HEARING PART-HELD IN PRIVATE

Professional Conduct Committee
Initial Hearing

23 to 26 March and 30 March to 1 April 2026

Name:	MAHMOOD, Ishaq Arif
Registration number:	227438
Case number:	CAS-209971

General Dental Council:	Guy Micklewright, counsel Instructed by Rashidah Conroy, IHLPS
Registrant:	Present Represented by Vivienne Tanchel, counsel Instructed by Lily Rose Lloyd, MDDUS

Fitness to practise:	Impaired by reason of misconduct
Outcome:	Suspension
Duration:	28 days
Immediate order:	No order

Committee members:	Andrea Hammond (Dental Care Professional) (Chair) Annika Hindocha (Dentist) Laura Wallbank (Lay)
Legal adviser:	William Hoskins
Committee Secretary:	Gareth Llewellyn

Determination on preliminary matters – 23 March 2026

Mr Mahmood

1. This is a hearing before the Professional Conduct Committee (PCC). The hearing is being held in person at the offices of the Dental Professionals Hearings Service in central London.

2. You are present and are represented by Vivienne Tanchel of counsel, instructed by Lily Rose Lloyd of the Medical and Dental Defence Union of Scotland (MDDUS). Guy Micklewright of counsel, instructed by Rashidah Conroy of the General Dental Council's (GDC's) In-House Legal Presentation Service (IHLPS), appears for the GDC. Mr Micklewright participated remotely rather than in person on 23 March 2026.

The charge

3. The charge that you face at this hearing, as amended, reads as follows:

"That being a registered dentist, Ishaq Mahmood's (227438) fitness to practise is impaired by reason of misconduct in that:

1. You failed to provide an adequate standard of care to Patient A from around 11/11/2021 to 20/12/2022, by:

a. [withdrawn].

b. [withdrawn]

c. Not discussing the full risks and benefits of the proposed treatment with Patient A.

d. Not providing Patient A with all treatment options.

e. [withdrawn].

f. [withdrawn].

2. You failed to maintain contemporaneous records in respect of Patient A's appointments from around 11/11/2021 to 20/12/2022.

3. You amended records retrospectively in respect of Patient A's appointments from around 11/11/2021 to 20/12/2022.

4. You failed to indicate clearly on Patient A's record that it had been amended retrospectively.

5. You failed to obtain informed consent for the treatment provided to Patient A from around 11/11/2021 to 20/12/2022.

6. Your conduct in relation to charges 2, and/or 3, and/or 4 was

a. Misleading and/or

b. Dishonest."

Amendment to charge

4. At the outset of the hearing Mr Micklewright applied to amend the charge pursuant to Rule 18 of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules'). Mr Micklewright applied to withdraw heads of charge 1 (a), 1 (b), 1 (e) and 1 (f). The heads of charge in question read as follows:

    1. *You failed to provide an adequate standard of care to Patient A from around 11/11/2021 to 20/12/2022, by:*

        a. *Not carrying out sufficient planning.*
        b. *Providing a poor standard of treatment including orthodontic treatment and/or orthodontic diagnosis*
        e. *Your management of Patient A's condition.*
        f. *Your radiographic practice.*

5. Ms Tanchel on your behalf did not oppose the application. The Committee, having accepted the advice of the Legal Adviser, determined to accede to the application on the basis that it was fair and appropriate for the amendments to be made. The schedule of charge was duly amended.

Admissions

6. You tendered admissions to some of the heads of charge that you face. The heads of charge that you admitted were, namely, heads of charge 2, 3 and 4. Ms Tanchel also stated that you accept head of charge 1 (c) on the basis that you discussed most, but not all, of the risks and benefits of the proposed treatment with Patient A, and that you also accept head of charge 5 insofar as you admit that you did not discuss the full risks and benefits of the proposed treatment.

7. The Committee accepted the advice of the Legal Adviser. The Committee had regard to the GDC's *Fitness to Practise: Guidance for the practice committees* (January 2026) and the GDC's *Guidance on admissions made at the preliminary stage of fitness to practise hearings* (December 2025).

8. The Committee determined and announced that the facts alleged at heads of charge 2, 3 and 4 were proved on the basis of your admissions in accordance with Rule 17 (4) of the Rules. In respect of heads of charge 1 (c) and 5, the Committee decided not to make any determination at this stage given that the facts are disputed. The Committee instead decided to determine those alleged facts at the factual inquiry stage.

Application to proceed partly in private

9. The Committee, on the application of Ms Tanchel and supported by Mr Micklewright, directed that part of the hearing be held in private when matters relating to the health of a third party were heard.

Submission of no case to answer – 26 March 2026

10. At the conclusion of the GDC's case on 25 March 2026 Ms Tanchel submitted that there is no case for you to answer in respect of heads of charge 6 (a) and 6 (b), or indeed in respect of heads of charge 1 (c), 1 (d) and 5. Ms Tanchel made her application pursuant to Rule 19 (4) of the Rules.

