PUBLIC HEARING
Professional Conduct Committee
Initial Hearing

2 – 10 December 2025

Name:	ROWLAND, Gary Charles
Registration number:	69518
Case number:	CAS-209266-Z6C1M9

General Dental Council:	Natalie Bird, Counsel Instructed by IHLPS
Registrant:	Present Represented by Matthew McDonagh, Counsel Instructed by Kennedys Law

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Fitness to practise:	Impaired by reason of misconduct
Outcome:	Conditions imposed (with a review)
Duration:	18 months
Immediate order:	Immediate conditions of practice order

Committee members:	Helen Wagner (Chair, Lay Member) Yasmin Lawton (Dental Care Professional Member) Sukindar Sandhar (Dentist Member)
Legal adviser:	Paul Moulder
Committee Secretary:	Jenny Hazell

The charge was as follows: That, being registered as a dentist, Gary Rowland's (69518) fitness to practise is impaired by reason of misconduct, in that:

1. You failed to provide an adequate standard of care to Patient A, in that; having noted a swelling medial to the upper left tuberosity during Patient A's appointment with you on 19 October 2015, at this and subsequent appointments with Patient A, you failed to:

    a. Take a periapical radiograph, on:
        i. 19 October 2015;
        ii. 29 March 2016;
        iii. 11 October 2016;
        iv. 23 May 2017;
        v. 28 November 2017;
        vi. 23 January 2018;
        vii. 25 January 2018;
        viii. 16 February 2018;
        ix. 11 July 2018; and
        x. 8 February 2019.

    b. Carry out TTP testing to the UL7 and UL6, on:
        i. 19 October 2015;
        ii. 29 March 2016;
        iii. 11 October 2016;
        iv. 23 May 2017;
        v. 28 November 2017;
        vi. 23 January 2018;
        vii. 25 January 2018;
        viii. 16 February 2018;
        ix. 11 July 2018; and
        x. 8 February 2019.

    c. Examine the size, shape, and consistency of the swelling, on:
        i. 19 October 2015;
        ii. 29 March 2016;
        iii. 11 October 2016;
        iv. 23 May 2017;
        v. 28 November 2017;
        vi. 23 January 2018;
        vii. 25 January 2018;
        viii. 16 February 2018;
        ix. 11 July 2018; and
        x. 8 February 2019.

    d. Record the size, shape, and consistency of the swelling, on 8 February 2019.

    e. Discuss with Patient A the possible causes of the swelling, on:

        i. 19 October 2015;
        ii. 29 March 2016;
        iii. 11 October 2016;
        iv. 23 May 2017;

v. 28 November 2017;
vi. 23 January 2018;
vii. 25 January 2018;
viii. 16 February 2018;
ix. 11 July 2018; and
x. 8 February 2019.

f. Discuss with Patient A the options for managing the swelling, such as reviewing the swelling or referring for further assessment, on:

i. 19 October 2015;
ii. 29 March 2016;
iii. 11 October 2016;
iv. 23 May 2017;
v. 28 November 2017;
vi. 23 January 2018;
vii. 25 January 2018;
viii. 16 February 2018;
ix. 11 July 2018; and
x. 8 February 2019.

g. Refer the swelling for further assessment, on:

i. 19 October 2015;
ii. 29 March 2016;
iii. 11 October 2016;
iv. 23 May 2017;
v. 28 November 2017;
vi. 23 January 2018;
vii. 25 January 2018;
viii. 16 February 2018;
ix. 11 July 2018; and
x. 8 February 2019.

2. At Patient A's appointment with you on 11 July 2018, you conducted an inadequate periodontal examination, in that:

a. A hygienist had found a pocket of 8mm at the UL7 at an appointment with Patient A on 28 March 2018; and
b. You nevertheless recorded a BPE Code 1 at the upper left sextant.

8 December 2025

Preliminary application to amend the charge

1. This is a hearing before the Professional Conduct Committee ('the PCC'). You are present at this hearing and are represented by Mr McDonagh, Counsel. Ms Bird, Counsel, appears on behalf of the General Dental Council (GDC).

2. At the outset Ms Bird made an application under Rule 18 of the GDC (Fitness to Practise) Rules 2006 ('the Rules') to withdraw a number of the charges set out in the notification of hearing. This was in light of the joint expert report in which Dr Pal (GDC expert) (signed on 3 November 2025) and Dr Caro (Defence expert) (signed on 4 November 2025) set out the extent of the agreement between them. The GDC invited the Committee to withdraw a number of charges where both experts were not critical of the matters alleged. These were as follows: 1(b)(vi) to 1(b)(viii), 1(b)(x), 1(c)(v) to 1(c)(viii), 1(c)(x), 1(e)(vi) to 1(e)(viii), 1(f)(vi) to 1(f)(viii) and 1(g)(vi) to 1(g)(viii).

3. Mr McDonagh raised no objection to the proposed withdrawal of those charges.

4. Rule 18 provides that: *"(*1) At any stage before making their findings of fact in accordance with rule 19, a Practice Committee may amend the charge set out in the notification of hearing unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice…"

5. The Committee took into account the submissions of both Counsel. It accepted the advice of the Legal Adviser.

6. The Committee was satisfied that the proposed withdrawal of those charges could be made without injustice in light of the joint expert opinions. It was further satisfied that the withdrawal of those charges would not result in under-prosecution of the GDC's case as there were outstanding charges to be determined and some admissions on your part. The Committee therefore acceded to the GDC's unopposed application.

Admissions

7. At the outset you made admissions to charges 1(a)(v) - 1(a)(x) and 1(g)(x). In accordance with Rule 17(4), the Committee determined and announced that those charges were proven in light of your admissions You also made a partial admission in relation to charge 1(d) insofar as you accept that you failed to record the consistency of the swelling on 8 February 2019 but you do not accept that you failed to record its size and shape. The Committee noted your partial admission in relation to that charge but did not announce it as found proved as the admission was not to the entire allegation.

Summary of the case

8. Ms Bird outlined the background to the GDC's case against you. This is a single patient complaint brought against you by Patient A regarding the course of treatment you provided to them from around 19 October 2015 until around 8 February 2019. During this time Patient A was being treated in respect of periodontal disease by different clinicians, including yourself, as well as for other treatments, including tooth restoration and root surface debridement.

9. On 19 October 2015 Patient A presented with a palatal swelling. You made a note in Patient A's clinical records of swelling medial to the upper left tuberosity.

10. The GDC's case is that at the appointment on 19 October 2015, and at subsequent appointments with Patient A you failed to take a periapical radiograph (charge 1(a)); you failed to carry out Tender To Percussion (TTP) testing to the UL7 and UL6 on various dates (charge 1(b); you failed to examine the size, shape and consistency of the swelling on various dates (charge 1(c)); you failed to examine the size, shape and consistency of the swelling on 8 February 2019 (charge 1(d)); you failed to discuss with Patient A the possible causes of the swelling on various dates (charge 1(e)); you failed to discuss with Patient A the options for managing the swelling on various dates (charge 1(f)) and you failed to refer the swelling for further assessments on various dates (charge 1(g).

11. In addition, the GDC alleges that at Patient A's appointment on 11 July 2018 you conducted an inadequate periodontal examination in relation to the BPE score (charge 2) in that you recorded a BPE score of 1 at the upper left sextant whereas a hygienist at an earlier appointment, dated 28 March 2018, had recorded a pocket depth of 7-8mm at the UL7.

