Dental Professionals Hearings Service

PUBLIC HEARING

Professional Conduct Committee
Initial Hearing

6-9 July 2026

Name:	Rosneva, Mariya
Registration number:	217616
Case number:	CAS- 211738-J6G0T1

General Dental Council:	Guy Micklewright, Counsel Instructed by Rashidah Conroy, IHLPS
Registrant:	Present Represented by Nick Peacock, Counsel Instructed by Ediri Okonedo, DMU

Fitness to practise:	Impaired by reason of misconduct
Outcome:	Conditions imposed (with a review)
Duration:	12 months
Immediate order:	Immediate conditions of practice order

Committee members:	Deborah Jones (Chair, Dental Care Professional Member) Lynn Vernon (Lay Member) Matthew Thomas Smith (Dentist Member)
Legal Adviser:	Paul Kilcoyne
Committee Secretary:	Jamie Barge

Dental Professionals Hearings Service

Ms Rosneva

1. This is a Professional Conduct Committee hearing in respect of a case brought against you by the General Dental Council (GDC). The charge relates to the standard of care that you provided to a single patient ('Patient A') between 12 January 2023 to 5 June 2024 at the practice where you worked as a dentist ('the Practice').

2. The hearing commenced on 6 July 2026 and is being conducted remotely by Microsoft Teams video-link.

3. You are represented at these proceedings by Mr Nicholas Peacock, Counsel. The Case Presenter for the GDC is Mr Guy Micklewright, Counsel.

Admissions to the charge – 6 July 2026

4. The Committee next heard your admissions to the heads of charge. In respect of the allegations relating to the standard of care you provided to Patient A, Mr Peacock told the Committee that you admitted heads of charge 2a , 2b and 2c.

Case background

5. In his opening submissions for the GDC, Mr Micklewright told the Committee that concerns arose from treatment that you provided to Patient A. The GDC first became aware of the concerns when it received a written complaint from the patient on 13 October 2023, regarding the standard of treatment that you had provided, specifically prosthodontic treatment. You provided this treatment to Patient A between January 2023 to June 2024. Patient A had complained about his lost lower posterior teeth and fractures of some of his upper teeth. He asked for a fixed option.

6. As part of its investigation into the complaint, the GDC obtained relevant dental records, and it provided those records, along with the patient complaint. The GDC's investigation raised a number of issues, including that significant restorative work had been carried out in the presence of the patient's progressive periodontal condition. Other concerns were raised in relation to the clinical justification for the treatment, the consent process, your radiographic practice and discrete issues in relation to your record keeping.

7. The GDC instructed an expert, Mr Geoffrey Bateman, whose report now forms the basis of the heads of charge before this Committee. The matter went before Case Examiners. It was their decision to refer the allegations for consideration to this Committee

Summary of the evidence

8. The Committee received both documentary and oral evidence. The factual documentary evidence received from the GDC was Patient A's records and radiographs.

9. In terms of expert evidence, the Committee received a report dated 19 May 2026, prepared by Mr Geoffrey Bateman, a Consultant in restorative dentistry, the expert witness who appeared on behalf of the GDC. The Committee also heard oral evidence from him.

10. In respect of your case, the Committee had before it your witness statement dated 26 March 2026. You also gave oral evidence to the Committee.

FINDINGS OF FACT – 7 July 2026

11. The Committee considered all the evidence presented to it. It took account of the closing submissions made by both parties in relation to the alleged facts, which were provided to the Committee orally. The Committee accepted the advice of the Legal Adviser.

12. The Committee noted that some of the factual matters were admitted by you during the preliminary stage of the hearing. However, given they related to record keeping, it decided to delay making its findings on these heads of charge, until it had heard all of the evidence.

13. In relation to alleged matters that remained outstanding, the Committee considered each of those allegations separately. It bore in mind that the burden of proof rests with the GDC, and that the standard of proof is the civil standard, that is, whether the allegations are proved on the balance of probabilities.

14. The Committee's findings in relation to the facts are set out below. For completeness, the findings include those matters admitted and found proved.

