Dental Professionals Hearings Service

PUBLIC DETERMINATION

PART-PRIVATE HEARING

Professional Conduct Committee
Initial Hearing

8 – 22 July 2026

Name:	MCGOVERN, Marius
Registration number:	70973
Case numbers:	CAS-202581 CAS-203330 CAS-204904 CAS-201352

General Dental Council:	Mr Daniel Mansell, Counsel. Instructed by Ervin Gjoleka, Capsticks
Registrant:	Present Represented by Miss Julia Furley, Counsel. Instructed by JFH Law

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Fitness to practise:	Impaired by reason of misconduct
Outcome:	Suspension (with a review)
Duration:	12 months
Immediate order:	None Imposed

Committee members:	Michael Speakman	(Chair) (Dentist)
	Caroline Ross	(Dental Care Professional)
	Paul Hepworth	(Lay)
Legal adviser:	Megan Ashworth	
Committee Secretary:	Andrew Keeling	

CHARGE

Marius McGOVERN, a dentist, BDS University of Liverpool 1995 is summoned to appear before the Professional Conduct Committee on 13 July 2026 for an inquiry into the following charge:

"That, being registered as a Dentist:

1. *From on or around 24 August 2020, you failed to cooperate, in a timely manner or at all, with solicitors representing Patient A (as identified in Schedule 1 below) in respect of a negligence claim.*

2. *From on or around 19 November 2020, you failed to cooperate, in a timely manner or at all, with solicitors representing Patient B (as identified in Schedule 1 below) in respect of a negligence claim.*

3. *From on or around 28 August 2021, you failed to comply, in a timely manner or at all, with a County Court Order that you disclose Patient B's records to the patient's solicitors.*

4. *From on or around 25 September 2019, you failed to cooperate, in a timely manner or at all, with solicitors representing Patient C (as identified in Schedule 1 below) in respect of the disclosure of the patient's records.*

5. *From on or around 1 October 2021, you failed to cooperate, in a timely manner or at all, with solicitors representing Patient D (as identified in Schedule 1 below) in respect of a negligence claim.*

6. *In respect of treatment provided on or around 30 July 2013 to Patient E (as identified in Schedule 1 below), you failed to adequately treatment plan, in that you had not taken an appropriate radiograph or radiographs.*

7. *You failed to obtain informed consent for treatment provided to Patient E on or around 30 July 2013.*

8. *From on or around 5 October 2021, you failed to cooperate, in a timely manner or at all, with solicitors representing Patient E in respect of a negligence claim.*

9. *On or around 30 January 2019:*

    a. *You failed to take reasonable steps to protect Patient H (as identified in Schedule 1 below) from injury in that you:*

        i. *Were insufficiently focused on the treatment; and/or*
        ii. *Used a rotating disc without a guard;*

10. *From on or around 16 October 2020, you failed to cooperate, in a timely manner or at all, with solicitors representing Patient H in respect of a negligence claim.*

11. *From on or around 30 June 2022, you failed to co-operate, in a timely manner or at all, with solicitors representing Patient G (as identified in Schedule 1 below) in respect of a negligence claim.*

12. *From on or around 12 February 2024, you failed to cooperate with an investigation conducted by the General Dental Council in respect of investigation CAS-204904-D6Q0K0.*

13. *In relation to Patient I (as identified in Schedule 1 below), you:*

    a. *Between around May 2019 and around May 2023, failed to communicate effectively with the patient regarding the progress of their treatment.*

    b. *Between around September 2021 and around May 2023, failed to progress the patient's treatment in a timely manner.*

14. *From on or around 3 December 2019 to on or around 29 March 2023, you failed to provide Patient I with access to their records, despite requests from the patient.*

15. *In relation to Patient J (as identified in Schedule 1 below), between around August 2022 and around March 2023, you:*

    a. *Failed to progress the patient's treatment in a timely manner;*

    b. *Failed to communicate effectively with the patient regarding the progress of their treatment.*

16. *From on or around 10 July 2023 to on or around 22 March 2024, you failed to co-operate with an investigation conducted by the General Dental Council in respect of CAS-203330-P2G4Y8, in that you did not provide information requested by the General Dental Council.*

And, by reason of the matters set out above, your fitness to practise as a Dentist is impaired by reason of your misconduct."

At this hearing the Committee made a determination that includes some private information. That information shall be omitted from any public version of this determination and the document marked to show where private material is removed.

Mr McGovern,

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

2. You were present at the hearing and represented by Miss Julia Furley, Counsel. Mr Daniel Mansell, Counsel, appeared on behalf of the General Dental Council (GDC).

3. The hearing was held in person at the hearing suite of the Dental Professionals Hearing Service in Wimpole Street, London.

Preliminary matters

Rule 25 Joinder application (9 July 2026)

4. Mr Mansell made an application for joinder under Rule 25(2) of the GDC Fitness to Practise Rules ('the Rules'). The application was to join three further particulars to the charge at this hearing.

5. Rule 25(2) states that:

'Where—

(a) an allegation against a respondent has been referred to a Practice Committee,
(b) that allegation has not yet been heard, and
(c) a new allegation against the respondent which is of a similar kind or is founded on the same alleged facts is received by the Council,

the Practice Committee may consider the new allegation at the same time as the original allegation, notwithstanding that the new allegation has not been included in the notification of hearing.'

6. Mr Mansell submitted that the new allegations fall within the requirements of Rule 25(2), in that the new allegations are of a similar kind to those included in the notice of hearing and are founded on the same alleged facts of Patient H's treatment. He submitted that the matters had not yet been heard and therefore given the similarities and the same facts to be considered, they can be considered at the same time.

7. Mr Mansell submitted that Rule 25(3) had also been followed appropriately in that you and your representatives had been put on notice that the GDC intended to make an application for joinder and that it was not opposed.

8. Ms Furley made no opposition to the application.

Committee's Decision on Joinder Application

9. In reaching its decision, the Committee considered all the evidence before it. It took account of the submissions made by both parties. The Committee accepted the advice of the Legal Adviser.

10. The Committee first satisfied itself that you had been properly notified of the GDC's intention to make an application for joinder, as required by Rule 25(3). The Committee noted that the submissions of Mr Mansell were that the proposed joinder had been communicated to you and your legal representatives. The Committee was satisfied, given Ms Furley's non-opposition and awareness of the joinder, that you had been duly notified of the GDC's intended Rule 25(2) application.

11. The Committee next considered the application itself. It had regard to the provisions of Rule 25(2) as set out above. The Committee was satisfied that the requirements of Rules 25(2)(a) and (b) were met, given that allegations against you had been referred to it for consideration, and that those allegations were yet to be heard as the hearing was still at the preliminary stage.

12. The Committee was also satisfied that the requirement in Rule 25(2)(c) had been met. It considered that the proposed new allegations were of a similar kind to those included in the original Notice of Hearing, and that the detail of the new matters are founded on the same alleged facts.

13. Accordingly, the Committee determined to accede to the GDC's Rule 25 application for joinder.

Rule 18 Application to Amend the Charge (9 July 2026)

14. Mr Mansell also made an application under Rule 18 of the Rules, to amend heads of charge 16 and 17.

15. In relation to charge 17, Mr Mansell submitted that the current charge only refers to one case number (CAS-203330-P2G4Y8). However, throughout its investigations and correspondence with you, the GDC has been referring to three cases, including a further two case numbers (CAS-205097-T3V9P3 and CAS-205937-M5G4Q1). He submitted that the allegations in this case as a whole were the subject of a number of case referrals from the Case Examiners, which have been amalgamated into one combined charge. This includes two allegations of failing to cooperate with the GDC, one captured in charge 12 and the other in charge 17. To differentiate between them, the relevant CAS reference numbers were added to the final charge. However, the

CAS reference number ending *'4Y8'*, which is referred to in charge 17 as currently drafted, relates to the eventual master reference number for the relevant investigation. That reference subsequently subsumed investigations CAS-205097-T3V9P3 and CAS-205937-M5G4Q1. He submitted therefore that a technical amendment is needed to add these CAS reference numbers to the charge to ensure that it accurately reflects the underlying evidence.

