Dental Professionals Hearings Service

HEARING HELD IN PUBLIC

Professional Conduct Committee
Initial Hearing

20 November 2025

Name:	**Dardis, Anthony**
Registration number:	**61452**
Case number:	**CAS- 203854-X0V6J1**

General Dental Council:	Tom Stevens, counsel Instructed by Terry Symon, IHLT
Registrant:	Not present and not represented

Fitness to practise:	Impaired by reason of misconduct
Outcome:	Erased with Immediate Suspension
Immediate order:	Immediate suspension order

Committee members:	Andy Waite (Lay) (Chair) Nicola Jordan (Dentist) Jenna Crookes (Dental Care Professional)
Legal adviser:	Alastair McFarlane
Committee Secretary:	Jamie Barge

1. This is a hearing before the Professional Conduct Committee (PCC). The hearing is being held remotely using Microsoft Teams in line with the Dental Professionals Hearings Service's current practice.

2. Mr Dardis is not present and is not represented in his absence. Mr Tom Stevens of counsel, appears for the GDC.

The charge

3. The charge that Mr Dardis, faces at this hearing, as amended as set out below, reads as follows:

"That being registered as a dentist:

1. You failed to provide an adequate standard of care to Patient A from 24 October 2019 to 25 August 2021, in that:

a) You did not carry out sufficient diagnostic assessments on:

i. 24 October 2019;
ii. 1 November 2019;
iii. 10 December 2020;
iv. 25 August 2021;

b) You provided a poor standard of treatment in relation to Patient A's UR2/UR3 bridge, on 13 December 2019;

c) you did not report on radiographs taken on:

i. 24 October 2019;
ii. 10 December 2020;
iii. 25 August 2021;

d) you did not discuss the full risks and benefits of the proposed treatment;

e) You did not provide Patient A with all treatment options;

f) you did not inform patient A, on or around 25 August 2021, of the poor post placement and/or adverse findings from the radiographic image taken;

2. By reason of your conduct in charge 1.d) and/or 1.e) you failed to obtain informed consent for the treatment provided to Patient A;

3. Your conduct in respect of Charge 1.f) was:

a. misleading;
b. dishonest, in that you knew these were matters that Patient A needed to be made aware of.

4. You failed to maintain an adequate standard of record keeping in respect of Patient A's appointments from 24 October 2019 to 25 August 2021

5. From 19 April 2023 to 22 May 2023, you failed to co-operate with an investigation into the treatment of Patient A conducted by the General Dental Council ('GDC') by not providing the GDC with any evidence of indemnity and/or employment information.

6. Between 10 July 2023 to 21 July 2023, you have provided dental services whilst suspended.

And that, by reasons of the facts alleged your fitness to practice is impaired by reason of misconduct.

Service of notice of hearing – 17 November 2025

4. At the outset of the hearing on 17 November 2025, Mr Stevens on behalf of the GDC submitted the service of notice of this hearing has been properly effected in accordance with Rules 13 and 65 of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules'). On 17 October 2025 a notice of hearing was sent to the address that Mr Dardis, has registered with the GDC, setting out the date and time of this hearing, as well as the fact that the hearing would be conducted remotely. The notice was sent using the Royal Mail's Special Delivery service. The Royal Mail's Track and Trace service records that an attempted delivery of the notice was made on 20 November 2025, however, there was no answer. Copies of the notice were also sent by first class post. In addition, efforts were made to contact the Registrant on 12 November 2025.

5. The Committee accepted the advice of the Legal Adviser. The Committee determined that service of the notice of this hearing has been properly effected in accordance with the Rules.

Proceeding in absence

6. The Committee then went on to consider whether to exercise its discretion to proceed in the absence of Mr Dardis, in accordance with Rule 54 of the Rules. Mr Stevens invited the Committee to proceed in the absence of Mr Dardis, on the basis that Mr Dardis, has voluntarily absented himself from the hearing, that an adjournment would serve no purpose, and that proceeding in his absence would ensure fairness to the GDC and its witnesses as well as meeting the public interest in an expeditious consideration of the case.

7. The Committee accepted the advice provided by the Legal Adviser. The Committee was mindful that its discretion to conduct a hearing in the absence of a registrant should be exercised with the utmost care and caution. After careful consideration the Committee determined that it would be fair and appropriate to proceed in Mr Dardis' absence. The Committee noted that Mr Dardis has not engaged substantively at all with the GDC since the beginning of its investigation in April 2023. His only response before the Committee was on 20 August 2025, where he wrote in a handwritten letter informing the GDC of his new address. The Committee notes that the case includes an allegation of non-cooperation with the GDC. In addition, the GDC made efforts last week on 12 November 2025 to contact Mr Dardis, however, without success. The Committee finds that Mr Dardis has voluntarily absented himself from this hearing. It also considers that an adjournment, which has not been sought, would be unlikely to secure his attendance. The Committee considers that any unfairness that may be caused to Mr Dardis, by the Committee proceeding in his absence, is outweighed by the public interest in the expeditious consideration of this case, as well as the need to ensure fairness to the GDC and the witnesses listed to give evidence.