12. On 23 September 2019 you referred Patient A to a subsequent treating dentist (STD) to review the swelling in the region of the upper left tuberosity.

13. On 15 October 2019, Patient A attended an appointment and was seen by the STD. An assessment was carried out and it was decided to refer Patient A for an opinion from a specialist at the maxillofacial surgery department in a hospital. In due course further tests were carried out on Patient A and the lesion was removed under general anaesthetic. It was confirmed that the histological analysis of the excised lesion had revealed the lesion to be a polymorphous adenocarcinoma, a salivary gland malignant cancer.

14. Patient A complained to the GDC in July 2023.

Your case

15. Your position is that at the appointment on 19 October 2015 you found and recorded the presence of a haematoma to the right of the midline of the palate. You also noted a small swelling in the upper left quadrant medial to the tuberosity. You considered that the swelling was likely to be associated with Patient A's longstanding periodontal condition. You described the swelling as small, with no clear margin and there were no concerning features present. You therefore deemed it was not necessary to conduct any further tests or investigations at that time but to keep the swelling "under review".

16. You also explained that you informed Patient A that the swelling would be kept under review. However, you deny that the swelling was present at the subsequent three appointments, namely 29 March 2016, 11 October 2016 and 23 May 2017. You made a note of the swelling at appointments on 28 November 2017, 23 January 2018, 16 February 2018, 11 July 2018 and 8 February 2019. You accepted that you should have taken a periapical radiograph from 28 November 2017 onwards. You also accepted that you should have considered a referral for further investigation or assessment of the swelling on 8 February 2019.

Evidence

17. The factual evidence provided by the GDC to the Committee comprised the patient records and radiographs as well as Patient A's record from the STD as well as Patient A's witness statement dated 10 April 2025 and associated exhibits. In addition, the Committee received oral evidence from Patient A. He confirmed the content of his witness statement.

18. The Committee also received expert evidence from Dr Pal. He produced a report dated 2 June 2025. In addition, Dr Pal provided an addendum report dated 27 November 2025 in which he set out his clarification in relation to agreeing to the wording "as reflected by the records" (referred to in the Joint Expert Report) which (from Dr Pal's perspective) refers to the fact that the clinical records for the specific dates set out in the sub charges do not state explicitly state that "no swelling was present."

19. In respect of your case, the Committee was provided with a copy of your witness statement dated 15 October 2025. In that statement you set out some of the professional and personal difficulties that you were going through at the time in question. You also gave evidence to the Committee.

20. The Committee considered the expert evidence of Dr Caro. She produced a report dated 26 September 2025. She also gave oral evidence in which she confirmed the opinions set out in her report.

21. The Committee has also had regard to the joint expert report of Dr Pal and Dr Caro dated 3/4 November 2025. During the course of the experts' evidence, reference was made to the Faculty of General Dental Practice (FGDP) Clinical Examination & Record Keeping guidance 2009 version as well as the FGDP Clinical Examination & Record Keeping guidance 2016 version.

Findings of Fact

22. The Committee considered all the evidence presented to it, both documentary and oral. It took account of the closing submissions on the alleged facts made by both parties. The Committee accepted the advice of the Legal Adviser.

23. The Committee considered the factual allegations separately, bearing in mind that the burden of proof rests with the GDC and that the standard of proof is the civil standard, that is, whether the alleged matters are proved on the balance of probabilities.

24. The Committee has considered firstly whether, on the balance of probabilities, the swelling in Patient A's upper left tuberosity was present at the appointment on 19 October 2015 and remained there throughout the course of treatment or whether the swelling was not present after 19 October 2015 but returned on 28 November 2017. It sets out its reasons on this decision in charge 1ai.

25. The Committee made the following findings:

1	*You failed to provide an adequate standard of care to Patient A in that; having noted a swelling medial to the upper left tuberosity during Patient A's appointment with you on 19 October 2015, at this and subsequent appointments with Patient A, you failed to:*
1a	*Take a periapical radiograph, on:*
1ai	*19 October 2015* ***Found proved*** In support of this charge the GDC relies on the evidence of Patient A and that of Dr Pal. Patient A's evidence, as set out in his witness statement, is that at this appointment you told him that there was some swelling in the upper left palate. He recollected that during that appointment you placed a gloved finger on the swelling and you told Patient A that you would keep an eye on it.

In his oral evidence Patient A accepted that he could not remember the specific details for each appointment. However, Patient A was adamant throughout his oral evidence that there was a swelling in his mouth from 2015 onwards which continued to grow. He described how his tongue had been touching that area on a daily basis.

Patient A also recollected that you placed a gloved finger on the swelling at the appointment on 29 March 2016. Patient A's evidence was that he also recollected discussing with his wife about the lump in his mouth following his appointment on 29 March 2016 and that they decided that if you were not "bothered about the swelling and he [you] is a professional dentist, then why should we be bothered about it?"

Your evidence is that during the course of the examination of Patient A you found and recorded the presence of a hematoma to the right of the midline of the palate. You also noted a small swelling in the upper left quadrant medial to the tuberosity. You considered that the swelling was likely to be associated with Patient A's longstanding periodontal condition. You described the swelling as small, with no clear margin and there were no concerning features present. You therefore deemed that it was not necessary to conduct any further tests or investigations at that time but to keep the swelling "under review".

Dr Pal accepted that bone loss had been present around Patient A's UL7. However, he noted that the BPE score record for the examination records a 2 in the upper left sextant, meaning there was no periodontal pocketing over 3.5mm. He also noted that the records do not indicate any sign of periodontal problems in the upper left sextant.

In Dr Pal's opinion, the swelling found on 19 October 2025 was unlikely to have been due to a periodontal condition. He opined that a reasonably competent general dental practitioner (GDP) would have investigated the area with a periapical radiograph and other tests. He noted that the features of the swelling were not recorded. In short Dr Pal considered that given the presence of the swelling and the fact that no recent radiographs had been that showed the bone levels, he considered there was an onus on you to take a periapical radiograph to assess any changes in bone levels which may affect the prognosis.

Dr Caro was of the opinion that having assessed the tooth as being vital and having continuously treated Patient A for periodontal disease in this area since 2008, then if you made the clinical diagnosis of swelling due to the ongoing periodontal issues, she would not be critical if a PA was not taken on this date if the result of that PA was not going to alter the management or add confidence to your diagnosis and treatment planning. However in oral evidence Dr Caro conceded that she would have taken a PA herself because she practices defensively.

The Committee has had regard to Patient A's history of periodontal disease as well as the fact that no PA radiograph had been taken since 2008. Further there is no recorded TTP test and no recorded tooth vitality for that particular area. In these circumstances, the Committee agrees with Dr Pal's opinion that it was unreasonable to have assumed that the swelling in the upper left sextant could only be associated with an underlying periodontal condition without having carried out a PA radiograph. Dr Caro conceded that she would have taken a PA radiograph at this appointment.

The Committee considers that you should have taken a PA on 19 October 2015 and accordingly finds this charge proved.

