

HEARING HELD IN PUBLIC

Professional Conduct Committee Initial Hearing

20 April to 1 May 2026

Name: ZANGANEH, Boran

Registration number: 71214

Case number: CAS-207891-D5V7G4

General Dental Council: Louise Price, Counsel
Instructed by Natasha Savovic, Kingsley Napley

Registrant: Present
Represented by Ben Rich, Counsel
Instructed by Maria Kai, MDDUS

Fitness to practise: Impaired by reason of misconduct

Outcome: Suspended with immediate suspension (with a review)

Duration: 12 Months

Immediate order: Immediate suspension order

Committee members: Carson Black (Chair, Dentist Member)
Amit Jinabhai (Lay Member)
Hannah Couch (Dental Care Professional Member)

Legal Adviser: Jane Kilgannon

Committee Secretary: Lola Bird

ZANGANEH, Boran, a dentist, Tandläkare Umeå University 1987 is summoned to appear before the Professional Conduct Committee on 20 April 2026 for an inquiry into the following charge:

The charge (as amended):

“That being registered as a dentist, Boran Zanganeh’s (71214) fitness to practice is impaired by reason of misconduct. In that:

Patient 1

1. *You failed to provide an adequate standard of care to Patient 1 from 17 June 2022 and 14 February 2023 including by;*
 - a. *incorrectly diagnosing, including*
 - i. *caries on LL5;*
 - ii. *need for extraction of LL5.*
 - b. *extracting the LL5 rather than the LL6;*
 - c. *providing treatment that was not clinically indicated at LL5;*
 - d. *providing a poor standard of treatment, including, failing to carry out extraction at LL6;*
 - e. *not discussing the risks and benefits of the proposed course of treatment.*
2. *You failed to obtain informed consent for the treatment provided to Patient 1 on 13 October 2022 in respect of the extraction of LL5.*
3. *You stated in your response about Patient 1’s treatment, including that;*
 - a. *“the LL5 appeared carious”;*
 - b. *“there was a request from the patient to remove the LL5 instead”;*
 - c. *“we did try to contact the practice”;*
 - d. *“there appears to have been a breakdown in communication and I understood that during a phone conversation with the orthodontic practice that the extraction of LL5 had been approved”.*

Patient 4

4. *You failed to provide an adequate standard of care to Patient 4 from 01 September 2022 to 12 September 2022 including by;*
 - a. *not carrying out sufficient diagnostic assessments, in particular tenderness to percussion and palpation and/or sensitivity testing and/or radiographic*

- examination;*
- b. *not carrying out sufficient treatment planning as your planning was based on an incorrect diagnosis of traumatic occlusion and you advised crown removal rather than occlusal adjustment;*
 - c. *not adequately communicating the treatment plan to Patient 4;*
 - d. *providing a poor standard of treatment, including:*
 - i. *WITHDRAWN;*
 - ii. *you unnecessarily removed the crown at LL6;*
 - iii. *you recemented the crown at LL6.*
 - e. *providing treatment that was not clinically indicated in that you removed the crown and then recemented the crown at LL6;*
 - f. *WITHDRAWN.*
5. *You failed to obtain informed consent for the treatment provided to Patient 4 from 01 September 2022 to 12 September 2022.*

Patient 10

6. *You failed to provide an adequate standard of care to Patient 10 on 28 November 2022 including by;*
- a. *not treating/not adequately treating Patient 10, including*
 - i. *WITHDRAWN;*
 - ii. *not diagnosing the issues with UL8, which were that it was over-erupted and sharp and was causing trauma;*
 - iii. *prescribing antibiotics when this was not clinically necessary.*
7. *Your actions in respect of allegations 3a-d above were;*
- a. *misleading as the comments made at 3a-d were not accurate;*
 - b. *dishonest as the comments made at 3a-d were not true;*
 - c. *lacking integrity as the comments made at 3a-d were not accurate and/or true.*
8. *WITHDRAWN;*
- a. *WITHDRAWN.*
9. *You have failed to uphold your duty of candour as you did not tell Patient 1 that*

the extraction of LL5 was not clinically necessary and/or was done in error.

Mr Zanganeh,

1. This is a Professional Conduct Committee (PCC) hearing in respect of a case brought against you by the General Dental Council (GDC). The charge relates to your treatment of three patients.
2. The hearing is being conducted in person at the Dental Professionals Hearings Service.
3. You are represented at these proceedings by Mr Ben Rich, Counsel. The Case Presenter for the GDC is Ms Louise Price, Counsel.

PRELIMINARY MATTERS

Decision on application to amend the charge – 20 April 2026

4. At the outset of the hearing, Ms Price made an application to amend the charge pursuant to Rule 18 of the *GDC (Fitness to Practise) Rules Order of Council 2006* ('the Rules'). She applied to correct a minor typographical error at head of charge 4(d)(i) by amending the reference to 'LL6' to 'UL6'. Ms Price submitted that there could be no prejudice to you in terms of the application, as you were aware that 'UL6' was the correct tooth, as referred to in your witness statement prepared for this hearing.
5. Mr Rich did not oppose the proposed amendment. He submitted that you had been aware at an early stage that head of charge 4(d)(i) referred to the wrong tooth and that you had flagged the matter in your witness statement.
6. Having heard from both parties and having accepted the advice of the Legal Adviser regarding its power under Rule 18 to amend the charge at any stage before making its findings of fact, the Committee acceded to the GDC's application. The Committee had regard to the merits of the case and the fairness of the proceedings, and it was satisfied that the correction of this minor typographical error could be made without causing any injustice. The Committee took into account that you had been aware of the error and that you had highlighted the matter in advance in your witness statement.
7. Accordingly, head of charge 4(d)(i) was amended to include reference to 'UL6' instead of 'LL6'. The amended version of the charge is as set out at the beginning of this document.

Decision on application to admit hearsay evidence – 21 April 2026

8. Ms Price next made an application to admit hearsay evidence in the form of two undated letters of complaint written about you by Patient 4. Ms Price told the Committee that the letters were relevant to a number of the allegations within the charge, the primary allegation being head of charge

4(f). Head of charge 4(f) alleges that you advised Patient 4 that “*Crown Treatment was not available on the NHS*”. Ms Price also referred to the associated allegations at heads of charge 7 and 8, which allege that your advising Patient 4 that Crown treatment was not available on the NHS was misleading, dishonest, lacking in integrity and financially motivated.

9. In applying to admit the hearsay evidence, Ms Price commended to the Committee her written skeleton argument on the matter. She also drew the Committee’s attention to its discretion under Rules 57(1) and 57(2) of the Rules, which state that:

“1) A Practice Committee may in the course of the proceedings receive oral, documentary or other evidence that is admissible in civil proceedings in the appropriate court in that part of the United Kingdom in which the hearing takes place.

(2) A Practice Committee may also, at their discretion, treat other evidence as admissible if, after consultation with the legal adviser, they consider that it would be helpful to the Practice Committee, and in the interests of justice, for that evidence to be heard.”

10. Ms Price outlined that the first of the two complaint letters written by Patient 4, sets out what the patient said you told her about the provision of NHS crowns, whilst in the second complaint letter, Patient 4 stated that all you kept telling her was that she needed to buy a new crown at a cost of £715.

11. Ms Price confirmed that Patient 4 would not be attending this hearing, hence the application to admit the letters of complaint as hearsay evidence. Ms Price asked the Committee, when considering the application, to have regard to the bundle of correspondence containing the GDC’s email communications with Patient 4 about her attendance at these proceedings as a witness.

12. Ms Price submitted that in reaching its decision, the Committee should consider the interests of justice. She stated that this should include careful consideration of the GDC’s overarching statutory objective, which is: to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the dental professions, and to promote and maintain proper professional standards and conduct for members of those professions.

13. Ms Price set out in detail in her written skeleton argument the relevant legal principles for the Committee to consider, including those from the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) (*‘Thorneycroft’*), which she summarised in her oral submissions. Ms Price stated that when considering the issue of fairness, the Committee should take into account the following factors:

- That the extent of your challenge to the hearsay evidence is limited.
- That whilst you deny head of charge 4(f), you have accepted that you conveyed to Patient 4 that cosmetic crowns were not available on the NHS.
- That it therefore follows that the level of factual dispute on the issue is limited.

14. Ms Price further highlighted that, as part of its consideration on whether to admit the hearsay evidence, the Committee would need to determine whether Patient 4’s two letters of complaint are

the sole and decisive evidence in relation to head of charge 4(f) and heads of charge 7 and 8, in so far as they relate to 4(f). It was Ms Price's submission that the two letters of complaint are not the sole and decisive evidence in respect of these allegations. She submitted that there are other sources of evidence to support the reliability of the letters, namely the evidence of the Practice Manager who received them, the clinical records from the relevant appointment, and your evidence as contained in your witness statement prepared for this hearing.

15. Finally, whilst Ms Price acknowledged that the issue of weight should not be conflated with a decision on admissibility, she submitted that any limited prejudice to you in admitting the two letters of complaint could be addressed by the Committee when determining what weight to attach to them.

16. In responding to the application, Mr Rich also provided the Committee with a written skeleton argument together with three case authorities and he made submissions orally. It was his submission that consideration of the GDC's overarching objective was implicit in the legal principles derived from the relevant case law. Mr Rich stated that the fundamental question for the Committee was whether it was fair to admit the hearsay evidence, given the difficulty of you being unable to challenge it in the absence of Patient 4 giving oral evidence. Mr Rich submitted that the Committee should consider the issue of fairness as a criterion in its own right, and only have regard to the matter of weight, if it determines that it is fair to admit the hearsay evidence.

17. With reference to relevant case law, Mr Rich made a number of submissions, which he asked the Committee to take into account when reaching its decision. This included his submission that the two letters in question were written by Patient 4 in the context of a complaint to a service provider, and not in the context of fitness to practise proceedings where a registrant's career is at stake. Mr Rich submitted that Patient 4 has never agreed to submit any formal evidence to the GDC in relation to the relevant allegations.

18. As set out in his written skeleton argument, Mr Rich went on to address in detail the legal principles arising from the case of *Thorneycroft*. He submitted the following:

- that the two letters, if read as the GDC appears to read them, are the sole and decisive evidence on the relevant allegations. He stated that the issue in head of charge 4(f) is simply whether or not you advised Patient 4 that "*Crown Treatment was not available on the NHS*". Mr Rich submitted that only Patient 4 suggests that any such thing was said, there is no other evidence that such a comment was made, and it is denied by you.
- that contrary to what was submitted by the GDC, head of charge 4(f) is challenged in its entirety. Mr Rich submitted that if the GDC is trying to say that adding the word "*cosmetic*" before "*crown treatment*" in the allegation would make no difference then no evidence has been served to suggest that would be an untrue statement. He submitted that the allegation at 4(f) clearly suggests that you refused Patient 4 an NHS crown by saying that such treatment is not available on the NHS.
- that although it is not suggested that Patient 4 is outright fabricating her complaints, she does have reasons to be angry with you, and that this would have been explored in cross-examination to establish if her account was distorted by it. Mr Rich highlighted

that in her second letter of complaint Patient 4 refers to seeking positive financial compensation for the pain she has suffered which, Mr Rich said, might also provide a distorting motive.

