PUBLIC HEARING

Professional Conduct Committee
Initial Hearing

15 to 25 September 2025

Name:	SEDDON, Ian Richard
Registration number:	64868
Case number:	CAS-208808-C3V8W6

General Dental Council:	Christopher Saad, Counsel Instructed by Saba Khan, IHLPS
Registrant:	Present Represented by Scott Ivill, Counsel Instructed by Ayaz Khoda, Clyde and Co.

Fitness to practise:	Impaired by reason of misconduct
Outcome:	Fitness to Practise Impaired. Reprimand Issued

Committee members:	Chris Weigh (Chair, Lay Member) Nicola Jordan (Dentist Member) Samantha Vowles (Dental Care Professional Member)
Legal Adviser:	Peter Jennings
Committee Secretary:	Lola Bird

The charge (as amended)

Ian Richard SEDDON, a dentist, BDS University of Manchester 1989, is summoned to appear before the Professional Conduct Committee on 15 September 2025 for an inquiry into the following charge:

"That being registered as a dentist:

1. *You failed to provide an adequate standard of care to Patient A from 03 August 2022 to 02 December 2022 by:*
    a) *not conducting an adequate periodontal assessment before preparing the teeth for veneers; and/or*
    b) *not discussing the full risks and benefits of the proposed treatment before preparing the teeth for veneers; and/or*
    c) *not taking bitewing radiographs on 3rd August 2022; and/or*
    d) *not taking periapical radiographs of the teeth veneers were to be put on before preparing the teeth for veneers.*
2. *By virtue of your conduct at allegation 1 (a) and/or 1 (b) and/or 1 (c) and/or 1(d), you failed to obtain Patient A's informed consent.*
3. *You failed to maintain an adequate standard of record keeping in respect of Patient A's appointments from 03 August 2022 to 02 December 2022 by:*
    a) *not completing a clinical record of the appointment that took place on 8th August 2022; and/or*
    b) *not completing a clinical record of the appointment that took place on 15th September 2022; and/or*
    c) *not customising the template record in relation to an appointment that took place on 12th October 2022.*
4. *WITHDRAWN:*
    i) *WITHDRAWN*
    ii) *WITHDRAWN.*
5. *WITHDRAWN:*
    a) *WITHDRAWN*
    b) *WITHDRAWN.*
6. *You failed to obtain informed consent for treatment provided to Patient A in relation to the patient's UL5 and UR5.*
7. *WITHDRAWN;*
    a) *WITHDRAWN.*
8. *WITHDRAWN;*
    a) *WITHDRAWN*
    b) *WITHDRAWN.*

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

Mr Seddon,

1. This is a Professional Conduct Committee hearing in relation to a charge brought against you by the General Dental Council (GDC). The charge relates to your treatment of one patient, Patient A, from 3 August 2022 to 2 December 2022, whilst working at a dental practice ('the Practice').

2. The hearing commenced on Monday, 15 September 2025, with the fact-finding stage of the hearing (Stage One) having taken place in person at the Dental Professionals Hearings Service. The remainder of the hearing is being conducted remotely with all parties attending by Microsoft Teams video-link.

3. You are represented at these proceedings by Mr Scott Ivill, Counsel. The Case Presenter for the GDC is Mr Christopher Saad, Counsel.

Decision on application to amend the charge – 15 September 2025

4. At the outset of the hearing, Mr Saad made an application to amend the charge, pursuant to Rule 18 of the *GDC (Fitness to Practise) Rules Order of Council 2006*. He first applied to change the original dates that were set out at heads of charge 1(c) and 3(b).

5. In relation to head of charge 1(c), Mr Saad applied to change the date from '3rd October 2022' to '3rd August 2022'. He asked the Committee to note the information in the clinical records, which indicated that Patient A's initial appointment with you was on 3 August 2022. Mr Saad stated that it was at that initial appointment that the GDC maintained that bitewing radiographs should have been taken, and therefore 3 August 2022 is the relevant date.

6. With regard to head of charge 3(b), Mr Saad applied to change the date from '15th August 2022' to '15th September 2022'. He drew the Committee's attention to entries in the Practice's records, which indicated that Patient A attended for an appointment on 15 September 2022 and not 15 August 2022 as originally stated.

7. Mr Saad next applied to withdraw heads of charge 4, 5, 7 and 8 in their entirety. In doing so, he explained the GDC's decision to request the withdrawals.

8. Mr Saad first addressed the Committee in respect of heads of charge 4 and 5. Head of charge 4 alleged that you maintained non-contemporaneous records in respect of two of Patient A's appointments, one on 19 October 2022 and the other on 2 November 2022. It was alleged at head of charge 5 that your conduct in maintaining those non-contemporaneous records was misleading and dishonest.

9. With regard to the first of the appointments in question, 19 October 2022, Mr Saad referred the Committee to the witness statement of Witness 1, dated 11 August 2025. At the material time, Witness 1, a qualified dental nurse, was employed at the Practice as a Practice Manager. Mr Saad outlined Witness 1's written evidence that she recalled that Patient A attended the Practice for an

appointment on 19 October 2022. Witness 1 also recalled taking a note of a discussion she said you had with Patient A in the Practice's reception waiting area, including in relation to the proposed treatment. Witness 1 stated in her witness statement that *"I think the reason the discussion was taking place in the reception area is because the surgery was still being setup and the patient was anxious…there were no other patients in attendance that day".*

10. Witness 1 exhibited with her witness statement a copy of her handwritten note, which she said was taken contemporaneously at the time of that discussion on 19 October 2022. Witness 1 stated that she recalled giving her handwritten note to the dental nurse who was assisting you that day, to scan and upload it onto the dental system when preparing the notes of Patient A's treatment. Witness 1's evidence was that when she was reviewing the records on the dental system as part of the request for the clinical records for this case, she noticed that the handwritten note had not been uploaded to Patient A's records on the system but had been kept in a filing cabinet.

11. In relation to 2 November 2022, which was the other date mentioned within head of charge 4, Mr Saad drew the Committee's attention to the clinical records indicating that Patient A had attended for a review appointment on that day. Mr Saad asked the Committee to note that those clinical records referred to Patient A's intention to contact the Practice the next day (3 November 2022) in relation to which treatment option she would prefer. A further clinical note was made on 3 November 2022 indicating that Patient A had emailed the Practice to confirm a treatment option.

12. Mr Saad told the Committee that the two expert witnesses in this case, Mr Edward Bateman, instructed by the GDC and Mr David Kramer instructed on your behalf, were no longer critical in relation to the matters alleged at head of charge 4, having jointly considered the available evidence indicating that there are contemporaneous notes in respect of the two appointments. Therefore, it was the position of the GDC that there was no longer a realistic prospect of proving head of charge 4, and consequently head of charge 5, to the requisite standard. Accordingly, Mr Saad's application was that heads of charge 4 and 5 should be withdrawn in their entirety.

13. Mr Saad next addressed the proposed withdrawal of heads of charge 7 and 8. Head of charge 7 alleged that you amended records retrospectively in respect of Patient A's appointment on 19 October 2022 by amending the records to state that UL5 to UR5 were to be prepared for veneers rather than UL4 to UR4, as agreed by Patient A. It was alleged at head of charge 8 that your actions in this regard were misleading and dishonest.