	<u>Whether the swelling was present the upper left sextant at subsequent appointments after 19 October 2015</u> Patient A accepted that he could not remember the specific details for each appointment. However, Patient A was consistent throughout his oral evidence in his recollection that there was a swelling in his mouth from 2015 which did not go away. He refuted the suggestion that the swelling decreased in size and said that it continued to grow. Patient A described how he thought it had initially come about through eating some crusty bread. The Committee found Patient A's evidence to be credible on this point. It considered that it was more likely than not that Patient A would be able to remember things happening inside his mouth such as the persistent nature of the swelling in his mouth. The Committee has borne in mind that there is no record in Patient A's notes of the swelling in the upper left quadrant for the appointments on 29 March 2016, 11 October 2016 and 23 May 2017. Your evidence was that you would have expected both the soft tissue examination and Identafi examination to have revealed any swelling if present and that if such a swelling was present, you would have recorded it in the notes for each of these appointments. You made the Committee aware that at the appointment on 19 October 2015 you had concluded that the swelling was periodontal in nature and had not considered another reason for it. The Committee has had regard to your clinical note referring Patient A to a STD in which you asked the STD to look at "this persistent lump" in the region of the UL Tuberosity. You further state "Distal pocket in the UL7, swelling/lump has been present for a few years and has remained unchanged." Although you suggested in your oral evidence that these were Patient A's words, the Committee concluded that you would have been unlikely to note something that you thought was incorrect without commenting further. The Committee has also had regard to the STD dated 15 October 2019 which states: "Lump present left palate. On going – Patient stated that it has persistently been there for 3 years…" . The Committee considers that the entry, one from you, written at the time when you were treating Patient A, and the other entry from the STD, support Patient A's account that the swelling persisted in the upper left sextant. Accordingly, the Committee is satisfied, on the balance of probabilities, that the swelling was present at the appointments of 29 March 2016, 11 October 2016 , 23 May 2017 and 11 July 2018.
1aii	*29 March 2016* ***Found proved*** You did not take a PA radiograph at this appointment and there is no record of the swelling in the notes. Both experts agree that if the Committee were to find that there was a swelling still present at this appointment, as reflected in Patient A's evidence, then they would be critical of your failure to take a PA radiograph. The Committee has accepted Patient A's oral evidence that the swelling was present at this appointment, together with the referral record confirming its presence for some years. Accordingly, it finds this charge proved.
1aiii	*11 October 2016* ***Found proved*** You did not take a PA radiograph at this appointment and there is no record of the swelling in the notes. Both experts agree that if the Committee were to find that there was a swelling still present at this appointment, as reflected in Patient A's evidence, then they would critical of your failure to take a PA radiograph. The Committee has

	accepted Patient A's oral evidence that the swelling was present at this appointment. Accordingly, it finds this charge proved.
1aiv	*23 May 2017* ***Found proved*** You did not take a PA radiograph at this appointment and there is no record of the swelling in the notes. Both experts agree that if the Committee were to find that there was a swelling still present at this appointment, as reflected in Patient A's evidence, then they would critical of your failure to take a PA radiograph. The Committee has accepted Patient A's oral evidence that the swelling was present at this appointment. Accordingly, it finds this charge proved.
1b	*Carry out TTP testing to the UL7 and UL6 on*
1bi	*19 October 2015* ***Found proved*** Dr Pal considered that the TTP test should have been carried out on this date. This was because there was a possibility that the swelling was related to an infection and TTP testing would assist in localising the source. Dr Pal noted there was some ambiguity in the notes as to whether vitality was undertaken for the LR6 alone, or of the LR6 and UL7. However, Dr Pal opined that even if it is accepted that vitality testing was undertaken of UL7 and was found to be positive, TTP should still have been carried out since this was a multi-rooted tooth and could still have had pulpal necrosis even with a positive vitality test. Dr Caro's evidence was that having tested for vitality (positive) and in the absence of a patient complaint of pain, there would be a range of opinion as to whether this test was necessary at this point in time. Dr Caro, in response to a question put to her by Ms Bird, agreed that a reasonably competent dentist would have been expected to record the outcome of a TTP test. Both experts agreed that the TTP test, although not mandated, was a very quick and easy test that should have been carried out. You maintain that you carried out the TTP test but you did not record it. The Committee has noted that elsewhere you have recorded when you have carried out the TTP test. It also noted for this appointment you recorded having carried out a vitality test in the lower right quadrant. The Committee acknowledges that the absence of a record does not mean that you did not carry out the TTP test. However, on this occasion, the Committee has concluded, on the balance of probabilities, that it is more likely than not that you did not carry out the TTP test because you had recorded tests on other areas at that appointment but not the UL6 and UL7.
1bii	*29 March 2016* ***Found proved*** Both agreed that if the swelling was present at this appointment, then the TTP test should have been performed. Given the Committee's conclusion that the swelling was present at this appointment, the Committee agrees with the experts that the TTP test should have been done to the UL7 and the UL6. The Committee has concluded, on the balance of probabilities, that you did not carry out the TTP test for similar reasons to those set out at 1bi.
1biii	*11 October 2016* ***Found proved*** For similar reasons as set out at 1bii above, the Committee found this charge proved.

1biv	23 May 2017 ***Found proved*** For similar reasons as set out at 1bii above, the Committee found this charge proved.
1bv	28 November 2017 ***Found proved*** There is a record in the notes for the diagnosis as follows "… chronic periodontitis, restored. Resolving periodontitis, restored, resolving periodontitis swelling in ULQ… " In the clinical notes it is recorded "UL swollen area on the L of the midline adj to the tuberosity, margins normal..." Both experts agreed that a TTP test should have been carried out on teeth in this quadrant. This would have assisted in reaching a differential diagnosis of the swelling. The Committee has borne in mind your position that if there was a swelling present at this point in time you would have carried out a TTP test in line with your usual practice. The Committee has concluded, on balance of probabilities, that you did not carry out a TTP test at this appointment, given that elsewhere in the notes for other appointments, you have made a record of a TTP test being carried out (such as on 8 February 2019).
1bix	*11 July 2018* ***Found proved*** You carried out a routine examination of Patient A. No abnormalities were noted. On this date you recorded you "reinforced aetiology perio and management. Congratulated good OH and encouraged maintenance". The Committee has concluded, on the balance of probabilities, that the swelling was present at this appointment for similar reasons set out in charge 1ai. The Committee has concluded that you did not carry out a TTP test and that you should have done so.
1c	*Examine the size, shape, and consistency of the swelling, on:*
1ci	*19 October 2015* ***Found not proved*** Both experts agreed that there is evidence in the records that an examination of the swelling was carried out and therefore they were not critical since it is likely that as you had examined the swelling you would have examined its size, shape and consistency, even if not recorded. The Committee has had regard to the clinical notes for that appointment in which it is clear that you have described the swelling as being "small" and you have described its location. The Committee considers that it is likely that you would have examined the swelling given that you have provided a description of it. The Committee agrees with the joint experts' opinion and accordingly finds this charge not proved.
1cii	*29 March 2016* ***Found proved*** The experts agreed that if the Committee were to find that swelling was present, then they would be critical of your failure to carry out an examination of the size, shape and consistency of the swelling.