- that the Committee would not need to be reminded of the seriousness with which dishonesty is taken in these proceedings, and the possible consequences for you should the relevant allegation be found proved.
- that Patient 4 does not have a good reason for not attending this hearing. Mr Rich highlighted that in her only substantive communication with the GDC, and having been told how important it was for her to take part in these proceedings, Patient 4 stated “*I understand but im too busy with my family and not time or money to travel to London im ever so sorry*”. Mr Rich asked the Committee to take into account that when Patient 4 was offered mitigations by the Council, including the possibility of participating in the hearing remotely via Microsoft Teams video-link, Patient 4 did not reply.
- that the GDC’s contact with Patient 4 has been limited. Mr Rich submitted that whilst the Council correctly stated that it contacted Patient 4 four times, he stated that two of those occasions was just for the checking of ID. Furthermore, that all of the contact was by email. Mr Rich submitted that as a minimum, an attempt should have been made to contact Patient 4 by telephone.
- that there is no dispute about the receipt or authenticity of the letters. However, the fact that the letters were received, which is not disputed, does not help with their credibility. It was Mr Rich’s submission that the fact that Patient 4 has good (and admitted) grounds for complaining about her treatment does not add to the credibility of her account of what you said.
- That this hearsay application only came about when you requested that Patient 4’s two letters of complaint be redacted as inadmissible, after receiving the hearing bundle. Mr Rich submitted, that in any case, you do not base your objection to the hearsay evidence on the timing of when the GDC made it clear it sought to rely on it, but on its fundamental unfairness.

The Committee’s decision on the hearsay application

19. The Committee considered the evidence provided to it. It took account of the submissions made, both orally and in writing, by Ms Price on behalf of the GDC and by Mr Rich on your behalf. The Committee accepted the advice of the Legal Adviser regarding its discretion to admit hearsay evidence under Rule 57, the important principles to be drawn from the case law brought to its attention and from the GDC’s ‘*Guidance for the practice committees (effective from 6 January 2026)*’ (‘the Guidance’).

20. The Committee noted from the Rules and the Guidance that it had a discretion to admit hearsay evidence if it considered it would be helpful and in the interests of justice. It also took into account that the issues of ‘relevance’ and ‘fairness’ should be key considerations in its decision-making. The Committee further bore in mind the overarching statutory objective of the GDC.

21. The Committee considered individually the factors set out in the case of *Thorneycroft*, as drawn to its attention by both parties. It reached the following conclusions:

- **Whether Patient 4's two letters of complaint are the sole or decisive evidence in support of head of charge 4(f) and heads of charge 7 and 8 in so far as they relate to 4(f)**

22. It was the view of the Committee that the two letters of complaint are the sole and decisive evidence in support of these allegations. The specific wording at head of charge 4(f) is that you advised "*Patient 4 that Crown Treatment was not available on the NHS*". Whilst the Committee noted the submission made by the GDC regarding other sources of evidence, it was not satisfied, having considered the material before it, that there is other evidence to corroborate that this is exactly what you told Patient 4. The only basis for the allegation at head of charge 4(f) is Patient 4's complaint letters. The fact that another witness received the letters is not, in the Committee's view, evidence of their reliability or accuracy. The Committee also considered that the limited information available in the clinical records does not assist with what it was you told Patient 4 about the availability of crown treatment on the NHS.

- **The nature and extent of the challenge to the contents of the letters**

23. The Committee considered the nature and extent of the challenge to the content of the letters to be significant. It took into account that the objections made on your behalf to the hearsay evidence is not restricted to the narrow issue of what you allegedly said to Patient 4 about the availability of crown treatment on the NHS. The Committee noted that during his oral submissions, Mr Rich highlighted a number of issues within the letters that are disputed, which he said that he would have explored with Patient 4 in cross-examination.

- **Whether there is any suggestion that Patient 4 had reasons to fabricate her complaint**

24. The Committee by no means intends to minimise Patient 4's complaint or her account of what she experienced. However, it noted that within her second letter she states that she would like to be financially compensated for what she described as "*unprofessional care*". The Committee took into account the submission made on your behalf, which was not challenged by the GDC, that Patient 4 had not paid anything towards her treatment with you. The Committee considered that, in the circumstances, it could not rule out that there might have been a financial motive. The Committee also noted from Patient 4's second letter of complaint that there is reference to you having informed her about an impacted tooth, but other evidence suggests that this was a conversation that she had at an appointment with another dentist. The Committee therefore considered the possibility that Patient 4 may have conflated the two appointments, which in its view does raise a question about reliability.

- **The seriousness of the charge, taking into account the impact which adverse findings might have on your career**

25. The allegations in question are very serious, including alleged dishonesty. The Committee bore in mind the potential consequences for your registration should head of charge 4(f) and the associated allegations at heads of charge 7 and 8 be found proved.

- **Whether there is a good reason for the non-attendance of Patient 4**

26. The Committee did not consider there to be a good reason for Patient 4's non-attendance at this hearing. It noted that she did not respond to the mitigations offered to her by the GDC, which included the potential of participating remotely and the Council's solicitors informing her that they did not anticipate her interview taking too long.

- **Whether the GDC has taken reasonable steps to secure Patient 4's attendance**

27. The Committee was not satisfied that the GDC has taken reasonable steps to secure Patient 4's attendance at this hearing. It considered that more should have been done to encourage her participation. In reaching its decision, the Committee noted that other than the two substantive email communications with Patient 4 that were drawn to its attention, no further contact appears to have been attempted, with all efforts having been abandoned as early as July 2025.

- **Whether you had prior notice that the letters would be relied upon by the GDC**

28. The Committee noted the submissions made on your behalf regarding the timing of this application made by the GDC. However, it also took into account that your objection to the admission of the hearsay evidence is not based on whether you had sufficient notice of the GDC's reliance on the letters, but rather, as Mr Rich described it, the fundamental unfairness of the application itself.

29. Having considered all the above factors, the Committee drew from its conclusions that the letters were potentially relevant to heads of charge 4(f), 7 and 8, but it would be fundamentally unfair and contrary to the interests of justice to admit them into evidence.

30. In reaching its decision, the Committee took into account that Patient 4's letters, which are the sole and decisive evidence in respect of the relevant allegations, were not written with this PCC hearing in mind. The letters cannot be equated to a formal witness statement with a signed declaration of truth. Furthermore, the Committee considered that some of the issues raised by Patient 4 in her letters lack clarity and specificity, particularly in relation to the key issue of what it was you discussed in relation to the availability of crown treatment on the NHS.

31. It was the Committee's view, that the letters are not demonstrably reliable, and it considered that in the absence of Patient 4, there would be no way of testing their contents. The Committee considered that it would be highly prejudicial to you to admit the letters as hearsay evidence in these circumstances, taking into account the nature and extent of your challenge to a number of matters Patient 4 raised in her complaint. The Committee bore in mind that cross-examination is not an unfettered right, but it considered that it would be significant for the untested letters to be admitted, given the gravity of the allegations concerned.

32. The Committee therefore determined to reject the GDC's application to admit Patient 4's two letters of complaint as hearsay evidence.

Decision on application to further amend the charge – 21 April 2026

33. In light of the Committee's determination to reject the GDC's application to admit the hearsay evidence, Ms Price made an application to further amend the charge by way of withdrawals. She applied to withdraw the allegations on which the unadmitted hearsay evidence was based, namely heads of charge 4(f) and 8 and head of charge 7 to the extent that it related to head of charge 4(f).

34. Mr Rich agreed with this further application to amend the charge, and he confirmed that he had no submissions to make in respect of it.

35. The Committee accepted the advice of the Legal Adviser in relation to its power under Rule 18 to amend the charge at any stage before making its findings of fact.

36. In acceding to the application to withdraw head of charge 4(f) and the associated allegations at heads of charge 7 and 8, the Committee noted that following its decision to reject the GDC's application to admit the hearsay evidence, there was now a lack of evidence to support these alleged matters. Therefore, having had regard to the merits of this case and the fairness of the proceedings, the Committee was satisfied that the allegations could be withdrawn without causing any injustice. The Committee considered the overarching statutory objective of the GDC, and it was satisfied that the withdrawal of head of charge 4(f) and the associated allegations at heads of charge 7 and 8 would not risk undercharging in this case. It took into account that the allegations to be withdrawn were limited to the specific comment that was alleged at head of charge 4(f) and that a number of other allegations relating to Patient 4 remain.

37. Accordingly, the charge was further amended to withdraw heads of charge 4(f) and 8 and to remove the references to 4(f) that were included at head of charge 7. The charge, as further amended, is set out at the beginning of this document.

Admissions to the amended charge – 21 April 2026

38. The Committee next heard your admissions to the amended charge. Mr Rich told the Committee that you admitted the following heads of charge: 1 to 3 (in their entirety), 4(b), 4(c), 4(d)(ii), 4(d)(iii), 4(e), 5, 6(a)(ii), 6(a)(iii), 7(a) in so far as 7(a) relates to 3(a), and 9.

39. In relation to your admission to head of charge 1(a)(i), which alleged that you incorrectly diagnosed caries on Patient 1's LL5, Mr Rich explained that you were not admitting this allegation on the basis that you saw caries in the tooth yourself and diagnosed it. Your admission was that you thought the LL5 was a tooth that was carious, based on a diagnosis that you thought had already been made in respect of that tooth. Mr Rich told the Committee that you considered accepting what you thought was the diagnosis of another practitioner was effectively diagnosing the caries yourself, hence your admission to 1(a)(i).

40. All the remaining allegations within the charge: 4(a), 4(d)(i), 6(a)(i), 7(a) in so far as 7(a) relates to 3(b) to 3(d), 7(b) in so far as 7(b) relates to 3(a) to 3(d) and 7(c) in so far as 7(c) relates to 3(a) to 3(d) were denied.

The Committee's decision on the admissions – 21 April 2026

41. Having considered your admissions and having noted Ms Price's confirmation that she was content with the basis on which they were made, the Committee heard and accepted the advice of the Legal Adviser. The Legal Adviser drew the Committee's attention to paragraphs 118 and 119 of the Guidance, which deal with admissions made at the preliminary stage of a Practice Committee hearing. The Legal Adviser also referred the Committee to the separate guidance issued by the Dental Professionals Hearings Service entitled '*Guidance on admissions made at the preliminary stage of fitness to practise hearings*' (December 2025).

42. Following its consideration of the relevant guidance, the Committee confirmed that it was content to accept the admitted heads of charge as proved. The Committee took into account that you are legally represented at this hearing. It was satisfied that the admissions you made through your Counsel were clear, unequivocal and were not made under duress. The Committee was further satisfied that you understood the basis on which you made the admissions.

43. Accordingly, the Committee announced at the preliminary stage of the hearing that the following heads of charge were 'Admitted and found proved': 1 to 3 (in their entirety), 4(b), 4(c), 4(d)(ii), 4(d)(iii), 4(e), 5, 6(a)(ii), 6(a)(iii), 7(a) but only in so far as 7(a) relates to 3(a), and 9.

The GDC's opening submissions and summary of the allegations

44. In opening the case for the GDC, Ms Price outlined that the alleged facts relate to a period when you were practising as a dentist at a dental practice ('the Practice'). You were employed by the Practice for approximately six months until January 2023, but it is understood that you stopped working there around mid-December 2022. The Committee noted from the evidence that the matters in this case arise from a complaint made to the GDC by the Practice in February 2023.

45. The allegations set out in the charge relate to your treatment of three patients, Patient 1, Patient 4 and Patient 10. Ms Price stated that the GDC's case against you suggests that the standard of treatment you provided to the patients was poor in several ways. Further, that some of your admitted actions relating to the treatment of Patient 1 are alleged by the Council to have been misleading, dishonest or lacking in integrity, and amounted to a failure to uphold your duty of candour.

46. The Committee noted from the summary provided by Ms Price in her opening submissions the individual circumstances in which each patient attended to see you at the Practice. The Committee heard that Patient 1 had been referred to see you for a number of extractions prior to planned orthodontic treatment with another practitioner. The factual matters concerning your treatment of Patient 1 include your admission that at one of the patient's appointments you extracted LL5 instead of LL6 which had been referred for extraction.

47. Patient 4 attended to see you at the Practice for an emergency appointment complaining of severe pain. You admitted, amongst other matters, that you did not carry out sufficient treatment planning, as the planning you did undertake was based on an incorrect diagnosis.

