radiograph following the occurrence of a tuberosity fracture to assess the extent of that fracture;

iii. On 2 August 2019, you failed to appropriately manage the tuberosity fracture by failing to refer the patient to a maxillofacial surgeon in a timely manner prior to your removal of the fractured portion of tuberosity maxilla;

iv. On 2 August 2019, you failed to advise Patient 14 about the risks and benefits of extraction at UL7:

(i) Prior to extraction; and/or
(ii) Following the tuberosity fracture.

(b) At UL8:

i. On 2 August 2019, you failed to carry out sufficient diagnostic assessment by failing to expose a radiograph to assess the restorability of the tooth and/ or prior to extraction of the tooth;

ii. On 2 August 2019, you provided a poor standard of care by proceeding to extract this tooth notwithstanding the occurrence of a tuberosity fracture whilst attempting extraction at UL7;

iii. On 2 August 2019, you failed to advise Patient 14 about the risks and benefits of extraction at UL8.

28. You failed to maintain an adequate standard of record keeping as your records on 2 August 2019 were inaccurate, in that:

(a) You recorded that the patient was “in agony”, when this was not the case;

(b) You recorded that the patient had not slept in two nights due to the “intense pain” at UL7, when this was not the case;

(c) You recorded that the patient requested extraction at UL7 on that day, when this was not the case;

(d) You recorded that you advised extraction of UL8 prior to the commencement of the procedure, when this was not the case;

(e) You recorded that you were not able to take further x-rays due to the patient's strong gag reflex and/or due to the patient saying the x-ray was making him feel sick, when this was not the case;

(f) You recorded that the patient "declined another attempt at taking PA xray of UL7", when this was not the case;

(g) You recorded that you "Discussed with patient all options, elected to extract and then discussed implications and possible complications- including inability to extract/ tooth/root/tuberosity fracture, oro antral communication/ paresthesia/ dry socket", when this information was not discussed.

29. By reason of your conduct alleged at Charge 27(a)(iv) and/or Charge 27(b)(iii), you failed to obtain informed consent for the treatment you provided to Patient 14's UL7 and/or UL8 on 2 August 2019.

30. Your actions at 28(a) to (g) above were misleading.

31. Your actions at 28(a) to (g) above were dishonest in that you intended to:

(a) Conceal that you had not conducted sufficient diagnostic assessment throughout the appointment;
(b) Conceal that you had not provided the patient with advice on the risks and benefits of extraction, before and/or after the fracture;
(c) Conceal that you had not provided the patient with one or more of the pieces of advice at particular 28(g);
(d) Provide justification for your clinical decision to extract UL7 and/or UL8.

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

Mrs Ali,

Findings of fact 17 September 2025

1. At the outset of the hearing the Committee acceded to an uncontested application by the General Dental Council (GDC) under Rule 25 of the General Dental Council (Fitness to Practise) Rules 2006 for the joinder of further allegations to those already contained in the notification of hearing. The Committee accepted the advice of the Legal Adviser. The Committee was satisfied the further charges were of a similar kind and are founded on the same alleged facts and that no prejudice would be caused to either party in allowing the joinder.

2. Having accepted the advice of the Legal Adviser, the Committee also acceded to an uncontested application by the GDC under Rule 18 for the charge to be amended mainly to correct typographical errors, to change dates and to withdraw certain heads of charge following a joint experts' report.

3. You made admissions to a number of the charges at the outset and during the course of the hearing. The Committee accepted your admissions and found the corresponding charges proved.

4. As part of its factual inquiry, the Committee heard oral evidence from Patient 5 and from the dentist who subsequently treated her after you left the practice (the "Subsequent Treating Dentist"). The Committee heard expert evidence from Mr Bateman and Mr Quelch, instructed on behalf of the GDC and on your behalf respectively.

5. The Committee had regard to the submissions made by both Counsel.

6. The Committee accepted the advice of the Legal Adviser.

7. The burden is on the GDC to prove each allegation on the balance of probabilities.

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

Patient 1
1. You failed to provide an adequate standard of care to Patient 1 (identified in Schedule B below) from 28 October 2014 to 27 November 2020, including by:
(a) On 6 June 2016, you failed in the technical execution of the filling at UL4, in that:
i. You failed to adequately treat caries;   **Admitted and found proved**
ii. You placed a filling with an overhang.   **Admitted and found proved**
(b) Providing a poor standard of root canal treatment at UL4, in that:
i. On 6 June 2016 you failed to use and/or record the use of a rubber dam;   **Admitted and found proved**
ii. On 6 June 2016 you did not treat all canals present;

Admitted and found proved

iii. On 6 June 2016 you did not control the apical extent of the root canal filling;

Admitted and found proved

iv. Between 1 June 2016 and 30 October 2018, you failed to adequately restore the tooth.

Admitted and found proved

(c) On 19 July 2016, you failed in the technical execution of a filling at UL4, in that you placed a filling with an overhang.

Admitted and found proved

(d) On 29 November 2017, you failed in the technical execution of a filling at UR4, in that you placed a filling with an overhang.

Admitted and found proved

2. You failed to maintain an adequate standard of record keeping in respect of Patient 1's appointments from 28 October 2014 to 27 November 2020, in that:

(a) You did not record an entry for the appointment on 30 June 2016;

Not proved

The appointment history for Patient 1 lists a 10-minute appointment with you on 30 June 2016 for an "Exam" and records that the patient had arrived "60 mins late". Many of the other appointments in the appointment history also record that the patient had arrived "60 mins late".

The appointment history is the only record of an appointment having taken place on 30 June 2016 and is the only documentary evidence on which the GDC relies in support of this allegation. There is no other record in the clinical notes of an appointment having taking place with Patient 1 on 30 June 2016.

The Committee heard from the Subsequent Treating Dentist that the data which makes up the appointment history was transferred from one IT system to another in October 2021 and that many anomalies appeared in the data following the transfer. He accepted that some of the data may be unreliable as a result. An example of this is the recording of undertaking a BPE seven years before he had any association with the practice. He stated that he could not comment on the interpretation of entries such as those indicating a patient was 60 minutes late, as the system pre-dated his time at the Practice.

You are unable to recall whether or not the appointment took place, which is entirely understandable given the passage of time. You suggested that the reason there is no clinical entry in the records for the appointment might be because the patient had not in fact attended the appointment on that occasion. You stated that the appointment history will automatically record that a patient arrived "60 mins late" unless the receptionist manually overrides this by recording a correct time of arrival: the fact that the appointment

history states that the patient arrived "60 mins late" does not necessarily mean that they had turned up.

Alternatively, your position is that any clinical entry which you had made for the appointment with Patient 1 on 30 June 2016 might not have been successfully transferred into the new software system which had been introduced at the Practice. You referred to various IT issues during the transition from the old software which meant that some records either did not transfer into the new system or were not correctly displayed.