16. In relation to charge 16, Mr Mansell applied to amend the date at the head of this charge from August 2022 to November 2022. He submitted that this would mirror the underlying evidence and narrow matters between the parties.

17. Ms Furley did not object to the amendments.

The Committee's Decision on the Rule 18 application

18. In reaching its decision, the Committee considered all the evidence before it. It took account of the submissions made by both parties. The Committee accepted the advice of the Legal Adviser.

19. The Committee noted that it was within its powers to amend the charges at any stage of the hearing before making its findings of fact. The Committee considered that the amendments to the charges do not alter the substance of the case. In relation to charge 17, it considered that the amendment would clarify and ensure that the charge incorporates all of the evidence available in relation to the alleged conduct. In relation to charge 16, the Committee considered that the amendment to the charge was in line with the evidence before it. It also considered that you and your representatives did not oppose the amendments. The Committee therefore was satisfied that no injustice would be caused by either amendment.

20. The Committee therefore acceded to the rule 18 application to amend the charges.

Amended Charges

21. Heads of charge 16 and 17, as amended, now read as follows:

> *16. In relation to Patient J (as identified in Schedule 1 below), between around November 2022 and around March 2023, you:*
>
> *a. Failed to progress the patient's treatment in a timely manner;*
> *b. Failed to communicate effectively with the patient regarding the progress of their treatment.*
>
> *17. Between on or around 10 July 2023 to on or around 22 March 2024, you failed to co-operate with an investigation conducted by the General Dental Council in respect of CAS-203330-P2G4Y8 and/or CAS-205097-T3V9P3 and/or CAS-205937-M5G4Q1, in that you did not provide information requested by the General Dental Council.*

Your Admissions (9 July 2026)

22. The Committee heard your admissions to the charges.

23. You admitted in full, heads of charge 1, 2, 3, 4 (in that it was not timely), 5, 10, 16a, 16b, and 17. You partially admitted charge 15 to the extent that records were not provided until January 2023.

24. You denied heads of charge 6, 7, 8, 9a, 9b, 9c, 11, 12, 13, 14a, and 14b.

25. Mr Mansell submitted that the admissions made were acceptable to the GDC, apart from charge 15. He submitted that this was on the basis that the charge details that records were not provided until January 2023, however Patient I suggests that by 29 March 2023 patient records were still not provided. Mr Mansell submitted that this should be assessed in analysing the evidence and therefore should not be accepted as admitted.

Committee's Decision on Admissions

26. The Committee heard and accepted advice from the legal adviser.

27. The Committee considered that in relation to charge 15, there is evidence that needs to be explored given the differing accounts within the evidence provided. It determined that it would require further explanation and therefore does not accept charge 15 to be proved by way of admission.

28. The Committee accepted charges 1, 2, 3, 4, 5, ,10, 16a, 16b, and 17 and, in accordance with Rules 17(4) and 17(5), announced the factual allegations that you had admitted as found proved on the basis of your admissions.

Background to the Case and Summary of Allegations

29. In opening the case for the GDC, Mr Mansell provided the Committee with written and oral submissions of the background and the GDC's evidential basis for this case.

30. Mr Mansell told the Committee that you are a dentist. He informed the Committee that concerns were raised about your treatment of patients and other conduct, including in relation to failing to respond to letters from Dental Law Partnership (DLP), who were representing several patients in negligence claims against you, and failing to cooperate with GDC investigations into your fitness to practise. The Case Examiners referred these concerns to the Professional Conduct Committee.

31. The concerns in respect of your clinical treatment relate to four patients, Patients E, H, I and J. You admitted to the allegations regarding Patient J (head of charge 16) in that between around November 2022 and around March 2023, you failed to progress the patient's treatment in a timely manner and failed to communicate effectively with the

patient regarding the progress of their treatment. The Committee has found these proved.

32. In respect of Patient E (heads of charge 6, 7 and 8), it is alleged that on or around 30 July 2013 you failed to adequately treatment plan the patient's treatment as you had not taken an appropriate radiograph or radiographs. As a result of this alleged failure, it is further alleged that you failed to obtain informed consent for the subsequent treatment provided to Patient E.

33. In respect of Patient H (heads of charge 9 (a), (b), (c) and 10), the allegations relate to the treatment (Interproximal Reduction – i.e. removing enamel between teeth to create space) you performed on 30 January 2019. It is alleged that you failed to obtain informed consent from Patient H before performing this treatment. To perform this procedure, you used a handpiece with a rotating disc. During the treatment, Patient H suffered an injury when the handpiece cut her upper lip. It is alleged that you failed to take reasonable steps to protect Patient H from injury in that you were insufficiently focused on the treatment and that you used a rotating disc without a guard. It is further alleged that you recorded in Patient H's clinical records that you had used a rotating disc with a guard when this was not the case. It is alleged that this was misleading and dishonest (heads of charge 13 (a) and (b)).

34. In relation to Patient I (heads of charge 14 and 15), it is alleged that between around May 2019 and around May 2023, you failed to communicate effectively with the patient regarding the progress of their treatment. It is also alleged that between around September 2021 and around May 2023, you failed to progress the patient's treatment in a timely manner. Furthermore, it is alleged that you failed to provide Patient I with access to their records, despite requests from the patient, between the period around 3 December 2019 and 29 March 2023. You admitted to this allegation, but only as it relates to the period up until January 2023 (as mentioned above).

35. The GDC, as part of its investigation into the clinical practice allegations, instructed an expert, Mr Conor Mulcahy, who has provided an independent expert report. Mr Mulcahy opined that the standard of the care you provided fell far below the standard expected in your radiographic practice, treatment planning, obtaining informed consent, communication, and progressing treatment in a timely manner.

36. The allegations you face in respect of failing to co-operate, in a timely manner or at all with solicitors representing patients in respect of prospective negligence claims relate to seven patients (Patients A, B, C, D, E, G and H) and cover the period between September 2019 and June 2022. You have admitted to the allegations in respect of Patients A, B (including a failure to comply with a County Court Order to disclose the patient's records to the patient's solicitors), C, D and H. The Committee has found these allegations proved.

37. Lastly, you faced two allegations in respect of your failure to co-operate with the GDC's investigation into your fitness to practise. You have admitted to the allegation in respect

of the cases CAS-203330-P2G4Y8 and/or CAS-205097-T3V9P3 and/or CAS-205937-M5G4Q1, relating to the period from July 2023 to March 2024. The Committee has found this proved. However, you deny this allegation in respect of case CAS-204904-D6Q0K0 and the period from February 2024 onwards.

38. Mr Mansell took the Committee through each charge and their corresponding evidential basis, including the evidence of the witnesses, the report of Mr Mulcahy, clinical records, and correspondence.

Evidence

39. The evidence provided to the Committee by the GDC was both documentary and oral. The documentary evidence included, but was not limited to, the following:

- Signed witness statements, dated 12 November 2024, 16 December 2024 and 18 December 2025, and associated exhibits from Person A;
- Signed witness statement, dated 19 November 2025, and associated exhibits from Ms Natalie Shaw, Casework Manager at the Fitness to Practice Team at the GDC;
- Signed witness statement, dated 18 December 2025, and associated exhibits from Patient H;
- Signed witness statement, dated 18 December 2025, and associated exhibits from Person B;
- Signed witness statement, dated 30 April 2025, and associated exhibits from Ms Hannah Smith, Caseworker in the Fitness to Practise Team at the GDC;
- Signed witness statement, dated 7 May 2026, and associated exhibits from Patient J;
- Signed witness statement, dated 17 June 2026; and associated exhibits from Patient I; and
- Expert reports, dated 1 November 2024, 16 December 2025 and 30 April 2026, from Mr Conor Mulcahy.