14. In respect of head of charge 7, Mr Saad submitted that, whilst on the face of it, different teeth were initially referred to in the records, it could be considered that any difference was due to a typographical error rather than anything cynical. He highlighted that the treatment provided to Patient A was from UL5 to UR5. It was Mr Saad's submission, taking into account the cogency of evidence required to support an allegation of dishonesty, that there was no longer a realistic prospect of proving head of charge 7, and consequently head of charge 8, to the requisite standard. He therefore requested that both heads of charge be withdrawn in their entirety.

15. Mr Ivill raised no objection to the proposed amendments to heads of charge 1(c) and 3(b) or to the proposed withdrawals of heads of charge 4, 5, 7 and 8.

16. In reaching its decision on the application, the Committee accepted the advice of the Legal Adviser, who referred to the relevant factors to be considered, as set out in Rule 18.

17. Having taken into account the merits of the case and the fairness of the proceedings, the Committee acceded to Mr Saad's application. It was satisfied that the proposed amendments to heads of charge 1(c) and 3(b), and the withdrawal of heads of charge 4, 5, 7 and 8, in their entirety, could be made without causing any injustice.

18. The charge was amended accordingly.

Admissions to the charge – 15 September 2025

19. The Committee next heard your admissions to the amended charge. Mr Ivill told the Committee that you admitted heads of charge 1(a), 1(c) (as amended), 3 (in its entirety) and 6.

20. The Committee noted the confirmation provided on your behalf that in admitting heads of charge 1(a) and 1(c), you were also admitting the stem at head of charge 1, namely that because of your omissions at 1(a) and 1(c), you failed to provide an adequate standard of care to Patient A.

21. The Committee was satisfied that your admissions were clear and unequivocal. It took into account that you are legally represented at this hearing, and it noted the confirmation that you understood the basis of your admissions. In all the circumstances, the Committee was content to accept your admissions and the matters alleged at heads of charge 1(a), 1(c), 3 (in its entirety) and 6 were announced as 'Admitted and found proved'.

Summary of the GDC's opening submissions

22. Mr Saad outlined the background to the allegations with reference to the evidence relied upon by the GDC. He stated that this case relates to cosmetic dental work that you carried out for Patient A in 2022. The Committee heard that two of the patient's appointments were undertaken at one branch of the Practice, whilst the remaining appointments took place at another branch.

23. In her witness statement provided for this hearing, Patient A described her oral health prior to seeing you as good but she had issues with five veneers that were previously done in 2011, and they needed to be replaced. The five existing veneers were on Patient A's upper front teeth. Patient A had also had veneers previously on these teeth: the 2011 veneers were her second set.

24. Patient A's initial appointment with you was on 3 August 2022. The patient's evidence was that at that appointment you asked her to smile, so you could look at her teeth. You recommended that eight of her top middle teeth should have veneers, as those were the teeth visible when she smiled. This included the replacement of the five previously placed veneers. Patient A agreed to that proposal, and she signed consent forms for GDPR, new patient and medical history and photography. Patient A stated that you did not carry out any investigations at that initial appointment, such as x-rays or images. She said that she explained to you that she has a phobia for dental work and preferred dental treatments to be done under sedation.

25. Patient A's second appointment was on 8 August 2022. This was for a hygiene appointment, with the treatment due to be undertaken under sedation. However, the sedation did not work on that occasion and the hygiene treatment could not go ahead. Patient A next attended the Practice on 15 September 2022, when hygiene treatment was undertaken under sedation in the presence of a sedation specialist. Patient A stated in her witness statement that this appointment went well. She attended a further appointment at the Practice on 12 October 2022 for the whitening of her teeth.

26. The next appointment Patient A attended with you was on 19 October 2022, again in the presence of the sedation specialist. The purpose of that appointment was to remove the five previously placed veneers and to prepare Patient A's teeth for the new veneers, all under sedation. Patient A's evidence was that when she had returned home following this appointment, she received a telephone call from the receptionist at the Practice, who explained that Patient A had been incorrectly charged for eight veneers instead of 10. Patient A said that she confirmed to the receptionist that only eight veneers were to be done. However, Patient A stated that she was able to feel in her mouth that 10 of her teeth had been prepared.

27. On 27 October 2022, Patient A sought a second opinion from a dentist at another dental practice who confirmed that 10 teeth had been prepared for veneers.

28. Patient A attended an appointment with you on 2 November 2022, at which you were said to have apologised for the two extra teeth having been prepared in error (UR5 and UL5). Patient A stated that you offered her the following three treatment options with no additional cost:

1. Polishing the two extra teeth, so that they were as smooth as the other teeth;
2. Applying a protective paint on the two extra teeth;
3. Placing veneers for the two extra teeth.

29. Patient A opted to have veneers placed on the two extra teeth.

30. The 10 veneers were placed on the relevant teeth under sedation at an appointment on 2 December 2022. Patient A had no complaints about the standard of the cosmetic work you provided.

31. The GDC's case relates to your alleged failure to provide Patient A with an adequate standard of care in other respects, some of which you have admitted. There are also the allegations relating to a failure to obtain informed consent for the treatment you provided to Patient A. In support of these alleged matters, the GDC relies upon the expert evidence of Mr Bateman.

32. With regard to the issue of informed consent, the Committee noted that the GDC's case, and your admission to head of charge 6, which relates specifically to the two extra teeth, UR5 and UL5, is that you did not discuss the relevant pricing of these teeth with the patient.

Evidence

33. The Committee received documentary and oral evidence. The factual evidence presented by the GDC was the witness statement of Patient A dated 7 March 2025, along with associated exhibits,

including her clinical records from the Practice. In addition, the Committee heard oral evidence from Patient A in relation to the factual matters in this case.

34. The Committee received an expert report prepared by Mr Bateman dated 9 March 2025. He also gave oral evidence to the Committee.

35. In relation to your defence case, the Committee received your main witness statement dated 13 August 2025, and two supplementary witness statements dated 15 August 2025 and 9 September 2025, along with associated exhibits. The Committee also heard oral evidence from you in relation to the alleged facts.

36. The Committee was further provided with the witness statement of Witness 1 dated 11 August 2025. As previously mentioned, Witness 1 was a Practice Manager at the Practice at the material time. Neither the Committee nor the parties had any questions of Witness 1 and so she was not required to give oral evidence.

37. By way of expert evidence on your behalf, the Committee received an expert report dated 9 September 2025 from Mr Kramer. It also heard oral evidence from Mr Kramer.

38. Also before the Committee was a joint expert report prepared by Mr Bateman and Mr Kramer dated 11 September 2025.

FINDINGS OF FACT – 22 September 2025

39. The Committee considered all the evidence presented to it, both oral and documentary. It took account of the closing submissions made by Mr Saad and Mr Ivill in relation to the alleged facts. The Committee accepted the advice of the Legal Adviser, who advised the Committee on legal matters relevant to its fact-finding task, including the burden and standard of proof.

40. The Committee considered each of the outstanding heads of charge separately, bearing in mind that the burden of proof rests with the GDC, and that the standard of proof is the civil standard, that is, whether the alleged matters are proved on the balance of probabilities.

