HEARING HELD IN PUBLIC

Professional Conduct Committee
Initial Hearing

9 to 19 March 2026

Name:	HEBEISH, Rafik George Nassif
Registration number:	84006
Case number:	CAS-205017-P8K5S9

General Dental Council:	Daniel Mansell, Counsel Instructed by Ervin Gjoleka, Capsticks
Registrant:	Present Represented by Ben Rich, Counsel Instructed by Lauren Griffiths, MDDUS

Fitness to practise:	Misconduct found Not impaired by reason of misconduct
Outcome:	Fitness to Practise Not Impaired. Case Concluded

Committee members:	Susan Stevens	(Chair, Dentist Member)
	Jane Jones	(Lay Member)
	Nosheen Kabal	(Dental Care Professional Member)
Legal Adviser:	William Hoskins	
Committee Secretary:	Lola Bird	

HEBEISH, Rafik, a dentist, Statutory Exam 2004 is summoned to appear before the Professional Conduct Committee on 9 March 2026 for an inquiry into the following charge:

The charge (as amended)

The hearing will be held to consider the following charge against you:

"That being registered as a Dentist:

1. *In respect of Patient 1, you:*
   (a) *Failed to adequately report on radiographs taken on:*
      i. *21 September 2020;*
      ii. *11 December 2020;*
      iii. *22 February 2021;*
      iv. *24 March 2021;*
      v. *19 April 2021;*
      vi. *25 October 2021.*
2. *In respect of Patient 2, you:*
   (a) Failed to carry out sufficient diagnostic assessments in that you did not obtain study models prior to placing an implant on 26 September 2012.
3. *WITHDRAWN:*
   (a) *WITHDRAWN;*
   (b) *WITHDRAWN;*
   (c) *WITHDRAWN.*
4. *In respect of Patient 4, you:*
   (a) *Failed to take a radiograph prior to the second stage of implant surgery on or before 20 April 2022;*
   (b) *Failed to provide an adequate standard of treatment on 20 April 2022, by pushing an implant into the patient's sinus.*
5. *In respect of Patient 5, you:*
   (a) *Failed to maintain an adequate standard of record keeping in respect of the patient's appointments in that you did not record the teeth incorporated into a bridge in or around March 2013;*
   (b) *Failed to provide an adequate standard of implant treatment:*
      i. *WITHDRAWN;*
      ii. *at the UL4 on 28 April 2017;*
   (c) *Failed to carry out sufficient treatment planning before providing a bridge on 22 March 2013;*
   (d) *Provided a bridge on 22 March 2013 which was not clinically appropriate because it linked natural teeth to an implant;*

(e) *Failed to diagnose caries and advise of the need for treatment on 24 October 2018.*

6. *In respect of Patient 6, you:*

(a) *Prior to providing treatment on 24 September 2021, discussed treatment options and risks and benefits while the patient was under the influence of temazepam;*

(b) *Failed to obtain informed consent for the implant treatment provided for the patient on 24 September 2021;*

(c) Failed to provide an adequate standard of implant treatment at the LR5 on 24 September 2021.

7. *In respect of Patient 7, you:*

(a) *Failed to maintain an adequate standard of record keeping in respect of the patient's appointments in that you did not record the preparation of teeth for crowns on 22 January 2020 and 16 March 2020;*

(b) *Failed to provide an adequate standard of implant treatment on 25 June 2021.*

8. *In respect of Patient 8, you:*

(a) *Failed to carry out sufficient treatment planning prior to placing an implant at the UR4 on 8 December 2021;*

(b) *Failed to carry out treatment in a timely manner in that you did not extract the UR5 on or soon after 27 September 2021;*

(c) *Failed to maintain an adequate standard of record keeping in respect of the patient's appointments, in that you did not record an appointment which occurred on 9 May 2022;*

(d) *Failed to adequately report on radiographs taken on:*

i. *27 September 2021;*

ii. *15 November 2021.*

9. *In respect of Patient 9, you:*

(a) *Failed to carry out sufficient diagnostic assessments prior to placing an implant on 3 December 2021;*

(b) *Failed to carry out sufficient pre-treatment investigations prior to placing an implant on 3 December 2021;*

(c) *Failed to provide an adequate standard of implant treatment on 3 December 2021, in that the implant at UR4 was placed too close the UR3;*

(d) *Failed to diagnose the reason for the implant failure.*

10. In respect of Patient 10, you:

(a) *Failed to take a radiograph of:*

i. *implant crowns on 6 October 2021;*

ii. *the left implant on 9 September 2022;*

(b) *Failed to report adequately, or at all, on radiographs taken on:*

i. *22 September 2021;*

ii. *9 September 2022.*

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

Mr Hebeish,

1. This is a hearing before the Professional Conduct Committee in respect of a case brought against you by the General Dental Council (GDC). The alleged matters relate to your treatment of a number of patients over a period of time.

2. The hearing commenced on Monday, 9 March 2026 and is being conducted in person at the Dental Professionals Hearings Service.

3. You are represented at these proceedings by Mr Ben Rich, Counsel. The Case Presenter for the GDC is Mr Daniel Mansell, Counsel.

Preliminary Matters – Application to amend the charge

4. At the outset of the hearing, Mr Mansell made an application under Rule 18 of the *GDC (Fitness to Practise) Rules 2006*, to amend the original charge, as was set out in the Notice of Hearing dated 13 February 2026.

5. Mr Mansell made his application in four parts. He first applied to amend head of charge 2(a) relating to Patient 2, which originally read: *"Failed to carry out sufficient diagnostic assessments in that you did not obtain study models on or around 16 August 2012"*, so that it would instead read:

> *"Failed to carry out sufficient diagnostic assessments in that you did not obtain study models prior to placing an implant on 26 September 2012"*

6. Mr Mansell submitted that the proposed amendment to head of charge 2(a) was intended to link the allegation to the date the implant was placed, by which time, the GDC maintained that study models should have been obtained.

7. Mr Mansell next applied for the withdrawal of head of charge 5(b)(i), which alleged a failure to provide an adequate standard of implant treatment to Patient 5 *"at the UL5 on 30 January 2017"*. Mr Mansell submitted that the criticism was in relation to a second implant that was placed at Patient 5's UL4 on 28 April 2017, and that criticism was already captured at head of charge 5(b)(ii). Mr Mansell stated that no issues had been raised in respect of the implant placed at UL5 and therefore head of charge 5(b)(i) could be withdrawn.

8. Mr Mansell further applied to amend head of charge 5(e), also relating to Patient 5, by replacing the word *'from'* with the word *'on'*, so that allegation would read as follows:

> *"Failed to diagnose caries and advise of the need for treatment on 24 October 2018"*

9. Mr Mansell submitted that the GDC's case is that caries was clinically detectable on 24 October 2018, and therefore the proposed amendment to head of charge 5(e) would clarify the Council's position and focus the matter on the relevant date.

10. Finally, Mr Mansell addressed the Committee in respect of head of charge 3, relating to Patient 3. Head of charge 3 alleged, amongst other things, that you failed to obtain informed consent from the patient for an extraction and that you failed to provide adequate aftercare instructions. Mr Mansell submitted that the matters alleged at head of charge 3 relied on Patient 3's account. However, Patient 3 had informed the GDC that they were no longer happy to attend this hearing to give oral evidence. Mr Mansell stated that attempts made by the Council to contact Patient 3 to discuss the matter had been unsuccessful. He stated that it was clear that Patient 3 did not wish to attend.

11. Mr Mansell submitted that the GDC had carefully considered what course to take in light of Patient 3's non-attendance. He stated that it was concluded that issuing Patient 3 with a summons to attend the hearing would be disproportionate, given the length of time that would be required to do so. Mr Mansell further stated that, as Patient 3 was the sole and decisive witness in relation to what are serious allegations, the GDC decided that it would not be appropriate to make a hearsay application in respect of the written witness statement Patient 3 had provided. In the circumstances, Mr Mansell submitted that there is no evidence to support head of charge 3 and he requested that it be withdrawn in its entirety.

12. It was Mr Mansell's submission that no injustice would be caused by agreeing to his application in its entirety, given that the proposed amendments would ensure that the allegations in question would more accurately reflect the expert evidence, clarify matters in terms of relevant dates and would remove those allegations for which there is no evidence.

13. In response, Mr Rich submitted that the proposed amendments relating to wording and dates were sensible. He also submitted that the withdrawal of head of charge 5(b)(i) would be sensible and appropriate. He stated that it had always been the case that the criticism related to the second of the two implants, namely the UL4 on 28 April 2017.

14. In relation to head of charge 3, Mr Rich highlighted that the evidence in relation to what you discussed with Patient 3 is disputed. Mr Rich submitted that, in these circumstances, to allow Patient 3's witness statement to stand as hearsay evidence, without challenge, would impact on the fairness of the proceedings. He therefore endorsed the GDC's application for the withdrawal of head of charge 3 in its entirety.

