Dental Professionals Hearings Service

PUBLIC DETERMINATION

PUBLIC HEARING
Professional Conduct Committee
Initial Hearing

29 June – 7 July 2026

Name:	AMPUERO, Brenda
Registration number:	159603
Case number:	CAS-211486

General Dental Council:	Abimbola Johnson, Counsel Instructed by Sarah Atkinson, Kingsley Napley LLP
Registrant:	Present Represented by Chris Gillespie, Counsel Instructed by Sarah Murdoch, MDDUS

Fitness to practise:	Impaired by reason of deficient professional performance and misconduct
Outcome:	Fitness to Practise Impaired. Reprimand Issued

Committee members:	Caroline Healy	(Chair and Lay Member)
	Vatsal Amin	(Dentist Member)
	Avril Fraser	(Dental Care Professional Member)
Legal adviser:	Justin Gau	
Committee Secretary:	Kate Anderson	

Ms Ampuero,

1. This was a Professional Conduct Committee (PCC) inquiry into the facts which formed the basis of the allegation against you that your fitness to practise is impaired by reason of misconduct.

2. You were present at the hearing and represented by Mr Christpher Gillespie, Counsel. Ms Abimbola Johnson, Counsel, appeared on behalf of the General Dental Council (GDC).

3. The hearing was held remotely on Microsoft Teams.

The Charges

4. The charges in this case are as follows:

'That being registered as a dentist Brenda Ampuero's (159603) fitness to practise is impaired by reason of misconduct and/or deficient professional performance; In that:

Patient B

1. *You failed to provide an adequate standard of care to Patient B on 12 May 2022 including by;*
    a) *Not identifying the underlying periodontal disease from your BPE examination*
    b) *Carrying out inaccurate risk assessments, namely, by*
        i. *Recording a low risk of dental caries for Patient B*
        ii. *Recording cancer risk as low*
    c) *Not identifying, adequately, or at all, the following findings and/or pathology from bitewing radiographs taken on or around 12 May 2022, including:*
        i. *The presence of caries in LL4*
        ii. *Bone loss around the implant at LL5*
        iii. *The extent and/or severity of the bone loss around UR4*
        iv. *An overhanging restoration at LL3*
2. *You failed to provide an adequate standard of care to Patient B on 26 January 2023 including by:*
    a) *Not identifying the underlying periodontal disease from your BPE examination*
    b) *Carrying out inaccurate risk assessments, namely, by*
        i. *Recording a low risk of dental caries;*
        ii. *Assessing cancer risk as low;*
    c) *As you incorrectly risk assessed Patient B for caries, you did not take a further set of bitewing radiographs*

Patient D

3. *You failed to provide an adequate standard of care to Patient D from 21 April 2022 to 6 March 2023, including by;*
    a) *not taking and/or recording BPE examinations on:*
        i. *21 April 2022*
        ii. *19 July 2022*
        iii. *10 October 2022*
        iv. *21 November 2022*
        v. *2 February 2023*
    b) *not taking any bitewing radiographs*
    c) *not adequately diagnosing periodontal disease in that you:*
        i. *did not take a periodontal chart*
        ii. *misdiagnosed the extent of Patient D's periodontal disease*
    d) *As you misdiagnosed the extent of Patient D's dental disease, you did not carry out sufficient treatment planning to deal with the underlying:*
        i. *dental caries*
        ii. *periodontal disease; and further you*
        iii. *planned a bridge prosthesis before stabilising Patient D*
    e) *not adequately treating Patient D's periodontal disease*
4. *You submitted inappropriate NHS claims for treatment provided to Patient D on:*
    a) *21 April 2022*
    b) *19 July 2022*
    c) *24 August 2022*
    d) *10 October 2022*
    e) *21 November 2022*
    f) *2 February 2023*

Patient E

5. *You failed to provide an adequate standard of care to Patient E on 31 March 2023 including by;*
    a) *Your radiographic practice including:*
        i. *Not taking any radiographs*

Patient F

6. *You failed to provide an adequate standard of care to Patient F on 22 June 2022 and 23 November 2022 by;*
    a) *Your radiographic practice including:*

i. *Not taking bitewing radiographs during the examination on 22 June 2022*

ii. *Not writing a radiographic report for the bitewing radiographs taken on 21 July 2022*

Patient H

7. *You failed to provide an adequate standard of care to Patient H from 26 April 2022 to 28 February 2023, including by:*

   a) *Your radiographic practice including:*

      i. *You did not take bitewing radiographs at your appointment with them on 26 April 2022*

      ii. *You did not take bitewing radiographs at your appointment with them on 28 February 2023*

Patient J

8. *You failed to provide an adequate standard of care to Patient J on 1 August 2022, including by:*

   a) *Not identifying pathologies from the radiograph dated 11 January 2022*

   b) *Carrying out inaccurate risk assessments, namely, by*

      i. *Assessing Patient J as having a low risk of cancer*

      ii. *Assessing Patient J as having a low risk of caries*

   c) *You did not take further radiographs*

Patient P

9. *You failed to provide an adequate standard of care to Patient P on 26 September 2022 including by;*

   a) *Taking insufficient diagnostic assessments, including*

      i. *Diagnosing early caries on the upper anterior teeth without recording:*

         1. *which teeth they were present in*

         2. *any further diagnosis*

   b) *Recording inaccurate risk assessments, including:*

      i. *Noting Patient P's caries risk as low*

   c) *Your radiographic practice, including*

      i. *Not taking any bitewing radiographs*

10. *You failed to provide an adequate standard of care to Patient P on 15 November 2022 including by:*

    a) *Your radiographic practice, including:*

i. *Not taking a radiographic examination for LL6 before commencing filling restoration on 15 November 2022*

b) *Not adequately removing the caries in the following teeth when restoring them on 15 November 2022:*

i. *LL6*

ii. *LR6*

11. *You failed to provide an adequate standard of care to Patient P from 26 September 2022 to 15 November 2022 including by:*

a) *Not identifying multiple caries cavities within Patient P's teeth, including in:*