41. For completeness, the following findings made by the Committee include those matters admitted and found proved at the beginning of the hearing:

1 (a).	*You failed to provide an adequate standard of care to Patient A from 03 August 2022 to 02 December 2022 by:* *not conducting an adequate periodontal assessment before preparing the teeth for veneers; and/or* **Admitted and found proved.**
1(b).	*You failed to provide an adequate standard of care to Patient A from 03 August 2022 to 02 December 2022 by:*

not discussing the full risks and benefits of the proposed treatment before preparing the teeth for veneers; and/or

Found proved.

Patient A stated in her oral evidence that she could not recall whether you discussed the risks and benefits of the proposed treatment with her, and there is very limited detail of such a discussion in the clinical records. The Committee noted that it has been accepted that the clinical records are deficient in this regard.

You stated in your witness statement that you discussed the risks and benefits of the proposed treatment with Patient A as part of her initial appointment on 3 August 2022. You told the Committee in your oral evidence that in terms of the benefit, you explained to Patient A that the proposed treatment would make her smile better. The Committee noted your evidence that you explained to Patient A that you would normally complete an even number of veneers *"to maintain symmetry and produce a cosmetically balanced look"*. It also noted the indication in the clinical records for 3 August 2022 that it was explained to Patient A that *"we normally do 2/4/6".*

The Committee took into account that both experts agreed that the only benefit to the proposed treatment was the aesthetic element.

In relation to any risks associated with the proposed treatment, you said that you told Patient A that veneer treatment is irreversible and that the veneers would require replacement in time. You stated that you considered that these were the only risks that were relevant to Patient A's treatment, and therefore they were the only ones you discussed with her.

It was Mr Kramer's opinion that there were no other reasonable risks that should have been mentioned to the patient other than those you explained to her. Mr Kramer stated in his oral evidence that the provision of veneers is a minimally invasive treatment. It was his view that, with minimal preparation of teeth, the risks associated with veneer treatment are minimal. In the circumstances, Mr Kramer considered the discussion you said you had with Patient A about the risks and benefits of the proposed treatment was sufficient.

Mr Bateman's oral evidence was that there are additional risks associated with the provision of veneers, which should have been discussed with Patient A. He outlined these additional risks in his report stating that, *"The main risks involved in this treatment would be damage to the teeth during preparation, which can result in sensitivity, pain and nerve damage to the tooth, and can ultimately need root canal treatment or extraction of the tooth if this occurs. There is also risk of failure of veneers by them fracturing or falling off."*

In addition, the Committee noted your admission in respect of head of charge 1(a) that you did not conduct an adequate periodontal assessment before preparing the teeth for veneers. The Committee took account of the expert evidence that following the recording of BPE scores of 3 for Patient A, further diagnostic assessment was indicated. Mr Bateman drew the Committee's attention to guidance from the Faculty of General Dental Practice (UK) (FGDP) on Clinical Examination and Record Keeping, which advises that for code 3, initial therapy

	including self-care advice, then post initial therapy a six-point pocket chart, should have been recorded. Mr Kramer also gave the opinion that in addition to the hygiene treatment that was carried out for Patient A, *"…detailed periodontal pocket probing depths should have been recorded".* You did not carry out six-point pocket charting for Patient A. Both experts agreed that a failure to monitor a patient's periodontal condition could risk deterioration of the condition. The Committee noted Mr Kramer's oral evidence that the fitting of the veneers did not preclude Patient A undergoing periodontal treatment in future. However, the Committee noted the evidence of Mr Bateman that *"…Failure to monitor ongoing periodontal condition could result in the periodontal condition worsening which can lead to bone loss, mobility, and eventually tooth loss, although this tends to happen over an extended period of time. It should have been ascertained that the periodontal condition was healthy before fabricating new veneers, as periodontal healing tends to result in recession of the gums, which could have a negative impact on the aesthetics on the new veneers provided".* Having taken account of the evidence, the Committee reached its view on whether you had discussed the full risks and benefits of the proposed treatment with Patient A. With regard to the benefit of the proposed treatment, the Committee noted that Patient A came to you with an aesthetic complaint and the Committee was satisfied on the evidence that you explained, and she understood, that the proposed treatment would improve her smile. It took into account that both experts agreed this was the only benefit. The Committee therefore considered that you adequately discussed the benefit of the proposed veneer treatment with Patient A. In relation to your discussion with Patient A about the risks of the proposed treatment, the Committee preferred the evidence of Mr Bateman. It took into account the inherent risk of the procedure to be undertaken, which included the preparation of the patient's teeth with a high-speed rotating handpiece. The use of such equipment is not without risk, and in the Committee's view, you should have discussed with Patient A the possibility of tooth damage during preparation, and that such damage could result in sensitivity, pain and nerve damage to the tooth, as outlined by Mr Bateman. The Committee noted Mr Kramer's comment that a dentist would not want to appear to be telling a patient that they could be getting things wrong. However, accidents can happen in dentistry, and the Committee considered that a reasonable person in Patient A's position would be likely to attach significance to the risk of tooth damage and its potentially long-term effects. The Committee also took into account that Mr Kramer's opinion regarding the risks of the proposed treatment being minimal was based on there being minimal preparation of the teeth. Patient A was a patient who had veneers provided on two previous occasions, and the clinical records for her initial appointment with you indicated that in certain areas her teeth were down to the dentine. The Committee accepted the evidence of Mr Bateman that the risk of nerve damage was increased in Patient A's circumstances, and it considered this risk particularly relevant to any discussion about her treatment.

	Taking account of Mr Bateman's opinion, the Committee also considered that you should have discussed with Patient A the issues that could arise if she needed periodontal treatment in future, given that periodontal healing tends to result in gum recession which would have impacted on the aesthetics of the new veneers. The Committee further considered that you should have discussed with the patient more specific risks of veneer failure (in addition to the fact that they would need replacing eventually), such as fracture or loss. In the Committee's view, given the considerable cost of the proposed treatment, at £750 per tooth, any potential problems with aesthetics and/or the risk of failure were risks to which a reasonable person in Patient A's position would be likely to attach significance. Whilst the Committee took into account that Patient A had previously had veneer treatment, it noted that both experts agreed that the risks and benefits of the treatment needed to be reiterated when Patient A came to see you, although they differed in their opinion as to the risks to be discussed. Having considered all the evidence, the Committee was satisfied that you did not have a full discussion with Patient A regarding the risks of the proposed treatment before preparing the teeth for veneers. On your own account you only addressed with the patient the irreversible nature of the treatment and the need to replace the veneers in time. In preferring the evidence of Mr Bateman, the Committee concluded that you ought to have discussed with Patient A the risks of the proposed treatment that he outlined, so that she was aware of all the possible adverse outcomes and consequences. In light of the fact that you did not do this, the Committee found on the balance of probabilities that you failed to provide Patient A with an adequate standard of care in this regard.
1(c).	*You failed to provide an adequate standard of care to Patient A from 03 August 2022 to 02 December 2022 by:* *not taking bitewing radiographs on 3rd August 2022; and/or* **Admitted and found proved (as amended).**
1(d).	*You failed to provide an adequate standard of care to Patient A from 03 August 2022 to 02 December 2022 by:* *not taking periapical radiographs of the teeth veneers were to be put on before preparing the teeth for veneers.* **Found not proved.** The Committee took account of the relevant guidelines on radiography drawn to its attention. It noted that statutory regulations require that radiographs should only be taken when clinically justified. The Committee understood from Mr Bateman's evidence that he considered that periapical radiographs of Patient A should have been taken for two reasons. Firstly, as part of your assessment of the patient's periodontal health following the

