Dental Professionals Hearings Service

PUBLIC DETERMINATION

PUBLIC

HEARING HELD PARTLY IN PRIVATE

Professional Conduct Committee
Initial Hearing

12 November 2025

Name:	Kontogiannis, Vassilis
Registration number:	69201
Case number:	CAS-197028 and CAS-197762

General Dental Council:	Natasha Tahta, counsel Instructed by Capsticks solicitors
Registrant:	Not present and not represented

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

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

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

2. Dr Kontogiannis, is not present and is not represented in his absence. Natasha Tahta of counsel appears for the GDC.

The charge

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

"That, being registered as a dentist:

Referral 1

1. You failed to maintain an adequate standard of care between December 2016 and November 2018 in that you failed to:

(a) obtain a medical history from patient B and/or their parent on 21 December 2016;

(b) provide full treatment options:

(i) to patient B and/or their parent, before commencing orthodontic treatment;

(ii) to patient C and/or their parent, before commencing orthodontic treatment.

2. You failed to obtain informed consent between December 2016 and January 2019 from:

(a) patient B and/or their parent, before commencing orthodontic treatment;

(b) patient B, before administering local anaesthetic;

(c) patient C and/or their parent, before commencing orthodontic treatment.

3. Between December 2016 and November 2018 you failed to treat patients with kindness and compassion, in that you:

(a) spoke rudely and/or abruptly to patient C, a child, on one or more occasions;

(b) spoke rudely and/or abruptly to patient B, a child, on one or more occasions;

(c) told patient B, a child, when she was crying, to "stop making a fuss", or words to that effect, on 18 July 2017;

(d) treated patient B, a child, roughly, by physically pushing her back into the chair when she tried to sit up on 18 July 2017.

4. Between January 2020 and 22 January 2021, you failed to ensure that appropriate cover was in place to cover emergency care whilst you were away from the practice.

5. Between June 2020 and 22 January 2021, you failed to maintain adequate

PUBLIC

standards of cross infection control, in that you:

(a) failed to provide safety glasses for patient use on or around 22 January 2021;

(b) failed to wear a plastic apron between June 2020 and 22 January 2021;

(c) failed to allow sufficient time between patient appointments to ensure that an adequate decontamination of the surgery could be carried out on:

(i) 16 September 2020;

(ii) 17 September 2020;

(iii) 18 January 2021;

(iv) 19 January 2021.

6. Between February 2019 and 8 December 2020, you instructed an unqualified and unregistered person, your receptionist, to triage orthodontic patients over the telephone in your absence.

*7. **WITHDRAWN***

8. Between June 2020 and 22 January 2021, you failed to adhere to current laws and regulations in place in respect of:

(a) decontamination, in that you carried out an inadequate number of autoclave cycles on 30 November 2020;

(b) medical emergencies, in that on or around the 22 January 2021, the:

(i) Automated External Defibrillator ("AED") pads expiry date was June 2019;

(ii) oxygen cylinder expiry date was 25 October 2020;

(iii) size 2 oro-pharyngeal airway expiry date was 2010 and the size 3 was not present;

(c) medical emergencies, in that, between February 2020 and 22 January 2021, the emergency medical kit was incomplete and contained expired drugs;

(d) Covid-19 protocols, in that between June 2020 and January 2021, you:

(i) failed to conduct adequate risk assessments for staff;

(ii) caused or allowed too many patients to be booked for appointments on one or more occasion, thus being unable to adequately comply with social distancing regulations.

9. Between February 2019 and 22 January 2021, you failed to protect patient confidentiality by not storing patient data securely, in that you instructed the staff to use their personal phones for the storage and/or transmission of patient data.

10. Between 27 June 2022 and 29 July 2022, you failed to co-operate with an

PUBLIC

investigation conducted by the GDC, in that you failed to provide the GDC with:

(a) evidence of your indemnity cover;

(b) patient records.

11. Your actions in respect of Heads of Charge 4, 5, 6, 7 and/ or 8 put patient and/ or staff safety at risk.

Referral 2

12. Between 26 September 2018 and 2 March 2021 you failed to treat Patient D, a child, with kindness and compassion, in that you:

(a) spoke aggressively and/ or rudely to Patient D on or around:

(i) 27 September 2018;
(ii) 14 December 2018;

(iii) 22 February 2019;

(iv) 14 June 2019;

(b) treated Patient D roughly, by hitting his head to move it to one side on one or more occasion on or around:

(i) 15 July 2019;

(ii) 22 November 2019.

13. You failed to ensure that Patient D's parent was provided with a copy of a complaints procedure when she requested it on or around 7 December 2020.