i. *UL5d*

ii. *UL6d,*

iii. *LL6m,*

iv. *LR5d,*

v. *LR6occ,*

vi. *LR7occ,*

vii. *UR4occ,*

viii. *UR5d,*

ix. *UR6occ*

b) *Not identifying areas of early decay, including in:*

i. *UL5m*

ii. *UL4d*

Patient U

12. *You failed to provide an adequate standard of care to Patient U on 30 January 2023 and 13 February 2023, including by;*

a) *Not taking bitewing radiographs during your appointment on 13 February 2023*

b) *Not diagnosing caries at:*

i. *UR8*

ii. *UR7*

c) *Not diagnosing retained roots at LL8*

Patient Z

13. *You failed to provide an adequate standard of care to Patient Z on 8 February 2023 including by;*

a) *Carrying out in sufficient diagnostic assessments for the patient's problems in the lower right in that you did not*

i. *take any periodontal charting around the loose teeth*

ii. check and/or record the presence of inflammation

iii. review the patient's sensitivity

b) Identifying the patient's bone loss from your basic periodontal examination

c) Not taking periapical radiographs of the lower right area

14. *You failed to provide an adequate standard of care to Patient Z on 1 March 2023 including by;*

a) Your radiographic practice, including:

i. Not identifying pathology and/or findings from bitewing radiographs, including;

1. Recurrent caries at LR4

2. Localised bone loss on UR4

3. A mesial radiolucency at UL4

Patient Aa

15. *You failed to provide an adequate standard of care to Patient AA on 31 January 2023 by;*

a) Your radiographic practice in that you

i. Did not take bitewing radiographs

16. *You failed to provide an adequate standard of care to Patient AA on 9 February 2023 by;*

a) Your radiographic practice in that you

i. Did not write a radiographic report on your diagnostic radiographs

b) Providing a root canal treatment which was poor in that

i. The root filling was underfilled

c) You failed to adhere to your duty of candour regarding the defect of the root canal treatment

Patient Ab

17. *You failed to provide an adequate standard of care to Patient Ab on 7 March 2023 including by;*

a) Not noting from the bitewing radiographs taken:

i. Patient Ab's bone levels

ii. Retained roots on the upper left

iii. Radiolucency at UL3

b) Not noting from the periapical radiographs taken:

i. Initial pathology on the root apex

ii. The cavity within LR5

18. *You failed to provide an adequate standard of care to Patient Ab on 14 March 2023 including by:*
    a) *Undertaking a root canal treatment without using a rubber dam when indicated*
    b) *Inaccurately recording that a rubber dam was used during the root canal treatment*
    c) *Not noting from the radiograph taken after the root canal treatment that:*
        i. *the root canal treatment and/or cement had gone through the apex*
19. *Your actions in relation to allegation 16c and/or 18b were misleading.*
20. *Your actions in relation to allegation 18b were dishonest.*
21. *Your actions in relation to allegation 18a put patient safety at risk.'*

Preliminary matters

Application to amend the charge

5. At the outset of the hearing, Ms Johnson made an application under rule 18 of the Fitness to Practise rules (hereby referred to as 'The Rules') to amend the charges at this hearing.

6. Ms Johnson submitted that the proposed amendments were pragmatic to ensure that the evidence available aligned with the allegations in this hearing. She submitted that the amendments can be made in fairness and will ensure clarity.

7. Ms Johnson applied to withdraw charges 1cii, 1ciii, 13b and 14ai2. These withdrawals were based on the expert reports and opinions. In regard to 1cii, the experts had opined that the bone loss was within normal limits and therefore this charge was no longer supported. For charge 2ciii, the experts had opined that it was difficult to diagnose bone loss from bitewings alone, and that when looking at the wider context of the clinical records, you had noted that the bone loss was moderate. In relation to charge 13b, Ms Johnson submitted that a BPE was a screening tool and not used for diagnosis, therefore this charge should be withdrawn and that there are further allegations to still be considered that would deal with the matter. Lastly, Ms Jonhson submitted that charge 14ai2 could be withdrawn as the experts had opined that there was a diagnosis of localised bone loss in the clinical records. Ms Johnson submitted that the narrowing of the charges would not cause any injustice as there was sufficient evidence remaining to be considered.

8. Ms Johnson also applied to amend the wording in charges 12c and 13c. In relation to 12c, Ms Johnson applied to amend the wording of the charge to 'managing' rather than 'diagnosing' as the experts had jointly expressed that you did chart the roots of the teeth and therefore did diagnose roots, but had not discussed the management of these retained roots. In relation to 13c, Ms Johnson applied for the words 'on that date or at all' to be added to the end of the charge. She submitted that the experts had both agreed that periapical radiographs were required, and that in line with their comments this amendment would clarify the concerns surrounding these not being taken.

9. Mr Gillespie did not oppose the amendments. He agreed that the proposed withdrawal of allegations was based upon information from the experts opinions and therefore it was right and fair to remove any allegations for which there was no evidence. In relation to the proposed amendments, he supported Ms Johnson's view that the amendments were for clarification based on the information from the experts reports and therefore again did not oppose.

Committee's decision on amending the charge

10. The Committee accepted the legal advice in relation to amending the charge.

11. The Committee was satisfied that the charge could be amended without causing injustice, and therefore acceded to the application.

Your Admissions

12. The Committee heard your admissions to the charges.

13. You admitted charges 1bi,1bii, 1ci, 1civ, 2c, 3, 4, 5, 6, 7, 9bi, 9ci, 10, 11, 12, 13, 14, 15, 16, 17ai, 17aii, 17aiii, 18, 19, and 21.

14. Having heard your admissions, the Committee accepted them, and in accordance with Rules 17(4) and 17(5) of the GDC (Fitness to Practise) Rules 2006, the Chair of the Committee announced the factual allegations that you had admitted as 'found proved' on the basis of your admissions.

Background and Summary of the GDC's case

15. Ms Johnson told the Committee that you are a registered Dentist and that the allegations arise from your work at the Practice between April 2022 and March 2023. She told the Committee that the allegations are of repeated failures across a sample of patients over a period of approximately 11 months. Those failures concern core aspects of general dental practice: radiography, diagnosis, periodontal assessment, treatment planning, caries management, record keeping, NHS claiming, candour, and in one respect honesty.