	recording of BPE scores of 3. Mr Bateman stated in his report that *"When BPE of 3 or 4 is recorded at a site in the mouth, FGDP Clinical Examination and Record Keeping advises that a more detailed periodontal charting is required. The guidance advises that for code 3 initial therapy including self-care advice, then post initial therapy a six point pocket chart should have been recorded. In addition it is advised that radiographs should be taken for all code 3 and 4 sextants"*. Secondly, Mr Bateman stated that periapical radiographs were indicated for the teeth on which the veneers were to be placed, so as *"to assess the apical health and bone levels in order to inform prognosis and treatment options"*. In this regard, Mr Bateman relied upon the 'FGDP Standards in Dentistry 2018 – Guidance on indirect restorations' You stated in your witness statement that you did not take periapical radiographs before preparing the relevant teeth for veneers, given that there were no signs or symptoms of pathology associated with those teeth. You stated in your oral evidence that you considered Patient A to have good oral health with no reported problems. You also highlighted that Patient A was an anxious patient with a phobia of dentistry and that this factor also informed your decision not to take periapical radiographs, given your clinical judgement that such radiographs were unlikely to yield any additional diagnostic information. It was further noted that a dentist who had seen Patient A for a second opinion had not raised any issues in respect of the teeth to be treated. Mr Kramer stated in his report that *"It is my opinion that in the absence of any signs or symptoms of pathology associated with the teeth it was proposed to prepare for veneers, there was no indication for peri-apical radiographs to be taken. This is because if the teeth did develop periapical or periodontal pathology subsequently, they could be treated without disturbing the veneers provided. It is my opinion, therefore, that the standard of care was satisfactory in this regard"*. Mr Kramer maintained this position in his oral evidence. In reaching its decision, the Committee was mindful not to apply what might be regarded as the 'gold standard'. It considered what a reasonably competent practitioner may have done in the circumstances of Patient A's treatment. The Committee noted that the FGDP guidance on Clinical Examination and Record Keeping, referred to by Mr Bateman, recommends further periodontal assessment with BPE scores of 3, including six-point pocket charting. This guidance also states that radiographs should be taken with BPE scores of 3 and 4. However, it is stated that *"The type of radiograph used is a matter of clinical judgement but crestal bone levels should be visible. The periapical view is regarded as the gold standard".* Further guidance was also drawn to the Committee's attention by Mr Kramer from the FGDP Selection Criteria for Dental Radiography. In particular, that *"If a patient has generalised pocketing of 4 – 5 mm (BPE scores maximum Code 3 in any sextant) and little or no recession, horizontal bitewings are recommended. These may be supplemented by intraoral periapicals for selected anterior teeth, but only if this is likely to change management of the patient."* You admitted, as set out at head of charge 1(c) above, that you did not take bitewing radiographs of Patient A at the initial appointment on 3 August 2022, and that this was a failure on your part. The Committee noted that the question of

	whether periapical radiographs should also have been taken is a separate issue, and according to the guidance documents brought to its attention, is a matter of clinical judgement in the context of periodontal assessment. The Committee considered that it would be open to dentists following the guidance to take different views as to whether they considered periapical radiographs are required with BPE scores of 3. Indeed, the Committee noted the differing clinical opinions between the two expert witnesses, as well as your own clinical justifications for not taking periapical radiographs of Patient A. In relation to the distinct matter of whether you should have taken periapical radiographs to assess the apical health and bone levels prior to preparing the relevant teeth for veneers, the Committee had regard to the 'FGDP Standards in Dentistry 2018 – Guidance on indirect restorations' referred to in Mr Bateman's report. Whilst the Committee noted the need to take appropriate radiographs to assess and plan the restoration, it was not satisfied that it was demonstrated in evidence that periapical radiographs were mandated for Patient A as opposed to recommended. In the absence of any guidance indicating that you had a duty to take periapical radiographs of the teeth on which the veneers were to be placed before preparing those teeth, the Committee found this head of charge not proved. It considered that your decision not to take periapical radiographs, for the reasons you outlined, was a clinical judgment that a reasonably competent dentist could make based on the relevant guidance. Therefore, in this instance, you did not fail to provide Patient A with an adequate standard of care.
2.	*By virtue of your conduct at allegation 1 (a) and/or 1 (b) and/or 1 (c) and/or 1(d), you failed to obtain Patient A's informed consent.* **Found proved in relation to 1(a), 1(b) and 1(c).** As the Committee found head of charge 1(d) not proved, it only considered head of charge 2 in respect of 1(a), 1(b) and 1(c). It found all these matters proved. In reaching its decisions, the Committee took into account that 'informed consent' is different from merely consenting to dental treatment. Mr Bateman stated in his report that *"To demonstrate valid consent has been obtained, it is necessary to be able to show there has been a detailed discussion about the proposed treatment options, their risks and benefits including the alternative treatment and the option of no treatment, and that the patient has understood the conversation".* Mr Kramer stated in his report that *"In order to obtain consent, it is necessary to inform the patient with regard to all the reasonable options for treatment, together with the risks, benefits and costs of each option".* The Committee noted that the experts differed in their opinions as to whether you obtained informed consent for treatment from Patient A. However, the experts agreed that it was necessary for you to obtain informed consent from the patient for the proposed treatment. In their joint report, the experts stated that *"…it will be for the PCC to determine whether consent was obtained for the provision of veneers based on the evidence put before it".*

	The Committee was satisfied on the evidence that you were under a duty to obtain informed consent from Patient A for the treatment proposed. You admitted at 1(a) that you did not conduct an adequate periodontal assessment before preparing the teeth for veneers. It was the Committee's view that in the absence of an adequate investigation of her periodontal condition, which should have included six-point pocket charting following the BPE scores of 3, you would not have been able to have a fully informed discussion with Patient A regarding any underlying periodontal disease and the potential impact of that disease on the viability of the veneers. The Committee found proved at head of charge 1(b) that you did not have a full discussion with the patient about the risks of the proposed treatment, as you did not inform her of material information relevant to her treatment. This included the risk of tooth damage, which the Committee accepted was higher than usual in Patient A's circumstances, given that this was the third time that some of these teeth had been prepared, the effect that any future periodontal treatment may have on the aesthetics of the veneers, and the risk of failure of the veneers. You admitted in relation to head of charge 1(c) that you did not take bitewing radiographs of Patient A at the initial appointment on 3 August 2022. The Committee took into account that both experts agreed that bitewing radiographs should have been taken of Patient A, given that there was no evidence of bitewings having been taken within the previous year. Mr Bateman stated in his report that *"…As this was a new patient to the practice bitewing radiographs should have been taken to screen for posterior interproximal caries and assess bone levels".* In considering the absence of bitewing radiographs in the context of informed consent, the Committee distinguished them from periapical radiographs. As stated in its finding in respect of head of charge 1(d), the Committee accepted your clinical justification for not taking periapical radiographs in these circumstances. However, the Committee noted the expert evidence that bitewing radiographs are a wider screening tool to assess the overall oral health of a patient. In his report, Mr Kramer stated that *"…Failing to take bitewing radiographs meant that the Registrant was not well placed to be able to determine whether there was any pathology present in the teeth or supporting tissues that required treatment as a priority before the provision of treatment to improve aesthetics".* It was the view of the Committee, in the light of this evidence, that Patient A should also have been made aware of any issues with her general oral health in order to help inform her decision in proceeding with the cosmetic treatment. Having considered your failings at heads of charge 1(a), 1(b) and 1(c), the Committee was satisfied that you also failed to obtain informed consent from Patient A. It was its conclusion that it was not possible for you to have gained informed consent without ensuring that she was aware of all material information relevant to her oral health and the proposed treatment, including the full risks of the treatment. Accordingly, head of charge 2 is proved in relation to 1(a), 1(b) and 1(c).
3 (a)	*You failed to maintain an adequate standard of record keeping in respect of Patient A's appointments from 03 August 2022 to 02 December 2022 by:*