Findings of fact – 19 November 2025

Background to the case

8. The General Dental Council ("the Council") received a complaint from Patient A's representative, concerning the care and treatment of a single patient, Patient A, from 24 October 2019 to 25 August 2021. The clinical care involved the provision of a 2-unit bridge prothesis from Patient A's UR3 replacing his UR2. This was a replacement bridge for a bridge that had previously been fitted. The planning for that replacement bridge took place on 24 October 2019. The replacement bridge was fitted on 13 December 2019. Thereafter, Patient A returned on 10 December 2020 complaining of a bad taste and swelling and again on 25 August 2021, complaining that the bridge felt loose. In addition, Patient A attended a locum dentist, where the bridge had to be recemented in July 2021

9. At the final appointment with Mr Dardis on 25 August 2021, Patient A was informed by him that there was nothing further he could do, and Mr Dardis referred him to another dental clinic for further treatment. Assessment at this referral clinic, raised concerns about the quality of the bridge, and informed Patient A that there was infection caused by perforation of the root and this resulted in extraction of the tooth and replacement with an implant.

10. The GDC during its investigation, it obtained Patient A's relevant dental records from the Practice Manager where Mr Dardis worked at the time. The GDC instructed an expert witness, who having assessed all of the information obtained, provided an opinion and conclusion which forms the basis of the heads of charge before this Committee.

11. On further investigation, concerns were also raised regarding the adequacy of Mr Dardis' communication with Patient A both in advance of the treatment provided, more particularly surrounding the consent process, and also his failure to communicate with Patient A at the emergency appointment in August 2021. In addition, there are associated probity concerns. Finally, there are concerns in relation to Mr Dardis failing to cooperate with the GDC investigation by failing to provide evidence of indemnity insurance and employment information, as well as providing dental services in July 2023 whilst suspended by the GDC.

Evidence

12. The Committee has been provided with documentary material in relation to the heads of charge that Mr Dardis, faces. This material includes:

    - The witness statements and documentary exhibits of the following witnesses:
        - Witness Majed El-Giathi, GDC Senior Para legal dated 19 March 2024;
        - Witness 1, a Practice Manager, dated 19 March 2024;
        - Parent A dated 31 March 2025;
        - Terence Symon, GDC Presentation Lawyer dated 7 October 2025;

    - The expert reports of the GDC expert witness in this case, dated 19 February 2025 and 7 October 2025;
    - The records of Patient A;

13. The Committee heard no oral evidence from any witnesses. All witnesses were available to be tendered to confirm their statements. However, the Committee determined it had no questions for them.

Committee's findings of fact

14. The Committee has taken into account all the evidence presented to it. It has borne in mind that as Mr Dardis was neither present nor represented at this hearing, none of the witness evidence, including the expert witness was subject to the challenge of cross-examination.

The Committee has considered the submissions made by Mr Stevens on behalf of the GDC and has had regard to the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016, updated December 2020).

15. The Committee has accepted the advice of the Legal Adviser concerning its powers and 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, namely, the balance of probabilities. It reminded itself of Collins J's observations in Lawrance v GMC 2015 EWHC 581(Admin) to the effect that in cases of dishonesty cogent evidence was required to reach the civil standard of proof. The Committee heard that there had been no previous findings against Mr Dardis and accepted that it was relevant to put his good character into the balance in his favour.

16. 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 24 October 2019 to 25 August 2021, in that:*
1.(a).	*You did not carry out sufficient diagnostic assessments on:*
1(a).(i)	*24 October 2019;* **Proved.** The GDC expert in his report stated regarding the pre-treatment appointments*" "...Prior to providing a replacement dental bridge a dentist should carry out and document some diagnostic assessments to ensure proper and thorough treatment planning. This could include some of the following, the patient's history after an examination, a clinical evaluation of the oral cavity, radiographic examination and an assessment of the proposed procedure… A reasonable dentist would explore and then record, why the bridge was loose and what symptoms the patient was having, which would assist in obtaining a full diagnosis to justify any proposed treatment."* Whilst not reversing the burden of proof in any way, the Committee was mindful that there were no responses or challenges from Mr Dardis to the GDC's evidence. The Committee took into account the records of Patient A. It noted that the records are sparse, for example, no record of a medical history being taken. The Committee had regard to the patient notes of the first assessment on 24 October 2019, when a replacement bridge was required. The notes do not show that Mr Dardis carried out either a periodontal or occlusal assessment. It noted that a radiograph was taken on this date, but no record that Mr Dardis had reported on this. The Committee accepts the evidence of the GDC expert. It is satisfied that prior to replacing a replacement bridge, it is incumbent on a dentist to carry out a full diagnostic assessment. These include assessing a patient's dental history after examination, taking a BPE score, and a clinical examination of the oral cavity. Mr Dardis had a duty to carry these out but failed on either date of 24 October 2019 or 1 November 2019 to conduct sufficient diagnostic assessments prior to the placement of the replacement dental bridge being fitted on 13 December 2019. The Committee is satisfied that Mr Dardis failed to carry out sufficient diagnostic assessments on these dates. It therefore finds this head of charge proved.