The Committee's decision on the application to amend the charge – 9 March 2026

15. In reaching its decision, the Committee took account of the submissions made by both Mr Mansell and Mr Rich. It noted that there was no objection on your behalf to any aspect of the GDC's application.

16. The Committee accepted the advice of the Legal Adviser regarding its power under Rule 18 to amend the charge at any stage prior to making its findings of fact.

17. The Committee considered separately the four parts of the GDC's application. It was satisfied that the proposed amendments to heads of charge 2(a) and 5(e), which are in respect of wording and dates, would ensure that these allegations accurately reflect the evidence and/or provide clarity in terms of what is being alleged.

18. The Committee was also satisfied that head of charge 5(b)(i) could be withdrawn as requested, given that the relevant criticism is captured at head of charge 5(b)(ii), which is an allegation that will remain.

19. In relation to head of charge 3, the Committee noted that there is a conflict between your evidence, which appears to be supported by the evidence contained in the clinical records, and the account given by Patient 3, in terms of what was discussed regarding their treatment. It was the view of the Committee that the only way to resolve this conflict would be to hear from Patient 3, whose evidence is sole and decisive on the matter. The Committee considered that it would be unfair in the circumstances to proceed based on Patient 3's witness statement alone. It also agreed that issuing the patient with a summons would cause undue delay to these proceedings, particularly given the indication that Patient 3 has chosen to disengage with the GDC. The Committee concluded that in the absence of any oral evidence from Patient 3, there would be no realistic prospect of finding the alleged matters at head of charge 3 proved. Accordingly, it was satisfied that it was appropriate for head of charge 3 to be withdrawn in its entirety at this preliminary stage.

20. Having had regard to the merits of the case and the fairness of the proceedings, the Committee was satisfied that all the proposed amendments could be made without causing injustice.

21. The charge was amended accordingly.

Admissions to the amended charge – 9 March 2026

22. The Committee next heard your admissions to the amended charge. Mr Rich stated that you admitted the following heads of charge: 1(a)(i) to 1(a)(vi), 4(a), 6(a), 7(a), 8(b), 8(c), 8(d)(i), 8(d)(ii), 9(a), 9(b), 10(a)(i), 10(b)(i) and 10(b)(ii).

23. Mr Mansell drew the Committee's attention to paragraph 120 of the GDC's *Guidance for the practice committees (Effective from 6 January 2026),* which states that:

> *"Where heads of charge are admitted, the [Practice Committee] proceeds to determine those facts based on the admission(s). In most instances, this will result in the facts being found proved on the basis of the admission(s) without the need to adduce any further evidence"*

24. Whilst the Committee had regard to this guidance, it also took into account the submissions made on your behalf, and the advice given by the Legal Adviser, in relation to the potential complications of finding admitted allegations proved at the preliminary stage. The Committee was advised that finding admitted matters proved at this stage could produce complications if some unexpected information were to arise from the evidence to be presented. Having considered this advice, the Committee decided to note your admissions and defer any factual findings on them until all the evidence had been adduced.

Summary of the GDC's opening submissions and the allegations

25. The charge, as amended, relates to your treatment of nine patients over the period March 2013 to September 2022.

26. In opening the case for the GDC, Mr Mansell provided the Committee with a written opening note and he made submissions orally. He submitted that you are a dentist and that concerns were raised about your treatment of patients. He stated that the concerns were referred to the Professional Conduct Committee by the GDC's Case Examiners. Mr Mansell told the Committee that the GDC's investigation into the matters raised involved the instruction of an expert, Mr David Kramer.

27. Mr Mansell went on to outline the details in relation to the treatment you provided to each of the patients referred to in the charge, drawing the Committee's attention to the relevant clinical records. Mr Mansell also referred the Committee to the specific criticisms made by Mr Kramer in respect of your clinical practice, as set out in his expert reports.

28. The alleged matters in this case include failings in relation to radiography, carrying out sufficient diagnostic assessments and pre-treatment investigations, sufficient treatment planning, obtaining informed consent, diagnosing caries, providing an adequate standard of implant treatment and record keeping. It was noted in the GDC's opening submissions that you made a number of admissions at the outset of this hearing in respect of the alleged failings.

Further admissions to the amended charge – 10 March 2026

29. At the commencement of the proceedings on 10 March 2026, Mr Rich told the Committee that you had been reflecting on the allegations, and as a result, some further admissions were to be made on your behalf. These further admissions were in respect of heads of charge: 5(a), 7(b), 8(a) and 10(a)(ii).

30. As previously, the Committee noted these additional admissions but deferred any findings in respect of them until the fact-finding stage.

Evidence

31. The evidence provided to the Committee by the GDC was both documentary and oral. The documentary evidence comprised the clinical records including radiographs for the nine patients concerned, the main expert report of Mr Kramer dated 12 August 2025 and his addendum expert report dated 12 February 2026. In terms of oral evidence, the Committee heard from Mr Kramer during which he expanded on his opinions given in his reports.

32. The documentary evidence received by the Committee on your behalf in response to the allegations was your witness statement dated 23 January 2026, a radiograph taken of Patient 6 dated 4 July 2024 and an article entitled *'Combined Implant and Tooth Support: An Up-to-Date Comprehensive Overview'* (March 2017). In addition, you gave oral evidence to the Committee in relation to the alleged facts.

The Committee's findings of fact – 16 March 2026

33. The Committee considered all the evidence presented to it, both documentary and oral. It took account of the closing submissions made by Mr Mansell on behalf of the GDC and those made by Mr Rich on your behalf. Both Counsel provided their submissions in writing and they made submissions orally. Mr Mansell highlighted the evidence provided by the GDC, including the expert evidence, and he invited the Committee to find the factual allegations proved in their entirety. Mr Rich first made some general submissions, and then he addressed the evidence in relation to the individual heads of charge that were not admitted. He invited the Committee to conclude that those outstanding allegations had not been proved to the requisite standard.

34. The Committee accepted the advice of the Legal Adviser, including in relation to the burden and standard of proof, the need to consider the alleged matters separately, the need to have regard to the specific wording of each allegation and how to approach the evidence. The Committee also noted the Legal Adviser's comments regarding the admissions made by you in this case which, he highlighted, were made with the benefit of legal representation.

35. In making its findings on the facts, the Committee bore in mind that the burden of proof rests with the GDC. There was no requirement for you to prove anything. Also, that the standard of proof is the civil standard, that is, whether the alleged facts are proved on the balance of probabilities. The Committee has had to decide whether it is more likely than not that the alleged matters are proved.

36. The Committee considered each head of charge separately and made the following findings:

Patient 1	
1(a)	*In respect of Patient 1, you:* *Failed to adequately report on radiographs taken on:*
1(a)(i)	*21 September 2020;* **Admitted and found proved.**
1(a)(ii)	*11 December 2020;* **Admitted and found proved.**
1(a)(iii)	*22 February 2021;* **Admitted and found proved.**
1(a)(iv)	*24 March 2021;* **Admitted and found proved.**
1(a)(v)	*19 April 2021;* **Admitted and found proved.**
1(a)(vi)	*25 October 2021.*

	Admitted and found proved.
Patient 2	
2(a)	*In respect of Patient 2, you:* *Failed to carry out sufficient diagnostic assessments in that you did not obtain study models prior to placing an implant on 26 September 2012.* **Found not proved.** In the clinical records for Patient 2, it is noted on 18 August 2012 that the treatment you planned to provide to the patient involved the removal of a lower right bridge. In addition, an implant was to be placed at the patient's LR6 site. The clinical records indicate that the implant was placed on 26 September 2012. The GDC's case, which was based on the opinion of Mr Kramer, was that you had a duty to take study models of Patient 2's teeth prior to the placing of the implant, but that you failed to do so. Mr Kramer's opinion, as set out in his main report, was that *"The records do not show that any pre-treatment models (diagnostic casts) of the patient's dentition were obtained. These are required when planning more complex restorative dental treatment, such as implant retained crowns and the provision of fixed and removable prostheses. Study models enable an assessment of the patient's occlusion (the way the upper and lower teeth meet together) to be made and also enable proper planning of the position in which any replacement prosthetic teeth should be put. Having study models allows the required assessments to be made, without the patient present. In view of the fact that the treatment involved the last standing molar tooth and the adjacent tooth, with consequent risk of the occlusion changing, it is my opinion that study models should have been obtained. This should have been done at the time of planning treatment on 16.08.2012."* It was your evidence that you did obtain study models prior to placing the implant on 26 September 2012, but you failed to record having done so. You noted that the treatment was undertaken almost 14 years ago, but you stated that it would have been your usual practice at the time to have obtained study models in the circumstances of Patient 2's treatment. You gave examples of when you might not have obtained study models but stated that in 'big cases' such as Patient 2's, you would have obtained them. The Committee was satisfied from Mr Kramer's expert evidence that you had a duty to obtain study models prior to the placing of the implant on 26 September 2012. Whilst the Committee was not necessarily persuaded that this had to be on 16 August 2012, as specified by Mr Kramer, it considered that study models should have been obtained at a reasonable time before the implant placement. The Committee also noted your oral evidence in which you agreed that the treatment you planned for Patient 2 required study models. In deciding whether study models were actually obtained, the Committee noted the absence of any reference to study models in the clinical records prior to 26 September 2012, which was the date the implant was placed at the LR6 site. However, there is a note in the clinical records in relation to that appointment on 26 September 2012 stating, *"checked plan for surgery again using study models*