11. Miss Tanchel submitted that there is no, or in the alternative no sufficient, evidence to support the facts alleged at heads of charge 6 (a) and 6 (b). Ms Tanchel submitted that any evidence that you may decide to give, including your witness statement, has not yet been adduced, and as such cannot properly be taken into consideration by the Committee in relation to Ms Tanchel's application of no case to answer. Ms Tanchel submitted that the only evidence that the Committee can properly consider in relation to her application is that already adduced by the GDC, consisting of the oral, written and documentary evidence of Patient A, Patient A's records, and the oral and written evidence of the GDC's expert witness, namely Edward Bateman.

12. Ms Tanchel submitted that the evidence of Patient A about the discussions that took place at the appointments that she had with you cannot be relied upon in light of what she characterised as inconsistencies and a lack of credibility in Patient A's evidence. Ms Tanchel referred to other clinical records relating to Patient A's health and circumstances which, she submitted, makes it unsafe to rely upon Patient A's evidence in respect of appointments that she attended with you. She also referred the Committee to a signed consent form completed on an iPad which she submitted demonstrated that, contrary to Patient A's testimony, many of the risks and benefits of the proposed course of treatment had been discussed with her. Ms Tanchel submitted that, accordingly, the GDC's allegation that you made misleading and dishonest entries about those discussions, predicated as they are on Patient A's evidence, is not made out. Ms Tanchel further submitted that the GDC has otherwise not adduced any, or any sufficient, evidence of you having acted in a misleading and dishonest way, including by reference to the patient's records.

13. Ms Tanchel further submitted that, in respect of head of charge 1 (c), Patient A's evidence was too unreliable to be given credence. Ms Tanchel submitted that, if the Committee were to accept her submission and determine that, contrary to Patient A's evidence, you had discussed the full risks and benefits of proposed treatment, the only remaining criticisms made by Mr Bateman in respect of head of charge 1 (c) would be minor, and would relate to shortcomings that would fall below, but not far below, the standard reasonably to be expected. Accordingly, any shortcomings could not form the basis for a finding of misconduct. Ms Tanchel submitted that the lack of evidence in respect of head of charge 1 (c) also undermines the basis for any finding that you failed to obtain informed consent for the treatment provided as alleged at head of charge 5.

14. Ms Tanchel invited the Committee to determine that there is no case for you to answer in respect of these, and indeed all, of the heads of charge that remain in dispute, including in respect of head of charge 1 (d) in light of what she characterised as the unreliability of Patient A's evidence in the terms summarised above. Ms Tanchel referred to a number of cases, including in particular to the cases of *Soni v General Medical Council* [2015] EWHC 364 (Admin) and *McLellan v General Medical Council* [2020] CSIH 12 in her submissions.

15. Mr Micklewright on behalf of the GDC opposed Ms Tanchel's submission of no case to answer. Mr Micklewright submitted that the patient's records and the evidence of Patient A support the allegations of dishonesty at head of charge 6 (b), as well as the facts alleged at heads of charge 1 (c) and 5. Mr Micklewright submitted that there are two strands to the GDC's allegations of dishonesty at head of charge 6 (b). First, that you acted dishonestly by, essentially, passing off as contemporaneous entries which were in fact retrospective. Second, that the entries that you made in retrospect were, in and of themselves, false, in that they did not properly reflect the conversations that you had with Patient A.

16. In respect of the first strand of dishonesty, Mr Micklewright submitted that there is sufficient evidence upon which the Committee, once properly directed, could go on to find this first strand proved. Mr Micklewright reminded the Committee that it has already found proven at heads of charge 2, 3 and 4 that you failed to make it clear that your retrospective amendments were not contemporaneous. Mr Micklewright further submitted that the patient's records are material to this first strand of dishonesty, and that those records can be relied upon.

17. In respect of the second strand of dishonesty, Mr Micklewright submitted that there is sufficient evidence upon which the Committee, once properly directed, could go on to find this second strand proved. Mr Micklewright submitted that the Committee can rely on the evidence that Patient A has given of the conversations that she had with you at her appointments.

18. Mr Micklewright addressed Ms Tanchel's submissions regarding heads of charge 1 (c) and 5 by reference to the expert evidence of Mr Bateman. Mr Micklewright submitted that Mr Bateman's evidence goes further than Ms Tanchel suggests, namely that he opines that there was an increased risk of relapse and a greater risk of overjet associated with the treatment that you proposed to provide to Patient A. Mr Micklewright therefore submitted that there is sufficient evidence for the Committee to go on to find these heads of charge proved. He emphasised that it was necessary for the Committee to see the '*wood and not just the trees*' when it came to assessing Patient A's evidence, and that any discrepancies in detail that there may be were not of themselves sufficient to render her evidence tenuous.

19. The Committee accepted the advice of the Legal Adviser concerning the principles to which it should have regard. The Committee has been careful not to determine the facts, but instead has considered whether the Committee could, once properly directed as to the law, go on to find some or all of the facts proved on the balance of probabilities. The Committee applied the test for 'no case to answer' derived from the case of *R v Galbraith* [1981] EWCA Crim. The test is that the case should be stopped where there is no evidence, or there is some evidence, but the evidence is tenuous, in that it is weak, vague or inconsistent, such that a Committee could not properly go on to find the facts proved. A Committee should take the evidence presented to it at its highest, whilst not ignoring any deficiencies. Where the strength or weakness of the GDC's case depends on the view to be taken of a witness's reliability, and where on one possible view of the facts there is evidence upon which a Committee could properly go on to find the facts proved, the Committee should allow the matter to proceed.