The Committee reminded itself that the burden of proof is not on you but on the GDC. It is for the GDC to show from the evidence that it is more likely than not that: (i) an appointment took place on 30 June 2016 which the patient had attended; and (ii) that you had failed to make an entry in the records of the appointment. The Committee determined that the appointment history on which the GDC relies is not sufficient to establish one way or the other whether the patient had in fact attended the appointment some years before. The data produced by the IT systems during the transfer on the evidence of the Subsequent Treating Dentist is inherently unreliable. The Committee cannot be satisfied in all the circumstances that the absence of an entry in the new system for an appointment on 30 June 2016 necessarily means that no entry was made at the time in the old software. Further, the evidence before the Committee is that the system generated "60 mins late" entry could be generated in circumstances where the patient attended on time, attended late or had not turned up at all.

Accordingly, the GDC has not discharged its burden of proof and this charge is found not proved.

(b) You did not record an entry for the appointment on 29 April 2019.
Admitted and found proved

Patient 3

3. You failed to provide an adequate standard of care to Patient 3 (identified in Schedule B below) from 30 September 2014 to 12 January 2022, including by:

(a) At UL4:

iv. You failed to carry out sufficient treatment planning from 12 May 2016 to 2 August 2018, in that you failed to plan a filling;
Admitted and found proved

v. On 2 August 2018, you failed in the technical execution of a filling in that you failed to diagnose and/or treat caries;
Admitted and found proved

vi. On 2 August 2018, you failed in the technical execution of a filling in that you placed a filling with an overhang.
Admitted and found proved

(b) At UL5:

ii. Not carrying out sufficient treatment planning from 21 May 2018 to 20 October 2021, in that you:

a. failed to plan a filling;
Admitted and found proved

b. failed to provide Patient 3 with all treatment options, including the risks and benefits of each;
Admitted and found proved

c. failed to adequately restore the tooth by treating caries.
Admitted and found proved

(c) At LL7:

ii. Not carrying out sufficient treatment planning from 21 May 2018, in that you:

a. failed to plan a filling;
Admitted and found proved

b. failed to provide Patient 3 with all treatment options, including the risks and benefits of each;
Admitted and found proved

c. failed to adequately restore the tooth by treating caries.
Admitted and found proved

(d) Your radiographic practice, in that you did not take and/or record bitewing radiographs on 21 April 2021, or at an appropriate interval.
Admitted and found proved

4. You failed to maintain an adequate standard of record keeping in respect of Patient 3's appointments between 30 September 2014 and 12 January 2022, in that:

(a) You did not record an entry for the appointment on 16 April 2021;
Not proved.

(b) You did not record an entry for the appointment on 28 April 2021;
Not proved.
For the same reasoning given under charge 2(a) above, the Committee was not satisfied that the GDC had discharged its burden of proof in respect of charges 4(a) and (b). Whilst the appointment history records appointments on 16 and 28 April 2021 it is not a reliable record of whether the patient had in fact attended. Further, the absence of any entry in the new software for these two appointments does not necessarily mean that no entry was made by you at the time, as it is possible that any such entries had not successfully transferred from the old software. The evidence taken as a whole is insufficient to establish one way or other whether the appointment took place and, if so, whether you had made an entry in the records at the time.

Accordingly, the Committee found charges 4(a) and (b) not proved.

(c) You did not record an entry for the appointment on 15 December 2021.
Admitted and found proved

Patient 4

5. You failed to provide an adequate standard of care to Patient 4 (identified in Schedule B below) from 23 September 2016 to 17 December 2021, including:

(a) by not carrying out sufficient treatment planning, in that you did not set in place a definitive plan for treating the caries present at UR4 between 27 November 2019 and 22 September 2020;
Admitted and found proved

(b) in relation to your radiographic practice, in that no radiographic report was made on 3 September 2021.
Admitted and found proved

6. You failed to maintain an adequate standard of record keeping in respect of Patient 4 in that you did not record an entry for the appointment on 3 September 2021.
Admitted and found proved

Patient 5

7. You failed to provide an adequate standard of care to Patient 5 (identified in Schedule B below) from 19 October 2018 to 8 March 2022, including by:

(f) Providing a poor standard of treatment on or around 14 February 2019, in that you placed a crown at LL6 which was poorly fitted distally, with a marginal defect.

Admitted and found proved

~~(g)~~ **WITHDRAWN**

(h) Not carrying out sufficient treatment planning, in that you:

~~i.~~ **WITHDRAWN**

ii. Or around 19 August 2019, placed a crown at UR4 when it was not clinically justified;

Not proved

Your evidence was that you placed the crown at UR4 because it "*…had fractured and I could not restore it with a filling*". You stated that half of the tooth tissue had fractured at the distal part of the tooth. You stated that you had discussed the fracture with Patient 5.

The GDC's case is that the tooth was not fractured and that placing the crown was therefore not clinically justified. The evidence on which the GDC relies is the absence of any clinical record in the notes of the tooth fracturing and Patient 5's evidence that her tooth had not fractured. It was the evidence of both experts that, if the tooth had fractured in the way you described, whilst it was possible that the patient would not feel pain, they would normally be aware of this as they would be able to feel with their tongue that part of the tooth was missing. However, Mr Quelch also acknowledged that, although unusual, it is possible that a patient might not be aware of the fracture given the proximity to a 2-part bridge which was causing issues to the patient.

Both experts were agreed that, if the tooth was fractured, the crown would have been clinically justified and are only critical of you if there was no fracture. Whether or not the tooth was fractured was therefore the crux of the matter which the Committee had to decide.

The Committee reminded itself of the burden of proof: it is not for you to prove that the tooth was fractured but for the GDC to prove its case that there was no fracture.

The Committee considered that the absence of a clinical record of the fracture to be unusual given that this would have been a significant event which should have been recorded by you. The Committee however noted you have admitted a number of failures to maintain an adequate standard of record keeping. You admitted in evidence that you did not always record appointments or make complete records because of a high workload. You said Patient 5 was an anxious patient who required more time and attention from you. This, you stated, would also have impacted on what remaining time you would have had to write up her notes. You stated that the appointment on 22 July took much longer than was booked. The Committee noted that there were no clinical records at all for this appointment and you have made admissions in relation to this.

The Committee had regard to Patient 5's evidence. The Committee accepted that Patient 5 honestly and genuinely believed what she was telling the Committee. However, it was difficult for the Committee to place reliance on her account because it appears to the Committee that her recollection of events is heavily influenced by what she had subsequently been told by others about the treatment she had received from you. Patient 5 stated in her witness statement that it was difficult to separate what she knew at the time of the events from what she knows now.

The evidence before the Committee, namely the text messages from Patient 5 to you, indicate she held you in high regard until her attendance with the Subsequent treating Dentist, who characterised the treatment she had received from you as amounting to malpractice which would require substantial remedial work. Up until that point she did not appear to consider there to be any issues with the standard

of care and treatment which you had provided to her. The Committee noted that the experts jointly were not critical of some aspects of care which others had criticised.

Patient 5 said her participation in a civil claim against you (the detail of which was not before the Committee), and these GDC proceedings, had also informed her interpretation of the care she received.