	and surgical stent", suggesting that study models were in existence. You referred to this note in your witness statement. It was highlighted during the evidence that some aspects of your clinical records for Patient 2 and for the other patients were derived from a template. Indeed, it was noted that the wording *"checked plan for surgery again using study models and surgical stent"* occurs in your clinical records on numerous occasions. You were open in confirming that this was template wording, but you also stated that it was usual practice to delete such a reference if study models were not obtained for a patient. The Committee considered that your oral evidence in relation to what your usual practice would have been at the material time, both in relation to the obtaining of study models and in respect of using this particular template, remained consistent. It also took into account your admissions made at this hearing in relation to the inadequate standard of your record keeping at the time. In all the circumstances, the Committee was not persuaded that the absence of any reference to study models prior to 26 September 2012 is, in itself, sufficient to discharge the burden of proof in relation to this allegation. Accordingly, the Committee found it not proved.
Patient 3	
3	WITHDRAWN
3(a)	WITHDRAWN
3(b)	WITHDRAWN
3(c)	WITHDRAWN
Patient 4	
4(a)	*In respect of Patient 4, you:* *Failed to take a radiograph prior to the second stage of implant surgery on or before 20 April 2022;* **Admitted and found proved.**
4(b)	*In respect of Patient 4, you:* *Failed to provide an adequate standard of treatment on 20 April 2022, by pushing an implant into the patient's sinus.* **Found proved.** On 8 September 2021, you placed implants at Patient 4's UR5 and UR6 region. It was noted in the clinical records for that day, that the implant placed at UR5 had *"no primary stability"* when a force of 30 Newtons per centimetre squared was applied to it. On 20 April 2022, the UR5 implant moved into the sinus when a healing abutment was being attached to it. It was not disputed that the implant entered the sinus. The Committee had before it radiographs showing that this occurred. The issue was whether this represented a failure to provide an adequate standard of care. In reaching its decision, the Committee took account of the evidence of Mr Kramer and your evidence,

	including in relation to the likely circumstances in which the implant moved into the sinus. In his main expert report, Mr Kramer stated that: *"The Registrant had noted that the implant was not firmly placed in bone on 08.09.2021 (no primary stability), hence he should have been aware of the risk that the implant had not integrated with the bone or had not done so adequately and so was at risk of being dislodged when attaching the healing abutment. It is my opinion that the Registrant should have been aware that the implant itself was turning when he was tightening the healing abutment screw. This is because the screw used to attach the healing abutment is short with few threads. Hence it does not take more than a few turns of the appropriate screwdriver to insert it properly. Also, very little force is required when tightening the screw. It is my opinion that failing to be aware and continuing to turn the screw driver led to the implant being pushed into the sinus. This demonstrates a failure to use reasonable skill and care in the placement of the healing abutment, in that the implant was pushed into the sinus in the process".* Mr Kramer maintained his view in his oral evidence and stated that the pushing of the implant into the sinus, as he described it, represented a poor standard of care. In your oral evidence, you stated that you had punched a small hole in the gum in order to fit the healing abutment, and as you were turning the screw on the healing abutment, you felt that something was wrong. You stated that you then opened up the gum and tried to retrieve the implant using tweezers, and that it was during this retrieval attempt that the implant moved into the sinus. In considering the evidence regarding the circumstances in which the sinus was breached, the Committee noted that your oral evidence was inconsistent with the account you provided in your witness statement, and with what was noted in the contemporaneous clinical records. In your witness statement, you stated that "*Whilst I was turning the healing abutment, the implant itself was not be visible so I would not have seen it moving. I did not feel any movement when I was turning the abutment. On the last turn of the healing abutment, the whole implant disappeared into the sinus.".* In the clinical records it is noted "*placed the healing abutment but all the implant had sunken in to the sinus"*. The Committee noted that there is no reference to using tweezers to try and retrieve the implant in either written account. You told the Committee during your oral evidence that you had been reflecting on the incident during this hearing and that you thought the implant accidentally moving into the sinus while you were trying to retrieve it with tweezers. Whilst the Committee accepted that this is what you now believe happened, it had concerns about the reliability of that belief, given the clear inconsistency with your written account and the contemporaneous clinical records. Both your witness statement and the clinical records indicate that the implant moved into the sinus whilst you were fitting the healing abutment. As noted in your witness statement, and in the evidence of Mr Kramer, the healing abutment needed to be screwed in place which, in the Committee's view, implies that some pressure was applied. Having taken all the evidence into account, the Committee was satisfied that it was more likely than not, that you did push the implant into Patient 4's sinus on 20 April 2022. It was also satisfied, on the basis of Mr Kramer's

	expert opinion, that in all the circumstances, this amounted to a failure to provide the patient with an adequate standard of care.
Patient 5	
5(a)	*In respect of Patient 5, you:* *Failed to maintain an adequate standard of record keeping in respect of the patient's appointments in that you did not record the teeth incorporated into a bridge in or around March 2013;* **Admitted and found proved.**
5(b)(i)	WITHDRAWN
5(b)(ii)	*In respect of Patient 5, you:* *Failed to provide an adequate standard of implant treatment* *at the UL4 on 28 April 2017* **Found proved.** The criticism in respect of the implant treatment at Patient 5's UL4 on 28 April 2017, was that the UL4 implant was placed too close to the implant at UL5. In his main expert report, Mr Kramer stated that *"The implants placed at and [sic] UL5 on 30.01.2017 and UL4 on 28.04.2017 appear to have been placed in contact with each other. Although it was possible to provide a bridge retained by the implants, it would not have been possible for the Patient to clean between the implants adequately. There was, therefore, a risk that the implants would fail sooner than should have been expected because of the risk of periimplantitis developing as a consequence of the Patient not being able to clean the implants adequately or at all".* In your witness statement, you stated that *"I do not consider that the placement of the UL4 implant on 28 April 2027 to be to an inadequate standard or placed too close to UL5. On the radiograph taken on 28 April 2017, there is a reasonable gap between the implant placements…".* During your oral evidence and in the closing submissions made on your behalf, the issue of angulation of the radiograph was raised. The radiograph taken of the UL4 and UL5 on 28 April 2017 was compared with a later radiograph taken of the same implants on 10 May 2017, seemingly showing a wider gap between the implants on the earlier radiograph. It was submitted on your behalf that *"…trying to gauge the relative distances between the various objects and structures within the mouth from a 2D radiograph is extremely difficult. The Committee should be very wary of finding proved the allegations that rely on concluding that the radiographs show the true spatial relations between the structures and objects they depict".* However, the Committee had before it six periapical radiographs taken over a period of time, including those dated 28 April 2017 and 10 May 2017. The Committee considered this to be an adequate sample of radiographs for the purposes of considering the proximity between the UL4 and UL5 implants. Whilst it noted, when looking at the six radiographs, that there were differences between them, which it understood were due to angulation of the radiographs, it found that four of the radiographs consistently show that the UL4 and UL5 implants were very close, possibly touching. Mr Kramer's opinion, which the Committee accepted,