	The Committee has had regard to paragraph 4.4.1 of the FGDP guidelines (the 2009 version) which under the heading "Soft tissue examination" states: "A thorough and methodical examination of the soft tissues of the mouth should be carried out at each course of treatment... Any pathological lesions should be recorded, and a note should be made of their size, site, shape, colour and texture." There is no record of you having carried out an examination of the swelling. In your witness statement, and confirmed in your oral evidence, you deny that the swelling was present at this appointment. You also maintain that if any swelling was present, you would have made a record of it. The Committee has already concluded, on the balance of probabilities, that the swelling in the upper left quadrant of Patient A's mouth was present at this appointment. There is nothing to suggest that you specifically carried out an examination of the size, shape and consistency of the swelling and/or applied any pressure to the swelling. The Committee has borne in mind Patient A's evidence that you ran your gloved hand around the area concerned at each appointment. However, given the absence of any record of any swelling in the notes for this appointment as well as your contention that there was no swelling at this appointment, the Committee has concluded that you failed to examine the size, shape and consistency of the swelling at this appointment.
1ciii	*11 October 2016* ***Found proved*** This is for the same reasons as set out at 1cii above, but in relation to paragraph 4.4.1 of the 2016 version of the FGDP guidelines.
1civ	*23 May 2017* ***Found proved*** This is for the same reasons as set out at 1cii above, but in relation to paragraph 4.4.1 of the 2016 version of the FGDP guidelines.
1cix	*11 July 2018* ***Found proved*** This is for the same reasons as set out at 1cii above. In addition, the Committee has borne in mind the evidence that at the previous three appointments (between 28 November 2017 and 16 February 2018) there is evidence in the records of an examination of the swelling. The Committee considers that it was even more important that you examined and recorded the swelling as per paragraph 4.4.1 of the FGDP guidelines (the 2016 version).
1d	*Record the size, shape and consistency of the swelling, on 8 February 2019* ***Found proved*** You recorded in the notes "Palate – normal with the exception of the L tuberosity which has enlarged so ther is asymmetry, UL7 and UL6 are not TTP, and respond to EC/endofrost normally". You accepted this charge in so far as not recording the consistency of the swelling but you deny the other elements on the basis that providing a more accurate description of the swelling "would have been difficult" due to the amorphous shape and the diffuse nature of the margins. Your evidence was that you still presumed the swelling to be

	periodontal in origin. You explained that the tissue was normal in appearance with no concerning features. Dr Pal's evidence was that if the swelling was greater than 3mm in size and not from a periodontal infection that you should have reviewed the patient in 3 weeks or referred the patient. His opinion is that the size and shape of the swelling should have been recorded. He opined that notwithstanding any apparent lack of margins, it was an elementary skillset for a dentist to be able to make an estimation of the size and shape of the intra-oral swelling. Dr Pal also explained that a failure to record theses features could hinder future monitoring of the lesion and have patient safety implications. Dr Pal confirmed this position in his oral evidence. He explained that the gradations along the BPE probe could have been used to provide an estimate, noting that in your oral evidence you said that you were screening patients using the BPE probe during an examination. Dr Caro was of the opinion that as a statement of fact the size and shape of the swelling have not been recorded beyond stating that the tuberosity has enlarged so there was asymmetry. She acknowledged that due to the lack of the margins, further measurements at that point may have been difficult. The Committee considers that your recording of the shape of the swelling as being enlarged and asymmetrical was insufficient and would provide little assistance to any referring clinician or be of use for comparative purposes. The Committee prefers Dr Pal's evidence on this matter. It considers that given the presence of the swelling at that appointment, it would have been important to have attempted to record in more detail its size and shape, even if the measurement may have been imprecise. This information would have been useful to any referring clinician. In this regard, the Committee has had regard to paragraph 4.4.1 of the FGDP guidance 2016 which states that "Any abnormal or suspicious lesions should be recorded, and a note be made of their size, shape, colour and texture." Accordingly, the Committee finds this charge proved.
1e	*Discuss with Patient A the possible causes of the swelling on:*
1ei	*19 October 2015* ***Found not proved*** Patient A's evidence was that at the first appointment he was aware that you noted in Patient A's medical records that there was some swelling in the upper left palate. He also recollected that you placed a finger on the swelling and said that you would "keep an eye on it". Patient A's recollection was that you did not discuss any treatment regarding the swelling. Patient A also recollected that you gave him a friendly lecture about his periodontal condition. In his oral evidence Patient A refuted the suggestion that you had a discussion with him about the swelling or that he was returning for frequent appointments with you in 2017/2018 due to you wanting to review the swelling. However, Patient A accepted that he could not remember all the details of each of the appointments. In your witness statement you say that whilst you have no direct recollection of the discussion that took place with Patient A you would not disagree with Patient A's evidence that you would have used words to the effect that you would "keep an eye on it." You also explained that in the absence of any concerning features and against a

	background of a chronic periodontal condition, with ongoing treatment, you were content to keep the swelling under review. The Committee has concluded that it is more likely than not that you had a discussion with Patient A as to a possible cause of the swelling - namely your view that it was attributable to Patient A's periodontal condition. That assertion is supported by what you recorded in Patient A's notes. The Committee recognises that you may not have come to the correct diagnosis at that time. However it was not satisfied that this amounted to having no discussion with Patient A about the possible causes of the swelling. On the balance of probabilities, the Committee is not satisfied that this charge is proved to the requisite standard.
1eii	*29 March 2016* ***Found proved*** You maintain that there was no swelling on this date and therefore the Committee concluded that you did not discuss the possible causes at that appointment. However, the Committee has concluded, on the balance of probabilities, that there was swelling present in the upper left quadrant at this date. Both experts indicated that they would be critical of your failure to discuss the possible causes of the swelling. In light of the experts' opinion, the Committee has found this charge proved.
1eiii	*11 October 2016* ***Found proved*** This is for the same reasons as set out at charge 1eii above.
1eiv	*23 May 2017* ***Found proved*** This is for the same reasons as set out at charge 1eii above.
1ev	*28 November 2017* ***Found not proved*** Patient A's evidence was that you did not comment on the swelling at this appointment. However, the experts agree that there is evidence in the records that there was a discussion relating to a further appointment for the review of the swelling. They also noted that it is usual for the patient to be informed why a review was required. Given that Patient A returned for the appointment on 23 January 2018, when you reviewed the swelling, the Committee considers that it is likely that some discussion regarding the swelling took place at the appointment on 28 November 2017 or Patient A would not have agreed to return for another appointment so soon for treatment. The Committee accepts that you may not have discussed with Patient A the possibility that it was anything more serious, but it is satisfied, on the balance of probabilities, that there was some discussion with Patient A regarding the possible causes of the swelling. Accordingly, the Committee finds this charge not proved.
1eix	*11 July 2018* ***Found proved*** There is no record of the swelling being present in the records. The Committee has, on the balance of probabilities, concluded that there was swelling at this appointment for the reasons set out at charge 1ai above.