16. Ms Johnson told the Committee that you worked at the Practice from 4 April 2022 until 23 March 2023. She informed the Committee that both your evidence and that of Witness 1 is that you worked around 4 days a week and saw 20 to 30 patients per day and around 90 to 100 patients per week. The practice was busy and some patients had high dental needs, particularly in the post-Covid period. Ms Johnson told the Committee however that these matters provide context, but they do not answer the factual allegations.

17. Ms Johnson informed the Committee that concerns began to be raised by dental nurses who worked with you. These concerns included that you were not telling patients what treatment they needed, were trying to do treatment in a single appointment rather than setting out a treatment plan, were not taking x-rays, and were recording BPEs incorrectly.

18. Ms Johnson told the Committee that an audit was undertaken by Witness 2, into whether patients were new or existing, whether up-to-date x-rays were on file, whether BPE scores were recorded, and what treatment had been offered and delivered. Witness 2 noted that you had not taken x-rays for a number of patients, or had recorded that x-rays were not needed in circumstances where x-rays had not been taken for a considerable period.

19. On 23 March 2023, there was a meeting attended by you, Witness 1, and Witness 2. Ms Johnson told the Committee that the meeting notes record that the agenda included a discussion of the audit, record keeping and matters of concern. You accepted in that meeting that there were errors on your part and that there were things you needed to improve. Ms Johnson informed the Committee that in your witness statement, you accept that a number of issues were raised with you and that you accepted deficiencies in your practise which required remedying.

20. The GDC instructed an expert (Mr Simon Quelch) to provide a report based on the clinical records, radiographs, witness evidence and other materials. Ms Johnson informed the Committee that the GDC rely on this report. She also told the Committee that you instructed an expert to create a report (Mr Balraj Dhami) upon which you rely.

21. Ms Johnson told the Committee that the experts have met and produced a joint report. In some respects, it supports withdrawal or amendment of parts of the charge. In many respects, both experts agree that the criticisms are made out and that the failures fell far below the standard expected. In other respects, the experts disagree as to whether the allegation is supported or as to whether the failure falls *'below'* or '*far below*' the expected standard.

22. Ms Johnson submitted that the GDC's position is that where the experts agree, their agreement is significant. Where they disagree, the Committee will need to assess their reasoning against the clinical records, radiographs and factual background.

23. Ms Johnson took the Committee through the evidential basis for the allegations.

Evidence

24. The evidence provided to the Committee by the GDC was both documentary and oral. The documentary evidence comprised of:
    - signed witness statements and associated exhibits of Witness 1
    - signed witness statements and associated exhibits of Witness 2
    - signed witness statements and associated exhibits of Witness 3
    - signed witness statements and associated exhibits of Witness 4
    - Expert report of Dr Simon Quelch

25. The documentary evidence received by the Committee on your behalf in response to the allegations were:
    - Your signed witness statements and associated exhibits
    - Expert report of Balraj Dhami

26. The Committee also received a joint expert report provided by Simon Quelch and Balraj Dhami.

27. The Committee heard oral evidence from Witness 1.

28. Dr Quelch and Dr Dhami both also gave oral evidence at the hearing.

29. Furthermore, you gave oral evidence at the hearing.

Statement of agreed fact

30. Having heard the evidence of the Experts, the Committee was provided with a statement of agreed fact from the parties, that you did not have a formal appraisal during your course of employment at the Practice.

31. The Committee accepted this statement.

Further application for amendment to the charges

32. Ms Johnson made a further application under rule 18 of the rules to withdraw charges, based upon there being no evidence by the GDC. She applied for allegations 9ai1, 9ai2, 17bi and 17bii to be withdrawn based on the fact that the GDC had no evidence in relation to these charges.

33. The Committee accepted the advice of the legal adviser. The Committee was satisfied that it was fair and no injustice would be caused by it accepting that the charges could be withdrawn due to the GDC offering no evidence.

Further admissions

34. Following the conclusion of oral evidence by both parties, Mr Gillespie submitted to the Committee that you wished to make further admissions. You admitted to charges 2bi, 8bii, and 8c.

35. Having heard your admissions, the Committee accepted them, and in accordance with Rules 17(4) and 17(5) of the GDC (Fitness to Practise) Rules 2006, the Chair of the Committee announced the factual allegations that you had admitted as 'found proved' on the basis of your admissions.

The Committee's findings of fact

36. The Committee considered all the evidence presented to it, both documentary and oral. It took account of the closing submissions made by Ms Johnson on behalf of the GDC and those made by Mr Gillespie, on your behalf.

37. The Committee accepted the advice of the Legal Adviser, including in relation to the burden and standard of proof, the need to consider the alleged matters separately, the need to have regard to the specific wording of each allegation and how to approach the evidence. The

Committee also noted the Legal Adviser's comments regarding the admissions made by you in this case.

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

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

That being registered as a dentist Brenda Ampuero's (159603) fitness to practise is impaired by reason of misconduct and/or deficient professional performance; In that:	
1	You failed to provide an adequate standard of care to Patient B on 12 May 2022 including by;
1a	Not identifying the underlying periodontal disease from your BPE examination **Found not proved** The Committee carefully considered the evidence before it, including the clinical records provided, the experts' opinions, and the evidence of Witness 1. The Committee considered that both experts were highly experienced and very helpful. On some occasions they demonstrated a range of opinion, however both of which were the opinions of highly experienced dentists who can be trusted to provide an independent and credible opinion. In relation to their assessment of radiographs, both experts admitted that different dentists may find different diagnoses as the details are so fine and that this is not unusual between practitioners. The Committee considered that both provided cogent evidence and considered both to have their merits in relation to the different allegations. It carefully considered both opinions alongside the clinical records in its assessment of the allegations. Therefore, in relation to this charge, the Committee noted both experts opinions. Mr Quelch's opinion was that given the high scores identified by Witness 1 on 26 May 2023, and that '*Gum disease is a chronic condition, and it take(s) years to develop so it is more likely than not, that it was present when the Registrant was examining the patient*'. Mr Dhami's opinion was that '*a patient who had active periodontal disease, which is now stable can present with bone loss on radiographs but BPE scores of 2 or less indicating (sic) an absence of active periodontal disease. It is not possible to draw any conclusions on the accuracy of BPE scores by comparing the BPE scores to the bone levels on radiographs'.* He also stated that a '*Patient with periodontal disease which is a chronic condition, can have period(s) of remission and activity. Therefore it is not uncommon for (a) patient to evidence a rapid deterioration in their periodontal health.'* On 12 May 2022, you noted a BPE score of X2X/212. The Committee noted from the clinical records that this was similar to previous scores identified. Dr