	not completing a clinical record of the appointment that took place on 8th August 2022; and/or **Admitted and found proved.**
3(b).	*You failed to maintain an adequate standard of record keeping in respect of Patient A's appointments from 03 August 2022 to 02 December 2022 by:* *not completing a clinical record of the appointment that took place on 15th September 2022; and/or* **Admitted and found proved (as amended).**
3(c).	*You failed to maintain an adequate standard of record keeping in respect of Patient A's appointments from 03 August 2022 to 02 December 2022 by:* *not customising the template record in relation to an appointment that took place on 12th October 2022.* **Admitted and found proved.**
4.	WITHDRAWN:
4(i)	WITHDRAWN
4(ii)	WITHDRAWN.
5.	WITHDRAWN:
5(a).	WITHDRAWN
5(b).	WITHDRAWN.
6.	*You failed to obtain informed consent for treatment provided to Patient A in relation to the patient's UL5 and UR5.* **Admitted and found proved.**
7.	WITHDRAWN:
7(a).	WITHDRAWN.
8.	WITHDRAWN:
8(a).	WITHDRAWN
8(b).	WITHDRAWN.

42. The hearing now moves to Stage Two.

Stage Two of the hearing – 23 to 25 September 2025

43. The Committee handed down its findings on the facts on 22 September 2025. Following a request for time made by Mr Ivill, the Committee agreed to adjourn the hearing until 23 September 2025 for the start of Stage Two.

44. At this second stage, the Committee has had to consider whether the facts found proved against you amount to misconduct, and if so, whether your fitness to practise is currently impaired

by reason of that misconduct. The Committee took into account that if it found current impairment, it would need to consider what sanction, if any, to impose on your registration.

45. The evidence before the Committee at this stage was a remediation bundle received on your behalf comprising your written reflections, evidence of your Continuing Professional Development (CPD) and a number of testimonials. The GDC provided the Committee with a copy of a letter of advice dated 18 December 2012, which was issued to you by the GDC's Investigating Committee.

Summary of the facts found proved

46. This case relates to your treatment of one patient, Patient A, from 3 August 2022 to 2 December 2022. The treatment you provided to Patient A was cosmetic dental work involving the provision of 10 veneers from UR5 to UL5. Five of those 10 veneers were to replace existing veneers that the patient had placed in 2011.

47. No concerns have been raised in this case regarding the quality of the treatment that you provided to Patient A. The matters found proved relate to other aspects of the care you provided to her.

48. The findings of the Committee, many of which you admitted, were that you failed to provide an adequate standard of care to Patient A over the period in question, in that you did not:

- conduct an adequate periodontal assessment before preparing the teeth for veneers;
- discuss the full risks of the proposed treatment before preparing the teeth for veneers;
- take bitewing radiographs at the patient's initial appointment on 3 August 2022.

49. The Committee found proved that, by virtue of the above failings, you also failed to obtain Patient A's informed consent for the treatment.

50. You also admitted, and the Committee found proved, that you further failed to obtain informed consent from Patient A in relation to the treatment provided to UR5 and UL5. This was specifically in relation to your failure to discuss the additional cost of placing veneers on those two extra teeth, when the treatment plan changed from providing 8 veneers to 10 veneers, encompassing UR5 and UL5.

51. There were also your admitted failures in record keeping. You admitted, and the Committee found proved, that you failed to maintain an adequate standard of record keeping in respect of Patient A's appointments over the period concerned. You admitted that you did not complete any clinical records in respect of two appointments, one on 8 August 2022 and the other on 15 September 2022. You further admitted that you did not customise a template record in relation to an appointment that took place on 12 October 2022.

Summary of parties' submissions at Stage Two

52. In accordance with Rule 20(1)(a) of the *GDC (Fitness) to Practise Rules Order of Council 2006*, Mr Saad first addressed your fitness to practise history. He referred the Committee to the letter

of advice dated 18 December 2012, issued to you by the GDC's Investigating Committee. Mr Saad submitted that the letter related to historical matters concerning your treatment of a single patient. Mr Saad submitted that it was a matter for the Committee what weight it attached to the letter of advice, given its age, and given that the course of treatment involved took place between 2005 and 2007.

53. In making his submissions in relation to this case, Mr Saad took the Committee to the relevant parts of the '*Guidance for the Practice Committees including Indicative Sanctions Guidance'* (the Guidance'). This included paragraph 4.8 of the Guidance, which states that:

> *"Findings of impairment are not made to a particular established standard of proof (such as civil or criminal); rather, it is a matter of judgment for the panel. Failure to adhere to fundamental GDC Standards is likely to lead to a finding of impairment."*

54. Mr Saad submitted that the Committee may find that the following standards from the GDC's *'Standards for the Dental Team'* (September 2013) ('the GDC Standards') are relevant in this case: 2.4, 3.1, 4.1 and 1.4. He reminded the Committee that for a finding of misconduct, any falling short of the GDC Standards must be serious. Mr Saad stated that in assessing the seriousness of the matters found proved, the Committee may find it helpful to consider the expert opinions of Mr Bateman and Mr Kramer, in terms of the aspects of your conduct that they deemed fell far below the standard expected. It was Mr Saad's submission that there were ample grounds on which misconduct could be found in this case.

55. In addressing the Committee on this issue of impairment, Mr Saad referred to paragraph 46 of the Guidance which relates to *'Single clinical incidents or single courses of treatment'*. In particular, he asked the Committee to note the guidance that if misconduct is found, *"…the Committee may wish to consider whether the failure was an isolated incident by a registrant who otherwise practised safely, and whether any deficiencies in practice may have been remedied by any subsequent actions, such as further training. In evaluating current impairment, the PCC may wish to consider any efforts made by the dental professional to remedy any deficiency(ies) in knowledge or skill".*

56. Mr Saad drew the Committee's attention to the remediation bundle provided on your behalf. He told the Committee that the GDC's expert, Mr Bateman, had reviewed the evidence contained within the bundle, and considered that you have undertaken targeted CPD in relation to radiographic practice, record keeping and the issue of informed consent. Mr Saad also noted that you have provided detailed written reflections.