1.(a).(ii)	*1 November 2019;* **Proved for the reasons provided above.**
1.(a).(iii).	*10 December 2020;* **Proved.** The GDC expert stated in his report *" In my opinion, the records don't provide reassurance that the Registrant undertook sufficient diagnostic assessments that would be expected for a reasonable practitioner, when proposing a replacement bridge and during the subsequent consultations. The ongoing failure to carry out investigations lead to the patient experiencing further symptoms from the bridge which might have been rectified at an earlier date, if the Registrant had been more thorough. If the Committee can establish that the Registrant didn't carry out enough diagnostic assessments when treating Patient A, then this failure is a gross or significant departure from the standard expected and represents a standard that is far below for a reasonable general dental practitioner."* The Committee accepts the evidence of the GDC expert. It noted that this was an emergency appointment approximately 1 year after the bridge was placed. Patient A was complaining of bad taste and swelling from the front upper right area. There is no evidence that diagnostic information was obtained regarding suspicion of the bridge. The only diagnostic assessment seen on the patient notes was a radiograph of the upper right central incisor, which did not sufficiently show the bridge. Accordingly, the Committee is satisfied that this did not amount to a sufficient diagnostic assessment given the presentation at this emergency appointment. It therefore finds this head of charge proved.
1.(a).(iv).	*25 August 2021;* **Proved.** This was another emergency appointment, where Patient A had complained of the bridge being loose. At this appointment a radiograph was taken of the bridge. No other diagnostic assessments are evident on the patient notes. The Committee accepted the opinion of the GDC expert, that this was not sufficient and that further assessment of the bridge should have been undertaken, such as exploring this clinically. The Committee considers that given the absence of such clinical exploration recorded in the notes, it is satisfied that it is more likely than not that this was not done. The Committee finds this head of charge proved.
1.(b).	*You provided a poor standard of treatment in relation to Patient A's UR2/UR3 bridge, on 13 December 2019;* **Proved.**

	The Committee took into account the GDC expert who stated in his written report *"... The Registrant constructed a new bridge for the UR3 to replace UR2 which required removing the old post and placing a new one within the root canal system… However,… the metal post has deviated from the line of the RCT… a post should be placed within the RC system… I am critical of the Registrant's practise in deviating from the existing root filling... Based solely on the radiographic evidence, the bridge prothesis (UR2 and UR3) has not been provided to a reasonable standard as expected by a general dental practitioner. The deviation in post preparation has most likely led to the chronic infection and mesial bone breakdown. This will ultimately lead to the loss of the bridge… this represents a standard that is seriously below what is expected for a reasonable general dental practitioner."* The Committee took into account the radiograph taken on 25 August 2021 of Patient A's UR2 and UR3. The Committee considers this radiograph, on the balance of probabilities, shows that the metal post had deviated from the root canal. The Committee accepts the evidence of the GDC expert. The Committee is therefore satisfied that the replacement post had not been provided to the required standard of care. It is satisfied that the standard of care provided at this appointment by Mr Dardis was below the standards expected. The Committee therefore finds this head of charge proved.
1.(c).	*You did not report on radiographs taken on:*
1.(c).(i).	*24 October 2019;* **Proved.** The Committee notes the radiographs taken by Mr Dardis on 24 October 2019, 10 December 2020, and 25 August 2021. These were provided by the Practice Manager. *The GDC expert stated in his written report "Although the Registrant did take appropriate radiographs prior to the bridge construction on 24/10/19 and during the remedial consultations, there was some concerns regarding the Registrant's remedial practice. In my opinion, the records demonstrate that the Registrant failed to report on the results and was not thorough enough to take more views at an earlier opportunity. The evidence would suggest that the Registrant's radiographic practice has let the patient down and not diagnosed the developing pathology, which caused more suffering than was needed. The Registrant's practice falls seriously below the standard expected of a reasonable general dental practitioner".* The Committee noted the radiographs taken on 24 October 2019, 10 December 2020 and 25 August 2021. This was demonstrated in the dental records of Patient A. The Committee is satisfied there is no record in Patient A's notes that Mr Dardis had reported on the radiographs taken on these dates. The Committee is satisfied that Mr Dardis had a duty to report on these radiographs and failed to do so. This failing was a clear breach of the IRMER regulations.