20. The Committee has determined that there is evidence to support each of the facts alleged at the remaining heads of charge. The Committee took account of the evidence already presented to it, more particularly the oral, written and documentary evidence of Patient A, Patient A's records, and the oral and written evidence of the GDC's expert witness, namely Mr Bateman. It considers that this evidence is not so weak, vague or inconsistent to mean that the Committee could not find the facts alleged proved at heads of charge 1 (c), 1 (d), 5, 6 (a) and 6 (b) proved. The Committee also considers that it could, once properly directed, go on to find that those facts amount to misconduct.

21. In respect of head of charge 6 (a), the Committee has reminded itself that it has already found the facts upon which this head of charge is predicated proved. The Committee considers that it could, once properly directed, go on to consider that the proven facts at heads of charge 2, 3 and 4 could represent misleading conduct. In reaching this view the Committee has also had regard to the evidence presented to it, and in particular the evidence and records of Patient A. It does not consider that this evidence is tenuous, and it instead considers that this evidence is such that it could go on to find the facts alleged at head of charge 6 (a) proved.

22. In relation to head of charge 6 (b), the Committee has concluded that it could, once properly directed, go on to find that the proven facts at heads of charge 2, 3 and 4 amount to dishonest conduct. The Committee understands that the GDC alleges that such proven conduct was

dishonest in two respects, or 'strands', as summarised above. It considers that the underlying facts that it has found proved, and the evidence that has already been adduced, mean that it could go on to determine that those facts amount to dishonest conduct. The Committee, again, does not consider that the evidence of Patient A is so tenuous, in that it is weak, vague or inconsistent, that it could not properly arrive at such a finding. The Committee has arrived at the same conclusion in respect of the other evidence presented to it in respect of this head of charge, more particularly Patient A's records.

23. In respect of heads of charge 1 (c) and 1 (d), the Committee considers that there is some evidence upon which it could go on to find the facts at these two heads of charge proved. The Committee has had particular regard to the evidence of Patient A, and it does not consider that her evidence is so tenuous, in that it is weak, vague or inconsistent, that it could not find the facts alleged at heads of charge 1 (c) and 1 (d) proved. Patient A was consistent in some important features of her evidence, not least in what she said she was not told about the risks and benefits of her treatment. The Committee has also had regard to Mr Bateman's evidence and Patient A's records, and it similarly considers that this evidence is sufficient to establish that it could, in due course, go on to find these two heads of charge proved. In relation to the signed consent form drawn to the Committee's attention by Ms Tanchel, the Committee noted that Mr Bateman's evidence was that there would need to be a discussion about risks and benefits to ensure that those matters were properly understood.

24. In relation to head of charge 5, the Committee considers that it could go on to find the facts alleged at that head of charge proved. The Committee has again had regard to the evidence of Patient A, and does not consider that her evidence as to the alleged facts is so tenuous, weak, vague or inconsistent that it could not find the facts proved. The Committee has also again had regard to the expert evidence of Mr Bateman in reaching this conclusion. The Committee considers that it could, once properly directed, consider that any factual findings that it may make in respect of heads of charge 1 (c) and/or 1 (d) could lead to a conclusion that you failed to obtain informed consent.

25. Accordingly the Committee rejects Ms Tanchel's submission of no case to answer. It is now for Ms Tanchel to present her case on the facts that remain in dispute.

Findings of fact – 31 March 2026

26. Following the Committee's determination on Ms Tanchel's submission of no case to answer on 26 March 2026, the hearing resumed on 30 March 2026.

Background to the case and summary of allegations

27. The allegations giving rise to this hearing arise out of the standard of care and treatment that you provided to a patient, who is referred to for the purposes of these proceedings as Patient A, in the period of 11 November 2021 to 20 December 2022. The treatment took place at a dental practice at which you are employed in the capacity of associate dentist.

28. On 11 November 2022 Patient A attended a 'six month smiles' treatment assessment appointment with you. You had a discussion with Patient A about the possibility of orthodontic treatment in relation to her concerns about overlapping teeth. A course of 'six month smiles' orthodontic treatment then followed with the purpose of correcting the patient's overcrowding and aligning the patient's front teeth. It is understood that this treatment used an orthodontic appliance with round wires to tip the front teeth and align those teeth. Your last appointment with Patient A took place on 20 December 2022.

29. It is specifically alleged that you failed to provide an adequate standard of care to Patient A, in that you did not discuss the full risks and benefits of the proposed treatment with the patient, and did not provide her with all treatment options.

30. It is further alleged, and the Committee found proved at the preliminary stage, that you failed to maintain contemporaneous records of the patient's appointments, that you amended records retrospectively in respect of her appointments, and that you failed to make it clear that those amendments were made in retrospect. The GDC alleges that your conduct in these respects was misleading and was dishonest.