40. Person A, Patient H, Person B, Natalie Shaw, Patient I and Mr Mulcahy also gave oral evidence at the hearing.

41. The Committee received clinical records for Patients E, H, I and J.

42. The documentary evidence received by the Committee on your behalf in response to the allegations were:

- Your witness statement, dated 30 June 2026; and
- Your exhibit bundle

43. Furthermore, you gave oral evidence at the hearing.

Patient I

44. Patient I gave evidence-in-chief and was cross-examined by Miss Furley for an hour on Friday 10 July 2026. He was then unexpectedly unable to continue giving evidence on the afternoon of 10 July stating that he would make himself available for Monday 13 July. He subsequently informed the GDC that he was unexpectedly unavailable that day but would make himself available on Thursday 16 July. He then informed the GDC that he would not be available until Monday 20 July. In these circumstances, Mr Mansell submitted that the GDC would not be applying to adjourn these proceedings until then as this would have an adverse effect on the hearing concluding within the relevant time.

Rule 18 Application to Amend the Charge (14 July 2026)

45. In light of Patient I's unavailability, Mr Mansell made a further application under Rule 18 to delete heads of charges 14(a) and 14(b), and to amend head of charge 15.

46. He submitted that to proceed with heads of charge 14(a) and (b) would be unfair to you as Patient I was only part-way through giving his evidence and you have not had a chance to question him fully about these allegations.

47. In respect of head of charge 15, Mr Mansell submitted that the end date referred to should be amended from *'29 March 2023'* to *'January 2023'*. He submitted that you admitted to the head of charge in respect of the period until January 2023, but not in respect of the period between January and March 2023. However, he submitted that Patient I can no longer be cross-examined in respect of the period between January and March 2023 and therefore it would be fair to you to amend the charge to reflect this.

48. Head of charge 15 should now read as follows (with the proposed amendment in bold):

*'From on or around 3 December 2019 to on or around **January 2023**, you failed to provide Patient I with access to their records, despite requests from the patient.'*

49. Mr Mansell submitted that these amendments can be made without any injustice to you.

50. Miss Furley submitted that she agreed with the application to amend the charge.

The Committee's Decision on the Rule 18 application

51. The Committee accepted the advice of the Legal Adviser on the Rule 18 application.

52. The Committee took into account that Patient I was now not available to attend the hearing until 20 July 2026 and Mr Mansell was not applying to adjourn the hearing for

Patient I to continue giving his evidence. The Committee was mindful of its duty to protect the public. However, in the circumstances of this case, there were evidential difficulties. The Committee considered that fairness to you would dictate that heads of charge 14 (a) and (b) should be withdrawn as you would not have an opportunity to question Patient I about these matters. Furthermore, you would not have an opportunity to question Patient I in respect of the period January to March 2023 as it related to head of charge 15. The Committee was also mindful that you admitted to the head of charge in respect of the period up to January 2023.The Committee was, therefore, satisfied that the amendment could be made without injustice to either party.

53. The Committee, therefore, acceded to Mr Mansell's application to amend the charge.

Your Admission - Head of Charge 15 (14 July 2026)

54. Following the Committee's decision to amend head of charge 15, Miss Furley informed the Committee that you now admitted this head of charge.

Decision on Admission

55. The Committee accepted your admission and announced head of charge 15 as found proved.

The Committee's Findings of Fact (17 July 2026)

56. The Committee considered all the evidence presented to it, both documentary and oral. It took account of the closing submissions made by Mr Mansell on behalf of the GDC and those made by Miss Furley, on your behalf.

57. The Committee accepted the advice of the Legal Adviser. In accordance with that advice, it has considered each head 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 found proved on the balance of probabilities.

58. The Committee made the following findings:

1.	From on or around 24 August 2020, you failed to cooperate, in a timely manner or at all, with solicitors representing Patient A in respect of a negligence claim. **Proved by reason of admission**

2.	From on or around 19 November 2020, you failed to cooperate, in a timely manner or at all, with solicitors representing Patient B in respect of a negligence claim. **Proved by reason of admission**
3.	From on or around 28 August 2021, you failed to comply, in a timely manner or at all, with a County Court Order that you disclose Patient B's records to the patient's solicitors. **Proved by reason of admission**
4.	From on or around 25 September 2019, you failed to cooperate, in a timely manner or at all, with solicitors representing Patient C in respect of the disclosure of the patient's records. **Proved by reason of admission**
5.	From on or around 1 October 2021, you failed to cooperate, in a timely manner or at all, with solicitors representing Patient D in respect of a negligence claim. **Proved by reason of admission**
6.	In respect of treatment provided on or around 30 July 2013 to Patient E, you failed to adequately treatment plan, in that you had not taken an appropriate radiograph or radiographs. **Found Proved** When considering this head of charge, the Committee considered Mr Mulcahy's expert evidence. In his report, Mr Mulcahy stated: *'MMG prepared (30.07.13) four natural teeth for crowns (UR5 & UL1) or bridge abutments (UL3 & UL1). Prior to this point he had taken (26.04.13 & 25.07.13) two radiographs, both OPG images.* *It has been recommended for many years that, before preparing any tooth for a crown or as a bridge retainer, a peri-apical (PA) radiograph should be available as it will give baseline information. MMG relied on an OPG film. In my opinion this was inappropriate and that PA images should have been taken in addition to the OPG image. The reason for this is that it is recognized that PA x-rays provide a better diagnostic yield*

	and that OPG images can be subject to significant distortion in the anterior region.' Mr Mulcahy went on to state in his report that: '*I believe that MMG's treatment planning was flawed in that he relied inappropriately on OPG images before preparing four natural teeth for crowns or bridge abutments. As a result, it is my opinion that dental pathology could have gone unrecognized. It is, also, my opinion that this represents a standard far below that expected as the effective use of dental radiology is a basic skill expected of all dentists.'* In his oral evidence, Mr Mulcahy stated that his opinion was in accordance with the Faculty of General Dental Practice (FGDP) guidelines in place at the time. He referred to the 2004 FGDP document, *'Selection Criteria for Dental Radiography'*, which stated that: '*Before preparing any tooth for a crown or bridge retainer or as a denture abutment, a periapical radiograph should be available, as it will give baseline information'*. Mr Mulcahy also referred to the importance of taking a periapical radiograph in the context of the type of complex treatment that Patient E was to undergo. In oral evidence, Mr Mulcahy also stated she was having a full reconstruction and everything affects everything else. He said you have to be certain of progression for teeth you are going to keep. If any fail, the patient is committed to further treatment. You must be absolutely comprehensive with treatment planning, if you are wrong the outcomes can be quite severe. You denied this head of charge. In closing submissions, Miss Furley stated that not taking a periapical radiograph did not necessarily mean that your treatment planning of Patient E was a significant departure from acceptable clinical standards. She also advised the Committee to treat with caution the FGDP guidance as it did not constitute a rigid code but recognised that radiographic selection depended on the individual clinical circumstances. The Committee carefully considered the evidence. It took into account the complex and extensive treatment that Patient E was due to receive, which was a full arch reconstruction. The Committee was mindful of Mr Mulcahy's evidence that if there was dental pathology in one tooth, then it could create significant problems for the patient and that risk could have been reduced by the taking of the PA radiograph(s) and following the