57. It was Mr Saad's submission that the Committee may consider that the central deficiency in this case was your failure to obtain informed consent from Patient A. He stated that, with this in mind, it may be considered that you have more learning to do. Mr Saad referred to the evidence of your recent CPD relating to consent in cosmetic dental practice which, he noted, was undertaken on 3 September 2025. He submitted that, given the recent nature of this CPD, it could be said that your learning in relation to informed consent has not yet been embedded in your practice, and that this would be a matter for the Committee to consider when looking at the issue of current risk.

58. With regard to the wider public interest, Mr Saad referred to paragraph 22 of the Guidance in which it is stated that, *"The issue of informed or valid consent is a cornerstone of the public interest and must be paramount in a registrant's mind prior to carrying out any treatment or investigation. Failure to obtain consent is a serious matter and, if the panel is satisfied that it amounts to misconduct the PCC should consider whether a finding of impairment and the imposition of a sanction is appropriate in the public interest…"* Mr Saad stated that he commended this guidance to the Committee, given the centrality of the issue of informed consent in the patient-dentist relationship. He highlighted your failure to obtain informed consent from Patient A on two separate occasions, in relation to different aspects of her treatment. Mr Saad submitted that the Committee may consider that a finding of impairment would be in the wider public interest in these circumstances.

59. In relation to sanction, Mr Saad submitted that the GDC's position was that an order of conditions should be imposed on your registration. He provided the Committee with a set of draft conditions proposed by the Council, which included a requirement for workplace supervision and the maintenance of audits. Mr Saad invited the Committee to consider imposing a conditions of practice order in the terms suggested by the GDC, for a period of 12 months, with a review.

60. Mr Ivill submitted that it does not necessarily follow that all factual findings amount to misconduct. He stated, however, that he recognised that the expert witnesses agreed there were aspects of your conduct that fell far below the requisite standards. Mr Ivill stated that in the circumstances, his submissions would be focused on the issue of current impairment.

61. It was Mr Ivill's submission that not every finding of misconduct necessitates a finding of impairment. He submitted that in reaching its decision on impairment, the Committee must consider whether your fitness to practise is impaired as at the time of this hearing.

62. Mr Ivill submitted that the conduct found proved is plainly remediable. He drew the Committee's attention to your written reflections within which, he submitted, there is compelling evidence of your insight and remediation. Mr Ivill also asked the Committee to consider the evidence of the CPD you have undertaken, the evidence of what you have learnt from those courses, and the evidence of the measures you have put in place to prevent recurrence. He submitted that the CPD was commenced much earlier than outlined by the GDC. (The Committee noted that there was CPD on the subject of informed consent completed in 2024). Mr Ivill submitted that there is evidence that you understand the seriousness of your conduct and its impact, and that you have embedded your learning into your clinical practice. He told the Committee that you have now been practising unrestricted for a significant period of time since the events in this case in 2022, with no concerns raised. Mr Ivill submitted that there has been no suggestion that you have been providing anything other than safe and appropriate clinical care. He submitted that there was no better evidence of remediation than the absence of repetition.

63. Mr Ivill further invited the Committee to take into account your full engagement with the GDC process, your admission to many of the alleged matters, your expression of regret and your apology to Patient A. Mr Ivill also drew to the Committee's attention the testimonials tendered on your behalf which, he submitted, showed that you are held in high esteem. He told the Committee that all those

who had provided testimonials were aware of the nature of the allegations in this case and that you had previously received the letter of advice from the Investigating Committee.

64. It was Mr Ivill's submission that the Stage Two material provided on your behalf demonstrates that you are a conscientious and insightful practitioner who cares about the standard of his practice. Mr Ivill reiterated that your learning has been embedded and submitted that this is a case in which it can be said that the chance of your conduct being repeated in the future is so remote that your fitness to practise is not impaired. In support of his position that a finding of impairment is not warranted, Mr Ivill submitted the following:

- That you have shown full insight, reflected and remediated.
- That you have expressed genuine regret and apology.
- That your failings related to the treatment of one patient in 2022, during a career spanning 36 years, with no repetition.
- That there is no compelling evidence of risk to patient safety.
- That the risk of repetition is low.

65. Mr Ivill submitted that a number of these factors applied to the issue of public protection as well as to consideration of the wider public interest. In relation to the latter, Mr Ivill submitted that the public would be reassured by the evidence of your regret, remediation and reflection. He further submitted that the very fact of this rigorous fitness to practise process would serve to mark the public interest and uphold public confidence in the dental profession.

66. Mr Ivill made clear that his primary submission was that your fitness to practise is not currently impaired. However, he acknowledged the requirement to address the Committee on sanction at this stage. Accordingly, it was Mr Ivill's submission that if the Committee determined that a sanction should be imposed, a reprimand would be an appropriate and proportionate sanction in all the circumstances.

The Committee's decisions

67. In reaching its decisions, the Committee considered all the evidence presented to it, both at this stage and at the fact-finding stage. It took account of the submissions made by Mr Saad and Mr Ivill in relation to misconduct, impairment and sanction.

68. The Committee accepted the advice of the Legal Adviser in relation to the legal principles relevant to its decision-making. It took into account that the matters to be determined at this stage of the proceedings were for its independent judgement; there is no burden or standard of proof.

Decision on misconduct

69. The Committee first considered whether the facts found proved against you amounted to misconduct. It took into account that misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. It noted that the standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed in the particular circumstances. Accordingly, the Committee had regard to the GDC's

'Standards for the Dental Team' (September 2013) ('GDC Standards'), bearing in mind that a finding of misconduct requires a serious falling short of what is expected.

70. The Committee considered that the following GDC Standards are engaged in this case:

1.4 Take a holistic and preventative approach to patient care which is appropriate to the individual patient.

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

2.4 Give patients clear information about costs.

3.1 Obtain valid consent before starting treatment, explaining all the relevant options and the possible costs.

3.2 Make sure that patients (or their representatives) understand the decisions they are being asked to make.

3.3 Make sure that the patient's consent remains valid at each stage of investigation or treatment.

3.3.5 If you think that you need to change a patient's agreed treatment or the estimated cost, you must obtain your patient's consent to the changes and document that you have done so.

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

71. In assessing the seriousness of its factual findings, the Committee took account of the opinions of Mr Bateman and Mr Kramer. It noted that both experts agreed that not conducting an adequate periodontal assessment of Patient A before preparing the teeth for veneers, not discussing the full risks of the proposed treatment before preparing the teeth for veneers, and not taking bitewing radiographs at the patient's initial appointment on 3 August 2022, was conduct that fell far below the standard expected. In accepting the joint expert opinion in respect of all three matters, the Committee had regard to the reasons for their conclusions.

72. In relation to your failure to conduct an adequate periodontal assessment, the Committee had regard to Mr Bateman's opinion that following Patient A's BPE scores of 3, the periodontal health of the teeth should have been ascertained before preparing them for veneers. He stated that this was because all disease should be under control before carrying out elective cosmetic treatment. He also stated that the presence of active periodontal disease can result in poor treatment outcomes for veneers.