	was these implants should have been at least 3 millimetres apart, and that even the radiograph of 10 May 2017, which was highlighted on your behalf, did not show a large enough gap. The Committee was satisfied on the balance of probabilities that this head of charge is proved.
5(c)	*In respect of Patient 5, you:* *Failed to carry out sufficient treatment planning before providing a bridge on 22 March 2013;* **Found not proved.** It was Mr Kramer's opinion that the treatment planning in respect of the bridge proposed for Patient 5 was flawed because of the plan to link natural teeth to an implant. He stated in his main expert report that *"…an implant is held solidly in the surrounding bone, whereas teeth can move minutely in their sockets. This means that if a bridge links teeth and an implant there will be movement at one end and not the other, with consequent risk of the bridge debonding and uneven leverage being applied to the supporting teeth and implant.* In his addendum expert report, Mr Kramer further stated that *"It is accepted that implants and natural teeth can be reasonably linked on occasion, in order to spread occlusal load. However, whenever this is done it must be explained to the patient that it is a high-risk strategy because of the fact that natural teeth move and implants do not. Hence it is essential to properly assess the proposed natural bridge abutment teeth with regard to there being any mobility. There is nothing in the records to show that the Registrant did do that".* It was your evidence, as outlined in your witness statement, that "*The initial plan was for natural teeth to be on each side, with implant in the middle. The plan was for two bridges. UL1 implant failed. As such, the plan to use two bridges could not proceed. I therefore used UL3 instead. As a result, the bridge was made longer than initially planned. As per my notes, Patient 5 was offered telescopic crowns to reduce the stresses and add more protection for the abutment teeth. Patient 5 declined the offer on the basis of cost, knew about all risks and benefits of all options with and without telescopic crown and was able to choose the right option for her. These mitigation measures were not done, as the patient declined, otherwise I would have proceeded with telescopic crowns".* The Committee considered the evidence of your discussions with Patient 5 as detailed in the clinical records. It noted that as early as 30 July 2012, when the patient attended to see you, having lost their front bridge, you discussed treatment options with them in relation to a replacement denture or implants. At a review appointment on 17 August 2012, the Committee noted that treatment options were further discussed, with a note included in the records stating *"pt will have the extractions first+ bone grafts then will think about the options when she knows the cost".* On 4 February 2013, after an implant at the patient's UR1 had failed, you noted the following in the clinical records regarding your discussion with the patient on that day: *"…given ttt option of place another implant free of charge of do a bridge using the implant that osseointegrated and the natural teeth warned that i will have to drill in healthy teeth pt wants to go with the second option as doesn't want to*

	wait for more knows about all the risks of the bridge…". Further, as you highlighted in your witness statement, at an appointment on 1 March 2013, telescopic crowns and the costs of them were discussed with the Patient 5. It was the view of the Committee that this evidence of your discussions with Patient 5 demonstrated that you were considering various treatment options with the patient and contemplating treatment plans. The Committee took into account that an assessment as to any tooth mobility is not noted in the clinical records in the context of your planning for the bridge, which was a factor highlighted by Mr Kramer. However, the Committee had regard to your admissions regarding the standard of your record keeping at the time, and it concluded that the absence of such a record did not prove the issue of mobility was not discussed. You told the Committee that you had discussions with Patient 5, and it noted the reference in the clinical records to the patient knowing all about the risks of the proposed bridge and agreeing to go ahead. In all the circumstances, the Committee was not satisfied that it is proved that your treatment planning in respect of the bridge was insufficient.
5(d)	*In respect of Patient 5, you:* *Provided a bridge on 22 March 2013 which was not clinically appropriate because it linked natural teeth to an implant;* **Found not proved.** The Committee noted that the basis of this allegation was Mr Kramer's opinion that the linking of natural teeth and an implant on such a bridge was not clinically appropriate, given the consequent risk of the bridge debonding and uneven leverage being applied to the supporting teeth and implant. However, the Committee took into account the evidence that there are two schools of thought on this issue. It noted from the article provided on your behalf entitled '*Combined Implant and Tooth Support: An Up-to-Date Comprehensive Overview*' (March 2017), that it is considered that there are ways to mitigate the risks of linking natural teeth with implants within a bridge. In his oral evidence, Mr Kramer accepted that some dentists did not share his view on the inappropriateness of linking natural teeth to an implant. It appeared to the Committee, when considering Mr Kramer's evidence, that his criticism of providing such a bridge is based on his own belief. The Committee considered that the fact that he disagreed with the treatment, did not automatically make it clinically inappropriate in these circumstances for Patient 5. It further noted your oral evidence that you had little option in the circumstances, given that the bridge was the patient's choice, even after being told of the risks. Having considered the evidence, the Committee was not satisfied that this allegation is proved.
5(e)	*In respect of Patient 5, you:* *Failed to diagnose caries and advise of the need for treatment on 24 October 2018.*

	Found not proved. It was the opinion of Mr Kramer, based on a radiograph taken on 13 May 2019, that the caries at Patient 5's UR3 was so extensive that, on balance, it would have been visible when you examined the patient on 24 October 2018; therefore you should have diagnosed it. You told the Committee that when you saw the patient on 24 October 2018, you conducted a visual examination, including of UR3, and you found no caries clinically. You said that your visual examination had included probing around the edges of the crown on that tooth. You also stated that the patient had not complained of any pain or other symptoms. Your evidence was that when you took the radiograph on 13 May 2019, it was then that you diagnosed caries. In reaching its decision, the Committee took into account that it was you who saw the patient clinically on 24 October 2018, when you said no caries was detected in UR3. The Committee considered whether you would have had a duty to diagnose caries in a situation where you did not know it was there. Whilst the Committee took into account Mr Kramer's opinion regarding the extent of the caries in May 2019, it noted that this was some seven months after October 2018. Mr Kramer acknowledged in his oral evidence that caries can develop rapidly, albeit he did not consider this to have been the case with Patient 5's UR3. Notwithstanding this, it was the view of the Committee that there was insufficient evidence before it to prove on the balance of probabilities that caries would have been clinically detectable on 24 October 2018. This included the absence of any information to suggest that the patient had any symptoms. Accordingly, the Committee was not satisfied that this allegation is proved.
Patient 6	
6(a)	*In respect of Patient 6, you:* *Prior to providing treatment on 24 September 2021, discussed treatment options and risks and benefits while the patient was under the influence of temazepam;* **Admitted and found proved.**
6(b)	*In respect of Patient 6, you:* *Failed to obtain informed consent for the implant treatment provided for the patient on 24 September 2021;* **Found not proved.** As set out at head of charge 6(a) above, you admitted, and the Committee found proved, that you discussed treatment options and risks and benefits with Patient 6 while the patient was under the influence of temazepam. The temazepam had been prescribed to the patient by their General Medical Practitioner (GP) on account of their anxiety around dental treatment. The patient had taken the sedative prior to attending their appointment with you on 24 September 2021 for implant treatment. Your evidence was that whilst you had had previous discussions and obtained informed consent from the patient regarding the provision of one implant, prior to commencing treatment on 24 September 2021, you had a further discussion with

	the patient about the option of providing an additional implant, including in relation to risks and benefits. It was acknowledged on your behalf (albeit you were not aware of this at the material time), that guidelines indicate, as a matter of policy, that consent should never be taken from a patient under the influence of sedatives, because of the risk that they may not be able to fully consent. Indeed, the GDC's case was that Patient 6 had not given their informed consent to the implant treatment you provided on 24 September 2021, which included the provision of the additional implant, as she was under the influence of temazepam. In his main expert report, Mr Kramer gave the opinion that "…*it is probable the Patient would not be able to think clearly at the time and may not have been able to remember any information given to her because of the sedative effect of the temazepam".* It was your evidence that Patient 6 seemed to understand everything you discussed with her prior to providing the implant treatment on 24 September 2021. You stated that you had no concerns about the patient's ability to give consent. The Committee took into account your admission that you discussed treatment options and risks and benefits with Patient 6 while the patient was under the influence of temazepam. The Committee also took into account your oral evidence that you would not take consent from a patient in such circumstances again, given that you are now aware of the guidelines. In reaching its finding in relation to this allegation at head of charge 6(b), the Committee bore in mind the specific way in which the GDC put its case. This being that Patient 6 had not given informed consent for the implant treatment on 24 September 2021, as it was probable that the patient would not have been able to think clearly and may not have remembered any information given to them because of the sedative effect of temazepam. However, Mr Kramer acknowledged in his oral evidence that he is not an expert in pharmacology or sedation. It was the view of the Committee, taking this into account, that Mr Kramer was limited in what he could actually say about temazepam, particularly in relation to dosage, timings and its effects. The Committee received no evidence to support his opinion regarding Patient 6's probable cognitive state at the time. It was not provided with the prescription from the patient's GP, any guidelines in relation to temazepam or any expert evidence in relation to the effects of the drug. Furthermore, no evidence was obtained by the GDC from Patient 6 or any attending dental nurse, which may have assisted with how the patient presented at the appointment on 24 September 2021. In the absence of such evidence, the Committee was not satisfied that the GDC proved that it was more likely than not that Patient 6 had not consented to the implant treatment carried out on that day. Therefore, the Committee found this allegation at head of charge 6(b) not proved.
6(c)	*In respect of Patient 6, you:* *Failed to provide an adequate standard of implant treatment at the LR5 on 24 September 2021.* **Found proved.**