	FGDP guidance. It also took into account that the FGDP guidelines in place at the time recommended the taking of a periapical radiograph(s) before embarking on this type of treatment. The Committee bore in mind that this was guidance and not an inflexible rule. However, it was of the view that, in respect of this treatment, you had a duty to follow the FGDP guidelines unless there was a specific clinical reason not to do so. The Committee bore in mind the opinion of Mr Mulcahy to the effect that there was a difference in diagnostic quality between an OPG and periapical radiograph, and that, as a result, a periapical radiograph(s) would provide a greater diagnostic yield. The Committee accepted Mr Mulcahy's evidence in this regard. Taking all of this into consideration, the Committee concluded that in not taking a periapical radiograph(s), you failed to adequately treatment plan. Accordingly, the Committee found this head of charge proved.
7.	You failed to obtain informed consent for treatment provided to Patient E on or around 30 July 2013. **Found Proved** Following its finding at heads of charge 6, the Committee took into account Mr Mulcahy's expert report in which he stated, *'In my opinion it is axiomatic that for, informed consent' to be obtained a dentist must have followed a comprehensive treatment planning process'*. The Committee accepted Mr Mulcahy's evidence. It concluded that Patient E would not have been able to provide informed consent in circumstances where you had failed to adequately treatment plan by not taking a periapical radiograph, in that there were risks that you could have potentially not identified from using the OPG. Therefore, you would not have been able to give Patient E the full risks to enable them to make an informed decision Accordingly, the Committee found this head of charge proved.
8.	From on or around 5 October 2021, you failed to cooperate, in a timely manner or at all, with solicitors representing Patient E in respect of a negligence claim. **Found Not Proved**

	In order to find this head of charge proved, the Committee considered that the GDC had to establish that you knew or reasonably ought to have known what you should have been responding to in respect of the negligence claim. The Committee had sight of the letter of claim, dated 5 October 2021, which was purportedly sent to your practice. However, it noted that no documents confirming proof of service or receipt have been produced in respect of the letter and there was no evidence it was sent to you by email or that you were phoned about this letter. The Committee noted that evidence demonstrating receipt by you or the practice was provided in respect of the other similar heads of charge in this case to which you have admitted. The Committee considered Person A's evidence in respect of this matter. Person A is the Joint Managing Director at the firm of solicitors who were representing Patient E in respect of the prospective negligence claim. However, at the outset of his oral evidence, Person A stated that he had not directly worked on Patient E's case (or, in fact, any of the cases relating to the relevant charges at this hearing) and was not the individual who had referred the matter to the GDC. In oral evidence, Person A stated that it was normal practice for his firm to obtain proof of postage for the letters of claim. However, he could not explain why it was not provided for this case. Furthermore, he could not explain why there was no evidence of any emails or telephone calls made to you in respect of the letter of claim. In answer to questions about the firm's processes and systems, the Committee found that Person A's answers lacked detail and specificity. In particular, the Committee noted that to some of the questions put to him by Miss Furley, he simply answered *"no comment"*. The Committee also noted that Person A stated in his witness statement that you had *'largely disengaged'* with the process. The Committee inferred from this that you had, at least, shown some engagement with the claim. You denied this head of charge. You stated that you do not recall receiving the letter, dated 5 October 2021. You had previously provided documents from April 2021 to the solicitors' firm in respect of the matter, but heard nothing further from the solicitors and believed that the matter was being dealt with by your indemnity providers.

	Taking all of this into consideration, the Committee was not satisfied that the GDC had provided sufficient evidence to prove that you had received the letter dated 5 October 2021. The Committee found Person A's evidence to be unreliable and unclear on this point. He could not confirm that there was evidence of proof of posting or of receipt. There is also some evidence that you had engaged with the claim, albeit it is not clear to what extent. The Committee concluded that having a copy of the letter on the solicitor's file was insufficient evidence to find, on the balance of probabilities, that you failed to cooperate with Patient E's solicitors. Accordingly, the Committee found this head of charge not proved.
9.	On or around 30 January 2019:
9(a)	You failed to obtain informed consent before performing Interproximal Reduction on Patient H ; **Found Not Proved** The Committee considered Patient H's GDC witness statement, dated 18 December 2025. It considered that this evidence indicated that the patient was aware that she was having her tooth filed at the appointment on 30 January 2019: *The orthodontist said I needed some teeth filing, and the Registrant came in to file my teeth. I am not sure why as this was not explained, however, I assume it was to make space for my teeth to move. The Registrant told me he would be filing my teeth.* However, in oral evidence, the Committee noted that Patient H stated that she was unsure whether she was aware that her teeth were being filed. Furthermore, throughout her oral evidence Patient H provided incorrect dates for when her brace was fitted. The Committee considered that Patient H was inconsistent and unclear during her evidence. Furthermore, when challenged on the inconsistencies in her evidence, Patient H appeared unwilling to accept these inconsistencies. The Committee considered therefore that her evidence in respect of this head of charge lacked balance and reduced her credibility. The Committee also considered Person B's evidence. Person B was the Orthodontic Therapist who worked at your practice at the time. In her witness statement, she stated that at the appointment on 30 January 2019, you, *'...described the procedure and obtained informed consent while [Patient H] was sat in the chair…*'. Person B also confirmed this in oral evidence.

	The Committee found Person B's evidence to be consistent and reliable. You denied this head of charge. In your witness statement, you stated that before commencing treatment, you explained to Patient H what you were going to do and why. In oral evidence, you explained that informed consent was received from the patient when Person B was present. The Committee also noted the following entries, written by Person B, from Patient H's medical records regarding the appointments on 16 and 30 January 2019: 16 January 2019: *'NV U Retie , IPR [Person B]/MG'* 30 January 2019: *'Pt attended for Interpormixal [sic] reduction procedure today with Mr Mcgovern, benefits and risk explained to patient and consent gained.'* In oral evidence, you explained that *'NV'* signified 'next visit' and that the patient was booked in for an IPR and was told this at an appointment on 16 January 2019 with Person B present. In addition, you also wrote in the medical notes, *'consent obtained before with therapist*', and confirmed in oral evidence that this record meant that consent was obtained before the treatment and with Person B being present. Taking all of this into consideration, the Committee determined that there was insufficient evidence to prove that you failed to obtain informed consent from Patient H. It considered your written and oral evidence to be credible and consistent with the evidence from Person B. Furthermore, the contemporaneous records state that consent was obtained. In respect of Patient H's evidence, given that she was reliant on her memory from seven years earlier and along with factual inaccuracies in her evidence, the Committee preferred your evidence and the evidence of Person B. Accordingly, the Committee found this head of charge not proved.
9(b)	You failed to take reasonable steps to protect Patient H from injury in that you:
9(b)(i)	Were insufficiently focused on the treatment; and/or

Found Not Proved

The Committee noted Patient H's witness statement in which she stated:

'The orthodontist was stood in front of me to my right, and the dental nurse was stood in front of me to my left. There were a lot of voices in the room and the Registrant was talking to someone behind him, answering questions. …'.

In a further witness statement, dated 1 November 2022, in respect of her negligence claim, Patient H stated that:

'During the treatment I noticed people coming in and out of the room and my dentist was talking to people in the corridor, the door was open, and he was looking behind me. I felt as though he was distracted.'

When Patient H was questioned in oral evidence about whether you were looking behind whilst treating her, Patient H stated that she was not looking directly at your eyes.

In oral evidence, Patient H also confirmed that there were lots of people in the room at the time and that she knew you were distracted. She explained that this happened all the time. However, when questioned further about this by Miss Furley, she could not remember any details.

In her witness statement, Person B stated that apart from her and two other colleagues assisting you, '*there was no one else in the room'*. She further stated that, *'No conversations were taking place, other than reassurance being given to [Patient H]'*.