	The Committee accepts the evidence of the GDC expert and is satisfied there is no record of any reporting by Mr Dardis on the radiographs taken on these dates. It therefore finds this head of charge proved.
1.(c).(ii).	*10 December 2020;* **Proved for the reasons given above.**
1.(c).(iii).	*25 August 2021;* **Proved for the reasons given above.** The Committee notes this date was 20 months after the replacement of the bridge. The Committee was satisfied that there is no record that Mr Dardis had reported on the adverse findings, of the mesial bone loss and infection on UR3, identified in the radiograph.
1.(d)	*You did not discuss the full risks and benefits of the proposed treatment;* **Proved.** Patient A stated in his witness statement *"I do not recall the Registrant ever discussing risks or benefits of the treatment he was providing. He did say at one point during those appointments that I may eventually require implants. I do not recall exactly when he said that to me, but it was during one of the appointments when he was treating my UR3 tooth"* The GDC expert in his report stated ... *"There are no notes of any discussions in the Registrant's records over the risks and benefits of the treatment proposed. If a reasonable dentist was undertaking a replacement bridge where the previous bridge had failed, it was a very relevant risk that it might fail again, leading to the loss of the bridge and the potential support tooth. If the Committee can establish that risks were not discussed, then this will represent a failure that falls far below the standard expected for a reasonable general dental practitioner."* The Committee noted there was no record made in Patient A's notes that risks and benefits were discussed. The Committee accepts the evidence of Patient A who did not recall Mr Dardis ever discussing the full risks and benefits. The Committee also accepts the evidence of the GDC expert. The Committee considers that the failure to discuss the risks is serious, and that this failure occurred throughout the various appointments from the pre treatment appointment in October 2019 to the final appointment on 25 August 2021. The Committee considers there were real risks for example a possible failure of the new bridge, which Patient A should have been informed of. The Committee is satisfied that Mr Dardis had a duty to discuss these with Patient A but failed to do so. The Committee is satisfied on the balance of probabilities that Mr Dardis failed to discuss risk or benefits to Patient A prior to providing that prosthesis. It therefore finds this head of charge proved.

1.(e).	*You did not provide Patient A with all treatment options;* ***Proved.*** *The GDC expert witness stated in his report "…The treatment planned was for a replacement bridge for UR3/UR2. As this bridge had a doubtful prognosis, you would expect a reasonable dentist to run through all the options with a patient to ensure that the patient was fully informed and to obtain valid consent. There were many different treatment options and combinations so a reasonable dentist would take his/her time explaining these to their patient. It maybe that the patient would dismiss these as the driving factor for the patient may have been just a new replacement bridge, but it would be important to highlight the options available. In my opinion a reasonable dentist would have made sure the patient was aware that the new bridge might have a limited prognosis and that it might be prudent to consider other options. These may have included just leaving a space at UR2 and then restoring UR3. Another potential option was the placement of an implant at UR2 and then restoring UR3 with a new post crown. Alternatively, a denture at UR2 and a single post crown or extraction of UR3 and the replacement of both teeth by either denture, bridge or implants..".* *"…In my opinion, the records do not provide any reassurance that the patient was made aware of all the potential options for his treatment. If the Committee can establish this as fact, then this would mean that the Registrant has withheld clinical information which could have assisted the patient with his decision making and would be seriously below the standard for a reasonable general dental practitioner."* The Committee noted the records of Patient A. It is satisfied there is no record in Patient A's note of Mr Dardis having discussed all the available treatment options with Patient A, such as the provision of dentures or the option to do nothing, in advance of the treatment being provided. The Committee accepts the evidence of both Patient A and the GDC expert and considers that Mr Daris had a duty of care to provide full treatment options as required in the GDC's standards. A number of treatment options were available to Patient A, yet Mr Dardis had failed to discuss these with him in order to give him an informed decision. It concluded on the balance of probabilities, Mr Dardis failed to discuss all treatment options with Patient A. The Committee therefore finds this head of charge proved.
1.(f).	*You did not inform patient A, on or around 25 August 2021, of the poor post placement and/or adverse findings from the radiographic image taken;* **Proved.** Patient A in his written statement stated *"…The defect with the crown and post and puncture to my UR3 tooth wall only came to my attention when I sought advice from other practitioners. The UR3 treatment kept failing and I was later told by other dentists that the post of my crown had punctured the side of my UR3 tooth, and this had led to recurring infections and bone loss…"* *"My dental records have been provided to the GDC so all the information can be found on there. The appointments were over a long period of time, around a year and half of going back and forth. During this period, I was not aware that the Registrant had made a mistake as I trusted him fully…I was not*

	informed about the cause of the infections by the Registrant, it was the subsequent dentists I visited who informed me of this. I went to four or five consultations and was informed that the puncture in my tooth was causing the infections….The first I knew that there had been a puncture in the wall of my tooth is when I attended an appointment with another dentist, and they explained that the pin in the crown punctured the tooth and that is why I lost so much bone and tooth. It was explained to me that this is why I needed to have implants." The GDC expert report stated in his report *"Patient A then reattends the practice on 25/08/21 and it is noted that the bridge doesn't feel secure, and the first radiograph of the fitted bridge is taken by the Registrant. The records do not note that the patient was informed of the findings from the image and that subsequent treatment would be necessary for the failing bridge. The patient is only reassured that the Registrant could not identify a crack within the root."* *"A reasonably acting general practitioner would have a responsibility to disclose all the relevant findings from radiographs and clinical examinations. The Registrant was providing consultations for issues reported with the bridge and this included taking a radiograph on 25/08/21. The records would imply that the only information the Registrant has shared with the patient was related to the identification of a potential root fracture 'cannot see fracture on the xray'. I have reviewed the image, and that diagnosis can be supported, as cracks are difficult to identify on radiographs and I could not identify an obvious crack. However, the Registrant had a duty to point out all the information gained from image which would include the deviated post and developing pathology (bone loss and infection)."* The Committee considers that as of 25 August 2021, the radiographic evidence of UR3 demonstrated that the replacement post had deviated. There is no record in Patient A's notes that a discussion was made of any concerns regarding the post. The Committee is satisfied there is no evidence to suggest that Mr Dardis had any conversation about any adverse findings, i.e. placement of the post to Patient A on this date. The Committee is satisfied that Patient A was not aware until he was seen by a subsequent treating dentist that there was an adverse placement of the post. The Committee accepts the evidence of the GDC expert and Patient A. It is satisfied, having taken account of the radiograph taken on 25 August 2021, that Patient A's post in UR3 deviated from the root canal filling. Moreover, there is evidence contained in the radiograph of mesial bone loss and infection around the UR3. That being detected radiographically, those were matters that Mr Dardis should have informed Patient A of. There is no evidence that the Registrant had discussed this with Patient A. The Committee is satisfied that Mr Dardis did not inform Patient A of the poor placement. The Committee therefore finds this head of charge proved.
2.	*By reason of your conduct in charge 1.d) and/or 1.e) you failed to obtain informed consent for the treatment provided to Patient A;* **Proved.**