48. Patient 10 also attended the Practice for an emergency appointment. The patient was complaining of pain and constant issues with their wisdom teeth. You admitted not treating or not adequately treating Patient 10, including by not diagnosing issues with the UL8.

49. Following her opening submissions, Ms Price proceeded to adduce the evidence relied upon by the GDC in this case.

Decision on further admission to the amended charge – 22 April 2026

50. During the course of the GDC's evidence, you made a further admission to the amended charge. This was your partial admission to head of charge 4(a), which alleges that you failed to provide an adequate standard of care to Patient 4 from 1 September 2022 to 12 September 2022, including by:

“not carrying out sufficient diagnostic assessments, in particular tenderness to percussion and palpation and/or sensitivity testing and/or radiographic examination”.

51. Mr Rich referred the Committee to your written evidence, as set out in your witness statement, which stated that you would have done, and did do, tenderness to percussion and palpation diagnostic assessments. Mr Rich stated, however, that there was a mistake in your witness statement that you wished to correct. He referred the Committee to the relevant paragraph in which you stated that *“I did not carry out radiographic examination on the first occasion that the patient attended with me. It is my recollection that the patient was having difficulty opening their mouth, which made it difficult to obtain a radiograph”*. Mr Rich confirmed that this was in fact incorrect, as the clinical records shows that you did take a radiograph on that first occasion on 1 September 2022. However, you accepted that the radiograph was not adequate for the purpose of diagnosing, and you did not re-take a radiograph when the patient re-attended to see you on 12 September 2022. Mr Rich told the Committee that you accepted that you should have re-taken a radiograph. He told the Committee that it was on this basis that you admitted the radiographic examination element of head of charge 4(a). The other elements of 4(a) remained in issue.

52. The Committee accepted the advice of the Legal Adviser regarding the relevant guidance on admissions. It took into account its discretion to accept this further partial admission should it consider it appropriate to do so. The Committee was satisfied that your partial admission to head of charge 4(a) was clear, unequivocal, made without duress and that you understood the basis of it. In the circumstances, it determined that it could accept it. In doing so, the Committee noted that the remaining elements of head of charge 4(a) continued to be in dispute, and that it would need to make findings on those outstanding matters.

Summary of the GDC's evidence

53. The evidence received by the Committee from the GDC during the fact-finding stage (Stage One) was both oral and documentary.

54. The documentary evidence provided by the GDC comprised:

- The clinical records of Patient 1, Patient 4 and Patient 10.
- A witness statement dated 28 October 2025, along with an associated exhibit, from Witness 1, the Specialist Orthodontist who referred Patient 1 to you.
- A witness statement dated 7 October 2025, along with associated exhibits, from Witness 2, Senior Clinical Advisor at the Practice.
- A witness statement dated 8 October 2025, along with an associated exhibit, from Patient 1.
- A report dated 2 December 2025, prepared by Dr Jane Ward, the expert witness instructed by the GDC, whose expertise is in restorative dentistry.

55. Additionally, the Committee heard oral evidence from Witness 1, Witness 2, Patient 1 and Dr Ward, all of whom gave their evidence remotely by video-link.

Decision on further application to amend the charge – 22 April 2026

56. Following the conclusion of the GDC's evidence, with the Committee having heard from Dr Ward, Ms Price made a further application to amend the charge, pursuant to Rule 18 of the Rules. In light of Dr Ward's opinions on the relevant matters, Ms Price applied to withdraw the allegations at heads of charge 4(d)(i) and 6(a)(i) respectively.

57. Head of charge 4(d)(i) was the previously amended allegation that you provided a poor standard of treatment to Patient 4, including "*at UL6 you did not treat a fracture or investigate reported swelling*". Dr Ward agreed in her oral evidence that the reference to swelling in the clinical records appeared to her to relate to the left-hand side of the patient's lower jaw as opposed to the upper left. Dr Ward also stated that she considered that it was a reasonable decision, in all the circumstances, to have left the hairline fracture at UL6 for treatment on another occasion as opposed to the emergency appointment Patient 4 attended with you.

58. Head of charge 6(a)(i) was the allegation that you did not treat or treat adequately Patient 10, including "*not treating caries diagnosed at LL7*". Dr Ward's opinion was that the main issue at Patient 10's emergency appointment was in respect of the LL8. Dr Ward noted that the caries on LL7 was identified by you as an additional problem and that advice was given to the patient in relation to it. Dr Ward accepted, when asked in cross-examination, that it was reasonable for the patient to re-attend the Practice on a later date in respect of LL7, when a full examination could be undertaken.

59. Mr Rich agreed with the GDC's application to withdraw heads of charge 4(d)(i) and 6(a)(i) and he confirmed that he had no submissions to make in respect of the matter.

60. The Committee accepted the advice of the Legal Adviser in relation to its power under Rule 18 to amend the charge at any stage before making its findings of fact.

61. The Committee had regard to the merits of this case and the fairness of the proceedings, and it was satisfied that the allegations at heads of charge 4(d)(i) and 6(a)(i) could be withdrawn without causing any injustice. It noted that in the light of Dr Ward's opinions given in her oral evidence, there was insufficient evidence to support either allegation. In reaching its decision, the Committee considered the overarching statutory objective of the GDC, and it was satisfied that the withdrawal of 4(d)(i) and 6(a)(i) would not risk undercharging in all the circumstances of this case. The Committee took into account that the GDC had concluded that it was no longer in the public interest to pursue the allegations concerned.

62. The charge was therefore further amended to withdraw heads of charge 4(d)(i) and 6(a)(i). The charge, as it was further amended, is set out in its entirety at the beginning of this document.

63. Ms Price went on to formally close the GDC's case and the evidence on your behalf was presented.

Summary of the evidence on your behalf

64. The Committee received documentary and oral evidence in respect of your case at this fact-finding stage.

65. The documentary evidence provided to the Committee on your behalf comprised:

- Your witness statement prepared for this hearing dated 23 March 2026, along with a copy of your CV.
- The unredacted signature pages of the consent form signed by Patient 1 on 13 October 2022.

66. You also gave oral evidence in relation to the factual matters in this case.

The Committee's Findings of Fact – 27 April 2026

67. The Committee considered all the evidence presented to it, both documentary and oral. It took account of the closing submissions made in respect of the outstanding allegations by Ms Price on behalf of the GDC and by Mr Rich on your behalf. Both Counsel provided their submissions in writing and made them orally.

68. The Committee accepted the advice of the Legal Adviser in relation to the burden and standard of proof, how to approach the evidence, and the legal principles and guidance applicable to its decision-making, including the test for dishonesty as set out in the case of *Ivey v Genting*

Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67 (*Ivey*) and the definition of ‘integrity’ as provided in case law, including the case of *Wingate v Solicitors Regulation Authority* [2018] 1 WLR 3969.

69. 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, the balance of probabilities. The Committee has had to determine whether it was more likely than not that the alleged matters occurred.

70. The Committee’s findings are set out in the table below. For completeness, they include the factual matters that were announced as ‘Admitted and found proved’ earlier in the proceedings:

Patient 1	
1(a)(i)	<p>1. <i>You failed to provide an adequate standard of care to Patient 1 from 17 June 2022 and 14 February 2023 including by;</i></p> <p style="padding-left: 40px;"><i>a. incorrectly diagnosing, including</i></p> <p style="padding-left: 80px;"><i>i. caries on LL5;</i></p> <p>Admitted and found proved.</p>
1(a)(ii)	<p>1. <i>You failed to provide an adequate standard of care to Patient 1 from 17 June 2022 and 14 February 2023 including by;</i></p> <p style="padding-left: 40px;"><i>a. incorrectly diagnosing, including</i></p> <p style="padding-left: 80px;"><i>ii. need for extraction of LL5.</i></p> <p>Admitted and found proved.</p>
1(b)	<p>1. <i>You failed to provide an adequate standard of care to Patient 1 from 17 June 2022 and 14 February 2023 including by;</i></p> <p style="padding-left: 40px;"><i>b. extracting the LL5 rather than the LL6;</i></p> <p>Admitted and found proved.</p>
1(c)	<p>1. <i>You failed to provide an adequate standard of care to Patient 1 from 17 June 2022 and 14 February 2023 including by;</i></p> <p style="padding-left: 40px;"><i>c. providing treatment that was not clinically indicated at LL5;</i></p> <p>Admitted and found proved.</p>
1(d)	<p>1. <i>You failed to provide an adequate standard of care to Patient 1 from 17 June 2022 and 14 February 2023 including by;</i></p> <p style="padding-left: 40px;"><i>d. providing a poor standard of treatment, including, failing to carry out extraction at LL6;</i></p> <p>Admitted and found proved.</p>

1(e)	<p>1. <i>You failed to provide an adequate standard of care to Patient 1 from 17 June 2022 and 14 February 2023 including by;</i></p> <p style="padding-left: 40px;"><i>e. not discussing the risks and benefits of the proposed course of treatment.</i></p> <p>Admitted and found proved.</p>
2	<p>2. <i>You failed to obtain informed consent for the treatment provided to Patient 1 on 13 October 2022 in respect of the extraction of LL5.</i></p> <p>Admitted and found proved.</p>
3(a)	<p>3. <i>You stated in your response about Patient 1’s treatment, including that;</i></p> <p style="padding-left: 40px;"><i>a. “the LL5 appeared carious”;</i></p> <p>Admitted and found proved.</p>
3(b)	<p>3. <i>You stated in your response about Patient 1’s treatment, including that;</i></p> <p style="padding-left: 40px;"><i>b. “there was a request from the patient to remove the LL5 instead”;</i></p> <p>Admitted and found proved.</p>
3(c)	<p>3. <i>You stated in your response about Patient 1’s treatment, including that;</i></p> <p style="padding-left: 40px;"><i>c. “we did try to contact the practice”;</i></p> <p>Admitted and found proved.</p>
3(d)	<p>3. <i>You stated in your response about Patient 1’s treatment, including that;</i></p> <p style="padding-left: 40px;"><i>d. “there appears to have been a breakdown in communication and I understood that during a phone conversation with the orthodontic practice that the extraction of LL5 had been approved”.</i></p> <p>Admitted and found proved.</p>
Patient 4	
4(a)	<p>4. <i>You failed to provide an adequate standard of care to Patient 4 from 01 September 2022 to 12 September 2022 including by;</i></p> <p style="padding-left: 40px;"><i>a. not carrying out sufficient diagnostic assessments, in particular tenderness to percussion and palpation and/or sensitivity testing and/or radiographic examination;</i></p>

Admitted in part; on the basis that you did not carry out an adequate radiographic examination.

Found proved on the basis of your admission that you did not carry out an adequate radiographic examination but also on the basis that you did not carry out sensitivity testing.

The clinical records show that Patient 4 attended to see you on 1 September 2022 for an emergency appointment complaining of severe pain in all areas of her mouth and feeling pressure everywhere. The patient reported that the pain was so bad that she could not eat or sleep. A swelling was noted on the left side of the patient's jaw. Your diagnosis set out in the clinical records for 1 September 2022 was "*Traumatic occlusion LL6 metal crown to upper left 6. LL5 impacted tooth close to LL6 roots UL6m [mesially] hairline crack*". The clinical records further indicate that a periapical radiograph was taken to check the periapical pathology of LL6. You prescribed antibiotics and advised Patient 4 to book a review appointment.

In her expert report, Dr Ward stated regarding the periapical radiograph taken that "*The radiograph shows the crown LL6 and some of the roots however the apical portion of both roots has been missed so is not diagnostic and apical radiolucency could not be excluded*". It was Dr Ward's opinion that, as the periapical radiograph did not show the apical area, your radiographic examination at this emergency appointment on 1 September 2022 was not adequate. You admitted this to be the case. You also admitted that you did not re-take the radiograph when Patient 4 returned to see you for a review appointment on 12 September 2022, and that you should have done so.