The information she was provided with as part of these proceedings, including the draft charges before the Case Examiners, appears to have influenced how she now recalls and characterises in her own mind the treatment you had provided to her.

The Committee found significant inconsistencies between Patient 5's written and oral evidence as well as the answers she gave when being cross-examined.

In respect of her evidence in relation to whether the UR4 was fractured, Patient 5 stated in her witness statement that this was a "*healthy tooth*" but also stated later in the statement that "*The Registrant misled me to believe that I should have the crown placed at UR4 to save it*". The Committee noted that this reference to needing to "save" the UR4 with a crown is consistent with the tooth being fractured. Patient 5's witness statement also describes you as explaining that the crown was needed to "wedge" an adjacent loose-fitting bridge in place to stop it moving. Patient 5 maintained this account in her oral evidence and was adamant that you had used the word "wedge" to describe this process.

In his evidence, Mr Quelch stated that what Patient 5 described is not a procedure which is known to dentistry. The Committee accepted that evidence. The Committee considered that it is inherently unlikely that you would have intended to crown a healthy tooth in order to "wedge" an adjacent loose-fitting bridge in place. Such a procedure would not have worked and is unheard of in dentistry. The Committee considered it unlikely that you would have explained such a procedure to Patient 5 as a reason for the crown.

Under questioning, Patient 5 also changed her account that you had informed her she needed a crown at UR5 to "save" that tooth. She now stated that you had said to her that teeth are "better off crowned". In the Committee's view, this was a significant variation in her evidence. She appeared to be modifying her original account in response to the suggestion that being informed by you that the crown was needed to "save" the tooth was consistent with the tooth being fractured.

Having regard to the entirety of the evidence, the Committee could not be satisfied that the tooth was not fractured. It is more likely that it was fractured and that your placement of the crown was therefore clinically justified. Whilst Patient 5 does not recall seeing or feeling a fracture to the tooth, the Committee, on the evidence of Mr Quelch, could not rule out that the fracture was not noticed by her particularly as her attention might have been on the issues with the bridge in that area of her mouth, which she said was causing her discomfort.

	Accordingly, the Committee found charge 7(c)(ii) not proved.
~~iii.~~	**WITHDRAWN**
(i)	Failed to provide Patient 5 with all treatment options, in that you:
i.	Did not discuss the replacement of the 2-unit bridge with another 2-unit bridge, between 22 July 2019 and 19 August 2019; **Not proved**
ii.	Did not discuss the risks, benefits and/or alternative options to including the UR4 in a 3-unit bridge, with Patient 5 between 22 July 2019 and 29 November 2019; **Not proved** Charges 7(d)(i)-(ii) turned on the recollection of Patient 5 on whether and to what extent these matters were discussed with her. The Committee found Patient 5's recollection of events to be inconsistent and unreliable. The Committee noted that there was a signed FP17 form for the initial 2-unit bridge and clinical notes which indicated that other treatment options had previously been discussed. In respect of a discussion of a replacement 2-unit bridge, the expert opinion was that such a discussion did not need to be detailed as it was not the primary treatment option. As to a 3-unit bridge, Patient 5 could not rule out that such a discussion had taken place even if she could not recall it. The Committee noted that Patient 5 did not make any complaint about not having given informed consent until some years later. Her complaint in regard to this was following criticism of a 3-unit bridge by others. The Committee noted that the experts were not critical of treatment to place a 3-unit bridge following Patient 5's issues with a 2-unit bridge. In all the circumstances, the Committee was of the view that the evidence does not support a finding that you failed to adequately discuss the risks, benefits and treatment options with her at the time. Accordingly, the Committee found charges 7(d)(i)-(iii) not proved.
iii.	Told Patient 5 that a crown was necessary at UR4 to 'save' the tooth, when this was not the case. **Not proved** This charge fell away in light of the Committee not finding charge 7(c)(ii) proved. A crown would have been clinically justified to "save" the tooth because it was fractured. Accordingly, the Committee found charge 7(d)(iii) not proved.
(j)	In light of your failure to provide all treatment options to Patient 5, as particularised at Charge 7(d)(ii), you failed to obtain informed consent from Patient 5 for the preparation of the UR4.

Not proved

Charge 7(e) fell away in light of the Committee not finding the underlying charge 7(d)(ii) proved.

Accordingly, the Committee found charge 7(e) not proved.

8. You failed to maintain an adequate standard of record keeping in relation to radiographs in respect of Patient 5 in that, you exposed a radiograph on 18 October 2019 but provided no radiographic report to justify future treatment.
Admitted and found proved

9. You failed to maintain an adequate standard of record keeping in respect of Patient 5's appointments from 23 September 2018 to 3 March 2022, in that:

(k) You did not record an entry for the appointment on 6 February 2019;

Not proved.
For the same reasoning given under charge 2(a) above, the Committee was not satisfied that the GDC had discharged its burden of proof in respect of charge 9(a). Whilst the appointment history records an appointment on 6 February 2019 it is not a reliable record of whether the patient had in fact attended. Further, the absence of any entry in the new software for the appointment does not necessarily mean that no entry was made by you at the time, as it is possible that any such entry had not successfully transferred from the old software. The Committee also had before it the patient's attendance history which recorded the appointment as having been cancelled. The evidence taken as a whole is insufficient to establish one way or other whether the appointment took place and, if so, whether you had made an entry in the records at the time.

Accordingly, the Committee found charge 9(a) not proved.

(l) You did not record an entry for the appointment on 9 July 2019;
Admitted and found proved

(m) You did not record an entry for the appointment on 22 July 2019;
Admitted and found proved

(n) You did not record an entry for the appointment on 18 October 2019;
Admitted and found proved

(o) You did not record an entry for the appointment on 8 November 2019;
Admitted and found proved

(p) You did not record an entry for the appointment on 28 November 2019;
Admitted and found proved

(q) You did not record an entry for the appointment on 9 January 2020;
Admitted and found proved

(r) You did not record an entry for the appointment on 28 January 2020;
Admitted and found proved

~~(s)~~ **WITHDRAWN**

~~(t)~~ **WITHDRAWN**

10. You failed to maintain appropriate standards of behaviour towards Patient 5, including by:

(d) Contacting Patient 5 on their personal mobile phone and asking them to join your new practice- Mydentist- Brockfield;

Not proved

Your account was that Patient 5 became distressed during an appointment when you told her you were going to leave and expressed a wish to follow you. You conceded that you spoke to Patient 5 on her personal mobile telephone about the new practice and that you were unsure who placed the call.

Patient 5 said that you of your own volition stated that you contacted her on numerous occasions to persuade her to follow you in order to conceal poor dentistry and that she had no wish to do so. She maintained that she felt uncomfortable with your communication and that you registered her with your new dental surgery without her involvement. The Committee considered that Patient 5's account cannot be reconciled with the content of the text messages in which Patient 5 said: "*Brilliant. Thank you. I will look out for the forms. If I do not get them I will register at Brock Street and book in with you anyway.*" Given the inconsistency, the Committee concluded that Patient 5's account was not reliable.