	Dr Pal's evidence was that if a swelling was found to be present then not discussing possible causes was far below the standard expected The Committee accepts Dr Pal's evidence. Accordingly, it finds this charge proved.
1ex	*8 February 2019* ***Found not proved*** Patient A's recollection was that he attended the Practice for a further oral screening appointment. He described having a light shone in his mouth. However, he had no recollection of you telling him about the swelling or any other tests during this appointment. You recorded that the swelling on the left-hand size of the palate had enlarged and had become asymmetrical. You also took BW radiographs which revealed that Patient A had bone loss. You accepted that you do not recall the precise discussions with Patient A at this appointment but explained that your usual practice would have been to have a discussion about the probable cause of the swelling. Your evidence was that you assumed it to be periodontal in origin. Your evidence was that there was a discussion about the swelling which is consistent with the entries in your clinical notes. In light of your clinical records for Patient A for this appointment, the Committee has concluded that it is more likely than not that there was some discussion with Patient A regarding the possible causes of the swelling. Accordingly, it finds this charge not proved.
1f	*Discuss with Patient A the options for managing the swelling, such as reviewing the swelling or referring for further assessment, on:*
1fi	*19 October 2015* ***Found not proved*** The Committee has borne in mind that this was the first time you recorded the small swelling in the upper left quadrant. You explained that you considered that the swelling was likely to be associated with Patient A's longstanding periodontal condition. You described the swelling as small with no other concerning features present. It is accepted by Patient A and yourself that you informed Patient A that you would keep the swelling under review. The experts agree that no referral would need to be made at this point if you were confident that the swelling was of periodontal origin. The Committee has noted that you referred Patient A to the dental hygienist for treatment of his periodontal condition. Dr Pal qualified his opinion by stating that if the swelling was greater than 3mm then you should have referred Patient A for further assessment. However, no evidence was adduced by the GDC to demonstrate that the swelling was 3mm at this appointment. In light of the experts opinion, the Committee finds this charge not proved.
1fii	*29 March 2016* ***Found proved*** Patient A maintained that there had been no discussions about managing the swelling.

	You deny that any clinically evident swelling was present on this date. The Committee therefore concluded that there were no discussions with Patient A regarding the management of the swelling. The Committee has, on the balance of probabilities, concluded that the swelling was present at this appointment. Both experts considered that if the Committee were to find that there was swelling present, they would be critical of you not discussing options with Patient A regarding its management. In light of the experts opinion, the Committee finds this charge proved.
1fiii	*11 October 2016* ***Found proved*** This is for the same reasons as set out at charge 1fii above.
1fiv	*23 May 2017* ***Found proved*** This is for the same reasons as set out at Charge 1fii above.
1fv	*28 November 2017* ***Found not proved*** Patient A's evidence was that you did not comment on the swelling at this appointment You carried out a routine examination and noted the presence of a small swelling in the upper left quadrant. The Committee has concluded that the swelling was present and that there was some discussion with Patient A regarding the management of the swelling. Your evidence is that you informed Patient A of the presence of the swelling and that he should return to have the swelling reviewed. You accepted that you could not recall the precise discussion you had with Patient A, but you believed that it would have been along the lines that the swelling was likely to be periodontal in nature. Your plan was to review Patient A to see if the swelling had resolved or changed. The Committee noted that an appointment was arranged for 23 January 2018, which Patient A attended. The Committee accepts that you may not have discussed with Patient A other possible more serious causes of the swelling. However, it is satisfied, on the balance of probabilities, that there was some discussion with Patient A regarding the options for managing the swelling. Notwithstanding Patient A's evidence that you did not comment on the swelling at the appointment, the Committee has inferred that it is likely that you had had a discussion with Patient A regarding the management of the swelling given that Patient A attended for an appointment some two months later (January 2018). Accordingly, the Committee finds this charge not proved.
1fix	*11 July 2018* ***Found proved*** You accepted that there is no record of the swelling in the notes. Your position is that you believed that the swelling had been resolved following root surface debridement. Dr Pal's opinion was that if the swelling was found to be present, then he was critical of you not considering the options of treatment. Dr Caro opined that if there was no factual evidence from either you or Patient A relating to the swelling in this date, then it may be assumed that one was not present. However, the Committee has accepted Patient A's oral evidence that the swelling was present at each appointment and that he said that it continued to grow.

	The Committee prefers Dr Pal's evidence on this matter and accordingly finds this charge proved.
1fx	*8 February 2019* ***Found proved*** You noted that the swelling had enlarged and became asymmetrical. A plan was made to recall Patient A in six months' time. You accepted that on this date, you should have referred Patient A for further investigation/assessment and that you did not do so. Although the Committee had accepted there was some discussion regarding the management of the swelling, in view of the need for referral, it found that the discussion was inadequate. Both experts agreed that if the swelling was found to be present, then not discussing the options with Patient A for managing the swelling, such as reviewing the swelling, or referring for further assessment, then they would be critical. The Committee has also had regard to paragraph 4.4.1 of the 2016 edition of the FGDP's guidance. The Committee agrees with the experts and accordingly finds this charge proved.
1g	*Refer the swelling for further assessment on:*
1gi	*19 October 2015* ***Found not proved*** The Committee notes that this was the first time when you noticed and recorded the swelling. The experts agree that no referral would have been made at this point if you were confident that the swelling was of periodontal origin. The Committee has noted that you have referred Patient A to the dental hygienist for treatment if his periodontal condition. The Committee accepts the evidence of the experts and accordingly finds this charge not proved.
1gii	*29 March 2016* ***Found proved*** The Committee has concluded, on the balance of probabilities, that the swelling was present on this date. The experts opined that if the Committee were to find that swelling was present, then they would have been critical of your failure to refer for further assessment. The Committee accepts the evidence of the experts and finds that you did not refer the swelling for further assessment on this date. Accordingly the Committee finds this charge proved.
1giii	*11 October 2016* ***Found proved*** The Committee has concluded, on the balance of probabilities, that the swelling was more likely than not to have been present on this date. In these circumstances, for similar reasons set out at 1gii, the Committee finds this charge proved.
1giv	*23 May 2017* ***Found proved*** This is for the same reasons as set out at charge 1gii above.
1gv	*28 November 2017* ***Found proved***

	The experts agree that if there had been no swelling in 2016 or 2017 in the upper left area, as it was being monitored and further appointments were planned there would be no need to refer. However, Dr Pal opined that if it was found that a swelling was present from 29 March 2016 to 28 November 2017, he would be critical. The Committee has concluded, on the balance of probabilities, that the swelling was present during these dates. Accordingly, it accepts Dr Pal's evidence. It therefore finds that a referral should have been made on that date.
1gix	*11 July 2018* ***Found proved*** Dr Pal's evidence was that if a swelling was found to be present at this appointment then he would be critical of you not referring Patient A. The Committee has concluded, on the balance of probabilities, that the swelling was present at this appointment. Accordingly, the Committee finds this charge proved on the basis that the swelling should have been referred for further assessment.
2	*At Patient A's appointment with you on 11 July 2018, you conducted an inadequate periodontal examination in that:*
2a	*A hygienist had found a pocket of 8mm at the UL7 at an appointment with Patient A on 28 March 2018* ***Found not proved*** In support of charge 2 the GDC relies on the dental hygienist's note dated 28 March 2018. They have recorded a pocket depth of 7-8mm palatally at the UL7. They have also recorded no bleeding on probing. The statement is then qualified by the record of "… has settled since saw GR[you]." Dr Pal accepted that errors can be made in the recording of the scores of BPEs. However, in his view, your recording of a BPE score of 1 on 11 July 2018, which would indicate a pocket depth of 3.5 mm or less was inaccurate Dr Caro explained that a pocket depth of 7-8 mm would equate to a BPE score of 4 in the upper left sextant and a probing depth of 5.5mm. However, Dr Caro opined that it would be unusual to have a pocket depth of 7-8mm and no bleeding on probing. Dr Caro observed that there was a large difference between the two scores taken four months apart. Her position is that she was not able to state that one clinicians score was incorrect purely based on another score. It was raised in evidence that the hygienist's scores may have been wrong because the information from two appointments looked identical, which may suggest that the information had been cut and pasted. However, it was not possible for the Committee to ascertain the accuracy or otherwise of the assessment carried out by the dental hygienist on 28 March 2018 since they were not called to give evidence. The Committee accepts that as a matter of fact the scores are recorded in the evidence as set out in charges 2a and 2b. However, it is not satisfied that the evidence in support of this charge is sufficiently reliable to amount to a culpable failure on your part. It accepts the evidence of Dr Caro and accordingly finds this charge not proved.
2b	*You nevertheless recorded a BPE Code 1 at the Upper left sextant* ***Found not proved*** This is for the same reasons as set out at charge 2a above.