It was Dr Ward's opinion that, in addition to an adequate radiographic examination, you should have conducted a number of diagnostic tests on Patient 4 prior to diagnosing the cause of her pain. Dr Ward noted in her expert report that there is no reference in the clinical notes to any diagnostic tests, which she said should have included testing to check if the patient's LL6 was tender to percussion or palpation and sensitivity testing.

It was your evidence that, whilst not recorded in the clinical records of the emergency appointment on 1 September 2022, you would have palpated Patient 4's LL6 and checked whether the tooth was tender to percussion. You told the Committee that this would have been in accordance with your usual practice. You stated, however, that you did not carry out any sensitivity testing of Patient 4, as the patient was in too much pain and you exercised your clinical judgement not to carry out such testing in the circumstances.

The Committee found proved, on the basis of your admission, that you did not carry out a sufficient diagnostic assessment as far as a radiographic examination was concerned for the reason explained by Dr Ward regarding the inadequacy of the periapical radiograph of LL6. The Committee was satisfied from your admission and Dr Ward's evidence that you should have carried out an adequate radiographic examination.

The Committee was also satisfied, taking into account Dr Ward's expert opinion, that further diagnostic assessments by way of diagnostic tests were required in the circumstances of Patient 4's presenting condition. The

Committee considered that Dr Ward was clear and consistent in stating that before a correct diagnosis could be achieved, all the basic assessments needed to be undertaken, which, she said, was especially important, given the vagueness of the symptoms reported by the patient.

In reaching its decision on the sufficiency of your diagnostic assessments of Patient 4, as far as diagnostic tests were concerned, the Committee noted your evidence that you would have carried out tender to percussion testing or palpating on the patient's LL6. You stated in your witness statement that whilst you had no specific memory of doing so, you believed that you did carry out both tests because you always do this as part of your clinical practice.

In considering your evidence, the Committee took into account that there is no reference in the clinical records for either of Patient 4's appointments on 1 September 2022 and 12 September 2022 of you having undertaken palpation of the tooth or percussion testing. The Committee bore in mind that the burden of proof rests with the GDC and that the absence of a record does not necessarily mean that those diagnostic tests were not carried out. The Committee noted that whilst there are no allegations of poor record keeping in this case, issues have been highlighted regarding the general standard of some of your records, including by Dr Ward. You also stated in your witness statement that you should have made a record in the patient's notes of the diagnostic tests carried out, and that you could "... see with the benefit of hindsight how this would be confusing for anyone reviewing the notes".

The Committee further took into account that you admitted all the clinical allegations in this case where you considered there were failures in your clinical practice, including in relation to other aspects of your treatment of Patient 4. This included your partial admission to this allegation at head of charge 4(a).

It was the view of the Committee, having considered all the evidence, that the GDC has not proved on the balance of probabilities, that you did not follow your usual practice of carrying out palpation and percussion testing of Patient 4's LL6 prior to reaching a diagnosis at the emergency appointment on 1 September 2022. The Committee was not satisfied that the GDC proved that the absence of any notes was anything other than a failure of record keeping.

The Committee went on to consider the issue of sensitivity testing. It noted your evidence that you did not carry out this diagnostic test on account of Patient 4 being in too much pain. The Committee noted Dr Ward's opinion that sensitivity testing should have been carried out. She explained that, unlike palpation and percussion testing, sensitivity testing checks a different aspect of the tooth, namely the vitality of the pulp. Dr Ward stated that sensitivity testing was particularly important in the absence of a diagnostic radiograph of the LL6 showing the apex of the tooth. She stated that sensitivity testing is quick and easy to do, that it would have assisted in assessing whether the pulp of the tooth was dead or alive, and that it would have been helpful and useful for making a diagnosis and planning treatment.

Having considered Dr Ward's evidence, the Committee was satisfied that by not carrying out sensitivity testing, you omitted an important and necessary diagnostic assessment in the context of Patient 4's presenting complaint. The

	<p>Committee noted that in your oral evidence, you acknowledged that sensitivity testing would have provided you with useful clinical information. The Committee also took into account that your diagnosis of “<i>Traumatic occlusion</i>” as being the cause of Patient 4’s pain was incorrect, and because of this you advised crown removal rather than occlusal adjustment. Dr Ward’s opinion was that occlusal adjustment would have been the treatment of choice. The Committee considered that your incorrect diagnosis may have been avoided had your diagnostic assessments included sensitivity testing. The Committee took the view that no reasonable body of dentists would have omitted sensitivity testing in the circumstances of Patient 4 experiencing severe pain, especially given the absence of an adequate radiograph. The Committee noted Dr Ward’s evidence that sensitivity testing is quick and easy to do, and it considered that it was unusual that you did not do it.</p> <p>Accordingly, the Committee was satisfied that this allegation at 4(a) is proved on the basis that you did not carry out sensitivity testing, as well as on the basis of your admission of not having carried out an adequate radiographic examination.</p>
4(b)	<p>4. <i>You failed to provide an adequate standard of care to Patient 4 from 01 September 2022 to 12 September 2022 including by;</i></p> <p><i>b. not carrying out sufficient treatment planning as your planning was based on an incorrect diagnosis of traumatic occlusion and you advised crown removal rather than occlusal adjustment;</i></p> <p>Admitted and found proved.</p>
4(c)	<p>4. <i>You failed to provide an adequate standard of care to Patient 4 from 01 September 2022 to 12 September 2022 including by;</i></p> <p><i>c. not adequately communicating the treatment plan to Patient 4;</i></p> <p>Admitted and found proved.</p>
4(d)(i)	WITHDRAWN.
4(d)(ii)	<p>4. <i>You failed to provide an adequate standard of care to Patient 4 from 01 September 2022 to 12 September 2022 including by;</i></p> <p><i>d. providing a poor standard of treatment, including:</i></p> <p><i>ii. you unnecessarily removed the crown at LL6;</i></p> <p>Admitted and found proved.</p>
4(d)(iii)	<p>4. <i>You failed to provide an adequate standard of care to Patient 4 from 01 September 2022 to 12 September 2022 including by;</i></p> <p><i>d. providing a poor standard of treatment, including:</i></p> <p><i>iii. you recemented the crown at LL6.</i></p> <p>Admitted and found proved.</p>

4(e)	<p>4. You failed to provide an adequate standard of care to Patient 4 from 01 September 2022 to 12 September 2022 including by;</p> <p>e. providing treatment that was not clinically indicated in that you removed the crown and then recemented the crown at LL6;</p> <p>Admitted and found proved.</p>
4(f)	WITHDRAWN.
5	<p>5. You failed to obtain informed consent for the treatment provided to Patient 4 from 01 September 2022 to 12 September 2022.</p> <p>Admitted and found proved.</p>
Patient 10	
6(a)(i)	WITHDRAWN.
6(a)(ii)	<p>6. You failed to provide an adequate standard of care to Patient 10 on 28 November 2022 including by;</p> <p>a. not treating/not adequately treating Patient 10, including</p> <p>ii. not diagnosing the issues with UL8, which were that it was over-erupted and sharp and was causing trauma;</p> <p>Admitted and found proved.</p>
6(a)(iii)	<p>6. You failed to provide an adequate standard of care to Patient 10 on 28 November 2022 including by;</p> <p>a. not treating/not adequately treating Patient 10, including</p> <p>iii. prescribing antibiotics when this was not clinically necessary.</p> <p>Admitted and found proved.</p>

The allegations at head of charge 7 relate to a letter dated 14 February 2023, which you sent to Witness 1, the Specialist Orthodontist who referred Patient 1 to you for the extraction of four teeth, namely UR5, UL5, LL6 and LR5. You sent the letter to Witness 1 in response to his letter to the Practice dated 13 January 2023, in which he stated that “...the Dentist has removed the LL5, rather than the heavily filled and compromised LL6 as we prescribed”.

It was maintained by the GDC, as reflected in the allegations at head of charge 7(a) that you made four comments in your letter of response to Witness 1 that were not accurate and therefore misleading. Furthermore, it was the GDC’s case at head of charge 7(b) that in making the comments, you acted dishonestly because you knew they were not true. The GDC maintained that having mistakenly removed the wrong tooth, namely the LL5 rather than the LL6, you sought to make excuses for that error by making the comments in your letter of response to Witness 1.

The Committee also noted that the GDC alleged at head of charge 7(c) that your actions in respect of your letter were lacking in integrity. However, it was clarified that the alleged lack of

integrity is charged as an alternative to dishonesty. Therefore, the Committee would only need to consider whether your actions in respect of the letter lacked integrity if it found that you had not acted dishonestly.

In reaching its decisions, the Committee considered your letter to Witness 1 dated 14 February 2023. As you admitted, and as the Committee found proved at heads of charge 3(a) to 3(d) above, you stated in that letter that *“...I was aware that you needed the LL6 extracted however, on the day they presented, the LL5 appeared carious and there was a request from the patient to extract LL5 instead. We did try and contact the practice however, there appears to have been a breakdown in communication and I understood that during a phone conversation with the orthodontic practice that the extraction of LL5 had been approved. Clearly, this is not the case from the content of your letter and I am sorry that there has been a very clear breakdown in communication I suspect at our end. I note that you now wish LL6 extracted which we are more than happy to arrange...”*

Having had regard to the letter, the Committee went on to consider whether the individual comments highlighted in the charge at heads of charge 3(a) to 3(d) were misleading and/or dishonest. It bore in mind that if it did not find dishonesty in relation to one or more of the comments, it would need to consider whether, alternatively, your actions in making them amounted to a lack of integrity.

7(a)	<p>7. <i>Your actions in respect of allegations 3a-d above were;</i></p> <p>a. <i>misleading as the comments made at 3a-d were not accurate;</i></p>
7(a) in respect of 3(a)	<p>Admitted and found proved.</p> <p>The Committee took into account the context in which your comment at 3(a) was made. It noted that you specifically stated in your letter of 14 February 2023 that, <i>“...however, on the day they presented, the LL5 appeared carious...”</i></p> <p>You acknowledged that there was no evidence of caries in Patient 1’s LL5. Accordingly, you admitted this allegation at 7(a), namely that commenting in your letter that <i>“LL5 appeared carious”</i> was misleading because it was inaccurate, although you stated that this was inadvertent.</p> <p>The Committee found head of charge 7(a) in respect of 3(a) proved on the basis of your admission. It also noted from the radiographic evidence, the opinion of Dr Ward, who reviewed the radiographic evidence, and the evidence of Witness 1, the referring Specialist Orthodontist, that Patient 1’s LL5 was not carious. The Committee was satisfied that stating that the LL5 appeared carious was not accurate, and therefore it was a comment that was misleading.</p>
7(a) in respect of 3(b)	<p>Found proved.</p> <p>This was your comment in your letter of 14 February 2023 that <i>“there was a request from the patient to remove the LL5 instead”</i>.</p> <p>The Committee noted your evidence as set out in your witness statement. You stated that <i>“Patient 1 was referred to me by an orthodontist for the removal of four teeth. On 29 July 2022, I saw Patient 1 for an examination.</i></p>