In oral evidence, Person B confirmed that the only conversations taking place would have been in respect of reassurances given to the patient or you discussing the procedure with Person B (she stated that she was observing the procedure as she had not seen it undertaken before).

In your witness statement, you explained:

'I was not distracted during the procedure. I would have been speaking to [Person B] and my nurse, asking them to pass me materials etc. I may well have been explaining to [Person B] what I was doing as part of a teaching exercise. If Patient H did hear voices, then they would have been coming from outside of the room. It is possible that the door was left open to improve airflow on a warm day – but I certainly was not speaking to people outside of the room.'

	In oral evidence, you explained that as you were using a sharp bladed handpiece, if you had been distracted or had looked away, this would have been a safety concern not only for the patient, but also for you and the dental nurse assisting you. As explained in its reasoning above, the Committee preferred your evidence and that of Person B to Patient H's evidence. Taking everything into consideration, therefore, the Committee determined that the GDC had provided insufficient evidence to prove on the balance of probabilities that you were insufficiently focused on the treatment. Accordingly, the Committee found this head of charge not proved.
9(b)(ii)	Used a rotating disc without a guard; **Found Not Proved** The Committee noted that it was recorded in the patient's records that a guard was used on the handpiece: *'IPR between UL2/3 completed with rotating disc + guard and straight handpiece'.* In Patient H's witness statement she stated that you called her a few days after the appointment and told her that the rotating disc did not have a guard: *'I asked if there was a guard on the file, as I did not see the instrument as I was laid back in the chair. The Registrant said they did not always have to operate the file with a guard and there was not a guard on the file.'* However, the Committee took into account that this was not mentioned in Patient H's witness statement, dated 1 November 2022, in respect of her negligence claim. In addition, the Committee also noted that Patient H stated in her oral evidence that she had spoken to a number of dental professionals about what the device was he may have been using before making her witness statement for the civil proceedings in 2022. The Committee also noted that, in Patient H's 2022 witness statement, she stated she had noticed you had taken your foot off the pedal, which was controlling the saw. However, in oral evidence she stated that she had in fact not seen this and had formed the opinion after speaking to other dental professionals. The Committee considered this significant and reduced Patient H's credibility.

	The Committee considered that it was unlikely, three days later, that you would have informed Patient H that a guard was not used after stating in her clinical records that it was used. Furthermore, the Committee considered it significant that Patient H's witness statement, in which it was first mentioned that a guard had not been used, was written in December 2025, nearly seven years after the incident. The Committee placed more weight on the contemporaneous clinical records. Taking all this into consideration, therefore, the Committee determined, that there was insufficient evidence provided to support the allegation that a guard was not used. Accordingly, the Committee determined that this head of charge is not proved.
9(c)	You recorded that you had used a rotating disc with a "guard" when treating Patient H when no guard was used. **Found Not Proved** As explained in its reasoning above, the Committee determined that it was more likely than not that a guard had been used. Accordingly, it determined that this head of charge is also not proved.
10.	From on or around 16 October 2020, you failed to cooperate, in a timely manner or at all, with solicitors representing Patient H in respect of a negligence claim. **Proved by reason of admission**
11.	From on or around 30 June 2022, you failed to co-operate, in a timely manner or at all, with solicitors representing Patient G in respect of a negligence claim. **Found Not Proved** In order to find this head of charge proved, the Committee considered that the GDC had to establish that you knew or reasonably ought to have known what you should have been responding to in respect of the negligence claim. The Committee had sight of the letter of claim, dated 30 June 2022, which was purportedly sent to your practice. However, it noted that no

	documents confirming proof of service or receipt have been produced in respect of the letter and there was no evidence it was sent to you by email or that you were phoned about this letter. The Committee noted that evidence demonstrating receipt by you or the practice was provided in respect of the other similar heads of charge in this case to which you have admitted. The Committee considered Person A's written and oral evidence. For the same reasons as detailed above at head of charge 8, it found Person A's evidence to be unreliable and unclear on this point as he could not confirm that there was evidence of proof of posting or of receipt of the letter. In respect of this charge, the Committee noted that Person A could not explain why the letter was purportedly sent to your home address rather than to the practice. Furthermore, Person A could not explain why the chaser letter made no reference to the letter of 30 June 2022, and did not include a copy of that letter, which would have made it difficult for you to know what you were supposed to be responding to. Accordingly, the Committee found this head of charge not proved.
12.	From on or around 12 February 2024, you failed to cooperate with an investigation conducted by the General Dental Council in respect of investigation CAS-204904-D6Q0K0. **Found Not Proved** The Committee noted Natalie Shaw's witness statement. It noted that a letter, dated 12 February 2024, was sent to you by the GDC. Further chase letters were posted and emailed to you and an attempt to call you was made on 12 March 2024. The Committee also had sight of a letter, dated 13 February 2024, which was sent to the GDC by your legal representatives in respect of another fitness to practise matter. This letter informed the GDC that you were not currently working owing to matters concerning your private life. However, the Committee noted that this information was not shared with the relevant GDC caseworkers in respect of CAS-204904-D6Q0K0. In oral evidence, Ms Shaw stated that different teams within the GDC did not share information to ensure that there was no bias when making decisions on cases. Ms Shaw stated that if she had known about your personal circumstances at the time, she would have contacted your legal representatives and dealt with the case differently.

	Furthermore, Ms Shaw stated in her witness statement that on 28 March 2024, the GDC legal team contacted your legal representatives to enquire whether they were representing you in respect of this case. Your legal representatives were unable to confirm this. Miss Furley stated that the GDC's email, *'did not clearly identify the CAS reference and did not provide sufficient information to enable the representatives to understand which investigation was being referred to'*. The Committee was mindful that there was a duty on you to co-operate with a fitness to practice investigation conducted by the GDC. It also took into account that your legal team were in contact with the GDC in February 2024 in respect of other matters but this was not known by the relevant team in this case. There were also multiple cases being investigated by the GDC and various correspondence was sent to you in respect of those cases, and your legal team was dealing with many of these matters on your behalf. The Committee did not consider, on the available evidence, that your non-response was deliberate. The Committee determined, therefore, that in respect of this matter there is insufficient evidence that you were not co-operating with the GDC's investigation. Accordingly, the Committee found this head of charge not proved.
13.	Your conduct in respect of allegation 9c above was:
13(a)	Misleading; This head of charge falls away as allegation 9(c) was found not proved.
13(b)	Dishonest, in that you knew the information was inaccurate. This head of charge falls away as allegation 9(c) was found not proved.
14.	In relation to Patient I (as identified in Schedule 1 below), you:
14(a)	Withdrawn
14(b)	Withdrawn
15.	From on or around 3 December 2019 to on or around January 2023, you failed to provide Patient I with access to their records, despite requests from the patient.

	Proved by reason of admission
16.	In relation to Patient J, between around November 2022 and around March 2023, you:
16(a)	Failed to progress the patient's treatment in a timely manner; **Proved by reason of admission**
16(b)	Failed to communicate effectively with the patient regarding the progress of their treatment. **Proved by reason of admission**
17.	Between on or around 10 July 2023 to on or around 22 March 2024, you failed to co-operate with an investigation conducted by the General Dental Council in respect of CAS-203330-P2G4Y8 and/or CAS-205097-T3V9P3 and/or CAS-205937-M5G4Q1, in that you did not provide information requested by the General Dental Council. **Proved by reason of admission**

59. We move to stage two.

Stage 2

60. Having announced its decision on the facts, the hearing proceeded to Stage 2, which involved the consideration of misconduct, and if necessary, the matters of impairment, and if impairment is found, sanction.

61. The Committee also had regard to further documents, which were handed up following the announcement of the findings of fact. This included your signed witness statement, dated 17 July 2026, and associated exhibits, a signed witness statement, dated 20 July 2026, from your previous workplace supervisor and documents from the GDC in respect of your fitness to practise history.