Evidence

31. The Committee has been provided with documentary material in relation to the heads of charge that you face, including the witness statement, patient records and documentary exhibits of Patient A; the reports of GDC's expert witness, namely Edward Bateman; your witness statement and documentary exhibits; the witness statement and documentary exhibits of your practice manager colleague, who is referred to as Witness 1, and the witness statement of your dental nurse colleague, who is referred to as Witness 2. The Committee also received a bundle of testimonial letters submitted on your behalf from professional colleagues.

32. The Committee heard oral evidence from Patient A, from Mr Bateman, from you, and from Witness 1. Witness 1 gave her evidence remotely.

Committee's findings of fact

33. The Committee has taken into account all the evidence presented to it, both written and oral. It has considered the submissions made by Mr Micklewright on behalf of the GDC and those made by Ms Tanchel on your behalf. The Committee has again had regard to the GDC's *Fitness to Practise: Guidance for the practice committees* (January 2026).

34. The Committee has accepted the advice of the Legal Adviser concerning the principles to which it should have regard. The Committee is mindful that the burden of proof lies with the GDC, and has considered the heads of charge against the civil standard of proof, that is to say, the balance of probabilities. The Committee has considered each head of charge separately, although some of its findings will be announced together.

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

1.	*You failed to provide an adequate standard of care to Patient A from around 11/11/2021 to 20/12/2022, by:*
1. (a)	[withdrawn]
1. (b)	[withdrawn]
1. (c)	*Not discussing the full risks and benefits of the proposed treatment with Patient A.* **Proved**
	In approaching this head of charge, as well as the other heads of charge that fall to be determined, the Committee has paid careful regard to the oral, written and documentary evidence presented to it. The Committee has heard that your case is that you discussed most, but not all, of the risks and benefits of the proposed treatment with Patient A. In your oral evidence you stated that you went through those risks individually with Patient A. Patient A's evidence is that you did not discuss the risks of the proposed treatment with her. The expert evidence of Mr Bateman is that there were specific risks associated with the proposed treatment that should have been discussed. Mr Bateman opines that there is an increased risk of relapse when using a round wire rather than a square wire, and a greater risk of an increased overjet, when compared to more conventional orthodontic treatment. You accept that you did not discuss these specific risks with Patient A. In your oral evidence you characterised the risks that you omitted to discuss as 'material' risks, You clarified that the risks that you omitted were, namely, the increased risk of relapse with such short-term orthodontic treatment, and the greater risk of an increased overjet with such treatment. The Committee finds the facts alleged at head of charge 1 (c) proved. The Committee considers that you did not, as you accept, discuss two of the risks of the treatment that you proposed to provide, namely the increased risk of relapse and the greater risk of an increased overjet. The Committee also accepts the expert evidence of Mr Bateman as summarised above, and notes that he is of the view that these two risks should have been discussed. The Committee finds that you did discuss some risks, and notes that this is supported by the mentioning of those risks on the consent form that Patient A signed. The Committee notes that the GDC does not allege that you did not discuss any risks whatsoever, and instead puts its case on the basis that you discussed some, but not all, of the risks of treatment. Having determined that you did not discuss all of the risks of the proposed treatment, the Committee accepts the expert evidence of Mr Bateman that this amounts to a failure to provide an adequate standard of care to Patient A. Accordingly, the Committee finds the facts alleged at head of charge 1 (c) proved.
1. (d)	*Not providing Patient A with all treatment options.*

	Not proved
	The expert evidence of Mr Bateman is that there were a number of treatment options that should have been discussed with Patient A. Mr Bateman opines that the objectives of the proposed treatment, namely to align the front teeth, could have been achieved using the alternative method of clear aligners, which are a series of clear, removeable appliances, and which progressively move the teeth into alignment. Mr Bateman further opines that another possible treatment option would have been for Patient A to have completed conventional comprehensive orthodontics with fixed appliances that use rectangular wires to move the roots into the correct position, following initial alignment with round wires. Mr Bateman opines that such a treatment option could have been on referral to a specialist orthodontist. In her evidence Patient A stated that you did not provide her with any option other than the 'six month smiles' treatment that you subsequently provided. Your evidence is that you did discuss the options for treatment with Patient A, namely fixed braces, aligners or referral to a specialist orthodontist for conventional orthodontic treatment. You deny head of charge 1 (d) on this evidential basis. Mr Bateman's evidence is that, if you did indeed discuss these treatment options, he would offer no criticism of you. In your oral evidence you stated that you '*do recall all of* [Patient A's] *appointments well'*. The Committee has therefore sought to determine whether you did, as you maintain, offer Patient A the treatment options relevant to her presenting condition. The Committee finds the facts alleged at head of charge 1 (d) not proved. The Committee considers that the GDC has not adduced sufficient evidence to demonstrate that you did not provide Patient A with all treatment options. The Committee accepts your evidence that you offered the relevant treatment options to Patient A as summarised above. The Committee considers that your evidence of you providing Patient A with the treatment options is credible. The Committee notes that the contemporaneous entries that you made in Patient A's records, which refer to you giving a treatment option of a referral for conventional orthodontic treatment, support your account. The Committee has taken careful note of the evidence of Patient A, namely that you did not provide her with treatment options. The Committee considers that it is more likely than not that you discussed the treatment options with her, albeit not using specific terms of 'specialist' or 'orthodontist' in relation to a referral. The Committee considers that it is important that patients are given information in a way that is clear and readily capable of being understood, but it does not consider that any shortcomings that there may have been in how you outlined these treatment options does not, in the particular circumstances, mean that you did not provide Patient A with the treatment options. Accordingly, the Committee finds the facts alleged at head of charge 1 (d) not proved.
1. (e)	[withdrawn]
1. (f)	[withdrawn]