	Dhami in his expert report also stated this. The Committee also noted that both Ms Johnson and Mr Quelch had informed it that there was no evidence of Patient B being treated for periodontal disease previously at the practice. The Committee accepted and preferred Mr Dhami's opinion and considered that Patient B may not have had active periodontal disease at this appointment on 12 May 2022, and with scores of X2X/212, no further assessments would have needed to be undertaken. The Committee noted disparities in the BPE scores and periodontal chart of Witness 1 and concluded that the periodontal chart did not relate correctly to the BPE scores. The Committee preferred the opinion of Dr Dhami that the disease may have progressed rapidly in a year. This was more credible than the alternative theory that every other dentist who had assessed Patient B's teeth previously were wrong. Witness 1 was the only Dentist to find active and advanced periodontal disease. The Committee therefore determined that on the balance of probabilities, you did provide an adequate standard of care to Patient B as there was no underlying periodontal disease to identify at this appointment. The Committee accordingly finds this charge not proved.
1b	Carrying out inaccurate risk assessments, namely, by
1bi	Recording a low risk of dental caries for Patient B **Admitted and found proved**
1bii	Recording cancer risk as low **Admitted and found proved**
1c	Not identifying, adequately, or at all, the following findings and/or pathology from bitewing radiographs taken on or around 12 May 2022, including:
1ci	The presence of caries in LL4 **Admitted and found proved**
1cii	**Charge withdrawn**
1ciii	**Charge withdrawn**
1civ	An overhanging restoration at LL3 **Admitted and found proved**

2	You failed to provide an adequate standard of care to Patient B on 26 January 2023 including by:
2a	Not identifying the underlying periodontal disease from your BPE examination **Found Not Proved** The Committee noted that this charge related to the same patient, and similar conduct as to that at charge 1a, but related to a different date. For the same reasons as in 1a, the Committee considered that the low BPE scores of X2X/212 recorded on 26 January 2023 would not have led to an inadequate standard of care in not identifying underlying periodontal disease. It also noted that there was less time between this appointment and Witness 1's appointment, but that the scores recorded on 26 January 2023 remained in line with those previously identified and in accepting Dr Dhami's advice this could have been due to stable, inactive periodontal disease. The Committee was not satisfied that the GDC had discharged its burden of proof in relation to this charge. The Committee accordingly found this charge not proved.
2b	Carrying out inaccurate risk assessments, namely, by
2bi	Recording a low risk of dental caries; **Admitted and found proved**
2bii	Assessing cancer risk as low; **Admitted and found proved**
2c	As you incorrectly risk assessed Patient B for caries, you did not take a further set of bitewing radiographs **Admitted and found proved**
3	You failed to provide an adequate standard of care to Patient D from 21 April 2022 to 6 March 2023, including by;
3a	not taking and/or recording BPE examinations on:
3ai	21 April 2022 **Admitted and found proved**
3aii	19 July 2022 **Admitted and found proved**
3aiii	10 October 2022 **Admitted and found proved**
3aiv	21 November 2022 **Admitted and found proved**

3av	2 February 2023 **Admitted and found proved**
3b	not taking any bitewing radiographs **Admitted and found proved**
3c	not adequately diagnosing periodontal disease in that you:
3ci	did not take a periodontal chart **Admitted and found proved**
3cii	misdiagnosed the extent of Patient D's periodontal disease **Admitted and found proved**
3d	As you misdiagnosed the extent of Patient D's dental disease, you did not carry out sufficient treatment planning to deal with the underlying:
3di	dental caries **Admitted and found proved**
3dii	periodontal disease; and further you **Admitted and found proved**
3diii	planned a bridge prosthesis before stabilising Patient D **Admitted and found proved**
3e	not adequately treating Patient D's periodontal disease **Admitted and found proved**
4	You submitted inappropriate NHS claims for treatment provided to Patient D on:
4a	21 April 2022 **Admitted and found proved**
4b	19 July 2022 **Admitted and found proved**
4c	24 August 2022 **Admitted and found proved**
4d	10 October 2022 **Admitted and found proved**
4e	21 November 2022 **Admitted and found proved**
4f	2 February 2023 **Admitted and found proved**

5	You failed to provide an adequate standard of care to Patient E on 31 March 2023 including by;
5a	Your radiographic practice including:
5ai	Not taking any radiographs **Admitted and found proved**
6	You failed to provide an adequate standard of care to Patient F on 22 June 2022 and 23 November 2022 by;
6a	Your radiographic practice including:
6ai	Not taking bitewing radiographs during the examination on 22 June 2022 **Admitted and found proved**
6aii	Not writing a radiographic report for the bitewing radiographs taken on 21 July 2022 **Admitted and found proved**
7	You failed to provide an adequate standard of care to Patient H from 26 April 2022 to 28 February 2023, including by:
7a	Your radiographic practice including:
7ai	You did not take bitewing radiographs at your appointment with them on 26 April 2022 **Admitted and found proved**
7aii	You did not take bitewing radiographs at your appointment with them on 28 February 2023 **Admitted and found proved**
8	You failed to provide an adequate standard of care to Patient J on 1 August 2022, including by:
8a	Not identifying ~~pathologies~~ (an area of pathology) from the radiograph dated 11 January 2022 **Found proved** The Committee had regard to the jpeg images of the radiographs dated 11 January 2022. The Committee noted the expert opinions of both Mr Quelch and Mr Dhami, who in oral evidence both confirmed that when it comes to radiographs there can be differences in opinions and that different practitioners could identify different pathologies on different days. Mr Quelch in his oral evidence stated that interpreting radiographs is not easy and there is no exact science to the process. The Committee accepted the opinion of both of the experts in its consideration.