Summary of the Committee's Findings

62. The Committee has found proved, based on your admissions, that dating back to September 2019 onwards you failed to co-operate, in a timely manner or at all, with solicitors representing patients in respect of prospective negligence claims concerning

five patients (Patients A, B, C, D and H). In addition, you admitted and the Committee found proved, that you failed to comply with a County Court Order to disclose the patient's records to the patient's solicitors in respect of Patient B.

63. In relation to Patient I, the Committee found proved, based on your admission, that you failed to provide Patient I with access to their records, despite requests from the patient, between the period around 3 December 2019 and January 2023.

64. The Committee also found proved, based on your admission, that you failed to co-operate with the GDC's investigation into your fitness to practise in respect of the cases CAS-203330-P2G4Y8 and/or CAS-205097-T3V9P3 and/or CAS-205937-M5G4Q1, relating to the period from July 2023 to March 2024.

65. In respect of Patient E, the Committee found proved that on or around 30 July 2013 you failed to adequately treatment plan the patient's treatment as you had not taken an appropriate radiograph or radiographs. As a result of this alleged failure, the Committee found proved that you failed to obtain informed consent for the subsequent treatment provided to Patient E.

66. In respect of Patient J, you admitted, and the Committee found proved, that between around November 2022 and around March 2023, you failed to progress the patient's treatment in a timely manner and failed to communicate effectively with the patient regarding the progress of their treatment.

Application for Part-Private Hearing

67. Before you gave oral evidence at this stage, Miss Furley made an application for the hearing to take place partly in private pursuant to Rule 53(1) and (2). Miss Furley submitted that any references made to your private life and health during your oral evidence should be heard in private. Mr Mansell did not oppose this application. The Committee heard and accepted the advice of the Legal Adviser as to the provisions of the Rules and the approach it should take to its decision.

68. The Committee bore in mind that, as a starting point, hearings should be conducted in public session. However, it was satisfied that the hearing should be held in private when matters regarding your private life and health are mentioned. The Committee therefore acceded to the application.

Oral Evidence

69. You gave oral evidence at Stage 2 and answered questions from Miss Furley, Mr Mansell and the Committee. The Committee also heard oral evidence from Person C, your current practice manager.

Submissions

70. In accordance with Rule 20(1)(a), Mr Mansell first addressed the Committee about your fitness to practise history. He stated that, in 2009 you were issued a warning by the Investigation Committee for 12 months. This warning was in respect of the following:

- Always put patient's interests first and show courtesy to patients.
- Ensure that patients are clear about whether they are receiving NHS or private treatment and to be clear to patients about costs.
- That patients seen by a student training to be a dentist are introduced, supervised and the patients have consented to be treated by a student and that all other relevant protocols are followed.
- Always provide patients with treatment plans.

71. Mr Mansell stated that in September 2019 you also appeared before the Professional Conduct Committee. It was found proved that you failed to provide an adequate standard of care to a patient by not obtaining radiographs prior to commencing treatment, not carrying out sufficient treatment planning, not diagnosing pathology at the UR7 from radiographs taken and that you provided a poor standard of treatment in relation to temporary restorations placed. You also failed to record an evaluation of radiographs taken. That Committee found your fitness to practise be impaired and issued you with a reprimand.

72. In September 2023, you appeared before a PCC. That Committee found proved, following your admissions, that you failed to hold adequate indemnity insurance during three periods (July 2015 to April 2016, April to September 2019 and September 2019 to May 2020) and that you also provided dental services during these periods. Furthermore, you admitted and the Committee found proved that you were misleading and dishonest when you informed the GDC that you held adequate indemnity insurance in December 2019, when you did not. That Committee found your fitness to practise be impaired and you were suspended for four months.

73. In addition to the above, Mr Mansell informed the Committee that there are currently five fitness to practise cases ongoing against you in respect of numerous allegations, which include the standard of clinical care towards multiple patients, not co-operating with complaints and failing to respond adequately to patients and their representatives. Mr Mansell, however, informed the Committee that these cases are currently with the GDC's case examiners and no findings have been made.

74. [PRIVATE].

75. Mr Mansell then addressed the Committee on the matter of misconduct. He first outlined the GDC Standards which you have breached. He then submitted that when considering misconduct and the seriousness of the clinical matters, the Committee would be assisted by Mr Mulcahy's expert reports. He submitted that in respect of the treatment provided to Patient E and your failure to take appropriate radiographs and

adequately treatment plan, Mr Mulcahy found this to be far below the expected standard as dental pathology could have gone unrecognised. In addition, he submitted that Mr Mulcahy found your failure to progress Patient J's treatment in a timely manner and your failure to communicate effectively with the patient were also both far below the expected standard.

76. Mr Mansell further submitted that your failure to co-operate with solicitors in respect of negligence claims, your failure to comply with a court order, your failure to provide a patient with access to their records and your failure to comply with the GDC's investigations also amounted to misconduct. He submitted that you had engaged in a persistent pattern of behaviour of non-co-operation for a period of four years when concerns were raised about your clinical practice. He submitted that this was conduct that fell far short of what was proper in the circumstances and would be considered deplorable by fellow practitioners.

77. In respect of impairment, Mr Mansell submitted that this could be divided into the personal and public components. As to whether your conduct was easily remediable, he submitted that the clinical issues were capable of remedy. However, your conduct in failing to co-operate with patients, solicitors, the GDC and with a court order was not easily remediable.

78. Mr Mansell submitted that an important factor for the Committee to consider would be your insight into your conduct and invited them to consider your witness statement and the oral evidence you have given at this stage. He submitted that the Committee may agree that you have shown a degree of insight but this is not yet complete. In particular, he submitted that when asked during your oral evidence about the impact of your conduct on patients and the public's confidence in the profession, your answer predominantly focussed on the embarrassment you have suffered. Furthermore, he submitted that the Committee may be concerned that you were initially resistant to the idea of setting aside a day to deal solely to deal with administration and any complaints. He also referred to the new systems and procedures that have recently been put in place at your practice to deal with any complaints and submitted that it may be a concern that it has only been running for six months. In respect of the clinical matters, he referred to the findings of the PCC in 2019 in which it was found that you lacked full insight and there was a risk of repetition and submitted that the Committee may find that there was the same degree of risk in this case.

79. Taking into consideration all of the above, Mr Mansell invited the Committee to find that your fitness to practise is currently impaired on the personal component.

80. Mr Mansell also invited the Committee to find that your fitness to practise is impaired on public interest grounds. He submitted that in respect of the seriousness of the matters found proved, an informed member of the public would be perturbed if a finding of impairment was not made. Furthermore, he submitted that a finding of impairment would be needed to maintain and uphold public confidence in the dental profession.

81. In respect of sanction, Mr Mansell submitted that erasure would be the most appropriate and proportionate outcome. He submitted that your behaviour of non-co-operation in respect of requests from patients, patients' solicitors, and non-compliance with GDC investigations and a court order was sustained over a period of time. He submitted that such conduct was highly damaging to the public's confidence in the profession and was fundamentally incompatible with the standards expected of dental professionals.

82. [PRIVATE].

83. In respect of misconduct, Miss Furley submitted that the clinical concerns in respect of Patient E relate to an isolated incident 13 years ago. She submitted that a single act or omission does not necessarily cross the threshold for misconduct. She submitted that, given the passage of time and as the failing was a relatively minor one, this would not amount to misconduct. In respect of your non co-operation with the GDC's investigation, she submitted that this was not indicative of a wider attitudinal problem as you have co-operated with the GDC on other matters. She submitted that this would also not amount to misconduct. However, in respect of your non-cooperation with patients and their solicitors regarding negligence claims and your failure to comply with a court order, she accepted that this would amount to misconduct as they are serious matters.