2.	*You failed to maintain contemporaneous records in respect of Patient A's appointments from around 11/11/2021 to 20/12/2022.* **Admitted and proved**
3.	*You amended records retrospectively in respect of Patient A's appointments from around 11/11/2021 to 20/12/2022.* **Admitted and proved**
4.	*You failed to indicate clearly on Patient A's record that it had been amended retrospectively.* **Admitted and proved**
5.	*You failed to obtain informed consent for the treatment provided to Patient A from around 11/11/2021 to 20/12/2022.* **Proved**
	The Committee has heard that your case is that you accept that you did not obtain informed consent insofar as you admit that you did not discuss the full risks and benefits of the proposed treatment. As set out above, you accept Mr Bateman's expert opinion that there is an increased risk of relapse when using a round wire rather than a square wire, and a greater risk of an increased overjet, when compared to more conventional orthodontic treatment. The Committee finds the facts alleged at head of charge 5 proved. The Committee has found above at head of charge 1 (c) that you did not discuss all the risks of the treatment that you proposed to provide. The Committee considers that it follows from this earlier finding that you did not obtain informed consent for the treatment. The Committee accepts the expert evidence of Mr Bateman, namely that all risks needed to be discussed, amongst other matters, in order for informed consent to be obtained. The Committee considers that, whilst Patient A signed a consent form, this does not amount to *informed* consent in light of your proven failure to discuss all the risks of the proposed treatment. The Committee considers that you failed in this duty to obtain informed consent. For these reasons, the Committee finds the facts alleged at head of charge 5 proved.
6.	*Your conduct in relation to charges 2, and/or 3, and/or 4 was*
6. (a)	*Misleading and/or* **Proved**
	The Committee finds the facts alleged at head of charge 6 (a) proved. The Committee considers that the retrospective entries that you made were misleading, as they were not identified, clearly or otherwise, as being made in retrospect. The retrospective entries that you made were objectively misleading. The entries that you added in retrospect were made against specific historic appointment dates, without any reference to when you made that addition or any

	reference to you making such additions retrospectively. Accordingly, the reader would have been entitled to assume that these additions had been made contemporaneously, when in fact they had been made in retrospect. Accordingly, the Committee finds the facts alleged at head of charge 6 (a) proved.
6. (b)	*Dishonest.* **Proved**
	In approaching this head of charge the Committee applied the test set out in *Ivey v Genting Casinos (UK) Ltd. t/a Crockfords* [2017] UKSC 67. The test is that the Committee must decide subjectively the actual state of an individual's knowledge or belief as to the facts, and must then apply the objective standards of ordinary and decent people to determine whether the individual's conduct is dishonest by those standards. The reasonableness or otherwise of an individual's belief is a matter of evidence, and is often in practice determinative, going to whether an individual held the belief, but it is not an additional requirement that their belief must be reasonable; the question is whether it is genuinely held. When once the individual's actual state of mind as to knowledge or belief as to facts is established, the question whether their conduct was honest or dishonest is to be determined by applying the objective standards of ordinary decent people. There is no requirement that the individual must appreciate that what they have done is, by those standards, dishonest. In your witness statement you state that, after the appointment that Patient A attended with you on 17 November 2022, and in around mid-December 2022, when it became apparent that Patient A required a referral to a specialist orthodontist, you sat down and went through your records of Patient A's appointments with you in order to collate information for the referral. You state that you identified that the records lacked detail in certain places, and that the specialist orthodontist receiving the referral may benefit from '*as much information as possible to ensure that the records of the consultations were comprehensive and accurately reflected the treatment and advice provided'*. You state in your oral evidence that you realised that some of the discussions that you had had with Patient A had not been fully reflected in the patient's records. However, you accepted in your oral evidence that the amended records were not provided to the orthodontist to whom Patient A was being referred. You state that you added the further details that you considered were required upon returning to work following a period of leave, and before Patient A made her complaint about you. You state that you did not delete the existing, or 'old' entries, and instead your existing entries were marked as 'void', and you added information to those existing entries '*to further illustrate the actual series of events and to clarify the treatment process'*. You state that it is your usual practice to make notes in a patient's records on as contemporaneous basis as possible, and usually whilst a patient remains in the dentist's chair or before the next patient is brought into the surgery room. You accept that you amended the records, and state that you made no attempt to conceal that from anyone, including Patient A and the GDC. You accept that, in making those amendments, you did not record when the amendments were made, and that the reader '*would not be able to see clearly when the amendments were made*'. You state that you mistakenly believed that the computer software in use at the practice '*automatically timed and date stamped*

any alterations or amendments'. You state that you have since learned that the computer software in question does not, in fact, automatically date and time stamp alterations.