	The Committee considered that both experts had identified a clear radiolucency on the UL6 mesial in their reports. The Committee accepted this, and noted that Mr Quelch had stated that he would have expected a *'reasonable general dental practitioner to identify the potential caries'* from these images. The Committee noted that there was no evidence of any pathologies identified in the clinical records dated 11 January 2022. The Committee was satisfied that the GDC had discharged its burden of proof in relation to an area of pathology on the UL6 mesial of Patient J on 11 January 2022. The Committee considered the comments made by Mr Gillespie in relation to amending this charge. Mr Gillespie submitted that the wording of this charge could be amended from the plural to singular 'pathology' without causing any unfairness, and in order to be in line with the evidence. The Committee having determined that there was a clear pathology at UL6 mesial that was not diagnosed, and having no evidence before it of any other pathologies, was satisfied that this charge could be amended to the singular 'area of pathology' without any issue of unfairness and would clarify matters. This accordingly leads to the charge being found proved in its entirety.
8b	Carrying out inaccurate risk assessments, namely, by
8bi	**Charge withdrawn**
8bii	Assessing Patient J as having a low risk of caries **Admitted and found proved**
8c	You did not take further radiographs **Admitted and found proved**
9	You failed to provide an adequate standard of care to Patient P on 26 September 2022 including by;
9a	**Charge withdrawn**
9ai	**Charge withdrawn**
9ai1	**Charge withdrawn**
9ai2	**Charge withdrawn**
9b	Recording inaccurate risk assessments, including:
9bi	Noting Patient P's caries risk as low

	Admitted and found proved
9c	Your radiographic practice, including
9ci	Not taking any bitewing radiographs **Admitted and found proved**
10	You failed to provide an adequate standard of care to Patient P on 15 November 2022 including by:
10a	Your radiographic practice, including:
10ai	Not taking a radiographic examination for LL6 before commencing filling restoration on 15 November 2022 **Admitted and found proved**
10b	Not adequately removing the caries in the following teeth when restoring them on 15 November 2022:
10bi	LL6 **Admitted and found proved**
10bii	LR6 **Admitted and found proved**
11	You failed to provide an adequate standard of care to Patient P from 26 September 2022 to 15 November 2022 including by:
11a	Not identifying multiple caries cavities within Patient P's teeth, including in:
11ai	UL5d **Admitted and found proved**
11aii	UL6d, **Admitted and found proved**
11aiii	LL6m, **Admitted and found proved**
11aiv	LR5d, **Admitted and found proved**
11av	LR6occ, **Admitted and found proved**
11avi	LR7occ, **Admitted and found proved**
11avii	UR4occ,

	Admitted and found proved
11aviii	UR5d, **Admitted and found proved**
11aix	UR6occ **Admitted and found proved**
11b	Not identifying areas of early decay, including in:
11bi	UL5m **Admitted and found proved**
11bii	UL4d **Admitted and found proved**
12	You failed to provide an adequate standard of care to Patient U on 30 January 2023 and 13 February 2023, including by;
12a	Not taking bitewing radiographs during your appointment on 13 February 2023
12b	Not diagnosing caries at:
12bi	UR8 **Admitted and found proved**
12bii	UR7 **Admitted and found proved**
12c	Not managing retained roots at LL8 **Admitted and found proved**
13	You failed to provide an adequate standard of care to Patient Z on 8 February 2023 including by;
13a	Carrying out in sufficient diagnostic assessments for the patient's problems in the lower right in that you did not
13ai	take any periodontal charting around the loose teeth **Admitted and found proved**
13aii	check and/or record the presence of inflammation **Admitted and found proved**
13aiii	review the patient's sensitivity **Admitted and found proved**
13b	**Charge withdrawn**
13c	Not taking periapical radiographs of the lower right area on that date or at all

	Admitted and found proved
14	You failed to provide an adequate standard of care to Patient Z on 1 March 2023 including by;
14a	Your radiographic practice, including:
14ai	Not identifying pathology and/or findings from bitewing radiographs, including:
14ai1	Recurrent caries at LR4 **Admitted and found proved**
14ai2	**Charge withdrawn**
14ai3	A mesial radiolucency at UL4 **Admitted and found proved**
15	You failed to provide an adequate standard of care to Patient AA on 31 January 2023 by;
15a	Your radiographic practice in that you
15ai	Did not take bitewing radiographs **Admitted and found proved**
16	You failed to provide an adequate standard of care to Patient AA on 9 February 2023 by;
16a	Your radiographic practice in that you
16ai	Did not write a radiographic report on your diagnostic radiographs **Admitted and found proved**
16b	Providing a root canal treatment which was poor in that
16bi	The root filling was underfilled **Admitted and found proved**
16c	You failed to adhere to your duty of candour regarding the defect of the root canal treatment **Admitted and found proved**
17	You failed to provide an adequate standard of care to Patient Ab on 7 March 2023 including by;
17a	Not noting from the bitewing radiographs taken:
17ai	Patient Ab's bone levels

	Admitted and found proved
17aii	Retained roots on the upper left **Admitted and found proved**
17aiii	Radiolucency at UL3 **Admitted and found proved**
17b	**Charge withdrawn**
17bi	**Charge withdrawn**
17bii	**Charge withdrawn**
18	You failed to provide an adequate standard of care to Patient Ab on 14 March 2023 including by:
18a	Undertaking a root canal treatment without using a rubber dam when indicated **Admitted and found proved**
18b	Inaccurately recording that a rubber dam was used during the root canal treatment **Admitted and found proved**
18c	Not noting from the radiograph taken after the root canal treatment that:
18ci	the root canal treatment and/or cement had gone through the apex **Admitted and found proved**
19	Your actions in relation to allegation 16c and/or 18b were misleading **Admitted and found proved**
20	Your actions in relation to allegation 18b were dishonest **Found Not Proved** In considering the test for dishonesty, the Committee noted that it must firstly consider whether your actions were deliberate. The Committee considered your oral and written evidence in which you stated that you were working under pressure in the Practice and felt rushed in your treatment of Patient Ab. You acknowledged that you used a template note, during a pressurized treatment, and you unsuccessfully attempted to use a rubber dam but that this wasn't reflected in the note and in turn your record keeping in this matter was misleading. You however denied that this was dishonest, and your oral evidence was that you cut and paste templates at the start of the appointment but that because of the high stress manner of this appointment, you panicked and forgot to make any changes.