1	*You failed to provide an adequate standard of care to Patient A from 12 January 2023 to 5 June 2024 including by:*
1(a)	*Not carrying out sufficient diagnostic assessments, in that you failed to conduct a six-point pocket chart.* **Proved.** The Committee when determining upon these heads of charge, notes that no written or oral evidence was provided by Patient A, who has failed to engage with the GDC's investigation. The Committee before it, has the written and oral evidence from you, and also from the GDC expert, Geoffrey Bateman. In addition, it had sight of the contemporaneous clinical notes of Patient A. The Committee also notes that Patient A is from Bulgaria whose level of English was poor. It notes that both parties agree that during appointments, discussions between you and Patient A were conducted in your first language of Bulgarian. It was also noted that various forms provided to Patient A by you, which were written

in English, including the consent form, were translated from English into Bulgarian using a phone app.

The Committee notes that Mr Bateman is a Consultant in restorative dentistry who also provide treatment in a specialist private restorative practice. This involves providing treatment planning advice and opinions to General Dental Practitioners. The Committee is satisfied given his experience and qualifications that he is able to give an expert opinion on the matters before this Committee. The Committee found his written and oral evidence to be clear and reliable and persuasive and relates to general practice. The Committee was not persuaded by Mr Peacock's submissions that Mr Bateman was an inappropriate expert for this matter.

The Committee then went onto to consider the written and oral evidence of Mr Bateman. In his report he stated:

"In my view, my concern about sufficient and accurate diagnostic assessments is in respect of the pocket charting it is averred was undertaken. On the evidence I have, I apprehend three potential factual constructions. If a pocket chart was either not taken or not recorded then in my view that falls far below a reasonable standard.

If a pocket chart was taken and recorded but then lost thereafter then I am not critical.

That a six-point pocket chart was not undertaken and the Registrant is mistaken; in my view, a failure to have recorded that chart put the patient at significant risk of not apprehending severity of disease and of failure of the crown and bridgework planned through periodontal progression. That would be a falling far below a reasonable standard in my view".

Your evidence is that you did carry out a six-point pocket chart but you stated that unfortunately the handwritten record had not been uploaded onto Patient A's dental records. You informed the Committee that you had offered to refer Patient A to a periodontal specialist due to his serious periodontal problems. However, he had refused.

You acknowledged in cross examination, that there is no record of this in the patient records. You also stated it is your usual practice to undertake a six-point pocket chart on patients and make contemporaneous notes after each appointment and that this is something you take seriously. You stated that documents and x-rays were routinely uploaded to patient records by reception staff.

The Committee noted in the patient records, that no note was made of you carrying out a six-point pocket chart at any of the appointments for Patient A between 12 January 2023 and 5 June 2024. The Committee notes that Patient A had attended with poor periodontal disease and it is clear this needed to be treated.

The Committee took into account that Mr Bateman was not overly critical of your note taking in general. However, for the appointments of 12 January 2023 onwards, he was critical that you had failed to make a number of records, including undertaking a six-point pocket chart. The Committee noted that, while

	your record keeping was of a reasonable standard, there were a number of obvious omissions. The Committee is satisfied that Patient A had active periodontal disease, poor oral health and little motivation to address this. It is also satisfied that a six-point pocket chart should have been performed in these circumstances. There is no indication in the notes or elsewhere that you had recognised this, or adapted your treatment plan accordingly. This is particularly apparent in the clinical record of the hygiene appointment on 16 January 2023, which is recorded only as a scale and polish. Had a six-point chart been performed, the Committee would have expected reference to periodontal treatment being carried out on this appointment. There is no record of a proper diagnosis of the patient's periodontal condition. In addition, the notes indicate that Patient A's condition had been deteriorating since 2017. The Committee noted the reference to the case of Miller v The Health Commissioner for England [2018] EWCA Civ 144, where it was pointed out that it is wrong to assume that if something is not written down it did not happen. However, the Committee was satisfied that there was sufficient circumstantial evidence to allow it to infer that you did not carry out a six-point pocket chart. The Committee is satisfied on the balance of probabilities, that it is more likely than not that, you had failed to carry out a six-point pocket chart for Patient A. It therefore finds this head of charge proved.
1(b)	*Proposing treatment which was not clinically indicated, in that you:*
1(b)(i)	*Proposed a bridge with a linked-retainer design at UR21.* **Proved.** Dr Bateman in his written expert report stated that "**…In my view however, no reasonable dentist would have planned or placed at bridge with the linked design at UR21 that the Registrant did. That design would preclude any sort of adequate interdental cleaning between UR2 and UR1 in a patient at significant risk of periodontal disease with poor motivation and apparently less than ideal plaque control. That would have put the patient at very significant risk of periodontal disease progression and future loss of teeth….** **In my view no reasonable dentist would have proposed 3 linked crowns at these teeth. There was no clear indication for the same where there was apparently sufficient tooth to retain single crowns or veneers. Conversely there was very significant risk of periodontal disease progression at linked crowns that would be very difficult to clean between. Further there was significant risk at the compromised UL3 tooth. Failure at any one of those teeth would mean the whole structure would be compromised… This was *three* linked teeth that would be even harder to maintain than the bridge at the upper right."**