	The GDC expert stated in his report *"... you would expect a reasonable dentist to run through all the options with a patient to ensure that the patient was fully informed and to obtain valid consent. There were many different treatment options and combinations…"* *"A dentist is expected to discuss the options with the risks and benefits so that patients can have all the information to help them with an informed choice…In my opinion the records do not provide reassurance that the Registrant obtained valid consent for the replacement bridge provided for Patient A. If the Committee can establish this as a fact that the options with risks were not discussed with the patient, then this would be far below the standard expected for a reasonable general dental practitioner."* *"Patient A recalls that he doesn't remember the Registrant 'ever discussing the risks and benefits of treatment'. A dentist has a duty to obtain valid consent from a patient before embarking on treatment. This includes making sure that the patient is fully informed about the treatment, its benefits, risks, alternatives (including not having treatment) and costs. A reasonable dentist would have discussed the risks/and benefits of providing this bridge before starting treatment and if there were any other alternatives. The tooth (UR3) supporting the bridge had a poor prognosis and the post further weakened the root, so the main risk was that the tooth holding the bridge might fracture. This was very relevant in this case, as it was a replacement bridge, where the root had broken previously, so there was a risk that the same thing was going to happen to the new bridge. There were other options such as implants or dentures, and these options carried their own risks and benefits which should have been discussed with the patient."* The Committee accepted the opinion evidence of the GDC expert that Mr Dardis failed to obtain the informed consent of Patient A. It is satisfied that Mr Dardis was under a professional duty to obtain informed consent from Patient A, as set out in the GDC's Standards. This was an integral aspect of providing care. The Committee is satisfied that having found proved that Mr Dardis did not provide Patient A with all risks and benefits as well as all treatment options, he could not have obtained Patient A's informed consent before commencing treatment. The Committee therefore finds this head of charge proved.
3.	*Your conduct in respect of Charge 1.f) was:*
3.(a).	*Misleading;* **Proved.** Misleading for the purposes of this charge refers to the objective effect of the conduct, regardless of Mr Dardis' intention. The Committee noted there is a record of a discussion between Mr Dardis and Patient A in which Mr Dardis told Patient A he could do no more for him and he would refer him onwards. However, there is no evidence that Mr Dardis had explained to Patient A of the poor placement of the post or the adverse radiographical findings.

	The Committee considers his failure to inform as found in head of charge 1(f), was objectively misleading at that material time, as he should have informed Patient A of the findings of the radiograph. The Committee therefore finds this head of charge proved.
3.(b).	*Dishonest, in that you knew these were matters that Patient A needed to be made aware of.* **Not 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 their conduct was dishonest by those standards. In accordance with the legal test set out above, the Committee first considered the actual state of Mr Dardis' knowledge or belief as to the facts when he failed to inform patient A, on or around 25 August 2021, of the poor post placement and/or adverse findings from the radiographic image taken. The Committee took into account there is evidence that a discussion between Mr Dardis and Patient A and that he would refer Patient A for further treatment. The Committee considers that there is a lack of evidence to suggest that Mr Dardis knew at that material time that the replacement post had failed. The Committee is therefore satisfied that there is a lack of cogent information to suggest that Mr Dardis was aware of the failed post and had deliberately withheld this information from Patient A. It considers there are a number of possibilities as to why Mr Dardis did not inform Patient A of the failed post or associated problems. For example, he was not aware of it himself. The Committee was not satisfied that the GDC has discharged the burden of proof to establish a dishonest motive. It therefore finds this head of charge not proved.
4.	*You failed to maintain an adequate standard of record keeping in respect of Patient A's appointments from 24 October 2019 to 25 August 2021* **Proved.** The GDC expert stated in his report "*The set of records made by the Registrant for all the consultations provided are very sparce and do not meet the guidelines or standards expected for a reasonable general dental practitioner... Overall… far below what is expected.*" The Committee noted Patient A's dental records and is satisfied that the records taken by Mr Dardis were inadequate. There is a lack of records in respect of medical histories, radiographic reports, diagnostic assessment, risk and benefits and treatment options provided to Patient A. This is supported by the opinion of the GDC expert witness.