	The Committee considered your credibility and reliability as a witness. It noted that you have made several admissions and there is evidence that you have openly admitted to any mistakes made throughout the course of the investigations. It noted that you had stated that you struggled to remember some details due to the passage of time, however you provided as much context as you could remember during your evidence and admitted when you could not recall. The Committee was satisfied that your oral and written evidence were consistent. The Committee noted that there appeared to be some amendments at the beginning of the clinical note in that the correct tooth and time are filled in, however this is in line with your oral evidence that you would prepare some of the notes before seeing a patient. The Committee considered your previous good character, and that you have never had any previous fitness to practise issues with the GDC. It also considered that you had admitted to making a mistake both at the meeting with Witness 1 and Witness 2 and throughout any subsequent investigations. The Committee considered that your use of templates caused inaccuracies in your notes, however it was not satisfied that the GDC had discharged the burden of proof that you had deliberately recorded that a rubber dam had been used during treatment, a fact to which you knew was untrue. On the balance of probabilities, the Committee determined that it is more likely that you were under stress and forgot to amend the note following the treatment rather than inputting a deliberately false note, especially given the other information that appeared to be false such as the working length despite no radiograph having been taken. The Committee considered your actions to be a mistake and oversight, but not a deliberate and dishonest act. The Committee accordingly found this charge not proved.
21	Your actions in relation to allegation 18a put patient safety at risk **Admitted and found proved**

40. We move to stage two.

41. Following its announcement of its decision on the facts, the hearing moved to Stage 2. At Stage 2, the Committee considered whether the facts found proved amounted to misconduct and, if so, whether your fitness to practise is currently impaired by reason of your misconduct. If it found that your fitness to practise is impaired, it would consider what sanction, if any, should be imposed.

Evidence

42. You provided further documents at this stage of the hearing including a stage 2 bundle, a statement signed by you, and 4 workplace supervisor reports.

43. You also gave further oral evidence.

44. You told the Committee about your background in dentistry, including your training and work before moving to the UK. You told the Committee that you had worked in the UK for 10 years

at two practices before working at the practice at which the allegations came about, and that since then you have worked at a further two practices. You told the Committee that you have had no issues at any other practice.

45. You told the Committee about your time working at the practice in which the issues took place. This included that you felt under pressure whilst working at this practice, there was no continuity in dental nurses, and you had no appraisal during your time employed there. You referred to your personal circumstances at the time.

46. You told the Committee about your remediation. You told the Committee that you were working for 5 days a week but dropped this down to 4 so that you could have a day dedicated to the areas that you needed to improve in your practice. You told the Committee that this had a significant financial impact on you as you lost a day of wages and were paying for CPD (Continued Professional Development) courses yourself. You also told the Committee about the courses you did and how these have helped you, so that you now work 5 days again. You told the Committee that after completing training your interim conditions were slowly relaxed and that you have now been working without restriction for a year.

47. You answered questions put forward by Ms Johnson regarding dealing with stress, your current practise compared to your old practise, the expectations at your new practice including that you now only see 15-20 patients per day, and whether you had completed a course specifically related to the duty of candour.

48. You also answered questions from the Committee.

Submissions

49. Ms Johnson first addressed the Committee in respect of misconduct and deficient professional performance.

50. With regard to misconduct, Ms Johnson referred the Committee to the relevant case law and the GDC's *Standards for the Dental Team (2013).*

51. Ms Johnson submitted to the Committee that the matters found proved related to multiple failures over many months. Ms Johnson took the Committee through the failures in relation to each of the 11 patients, and stated where Mr Quelch and Mr Dhami had identified the care falling below the standard expected. Ms Johnson submitted that the conduct found proved covered radiographic failings, caries failings, record keeping failings in relation to caries, periodontal disease not being properly diagnosed, inadequate restorative treatment, inaccurate record keeping (leading to an allegation of being misleading), issues with NHS claiming, and issues surrounding your duty of candour. She submitted that there were serious failings that all relate to patient care.

52. Ms Johnson submitted that your conduct was in breach of Standards 1.3, 1.4, 1.5, 2.2, 2.3, 3.1,4, 6,2, 6.2, 7.1, and 7.2. Ms Johnson therefore submitted that your conduct can be properly judged as misconduct.

53. Ms Johnson submitted that the threshold for deficient professional performance had also been met. She submitted that the findings related to multiple patients over repeated appointments across 11 months, and were over a range of clinical issues. She submitted that the evidence gathered covered 28 patients, and that the facts found proved relating to 11 patients reflect the narrowing of the charges following wider review. She submitted that this was not a cherry picked sample, and they cover all types of appointments and treatments. Ms Johnson

submitted that the extensive CPD and remediation that you undertook reflects the breadth of the issues and your wide-ranging underperformance. She submitted that the breadth of repetition across all themes proves that your standard of practice was unacceptably low and therefore your professional performance was deficient. She also submitted that the areas identified as misconduct in relation to patients Aa, Ab, and D were a serious professional failing which constitute the second statutory ground upon which deficient professional performance should be found.

54. Ms Johnson then moved on to the issue of current impairment. She referred to the relevant case law, and submitted that impairment can be considered in two parts: the public protection component and the public interest component.

55. Ms Johnson submitted that impairment could be found on both grounds in this matter, but the public interest limb in particular was engaged. In respect of public protection, she submitted that there had been a massive reduction in the risk of repetition given your positive history with Interim conditions, the positive testimonials and that you have been practising without any further issues since the concerns arose. She also submitted that you had demonstrated insight and remediation through your substantial CPD, audits, and examples of your templates However, she submitted that the Committee must still consider whether there is residual risk by any additional pressure at work, whether the CPD has addressed all concerns such as the duty of candour for which there is no specific certificate provided. In addition, the fact that your templates still contain pre-populated entries which have led to issues in the past. She also referred to your externalisation of issues such as blaming Covid, and a lack of continuity of nurses, despite you bearing the responsibility for safe patient care. Ms Johnson therefore submitted that there was a public protection risk.