	<p><i>On 1 September 2022, I extracted tooth LR5. A few days later on 6 September 2022, I extracted both UR5 and UL5. Patient 1 returned on 13 October 2022 for the removal of the remaining tooth. When she returned, I knew that a tooth needed to be removed, but I could not recall which one. The reception/nursing team and I were unable to find the paper referral form. This was compounded by the fact that the (assistant) staff were relatively new and did not have any experience, ... Additionally, the OPG was unavailable to me at the time, I am unsure whether this was because the nursing staff could not find it or because the computer was not working. Throughout my time at the practice, I had difficulties with the electronic system as the computer system was often extremely slow and was broken down. I cannot recall the precise reason I could not access the OPG / and the original referral letter from the Orthodontist, but I was unable to review this. I made the decision not to take a new x-ray, because I had no access without a computer”.</i></p> <p><i>You went on to state in your witness statement “I asked reception to call Patient 1’s orthodontist to ask which tooth needed to be removed. I also asked the patient herself, and she pointed to the LL5. I would not proceed on the patient’s instructions alone, so I waited for confirmation from the reception team who were calling the orthodontist. I then received a message back that it was the LL5 that needed extracting”.</i></p> <p>In relation to Patient 1 pointing out a particular tooth, the Committee noted that when you were questioned further under cross-examination at this hearing, you stated that Patient 1 may have mixed up the LL5 and LL6 as these teeth are close together. You subsequently conceded that Patient 1 pointing out a tooth to you was not the same as requesting the removal of LL5 “instead” of any other tooth.</p> <p>The Committee noted that Patient 1’s recollection of events was compromised by the passage of time. This limited the weight that could be placed on her evidence. Patient 1 had no recollection of being asked to point to the tooth to be removed. However, in the Committee’s view, regardless of whether she could remember this issue, it would have been highly unusual for you, a dentist with some 30 years’ experience, to ask a young patient (Patient 1 was 16 years old at the time) which tooth needed to be extracted and to rely on that. Furthermore, the Committee noted that you resiled from the suggestion that Patient 1 had requested the extraction of LL5 “instead”, as you stated in your letter to Witness 1. You accepted in your oral evidence that the patient had attended the Practice for the removal of ‘a tooth’, as opposed to requesting that a particular tooth be extracted.</p> <p>It was the finding of the Committee, having considered the evidence, that your comment in your letter of 14 February 2023 that “there was a request from the patient to remove the LL5 instead” was not accurate and that it was therefore misleading. The Committee was satisfied that by stating this, you gave the wrong impression to any reader of your letter, namely that Patient 1 had made a direct request for the LL5 to be removed instead of the LL6.</p>
<p>7(a) in respect of 3(c)</p>	<p>Found proved.</p>

This was your comment in your letter of 14 February 2023 that “*we did try to contact the practice*”, (meaning the Orthodontic Practice from which Patient 1 was referred).

The Committee decided to accept Witness 1’s evidence that there was no record of the Practice contacting the Orthodontic Practice about Patient 1’s extraction on 13 October 2022, and that it would be highly unusual for there to be no record made if such contact was made. This was information that was within Witness 1’s direct knowledge and his account was consistent throughout his written and oral evidence. The Committee decided that it would not be appropriate, however, to admit Witness 1’s evidence as to an internal investigation that he said was held with his administrative staff about whether such contact was received. This was because the Committee decided that it would be anonymous hearsay evidence which, by its nature, is unreliable. Furthermore, there is no evidence that the GDC made any efforts to secure witness statements or the attendance of those administrative staff at this hearing, and so admitting the anonymous hearsay evidence would be unfairly prejudicial to you.

In considering the accuracy of your comment “*we did try to contact the practice*”, the Committee noted that there is no evidence of any records or other documentation to support this statement. Witness 1 told the Committee that, had a telephone call been received by the Orthodontic Practice to ask about the correct tooth to be extracted, he would have expected this to have been recorded by his staff. The Committee further took into account that, despite your evidence regarding possible issues with the Practice’s computer system, it did have before it time and date stamped records of Patient 1’s appointment on 13 October 2022. The Committee found that it was more likely than not that you were able to view Patient 1’s clinical records and make computerised notes during the appointment. It noted that there is no mention in your notes about any confusion as to which tooth should be extracted or to any contact or attempted contact with the Orthodontic Practice.

The Committee considered that in another context, the absence of a record of contact or attempted contact with the Orthodontic Practice on 13 October 2022 would not necessarily be determinative. However, it noted the highly unusual nature of the situation that you say occurred. You stated that you were unsure about which tooth should be removed, with no access to Patient 1’s referral form or any other relevant records or radiographs, so you had to go to the extent of asking your reception staff to contact the Orthodontic Practice. Both Witness 1 and Dr Ward stated that they would have expected some sort of record to have been made in the circumstances. The Committee noted Dr Ward’s evidence that the extraction of a wrong tooth is regarded in dentistry as a ‘*never event*’. It also heard from Witness 1 that an incorrect extraction is something that he would meticulously try to avoid, given the seriousness of such an error. The Committee also considered that if the Practice had contacted the Orthodontic Practice it would have been highly unlikely that staff there would have referred to LL5 as their own notes only referred to LL6.

Having considered the evidence, the Committee concluded that the absence of any record in relation to what was a very unusual situation is significant. The Committee found that it was more likely than not that no attempt was

	<p>made to contact the Orthodontic Practice. Accordingly, it was satisfied that your comment in the letter stating “<i>we did try to contact the practice</i>” was not accurate and it was misleading.</p>
7(a) in respect of 3(d)	<p>Found proved.</p> <p>This was your comment in your letter of 14 February 2023 that “<i>there appears to have been a breakdown in communication and I understood that during a phone conversation with the orthodontic practice that the extraction of LL5 had been approved</i>”.</p> <p>The Committee found head of charge 7(a) proved in respect of 3(d) for the same reasons given in relation to 7(a) in respect of 3(c) above.</p> <p>The Committee considered that the absence of any record from 13 October 2022 indicating that such a phone conversation took place, and more importantly, that the Orthodontic Practice had “<i>approved</i>” the extraction of LL5 is significant. The Committee found that Witness 1 was clear and credible in his evidence that, had a telephone call been received by the Orthodontic Practice to ask about the correct tooth to be extracted, he would have expected this to have been recorded by his staff. The Committee also noted the absence of any mention of the unusual situation in your clinical records for Patient 1’s appointment on 13 October 2022.</p> <p>It was the conclusion of the Committee, having taken account of the evidence, that it was more likely than not, that the Orthodontic Practice was not contacted and therefore no such conversation occurred. Accordingly, the Committee was satisfied that your comment about a breakdown in communication and your understanding from a phone conversation with the Orthodontic Practice was not an accurate reflection of what happened and as such it was misleading.</p>
7(b)	<p>7. <i>Your actions in respect of allegations 3a-d above were;</i></p> <p style="padding-left: 40px;">b. <i>dishonest as the comments made at 3a-d were not true;</i></p> <p>In reaching its decisions in relation to this head of charge, 7(b), as it relates to heads of charge 3(a) to (3d), the Committee applied the test for dishonesty as set out in the case of <i>Ivey</i>. In accordance with that test, it first ascertained (subjectively) your actual state of knowledge or belief as to the facts. Having established your actual state of knowledge or belief as to the facts, the Committee went on to determine whether (objectively) your actions were honest or dishonest by the standards of ordinary decent people.</p>
7(b) in respect of 3(a)	<p>Found proved.</p> <p>This was your comment in your letter of 14 February 2023 that “<i>the LL5 appeared carious</i>”.</p> <p>You admitted in your oral evidence that this comment was inaccurate, as there was no evidence that the LL5 was carious. You told the Committee that what you had been trying to convey in your letter was that you had thought</p>

the LL5 was the carious tooth that had been identified for extraction, but that you did not explain yourself properly.

The Committee took into account that English is not your first language. It had regard to the submission made on your behalf that given the quality of your English, it is credible that you expressed yourself badly in this way, and that you acknowledge that the comment was factually misleading. However, the Committee considered, having read your letter to Witness 1 of 14 February 2023, that it is well written. The Committee also took into account that you have been practising as a dentist in the UK for a significant period of time. At this hearing, in response to questions from the Committee, you confirmed that you were able to fully participate without the assistance of an interpreter to understand what you were being asked and to give full answers. In the circumstances, the Committee did not accept that a language barrier was a contributing factor.

The Committee had regard to the inconsistent nature of your explanations around the extraction of the LL5 instead of the LL6. It noted that your stance as to what led to the error changed during the course of your evidence. You cited lack of access to your previous clinical records and the patient referral form at the material time as one of the problems. You also maintained that Patient 1 had requested the removal of the LL5 instead of LL6. The Committee noted that the patient requesting the removal of a specific tooth is an explanation from which you have since resiled.

Eventually, in answer to questions from the Committee, you admitted that because the other three teeth that had been referred for extraction were premolars (UR5, UL5, and LR5), you had assumed that the fourth tooth to be removed on 13 October 2022 was also a premolar, and that is what led to your mistake of extracting LL5 instead of LL6. It was the view of the Committee, having considered your evidence, that your explanation about assuming all the teeth to be extracted were premolars was the most credible. For whatever reason, you did not look at Patient 1's notes at the time and you extracted the wrong tooth based on your assumption.

It was the conclusion of the Committee that your actual state of knowledge, at the time you wrote your letter of 14 February 2023 to Witness 1, was that you knew you had made a mistake by removing LL5 instead of LL6. You accepted in your oral evidence that you could have checked Patient 1's clinical records prior to writing the letter. The Committee also noted that you stated in the letter to Witness 1 that "*I was aware that you needed LL6 extracted...*". The Committee was satisfied on the evidence that when you commented in that letter "*the LL5 appeared carious*", you did mean exactly what you wrote and it was not true. You knew by that time that there was no other clinical reason for the LL5 to have been removed, and the Committee was satisfied that it was more likely than not that you made the comment to justify your erroneous extraction of the LL5.

The Committee was satisfied that ordinary decent people would consider that making a comment, with an intent to disguise a mistake, is conduct that is dishonest.

	Accordingly, head of charge 7(b) is found proved in respect of head of charge 3(a).
7(b) in respect of 3(b)	<p>Found proved.</p> <p>This was your comment in your letter of 14 February 2023 that <i>“there was a request from the patient to remove the LL5 instead”</i>.</p> <p>Having considered the well-written nature of the letter and your years of experience practising as a dentist in the UK, the Committee rejected the suggestion that this was also a statement that was not inadvertently poorly expressed.</p> <p>The Committee found that your state of knowledge at the time of writing the letter to Witness 1, was that you knew that you had made a mistake in extracting LL5. You admitted at this hearing that the LL5 did not appear carious. Furthermore, the Committee took into account that there was no other apparent clinical justification for the removal of that tooth.</p> <p>Whilst the Committee had regard to the fact that Patient 1 signed consent forms pertaining to the extraction of LL5, it again noted her young age. The Committee also took into account that the circumstances of the appointment on 13 October 2022 were such that you, the treating dentist, said you could not recall the exact tooth to be extracted. However, your records show no note of this being the case.</p> <p>You conceded in your oral evidence at this hearing that Patient 1 had not requested the removal of LL5 instead of any other tooth but was aware that she had attended for an extraction. The Committee was satisfied that when you made the comment in your letter to Witness 1 that Patient 1 had requested the removal of <i>“LL5 instead”</i>, alongside the also untrue assertion that the tooth appeared carious, you were trying to conceal that you had made an error in extracting the tooth.</p> <p>The Committee was satisfied that ordinary decent people would consider that making a comment, with an intent to disguise a mistake, is conduct that is dishonest.</p> <p>Accordingly, head of charge 7(b) is found proved in respect of head of charge 3(b).</p>
7(b) in respect of 3(c)	Found proved.
7(b) in respect of 3(d)	<p>Found proved.</p> <p>In reaching its decisions on dishonesty in respect of your comments set out at heads of charge 3(c) and 3(d), the Committee considered the matters separately but made the same findings for the same reasons.</p> <p>These were your comments that <i>“we did try to contact the practice”</i> (meaning the Orthodontic Practice from which Patient 1 was referred) and <i>“there appears to have been a breakdown in communication and I understood that</i></p>