26. The hearing moves to Stage Two.

Proceedings at stage two – 10 December 2025

27. The Committee received further documentary information from both parties in relation to Stage 2. This included a bundle of documents provided on behalf of the GDC which contains a copy of your observations dated 30 May 2023 to the GDC's allegations dated 18 October 2022, as well as the Case Examiner (CEs) Decision Sheet dated 5 September 2023. The allegations related to a failure to provide an adequate standard of care in respect of five different patients, covering the period from around October 2014 until around February 2020. The CEs concluded that there was no prospect of misconduct or deficient professional performance being found. However, taking into account the expert view of the clinical adviser, the CEs decided to issue advice to you as follows "The Registrant is advised to ensure that he undertakes further continuing high-quality study and training, to assure himself that the concerns raised by the clinical adviser, and highlighted in the GDC allegations, are fully addressed."

28. The Defence bundle provided on your behalf included a copy of your 14 page statement signed and dated 9 December 2025 (which had been prepared following the conclusion of stage 1 of the factual enquiry). In that statement you set out the background to the sale of your dental practice in 2015 and consequent events, as well as matters relating to your health. You also set out your apologies to Patient A for the fact that the swelling was not detected in some of your examinations. You also set out throughout the GDC's investigation and during your preparation for the fitness to practise hearing how you have reflected on the seriousness of the matters relating to Patient A.

29. The Defence bundle also contained copies of Certificates of Continuing Professional Development (CPD) covering the period 2022 until 2025, including courses relating to the field of oral cancer. The Committee also received written testimonials from professional colleagues and patients in the knowledge of the charges against you. Two of the colleagues, Dentist 1 and Dentist 2, gave oral evidence at this stage of the proceedings.

30. Furthermore, the Committee was furnished with a copy of your Personal Development Plan (PDP) as well as copies of your record keeping audits, covering 20 patients' records from November 2020 to January 2021 and from February 2023 to March 2023. The Committee understands that the audits were compiled to identify issues relating to radiographic practice; diagnosing caries and risk assessment; quality of record keeping; treatment options including risks and benefits; consent and appropriate referral.

31. In accordance with Rule 20, the Committee heard submissions from Ms Bird on behalf of the GDC and those made by Mr McDonagh on your behalf.

32. Ms Bird referred to the GDC's CEs Decision sheet dated 5 September 2023, albeit there were no findings against you. She submitted that the alleged concerns were similar in nature to those present in the case of your treatment of Patient A.

33. Ms Bird submitted that the facts found proved are serious and fell short of what would be judged to be proper in the circumstances and amount to misconduct. She cited a number of the GDC's "Standards For the Dental Team" which she said you breached.

34. In respect of current impairment, Ms Bird submitted that the concerns in this case are clinical in nature. The GDC's position is that whilst the clinical concerns are remediable, there was a question as to whether the remediation is sufficiently embedded into your practice in light of your denial of some of the charges. There therefore remains a risk of repetition of the matters found proved.

35. Ms Bird submitted that you currently pose a risk to the public and therefore invited the Committee to reach a finding of current impairment for the protection of the public She also submitted that the findings against you, which included your failure to refer Patient A for further investigation of the swelling between 2015 and February 2019, are sufficiently serious to warrant a finding of current impairment on the grounds of the public interest. During the course of her submissions Ms Bird referred the Committee to paragraphs 31 to 33 (under the heading 'Failure to provide an acceptable level of treatment of care) of the GDC's Guidance for the Practice Committees including Indicative Sanctions Guidance (revised December 2020) ('the Guidance') which she said are relevant in this case. She submitted that the extent to which your delay in referring Patient A for further investigation increased the risk of harm remained unknown but raised it as a possibility.

36. In terms of sanction, Ms Bird invited the Committee to conclude this case with an order of conditions for a period of between 12 to 24 months, with a review to take place before the expiry of the order. She submitted that the issues identified in this case can be addressed by way of conditions and would serve to monitor your clinical practice during the time when you were subject to the order. Ms Bird referred the Committee to some of the factors which are present in this case, as set out under the heading of conditions in paragraphs 6.10 onwards of the GDC's Guidance. Ms Bird also invited the Committee to consider the draft set of conditions proposed by the GDC.

37. Mr McDonagh referred the Committee to the supportive testimonials submitted on your behalf, including the two dentists who gave evidence in support of you. These describe you as a highly respected, motivated and forward thinking dentist. Both of the dentists who gave evidence described the stressful circumstances surrounding the sale of your former practice in 2015 and how this impacted on you.

38. Regarding your treatment of Patient A, it was Mr McDonagh's submission that you made a mistake in relying on your diagnosis that the cause of the swelling was due to periodontal disease, which you thought had got better over the time you treated Patient A. However, you acknowledge the seriousness of the charges as well as that there were elements of your practice which fell below the standards that are to be expected. Mr McDonagh conceded on your behalf that the findings made by the Committee against you amount to misconduct.

39. Turning to the issue of whether your fitness to practise is impaired, Mr McDonagh invited the Committee to have regard to the evidence of your remediation, including the CPD you have completed in areas relevant to the matters in this case, as well as your reflections and expressions of remorse. He submitted that you are more acutely aware of the need to consider a differential diagnosis, where appropriate, and when you need to refer a patient for further investigation. This was not a dentist, Mr McDonagh submitted, who is shy of treating a patient but rather you were blinded to the problem regarding the swelling in Patient A's upper left area. Further, you did eventually refer Patient A's swelling for further assessment on 23 September 2019.

40. Mr McDonagh submitted that you have shown insight into the matters that have brought you before your regulator, that there have been no adverse findings against you before or since the events in question and that you are a man of good character. The Committee has been informed that you are currently employed as an Associate Dentist at another dental practice where you carry out general dentistry, but you also accept referrals for endodontic and restorative work at other practices.

41. Further, Mr McDonagh submitted that you have demonstrated that you understand the seriousness of your actions and have reflected on how you would behave differently in the future., It was Mr McDonagh's submission that the likelihood of repetition was very low and that the events concerning Patient A were isolated in nature, albeit they took place over a number of years. In short, Mr McDonagh submitted that a finding of current impairment on the grounds of the protection of

public or on the grounds of the public interest is not necessary given your full insight, your reflections, the remediation you have undertaken and the absence of any repetition of the events in question.