Your evidence is that your understanding at the time was that the additions that you made to Patient A's records would be clearly marked as amendments. You state that you did not intend to conceal records or provide information that was misleading, and that you instead made additions to provide additional clarity for subsequent treatment.

The GDC alleges that, in anticipation of a complaint from Patient A, you '*beefed up*' the notes that you had made of her appointments with you in order to put yourself in a more favourable light. The GDC relies in part on the written evidence of Witness 2, who in her witness statement refers to the regular high standard of your record-keeping.

As set out in its foregoing determination, the Committee has heard that there are two strands to the GDC's allegation of dishonest conduct. First, that you acted dishonestly by, essentially, passing off as contemporaneous entries which were in fact retrospective. Second, that the entries that you made in retrospect were, in and of themselves, false, in that they did not properly reflect the conversations that you had with Patient A.

The Committee considers that you acted in a dishonest manner by making retrospective entries without identifying them as such. The Committee does not accept your evidence that you were not aware that the computer software would not mark your retrospective entries as retrospective. The Committee has heard that you had been working at the practice, and using the software in question, for a number of years, and that you were an experienced dentist whose record-keeping was held in high regard. The Committee considers it implausible that you did not appreciate at the time at which you made your retrospective additions that those additions would appear, and be understood, as contemporaneous entries. The Committee therefore finds that your state of mind at the time was that you knew that your retrospective entries would appear as contemporaneous entries.

The Committee has borne in mind the testimonial evidence submitted on your behalf, but this evidence does not alter its findings in the particular circumstances of this case.

The Committee does not find, in relation to the second potential strand of dishonesty, that the retrospective additions were, in and of themselves, dishonest. The Committee considers that you were motivated by a desire to tighten or tidy up the contemporaneous entries that you had made, but the Committee considers that the GDC has not adduced sufficient evidence to demonstrate that the additions that you made were false, in that they represented discussions or other aspects of Patient A's care which had not happened or which were not true. The Committee does not consider that there were hugely significant changes that were made to the records. Instead, the Committee finds that your dishonest conduct relates solely to the retrospective nature of entries which you sought to pass off as contemporaneous. The Committee considers that your motivation to tidy up the patient's records was occasioned, or fuelled, by the patient's impending complaint about her care.

Having decided your actual knowledge and belief, the Committee went on to apply the objective standards of ordinary and decent people to determine whether your conduct is dishonest by those standards. The Committee considers that your conduct was dishonest by reference to those standards. In its judgement an

	ordinary and decent person would consider that you deliberately sought to mislead those who would read Patient A's records into believing that all of the entries that you had made in those records had been made contemporaneously, when in fact some of them had been made in retrospect. Accordingly, the Committee finds the facts alleged at head of charge 6 (b) proved.

36. We move to stage two.

37. Following the handing down of the Committee's findings of fact on 31 March 2026, the hearing proceeded to stage two; that is to say, misconduct, impairment and sanction.

Proceedings at stage two

38. The Committee has considered all the evidence presented to it, both oral and written. It has taken into account the submissions made by Mr Micklewright on behalf of the GDC and those made by Ms Tanchel on your behalf. In its deliberations the Committee has had regard to the GDC's *Fitness to Practise: Guidance for the practice committees* (January 2026). The Committee has accepted the advice of the Legal Adviser concerning its powers and the principles to which it should have regard.

Evidence at stage two

39. The Committee received a bundle of documents submitted on your behalf, including certificates of, reflections on, and a log of, continuing professional development (CPD) that you have undertaken, further testimonial letters from colleagues, a personal development plan (PDP), and a reflective statement.

40. The Committee also heard further oral evidence from you. In your oral evidence you described the changes that you have made in your practice in an effort to overcome the failings that the Committee has identified. You referred to your reflections on your CPD, and to the greater prominence that you have accorded to ethical considerations in your day-to-day practice. You also described the changes that you have made to your process of obtaining informed consent from patients.

Summary of submissions

41. Mr Micklewright submitted that the GDC is neutral as to whether the facts that the Committee has found proved at heads of charge 1 (c) and 5, which relate to your failure to discuss the full risks and benefits of treatment and your associated failure to obtain informed consent, amount to misconduct. Mr Micklewright however invited the Committee to determine that the other facts that the Committee has found proved, more particularly your misleading and dishonest conduct arising out of your retrospective amendment of Patient A's records, do amount to misconduct. Mr Micklewright invited the Committee to consider whether you have remedied such misconduct to the extent that your fitness to practise is not currently impaired on public protection grounds. Mr Micklewright submitted that, in any event, the Committee may consider that a finding of impairment is required in the wider public interest, given the dishonest nature of your conduct. Mr Micklewright submitted that the appropriate sanction in the particular circumstances of this case is one of suspension for a period of six months.