	<p><i>during a phone conversation with the orthodontic practice that the extraction of LL5 had been approved”.</i></p> <p>The Committee found on the evidence that it was more likely than not that there was no contact or attempted contact with the Orthodontic Practice for the reasons given in respect of head of charge 7(a) above. It therefore found that both comments at heads of charge 3(c) and 3(d) were misleading. In finding that they were also dishonest, the Committee took into account the contradiction between your evidence and the explanation you gave in your letter to Witness 1 regarding the extraction of LL5.</p> <p>Your evidence was that prior to extracting the LL5 on 13 October 2022, you asked for Witness 1 and/or the Orthodontic Practice to be contacted because you were unsure which tooth needed to be removed. You stated that you received a message back indicating that it was LL5 that needed to be extracted. However, in your letter of 14 February 2023 to Witness 1, you stated that you had been aware that the Orthodontic Practice had requested that LL6 be extracted and you stated that <i>“the LL5 appear carious”</i> and <i>“there was a request from the patient to remove the LL5 instead”</i>, giving the impression that you took alternative action for those reasons. It therefore appeared to the Committee, on its reading of your letter, that when you then went on to say <i>“we did try to contact the practice”</i> and <i>“there appears to have been a breakdown in communication and I understood that during a phone conversation with the orthodontic practice that the extraction of LL5 had been approved”</i>, you were not saying that you had contacted the Orthodontic Practice to find out what the actual treatment plan was, as suggested in your evidence, but to communicate why there had been a change of plan from the extraction of LL6 to LL5 on that occasion. You go on to state in your letter that <i>“I note that you now wish LL6 extracted which we are more than happy to arrange”</i>.</p> <p>As already stated, the Committee has found, on balance, that there was no contact or attempted contact with the Orthodontic Practice. In its view, given your state of knowledge at the time of writing the letter, namely that you knew you had made a mistake, the inconsistencies in your explanation for how the mistake occurred and the absence of any supporting records, the Committee was satisfied that it was more likely than not that you included the untrue comments about having contacted and received confirmation from the Orthodontic Practice in the letter to justify your error.</p> <p>The Committee was satisfied that ordinary decent people would consider that making misleading comments to justify a mistake is conduct that is dishonest.</p> <p>Accordingly, head of charge 7(b) is found proved in respect of heads of charge 3(c) and 3(d).</p>
7(c)	<p>7. <i>Your actions in respect of allegations 3a-d above were;</i></p> <p><i>c. lacking integrity as the comments made at 3a-d were not accurate and/or true.</i></p> <p>In view of the Committee’s findings at 7(b) above, head of charge 7(c) falls away.</p>

	Having found dishonesty proved in respect of all your actions at heads of charge 3(a) to 3(d), the Committee has not had to consider this alternative allegation regarding a lack of integrity at 7(c). It therefore falls away.
8(a)	WITHDRAWN.
9	<p>9. <i>You have failed to uphold your duty of candour as you did not tell Patient 1 that the extraction of LL5 was not clinically necessary and/or was done in error.</i></p> <p>Admitted and found proved.</p>

71. The hearing now moves to Stage Two.

Stage Two of the hearing – 28 April to 1 May 2026

72. The facts found proved in this case relate to your treatment of three patients, Patient 1, Patient 4 and Patient 10, whilst you were practising as a dentist at the Practice. You admitted, and the Committee found proved, that you provided a poor standard of care to the respective patients on account of a number of clinical failings. The Committee also found proved that you failed to provide an adequate standard of care to Patient 4 by not carrying out sufficient diagnostic assessments.

73. The Committee further found proved that comments you made in a letter dated 14 February 2023, which you sent to Patient 1's Orthodontist (Witness 1) regarding the extraction of a wrong tooth, were misleading and dishonest. The Committee also found proved, on the basis of your admission, that you failed to uphold your duty of candour, as you did not tell Patient 1 that the extraction of her LL5 instead of her LL6 was not clinically necessary and done in error.

74. The Committee's considerations at this second stage of the hearing were 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.

75. In its considerations, the Committee considered all the evidence presented to it, both at Stage One of the hearing and at this stage. The evidence received at this stage comprised a 'Stage 2 Bundle' submitted on your behalf, which included evidence of your Continuing Professional Development (CPD), a number of Supervisor Reports from your Workplace Supervisor appointed under an interim conditions of practice order that is currently in place on your registration, logs covering various aspects of your clinical practice, and a testimonial dated 22 April 2026 from your Workplace Supervisor. The Committee was also provided with a witness statement from your Workplace Supervisor dated 27 April 2026.

76. The Committee heard submissions from Ms Price on behalf of the GDC and from Mr Rich on your behalf in relation to misconduct, impairment and sanction.

Summary of parties' submissions

77. Ms Price provided her submissions in writing, and she made supplementary submissions orally. In accordance with Rule 20(1)(a) of the Rules, Ms Price first addressed the Committee on your fitness to practise history before the GDC. She referred to the details of that history, as included in her written submissions. She set out that you had one previous regulatory finding made against you in 2008. The Committee on that occasion found that a patient, 'Patient A', attended to see you on 4 October 2005 complaining of pain at the back of the right side of her mouth. On that day, you extracted her upper and lower right third molar (wisdom) teeth.

78. The Committee in 2008 found that, prior to carrying out treatment, you did not undertake an adequate investigation into Patient A's symptoms, nor did you provide her with an explanation of the alternative treatments available. It was also found that you did not obtain Patient A's informed consent to the treatment, and that you did not explain the risks involved. As a result of your failures, you extracted Patient A's lower right and upper right wisdom teeth when it was not clinically justified to do so. The Committee in 2008 found that the proven facts in that case amounted to misconduct and that your fitness to practise was impaired. That Committee imposed a substantive conditions of practice order on your registration for a period of two years.

79. Ms Price submitted that your fitness to practise history was plainly a relevant matter for this Committee's consideration.

80. In addressing the issues of misconduct, impairment and sanction in relation to this current case, Ms Price invited the Committee to take account of her written submissions, including her references to the relevant case law and guidance. She also set out in her written submissions the GDC's '*Standards for the Dental Team*' (September 2013) ('the GDC Standards'), which the Council considered applicable in this case.

81. In summary, Ms Price submitted that this Committee ought to find misconduct on the facts that it has found proved. She stated that you admitted serious clinical failures in respect of the three patients concerned. She highlighted that in one case you extracted the wrong tooth (Patient 1). In another case, at an emergency appointment, you failed to diagnose the cause of the patient's pain (Patient 4), and that in the third case you misdiagnosed the clinical issue and unnecessarily removed a crown that caused the patient to have further unnecessary clinical treatment, whilst also not resolving the presenting concern (Patient 10).

82. Ms Price further highlighted your admission in relation to your failure to uphold your duty of candour with Patient 1 following your error in extracting the wrong tooth. Ms Price asked the Committee to take into account the oral evidence of Dr Ward, the GDC's expert witness, that a wrong tooth extraction is a 'never event'. Ms Price also submitted that Witness 1 emphasised the steps taken by dental practitioners to avoid such an occurrence. It was Ms Price's submission that any member of the dental profession would find your conduct deplorable and that these matters alone would warrant a finding of misconduct. She referred to the Committee's additional finding that you acted dishonestly in respect of the letter dated 14 February 2023, which you sent to Witness 1 regarding the incident. Ms Price submitted that honesty is a fundamental tenet of the dental profession. She submitted that taking all these matters into account, the only course would be to make a finding of misconduct.

83. Ms Price reminded the Committee that there are two elements to the issue of impairment and that it must consider both. The first being the personal element and the second the public element. In relation to the personal element, Ms Price outlined the evidence provided on your behalf at this stage, including the Supervisor Reports from your Workplace Supervisor. It was Ms Price's submission that, in view of the wide range of clinical failings found proven, the Committee may consider that there has been insufficient insight demonstrated and insufficient time for your learning to be embedded.

84. Addressing the Committee on the public element of impairment, Ms Price submitted that, given the gravity of the errors made in clinical treatment, coupled with your lack of candour in dealing with some of the errors, if no finding of impairment were made in this case, the public would be shocked and public confidence in the dental profession would be undermined. She stated in her oral submissions that there was no, or insufficient, evidence of your insight into the Committee's factual findings made at Stage One. It was Ms Price's submission that a finding of impairment is required to uphold the public's confidence and to ensure that other dental professionals and the profession as a whole, understand the standards required of them.

85. By way of sanction, Ms Price invited the Committee to impose a suspension order on your registration for a period of six to nine months, with a review. She submitted that anything less than a suspension order would not adequately meet the GDC's overarching statutory objective.

86. In answer to a question from the Committee regarding its duty to consider the range of available sanctions in ascending order, including the possibility of a conditions of practice order, which is the sanction immediately preceding a suspension order, as well as the sanction above a suspension, which is the highest sanction of erasure, Ms Price submitted that all sanctions were open to the Committee. She submitted, however, that a conditions of practice order could not properly address the very serious matters found proved in this case, which include a failure in the duty of candour and dishonesty. In relation to the sanction of erasure, Ms Price stated that the imposition of this highest sanction would be a matter for the Committee to decide, exercising its judgement as to what is appropriate and proportionate in all the circumstances.

87. The Committee next heard submissions from Mr Rich. He accepted, on your behalf, that all the conduct matters found proved were serious enough to amount to misconduct, namely the findings of misleading conduct, dishonesty and lack of candour. He reminded the Committee that it should consider the clinical failings individually when reaching its decision on misconduct, as opposed to adding them up to find misconduct. He accepted, however, that in broad terms, misconduct would rightly be found in relation to the clinical matters too.

88. In addressing the Committee on the issue of impairment, Mr Rich submitted that the clinical findings relate to your treatment of three patients, although there were a number of issues, the most serious being the wrong tooth extraction from Patient 1. Mr Rich submitted that all the other findings relating to Patient 1's treatment flowed from that extraction. It was his submission that you were confused about which tooth needed to be taken out, and that is what led to the error. He told the Committee that you accept that you should have checked thoroughly and not gone ahead without being sure of the tooth to be removed.

89. Mr Rich asked the Committee to consider your witness statement prepared for this hearing. In particular, he drew the Committee's attention to where you stated in relation to extracting the wrong tooth from Patient 1, *"I appreciate now with the benefit of hindsight that this was incredibly irresponsible of me...I admit that this was a massive mistake..."*. Mr Rich submitted that the Committee would see from your statement a degree of insight into what happened in relation to the wrong tooth extraction, as well as your sincere apology for the distress caused to Patient 1. Further, that the Committee would see that you understand the seriousness of what occurred and the size of the mistake you made. Mr Rich submitted that the risk that you would repeat such a mistake is minimal, given your appreciation of your error and because you have gone through a *"considerable process"* over the last two years, which has significantly reduced any risks.

90. Mr Rich highlighted that you admitted all the clinical allegations in this case, except for the issue relating to sensitivity testing at Patient 4's emergency appointment. Mr Rich submitted that this demonstrates that you have insight into your clinical failings. He asked the Committee to consider your *"detailed and targeted"* CPD included in the Stage 2 Bundle submitted on your behalf. He submitted that you have undertaken a comprehensive programme of CPD, over several years, and that you have addressed all the areas of concern. Furthermore, that you have demonstrated that your learning has been embedded. Mr Rich told the Committee that you have been working under interim conditions with a Workplace Supervisor since August 2024. He drew the Committee's attention to the Supervisor Reports which, he said, contain an up-to-date assessment of your clinical work.