(e) Instructing Patient 5 to only book appointments with you at MyDentist- Brockfield;

Not proved

The Committee considered that the text message relating to this charge which states: "*no problem but you have to say you want to be with Samina Ali else they can book you with any dentist*" does not amount to an instruction to only book appointments with you. The Committee does not find Patient 5's account of telephone communication relating to this to be reliable given its earlier finding that the content of the text messages was inconsistent with Patient 5's account of the contact at this time.

(f) Informing Patient 5 that Silk Dental Practice was going to stop offering NHS care.

Not proved

The evidence offered by the GDC is Patient 5's account of what you said to her. There are no text messages to support this charge. The Committee noted Patient 5's evidence that the Subsequent Treating Dentist told her that you had told other patients Silk Dental Practice was going to stop offering NHS care. It further noted from the text messages that you initially told Patient 5 that the new practice could not accept her as an NHS patient. The Committee finds Patient 5's account is not sufficiently reliable to find this proved. Further, it considers that there may have been some misunderstanding about which practice was being discussed.

11. Your actions at Charge 7(d)(iii) were:

(a) Misleading, in that placing a Crown was not necessary to save UR4; and/or

Not proved

(b) Dishonest, in that you knew placing a Crown at UR4 was not necessary to save UR4.

Not proved

Charges 11(a) and (b) fell away in light of the Committee not finding the underlying actions at charge 7(d)(iii) proved.

Accordingly, the Committee found charges 11(a) and (b) not proved.

12. Your actions at Charge 10 (c) were misleading, in that Silk Dental Practice was continuing to offer NHS care.

Not proved

Charge 12 fell away in light of the Committee not finding the underlying actions at charge 10(c) proved.

Accordingly, the Committee found charge 12 not proved.

13. Your actions at Charge 10 (a), and/or (b), and/or (c) were dishonest, in that you intended to conceal that you had provided a poor standard of care to Patient 5.

Not proved

Charge 13 fell away in light of the Committee not finding the underlying actions at charges 10 (a), (b), and (c) proved.

Accordingly, the Committee found charge 13 not proved.

Patient 6

14. You failed to provide an adequate standard of care to Patient 6 (identified in Schedule B below) in that on or around 15 July 2019, you placed a crown at LL7 with a significant mesial ledge.

Admitted and found proved

15. You failed to maintain an adequate standard of record keeping in respect of Patient 6's appointments from 5 December 2014 to 24 November 2020, in that:

(a) You did not record an entry for the appointment on 21 June 2019;

Admitted and found proved

(b) You did not record an entry for the appointment on 19 July 2019;

Not proved

For the same reasoning given under charge 2(a) above, the Committee was not satisfied that the GDC had discharged its burden of proof in respect of charge 15(b). Whilst the appointment history records an appointment on 19 July 2019 it is not a reliable record of whether the patient had in fact attended. Further, the absence of any entry in the new software for the appointment does not necessarily mean that no entry was made by you at the time, as it is possible that any such entry had not successfully transferred from the old software. The evidence taken as a whole is insufficient to establish one way or other whether the appointment took place and, if so, whether you had made an entry in the records at the time.

Accordingly, the Committee found charge 15(b) not proved.

Patient 8

16. You failed to provide an adequate standard of care to Patient 8 (identified in Schedule B below) in that you failed to adequately restore the LL7 by removing caries between 9 November 2021 and 14 February 2022.

Not proved

The GDC's case in respect of this charge related to an entry in the clinical notes made by the Subsequent Treating Dentist which recorded "*All caries removed…*". It was on that basis that the GDC alleged that you had previously failed to remove caries at LL7 between 9 November 2021 and 14 February 2022. In oral evidence, the Subsequent Treating Dentist stated that he could not recall removing caries for the patient and conceded that the reference to "*All caries removed…*" might have been included in error through his use of a pro-forma template when making the clinical notes. If that were to be the case, then Mr Bateman confirmed that he would not have criticism of you and the GDC accordingly advanced no positive case in support of this charge.

Your evidence was that you had removed the caries at the earlier appointment on 9 November 2021.

The Committee determined that this charge is not proved given the concession made by the Subsequent Treating Dentist. There is no longer any reliable evidence to show that caries had remained untreated by you at the LL7.

Accordingly, the Committee found charge 16 not proved.

17. You failed to maintain an adequate standard of record keeping in respect of Patient 8's appointments from 7 July 2014 to 9 November 2021, in that you did not record an entry for the appointment on 30 August 2018.

Not proved

For the same reasoning given under charge 2(a) above, the Committee was not satisfied that the GDC had discharged its burden of proof in respect of charge 17. Whilst the appointment history records an appointment on 30 August 2018 it is not a reliable record of whether the patient had in fact attended. The absence of any entry in the new software for the appointment does not necessarily mean that no entry was made by you at the time, as it is possible that any such entry had not successfully transferred from the old software. The evidence taken as a whole is insufficient to establish one way or other whether the appointment took place and, if so, whether you had made an entry in the records at the time.

Accordingly, the Committee found charge 17 not proved.

Patient 9

18. You failed to provide an adequate standard of care to Patient 9 (identified in Schedule B below) from 8 May 2015 to 26 November 2021, including by:

(a) Not carrying out sufficient diagnostic assessment, in that:

iv. Your recorded basic periodontal examination ('BPE') scores did not adequately reflect the presence and/or severity of periodontal disease, between 13 January 2017 and 26 November 2021;

Admitted and found proved

v. You did not conduct detailed pocket charting between 13 January 2017 and 26 November 2021;

Admitted and found proved

vi. You failed to undertake sufficient periodontal care with root-surface debridement of pockets with adjunctive local anaesthetic, between 13 January 2017 and 26 November 2021.

Admitted and found proved

19. You failed to maintain an adequate standard of record keeping in respect of Patient 9's appointments from 8 May 2015 to 9 November 2021, in that you did not record an entry for the appointment on 23 September 2016.

    Not proved

    For the same reasoning given under charge 2(a) above, the Committee was not satisfied that the GDC had discharged its burden of proof in respect of charge 19. Whilst the appointment history records an appointment on 23 September 2016 it is not a reliable record of whether the patient had in fact attended. The absence of any entry in the new software for the appointment does not necessarily mean that no entry was made by you at the time, as it is possible that any such entry had not successfully transferred from the old software. The evidence taken as a whole is insufficient to establish one way or other whether the appointment took place and, if so, whether you had made an entry in the records at the time.

    Accordingly, the Committee found charge 19 not proved.

Patient 10

20. You failed to provide an adequate standard of care to Patient 10 (identified in Schedule B below) on or around 29 January 2020, in that you placed a crown at UL6 which was poorly fitted, with significant ledges present.

    Admitted and found proved

Patient 11

21. You failed to provide an adequate standard of care to Patient 11 (identified in Schedule B below) from 11 April 2018 to 16 March 2022, including by:

    (a) At UR2:

    i. Providing a poor standard of root canal treatment, in that the root canal filling was poorly obturated;

    Admitted and found proved

    ii. Not carrying out sufficient treatment planning, by placing a crown notwithstanding the poor standard of root canal treatment at that tooth.