42. Ms Tanchel invited the Committee to conclude that there is no basis for a finding of misconduct in respect of the Committee's findings at heads of charge 1 (c) and 5 as summarised above. Ms Tanchel submitted that, in respect of impairment, you have remediated the Committee's remaining findings in relation to your dishonest conduct and underlying behaviour such that there is no risk of you repeating that conduct. Ms Tanchel therefore submitted that your fitness to practise is not currently impaired. In addition to her references to your insight and remediation, Ms Tanchel also submitted that the Committee should pay careful regard to the specific nature of the dishonesty that it has found, and invited it to conclude that such dishonesty is '*minor in nature*', and is not such as to require a finding of impairment with regard to wider public interest considerations. Ms Tanchel submitted that, in the alternative, were the Committee to find impairment, the Committee may determine that no higher sanction than that of a short period of suspension of not more than 28 days' duration would be warranted.

Fitness to practise history

43. Mr Micklewright addressed the Committee in accordance with Rule 20 (1) (a) of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules'). Mr Micklewright stated that you have no fitness to practise history with the GDC.

Misconduct

44. The Committee first considered whether the facts that it has found proved at heads of charge 1 (c), 2, 3, 4, 5, 6 (a) and 6 (b) constitute misconduct. In considering this and all other matters, the Committee has exercised its own independent judgement.

45. In its deliberations the Committee has had regard to the following paragraphs of the GDC's *Standards for the Dental Team* (September 2013) in place at the time of the incidents giving rise to the facts that the Committee has found proved. These paragraphs state that as a dentist:

1.3 You must be honest and act with integrity.

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.

4.1 You must make and keep contemporaneous, complete and accurate patient records.

4.1.5 If you need to make any amendments to a patient's records you must make sure that the changes are clearly marked up and dated.

9.1 You must ensure that your conduct, both at work and in your personal life, justifies patients' trust in you and the public's trust in the dental profession.

46. The Committee's findings of fact arise out of the standard of care and treatment that you provided to Patient A in the period of 11 November 2021 to 20 December 2022. The Committee found that you failed to provide an adequate standard of care to Patient A, in that you did not discuss the full risks and benefits of the proposed treatment with the patient. The Committee further determined that, as a consequence, you failed to obtain the patient's informed consent for the treatment.

47. The Committee also found that you failed to maintain contemporaneous records of the patient's appointments, that you amended records retrospectively in respect of her appointments, and that you failed to make it clear that those amendments were made in retrospect. The Committee found that your conduct in respect of these specific findings was misleading and dishonest.

48. The Committee has determined that the facts that the Committee has found proved at heads of charge 1 (c) and 5, which relate to your failure to discuss the full risks and benefits of treatment and your associated failure to obtain informed consent, do not amount to misconduct. In reaching this conclusion the Committee has, as with all matters that fall to be determined at this stage of the hearing, exercised its own independent judgement. The Committee has however taken into consideration the expert opinion of Mr Bateman that these failings fall below, but not far below, the standard reasonably to be expected of a registered dentist. Whilst the Committee considers that such failings were a departure from what would reasonably be expected, the Committee does not consider that the sole incident in question was of such seriousness as to amount to misconduct.

49. The Committee has determined that the other facts that it has found proved, namely those at heads of charge 2, 3, 4, 6 (a) and 6 (b), amount to misconduct. The Committee considers that your conduct was a serious departure of the standards reasonably to be expected of a registered dentist, and that your acts and omissions would be viewed as deplorable by your fellow practitioners. In the Committee's judgement you breached a fundamental tenet of the profession, namely the need to act honestly. The Committee was particularly troubled by the context in which you were dishonest, namely in connection with an impending patient complaint.

50. The Committee has therefore determined that the facts that it has found at heads of charge 2, 3, 4, 6 (a) and 6 (b) amount to misconduct.

Impairment

51. The Committee next considered whether your fitness to practise is currently impaired by reason of the misconduct that it has found. In doing so, the Committee again exercised its own independent judgement. Throughout its deliberations, the Committee has borne in mind that its overarching objective is to protect the public, which includes the protection of patients and the wider public, the maintenance of public confidence in the profession and in the regulatory process, and the declaring and upholding of proper standards of conduct and behaviour.

52. The Committee has determined that your fitness to practise is not currently impaired with regard to public protection considerations. The Committee has had regard to the evidence that you have provided of your insight into, reflections upon, and remediation of, your misconduct. The Committee considers that your insight is detailed, relevant and focussed, and takes into consideration all relevant aspects of the impact that your conduct has had on the patient in question, the wider public and the profession. In the Committee's judgement your commitment to addressing the Committee's findings is readily apparent and extensively developed. This commitment is mirrored in the evidence of the steps that you have taken to remedy your misconduct. The changes that you have made in your underlying conduct with regard to record-keeping, as well as your dishonesty in that regard, is evidenced in the improvements that you have made in your approach to record-keeping. The Committee considers that the audits that have been conducted illustrate the embedding of the necessary changes in your practice. Although the Committee recognises that dishonesty may be more difficult to remedy than, for instance, clinical shortcomings, the Committee is satisfied that the evidence that you have produced is sufficient for it to conclude that the risk of repetition of your dishonesty and your underlying conduct is now highly unlikely to recur. The Committee therefore finds that you do not pose a risk to the public, and that your fitness to practise is not impaired with regard to such public protection considerations.