	It was Mr Kramer's opinion in respect of this allegation, that the LR5 implant was very close to, or actually touching, the root apex of LR4. He stated in his main expert report that *"It is my opinion that the implant at LR5 was placed in the wrong position, too close to LR4 and this caused that tooth to lose pulp vitality and become infected. It is probably this that led to the site not healing after the implant was removed."* It was your evidence in your witness statement that *"…measurements were taken from the CBCT of the patient, length to mental and ID nerve were noted, it was over 10 mm. Planning was made to place 8.5 mm".* Submissions were also made on your behalf in relation to angulation of the radiographs. The Committee had before it a sample of radiographs showing the LR5 implant was placed close to the apex of the root of the LR4. The Committee also noted from the clinical records of 24 September 2021 that you had questioned whether the LR5 implant looked close to the LR4, although you also raised the issue of angulation of the radiograph. The Committee considered that Mr Kramer's evidence, based on the relevant radiographs, was clear. It was his opinion that this implant should have been at least 1.5 millimetres from the LR4, and the Committee was satisfied, based on his evidence, that this was not the case. The Committee was satisfied that this head of charge is proved on the balance of probabilities.
Patient 7	
7(a)	*In respect of Patient 7, you:* *Failed to maintain an adequate standard of record keeping in respect of the patient's appointments in that you did not record the preparation of teeth for crowns on 22 January 2020 and 16 March 2020;* **Admitted and found proved.**
7(b)	*In respect of Patient 7, you:* *Failed to provide an adequate standard of implant treatment on 25 June 2021.* **Admitted and found proved.**
Patient 8	
8(a)	*In respect of Patient 8, you:* *Failed to carry out sufficient treatment planning prior to placing an implant at the UR4 on 8 December 2021;* **Admitted and found proved.**
8(b)	*In respect of Patient 8, you:* *Failed to carry out treatment in a timely manner in that you did not extract the UR5 on or soon after 27 September 2021;*

	Admitted and found proved.
8(c)	*In respect of Patient 8, you:* *Failed to maintain an adequate standard of record keeping in respect of the patient's appointments, in that you did not record an appointment which occurred on 9 May 2022;* **Admitted and found proved.**
8(d)(i)	*In respect of Patient 8, you:* *Failed to adequately report on radiographs taken on:* *27 September 2021;* **Admitted and found proved.**
8(d(ii)	*In respect of Patient 8, you:* *Failed to adequately report on radiographs taken on:* *15 November 2021.* **Admitted and found proved.**
Patient 9	
9(a)	*In respect of Patient 9, you:* *Failed to carry out sufficient diagnostic assessments prior to placing an implant on 3 December 2021;* **Admitted and found proved.**
9(b)	*In respect of Patient 9, you:* *Failed to carry out sufficient pre-treatment investigations prior to placing an implant on 3 December 2021;* **Admitted and found proved.**
9(c)	*In respect of Patient 9, you:* *Failed to provide an adequate standard of implant treatment on 3 December 2021, in that the implant at UR4 was placed too close the UR3;* **Found proved.** In his main expert report, Mr Kramer stated in respect of the implant at UR4 that *"The radiographs show that the implant was placed too close to the adjacent UR3. The distance between an implant and an adjacent natural tooth should be 1.5mm. If an implant is placed too close to the adjacent tooth it is likely to lead to bone loss in that site and consequent reduced prognosis for both implant and tooth…".*

	The Committee noted the issue raised on your behalf in relation to angulation of the radiographs and the difficulties around assessing a two dimensional image. However, it found Mr Kramer's evidence to be clear and compelling. In accepting his opinion, the Committee took into account the radiographic evidence on which his conclusion was based. The Committee noted that it had before it a number of radiographs, all of which show, as explained by Mr Kramer, that the implant at UR4 appears to be very close to the UR3, to the extent that they appear to be touching or almost touching. The Committee also took account of your evidence in your witness statement in which you denied this particular allegation but stated that *"I do however accept that it would have been better placement if the implant is shifted 1-2 mm distally".* In all the circumstances, the Committee was satisfied that this head of charge is proved.
9(d)	*In respect of Patient 9, you:* *Failed to diagnose the reason for the implant failure.* **Found not proved.** This allegation relates to the subsequent failure of the implant placed at UR4. Mr Kramer commented in his main expert report that the clinical records do not detail what you considered to be the reason for the implant failure. It was his opinion that the UR4 implant failed because it was placed too close to the UR3. You told the Committee in your oral evidence that the patient had attended to see you holding the failed implant in their hand. You stated that you cleaned the implant site and left it to heal. You said that you would have been unable to diagnose the cause of the failure even if you had wanted to, as you were unsure about when the implant fell out. The Committee noted that there was some indication that, in the intervening period following the placement of the implant and it falling out, Patient 9 was seen by another clinician in your absence from the practice, although there are no apparent clinical records of this. Your account of the implant having already fallen out at the time you saw Patient 9 was not challenged by the GDC. The Committee noted that whilst Mr Kramer gave his opinion as to why he thought the implant at UR4 had failed, he did not state in his written or oral evidence why there would have been a duty on you to diagnose the cause of the failure. Having considered the evidence in relation to this allegation, the Committee was not satisfied that the GDC proved to the requisite standard that you had a duty to diagnose the reason for the implant failure in these particular circumstances. In the absence of any evidence of a duty, the Committee could not find that a lack of a diagnosis amounted to a failure on your part.
Patient 10	
10(a)(i)	*In respect of Patient 10, you:* *Failed to take a radiograph of:* *implant crowns on 6 October 2021;* **Admitted and found proved.**

10(a)(ii)	*In respect of Patient 10, you:* *Failed to take a radiograph of:* *the left implant on 9 September 2022;* **Admitted and found proved.**
10(b)(i)	*In respect of Patient 10, you:* *Failed to report adequately, or at all, on radiographs taken on:* *22 September 2021;* **Admitted and found proved.**
10(b)(i)	*In respect of Patient 10, you:* *Failed to report adequately, or at all, on radiographs taken on:* *9 September 2022.* **Admitted and found proved.**

37. The hearing now moves to Stage Two.

Stage Two of the hearing – 17 to 19 March 2026

38. The facts found proved by the Committee relate to clinical failings across your treatment of eight patients from March 2013 to September 2022. The identified shortcomings, a number of which you admitted, were in respect of:

- radiography, including failing to take radiographs and failing to adequately report on radiographs taken;
- insufficiency of treatment planning and pre-treatment investigations;
- failing to provide an adequate standard of implant treatment to a number of the patients;
- discussing treatment options, risks and benefits with a patient while they were under the influence of temazepam; and
- failing to maintain an adequate standard of record keeping on a number of occasions.

39. The Committee's considerations at this second stage of the hearing were whether the facts found proved against you amount to misconduct, and if so, whether your fitness to practise is currently impaired by reason of that misconduct. The Committee took into account that if it found current impairment, it would need to go on to consider what sanction, if any, to impose on your registration.

Summary of the evidence at this stage

40. The Committee had before it all the evidence presented at the fact-finding stage, as well as further evidence provided at this stage. The further evidence received comprised a remediation bundle submitted on your behalf, which contained information relating to your ongoing programme of study towards a Master's Degree in Dental Implantology, including your Postgraduate Diploma in Dental Implantology awarded with distinction in November 2025. Also included in the remediation bundle was evidence of your Continuing Professional Development (CPD), Workplace Supervisor Reports covering the period February 2024 to December 2025 from your Workplace Supervisor appointed under interim conditions which were imposed on your registration by the Interim Orders Committee, a number of implant logs relating to implant treatment you provided from August 2024 to December 2025, a record keeping audit dated February 2026, and a number of testimonials. The Committee further received a copy of your Reflective Statement in respect of the matters in this case.

41. Additionally, the Committee heard oral evidence from your Workplace Supervisor, an Oral and Maxillofacial Surgeon, who explained that he has also mentored you as part of your postgraduate studies.

42. The evidence received from the GDC at this stage was information relating to your fitness to practise history before the Council.

Summary of the submissions made by the parties

43. The Committee heard submissions on misconduct, impairment and sanction from Mr Mansell on behalf of the GDC, and from Mr Rich on your behalf, who also provided an outline of his submissions in writing.

44. However, firstly, in accordance with Rule 20(1)(a) of the *GDC (Fitness to Practise) Rules 2006*, Mr Mansell addressed the Committee on your fitness to practise history. He outlined that in June 2012, you were issued with a warning by the GDC's Investigating Committee in relation to an allegation that, in 2009, you allowed an unregistered Dental Hygienist to work at your practice, and you failed to take action in respect of that individual's treatment of two patients.

45. Mr Mansell went on to address the Committee in relation to the facts found proved at this hearing. In dealing with the issue of misconduct, he stated that the courts have held that 'misconduct' is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. Mr Mansell submitted that the Committee may be assisted by the expert evidence of Mr Kramer in assessing the seriousness of the facts it has found proved. It was Mr Mansell's submission that Mr Kramer was fair and reasonable in his approach to this case, and that the Committee may wish to take this into account when considering his views.