	Mr Bateman in oral evidence stated that he does not criticise the provision of a bridge, just the type and design of this bridge. He stated that this type of linked restorations are extremely difficult to clean and in the particular circumstances of Patient A's periodontal condition, this was not an appropriate option. He stated in oral evidence that there was an increased risk of periodontal instability, because the vulnerable areas could not be cleaned in a meaningful way. You stated in oral evidence that after examination you had offered Patient A a range of treatment options. You stated that Patient A had refused to consider dentures and had requested a "*quick and cheap option*", as he was planning to travel to Turkey or Bulgaria for implants at a later stage. You stated that you also had a discussion about the types of crowns available and the different bridge options. You stated to the Committee that in your opinion linked restorations offered more stability than individual crowns. The Committee accepted the evidence of Mr Bateman. Given the risks identified, Patient A's history of poor oral health and the design of the bridges, this was not an appropriate option. The Committee is satisfied that the provision of linked bridges and crowns was potentially detrimental to Patient A's oral health, risking deterioration of his periodontal condition and future loss of teeth. It therefore finds this head of charge proved.
1(b)(ii)	*Proposed 3 linked crowns at UL123.* **Proved – for the same reasons as above**
1(c)	*Not providing the full risks and benefits in respect of the treatment proposed, in that you did not:*
1(c)(i)	*Explain the significant risk of the patient being unable to clean interdentally.* **Proved.** Mr Bateman in his written report stated; "**If she had discussed those options and they were rejected then I am still critical of the linked crown at UL123 teeth. No reasonable dentist would have planned such high-risk care. That would have been a far-below standard on planning alone rather than reasonable given consent for the same. I note that the Registrant does not admit this element on the basis, as I understand it, that she does not accept such care was not clinically indicated at P40 of her Witness Statement. I do not support that position myself.** **In my view the very significant risk of the patient being unable to clean interdentally, progression of periodontal disease and future loss of the teeth because of that, were not reflected in the records. The Registrant notes in her Witness Statement at P. 21- 22 that she advised the patient that the bridge would not assist with his general oral hygiene and on maintain his oral hygiene…"**

	Mr Bateman further stated in his report; "I **remain of the view, per my 80-82, that no reasonable dentist would have provided such care regardless of risks discussed.** **Any reasonable dentist would have explained:** i. **the very significant risk of the patient being unable to clean interdentally;** ii. **the risk of progression of periodontal disease as a consequence of linked crowns;** iii. **The risk of future loss of the teeth because of linked crowns.** iv. **The facts as to what was discussed are for the committee…"** Mr Bateman stated in oral evidence that even with the highest quality laboratory work, those teeth could be not properly cleaned interdentally. In your written statement you stated "*I discussed treatment with RG. I advised him that the bridge would not assist with his general oral hygiene. I discussed oral hygiene with RG including advice surrounding brushing, using mouthwash, floss, and visiting a periodontist*". In addition, you stated in oral evidence that you had discussed with Patient A proper oral hygiene and the risks of not being able to clean his teeth interdentally. However, you acknowledge this was not recorded in the patient notes. The Committee accepts Mr Bateman's evidence that this design of bridge is extremely difficult to clean and the information on the consent form is not sufficient because it is not specific to the particular risks of that design. It is satisfied there is nothing in the notes that deals with specific issues that should have been brought to the attention of Patient A, such as interdental cleaning, and the risk of progression of periodontal disease, and the risks of losing teeth in the future. It notes your records make mention of you providing other options but nowhere in the notes is there a recognition of the severity of his periodontal condition or the specific risks involved with this particular course of treatment. In particular at the bridge fit appointment of 3 May 2023, the Committee would have expected there to have been evidence of aftercare instructions specific to the linked bridges given to Patient A. While there were clinical notes made at this appointment relating to risks, they were only generalised ones. The Committee is satisfied on the balance of probabilities, that you failed to discuss the associated risks identified in heads of charge 1c i-iii, with Patient A. It therefore finds this head of charge proved.
1(c)(ii)	*Explain the risk of progression of periodontal disease.* **Proved for same reasons as in head of charge 1.c.i.**