56. In respect of public interest, Ms Johnson submitted that an informed member of the public would be concerned should no finding of impairment be made given the seriousness of the case. She submitted that even with your remediation work, the issues were serious, you had created inaccurate records, and a colleague felt the need to raise a complaint. For these reasons, Ms Johnson submitted that even if the risk of repetition is low and the Committee decide that no finding of impairment is made on the grounds of public protection, a finding is still necessary in the public interest.

57. Ms Johnson lastly addressed the Committee on the matter of sanction. She submitted that the Committee must consider proportionality and consider the range of sanctions available to it. She submitted that there were mitigating factors that the Committee must consider such as the Committee making no findings on dishonesty or a deliberate disregard to patient safety, there was no evidence of a deep-seated attitudinal issue, you made extensive admissions to charges, your engagement throughout the process, positive testimonials from your peers, and an extensive show of remorse and insight. She submitted however that there were still aggravating factors to be considered, these being that the matters proved were serious and there had been a repetition of the behaviour over 11 months.

58. Ms Johnson submitted that to conclude with no further action would be insufficient to mark the seriousness of the matters at this hearing. Ms Johnson therefore submitted that a reprimand was necessary and appropriate to recognise the professional seriousness of the matters proved, would satisfy the public interest, would maintain and uphold professional standards, and would not impose a restrictive sanction on someone who has proved that they are improving their practise.

59. Mr Gillespie submitted that you are not impaired at all and that there is no longer a sufficient risk to patient safety that would warrant any further action. He submitted that based upon the

facts of this case, the Committee should not find impairment on public interest grounds alone. However, if the Committee do not agree then a finding of impairment alone is enough. He submitted that should the Committee still not be in agreement and believe that a sanction should be imposed, this should not be any more than a reprimand.

60. Mr Gillespie submitted that he had no positive submission to make on misconduct not being found. He submitted that the admitted facts in this case are misconduct bearing in mind their serious nature, including the non-use and inaccurate recording of a rubber dam during root canal treatment. He however submitted that the Committee should not consider that you had breached standard 1.3 as Ms Johnson had proposed as no finding of dishonesty or lack of integrity had been found. He also submitted that standards relating to a lack of consent should not be considered as this is not a case based on consent. He did however submit that standards 7.1. and 7.2 are very relevant to the case.

61. In relation to deficient professional performance, Mr Gillespie submitted that the way the evidence came to the GDC was not fair as there was no way of knowing exactly how the sample was chosen. Whilst there are allegations relating to 11 patients, these should still be considered fairly. He submitted that if misconduct was found, a finding of deficient professional performance would not affect the outcome and therefore asked the Committee to consider whether this was necessary.

62. Mr Gillespie next made submissions in relation to impairment. He submitted that there is no risk that you'll fail to protect the public. He submitted that there is no evidence before the Committee that you have minimised the events, and how you articulated these events is not as important in consideration as to the fact that you have admitted all your conduct. Mr Gillespie submitted that whilst your clinical care of patients was your responsibility, there is the potential that there was a mismatch between you and the practice at the time of the allegations, especially given that no concerns have arisen since. He submitted that you had provided several positive testimonials that include but aren't limited to details regarding your hard-working character and your abilities as a good mentor. He also referenced one testimonial in particular that refers to you as someone who really wants to make a difference, are transparent about where you are lacking, and you show the markers of a safe and effective practitioner.

63. Mr Gillespie submitted that whilst the test at this stage is different to that at an Interim Orders Committee (IOC), it is important to note that you complied with conditions imposed, continued to work hard and did not give up, and showed dedication to your patients and the profession. He submitted that your hard work led to the conditions being removed from your registration.

64. Mr Gillespie submitted that the matters are now three years old, and that in this time no new matters have been raised with the GDC regarding your practice. He submitted that this presents the picture of some who has fully remediated their actions. He submitted that no idea have been made out that you will cause harm to patient safety, breach professional standards, or bring the profession into disrepute. He submitted that it was highly unlikely that there would be any repetition of the matters. Therefore, there is no risk to the public.

65. On public interest grounds, Mr Gillespie submitted that it is plainly in the public interest for dentists to engage with the GDC, which you have done and could not have done any more. He submitted however that your failings do not mean that a finding needs to be made to show the public that action has been taken. He submitted that the clinical concerns and issues surrounding duty of candour were not issues that took place over a lengthy period of time, but were just one period where you did not show yourself at your best. He submitted that a finding of impairment did not need to be found in the public interest.

66. Mr Gillespie therefore finally submitted you have done all you can and there is no risk to public safety nor should any finding be made in the public interest. If the Committee do not agree, then impairment alone is enough. Should the Committee still not be in agreement and believe that a sanction should be imposed, a reprimand is sufficient and acceptable.

Committee's Decision

67. The Committee has borne in mind that its decisions on misconduct, impairment and sanction are matters for its own independent judgment. There is no burden or standard of proof at this stage of the proceedings. The Committee had regard to the *GDC's* Guidance document, *'Fitness to Practise: Guidance for the practice committees' (6 January 2026)* (the GDC's Guidance) and the relevant case law. The Committee also received advice from the Legal Adviser which it accepted.

Misconduct

68. The Committee first considered whether the facts found proved amounted to misconduct and deficient professional performance. In doing so, the Committee had regard to the GDC's publication, *Standards for the dental team* (September 2013).

69. The Committee considered that the conduct proved in this case was wide-ranging and repeated over an 11-month period. There were repeated failures that affected multiple patients based upon the basic competencies of a dentist, which in particular affected one patient and brought another at serious risk of harm. The Committee therefore considered that you had breached fundamental standards of dentistry.