73. With regard to your not discussing the full risks of the proposed treatment with Patient A before the preparation of the teeth for veneers, the Committee noted Mr Bateman's evidence that a

discussion about risks and benefits was *"… an essential part of gaining informed consent for this treatment".* The Committee considered that the relevant GDC Standards make clear the importance of gaining valid consent for treatment.

74. In respect of your failure to take bitewing radiographs at Patient A's initial appointment, the Committee noted that both experts agreed that such radiographs should have been taken in the circumstances. Mr Kramer opined that your failure to take bitewing radiographs meant that you were not well placed to be able to determine whether there was any pathology present in Patient A's teeth or supporting tissues that required treatment as a priority before the provision of the aesthetic treatment.

75. It was the finding of the Committee that by virtue of your failings outlined above, you failed to obtain informed consent from Patient A for the proposed treatment. Mr Bateman and Mr Kramer agreed that the consequential failure to obtain informed consent fell far below what was expected in the circumstances. Mr Bateman stated in his report that, *"…gaining informed consent is basic, and at the heart of dentist/patient relationship"*. His opinion was that, in all the circumstances, it would have been impossible for you to inform Patient A about the prognosis of the proposed treatment. In addition to the expert evidence and the GDC Standards, the Committee also had regard to paragraph 22 of the Guidance which states that *"The issue of informed or valid consent is a cornerstone of the public interest and must be paramount in a registrant's mind prior to carrying out any treatment or investigation. Failure to obtain consent is a serious matter…"*

76. You admitted, and the Committee further found proved, that you failed to obtain informed consent from Patient A in relation to UR5 and UL5, specifically in relation to the additional cost that would be incurred in treating those two teeth. The Committee noted that in relation to the question of additional cost alone, Mr Bateman and Mr Kramer differed in their opinions as to whether this was an issue that fell far below the standard expected. Mr Bateman, the GDC's expert, in his oral evidence regarded the failing as falling below the standard expected, so long as the patient had been informed of the cost of each veneer, whilst Mr Kramer, the defence expert, assessed the failing as being far below standard.

77. The Committee took into account that Patient A was provided with cost information for eight veneers, which included breakdown information indicating that the cost of each veneer was £750. However, she was not provided with updated cost information when the proposed treatment changed from 8 to 10 veneers. The Committee considered that this was a fundamental failing, especially given the significant amount of money involved. In its view, it was not adequate for you to rely on the fact that Patient A had been informed of the cost per item. The Committee considered that you had a duty, as part of the informed consent process, to ensure that Patient A was provided with an updated cost calculation for the 10 veneers. The Committee concluded that not doing so was a significant departure from what was expected in the circumstances.

78. In considering your failures to obtain informed consent, the Committee bore in mind that Patient A was a patient with particular vulnerabilities, in that she was a highly anxious patient with a phobia of dental treatment. In the circumstances, the Committee considered that it was incumbent on you to make sure that she was aware of and understood all issues relevant to the proposed

treatment. This should have included any adverse consequences or outcomes, given that such outcomes would have meant further dental treatment for her, and the full cost of the proposed treatment.

79. Finally, the Committee considered the record-keeping failings admitted and found proved. In doing so, it noted that there was also a difference of opinion between the experts on this issue. Mr Bateman considered that, as individual failures, the deficiencies in your record-keeping would fall below the standard expected, as opposed to far below. However, he did state that taken cumulatively, for one patient over a short space of time, your failures were indicative of a standard of record keeping that fell far below what was expected. Mr Kramer's opinion was that each of your record-keeping failings fell far below standard.

80. It was the view of the Committee that the making and keeping of complete patient records is an important part of dentistry. It also took into account a patient's right to access their dental records at any time. You admitted that you did not complete any records for two of Patient A's appointments, and that for one appointment you did not customise the template record. The Committee had regard to Mr Kramer's evidence, as set out in his report, that clinical records should have been made, so that any subsequent treating practitioner would be able to understand what took place at the appointments and act accordingly. In relation to your failure to customise the template record, the Committee noted Mr Kramer's opinion that the clinical records for that appointment are unclear, confusing and inaccurate. It was the conclusion of the Committee, having considered the expert evidence, that each of your record-keeping failings fell far below the standard expected.

81. Having considered all the evidence, the Committee was satisfied that the facts found proved in this case, individually and cumulatively, amounted to misconduct.

Decision on current impairment

82. The Committee considered whether your fitness to practise is currently impaired by reason of your misconduct. In doing so, it had regard to the over-arching objective of the GDC, which is: the protection, promotion and maintenance of the health, safety, and well-being of the public; the promotion and maintenance of public confidence in the dental profession; and the promotion and maintenance of proper professional standards and conduct for the members of the dental profession.

83. The Committee considered the factors in relation to impairment referred to by Dame Janet Smith in her fifth Shipman report, which were outlined in the case of *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council and Grant* [2011] EWHC 927 (Admin). Applying those factors, the Committee considered whether you:

a. have in the past acted and/or are liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or
b. have in the past brought and/or are liable in the future to bring the dental profession into disrepute; and/or
c. have in the past breached and/or are liable in the future to breach one of the fundamental tenets of the dental profession;

d. ....

84. The Committee was satisfied that the impairment factors at a, b and c above are engaged in this case. It considered that your clinical failings did put Patient A at unwarranted risk of harm. It also considered that you have brought the dental profession into disrepute, given that your conduct, as found proved, represented serious breaches of the GDC Standards, including in relation to basic functions of dentistry. The Committee also considered that your failings in obtaining informed consent amounted to a breach of a fundamental tenet of the profession.

85. The Committee went on to consider whether your fitness to practise is impaired as of today. In reaching its decision, the Committee considered whether your misconduct is remediable, and if so, whether it has been remedied and whether it is likely to be repeated.

86. The Committee concluded that your misconduct, which relates to clinical failings, is capable of being remedied. In considering whether you have remedied it, the Committee had regard to the evidence of the steps you have taken to address the concerns raised in this case.

87. The Committee found the evidence of your remediation to be detailed and precise. It noted that you have undertaken a number of courses targeted to the areas of deficiencies, as acknowledged by Mr Bateman. The Committee noted that as a result of your learning, you have implemented a number of changes in your clinical practice, which has included altering your clinical workflow. It noted that you now have a number of checks and balances in place around your treatment planning and clinical record keeping. This has included your development of a system which does not allow you to progress through the clinical records until you have confirmed that certain steps have been taken in respect of a patient's treatment.

88. The Committee was also impressed by your endeavours in undertaking audits of your clinical practice. It noted the evidence of the work you have undertaken with the assistance of a colleague. In his testimonial letter tendered on your behalf, he refers to your having worked on a project together over the last two years, focused on record keeping which, he said, had allowed him to review a number of your cases. From the cases he has seen, your colleague provided positive testimony in relation to your clinical competence and ability, your conducting of periodontal assessments, treatment planning, radiographic practice and record keeping and your communication with patients.