1(c)(iii)	*Explain the risk of future loss of teeth.* **Proved for same reasons as in head of charge 1.c.1.**
1(d)	*Not providing the patient with all treatment options in that you:*
1(d)(i)	*Did not discuss the option of veneers or single crowns at UR2 or UR1.* **Proved.** Mr Bateman in his written report stated; ***"In respect of treatment options:*** ***a. I remain of the view, per my 80-82, that no reasonable dentist would have provided such care regardless of options discussed.*** ***b. A body of reasonable dentists would have discussed*** *i.* ***Simpler bridgework at the upper right without linking abutments at UL12.*** *ii.* ***The options of either separate composites, crowns or veneers at UR21, if the patient wished to change their appearance.*** *iii.* ***The options of either separate composites, crowns or veneers at UL123 if the patient wished to change their appearance".*** You maintained in your oral evidence that you had discussed this with Patient A. You stated that you realised that you failed to make a record of this and your record keeping at that time was poor. However, you maintain that you had discussed the option of veneers with Patient A. The Committee accepts the evidence of Mr Bateman. It notes there is no record either in Patient A's notes or in your written statement that you had discussed the option of veneers with Patient A. It notes in the clinical records that 4 different treatment options were offered by you to Patient A, including crowns and bridges. However, there is no detail of the options recorded such as single or linked crowns or veneers. Nor was there any mention of options for different designs of the bridges. Your records do not give enough detail to demonstrate you had provided Patient A with adequate information. The Committee notes your oral evidence that you had offered this option, yet your written statement did not make any mention of this. The Committee therefore finds this head of charge proved.
1(d)(ii)	*Did not discuss the option of veneers or single crowns at UL1, UL2 or UL3.* **Proved – for same reason as given in heads of charge 1 d.i.**

2.	*You failed to maintain an adequate standard of record keeping in respect of Patient A's appointments from 12 January 2023 to 5 June 2024 in that you;*
2(a)	*Failed to make any or any adequate record of a six-point pocket chart on 12 January 2023.* **Admitted but found not proved.** In finding this allegation not proved, the Committee noted that it is alleged that you failed to maintain an adequate standard of record keeping, in that you did not record the matters as outlined above in heads of charge 1. The Committee took into account that to allege a *'failure'* implies that you had a duty to make such a record. However, given that the Committee has found that you did not carry out a six-point pocket chart, you could not have had a duty to record something which you had not done. Accordingly, this head of charge is not proved.
2(b)	*Failed to make any or any adequate record of those matters particularised in paragraph 1c) above.* **Admitted but found not proved for the same reasons as in head of charge 2.a.**
2(c)	*Failed to make any or any adequate record of those matters particularised in paragraph 1d) above.* **Admitted but found not proved for the same reasons as in head of charge 2.a.**
3	*You failed to obtain informed consent for treatment provided to Patient A between 12 January 2023 and 5 June 2024.* **Proved.** Mr Bateman stated in written evidence that; "**Central to my view on consent is that I do not consider that any reasonable dentist would have provided the restorations that the Registrant did at separately the UR321 and the UL123 for the reasons I describe above. That is independent of what the committee find in respect of pocket charting, treatment options and risks. I say that the treatment was not clinically indicated and consent could not have been given for that in any event. I say that in respect of allegation 3 above, that care fell far below a reasonable standard".**

	In his oral evidence he stated that, because you failed to provide all associated treatment options and the high risks that you could not have obtained Patient A's informed consent. Following on from its findings at head of charge 1, the Committee determined that as you had not adequately discussed the risks associated and all the treatment options available, you did not obtain Patient A's informed consent. Accordingly, the Committee found this head of charge proved.

15. The hearing now moves to Stage Two.

Proceedings at stage two

16. The Committee has considered all the evidence presented to it. It has also taken into account the submissions made by Mr Guy Micklewright on behalf of the GDC and those made by Mr Nicholas Peacock on your behalf. The Committee has accepted the advice of the Legal Adviser.

Evidence

17. The Committee has been provided with documentary material relevant to its consideration at this second stage of the hearing, namely certificates and logs of continuing professional development (CPD), and reflections on learning. In addition, you submitted a number of testimonials.