70. The Committee determined that you had breached the following standards:

- 1.4 - You must take a holistic and preventative approach to patient care which is appropriate to the individual patient
- 2.2 - You must recognise and promote patients' rights to and responsibilities for making decisions about their health priorities and care
- 2.3 - You must give patients the information they need, in a way they can understand, so that they can make informed decisions
- 3.1 - You must obtain valid consent before starting treatment, explaining all the relevant options and the possible costs.
- 4.1 - Make and keep contemporaneous, complete and accurate patient records
- 6.2 - Be appropriately supported when treating patients
- 6.3 - Delegate and refer appropriately and effectively
- 7.1 - Provide good quality care based on current evidence and authoritative guidance
- 7.2 - Work within your knowledge, skills, professional competence and abilities

71. As a result of these breaches, the Committee determined that the facts found proved amounted to misconduct.

72. The Committee also considered whether your conduct amounted to deficient professional performance. The Committee considered that the sample of patients was diverse, including

both new and old patients with a range of clinical issues and treatments. It also considered that whilst 11 patients had been included in the charges, these had stemmed from a sample of 28 that the experts had considered before narrowing down, and that this case therefore did not relate to a single incident or a narrow sample of patients. Given this number of patients, range of issues, and the sustained conduct over 11 months, the Committee was satisfied that a fair sample had been provided and that it was enough to demonstrate deficient professional performance. The Committee therefore determined that your failings fall under deficient professional performance.

Impairment

73. The Committee then considered whether your fitness to practise is currently impaired by reason of your misconduct and deficient professional performance on the ground of the protection of patients and/or is in the wider public interest.

74. The Committee first considered whether your fitness to practise is impaired by your misconduct and deficient professional performance on public protection grounds. The Committee considered that you have carried out extensive remediation through re-training and that whilst you were subject to previous Interim conditions you complied and improved to the extent that these were removed as you no longer posed a risk. The Committee considered that there is currently a low risk of repetition given the extensive remediation and insight that you have demonstrated. The Committee also considered the submissions Ms Johnson made in that you remained impaired for issues relating to your duty of candour and the lack of specific training on this, your externalising of issues, and a remaining record keeping issue with your use of templates. The Committee however considered that you understood your duty of candour, had demonstrated this in your oral evidence and through your significant number of admissions, and accepted that other courses you had completed would include training on this matter. The Committee also considered that you were explaining context by referring to the environment at the Practice and not externalising and blaming the issues on others, as evidenced by the admissions you made. Lastly it considered that your use of templates was no longer a record keeping issue, as you had stated clearly that you do not carry out root canal treatment without a rubber dam *'end of',* and therefore to pre-populate this section of the record ensured that all of the information was included, and did not run the risk of missing key information. The Committee was therefore satisfied that you do not currently pose a risk to the public.

75. Accordingly, the Committee determined that a finding of impairment of fitness to practise is not required on public protection grounds.

76. The Committee then went on to consider whether a finding of impaired fitness to practise is required to uphold standards and/or to maintain public confidence in the dental profession. The Committee concluded that, given the serious and repeated nature of the conduct found proved, which related to 11 patients, if a finding of impairment was not made this would undermine public confidence in the dental profession and the GDC as a regulator. Therefore, the Committee determined that a finding of impairment is necessary in the wider public interest, to maintain public confidence in the profession and to uphold proper standards of conduct.

77. Accordingly, the Committee has determined that your fitness to practise is currently impaired by reason of your misconduct and deficient professional performance, solely on public interest grounds.

Sanction

78. The Committee next considered what sanction, if any, to impose on your registration. It recognised that the purpose of a sanction is not to be punitive although it may have that effect. The Committee applied the principle of proportionality balancing your interest with the public interest. It also took into account the *GDC's Guidance*.

79. The Committee considered the mitigating and aggravating factors in this case and took into consideration the relevant paragraphs in the *GDC's Guidance* on these matters.

80. The mitigating factors in this case are that:

- You have previous good character, in that you worked at four other practices in the UK, two before and two after the Practice at which the conduct occurred and there have been no issues;
- There was no financial or other gain on your part. Whilst some reference was made to financial gain in the issues surrounding NHS claiming, this was not deliberate and therefore not for financial benefit;
- There is evidence of good conduct following the allegations in question in that you have completed extensive and targeted CPD, you have complied with all GDC investigations, and your interim order workplace supervisor reports were all very positive;
- Evidence of remorse, insight and/or apology in that you made extensive admissions at the hearing and provided written statements;
- Remedial action taken through your additional training, including reducing your working days from 5 to 4, at a significant financial impact, to dedicate time to improving your practice in relation to the identified issues;
- The work environment at the practice was hostile, and there was a lack of continuity and support to the level that you were accustomed to;
- Multiple positive testimonials have been provided.

81. The aggravating factors in this case are that:
    - There was a risk of harm to the patients treated;
    - The misconduct was repeated over multiple patients and sustained over 11 months.

82. The Committee decided that it would be inappropriate to conclude this case with no further action. It would not satisfy the public interest given the seriousness of the matters, and determined that a sanction was required to uphold and maintain standards in the dental profession.

83. The Committee next considered a sanction of a reprimand. The Committee considered that you have shown insight into your conduct and expressed remorse through your statements and

admissions made at this hearing, and undertaken rehabilitative and corrective steps through your various training, all of which amount to significant remediation. The Committee also considered that your behaviour was not deliberate. The Committee having decided that your fitness to practise is not currently impaired on public protection grounds considered that there was no evidence to suggest that you pose a risk to the public should you be able to practise without restriction. The Committee therefore determined that a reprimand was the appropriate and proportionate sanction to impose in all the circumstances of this case.

84. The Committee considered that the higher sanction of conditions could have been appropriate to deal with the concerns in this case, however it determined that you had undertaken a significant amount of remedial work, had demonstrated genuine remorse and insight, fully engaged with proceedings and made many admissions from the outset. It also considered that you were previously subject to interim conditions of practice, but that these were removed given the low risk to the public that you had proved by way of your remedial actions. The Committee considered that the GDC had offered no new evidence to suggest that there was a risk to the public that conditions needed to mitigate.

85. The Committee has therefore determined that a reprimand should be recorded against your name in the Register. The fact of this reprimand, and a copy of this determination, will appear alongside your name in the Register for a period of 12 months. The reprimand forms part of your fitness to practise history and is disclosable to prospective employers and prospective registrars in other jurisdictions.