84. In respect of impairment, Miss Furley submitted that you have provided a clear and cogent explanation as to what was going on in your life at the relevant time. She submitted that you are undeniably a different man now compared to when these events took place. She submitted that you have demonstrated very clear insight into your personal circumstances and your [PRIVATE] such that the concerns have been remedied and a finding of current impairment is not necessary.

85. [PRIVATE].

86. Miss Furley submitted that your witness statement demonstrates that you possess real insight into your conduct. She submitted that since 2023 you have pared down your commitments and have a more simplified professional life. She referred the Committee to the oral evidence of Person C and the structures and processes you now have in place to ensure that patients' complaints are dealt with properly. She submitted that you have demonstrated that you have a more mature approach to your clinical practice. She submitted that the risk of repetition of your conduct is much lower now as the risk factors have either been removed or are controlled, and you are no longer trying to run away from your responsibilities.

87. Miss Furley invited the Committee to find that your fitness to practise is not currently impaired. She submitted that the public would be sympathetic to the situations you

have found yourself in and that the public interest would not be served by a finding of current impairment when the risks have been addressed.

88. In respect of sanction, Miss Furley submitted that, if a finding of impairment was made, then erasure would be entirely disproportionate. She submitted that a reprimand or a conditions of practice order would be appropriate and proportionate as there is no evidence that you pose a risk to the public and you have shown insight into your failings.

Committee's Decision

89. The Committee reminded itself that its decisions on misconduct, impairment and sanction are matters for its own independent judgement. There is no burden or standard of proof at this stage of the proceedings. It had regard to its duty to protect the public, declare and uphold proper standards of conduct and competence and maintain public confidence in the profession. Where applicable, the Committee took into consideration the GDC's "Standards for the Dental Team" ('GDC's Standards') and the document titled, *'Fitness to Practise: Guidance for the Practice Committees'* (effective 6 January 2026) ('the GDC's Guidance'). The Committee also had regard to relevant case law and has accepted the advice of the Legal Adviser.

Misconduct

90. The Committee first considered whether the matters found proved against you amounted to misconduct. In doing so it considered that the matters found proved could be grouped into the following themes:

    - Failure to co-operate with legal processes and GDC investigations; and
    - Clinical matters (Patients E and J).

91. The Committee also had regard to the GDC's Standards (effective from 30 September 2013). It determined that your conduct was in breach of the following standards:

    1 - Put patients' interests first

    2.1 Communicate effectively with patients – listen to them, give them time to consider information and take their individual views and communication needs into account.

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

    4.4: You must ensure that patients can have access to their records

4.4.1 Although patients do not own their dental records, they have the right to access them under Data Protection legislation. If patients ask for access to their records, you must arrange for this promptly, in accordance with the law.

9.4 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

9.4.1 If you receive a letter from the GDC in connection with concerns about your fitness to practise, you must respond fully within the time specified in the letter. You should also seek advice from your indemnity provider or professional association.

9.4.2 You must co-operate with:

…

- *any solicitor, barrister or advocate representing patients or colleagues.*

92. However, the Committee noted that the matters found proved in respect of Patient E related to July 2013 when the GDC's previous standards guidance was in effect titled *'Standards for Dental Professionals'*. The Committee determined that your conduct in respect of Patient E was in breach of the following standard from that guidance:

1.1 Put patients' interests before your own or those of any colleague, organisation or business.

93. The Committee considered that your failure to co-operate with patients' solicitors in respect of negligence claims and your failure to comply with a court order demonstrated a pattern of behaviour over several years, included failures in communication and involved multiple patients. The Committee considered that patients have a legitimate right to access their records and pursue claims if necessary. However, your actions obstructed this process and was a clear breach of GDC Standards. In particular, the Committee found your failure to comply with a court order, in and of itself, to be particularly significant and amounted to a serious failing.

94. In respect of your non-cooperation with GDC investigations, the Committee noted that the GDC Standards clearly state that you are expected to co-operate fully with any GDC investigation into your fitness to practise. Your non-cooperation was in respect of three separate investigations and covered a period of eight months.

95. Taking everything into consideration, the Committee concluded that your failure to co-operate with legal processes and the GDC investigations fell far short of the standards of conduct that are proper in these circumstances and amounted to misconduct.

96. In respect of the clinical matters and Patient E, the Committee noted from Mr Mulcahy's expert report that your failure to take a periapical radiograph fell far below the expected standard as dental pathology could have been missed. Your actions placed Patient E at unwarranted risk of harm, albeit the Committee acknowledged that no harm was caused to Patient E. Your failure in treatment planning also resulted in a failure to obtain informed consent from Patient E. The Committee noted and accepted Mr Mulcahy's opinion in his expert report that this also fell far below the expected standard.

97. In respect of Patient J, the Committee noted and accepted Mr Mulcahy's opinion that your failure to progress the patient's treatment in a timely manner and to communicate effectively with the patient regarding the progress of their treatment fell far below the expected standard.

98. In conclusion, the Committee determined that your clinical failings in respect of Patients E and J were serious, fell far below the expected standards and amounted to misconduct.

Impairment

99. The Committee then considered whether your fitness to practise is currently impaired by reason of your misconduct.

100. In respect of your failure to co-operate with legal processes and GDC investigations, the Committee considered that as this was an attitudinal issue it would be difficult to remediate as it would involve changing behaviour over a sustained period of time. The Committee then considered whether it has been remedied. [PRIVATE].

101. The Committee also took into account the systems and processes you now have in place to ensure that you track the progress of various processes within the practice, including complaints. The Committee noted the oral evidence of Person C, your Practice Manager, who explained to the Committee that these systems have been in place for six months and are working well. You have also dedicated a day each week to deal with administration at the practice.

102. The Committee considered your oral evidence. It noted that you now have a much simpler professional life as you no longer own a number of dental practices. You have also shown remorse for your actions. However, the Committee was of the view that you did not sufficiently address the impact of your misconduct on patients and the public's confidence in the profession. The Committee considered that you were more focused on the impact that your failings have had on you personally, in particular when you stated that you felt embarrassed by your conduct. The Committee considered, therefore, that although you have shown some insight into your failings, this was still developing.

103. The Committee then considered the likelihood of repetition of your misconduct. Whilst doing so, it was mindful of your previous fitness to practise history. It also noted the five current GDC investigations, which involve similar allegations of non-co-operation, but acknowledged that no findings have yet been made in respect of these matters. Taking this into consideration and bearing in mind that your insight into your misconduct is not fully developed, the Committee determined that your misconduct could be repeated. This, in the Committee's view, could place patients at risk of harm if you were not to co-operate with legal processes or any GDC investigation in future.

104. Accordingly, the Committee determined that a finding of impairment is necessary for public protection in respect of the non-cooperation matters.

105. The Committee also determined that a finding of impairment was required to maintain public confidence in the dental profession, to uphold the reputation of the dental profession, and to declare and uphold appropriate standards of conduct among dental professionals. It concluded that a reasonable and informed member of the public would lose confidence in the profession and the dental regulator if a finding of impairment was not made in circumstances where you have not co-operated with legal processes, including a court order, and with GDC investigations into your fitness to practise.

106. The Committee next considered whether your fitness to practise is impaired in respect of the clinical matters.

107. In respect of Patient E, the Committee took into account that the treatment took place 13 years ago and in respect of Patient J, three years ago. The Committee noted that you have worked under conditions for the previous three years and noted the positive reports from your workplace supervisor. It has also had sight of the audits of your radiographs and the positive testimonials about your clinical practice. You have also now implemented systems at your practice to monitor patients' treatments and the Committee has heard from Person C about how well this has been working. You have also set aside a day a week to undertake administration tasks.