46. Mr Mansell stated that the Committee may also be assisted by the GDC's *'Standards for the Dental Team (September 2013)'* ('the GDC Standards') in terms of what was expected by the profession in the circumstances of this case. He outlined the following GDC Standards, which he considered would be relevant to the Committee's considerations: 1.4, 1.9, 4.1 and 7.1.

47. Mr Mansell submitted that this is a case in which there were clinical failings across your treatment of eight patients. He highlighted Mr Kramer's opinion that each of the failings fell far below the standard expected, and that Mr Kramer's rationale in giving his opinions was, in many instances, linked to actual patient harm or a risk of harm. Mr Mansell invited the Committee to find that the identified failings do amount to misconduct.

48. With regard to current impairment, Mr Mansell submitted that the Committee would need to consider both the personal and public components of impairment. In relation to the personal component, he stated that the Committee should consider whether your clinical failings are remediable, whether they have been remedied and whether they are likely to be repeated. Mr Mansell stated that the clinical failings in this case relate to complex dental treatment and he questioned how easily remediable they are in the circumstances. He acknowledged that some of the matters found proved date back a number of years but stated that this could also be taken to mean that the deficiencies in your clinical practice persisted for so long without you realising that remedial action was needed.

49. Mr Mansell referred to the evidence provided on your behalf at this stage, and he submitted that the Committee may consider it clear that you have undertaken remediation. He also referred to the oral evidence of your Workplace Supervisor, who confirmed that he had no concerns about your current clinical practice. However, Mr Mansell invited the Committee to consider certain aspects of the findings made, including in relation to your misplacing of implants. He also asked the Committee to take into account, when considering the matter of insight, that you denied a number of the allegations relating to the provision of implant treatment, which were found proved. In particular, Mr Mansell submitted that the Committee may be concerned that you lack insight into the facts found proved at heads of charge 5(b)(ii), 6(c) and 9(c), which relate to placing implants too close to natural teeth or other implants. He also raised the issue found proved at 4(b), relating to your pushing of an implant into the sinus. It was Mr Mansell's submission that you have had many years to reflect on these issues and to consider the GDC's evidence, but you still did not accept that you provided a poor standard of implant treatment. Mr Mansell questioned whether you now understand what you need to do to ensure that such failings do not happen again. He submitted that in all the circumstances, it may be considered that you lack insight, and as such, there is a risk of repetition. For this reason, he invited the Committee to find impairment on the personal component.

50. In relation to the public component, Mr Mansell submitted that the Committee would need to consider whether public confidence in the dental profession and the upholding of proper professional standards would be undermined if a finding of impairment were not made in this case. He outlined the facts found proved and submitted that these represented a range of clinical failings across a number of patients. He stated that an informed member of the public would be perturbed if a finding of current impairment were not made in the circumstances. Accordingly, Mr Mansell invited the Committee to make a finding of impairment in the wider public interest.

51. Addressing the Committee on sanction, Mr Mansell referred to the GDC's '*Fitness to practise: Guidance for the practice committees (effective from 6 January 2026)'* ('the PC Guidance') and set out what he considered to be the mitigating and aggravating features of this case. Mr Mansell referred to your fitness to practise history but noted that matter was not of a similar nature and is of some age. It was Mr Mansell's submission on behalf of the GDC that the appropriate and

proportionate sanction would be the imposition of a conditions of practice order on your registration for a period of 12 months, with a review. He provided the Committee with a set of draft conditions proposed by the Council.

52. At the outset of his submissions, Mr Rich stated that you were entitled to defend the allegations against you, and that you should not be penalised for doing so. He stated that now findings have been made, you accept them and that you wished to persuade the Committee that you are safe to practise.

53. It was Mr Rich's submission that your fitness to practise is not currently impaired after the lengthy process you have undergone with your Workplace Supervisor and the CPD you have undertaken. Mr Rich submitted that the identified deficiencies in your clinical practice have been remedied and there is no risk of repetition. He stated that you have been practising safely and that you will continue to do so if allowed to return to unrestricted practice.

54. Mr Rich took the Committee through the evidence contained within your remediation bundle. He highlighted your postgraduate qualification in Dental Implantology and the significant amount of CPD you undertook to obtain it. He told the Committee that so far, you have undertaken two years of comprehensive study as part of your Master's Degree course to increase your expertise on implants. Mr Rich also invited the Committee to take into account the oral evidence of your Workplace Supervisor who reviewed your work on the course. Mr Rich further highlighted the evidence of other CPD, including on relevant topics such as radiography and record keeping. He submitted that it is notable that you have been undertaking CPD since the period when the allegations in this case arose and before the imposition of any interim order. He stated that your CPD has been comprehensive across all aspects of implant treatment which, he submitted, is a good indicator of well-developed insight.

55. Specifically in relation to this issue of misconduct, Mr Rich reminded the Committee of relevant case law, including the requirement to consider each of its findings separately. It was his submission that some of the matters found proved do not meet the threshold for a finding of misconduct. In particular, your admitted failure to report on a number of radiographs, as found proved at head of charge 1, given the context of those failings, and the matters admitted and found proved at heads of charge 5(a) and 7(a), which Mr Rich referred to as minor record keeping failings. Mr Rich also submitted that your discussing treatment options, risks and benefits with a patient while they were under the influence of temazepam does not amount to misconduct. He highlighted that the Committee had not found proved a lack of consent, and whilst what you did was contrary to the guidelines and represented a falling short, it was not so serious as to be characterised as misconduct. Mr Rich submitted that there had been no issues with the patient's understanding of the discussions.

56. Mr Rich went on to submit that the facts found proved in this case are all historic, derived from as far back as 2013, with the most recent around four years ago. He submitted that you have been practising under supervision for two years, which has included your Workplace Supervisor observing you performing implant surgery, and you have demonstrated that you can practise appropriately. He invited the Committee to take into account the evidence of your Workplace Supervisor regarding the success of your remediation. Mr Rich also invited the Committee to

consider your Reflective Statement on the concerns raised. It was his submission that a finding of impairment on the grounds of public protection is not justified in this case.

57. In relation to a potential finding of impairment on wider public interest grounds to maintain public confidence and uphold proper professional standards, Mr Rich submitted that such a finding fits more appropriately with conduct cases, as opposed to clinical ones. He submitted that the confidence of a fair-minded member of the public would not be undermined if a finding of impairment were not made in the circumstances of this case, where there has been no suggestion that you acted deliberately or that you did not care about your patients.

58. Mr Rich acknowledged that if the Committee disagreed with him on the issue of current impairment, it would need to consider the issue of a sanction. He urged the Committee, should it get to sanction, to carefully consider the issuing of a reprimand. He acknowledged the GDC's request for the imposition of conditions on your registration, but he submitted that the clinical issues in this case have been remedied. He submitted that the suspension of your registration would be disproportionate, so it may be considered that a reprimand is the appropriate sanction. He submitted that a reprimand would mark the clinical failures admitted and found proved, without doing unnecessary damage to the public interest by preventing you from working as a dentist.

59. With reference to the PC Guidance, Mr Rich outlined what he considered to be the mitigating and aggravating factors in this case, highlighting that the historic fitness to practise matter was closed by the GDC without reference to a Practice Committee. He submitted that you have considered the deficiencies in the clinical practice, have accepted your failings, and have remedied them such that there is no longer a risk. Mr Rich submitted that a fair-minded member of the public would not require a finding of impairment in these circumstances.

The Committee's decisions – 19 March 2026

60. The Committee considered all the evidence before it. It took account of the submissions made by Mr Mansell on behalf of the GDC and those made by Mr Rich on your behalf. The Committee accepted the advice of the Legal Adviser in relation to the applicable legal principles and guidance, and the approach it should take in its decision-making.

61. The Committee reminded itself that its decisions were for its independent judgement. There is no burden or standard of proof at this stage of the proceedings.

Decision on misconduct

62. The Committee first considered whether the facts found proved in this case amount to misconduct. It took into account that a finding of misconduct in the regulatory context requires a serious falling short of the standards expected of a dental professional. Whilst the Committee noted the submissions made by the GDC in relation to the applicable GDC Standards, in its view, it found the following to be the most relevant:

> Standard 1.9 Find out about laws and regulations that affect your work and follow them.

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

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

63. Taking the above GDC Standards into account, the Committee considered its individual findings. In relation to the matters found proved at head of charge 1, namely your persistent failure to adequately report on radiographs taken of Patient 1 over the period 21 September 2020 to 25 October 2021, the Committee was content that it could consider these failings together. In its view, they represented a course of conduct in relation to the same patient and concerning the same lesion on the UL7, albeit there were six separate radiographs.