    Admitted and found proved

    (b) At UR5:

    i. Providing a poor standard of filling care, in that you:

    a. Failed in the technical execution of a filling on 10 May 2019 by failing to adequately treat caries;

    Admitted and found proved

b. Failed in the technical execution of a filling on 10 May 2019 by placing a filling with an overhang;

Admitted and found proved

c. Failed in the technical execution of a filling on 14 January 2020 by placing a filling with an overhang.

Admitted and found proved

ii. Not carrying out sufficient treatment planning, by failing to replace the poor quality fillings at that tooth between 13 September 2021 and 16 March 2022.

Admitted and found proved

(c) At UL6:

i. Providing a poor standard of filling care, in that you:

c. Failed in the technical execution of a filling on 12 January 2021 by failing to adequately treat caries;

Admitted and found proved

d. Failed in the technical execution of a filling on 12 January 2021 in that you placed a filling with an overhang.

Admitted and found proved

ii. Not carrying out sufficient treatment planning, by failing to replace the poor quality filling at that tooth between 13 September 2021 and 16 March 2022.

Admitted and found proved

Patient 12

22. You failed to provide an adequate standard of care to Patient 12 (identified in Schedule B below) from 21 January 2021 to 1 March 2022, including by:

(a) Not carrying out sufficient diagnostic assessment on 21 January 2022 by failing to appropriately assess periapical pathology at UR5 as revealed by the radiograph from the same date

Admitted and found proved

(b) Not carrying out sufficient treatment planning, in that you:

iii. Failed to plan root canal treatment at UR5 on 21 January 2022;

Admitted and found proved

iv. In light of charge 22(b)(i), failed to provide Patient 12 with all treatment options, in that you did not offer root canal treatment at UR5 on 21 January 2022.

Admitted and found proved

23. Between 21 January 2022 and 22 June 2022, you caused or permitted one or more claims to be made in your name for Units of Dental Activity ('UDA') under the provisions of the National Health Service ('NHS') when the claimed treatment had not been carried out.

    Admitted and found proved

24. Your conduct at paragraph 23 was misleading, as the submitted claim indicated treatment had been undertaken when it had not.
    Admitted and found proved

25. In the alternative to paragraph 24, your conduct at paragraph 23 was dishonest, as you submitted a claim for treatment which you knew had not been undertaken.
    Not proved

    The underlying facts in relation to this charge were not in dispute. The issue for the Committee to decide was what your intention would have been and whether this would be regarded as dishonest by the standards of ordinary decent people.
    The claim in question was submitted by you in respect of a crown. You do not recall the claim but accept responsibility for it as it was submitted in your name. You were using relatively new software to submit the claim and ticked a box to declare that the treatment was completed. This was misleading as you had not yet fitted the crown and therefore had not completed the treatment for which you were claiming. Whilst the crown had been manufactured and an appointment scheduled for it to be fitted you had not at the time of submitting the claim completed the treatment.

    The GDC's case is that you were dishonestly submitting the claim early because you were struggling to recoup fees which were owing to you by your practice. However, the Committee concluded from the chronology and the evidence that this would have been inherently unlikely. The premature claim would only have resulted in a relatively modest financial payment to you and the chronology indicates that you were unaware at the time of any difficulty in recouping fees owed to you by your practice.

    In the Committee's judgment, the evidence does not show that you deliberately submitted the claim with the intention of being paid for work which you were not going to complete or being paid for the work earlier than you were entitled. It noted that an appointment for the crown fit had been made but was subsequently cancelled and you then left the practice. Your intention was to fit the crown and you had submitted the claim in anticipation of completing the treatment. The Committee accepted your evidence that you found the new software system confusing in terms of ticking boxes and submitting claims. The Committee accepted that you did not realise that you were positively declaring as part of the claim that the crown had already been fitted. Applying the test in *Ivey*, the Committee determined that your actions would not be regarded as dishonest by the standards of ordinary decent people. Whilst your claim was objectively misleading in that it was submitted prematurely, it was not intentionally misleading and it was not submitted with any intention of being paid for work which you were not going to complete.
    Accordingly, the Committee found charge 25 not proved.

Patient 13
26. You failed to provide an adequate standard of care to Patient 13 (identified in Schedule B below) from 4 October 2016 to 15 February 2022, including by:
(a) At UL6, you failed in the technical execution of a crown on or around 3 November 2021 as you failed to adequately treat caries prior to placing that crown; **Admitted and found proved**
(b) At UL7, you failed in the technical execution of a filling on or around 3 November 2021 as you failed to adequately treat caries prior to placing that filling. **Admitted and found proved**
Patient 14
27. You failed to provide an adequate standard of care to Patient 14 from 29 July 2019 to 2 August 2019, in that:
(a) At UL7:
v. On 2 August 2019, you failed to carry out sufficient diagnostic assessment by failing to expose a periapical radiograph to assess the restorability of the tooth and/ or prior to extraction of the tooth; **Admitted and found proved**
vi. On 2 August 2019, you failed to carry out sufficient diagnostic and/or risk assessment by failing to expose a radiograph following the occurrence of a tuberosity fracture to assess the extent of that fracture; **Admitted and found proved**
vii. On 2 August 2019, you failed to appropriately manage the tuberosity fracture by failing to refer the patient to a maxillofacial surgeon in a timely manner prior to your removal of the fractured portion of tuberosity maxilla; **Admitted and found proved**
viii. On 2 August 2019, you failed to advise Patient 14 about the risks and benefits of extraction at UL7:
(iii) Prior to extraction; and/or **Admitted and found proved**
(iv) Following the tuberosity fracture. **Admitted and found proved**
(b) At UL8:

iv. On 2 August 2019, you failed to carry out sufficient diagnostic assessment by failing to expose a radiograph to assess the restorability of the tooth and/ or prior to extraction of the tooth; **Admitted and found proved**
v. On 2 August 2019, you provided a poor standard of care by proceeding to extract this tooth notwithstanding the occurrence of a tuberosity fracture whilst attempting extraction at UL7; **Admitted and found proved**
vi. On 2 August 2019, you failed to advise Patient 14 about the risks and benefits of extraction at UL8. **Admitted and found proved**
28. You failed to maintain an adequate standard of record keeping as your records on 2 August 2019 were inaccurate, in that:
(a) You recorded that the patient was “in agony”, when this was not the case; **Admitted and found proved**
(b) You recorded that the patient had not slept in two nights due to the “intense pain” at UL7, when this was not the case; **Admitted and found proved**
(c) You recorded that the patient requested extraction at UL7 on that day, when this was not the case; **Admitted and found proved**
(d) You recorded that you advised extraction of UL8 prior to the commencement of the procedure, when this was not the case; **Admitted and found proved**
(e) You recorded that you were not able to take further x-rays due to the patient’s strong gag reflex and/or due to the patient saying the x-ray was making him feel sick, when this was not the case; **Admitted and found proved**
(f) You recorded that the patient “declined another attempt at taking PA xray of UL7”, when this was not the case; **Admitted and found proved**
(g) You recorded that you “Discussed with patient all options, elected to extract and then discussed implications and possible complications- including inability to extract/ tooth/root/tuberosity fracture, oro antral communication/ paresthesia/ dry socket”, when this information was not discussed. **Admitted and found proved**