	It therefore considers that the standard of Mr Dardis' record keeping is far below the standards expected and finds this head of charge proved.
5.	*From 19 April 2023 to 22 May 2023, you failed to co-operate with an investigation into the treatment of Patient A conducted by the General Dental Council ('GDC') by not providing the GDC with any evidence of indemnity and/or employment information.* **Proved.** The Committee noted the GDC Standard 9.4.1 "*If you receive a letter from the GDC in connection with concerns about your fitness to practise, you must respond fully within the time specified in the letter*" Witness statement of the GDC Senior Para legal, stated "*On 19 April 2023 the GDC sent a letter to the Registrant informing him that we are in the early stages of considering concerns received about him. The letter also asked him to provide information on his working arrangements, proof of indemnity and patient records…I also exhibit a copy of the Royal Mail tracking receipt dated 20 April 2023 showing that the letter dated 19 April 2023 was signed for by 'DARDIS'. I can confirm the GDC did not receive a response from the Registrant.* *On 09 May 2023 the GDC attempted to contact the Registrant using the telephone number on his contact card on CRM. The Registrant did not answer the call, and a voicemail was left requesting a call back. I exhibit a copy of the telephone attendance not ("TAN"). I can confirm the GDC did not receive a call back from the Registrant.* *On 15 May 2023 the GDC sent a letter to the Registrant requesting a response to the letter dated19 April 2023. The Registrant was asked to respond to the letter by 22 May 2023. I exhibit a copy of the letter. I can confirm the GDC did not receive a response from the Registrant*". The Committee is satisfied that Mr Dardis has not responded to any of the GDC's correspondence regarding the investigation. Communications sent from the GDC to Mr Dardis include, an email dated 19 April 2023, letter dated 19 April 2023, a further letter dated 19 April 2023, telephone call made on 9 May 2023 and finally a letter dated 15 May 2023. Mr Dardis only contact was a handwritten note of 20 August 2025 to the GDC where he provided a new contact address and nothing else. It noted the letter contained the reference number of the GDC investigation, and the Committee was satisfied that this was evidence of Mr Dardis being fully aware of its investigation. The GDC expert witness stated in his evidence that not to comply with the regulatory standards is a very serious matter. The Committee accepted the evidence of the GDC Senior Para Legal and also the GDC expert. It is satisfied that Mr Dardis had a duty to cooperate with his regulator but failed to do so. The Committee considers that the GDC's evidence clearly outlines the period where Mr Dardis, upon various requests, failed to cooperate with the GDC and provide evidence of indemnity cover and employment information.

	It therefore finds this head of charge proved.
6.	*Between 10 July 2023 to 21 July 2023, you have provided dental services whilst suspended.* **Proved.** The Committee notes the witness statement of Witness 1, Practice Manager at Registrant's Practice, who stated "*The Registrant's contract with the Practice was signed on 01.04.2014, before I joined the Practice. I would say that was his first day at the Practice as far as I 'm concerned. The 21st of July 2023 was his last day at the Practice.* *The reason why the Registrant left the Practice was because we found out that he was suspended from practising as a dentist and he was therefore advised by us not to return to work. We found out that he was suspended through the operations manager who stumbled on the GDC website stating that he was suspended. She found this out over the weekend of the 22/23 July 2023, and she tried to contact him to speak to him about it. As far as I'm aware she could not get a hold of him….. I have provided records showing that the Registrant did provide dental services at the Practice between 10 July 2023 and 21 July 2023. We had no idea he had any issues and was suspended until the operations manager informed us*." The Committee also noted Terry Symons witness statement, which provides evidence of Mr Dardis being served documentation confirming that he was suspended by the GDC's Interim Orders Committee on 5 June 2023 for a period of 18 months. Evidence indicates the start date is recorded as 10 July 2023. The Committee accepted the evidence of Terry Symons and also Witness 1, The Committee notes the last day of this period, 21 July 2023, was the date when the practice first became aware that he was suspended by the GDC. Witness 1 also provided the GDC with the appointment/time sheets for the relevant dates, which confirmed Mr Dardis had worked and provided dental services on separate dates during this period. The Committee is satisfied that Mr Dardis was suspended between the dates of 10 July 2023 to 21 July 2023, which prohibits Mr Dardis providing dental services. The Committee is therefore satisfied that Mr Dardis had worked on these dates whilst suspended by the GDC. It therefore finds this head of charge proved.

17. We move to stage two.

<u>Determination on misconduct, impairment and sanction – 20 November 2025</u>

18. Following the handing down of the Committee's findings of fact on 19 November 2025, the hearing proceeded to stage two; that is to say, misconduct, impairment and sanction.