18. The Committee has also had regard to the documentary evidence presented to it at the previous, factual stage of the hearing.

19. The Committee heard no oral evidence at this stage of the hearing.

Fitness to practise history

20. Mr Micklewright addressed the Committee in accordance with Rule 20 (1) (a) of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules'). He informed the Committee of your previous Fitness to Practice history, where in October 2014 you received advice provided from the GDC's Investigating Committee. He stated that he doesn't place any reliance on it during his submissions on either on impairment or sanction.

Submissions

21. Mr Micklewright submitted that the facts that the Committee has found proved, amount to misconduct. He submitted that the treatment plan you embarked upon involved high-risk care and your standard of care fell short of the standards expected. Mr Micklewright submitted that this single

course of treatment was high-risk and compounded by the fact there was no consent, in a context where there was no adequate discussion of risks and benefits and other treatment options. He submitted this placed Patient A at risk of harm and the treatment was plainly not in his best interests. Mr Micklewright identified standards 1, 1.4, 1.4.2, 2, 2.2, 2.2.1, 2.3 and 3. He submitted that the conduct can properly be characterised as serious misconduct.

22. Mr Micklewright submitted that your fitness to practise is currently impaired, and that a finding of impairment is also required in the public interest. He submitted that your misconduct can potentially be remediable but has yet to be fully remediated. He submitted that there is evidence of developing insight and suitable remediation but there is more to do. Accordingly, there remains a risk of repetition. He referred to your stage 2 bundle which included a number of testimonials. He submitted you have provided a personal development plan, which lacks detailed reflection on the issues relating to the charges that have been found proved. Mr Micklewright stated that your learning seems to be rather short of what a Committee would expect to see. In addition, your learning in diagnosis and investigation and also informed consent seems to be incomplete. Also, your audits are focused on the standards of your records, and are limited in the information they provide. Some of the audits are not applicable to the matters of concern.

23. Mr Micklewright submitted that your written reflective letter and Continuing Professional Development (CPD) reflections are limited, superficial and lack real meaningful insight. They do demonstrate some evidence of insight, however, there is no evidence that you have considered the potential impact of your failures on Patient A or the wider public interest. There is no information as to how you would embed this learning.

24. Mr Micklewright therefore submitted that given your remediation has some way to go, you remain a risk to the public and that a finding of impairment is required for the protection of the public. In addition, a finding of impairment is otherwise required in the public interest given the seriousness of the failings that have been found proved.

25. Mr Micklewright provided a set of proposed conditions and invited the Committee to impose a conditions of practice order for a period the Committee deems appropriate and proportionate, with a review hearing to take place prior to the end of that period.

26. Mr Peacock invited the Committee to consider each head of charge found proved with particular care. He submitted that the charges found proved do not amount to misconduct. He submitted this was a single course of treatment and consultation with Patient A. Mr Peacock submitted that nothing Mr Bateman has said could lead this Committee to finding these failures as being particularly grave. He submitted that this case is not at all clear to satisfy the legal criteria that it constitutes misconduct.

27. Mr Peacock submitted that, even if the Committee were to find misconduct, your fitness to practise is not currently impaired. Mr Peacock submitted that your previous fitness to practise history

carries little or no weight. He submitted that the events complained of, have been remediated and they are highly unlikely to be repeated. He submitted that you have undertaken a focused approach to your CPD and learning. Mr Peacock submitted that you have demonstrated a commitment to your learning as shown in the audits and written reflection provided.

28. Mr Peacock submitted that with regard to the issue of repetition, you have undergone a lengthy GDC investigation, faced a PCC hearing, which has been made public. He submitted having had to go through that process is an element to be weighed in the impairment stage. He submitted that there is no effective risk posed by you. This was a single patient episode, and in the specific circumstances of this case, the risk of repetition is low. He acknowledged some of your reflections are limited, however, you are plainly a Registrant who has shown insight and remorse. In addition, testimonials from your mentor, colleagues and patients attest to you being a competent and likeable registrant.

29. Mr Peacock submitted that taking all of this into account, you have remediated the identified concerns which should enable this Committee to determine that you demonstrate no risk of repetition and that your fitness to practise is not impaired.

30. Mr Peacock submitted that were the Committee to find that your fitness to practise is currently impaired, no higher sanction than that of a reprimand is the most appropriate and proportionate sanction. However, if the Committee were minded to consider otherwise, that they should go no further than conditional registration for a period of 6-9 months.