29. By reason of your conduct alleged at Charge 27(a)(iv) and/or Charge 27(b)(iii), you failed to obtain informed consent for the treatment you provided to Patient 14's UL7 and/or UL8 on 2 August 2019. **Admitted and found proved**
30. Your actions at 28(a) to (g) above were misleading. **Admitted and found proved**
31. Your actions at 28(a) to (g) above were dishonest in that you intended to:
(a) Conceal that you had not conducted sufficient diagnostic assessment throughout the appointment; **Admitted and found proved**
(b) Conceal that you had not provided the patient with advice on the risks and benefits of extraction, before and/or after the fracture; **Admitted and found proved**
(c) Conceal that you had not provided the patient with one or more of the pieces of advice at particular 28(g); **Admitted and found proved**
(d) Provide justification for your clinical decision to extract UL7 and/or UL8. **Admitted and found proved**

9. We move to Stage Two.

STAGE TWO – 22 September 2025

10. You qualified overseas in 2002 and passed the statutory examination for registration with the GDC in 2008. Since 2010 you have worked in the United Kingdom as a General Dental Practitioner. You were employed at the Practice which is the subject of these proceedings from June 2014 until March 2022, providing mostly NHS dental care to patients.

11. In June 2021, the witness referred to in these proceedings as the "Subsequent Treating Dentist" purchased the Practice. In his role as the practice principal he came to identify failings in your clinical skills and record keeping which ultimately led to his decision to terminate your employment at the Practice. In May 2022, an audit was carried out at the Practice of a random sample of approximately 30 patients who had been treated by you. The audit identified issues in respect of your care and treatment 13 of those patients, which the Subsequent Treating Dentist then reported to the GDC.

12. In addition, a patient referred to in these proceedings as Patient 14, directly reported concerns to the GDC regarding the care and treatment you had provided to him.

13. The Committee's findings of fact encompass wide-ranging clinical and record keeping failings in respect of the 14 patients. There were a broad range of failings over a period of years that relate to basic aspects of dentistry. These include not treating caries, a poor standard of restorative work and failures in: record keeping; diagnostic assessments, including by not carrying out Basic Periodontal Examinations; radiography and treatment planning. There were also failures to discuss with patients their treatment options and the risks and benefits of proposed treatment.

14. Patient 14 had attended you on a total two occasions on 29 July 2019 and 2 August 2019 in relation to a toothache. The GDC expert, having reviewed Patient 14's clinical record, observed the following:

> "The Registrant examined Patient 14 for the first time on 29/07/19 for a consultation and they set out a plan to extract LL5 and place a filling at UL6 [UL7].
> The Registrant saw the patient on 02/08/19 when they attended with pain at the upper left-hand side.
> The Registrant extracted LL5 and UL78 on that occasion. There was a fracture of the maxillary (upper jaw) bone and UL7 and UL8 were removed with significant loss of bone and soft tissue. That left a large defect, and the patient was urgently referred to a local hospital thereafter.
> The portion of the upper jawbone that fractured was referred to as the tuberosity. That is the backmost portion on each side of the upper jaw (vide infra) behind the last standing tooth.
> The tuberosity is an important anatomical structure of bone that forms the floor and the side wall of the maxillary sinus (upper jaw natural air space).
> Thereafter the patient had significant hospital care with general anaesthetic to repair the defect and suffered from significant sequelae."

15. At the appointment on 2 August 2019 you performed an extraction of Patient 14's UL7 having failed to carry out any radiographic assessment of the tooth to assess its restorability and in any event to plan the extraction. You failed to manage the tuberosity fracture by failing to undertake any radiographic assessment of the extent of the fracture and by failing to refer the patient a maxillofacial surgeon in a timely manner prior to your removal of the fractured portion of tuberosity maxilla. You had failed to discuss with him the risks and benefits of extracting the UL7, both prior to the planned extraction and following the tuberosity fracture.

16. You extracted the UL8 despite not having discussed this first with the patient and having not informed him of the risks and benefits of the extraction. As with the UL7, you had not carried out any radiographic assessment of the tooth to assess its restorability and in any event to plan the extraction. You provided a poor standard of care by proceeding to extract the UL8 notwithstanding the occurrence of the tuberosity fracture.

17. Accordingly, you had failed to obtain Patient 14's informed consent to the extraction of both the UL7 and the UL8. You arranged for Patient 14 to attend hospital in relation to the fracture and wrote up his clinical notes approximately 1-2 hours after the appointment, in which you made the following inaccurate statements:

(a) You recorded that the patient was "in agony", when this was not the case;

(b) You recorded that the patient had not slept in two nights due to the "intense pain" at UL7, when this was not the case;

(c) You recorded that the patient requested extraction at UL7 on that day, when this was not the case;

(d) You recorded that you advised extraction of UL8 prior to the commencement of the procedure, when this was not the case;

(e) You recorded that you were not able to take further x-rays due to the patient's strong gag reflex and/or due to the patient saying the x-ray was making him feel sick, when this was not the case;

(f) You recorded that the patient "declined another attempt at taking PA xray of UL7", when this was not the case;

(g) You recorded that you "Discussed with patient all options, elected to extract and then discussed implications and possible complications- including inability to extract/ tooth/root/tuberosity fracture, oro antral communication/ paresthesia/ dry socket", when this information was not discussed.

19. These inaccurate entries were dishonestly made by you with the intention of: concealing that you had not conducted sufficient diagnostic assessment throughout the appointment; concealing that you had not provided the patient with advice on the risks and benefits of extraction, before and/or after the fracture; concealing that you had not provided the patient with one or more of the pieces of advice at particular 28(g); and providing justification for your clinical decision to extract UL7 and/or UL8.

Stage Two of the hearing

20. At this stage of the hearing the Committee shall decide whether the facts found proved amount to misconduct and, if so, whether your fitness to practise as a Dentist is currently impaired by reason of that misconduct. If the Committee were to find current impairment, it shall then decide on what action, if any, to take in respect of your registration.

21. The Committee received oral and written evidence from you on your reflection and remediation. The Committee also heard oral evidence from your Workplace Supervisor and from your current Practice Principal.

22. The Committee had regard to the submissions made by both Counsel.

23. Mr Smith, on behalf of the GDC, submitted that both your clinical failings and your dishonesty amount to misconduct and that your fitness to practise is currently impaired by reason of that misconduct. He submitted that the only appropriate outcome in this case is erasure, given the seriousness of your dishonesty.

24. Mr Rawlinson, on your behalf, submitted that your clinical failings do not amount to current impairment given the level remedial work you have undertaken whilst working under supervision. He did not make any submissions against a finding of misconduct and impairment in relation to your dishonesty and submitted that a period of suspension, rather than erasure, would be the appropriate outcome to mark the seriousness of your dishonesty.