91. In relation to the dishonesty found proved, Mr Rich said that you understand how seriously dishonesty is taken by your regulatory body. He stated that you accepted that a finding of impairment in the public interest could be made based on the dishonesty finding alone. However, it was his submission that this did not mean that the seriousness of the dishonesty and lack of candour should not be assessed. Mr Rich submitted that dishonesty encompasses a wide range of facts and circumstances, and he invited the Committee to consider the section on 'Dishonesty' in Appendix 1 of the Guidance, in particular the mitigating factors that he submitted are present in this case. He submitted that the dishonesty found proved by the Committee was not multi-faceted but related to one letter. Further, that the conduct represented an uncharacteristic lapse in a challenging situation and did not result in any financial gain (or attempted financial gain).

92. Mr Rich told the Committee that you have been making attempts to mitigate the damage done. He reiterated that the extraction of the wrong tooth from Patient 1 was a product of genuine confusion. He submitted that the Committee could be reassured by the fact that no concerns have been raised regarding any misleading and dishonest behaviour or a lack of candour in the three and half years since the incident involving Patient 1.

93. With regard to sanction, Mr Rich submitted that you could not complain if a suspension order was imposed on your registration in the circumstances of this case. However, he disagreed that a conditions of practice order would not be appropriate, stating that the dishonesty matters are closely tied to a clinical failing. It was Mr Rich's submission that the Committee could impose conditions with a review. He submitted that you have shown insight into the breadth of your clinical failings, and that there is a public interest in keeping a registrant in work if this can be done safely. It was his submission that this could be done safely in this case, given the considerable progress you have made in your remediation.

94. Mr Rich submitted that if the Committee were minded to impose a suspension order, the period of suspension should be as short as possible, bearing in mind your remediation, the insight you have shown, as far as you have been able, and the long period that you have remained in practice with no repetition.

95. In relation to your fitness to practise history, Mr Rich acknowledged that the Committee was entitled to take this into account, but he submitted that the matters in that case were relatively limited and that they occurred almost 20 years ago around the time that you first started to work in the UK.

96. In answer to a question from the Committee regarding the issue of an apology to any of the patients in this current case, Mr Rich told the Committee that you had apologised through the Practice. He later provided extra information that you had written apology letters to all three patients and that these letters were provided to the Practice Manager for submission in accordance with Practice policy.

97. In response to further questions from the Committee, Mr Rich confirmed that, although your Workplace Supervisor's witness statement is dated 27 April 2026, he had not been informed of the Committee's Stage One findings when preparing and signing the statement. Furthermore, Mr Rich stated that he did not think that your Workplace Supervisor had been informed about your previous fitness to practise history from 2008 when preparing his testimonial and his witness statement.

The Committee's decisions – 1 May 2026

98. In reaching its decisions, the Committee considered all the evidence before it. It took account of the submissions made by Ms Price on behalf of the GDC, both written and oral, as well as the submissions made orally by Mr Rich on your behalf.

99. The Committee accepted the advice of the Legal Adviser as to the approach it should take to its decision-making and the relevant legal principles and guidance. The Legal Adviser reminded the Committee that there is no burden or standard of proof at this stage of the proceedings, and that its decisions were for its independent judgement.

100. The Committee bore in mind the overarching statutory objective of the GDC. It also took account of the Guidance issued by the GDC for Practice Committees.

Decision on misconduct

101. The Committee considered whether the facts found proved in this case amount to misconduct. It took into account that a finding of misconduct in the regulatory context requires a serious falling short of the standards expected of a registered dental professional. It also took into account that Ms Price on behalf of the GDC and Mr Rich on your behalf had submitted that the conduct found proved at Stage One was serious enough to amount to misconduct.

102. The Committee first considered the facts found proved in relation to your treatment of Patient 1, including the matters of your dishonesty and lack of candour. The Committee had regard to the individual clinical failings that led to your overall provision of a poor standard of care to Patient 1.

These were your incorrect diagnoses of caries on LL5 and that the LL5 needed extracting, the wrong extraction of LL5 instead of LL6, not discussing with Patient 1 the risks and benefits of the proposed treatment, and failing to carry out the extraction of LL6.

103. The Committee noted the expert opinion of Dr Ward, as set out in her report, that the *“Standard of treatment is poor as LL5 was extracted with no indication and the Registrant failed to extract LL6 that had clear evidence of pathology in addition to having been requested as part of an orthodontic plan... The main risk of extracting LL5 is that the patient would not only be left with a gap but would also have pathology left at LL6. There would be no benefit to extraction of LL5 as this was not clinically necessary”*. The Committee accepted Dr Ward’s opinion that the overall standard of your care of Patient 1 fell far below that expected of a reasonably competent dentist. The Committee also noted that actual harm was caused to the patient on account of your clinical shortcomings.

104. The Committee further noted that, as a result of your extracting LL5 instead of LL6, you failed to obtain informed consent from Patient 1, as she could not consent to the removal of the wrong tooth. Whilst it noted that Patient 1 signed a consent form in respect of the extraction of LL5, consent is more than just a signature. Consent must remain valid throughout treatment, and in the Committee’s view, Patient 1’s consent to the extraction of LL5 was not informed. The Committee was satisfied from the evidence of Dr Ward that a failure to obtain informed consent for any procedure falls far below the expected standard. Obtaining informed consent is a basic and fundamental part of clinical practice.

105. The Committee next considered your dishonesty associated with Patient 1’s treatment. You admitted, as matters of fact, that you made four comments relating to the extraction of LL5 instead of LL6 in a letter to Witness 1, Patient 1’s Orthodontist, dated 14 February 2023. It was the finding of the Committee that those comments, as set out at heads of charge 3(a) to 3(d), were misleading and dishonest. It found that the comments were inaccurate and untrue, and that you sought to minimise your culpability of having extracted the wrong tooth. This was dishonesty in the course of your clinical practice. Furthermore, the Committee took into account that in making the comments you sought to deflect blame for the wrong tooth extraction onto the young patient herself, members of reception staff at the Practice and staff at the Orthodontic Practice, whom you falsely reported had *“approved”* the extraction of LL5. Your blaming of others demonstrated your unwillingness to accept responsibility for your mistake, and in the Committee’s view, raised the level of seriousness of your dishonesty. Your dishonesty represented a significant breach of a fundamental tenet of the dental profession, namely the requirement to act honestly and with integrity.

105. The Committee also considered that your admitted failure to uphold your duty of candour, in that you did not tell Patient 1 that the extraction of LL5 was not clinically necessary and was done in error, was a serious departure from what was expected of you in the circumstances. It was incumbent on you, as a registered professional, to be clear with the patient what your mistake was, including the cause. However, you did not do this and therefore failed to follow your duty of candour. The Committee noted that you did not admit your mistake in the clinical records or in any of the letters placed before it.

106. It was clear to the Committee that by any measure your dishonesty and lack of candour were unacceptable and that other dental professionals would find your actions and omissions deplorable.

107. In providing a poor standard of care to Patient 4, you failed to carry out sufficient diagnostic assessments, in particular, sensitivity testing and an adequate radiographic examination. You also failed to carry out sufficient treatment planning, as your planning was based on an incorrect diagnosis. You did not adequately communicate the treatment plan to Patient 4 and ultimately, you provided treatment that was not clinically indicated in that you removed and recemented the crown at the patient's LL6.

108. The Committee accepted Dr Ward's opinion that, irrespective of Patient 4 having been in pain at the emergency appointment in question, you should have carried out sensitivity testing. She told the Committee that this would have been quick and easy to do, and that it would have been helpful for you to diagnose the cause of the patient's symptoms and plan appropriate treatment. Your evidence was that the crown at LL6 was removed carefully with a minimally invasive technique and that it came off easily. However, Dr Ward referred in her report to subsequent clinical photos showing that the crown had been drilled significantly and could only be used as a temporary. In concluding that each of your clinical failings in your treatment of Patient 4 fell far below the standard expected of a reasonably competent dentist, the Committee noted that Dr Ward commented in her report that *"The treatment plan seems confused and not tailored to the clinical situation or patient wishes. Least invasive interventions such as occlusal adjustment and restoration of UL6 should have been carried out"*. Dr Ward goes on to state that Patient 4 suffered unnecessarily for a potentially costly crown removal.

109. The Committee also noted that you failed to obtain informed consent from Patient 4 in all the circumstances. Dr Ward stated that there is no evidence of written consent from the patient for the removal of the crown, only in relation to an extraction. The Committee was satisfied on the expert evidence that your failure in obtaining informed consent fell far below the expected standard.

110. At Patient 10's emergency appointment, you did not treat or adequately treat the patient, in that you did not diagnose issues with UL8, namely that this tooth was over-erupted, sharp and was causing trauma. You also prescribed antibiotics to the patient when this was not clinically indicated. In determining that these individual clinical failings fell far below the expected standard, the Committee accepted the opinion of Dr Ward, who stated that your assessment and diagnosis of the patient's problem was inadequate. The Committee also took into account the general concerns around the inappropriate prescribing of antibiotics, and how this can affect the efficacy of such medications.

111. The Committee was satisfied, taking into account the expert evidence regarding your clinical failings in respect of each of the three patients and the matters of your dishonesty and your lack of candour towards Patient 1, that your conduct in relation to each charge found proved represented a significant departure from the following GDC Standards:

1.3 Be honest and act with integrity.

1.4.2 You must provide patients with treatment that is in their best interests, providing appropriate oral health advice and following clinical guidelines relevant to their situation...

- 1.3.1 You must justify the trust that patients, the public and your colleagues place in you by always acting honestly and fairly in your dealings with them. This applies to any business or education activities in which you are involved as well as to your professional dealings.
- 1.3.2 You must make sure you do not bring the profession into disrepute.
- 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.
- 3.1.2 You should document the discussions you have with patients in the process of gaining consent. Although a signature on a form is important in verifying that a patient has given consent, it is the discussions that take place with the patient that determine whether the consent is valid.
- 3.1.3 You should find out what your patients want to know as well as what you think they need to know. Things that patients might want to know include: options for treatment, the risks and the potential benefits; why you think a particular treatment is necessary and appropriate for them; the consequences, risks and benefits of the treatment you propose.
- 3.1.4 You must check and document that patients have understood the information you have given.
- 3.2.1 You must provide patients with sufficient information and give them a reasonable amount of time to consider that information in order to make a decision.
- 3.2.5 You must check and document that patients have understood the information you have given them.
- 9.1 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.

112. It was the view of the Committee that its findings in this case, both individually and cumulatively, were serious enough to amount to misconduct.

Decision on impairment

113. In considering the issue of impairment, the Committee took into account that it must determine whether your fitness to practise is impaired currently, as at the time of this hearing. In

reaching its decision, it had regard to the following test for impairment formulated by Dame Janet Smith in her fifth Shipman Report, as set out in the case of *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council and Grant* [2011] EWHC 927 (Admin):

“Do our findings of fact in respect of the [dentist’s] misconduct ... show that his/her fitness to practise is impaired in the sense that s/he:

- a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
- b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
- c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
- d. has in the past acted dishonestly and/or is liable to act dishonestly in the future.”*

114. Having considered the various aspects of your misconduct, the Committee was satisfied that all the factors at (a) to (d) above are engaged in this case. In assessing whether you are liable to act in these ways in the future, the Committee considered the questions arising from the case of *Cohen v General Medical Council* [2008] EWHC 581 (Admin), namely whether your misconduct is remediable, whether it has been remedied and whether it is likely to be repeated.

115. The Committee considered that clinical failings are usually remediable with further education and training. It considered that behavioural issues, such as dishonesty, are more difficult to remedy, although not impossible.

116. The Committee considered whether your clinical failings, as identified in its findings, have been remedied. In doing so, it had regard to the evidence of the steps you have taken to address the matters raised regarding your clinical practice. The Committee took into account the evidence of your CPD, which it found to be targeted to the areas of concern, including in relation to Orthodontic Referrals, Consent, Treatment Planning, Preventing Wrong Tooth Extraction, Communication with Patients and Radiography. The Committee also had before it a number of Supervisor Reports covering the period November 2024 to March 2026, which indicate steady and positive progress in your work under your interim conditions. The Committee noted that in his witness statement dated 27 April 2026, your Workplace Supervisor states regarding his assessment of your patient records, that *“I can see that Mr Zanganeh has considered their symptoms carefully and is making considered and appropriate clinical decisions and diagnoses”*.