64. It was Mr Kramer's opinion that your failure to report on the radiolucency visible on the radiographs in the distal aspect of Patient 1's UL7, fell far below the standard expected in the circumstances. His view was that a dentist should report on everything that can be seen from a radiograph, and any subsequent radiographs, even if there are no changes. However, he did accept in his oral evidence that this was a matter that could be considered 'on the cusp' in terms of whether your omissions fell below or far below standard.

65. In reaching its decision on whether your failings at head of charge 1 amount to misconduct, the Committee took into account that there are regulations which require dentists to report on radiographs. It also took into account your admissions and its findings that not making adequate reports on each occasion to include the lesion at UL7 represented a failure on your part. However, in assessing the seriousness of your falling short, the Committee had regard to the context in which this course of conduct occurred. It noted that you did report on each of the radiographs concerned, although you did not specifically reference the presence of the lesion at UL7. However, its presence had been reported on previously by a different dentist. Patient 1 knew about the lesion, and a treatment plan had been put in place for extraction of the tooth if the patient began to experience any symptoms. You also stated in your evidence that you recalled discussing the lesion with the patient on a regular basis having noted from the radiographs that there had been no change to it. Taking all the evidence into account, the Committee concluded that, whilst your continued failure to adequately report on the radiographs was a breach of your duty, it was not so serious as to amount to misconduct in the particular circumstances outlined.

66. The Committee considered its findings at heads of charge 4(a) and 4(b) separately but noted the link between the two matters. These were your failure to take a radiograph prior to the second stage of implant surgery for Patient 4 on or before 20 April 2022 and the incident of pushing the implant into the patient's sinus on 20 April 2022. The Committee noted that you had already identified that there was no primary stability at the time of the implant placement on 8 September 2021. It accepted the expert evidence of Mr Kramer that by not taking a radiograph before the second stage surgery in April 2022 to expose the implant, you were not well placed to know whether there had been osseo-integration of the implant with the surrounding bone. In the Committee's view, your failure in this regard put the patient at greater risk of harm.

67. Furthermore, having noted the lack of primary stability in September 2021, the Committee was satisfied, on the basis of Mr Kramer's evidence, that you should have been aware of the potential

for movement of the implant whilst screwing in the healing abutment. However, you failed to use reasonable skill and care, and the implant was pushed into the patient's sinus. The Committee considered that had you taken a radiograph prior to this second stage of implant treatment, this may not have happened. It was the judgement of the Committee, taking into account the consequences for Patient 4, that your failings at heads of charge 4(a) and 4(b) were serious and they amount to misconduct.

68. The Committee next considered your record keeping failing found proved at head of charge 5(a). On your own admission, you did not record the teeth incorporated into a bridge for Patient 5 on or around March 2013. Whilst the Committee noted the submission made on your behalf in respect of this finding, the Committee did not regard this as a minor record keeping failing. In finding that this instance of poor record keeping does amount to misconduct, the Committee took into account the fact that your omission made the relevant records unclear and very difficult to follow. This was highlighted during the evidence by Mr Kramer and by the Committee itself. Record keeping is a basic and fundamental aspect of clinical practice, which is important for the safe continuity of patient care. The Committee considered the poor standard of your record keeping in this instance represented a significant departure from what was expected in the circumstances.

69. During its discussions, the Committee considered its findings at 5(b)(ii), 6(c), and 9(c) separately, but reached the same conclusion in respect of each. These were your respective failings to provide an adequate standard of implant treatment to Patients 5, 6 and 9 on account of the implants you placed being too close to existing natural teeth or other implants. The Committee accepted the evidence of Mr Kramer that each of the findings at 5(b)(ii), 6(c) and 9(c) represented a standard of treatment that fell far below that expected. The Committee took into account the associated consequences for each patient, as outlined in Mr Kramer's main expert report. In relation to Patient 5, Mr Kramer highlighted the risk of implant failure and the risk of periimplantitis developing from not being able to clean adequately or at all implants that were too close together. In relation to Patient 6 and your placing of an implant too close to the apex of a natural tooth, Mr Kramer gave the opinion that this led the natural tooth to lose pulp vitality and become infected. With regard to your treatment of Patient 9, which involved your placing an implant too close to an adjacent natural tooth, Mr Kramer stated that this could likely lead to bone loss in that site and consequent reduced prognosis for both implant and tooth. The Committee was satisfied, having considered the risks and/or actual consequences for the patients of your poor planning of their implant treatment, that your failings at heads of charge 5(b)(ii), 6(c) and 9(c) amount to misconduct. The Committee considered it to be a basic aspect of implant treatment to place implants appropriately.

70. In relation to its finding at head of charge 6(a), namely that you discussed treatment options, risks and benefits with Patient 6 whilst they were under the influence of temazepam, Mr Kramer acknowledged that he is not an expert in pharmacology, and the dose of temazepam and its effects on Patient 6 were unclear. It was the view of the Committee that whatever the extent to which Patient 6's understanding and decision-making may have been affected by temazepam, it was a highly inappropriate time to have such important discussions with the patient. In the circumstances, the Committee concluded that discussing treatment options, risk and benefits whilst the patient was under the influence of temazepam does cross the threshold for a finding of misconduct.

71. The Committee next considered your record keeping failing at head of charge 7(a). In doing so, it noted that you did not record anything at all in relation to Patient 7's appointments for the preparation of teeth for crowns on 22 January 2020 and 16 March 2020. The Committee accepted the expert opinion of Mr Kramer that your omissions in this regard were far below the expected standard. Record keeping is a basic and fundamental aspect of clinical practice and there is nothing in the records to indicate that the patient attended for treatment at all on these dates. In the Committee's view, this is a serious failing which amounts to misconduct.

72. The Committee also found that your failure to provide Patient 7 with an adequate standard of implant treatment on 25 June 2021 amounts to misconduct. You admitted this matter at head of charge 7(b) on the basis that it was likely that the persistent numbness reported by the patient after the placement of implants at LL5 and LL6 on 25 June 2021 was due to the LL5 implant impinging on the inferior dental nerve. You noted that when the implant was removed the numbness went away. It was Mr Kramer's opinion, which the Committee accepted, that placing an implant that caused persistent numbness demonstrated a lack of skill and care. The Committee considered it to be a fundamental aspect of implant treatment to be aware of the anatomy and to avoid impinging on nerves. It also took into account the risk of nerve damage to the patient.

73. The Committee's finding at head of charge 8(a) was in relation to your admitted failure to carry out sufficient treatment planning prior to placing an implant at Patient 8's UR4 on 8 December 2021. You placed the implant next to the UR5, which was a natural tooth that you knew was infected and loose. The Committee accepted the opinion of Mr Kramer that your failure to plan to extract the UR5 prior to placing the implant at UR4 was poor treatment planning that fell far below what was expected. The Committee was satisfied that this amounted to misconduct.

74. In respect of the factual finding at head of charge 8(b), it was highlighted by Mr Kramer in his main expert report that, based on the clinical records and a radiograph of 27 September 2021, Patient 8's UR5 had a very poor prognosis. Mr Kramer's opinion was that the tooth should have been extracted. The tooth was not extracted until 23 March 2022, some months later and after the implant had been placed at UR4. You admitted that you failed to carry out treatment for the UR5 in a timely manner. In finding that this was serious and it amounts to misconduct, the Committee took into account Mr Kramer's evidence that *"Failing to take the tooth out in view of its very poor prognosis meant that the Patient might have to undergo further round of remedial treatment that could have been carried out in one go, had the tooth been taken out earlier. The presence of infection around UR5 could also have had a detrimental effect on the implant placed in UR4 site, with consequent failure to integrate with the bone".*

75. The Committee went on to consider your record keeping failure at 8(c), in that you did not make any record at all in relation to an appointment for Patient 8 which occurred on 9 May 2022. The Committee was satisfied that this complete lack of a record was serious and amounts to misconduct for the same reasons given previously in respect of missing records.

76. The Committee considered its individual findings at heads of charge 8(d)(i) and 8(d)(ii), and it noted that you did not report on either radiograph taken on 27 September 2021 and 15 November 2021 respectively. The Committee understood from Mr Kramer's expert evidence that there were a number of issues that required reporting, including a radiolucency in the distal aspect of UR3, bone

loss, defective restorations and defective root canal treatment. The Committee accepted his opinion that failing to report on the radiographs fell far below the standard and it was satisfied that each instance amounts to misconduct. In reaching its decisions, the Committee distinguished these failings from those at head of charge 1, where there was some evidence of a report and discussion with the patient. Your failings at heads of charge 8(d)(i) and 8(d)(ii), indicated to the Committee no active monitoring of the issues as identified by Mr Kramer.