Proceedings at stage two

19. The Committee has considered all the evidence presented to it, both oral and documentary. It has taken into account the submissions made by Mr Stevens on behalf of the GDC. In its deliberations the Committee had regard to the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016, updated December 2020). 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

20. The Committee received no further oral or documentary evidence at this second stage of the hearing.

Summary of submissions

21. Mr Stevens on behalf of the GDC submitted that the facts that the Committee has found proved comfortably amount to misconduct. He submitted that some of the clinical failings resulted in actual harm to Patient A. He submitted that the failure to cooperate and practising whilst suspended were particularly serious both in relation to patient safety and the public interest and sufficient to meet the threshold for misconduct. He submitted that Mr Dardis' fitness to practise is currently impaired by reason of that misconduct, and that a finding of impairment is also required for the protection of the public and is required the wider public interest. Mr Stevens invited the Committee to impose the appropriate sanction, namely erasure from the register.

Fitness to practise history

22. Mr Stevens addressed the Committee in accordance with Rule 20 (1) (a) of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules'). Mr Stevens stated that Mr Dardis, has no fitness to practise history with the GDC.

Misconduct

23. The Committee first considered whether the facts that it has found proved constitute misconduct. In considering this and all other matters, the Committee has exercised its own independent judgement.

24. 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.

1.3.2 You must make sure you do not bring the profession into disrepute.

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

2.2.1 You must listen to patients and communicate effectively with them at a level they can understand. Before treatment starts you must:

• explain the options (including those of delaying treatment or doing nothing) with the risks and benefits of each; and

• give full information on the

3.1 you must obtain valid consent before starting treatment, explaining all the relevant options and the possible costs

3.1.3 You should find out what your patients want to know as well as what you think they need to know. Things that patients might want to know include:

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

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

7.1 Provide good quality care based on current evidence and authoritative guidance.

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.

9.4 you must co-operate with any relevant formal or informal inquiry and give full and truthful information.

25. The Committee's findings of fact relate to a number of failings. With these proven facts in mind, the Committee then turned to the question of whether those facts amount to misconduct.

26. The Committee has taken account the evidence of the GDC's expert witness and accepts his opinion that Mr Dardis' conduct was far below the standards expected of a dentist in respect of all of the heads of charge found proved.

27. The Committee considered that the heads of charge found proved, related to one patient, one course of treatment over two years, concerning a broad area of dentistry. These included repeated failures to carry out sufficient diagnostic assessments, repeated failures to discuss risk and benefits and provide all treatment options. Also, Mr Dardis provided a poor standard of treatment in relation to Patient A's bridge, which led to actual harm to Patient A and him seeking implants from a subsequent treating dentist. In addition, there were repeated failures to report on radiographs and record keeping.

28. The Committee considered that Mr Dardis failed during the last appointment to inform Patient A of the poor placement of the bridge, which was found to be misleading as it led to actual patient harm.

29. In addition, the Committee found proved that Mr Dardis failed to properly communicate with Patient A and obtain his informed consent, which the Committee considers is a very serious breach of the trust the public places in dentists. The Committee also found proved Mr Dardis' failure to cooperate with his regulator on more than one occasion. The Committee considers that his conduct was a blatant and wilful disregard to the regulatory process. In addition, Mr Dardis practised whilst suspended by the GDC. It is incumbent on a registered dental professional to cooperate with their regulatory body's investigation, and that a failure to do so,

seriously undermines the systems put in place to protect the public and uphold the public interest.

30. Furthermore, Mr Dardis's clinical failings all had the potential to place patients at serious risk of harm. In the Committee's judgement those clinical failings similarly constitute misconduct.

31. The Committee is satisfied that taken together that the facts found proved demonstrate a pattern of serious misconduct. Mr Dardis' conduct poses a real risk to patient safety and breaches fundamental principles of patient care. In addition, the Committee finds that Mr Dardis' acts and omissions represent a serious and sustained departure from professional standards. His conduct fell far short of the standards reasonably to be expected of a registered dental professional, and his behaviour would be viewed as deplorable by his fellow practitioners.

32. The Committee has therefore determined, and has had little difficulty in finding, that the facts that it has found proved amount to misconduct.

Impairment

33. The Committee next considered whether Mr Dardis' 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.

34. 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.

35. The Committee considers that the findings that it has made in relation to Mr Dardis' clinical misconduct is, in theory, capable of being remedied. Those findings, some repeated, relate to specific and identifiable aspects of his clinical practice. However, the Committee also found that failing to cooperate with the regulator and practising whilst suspended by the GDC are far more difficult matters to remediate and the Committee considers these failings demonstrate an attitudinal problem and were a sustained pattern of behaviour.

36. The Committee has been provided with no evidence to suggest that Mr Dardis has demonstrated any meaningful insight into his misconduct, or that he has taken steps to remedy his failings. The Committee has not drawn any inference from Mr Dardis' absence at this hearing. At the same time, Mr Dardis' lack of participation in this process means that the Committee has not been provided with any meaningful evidence from him, as to his reflections upon, and remedying of, the serious misconduct that has been found. For instance, the Committee has not been provided with any reflection or expression of remorse, or any information setting out any learning that he has undertaken, or intends to undertake, in order to address and overcome the misconduct that the Committee has found.