117. The Committee considered that the evidence of your CPD and the comments of your Workplace Supervisor demonstrate a level of remediation and show that you have a degree of insight into the clinical failings that brought you before your regulatory body. In considering your insight, the Committee also took into account your early admissions to virtually all the clinical allegations in the charge, and your recognition in your witness statement of how you should have acted differently in your treatment of the three patients.

118. However, the Committee was not reassured that there is evidence before it to show that your learning has been sufficiently embedded into your clinical practice. Whilst it took into account the positive assessment of your Workplace Supervisor in his witness statement, the Committee was concerned that the written reflections you provided on your CPD courses lacked detail and did not sufficiently engage with the allegations you faced. The Committee also noted that you had not provided a reflective statement clearly addressing the causes of your clinical misconduct, its gravity and how you would avoid repetition, particularly given the similarity of some of the matters found proved against you in 2008. The findings on that occasion included that you did not undertake an adequate investigation into that patient's symptoms prior to providing treatment, did not explain to the patient the alternative treatments available, did not obtain the patient's informed consent and that you extracted two of the patient's teeth when it was not clinically justified to do so.

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

120. The Committee went on to consider the behavioural aspects of your misconduct, namely your dishonesty and your lack of candour associated with the wrong tooth extraction from Patient 1. It noted that your Workplace Supervisor states in his testimonial dated 22 April 2026 that, "*Boran consistently demonstrates many positive qualities, including honesty, professionalism, accountability, empathy and strong ethical judgment...*". However, the Committee noted that your Workplace Supervisor has not provided any examples of how you have demonstrated honesty.

121. The Committee took into account that you have not had time to demonstrate insight, reflection and remediation into the dishonesty found proved, given that you defended that allegation, as is your right, and no time has elapsed between the Committee's factual findings and its consideration of impairment at this stage. The Committee recognised that it is only now that the relevant findings have been made, that you will be able to take steps to demonstrate your insight and remediation in those matters. However, your failure to uphold your duty of candour was an allegation that you admitted, and as such, you have had time to address it. The Committee noted that you acknowledged in your witness statement that you should have communicated directly with Patient 1 "*to uphold patient trust and my duty of candour*". You have also undertaken CPD in relation to the duty of candour, albeit the evidence of your reflections on your learning is, in the Committee's view, very limited. The Committee found that your written reflections on your duty of candour CPD courses lack necessary detail, including why you neglected to tell Patient 1 about the wrong tooth extraction, and what you would do differently in terms of being open and transparent with patients in future.

122. It was the conclusion of the Committee, noting the lack of evidence of insight, reflection and remediation in relation to the dishonesty finding (acknowledging that you have not yet had time to reflect on that finding), and the limited action you have taken in reflecting on your duty of candour, that there remains a risk of repetition in respect of the conduct matters found proved in this case.

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

124. The Committee went on to consider the wider public interest. Whilst it took into account your clinical failings, it considered that the public interest considerations in this case relate primarily to the conduct matters found proved. It was the view of the Committee that a reasonable and well-informed member of the public would be shocked and dismayed, if a finding of impairment were not made in respect of a dentist who, after having extracted the wrong tooth, was dishonest about the circumstances in which it happened and failed to discharge their duty of candour to the patient. Accordingly, the Committee determined that a finding of impairment is required in the public interest, to promote and maintain public confidence in the dental profession and to uphold proper professional standards and conduct.

125. The Committee therefore determined that your fitness to practise is currently impaired by reason of your misconduct.

Decision on sanction

126. Having found your fitness to practise to be impaired, the Committee considered what sanction, if any, to impose on your registration. It took into account that the purpose of any sanction is not to be punitive, although it may have that effect, but to protect the public and 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.

127. The Committee noted that it was open to it to conclude this case without taking any action in relation to your registration. However, it decided that such an outcome would be wholly inappropriate, given the gravity of its findings and the identified risk of repetition. The Committee was clear that taking no further action would not serve to protect the public or uphold the wider public interest.

128. In deciding on the appropriate sanction, the Committee considered the issue of mitigating and aggravating factors. In relation to the clinical matters, it considered the following in mitigation:

- Your early admissions to virtually all the clinical allegations.
- No evidence of any repetition of the clinical concerns in the years that have elapsed.
- The Committee received information regarding your apology to each of the three patients.

129. The Committee identified the following aggravating factors in respect of your clinical failings:

- Actual harm to three patients.
- Your clinical misconduct was repeated.
- The adverse regulatory findings made against you in 2008 in relation to previous clinical failings of a similar kind.
- Insufficient insight and remediation, particularly given the considerable period of time that has passed.

130. The Committee considered separately the aggravating and mitigating features in relation to the conduct matters. In doing so, it had regard to the paragraphs 41 and 42 of Appendix 1 of the Guidance which deal with dishonesty. The Committee noted in mitigation that your dishonesty was an isolated incident involving one letter. However, it identified the following aggravating factors:

- Your attempts to minimise your culpability, which included trying to deflect blame onto others, including Patient 1.
- That your dishonesty occurred in your performance of your clinical duties.
- Your insufficient insight into your failure to uphold your duty of candour.

131. Having noted all these features, the Committee considered the available sanctions. It started with the least restrictive as it is required to do. The Committee first considered whether it would be appropriate and proportionate to issue you with a reprimand. However, it considered the factors listed at paragraph 263 of the Guidance and was not satisfied that a reprimand would be suitable. The Committee also took into account paragraph 262, which states that *“A reprimand does not restrict a registrant’s ability to practise, and may therefore be appropriate where the issues identified are at the lower end of the spectrum of seriousness, where a restrictive sanction is not required to protect the public or the public interest”*. This is not such a case.

132. The Committee next considered whether to impose a substantive conditions of practice order on your registration. It noted that you are currently practising under interim conditions, but took into account that those conditions were imposed on a temporary basis when no findings had been made against you. Findings of fact have now been made, and whilst the Committee considered that a conditions of practice order could potentially address the clinical concerns, it bore in mind that it has made a serious finding of dishonesty. It was the view of the Committee that it could not formulate any workable, appropriate, measurable or enforceable conditions that would address your dishonesty and your admitted failure in relation to your duty of candour. The Committee therefore determined that imposing conditions would not be sufficient, appropriate or proportionate in all the circumstances.

133. The Committee went on to consider whether to suspend your registration for a specified period, up to a maximum of 12 months. It took account of paragraph 277 of the Guidance, which states that:

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

- a. There is evidence of repetition of the behaviour.*
- b. The registrant has not shown insight into the issues which led to a finding of current impairment being made, and/or poses a significant risk of repeating the behaviour.*
- c. A lesser sanction would be insufficient to meet the public interest.*
- d. There is no evidence of harmful deep-seated personality or professional attitudinal problems (which might make erasure the appropriate order)”*.

134. The Committee considered that the above factors listed at (a), (b) and (c) are present in this case because your clinical misconduct occurred on more than one occasion over a three-month

period, you have shown insufficient insight, which has led to a finding of impairment, and the Committee considered that a lesser sanction would be insufficient to meet the public interest. It carefully considered the factor at (d). It noted that neither party submitted that there is evidence that you have harmful deep-seated personality or professional attitudinal problems. Given that the dishonesty finding related to a single letter, the Committee did not find that you have a harmful deep-seated personality or professional attitudinal problems.

135. However, the Committee's findings made against you include serious breaches of fundamental tenets of the dental profession, including dishonesty during the course of your professional practice. Therefore, in deciding whether the sanction of suspension would be adequate appropriate and proportionate, the Committee considered the section of the Guidance that deals with the sanction of erasure. This included the relevant factors set out at paragraph 282 of which the Committee found the following to be engaged:

- The findings include serious departure(s) from the relevant professional standards.
- Serious harm to patients has occurred.
- A continuing risk of serious risk harm to patients has been identified.
- The findings include dishonesty.

136. Given that these factors for erasure are present in this case, the Committee gave careful consideration to whether a suspension order, even for the maximum period of 12 months, would be sufficient, particularly to meet the wider public interest.

137. In reaching its decision, the Committee reminded itself of its duty to act proportionately, and it weighed the public interest with your own interests. It was the conclusion of the Committee that, on balance, the erasure of your name from the Dentists Register would be disproportionate. It took into account its finding that your failings are remediable. In relation to your dishonesty, the Committee bore in mind that its finding related to a single incident. Further, that there is no evidence before the Committee of a repetition of any of the concerns. As such, the Committee concluded that your behaviour is not fundamentally incompatible with continued registration.

138. The Committee noted from paragraph 278 of the Guidance that *"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"*. It also took account of paragraph 279 of the Guidance which states, *"the sanction of erasure should only be imposed where there is no other means of protecting the public and/or maintaining confidence in the dental professions"*. The Committee was satisfied, having considered the matters in this case in the round, that such protection would be afforded by a suspension order with a review, therefore the sanction of erasure was not necessary.

139. Accordingly, the Committee determined to impose a suspension order on your registration with a review. It then considered what would be the appropriate and proportionate duration of the suspension order. The Committee noted that the GDC considered that a period of six to nine months would be sufficient, and on your behalf, it was submitted that the shortest period possible should be imposed. The Committee decided that a longer period was required in the circumstances of this case. It considered that a 12-month period is necessary to mark the seriousness of your misconduct

and would send a signal to you and the wider profession that your behaviour, particularly your dishonesty and your lack of candour with a patient, was unacceptable. Acknowledging that you have not yet had time to develop insight into the serious finding of dishonesty, the Committee also considered that you would need a considerable period to reflect on that finding and demonstrate remediation.

140. The Committee was cognisant of the potential consequences for you in suspending your registration, particularly for the maximum period, but it was satisfied that the need to protect the public and the wider public interest outweighed your own interests.

141. The Committee directs that a review of the suspension order should be conducted at a resumed hearing to be held shortly before the expiry of the 12-month period. The Committee at the resumed hearing will consider what action to take in respect of your registration at that time. You will be informed of the date and time of that hearing in due course.

142. This Committee considered that the reviewing Committee may be assisted by receiving the following from you:

- A Personal Development Plan.
- A reflective statement which addresses the reasons for your clinical misconduct and your dishonesty, acknowledgement of their seriousness, their impact on patients and on the wider profession, and what steps you have put in place to ensure such conduct is not repeated.
- Evidence that you have completed CPD courses targeted at the relevant regulatory concerns dealt with at this hearing along with your detailed reflection on the courses and what you have learned to improve your practice.
- Evidence that you have kept your professional knowledge and skills up to date.
- Any relevant references and testimonials.

143. Unless you exercise your right of appeal, your registration will be suspended for a period of 12 months, starting 28 days from the date that notice of this Committee's direction is deemed to have been served upon you.

144. The Committee now invites submissions from Ms Price and from Mr Rich, as to whether an immediate order of suspension should be imposed on your registration to cover the 28-day appeal period, pending the taking effect of its substantive direction for suspension.

Decision on an immediate order – 1 May 2026

145. The Committee has made a substantive determination in this case regarding your fitness to practise, therefore the interim order currently in place on your registration in relation to these matters is hereby revoked.

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

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

148. Mr Rich stated that he had no submissions to make in respect of an immediate order, and that the matter was for the Committee.

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

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

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

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

153. The effect of the foregoing substantive determination and this order is that your registration will be suspended to cover the appeal period. Unless you exercise your right of appeal, the substantive direction for suspension for a period of 12 months (with a review) will take effect 28 days from the date of deemed service.

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

155. That concludes this determination.