Misconduct

31. The Committee first considered whether some or all the facts that it has found proved constitute misconduct. In considering this matter, the Committee has exercised its own independent judgement.

32. 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 facts that it has found proved. These paragraphs state that as a dentist:

> ***Standard 1.0****: Put patients' interests first*
>
> ***Standard 1****.4 Take a holistic and preventative approach to patient care which is appropriate to the individual patient.*
>
> ***Standard 1****.4.2 You must provide patients with treatment that is in their best interests, providing appropriate oral health advice and following clinical guidelines relevant to their situation. You may need to balance their oral health needs with their desired outcomes. If their desired outcome is not achievable or is not in the best interests of their oral health, you must explain the risks, benefits and likely outcomes to help them to make a decision.*

Standard 2.0 *Communicate effectively with patients*

Standard 2.2 *Recognise and promote patients' rights to and responsibilities for making decisions about their health priorities and care.*

Standard 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 treatment you propose and the possible costs.*

Standard 2.3 *You must give patients the information they need, in a way they can understand, so that they can make informed decisions.*

Standard 3.0 *Obtain valid consent.*

33. The allegations giving rise to this case concern the standard of care and treatment that you provided to Patient A between March 2023 and June 2024. The Committee's specific findings relate to failings in not discussing treatment options or associated risks with Patient A . In addition, you failed to obtain Patient A's informed consent.

34. The Committee first considered whether the facts that it has found proved, at heads of charge 1 and 3 amount to misconduct. The Committee notes the expert view of Mr Bateman that most if not all of the heads of charge involved care that fell far below the standard expected of the reasonable practitioner. The Committee finds that although this was a single course of treatment, it was over multiple appointments. The Committee considers that these acts and omissions represent conduct which falls far short of the standards reasonably to be expected of a general dental practitioner. In particular the Committee finds that you embarked on a high-risk course of treatment that potentially placed Patient A at risk of harm.

35. The Committee is satisfied that your conduct as found proved would be considered deplorable by fellow practitioners as they each relate to serious misconduct, some of which placed Patient A at unwarranted risk of harm.

36. The Committee therefore finds that each of the facts that it has found proved amount to misconduct.

Impairment

37. The Committee then went on to consider whether your fitness to practise is currently impaired by reason of the misconduct that it has found. In doing so, the Committee has again

exercised its independent judgment. Throughout its deliberations, the Committee has borne in mind that its primary duty is to address the public interest, which includes the protection of patients, 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.

38. The Committee has determined that your fitness to practise is currently impaired. The Committee considers that your acts and omissions relate to specific, basic and fundamental aspects of dentistry, and that you have not demonstrated sufficient remediation of these matters.

39. The Committee accepts that you have demonstrated some level of insight. You made admissions to a number of the heads of charge, and you have made attempts to remediate. However, the Committee has not been presented with evidence to demonstrate that your recent learning has been embedded in your practice.

40. The Committee finds that the steps that you have taken to remedy your clinical failings are lacking. The Committee notes that your recent CPD relates to areas such as fire training and record keeping but is not targeted towards areas such as prosthodontics, periodontic diagnosis, treatment planning and informed consent. The Committee is concerned that only a limited amount of CPD has been undertaken in respect of prosthetics and consent, and most of these are brief online courses. The Committee was also concerned at the lack of detail in your Personal Development Plan (PDP). In particular it considers that the reflections contained were not focused on the importance of obtaining a patient's informed consent and the need for a proper diagnostic assessment. It is not confident that your knowledge base in this field of dentistry has significantly increased. Also, your written reflections lack detail and do not specifically relate to all the areas of concern. In addition, the Committee was concerned at the quality and lack of detail of your audits. Some of the areas contained in the audits were marked not applicable "*N/A*" when the Committee considers that they are basic areas of routine dental examination.

41. In short, the Committee's findings suggest a lack of understanding on the areas of concern. It noted that, during your stage 1 oral evidence, you stated that upon reflection, you would provide this course of treatment again. The Committee considers that the process of remedying the clinical deficiencies that the Committee has identified is not complete, and that you continue to pose a risk to patients. Accordingly, the Committee finds that your fitness to practise is currently impaired.