25. The Committee accepted the advice of the Legal Adviser.

26. The Committee had regard to the *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016, last revised December 2020).

27. The Committee had regard to your fitness to practise history, which consists of a published warning from the Case Examiners in 2017 relating to clinical and record keeping failings.

Misconduct

28. Misconduct is a serious falling short of the standards reasonably expected of a dental professional. In assessing whether the facts found proved, or any of them, amount to misconduct the Committee had regard to the following principles from the GDC's *Standards for the Dental Team* (September 2013):

1.1.1- You must listen to your patient
1.2.2- You should take patients' preferences into account and be sensitive to their individual needs and values
1.2.3- You must treat patients with kindness and compassion
1.2.4- You should manage patients' dental pain and anxiety appropriately.
1.3.1- You must justify the trust that patients, the public and your colleagues place in you by always acting honestly and fairly in your dealings with them.

1.3.2- ‘You must make sure you do not bring the profession into disrepute.’
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...’
1.7.1 ‘You must always put your patients’ interests before any financial, personal or other gain’.
1.7.7- If you believe that patients might be at risk because of your health, behaviour or professional performance… you must take prompt and appropriate action.
2.2: recognise and promote patients’ rights to and responsibilities for making decisions about their health priorities and care
2.2.1- you must listen to patients and communicate effectively with them at a level they can understand. Before treatment starts you must:

> Explain the options (including those of delaying treatment or doing nothing) with the risks and benefits of each; and
>
> Give full information on the treatment you propose and the possible costs.

2.3- Give patients the information they need, in a way they can understand, so they can make informed decisions.
2.3.5- you should make sure that patients have enough information and enough time to ask questions and make a decision.
2.3.6- you must give patients a written treatment plan, or plans, before their treatment starts and you should retain a copy in their notes…
2.3.8- you should keep the treatment plan… under review during treatment. You must inform your patients immediately if the treatment plan changes and provide them with an updated version in writing.
3.1.1- You must make sure you have valid consent before starting any treatment or investigation. This applies whether you are the first member of your team to see the patient or whether you are involved after other team members have already seen them. Do not assume that someone else has obtained the patients consent.
3.1.2- You should document the discussions you have with patients in the process of gaining consent. Although a signature on a form is important in verifying that a patient has given consent, it is the discussions that take place with the patient that determine whether the consent is valid.
3.1.3- You should find out what your patients want to know as well as what you think they need to know. Things that patients might want to know include:

- options for treatment, the risks and the potential benefits;
- why you think a particular treatment is necessary and appropriate for them;
- the consequences, risks and benefits of the treatment you propose;
- the likely prognosis;
- your recommended option;
- the cost of the proposed treatment;
- what might happen if the proposed treatment is not carried out; and
- whether the treatment is guaranteed, how long it is guaranteed for and any exclusions that apply.

3.1.4- You must check and document that patients have understood the information you have given.
3.2- You must make sure that patients (or their representatives) understand the decisions they are being asked to make.
3.2.1- You must provide patients with sufficient information and give them a reasonable amount of time to consider that information in order to make a decision.
4.1- Make and keep contemporaneous, complete and accurate patient records.
4.1.1- You must make and keep complete and accurate patient records, including an up-to-date medical history, each time that you treat patients. Radiographs, consent forms, photographs, models audio or visual recordings of consultations, laboratory prescriptions,

statements of conformity and referral letters all form part of patients records where they are available.
4.1.2- You should record as much detail as possible about the discussions you have with your patients, including evidence that valid consent has been obtained. You should also include details of any particular patient's treatment needs where appropriate.
4.1.4- You must ensure that all documentation that records your work, including patient records, is clear, legible, accurate, and can be readily understood by others. You must also record the name or initials of the treating clinician.
7.1 'Provide good quality care based on current evidence and authoritative guidance.'
7.1.2 'If you deviate from established practice and guidance, you should record the reasons why and be able to justify your decision'.
9.1 'You must ensure that your conduct, both at work and in your personal life, justifies patients' trust in you and the public's trust in the dental profession'.

29. Both experts were in agreement that many of your failings fell far below the standard expected of a reasonably competent dental practitioner. In the Committee's judgement, your clinical and record keeping failings, often in relation to basic aspects of dentistry, were so widespread and frequent that they amounted to substantial breaches of the above standards. The Committee was satisfied that your clinical failings were so serious as to meet the threshold of misconduct.

30. As to your dishonesty, this is particularly serious. It was fundamental dishonesty in the course of your work as a Dentist, whereby you had breached the trust placed in you in order to conceal your own clinical failings when a serious complication arose during your treatment of Patient 14 which required him to be admitted to hospital. Your dishonesty was self-evidently a substantial breach of fundamental professional standards and clearly meets the threshold for misconduct.

Impairment

31. The next consideration for the Committee was whether your fitness to practise as a Dentist is currently impaired by reason of misconduct. In deciding the question of impairment, the Committee had regard to whether your misconduct is remediable, whether it had been remedied and the risk of repetition. The Committee also had regard to the wider public interest, which includes the need to uphold and declare appropriate standards of conduct and behaviour.

32. The Committee first considered the question of impairment in relation to your clinical and record keeping failings. On 31 August 2023 your registration was made subject to an order for interim conditional registration. The interim conditions (as extended by the High Court) remain in place pending the final outcome of this hearing and include conditions which require you to work under supervision and to maintain supervised logs of your work in relation to: Diagnosis; Treatment plans; Risks and benefits of treatment; Crownwork; bridgework; and Root Canal Treatment; Record keeping; BPEs; Periodontal disease; and Caries. The Committee heard evidence from your workplace supervisor who has supervised your work since September 2023. He spoke highly of the consistent steps you have taken with him over the past two years to reflect upon and remedy the clinical concerns which are the subject of these proceedings. In his written report for the Committee dated 12 September 2025, he stated: "It is my opinion as a dentist with 40 years' experience, having been an Educational Supervisor for 21 years that Dr Ali's fitness to practise is no longer impaired", an opinion which he maintained in his oral evidence.

33. The Committee also heard evidence from your current Practice Principal who spoke highly of your character and performance as a Dentist and expressed his confidence in support of your standard of work.

34. The Committee had regard to your detailed reflection and to your comprehensive Continuing Professional Development (CPD) record of targeted training and learning.

35. Having regard to all the evidence, in particular the evidence of your workplace supervisor, the Committee was satisfied that you have taken these proceedings extremely seriously and have consistently worked hard to address the clinical failings identified in these proceedings, all of which

you have admitted. You have been compelled to confront those failings head on with a self-critical eye. You have used the interim conditions on your registration to work hard to identify, deeply reflect upon and remedy your clinical failings with your workplace supervisor. In the Committee's judgment, you are now unlikely to repeat those clinical failings and therefore would not pose a risk to patients should you be allowed to resume unrestricted practice. In relation to the clinical and record keeping failures, the Committee determined that a finding of impairment is not necessary on public protection grounds and is not otherwise in the wider public interest, given your full admissions, reflection, remedial steps and the evidence given by both your Practice Principal and your workplace supervisor.