108. Taking all of this into consideration, the Committee was satisfied that the clinical matters have been sufficiently remedied such that they are unlikely to be repeated.

109. Accordingly, the Committee determined that a finding of impairment is not necessary for public protection in respect of the clinical matters.

110. Furthermore, the Committee determined that a finding of impairment is not required in the public interest in respect of the clinical matters. It determined that in light of the remediation you have undertaken, an informed member of the public would not lose confidence in the dental profession if a finding of impairment was not made.

Sanction

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

112. The Committee considered the mitigating and aggravating factors in this case as outlined in the GDC's guidance.

113. The mitigating factors in this case included the following:

- Personal circumstances – [PRIVATE];
- Positive testimonials;
- Evidence of remediation and developing insight.

114. The aggravating factors in this case included the following:

- Risk of harm to patients in respect of the potential stress /anxiety caused to the patients as a result of your non-cooperation with their prospective legal claims;
- Multiple patients affected by your misconduct;
- Misconduct which spanned several years;
- Repeated non-cooperation with solicitors, the court and GDC investigations;
- Adverse fitness to practise history.

115. The Committee decided that it would be inappropriate to conclude this case with no further action. It would not protect the public or satisfy the public interest given the serious nature of the misconduct and the fact that the Committee has found your fitness to practise to be currently impaired on both public protection and public interest grounds in respect of your non-cooperation.

116. The Committee then considered the available sanctions in ascending order starting with the least serious.

117. The Committee concluded that misconduct of this nature cannot be adequately addressed by way of a reprimand. In the Committee's judgement, the misconduct found proved is serious, in particular your failure to comply with a court order. The Committee therefore determined that a reprimand would be inappropriate and inadequate as it would not sufficiently address the public protection and public interest concerns arising from this case.

118. The Committee considered whether a conditions of practice order would be appropriate. The Committee considered that this would be more appropriate to address discrete clinical failings and that conditions would not sufficiently address the behavioural failings in this case. Furthermore, the Committee considered the serious nature of the misconduct, which involved non-cooperation with legal processes and GDC investigations, and concluded that imposing conditions on your practice would not be sufficient or proportionate to maintain public confidence in the profession.

119. The Committee next considered whether to suspend your registration for a specified period. It questioned whether a suspension would be sufficient in all the circumstances of the misconduct that it has found. In reaching its decision, the Committee had regard to the relevant section in the GDC's Guidance regarding suspension and considered the following factors to be appropriate as referenced in the guidance:

• there is evidence of repetition of the behaviour;
• patients' interests would be insufficiently protected by a lesser sanction;
• public confidence in the profession would be insufficiently protected by a lesser sanction;
• there is no evidence of harmful deep-seated personality or professional attitudinal problems (which might make erasure the appropriate order).

120. The Committee determined that a period of suspension was appropriate and proportionate to mark the seriousness of your misconduct. In deciding on this sanction, the Committee specifically looked at those paragraphs in the guidance relating to erasure:

278. The sanction of erasure is the most severe and reserved for conduct that is so damaging to a registrant's fitness to practise and to public confidence in the dental professions that removal from the register is the only appropriate outcome.

279. An erasure order should only be imposed where there is no other means of protecting the public and/or maintaining confidence in the professions.

…

282. Erasure will be appropriate when the registrant's behaviour is fundamentally incompatible with continued registration, and when all, or some, of the following factors are present:

1. *The findings include serious departure(s) from the relevant professional standards.*

2. *Where serious harm to patients, colleagues, or other persons has occurred, either deliberately or through incompetence.*
3. *Where a continuing risk of serious harm to patients, colleagues, or other persons is identified.*
4. *Where the findings include the abuse of a position of trust or violation of the rights of patients, colleagues, or other persons, and particularly if involving vulnerable persons.*
5. *Where there are convictions or findings of a sexual nature in relation to patients, colleagues, or other persons, including involvement in any form of child sexual exploitation and abuse.*
6. *Where the findings include serious dishonesty, particularly where persistent or covered up.*
7. *Where there is a persistent lack of insight into the seriousness of actions or their consequences.*
8. *A lesser sanction would be insufficient to meet the public interest.*

121. In respect of (a), the Committee was mindful that your misconduct was a serious departure from the relevant professional standards. In respect of (d), whilst there was no abuse of a position of trust, the Committee considered there had been a violation of the rights of patients to be provided with their clinical records. Nevertheless, the Committee was satisfied that in respect of these you had processes in place with a view to reducing the risk of repetition. The Committee did not consider that any of the other factors listed in paragraph 282, which may indicate erasure, were present in this case.

122. Therefore, the Committee determined that the option of erasure would be disproportionate and that your misconduct was not fundamentally incompatible with continued registration.

123. In reaching this view, the Committee considered that you have shown insight into your misconduct (albeit this is still developing) and that you have put in place systems and processes to mitigate the risk of repetition. The Committee also determined that, whilst the non-cooperation matters are attitudinal in nature, [PRIVATE] and the steps taken thus far to address matters, it is not harmful or deep-seated.

124. Accordingly, having had regard to all of the evidence, the Committee has determined to direct that your registration be suspended for a period of 12 months. The Committee is satisfied that this period of time is sufficient to mark the nature and extent of your misconduct, to protect the public, uphold professional standards and to maintain public confidence in the profession.

125. The Committee also directs that the suspension order be reviewed before its expiry. You will be informed of the date and time of that resumed hearing. That Committee will

consider what action it should take in relation to his registration. The reviewing Committee may be assisted by the following:

- A written reflective piece about how your non-cooperation with legal processes and the GDC's investigation affected the public and the public's confidence in the profession, and the impact it had on the regulatory process.

126. The Committee will now go on to consider whether an immediate suspension order should be imposed on your registration, pending the taking effect of its substantive order of suspension.

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127. The Committee has considered whether to make an order for the immediate suspension of your registration in accordance with Section 30 of the Dentists Act 1984 (as amended).

128. Mr Mansell, on behalf of the GDC, invited the Committee to impose an immediate order of suspension on your registration. He submitted that an immediate order is necessary on the grounds of public protection and the public interest. He submitted that this would be the logical and consistent approach given the Committee's findings.

129. Miss Furley submitted that an immediate order of suspension is not necessary for public protection owing to the safe rails in place at your practice. Furthermore, she submitted that it is also not in the public interest given the age of these issues, as there is an interim order in place on your registration in respect of another matter and as you are engaging with the GDC.

130. Miss Furley, on your behalf, submitted that an immediate order of suspension would have a materially negative impact on you and would also have the potential to put patients at risk as they would not receive their expected dental care over the next few weeks. She submitted that an immediate order would also impact on the handover of your clinical work, would have a significant impact on the people working at the practice and would also have a negative impact on you professionally and financially.

131. The Committee has considered the submissions made. It has accepted the advice of the Legal Adviser.

132. In respect of public protection, the Committee was mindful that in order for an immediate order to be necessary there has to be a significant risk of harm to patients. Whilst the Committee has determined that there is a risk of repetition, it also noted the procedures and processes in place to mitigate that risk. In the particular circumstances of this case, it was therefore satisfied that the threshold for necessity has not been reached.

133. Accordingly, the Committee has determined that an immediate order is not necessary on the grounds of public protection.

134. In respect of the public interest, the Committee was satisfied that the seriousness of your misconduct has been marked by its substantive sanction of a 12-month suspension and therefore does not require the imposition of an immediate order in addition to meet the public interest. It also was mindful of the impact that any immediate order would have on you professionally and personally.

135. Accordingly, the Committee has determined that an immediate order is not necessary on the grounds of public interest.

136. The Committee also directs that the interim conditions of practice order currently in place in respect of this case on your registration shall be revoked.

137. That concludes this hearing.