42. The Committee also finds that a finding of impairment is required in order to declare and uphold proper standards of conduct and behaviour and to maintain trust and confidence in the profession and in the regulatory process. The Committee is confident that a member of the public would expect somebody working in those circumstances to focus on patient care and have the necessary understanding and competence in periodontic assessments. In the Committee's judgment public trust and confidence in the profession, and in the regulator, would be seriously undermined if a finding of impairment were not made in the particular circumstances of this case.

Sanction

43. The Committee then determined what sanction, if any, would be appropriate in light of the findings of fact, misconduct and impairment that it has made. The Committee recognises that the purpose of a sanction is not to be punitive, although a sanction may have that effect, but is instead imposed in order to protect patients and safeguard the wider public interest referred to above. In reaching its decision the Committee has taken into account the *GDC's* Guidance document, *'Fitness to Practise: Guidance for the practice committees' (6 January 2026)* (the GDC's Guidance).

44. The Committee has considered the mitigating and aggravating factors present in this case.

45. In relation to mitigating factors, the Committee is mindful that you made some admissions to the facts that the Committee found proved, and that there have been no further reported instances of these or other matters. You have taken steps to avoid repetition. The Committee is also mindful that an amount of time has elapsed since the time of the incidents giving rise to these proceedings, and that you have shown some insight into your misconduct. You have engaged in these proceedings.

46. In relation to aggravating factors, the Committee notes that your acts and omissions entailed a real risk of harm to patients. Whilst you have no previous FTP findings, it notes the GDC advice letter of October 2014 relating to an incident of a single patient involving treatment planning and record keeping. There was also a risk of harm to Patient A, and a limited insight into the identified concerns.

47. The Committee has considered the range of sanctions available to it, starting with the least restrictive. In the light of the findings made against you, the Committee has determined that it would not be appropriate to conclude this case with no action or with a reprimand. Such outcomes would leave the public and the public interest at considerable risk of harm on account of your unremediated misconduct. Taking no action, or issuing a reprimand, would be insufficient to protect the public, would undermine public confidence and trust in the profession and in the regulatory process, and would not be sufficient to declare and uphold proper standards of conduct and behaviour.

48. The Committee next considered whether a period of conditional registration would be appropriate. As noted above the Committee considers that your misconduct is remediable and that in that regard conditions might be suitable.

49. The Committee took account of the ISG, which states conditions may be suitable where most of the following factors are present:

- there are discrete aspects of the Registrant's practice that are problematic;

- any deficiencies are not so significant that patients will be put at risk directly or indirectly as a result of continued – albeit restricted – registration;
- Registrant has shown evidence of insight and willingness to respond positively to conditions;
- it is possible to formulate conditions that will protect the public during the period they are in force.

50. The Committee noted that any conditions must be:

- necessary in order to protect patients, the public or the interests of the profession;
- clear;
- relevant to the identified shortcomings;
- proportionate to the identified impairment;
- workable (conditions must not be such that in reality they amount to suspension);
- capable of being monitored for compliance by the executive and/or at a review hearing;
- addressed only to the Registrant and not to a third party.

51. The Committee determined that it would be possible to formulate appropriate and proportionate conditions which would address the failings highlighted in this case. This case concerns a single patient complaint, and the Committee was encouraged to see that you are working with a mentor. The Committee also finds that you have demonstrated some insight, although this is still developing. You have demonstrated a willingness to engage in these proceedings. The Committee also notes that the issues of concern are clinical only.

52. Having had regard to the matters it has identified, the Committee concluded that conditions would mark the importance of maintaining public confidence in the profession and will send the public and the profession a clear message about the standards of practice required of a dentist.

53. The Committee did consider a more restrictive sanction but was satisfied that a suspension would be wholly disproportionate and would not be a reasonable response in the circumstances of your case.

54. Balancing all of these factors, the Committee determined the following conditions are appropriate and proportionate in this case:

1 You must provide the GDC, within seven days, the contact details and arrangements for any appointment you accept or are currently undertaking which requires GDC registration.

2 You must allow the GDC to exchange information with your employer or any contracting body for which you provide dental services.

3 You must provide the GDC, within seven days, the contact details for the commissioning body in whose Dental Performers List you are included or seeking inclusion at the time of application.

4 From the date that these conditions take effect, you must inform the GDC within seven days of being notified of:

- any formal disciplinary action taken against you
- any NHS investigation
- any regulatory or enforcement action taken against you or a practice for which you are the registered provide
- any patient complaint received about your clinical practice or conduct at work.