37. Mr Dardis' conduct, is highly damaging to his fitness to practise, relating as it did to a blatant disregard for restrictions put in place on his practice to protect the public and was a deliberate departure from the fundamental tenet of providing good quality care to patients. The Committee took into account that Mr Dardis has no previous fitness to practise history. However, it has also noted that the heads of charge it has found proved were committed over a considerable period of time, are unremediated and placed patients at significant risk of harm, and in Patient A's case caused actual harm. In addition, Mr Dardis's repeated conduct in failing to cooperate with the GDC and practising whilst suspended by the GDC, demonstrates an on-going risk of repetition. The Committee has found that the lack of insight and remediation present in this case means that there is a high risk of repetition.

38. The Committee therefore finds that Mr Dardis' fitness to practise is currently impaired in respect of public protection.

39. The Committee considers that a finding of impairment is also, and undoubtedly, 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 the particularly serious nature of Mr Dardis' misconduct. Mr Dardis' actions were liable to have brought the reputation of the profession into considerable disrepute and relate to a breach of a fundamental tenet of the profession, namely to provide safe and effective care; and uphold public safety and confidence in the profession.

40. Accordingly, the Committee finds that Mr Dardis' fitness to practise is currently impaired by reason of his misconduct.

Sanction

41. 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.

42. In reaching its decision the Committee has again taken into account the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016, updated December 2020). The Committee has applied the principle of proportionality, balancing the public interest with Mr Dardis' own interests. The Committee has once more exercised its own independent judgement.

43. The Committee has paid careful regard to the mitigating and aggravating factors present in this case.

44. In respect of the mitigating factors that are present, the Committee notes that Mr Dardis, has no fitness to practise history.

45. In terms of aggravating factors, the Committee notes that Mr Dardis, placed patients at actual risk of harm. His conduct amounted to a breach of the trust that patients had placed in him. His clinical failings and other misconduct were sustained and repeated over a period of time. Mr Dardis has not remediated at all or provide evidence of any insight into his misconduct. He has also displayed a blatant and wilful disregard towards his regulator.

46. Having identified the mitigating and aggravating factors present in this case, the Committee then moved on to determine what sanction, if any, would be appropriate in this case.

47. 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 be wholly insufficient 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. The Committee also considers that taking no action or issuing a reprimand would not adequately protect the public and would not be sufficient to declare and uphold proper professional standards of conduct and behaviour.

48. The Committee also considers that a direction of conditional registration would not be sufficient to meet the public protection and public interest considerations engaged in this case. The Committee considers that conditions could not be formulated to deal with the risks that it has identified. Further, it was satisfied conditions would not be workable given Mr

Dardis' lack of engagement in this case. The Committee also considers that, even if conditions could be formulated, a direction of conditional registration would be entirely inadequate to declare and uphold proper professional standards of conduct and behaviour because of the serious nature of Mr Dardis' misconduct.

49. The Committee then went on to consider whether a direction of suspended registration would represent an appropriate and proportionate outcome. After careful consideration the Committee has determined that suspension would not be sufficient to protect the public or meet the public interest considerations that it has identified above.

50. The Committee has found repeated and serious clinical failures, that occurred over a prolonged period of time which were manifested in different aspects of Mr Dardis' practice. Further, he practised dentistry when suspended by the GDC and repeatedly failed to engage with the GDC during its investigation. The Committee has found that Mr Dardis has a deep-seated attitudinal problem and disregard towards his regulator and the safeguards put in place to protect the public. Mr Dardis has demonstrated no insight or remediation in relation to his conduct and the Committee is satisfied Mr Dardis poses an ongoing risk of significant harm to the public. The Committee considers that a period of suspended registration would not be sufficient to uphold the reputation of the dental profession and to protect the public or the wider public interest considerations referred to above in the serious circumstances of this case.

51. In short, Mr Dardis' conduct is fundamentally incompatible with registration. The Committee has therefore determined that the only appropriate and proportionate sanction to impose in the particular circumstances of this case is that of erasure.

52. The Committee hereby directs that Mr Dardis' name be erased from the register.

Determination on immediate order

53. Mr Stevens on behalf of the GDC submitted that an immediate order of suspension is necessary to protect the public and is otherwise in the public interest.

54. The Committee accepted the advice of the Legal Adviser concerning its powers and the principles to which it should have regard. The Committee has again had regard to the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016, updated December 2020).

55. In all the circumstances, the Committee considers that an immediate order of suspension is necessary to protect the public and is otherwise in the public interest. The Committee has determined that, given the risks to the public and the public interest that it has identified, it would not be appropriate to permit Mr Dardis, to practise before the substantive direction of erasure takes effect. The Committee considers that an immediate order for suspension is consistent with the findings that it has set out in its foregoing determination.

56. The effect of the foregoing determination and this immediate order is that Mr Dardis' registration will be suspended from the date on which notice of this decision is deemed to have been served upon him. Unless Mr Dardis, exercises his right of appeal, the substantive direction of erasure will be recorded in the register 28 days from the date of deemed service. Should Mr Dardis, decide to exercise his right of appeal, this immediate order of suspension will remain in place until the resolution of any appeal.

57. That concludes this case.