77. The Committee also found misconduct on the basis of both its findings at heads of charge 9(a) and 9(b). You admitted that you failed to carry out sufficient diagnostic assessments, in this case a full examination, and sufficient pre-treatment investigations, prior to placing an implant for Patient 9 on 3 December 2021. The placing of an implant is a significant dental procedure and in the Committee's view, to go ahead with such treatment without sufficient diagnostic assessment and pre-treatment investigations is serious. It accepted the evidence of Mr Kramer that these failings represented a standard of clinical practice that was far below what was expected.

78. The Committee went on to consider your failings at heads of charge 10(a)(i) and 10(a)(ii). These were its findings, based on your admissions, that you failed to take a radiograph of Patient 10's implant crowns on 6 October 2021 and of the left implant on 9 September 2022. The Committee accepted the opinion of Mr Kramer in both regards. He set out in his expert report that *"No radiographs were taken on 06.10.2021 at the time of fitting of the implant crowns to verify that they were correctly seated. If the crowns were not properly seated, there would be a risk that plaque would accumulate at the gap between crown and implant with consequent risk of peri-implantitis developing. Also, no radiograph was taken of the left implant at the time of examination on 09.09.2022. It is my opinion that failing to take these radiographs was far below the standard expected. This is because without the relevant radiographs, the Registrant could not know whether the treatment had been satisfactorily provided or if there was any deterioration in the bone levels around the implants that might require treatment"*. It was the view of the Committee, taking into account the potential consequence for the patient of the absence of radiographs in these instances, that both failings amount to misconduct.

79. Finally, the Committee had regard to your admitted failure to report adequately, or at all, on radiographs taken of Patient 10 on 22 September 2021 and 9 September 2022. The Committee noted from Mr Kramer's evidence that the radiograph taken on 22 September 2021, shows bone loss around the LL6 implant, whilst the radiograph of 9 September 2022 showed bone loss around the LR6 implant. Mr Kramer stated that he would have expected these findings of bone loss to have been reported on because of the potential significance to future implant treatment, however, you made no reports. The Committee considered that failing to make any reference to such significant findings fell far below standard on each occasion, amounting to misconduct.

80. Having considered its individual findings in this case, the Committee was satisfied that all of the matters found proved, save for those at head of charge 1, amount to misconduct.

Decision on impairment

81. The Committee next considered whether your fitness to practise is currently impaired by reason of your misconduct. It bore in mind the overarching objective of the GDC, which is: the

protection, promotion and maintenance of the health, safety, and well-being of the public; the promotion and maintenance of public confidence in the dental profession; and the promotion and maintenance of proper professional standards and conduct for the members of the dental profession.

82. The Committee considered that, in principle, the failings that led to your misconduct are remediable. Whilst your shortcomings were serious and related to your treatment of multiple patients, the concerns are all clinical in nature which, in the Committee's view, are capable of being remedied by further learning and professional development.

83. In considering whether your clinical failings have in fact been remedied, the Committee had regard to the evidence of the steps you have taken to address the issues identified in this case. It noted that since the alleged matters came to light, you have embarked on a considerable process of upskilling to improve your clinical knowledge and skills, particularly in relation to implant treatment. You have completed two years of a three-year Master's Degree, receiving a Postgraduate Diploma in Dental Implantology with distinction in November 2025. The Committee had before it details of the modules you undertook as part of those two years of study. It noted that your areas of learning covered highly relevant topics, namely Patient Assessment and Treatment planning, Implant Surgery, Restorative Treatment and Maintenance and Dental Implant Procedures and Complex Cases. The Committee further took into account that these two years of study involved nearly 200 hours of CPD.

84. The Committee noted that you stated in your Reflective Statement that you decided to pursue a postgraduate qualification in Dental Implantology after having a number of failed implants, and that you chose a reputable institute and hospital at which to undertake your learning, under supervision, *"…to ensure my implant knowledge and clinical approach continued to reflect current guidance and best practice".* The Committee noted that you also obtained a Cone Beam Computed Tomography (CBCT) Level 1 and Level 2 qualification in November 2023, with a view to learning more about planning for implant treatment.

85. Additionally, the Committee had before it a range of other CPD that you have completed, which it found to be targeted to the areas of concern in this case. This included CPD on radiography, record keeping and consent, including consent specifically relating to implant dentistry, and a course on 'Reflection in practice'. You also provided the Committee with reflective logs detailing your reflections on what you had learnt whilst undertaking your CPD.

86. The Committee further noted, as part of the evidence of your remediation, that you provided a number of reports from your Workplace Supervisor, who has supervised you for the past two years under an interim conditions of practice order and who has been involved in your training on your postgraduate degree course. In his oral evidence to the Committee, your Workplace Supervisor said that he had no concerns about your current clinical practice, including your practice in relation to implants. He described your practice as a dentist as excellent and that he *"consistently found [you] to be a highly competent and safe clinician"*. He also told the Committee in detail how you have been using the Implant Pro software system to make your practice safer. Your Workplace Supervisor stated that you use the software system for every implant case. The Committee noted this from the Implant Logs provided in relation to the implant cases you have undertaken since August 2024.

87. In addition to the evidence from your Workplace Supervisor, the Committee was provided with an independently verified record keeping audit in respect of your clinical practice dated 1 February 2026. The Committee noted that outcome of the audit was that *"Overall, record keeping was strong in key areas including medical history updates, risk assessments (caries and periodontal), treatment planning and consent. These elements were consistently documented and demonstrate good compliance with professional guidance. The audit found that in many cases where no operative treatment was needed, the diagnosis section was not omitted, however the treatment plan was clearly documented".*

88. Having considered the evidence of your remediation, the Committee was impressed, not only by the quality and quantity of your learning, but that your CPD has been ongoing over a number of years. The CPD evidence before the Committee dates from 2022 onwards. This demonstrated to it your genuine desire to improve the identified deficiencies in your clinical practice and a commitment to continued professional development. The Committee noted that you continue to work towards completing your Master's Degree.

89. The Committee attached weight to your Reflective Statement, in which you set out how you have proactively sought out remediation, having recognised that a range of concerns had been raised about your clinical practice over a number of years. The Committee found that you displayed a high level of reflection, giving reasons for why you attended certain courses and studied specific documents, what you learnt from them, and most importantly how you have used your learning to change and improve your clinical practice. This embedding of your learning into practice was supported by the positive comments of your Workplace Supervisor, who has observed you both in your working and learning environments. The Committee noted his years of experience and expertise and was reassured by his opinions and observations.

90. It was the view of the Committee that you have shown insight into your clinical failings, even in relation to those aspects of the case that you denied. The Committee has been impressed by the depth of your understanding of, and reflection on, what were serious shortcomings, and the action you have taken through a range of CPD and examinations. It took account of your written reflections on the issues raised, as set out in your Reflective Statement, in which you stated that *"…I recognise that there were aspects of my practice during that period that fell short of the standards expected, particularly in relation to documentation, radiographic use, consent processes and elements of treatment planning. I understand that shortcomings in these areas have the potential to affect patient confidence and the quality of care provided, and I regret that my practice may at times have created that risk. This process has been an important opportunity for me to reflect carefully on my professional responsibilities and the standards required in clinical practice. As a result, I have reviewed and strengthened my approach to implant dentistry, record keeping, consent protocols and radiography to ensure that my practice is fully aligned with current regulations and professional standards. The concerns raised relate to historic matters, but the reflection they have prompted has been significant for me..."*

91. Taking all the evidence into account, including the positive testimonials tendered on your behalf, the Committee was satisfied that you have addressed the matters that led to your misconduct, such that the risk of repetition is low. The Committee could not see what more you could have done

in the circumstances. Accordingly, it determined that a finding of impairment is not necessary in this case for the protection of the public.

92. The Committee went on to consider the wider public interest and whether a finding of impairment is required to maintain public confidence in the dental profession and the regulatory process. The Committee also considered the need to uphold proper professional standards. In doing so, it took account of your fitness to practise history before the GDC. The Committee noted that the warning you received in 2012 was in respect of an unrelated matter which occurred in 2009, some 17 years ago. Therefore, it did not consider it relevant to its consideration of the wider public interest in this case.

93. It was the view of the Committee that a well-informed and fair minded member of the public, taking into account the significant evidence of your insight, remediation and reflections, would not be shocked or troubled if you were found not to be currently impaired. In reaching its conclusion, the Committee also took into account that these fitness to practise proceedings have been ongoing for a number of years and that a finding of misconduct has been made against you which, in itself, is a serious outcome for any professional. Taking all of this into account, the Committee was satisfied that public confidence in the profession, the regulatory process and the upholding of proper professional standards would not be undermined if a finding of impairment were not made in all the circumstances of this case.

94. Accordingly, the Committee determined that your fitness to practise is not currently impaired by reason of your misconduct.

95. Having determined that your fitness to practise is not currently impaired, the Committee has not been required to consider any sanction.

96. The interim order currently in place on your registration is hereby revoked.

97. That concludes this determination.