36. The Committee next considered whether your fitness to practise is currently impaired in relation to your dishonesty. The Committee considered that dishonesty is very difficult to remedy, as it goes to the question of character. The dishonesty in the present case was particularly serious, as it related to the falsification of clinical records in order to conceal your clinical failings in relation to a serious incident.

37. Your evidence was that you had acted out of panic in making the false clinical records. Mr Smith submitted that you would not have been in a state of panic, as, on your own admission, you made those false entries some 1-2 hours after the appointment. The Committee accepted that, although there had been that delay, there was a degree of panic in your decision making.

38. More relevant, in the Committee's view, was whether your dishonesty can be properly described as isolated and out of character. There is no evidence before the Committee of any other dishonesty and you put before the Committee numerous testimonials from patients and colleagues, aware of the allegations against you, who spoke highly of your character and your caring nature as a Dentist. The Committee accepted that you are a practitioner who is essentially of good character. Whilst you have a fitness to practise history in the form of a published warning from the Case Examiners, that warning relates to clinical and record keeping failings only, where you were maintaining incomplete records. There was no suggestion that the record keeping failings on that occasion were the result of dishonesty.

39. The Committee also concluded that your dishonesty was in effect a single isolated incident because it related to a single patient on a single occasion. It was extremely serious and is wholly unacceptable but there is no evidence before the Committee of any other dishonesty.

40. The Committee found from your oral evidence that you are genuinely remorseful for your action and that you are thoroughly ashamed of yourself. You had not sought to minimise your dishonesty or downplay its seriousness. You have demonstrated insight into the impact of your actions on Patient 14 and on public confidence in dental professionals. The Committee was reassured from your evidence that you would not act in the same way again. The Committee considered that you have full insight into your dishonesty. Having considered all the circumstances, the Committee considered that your actions were not a result of a fundamental and deep-seated character trait but were an instance of very poor decision making which you are unlikely to repeat because of your genuine and significant reflection since the events. The Committee therefore concluded the risk of repetition is low.

41. As the Committee has found the risk of repetition to be low, it follows that your fitness to practise is not impaired on public protection grounds. However, it is clearly impaired in the wider public interest, namely maintaining public confidence and upholding proper professional standards. Members of the public trust dental professionals to be candid and own up to their clinical failings rather than resort to dishonestly fabricating clinical records to conceal them. By acting dishonestly you had breached a fundamental tenet of the profession and public confidence in the profession and in this regulatory process would be seriously undermined if no finding of impairment were to be made.

42. Accordingly, the Committee determined that your fitness to practise as a Dentist is currently impaired on wider public interest grounds by reason of your misconduct. A finding of impairment is

necessary to mark the seriousness of your dishonesty and maintain public confidence in dental professionals and reaffirm professional standards.

Sanction

43. The next consideration for the Committee was what action, if any, to take in respect of your registration. The purpose of a sanction is not to be punitive, although it may have that effect, but to protect the public and to maintain wider public confidence in the profession and its regulation.

44. In deciding on sanction, the Committee had regard to the aggravating and mitigating features present in this case. The aggravating features include dishonesty, breach of trust and attempts to cover up wrongdoing. In mitigation, the Committee recognised that you are genuinely remorseful and that you show good insight. Your dishonesty was a single isolated event which you have deeply reflected upon and which you have fully admitted along with all the other clinical failings which were found proved by the Committee.

45. The Committee also had regard to the positive testimonials in support of your character.

46. The Committee considered sanction in ascending order of severity.

47. To conclude this case with no further action or a reprimand would be wholly inappropriate given the seriousness of your dishonestly. Likewise, no conditions of practice could be formulated which would adequately address the nature of your dishonesty and its seriousness.

48. The Committee considered whether to direct that your registration be suspended for a period of up to 12 months, with or without a review would be sufficient to mark the seriousness of the dishonesty in this case. You put your own interests before those of your patient and chose to fabricate clinical records to cover up clinical failings. The Committee did not consider that a short suspension could adequately mark your misconduct. In assessing the sufficiency of a period of suspension the Committee also had regard to the ultimate sanction of erasure. This was a matter over which the Committee deliberated at considerable length. The dishonesty here is particularly serious and the Committee gave very careful consideration to whether to direct erasure.

49. Throughout its deliberations, the Committee's primary consideration was the overarching objective and the public interest. Your dishonesty, although particularly serious, was a single isolated event which is unlikely to be repeated. You are genuinely remorseful and ashamed. You made full admissions to your dishonesty and did not seek to downplay its seriousness or to shift blame. You are now an otherwise competent clinician who, on the testimonial evidence, is a caring practitioner who is highly committed to her patients. The Committee bore in mind the public interest in maintaining an otherwise competent clinician in practice.

50. The Committee noted the straightforward terms of Patient 14's witness statement, in which he stated that he wished for you to be held to account for what happened to him and the dishonest entries you made but that he would not want you to lose your job over it.

51. In light of the factors identified above, the Committee did not consider that your misconduct was fundamentally incompatible with remaining on the Register. In all the circumstances, the Committee concluded that a period of suspension would be sufficient to mark the seriousness of your misconduct and to maintain public confidence in the profession. The Committee concluded that erasure would be disproportionate in all the circumstances.

52. Accordingly, the Committee directs that your registration be suspended for a period of 12 months. In deciding this period, the Committee noted the submissions of Mr Rawlinson that you might become deskilled by a longer period of suspension but considered that this maximum period of suspension which can be directed is necessary in order to mark the seriousness of your dishonesty.

53. The Committee considered whether it was necessary to direct a review of your suspension

order. In light of its findings that you are impaired only in relation to public confidence and professional standards in respect of the dishonesty, and that you have full insight into it, such that the risk of repetition is low, the Committee concluded that a review hearing is not required in these circumstances.

54. The Committee now invites submissions on the question of an immediate order.

The interim order on your registration is hereby revoked.

Mr Smith, on behalf of the GDC, submitted that an immediate order under section 31(1) of the Dentists Act 1984 is not sought by the Council given that the Committee's finding of impairment is on wider public interest grounds alone.

Mr Rawlinson, on your behalf, submitted that no immediate order should be made. He submitted that public confidence in the profession would not be undermined should the Committee allow you a brief period of continued practice to enable you to make arrangements for the continuity of care of your patients pending the 12-month period of suspension taking effect.

The Committee accepted the advice of the Legal Adviser on its power to make an immediate order.

The Committee determined that an immediate order is not necessary for the protection of the public, otherwise in the public interest or in your own interests. The Committee's finding of impairment engages only the wider public interest. There are no public protection concerns which would necessitate an immediate order. Wider public confidence in the profession would not, in the Committee's judgment, require an immediate order to be made pending the taking effect of the substantive period of suspension in light of the Committee's findings at the substantive stage. Moreover, the immediate suspension of your registration would interfere with the continuity of care for your current patients whose treatment needs to be completed and/or transferred to another practitioner.

Accordingly, no immediate order is made.

That concludes this determination.