42. In terms of sanction, Mr McDonagh invited the Committee to consider that the mitigating factors outlined in paragraph 5.17 of the GDC's guidance were engaged in this case. This was not a situation where you were deliberately choosing not to treat Patient A but where there was a history of periodontal disease and where you had this at the forefront of your mind when treating Patient A. He also referred to the difficult situation that had arisen when you were selling your dental practice as well as the health concerns that you were going through. In short, Mr McDonagh submitted that were the Committee to conclude that your fitness to practise is impaired, then it would be sufficient and appropriate to conclude the case with a reprimand. He made the point that the list of factors set out at paragraph 6.9 of the GDC's guidance was applicable in this case.

43. Mr McDonagh submitted that the GDC's proposed set of conditions would not be appropriate given that your current working arrangements involves you working two days a week as a general dentist and the other three days where you go into different dental practices and receive referrals from other practitioners for restorative treatment. Mr McDonagh also submitted that there could be difficulties with the practical interpretation of the word 'swelling', as set out in the wording of various conditions proposed by the GDC. Finally, Mr McDonaugh submitted that an order of suspension would be disproportionate given that there are no real ongoing patient concerns, and would also have a detrimental financial impact on you.

44. The Committee has considered the submissions carefully. It has accepted the advice of the Legal Adviser.

Misconduct

45. The Committee first considered whether the facts found proved amount to misconduct. In so doing, it has had regard to the opinions of Dr Pal and Dr Caro, as set out in their joint report dated 4 November 2025. It has borne in mind that the experts considered that were the Committee to find that there was swelling present at the various appointments, then the various failures set out in the charges would fall far below the standards expected of a reasonably competent general dental practitioner. As already announced in its findings of fact, the Committee has concluded that the swelling was present at all the appointments from 19 October 2015 onwards.

46. In respect of your failure to take a periapical radiograph (PA) on 10 separate appointments from 19 October 2015 until 8 February 2019, the experts agree that a failure to take a PA would fall far below the standards expected of a reasonably competent general dental practitioner. It has also borne in mind that in the clinical notes Patient A had a recorded history of smoking well before 2015. The Committee agrees with the experts.

47. Turning to your failure to carry out the TTP testing to the UL7 and UL6 at five appointments between 19 October 2015 and 28 November 2017 and on 11 July 2018, Dr Pal opined that if the swelling was present at each of these appointments then the TTP testing should have been carried out and that your failure to do so fell far below the standards expected of a reasonably competent general dental practitioner. The Committee agrees with Dr Pal.

48. Both experts agree that if the swelling was present, then your failure to examine its size, shape and consistency would fall far below the standards expected of a reasonably competent general dental practitioner. The Committee agrees with the experts.

49. In respect of your failure to record the size, shape and consistency of the swelling on 8 February 2017, notwithstanding the difficulties you say you were experiencing in trying to access the

swelling, the Committee considers that you should have attempted to measure its size and shape. It agrees with Dr Pal that this was an elementary skillset for a general dental practitioner to be able to make an estimate of the size and shape of an intra oral lesion and that your failure to do so could have hindered the future monitoring of it. Dr Pal opined that this failure would fall far below the standards expected of a reasonably competent general dental practitioner.

50. Regarding the Committee's findings that at four appointments you failed to discuss with Patient A the possible cause of the swelling at the various appointments, it agrees with the experts that this failure would fall far below the standards expected of a reasonably competent general dental practitioner.

51. In respect of your failure to discuss with Patient A the options for managing the swelling, such as reviewing it, or referring for further assessment, the Committee has had regard to the experts opinion that from 29 March 2016 onwards you should have had those discussions with Patient A and that your failure to do so would fall far below the standards expected of a reasonably competent general dental practitioner.

52. Finally, in respect of your failure to refer the swelling for further assessment from 29 March 2016 until 8 February 2019, the experts agree that your failure to do so would fall far below the standards expected of a reasonably competent general dental practitioner. The Committee agrees with the experts. You did not refer the swelling for further assessment until 23 September 2019, over three years. The Committee has heard that the swelling subsequently was identified histologically as being malignant.

53. In your witness statement dated 9 December 2025 you expressed your regret that the treatment you provided to Patient A was not of an appropriate standard. In particular, you accepted that you should have taken additional steps to investigate the swelling when it was noted to be present. You apologised to Patient A for your omissions.

54. The Committee has considered you have breached the following GDC Standards For the Dental Team:

> 1.4: Take a holistic and preventative approach to patient care which is appropriate to the individual patient.
>
> 2.1: You must communicate effectively with patients – listen to them, give them time to consider information and take their individual views and communication needs into account
>
> 2.3 You must give patients the information they need, in a way they can understand, so that they can make informed decisions
>
> 4.1 You must make and keep contemporaneous, complete and accurate patient records
> 6.3 You must delegate and refer appropriately and effectively
>
> 7.1 You must provide good quality care based on current evidence and authoritative guidance

55. The Committee considered that you have failed to adhere to a significant number of GDC Standards for the Dental Team. The Committee has borne in mind that there was a repeat of the failings to carry out basic tests such as the taking of a periapical radiograph and carrying out TTP testing. These omissions occurred over the course of many consultations over several years. The Committee considers that your acts and omissions fell far short of the standards reasonably expected of a reasonably competent dentist.

56. Accordingly, the Committee has concluded that the findings against you are serious and amount to misconduct.

Committee's decision and reasons on impairment

57. The Committee next considered whether your fitness to practise is impaired by reason of misconduct on the grounds of the protection of patients and/or is in the wider public interest.

58. The Committee has borne in mind the steps you have taken to address the failings in Patient A's complaint, both at the time when you were notified of the complaint, and since then, as outlined in your witness statement dated 9 December 2025. This includes you having undertaken a number of hours of relevant and focused CPD, specifically within the field of oral cancer, as well as conducting regular case based discussions with a colleague. You also assist other colleagues in clinical decision making and have helped to educate your teams to increase the standard of treatment provided to patients.

59. In addition, you have conducted audits on clinical records from 2020/2021 and compared them to audits in early 2023.

60. Further, you set out in your witness statement dated 9 December 2025 that you attempted to organise shadowing in oral surgery departments at hospitals, but that after conversations with two consultants, it was not possible to organise it.

61. The Committee considers that it is clear from your witness statements and in your oral evidence that you have reflected long and hard about your treatment of Patient A. The Committee recognises that you have worked hard on your remediation and that you reached out to fellow dental practitioners to seek guidance and support, where necessary. It has borne in mind the supportive evidence of Dentist 1 and Dentist 2, albeit they confirmed that they had not observed your practice.

62. Notwithstanding the progress you have made, the Committee is not satisfied that the information before it is sufficient to indicate that the changes you have made are embedded into your practice. The Committee bore in mind that at the time of the allegations you were already at the forefront of cancer awareness. Notwithstanding this, you failed to identify the need to refer Patient A. With this in mind, the Committee considered it important to have evidence of learning being used in a workplace setting. Whilst it was evident that you had carried out some relevant CPD there was not objective assessment or confirmation of whether or how you have embedded this into your practice. Taking these factors into account, the Committee considers that you have shown some insight into your treatment of Patient A but is not satisfied that it is fully complete.

63. Further, the Committee had concerns about your response to a question regarding the link between Patient A's noted history of smoking and the absence of a risk assessment.

64. The Committee has borne in mind that the matters in this case relate to a single patient. However, they encompass a number of concerns and a failure to meet the standards required of a registrant. The Committee has concluded that there remains a risk of repetition of the concerns relating to Patient A and therefore you currently pose a risk to the public. It has determined that a finding of impairment is necessary on the ground of public protection.