5 You must inform the GDC, within seven days of these conditions taking effect, if you are registered with any overseas regulator (or equivalent authority) or within seven days of making an application for registration with any overseas regulator or equivalent authority.

6 You must formulate a Personal Development Plan specifically designed to address the deficiencies in the following areas of practice:

- Diagnostic assessments
- Examinations and treatment planning
- Informed consent
- Periodontal diagnosis and management.

7 You must forward a copy of your Personal Development Plan to the GDC within two months of the date on which these conditions become effective and at least 14 days prior to any review hearing.

8 You must produce a reflective statement addressing your progress towards achieving the aims set out in her Personal Development Plan and provide this to the GDC at least 14 days prior to any review hearing.

9 At any time you are employed to provide dental services which require you to be registered with the GDC, you must agree to the appointment of a workplace reporter nominated by you and approved by the GDC. The workplace reporter must be a GDC registered dentist. You must not start/restart work until your proposed workplace reporter has been approved by the GDC.

10. You must provide reports from your workplace reporter to the GDC every three months and at least 14 days prior to any review hearing. In addition to addressing general compliance with the conditions, any complaints received, and any other relevant information, the report must specifically address:

- Diagnostic assessments
- Examinations and treatment planning
- Informed consent

- Periodontal diagnosis and management.

11.You must carry out an audit every three months in the following areas of your practice:

- Diagnostic assessments
- Examinations and treatment planning
- Informed consent
- Periodontal diagnosis and management.

The audit must be checked and signed by your workplace reporter.

12. You must provide a copy of this audit to the GDC every three months and at least 14 days prior to any review hearing or, alternatively, provide a statement, which has been counter-signed by your workplace reporter, confirming there have been no such cases.

13. You must inform the following parties that your registration is subject to the conditions listed above:

- Any organisation or person employing you or who has an arrangement with you to undertake dental work (within seven days).
- Any professional regulatory body you are registered with (within seven days) or apply to be registered with (at the time of application).
- Any locum agency or out-of-hours service you are registered with (within seven days) or apply to be registered with (at the time of application).
- Any prospective employer (at the time of application), or any organisation or person with whom you intend to enter into an arrangement to undertake dental work (at the time the arrangement is made).
- The commissioning body in whose Dental Performers List you are included (within seven days), or seeking inclusion (at the time of application)

You must forward written evidence of your compliance with this condition to the GDC within seven days of notifying the relevant parties of your conditions.

14. You must permit the GDC to disclose the above conditions to any person requesting information about your registration status.

55. The period of this order is for 12 months, which will afford you the opportunity to develop your insight and provide evidence of remedial action in the areas of concern and how that has been embedded in your practise. The Committee directs that this order be reviewed before its expiry, and you will be informed of the date and time in writing. The reviewing Committee will consider what action it should take in relation to your registration following an assessment of the concerns affecting your fitness to practise.

56. The Committee now invites submissions as to whether an immediate order should be imposed to cover the 28-day appeal period.

Dental Professionals Hearings Service

Decision on Immediate Order (9 July 2026)

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

58. Mr Micklewright, on behalf of the GDC, submitted that such an order is necessary for the protection of the public and is otherwise in the public interest following the findings of the Committee that your fitness to practise is currently impaired on both of those grounds.

59. Mr Peacock opposes the application as there could be some delay in you appointing a workplace reporter, due to the practice owner being away on holiday. He invited the Committee to reject the GDC's application for an immediate order to be imposed on your registration.

60. The Committee has considered the submission made. It has accepted the advice of the Legal Adviser.

61. The Committee is satisfied that an immediate order of conditions is necessary for the protection of the public and is otherwise in the public interest. The Committee concluded that given the nature of its findings and its reasons for the substantive order of conditions in your case including the risk of repetition, it is necessary to direct that an immediate order of conditions be imposed on both of these grounds. The Committee considered that, given its findings, if an immediate order was not made in the circumstances, there would be a risk to public safety and public confidence in the profession would be undermined.

62. The effect of the foregoing determination and this order is that your registration will be subject to the aforementioned conditions immediately from the date on which notice is deemed to have been served upon you. Unless you exercise your right of appeal, the substantive direction for conditional registration as already announced, will take effect 28 days from the date of deemed service, and continue for a period of 12 months. In the event that you exercise your right of appeal, this immediate order will remain in place until resolution of the appeal.

63. That concludes this hearing.