53. However, the Committee considers that a finding of impairment is, nonetheless, required to maintain public confidence in the profession and to declare and uphold proper professional standards of conduct and behaviour. In the Committee's judgement the public's trust and confidence in the profession, and in the regulatory process, would be significantly undermined if a finding of impairment was not made given its finding of dishonest conduct. Accordingly, the Committee finds that your fitness to practise is currently impaired by reason of your misconduct on public interest grounds.

Sanction

54. The Committee then determined what sanction, if any, is appropriate in light of the findings of facts, misconduct and impairment that it has made. The Committee recognises that the purpose of a sanction is not to be punitive, although it may have such an effect, but is instead imposed to protect patients and safeguard the wider public interests mentioned above.

55. In reaching its decision the Committee has again taken into account the GDC's *Fitness to Practise: Guidance for the practice committees* (January 2026). The Committee has applied the principle of proportionality, balancing the public interest with your own interests. The Committee has once more exercised its own independent judgement.

56. The Committee has considered whether there are any mitigating and aggravating factors present in this case.

57. In respect of the mitigating factors that are present, the Committee notes that you are of previous good character with no fitness to practise history; that you have taken steps to demonstrate your insight into, and remediation of, your misconduct; that there is evidence of your good conduct since the events giving rise to these proceedings; that your dishonest conduct was isolated and appears to have been out of character; that your conduct did not result in, and was not motivated by, financial gain; that you have undertaken extensive reflection and remediation, and that you have expressed your remorse and an apology for your conduct. The Committee has again had regard to the recent and positive testimonials submitted on your behalf.

58. The Committee has identified one aggravating factor. It reminded itself of the context in which you were dishonest, namely in connection with an impending patient complaint.

59. The Committee has considered the range of sanctions available to it, starting with the least restrictive. In the light of its findings, the Committee considers that taking no action or issuing a reprimand would not be sufficient in the particular circumstances of this case. In the Committee's judgement public trust and confidence in the profession and in the regulatory process would be significantly undermined if no action were taken or if a reprimand were issued. Whilst the Committee considers that the seriousness of your conduct was at the lower end of the spectrum of dishonesty, it considers that your conduct, relating as it does to dishonesty, was at the higher end of the scale of seriousness of misconduct. The Committee considers that it is important to recognise that your dishonesty did not extend to including false information in the patient's records. Instead, you added further information to the clinical records which you had not included at the time. Your dishonest conduct was, therefore, passing off as contemporaneous that which was retrospective. Nonetheless, in the Committee's judgement a more restrictive sanction is required to declare and uphold proper professional standards of conduct and behaviour.

60. The Committee next considered whether it would be appropriate to conclude the case with a direction of conditional registration. The Committee considers that a direction of conditional registration would not adequately address the findings that it has made, given that it has found impairment on public interest grounds alone.

61. The Committee next considered whether to direct a period of suspended registration. After careful consideration, the Committee has determined that a direction of suspended registration is the appropriate and proportionate sanction to impose in the particular circumstances of this case. The Committee considers that any lesser sanction would be insufficient to meet the public interest considerations as referred to above. The Committee considers that the public must be entitled to rely on the honesty and integrity of registrants, and that a direction of suspension is required to mark the seriousness of your conduct.

62. The Committee has determined that the appropriate and proportionate length of your suspension is 28 days' duration. The Committee does not make any direction for a review of your suspension prior to its expiry, given that it imposes this sanction on public interest grounds alone.

63. The Committee did consider whether a higher sanction such as a period of erasure would be appropriate. It considered that no higher sanction than that of suspension is needed to address the public interest considerations referred to above.

Immediate order

64. The Committee now invites submissions as to whether your registration should be made subject to an immediate order of suspension, pending its substantive direction of suspension taking effect.

Determination on immediate order – 1 April 2026

65. The Committee has again had regard to the GDC's *Fitness to Practise: Guidance for the practice committees* (January 2026).

66. Mr Micklewright on behalf of the GDC did not apply for an immediate order.

67. Ms Tanchel on your behalf submitted that an immediate order is not required.

68. The Committee accepted the advice of the Legal Adviser concerning its powers and the principles to which it should have regard.

69. In all the circumstances, the Committee considers that an immediate order of suspension is not necessary to protect the public, is not otherwise in the public interest, and is not in your own interests. The Committee reminded itself that it has found that your fitness to practise is impaired solely on public interest grounds, and it has therefore determined that an immediate order is not required on the grounds of public protection or in your own interests. In relation to public interest, the Committee considers that an immediate order is not required on such grounds and that, instead, its findings of fact, misconduct, impairment and sanction are sufficient to meet the public interest considerations that it has identified.

70. Unless you exercise your right of appeal, the substantive direction of suspension will be recorded in the register 28 days from the date of deemed service.

71. That concludes this case.