65. Turning to the public interest, the Committee has borne in mind that dental professionals may make judgements which later prove to be mistaken. It also recognises that you were under the mistaken assumption that Patient A was suffering from periodontal disease and that this was uppermost in your mind when you were treating him.

66. However, the Committee has kept in mind the serious nature of the findings against you, which span a period of some four years, as well as your breaches of the GDC Standards for the Dental Team. Patient A was entitled to place their trust in your clinical judgement and you delayed in referring them for further assessment of the swelling. Notwithstanding the remediation you have undertaken as well as your apologies and expressions of remorse, given the findings against you, the Committee has concluded that a finding of current impairment in relation to your misconduct is necessary on the grounds of the public interest. It considers that public confidence in the dental profession would be undermined if a finding of impairment were not made in this case.

67. Accordingly, the Committee has determined that your practice is currently impaired by reason of your misconduct on the grounds of the protection of the public and the public interest.

Committee's decision and reasons on sanction

68. The Committee then determined what sanction, if any, would be appropriate in light of the findings of facts, misconduct and current impairment that it has made. The Committee recognises that the purpose of a sanction is not punitive, although it may have that effect, but is instead imposed in order to protect patients and safeguard the wider public interests. It has borne in mind that its finding of current impairment was made on the grounds of public protection as well as the public interest.

69. In reaching its decision the Committee has again taken into account the GDC's Guidance. It has applied the principle of proportionality, balancing the public interest with your own interests.

70. The Committee has considered the mitigating and aggravating factors present in this case. In terms of mitigating factors, the Committee has noted the incidents leading up to the event in question, namely the business problems relating to the sale of your previous practice as well as your health concerns. It has taken into account the steps you have taken since the events in question to address the conduct in this case and that you have no fitness to practise history. You also made partial admissions to some of the charges and you have also expressed your regret for your conduct. The Committee has further taken into account that the events in question took place over four years ago. The Committee has also had regard to the positive and supportive testimonials submitted on your behalf from professional colleagues.

71. In relation to aggravating factors, the Committee is mindful that there was a risk of harm to Patient A. The misconduct also spanned several years and multiple appointments. The Committee has found that although you have some insight into the misconduct, it is only partial.

72. The Committee had regard to its previous findings on misconduct and impairment in coming to its decision and considered each sanction in ascending order of severity.

73. The Committee first considered whether to impose no order or to issue a reprimand but concluded that this would be inappropriate in view of the risk of repetition of similar conduct that has been identified in this case. The Committee did not consider it would sufficiently protect the public, nor would it be in the public interest, to allow you to return to practice without some form of restriction in place.

74. The Committee then considered whether placing conditions on your registration would be a sufficient and appropriate response. Any conditions that may be formulated must be workable, measurable, enforceable and address the risks that have been identified.

75. 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 your clinical practice that are problematic;
- It is possible to formulate conditions that will protect the public during the period they are in force.

76. Having carefully considered the misconduct in this case, the Committee was satisfied that the discrete areas of your practice, namely your radiographic practice, your TTP testing, referrals for further assessments, your examinations and recordings of persistent lesions and discussions with patients were such that conditions of practice could be specifically formulated to protect the public and address the wider public interest whilst allowing you to return to practice.

77. In its consideration of whether a more restrictive sanction was required, the Committee concluded that a suspension or erasure would be disproportionate in the circumstances of your case. Accordingly, the Committee determined that an order of conditional registration would be appropriate and proportionate to address the areas of concern and sufficiently protect the public and the wider public interest. It therefore directs that your registration be made subject to a conditions of practice order.

78. The Committee has made some amendments to the conditions proposed by the GDC to more adequately address the concerns.

79. The order shall be for a period of 18 months. The Committee directs that this order be reviewed before its expiry and you will be informed of the date and time of that review hearing in writing. The Committee is satisfied that 18 months is sufficient and necessary for you to demonstrate that the remediative steps have been embedded into your daily practice so as to negate the risk of repetition.

80. The conditions will appear against your name in the Register as follows:

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:

    a. any formal disciplinary action taken against you
    b. any NHS investigation

c. any regulatory or enforcement action taken against you or a practice for which you are the registered provider
d. 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:

- Examination and treatment of swellings
- Diagnostic assessments of swellings
- Communication with patients with regards swellings and referrals
- Referrals
- Record keeping, particularly with regards to:
- Intra-oral examinations
- Risk assessments
- Radiographs
- TTP tests
- Radiographic Practice

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 your 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:

- Examination and treatment of persistent lesions
- Diagnostic assessments of lesions
- Communication with patients with regard to any lesions
- Referrals
- Record keeping, particularly with regards:
  - Radiographs
  - TTP tests
  - Risk assessments
- Radiographic Practice

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

- Examination and treatment of persistent lesions
- Diagnostic assessments of lesions
- Communication with patients with regard to any lesions
- Referrals
- Radiographic practice
- Record keeping, particularly with regards to
    - Radiographs
    - TTP tests
    - Risk assessments

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.

81. The Committee now invites submissions as to whether the conditions should take immediate effect to cover the 28-day appeal period.

Decision on immediate order – 10 December 2025

82. Ms Bird, on behalf of the GDC, made an application under Rule 22(1) that an immediate order of conditions should be imposed on your registration. She submitted that such an order is necessary for the protection of the public and is otherwise in the public interest in light of the Committee's findings at stages one and two. During the course of Ms Bird's submissions she referred to a number of paragraphs of this Committee's stage 2 determination in support of her application. She also referred to paragraphs 6.35 to 6.38 of the GDC's Indicative Sanctions Guidance (revised December 2020) which deals with immediate orders.

83. Mr McDonagh, on your behalf, submitted that an immediate order of conditions is not necessary for the protection of the public or is otherwise in the public interest. He made the point that you have been working without restrictions, with no reported concerns, since the events in question in this single patient complaint. Mr McDonagh also submitted that it will take time for you to put in place the necessary arrangements for the Workplace Reporter, potentially causing the cancellation of some of your patients, mid-way through their treatment. In short, he submitted the necessity test for the making of an immediate order is not made out.

84. The Committee has considered the submissions made. It has accepted the advice of the Legal Adviser. The Committee has also had regard to paragraphs 6.35 to 6.38 of the GDC's Indicative Sanctions Guidance (revised December 2020) which deals with immediate orders.

85. The Committee is satisfied that it is necessary for the protection of the public and is otherwise in the public interest that your registration be made conditional forthwith. In the Committee's judgement, taking full account of its findings of current impairment and reasons for directing that your registration be subject to an order of conditions, there is a risk of repetition of misconduct which makes an immediate order necessary for public protection. In light of the risk to the public, the Committee is also satisfied that an immediate order is required in order to maintain public confidence in the profession. The Committee recognises that this may have an impact on the treatment of some of your patients but it considers that the protection of the public outweighs this.

86. The effect of this order is that your registration is now subject to the conditions set out in the Committee's determination of your case. Unless you exercise your right of appeal the substantive 18 month period of conditional registration will commence 28 days from when notification of the determination is served on you. Should you exercise your right of appeal, this immediate order of conditions shall remain in force pending the disposal of the appeal.

87. The Committee's decision will be confirmed to you in writing in accordance with the Act.

88. That concludes this hearing.