89. It was the view of the Committee, having considered the evidence you have provided, that you have taken action to review your clinical practice in the light of your failings in Patient A's treatment. The Committee considered that you recognise how you should have behaved differently in those circumstances, and that you have identified with some precision and detail, the measures that needed to be put in place to prevent recurrence. The Committee took into account that you started your process of remediation some two years ago, and that you did so with the assistance of a colleague who was, in the Committee's view, well-placed to assist with the tools that you required.

90. The Committee remained mindful in its consideration of your remediation evidence that you were issued with a letter of advice by the GDC's Investigating Committee in December 2012. The factual particulars of that case related to your failure to provide a patient with an adequate standard

of care, arising from placing implants without treating the patient's periodontal disease. Failings were also identified in relation to your record keeping and your communication with that patient. The Committee noted that this matter did not lead to a Practice Committee hearing and that no formal findings were made against you. However, it did note that some of the concerns raised were similar to those in this current case. The Committee took into account the age of the previous concerns, which relate to treatment you provided between 2005 and 2007. It was reassured that it had before it at this hearing, evidence that you have undertaken learning over the last two years in order to address both the current and previous concerns. Furthermore, the Committee was satisfied on the evidence before it that you are continuing to embed this learning into your practice.

91. Notwithstanding this, the Committee did have some residual concerns about the insight behind your remediation. It noted that in your written reflections you expressed remorse and offered an apology to Patient A. It also noted your clear recognition of why the standard of care you provided to Patient A was not adequate and what you needed to do to remediate. However, the Committee considered, from reading your reflections, that you could have reflected more fully on the impact of your failings on Patient A and on public confidence in the dental profession.

92. The Committee carefully considered the elements of your insight that it assessed to be deficient in the overall context of your remediation. It was the conclusion of the Committee that you have a good understanding of what you should have done differently whilst treating Patient A. You have embedded and will continue to embed into your clinical practice relevant and detailed corrective measures to guard against repetition. It was the conclusion of the Committee that the issues it identified in relation to your insight did not necessarily undermine your remedial action. In reaching its conclusion, the Committee had regard to 5.26 of the Guidance which states that *"…the fact that a dental professional has recognised that corrective actions need to be undertaken is more important than the manner in which their insight is expressed".* In all the circumstances, the Committee was satisfied that the risk of repetition in this case is very low and therefore there is no ongoing risk to patients. The Committee therefore concluded that a finding of impairment is not necessary on public protection grounds.

93. The Committee considered whether a finding of impairment would be in the wider public interest, to promote and maintain public confidence in the dental profession and proper professional standards. Your conduct in the treatment of Patient A resulted in serious breaches of a number of your professional standards. This included breaches in relation to informed consent, which the Guidance regards as a cornerstone of the public interest. The Committee considered that a fully informed member of the public, aware of all the circumstances of this case, including that you are an experienced practitioner of many years, and that you previously received a letter of advice regarding similar concerns, albeit many years ago, would expect a finding of current impairment, notwithstanding the evidence of your remediation. The Committee concluded that public confidence in the dental profession and the maintenance of proper standards would be undermined if such a finding were not made in these circumstances.

94. Accordingly, the Committee determined that your fitness to practise is currently impaired by reason of your misconduct on wider public interest grounds only.

Decision on sanction

95. Having determined that your fitness to practise is currently impaired, the Committee considered what sanction, if any, to impose on your registration. It bore in mind that the purpose of a sanction is not to be punitive, although it may have that effect, but to uphold the wider public interest. The Committee had regard to the Guidance. It applied the principle of proportionality, balancing the public interest with your own interests.

96. In deciding on the appropriate sanction, the Committee first identified what it considered to be the aggravating and mitigating factors in this case. In mitigation, the Committee considered the following:

- evidence of good conduct following the incident in question, particularly your remedial action;
- evidence of remorse shown and apology given;
- evidence of steps taken to avoid a repetition;
- no financial gain on your part;
- that the matters relate to a single patient and a single course of treatment;
- the time elapsed since the incident with no repetition.

97. The Committee also had regard to the positive testimonials tendered on your behalf.

98. The Committee identified the following aggravating factors:

- the risk of harm to Patient A; and
- the involvement of a vulnerable patient, in so far as Patient A was highly anxious with a phobia of dental treatment;
- the limited evidence of your insight in relation to the impact of your failings on Patient A and the public's confidence in the profession.

99. The Committee also took into account the letter of advice you received from the GDC's Investigating Committee in December 2012. However, as previously indicated the Committee attached limited weight to this, given the age of the incident concerned and the remediation you have since undertaken.

100. Taking all the above factors into account, the Committee considered the issue of a sanction, starting with the least restrictive. The Committee noted that it was open to it to conclude this case without taking any action in respect of your registration. However, the Committee concluded that taking no action would not be appropriate in the light of its findings. It considered that such a course would not serve to maintain public confidence in the dental profession or uphold proper professional standards.

101. Accordingly, the Committee considered whether it would be appropriate and proportionate to issue you with a reprimand. In doing so, it had regard to paragraph 6.7 of the Guidance which states that *"A reprimand is the lowest sanction which can be applied and may therefore be*

appropriate where the misconduct or level of performance is at the lower end of the spectrum". The Committee was of the view that your misconduct, while not at the very lowest end of the spectrum, was at the lower as opposed to the higher end. It noted that paragraph 6.7 of the Guidance also states that *"A reprimand might be appropriate if the circumstances do not pose a risk to patients or the public which requires rehabilitation or restriction of practice".*

102. The Committee went on to consider paragraph 6.9 of the Guidance, which sets out a number of factors and states that a reprimand may be suitable where most of the factors are present. The Committee found that the majority of the listed factors are relevant in this case, namely that:

- there is no evidence to suggest that the dental professional poses any danger to the public;
- the dental professional has shown (some) insight into his/her failings;
- the behaviour related to a single patient and a single course of treatment;
- the behaviour was not deliberate;
- the dental professional has expressed remorse;
- there is evidence that the dental professional has taken rehabilitative/corrective steps.

103. Having noted the presence of these factors from paragraph 6.9 of the Guidance, and in deciding whether, in all the circumstances, the issuing of a reprimand would be sufficient, appropriate and proportionate, the Committee considered the next available sanction, namely a conditions of practice order. It had regard to the relevant paragraphs of the Guidance, including paragraph 6.18, which sets out when conditions may be appropriate. However, given the Committee's conclusion that you do not pose a risk to patient safety and the impairment identified is in relation to the wider public interest only, the Committee considered that no workable or meaningful conditions could be formulated, nor that any are needed. Whilst the Committee took into account the issues it identified in relation to your insight, it considered that to impose a conditions of practice order in circumstances where you are otherwise safe to practise without restriction would be disproportionate.

104. Accordingly, the Committee was satisfied that a reprimand is an appropriate and proportionate sanction in this case. It also considered that a well-informed member of the public would consider this a proportionate response. The Committee was satisfied that a reprimand meets the wider public interest and serves to maintain proper professional standards.

105. A reprimand will be publicly recorded as the outcome of the case against you. The fact that you have been issued with a reprimand and a copy of this public determination will appear alongside your name on the GDC register for a period of 12 months. A reprimand forms part of your fitness to practise history and is disclosable to prospective employers and prospective registrars in other jurisdictions.

106. That concludes this determination.