14. You provided NHS treatment to Patient D on or around 2 March 2021, whilst you were suspended from the NHS Dental Performer's List.

15. Between 24 October 2022 and 29 November 2022, you failed to co-operate with an investigation conducted by the GDC, in that you failed to provide the GDC with:

(a) evidence of your indemnity cover;

(b) patient records.

16. From 27 June 2022 until at least 6 February 2025 you failed to provide the GDC with an up to date registered address.

17. Your conduct in respect of Head of Charge 14 was:

(a) misleading;

(b) dishonest.

AND that by reason of the facts alleged, your fitness to practise is impaired by reason of misconduct".

Service of notice of hearing – 3 November 2025

PUBLIC

4. At the outset of the hearing on 3 November 2025, Ms Tahta on behalf of the GDC submitted that service of notice of this hearing has been properly effected in accordance with Rules 13 and 65 of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules'). On 22 September 2025 a notice of hearing was sent to the address that Dr Kontogiannis, has registered with the GDC, setting out the date and time of this hearing, as well as the fact that the hearing would be conducted remotely. The notice was sent using the Royal Mail's Special Delivery service. The Royal Mail's Track and Trace service records that the notice was returned to sender on 25 September 2025. Copies of the notice were also sent by first class post, International post and email to Dr Kontogiannis. The Notice was attempted to be delivered to an address in Greece via International delivery, and was returned on 22 October 2025. In addition, efforts were made to contact Dr Kontogiannis via telephone, where he hung up.

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

Proceeding in absence

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

7. The Committee accepted the advice provided by the Legal Adviser. The Committee was mindful that its discretion to conduct a hearing in the absence of a registrant should be exercised with the utmost care and caution. After careful consideration the Committee determined that it would be fair and appropriate to proceed in Dr Kontogiannis's absence. The Committee noted that Dr Kontogiannis has not responded and has not engaged with the GDC for over 4 years. The Committee finds that Dr Kontogiannis has failed to provide an up to date delivery address and has voluntarily absented himself from this hearing. It also considers that an adjournment, which has not been sought, would be unlikely to secure his attendance. The Committee considers that any unfairness caused to Dr Kontogiannis by the Committee proceeding in his absence is outweighed by the public interest in the expeditious consideration of this case, as well the need to ensure fairness to the GDC.

Application to amend and admit evidence

8. At the outset of the hearing Ms Tahta made an application to admit further documentary evidence. She explained that the evidence of Witness 1 was served on Dr Kontogiannis in the main hearing bundle. At paragraph 43 of that statement the witness referred to a meeting she attended between NHS England and Dr Kontogiannis on 15 January 2021. On the same day a letter was sent to Dr Kontogiannis with the outcome of this meeting. However, the last two pages of this letter were omitted in error from the original bundle (although Dr Kontogiannis had had them previously). Ms Tahta asked the Committee to admit these two pages as documentary evidence as part of the GDC case.

9. Ms Tahta then made two hearsay applications. The first relates to Parent C's statement. She indicated that the GDC did not plan to call any of the witnesses as Dr Kontogiannis had not requested their attendance, and would only be tendered for questioning if the Committee wanted. However, Patient C's parent had contacted the GDC last week to inform them that she is no longer able to give evidence [IN PRIVATE]. The parent has provided a sworn statement. Ms Tahta applied for her full written statement to be admitted as hearsay evidence. Ms Tahta submitted that Dr Kontogiannis has not asked for any of the witnesses to attend and be challenged.

PUBLIC

10. Ms Tahta also made an application to admit hearsay evidence contained within the NHS material. This evidence was the interview by the NHS during its investigation of Person X, who worked as a dental nurse with Dr Kontogiannis. The interview is included in the NHS material provided to the GDC. Person X, during the interview, explains various procedures undertaken by Dr Kontogiannis and her interview goes to heads of charge including 4, 5, 6, 8 and 9. Ms Tahta submitted that the witness has not responded to the GDC and has not provided a sworn witness statement. Ms Tahta submitted that her evidence is not sole and decisive, except in respect of head of charge 5(b). She submitted that it is relevant to the heads of charge and is fair in the circumstances to admit. Ms Tahta submitted that the Committee, if her application is accepted, can in due course, decide what weight to attach to the evidence.

Committee's findings

11. The Committee accepted the advice of the Legal Adviser on all the GDC's applications. In relation to the hearsay application the Committee noted the review of the authorities undertaken by Spencer J in El Karout v *Nursing and Midwifery Council* [2019] EWHC 28 (Admin) and in particular the Court's approval of the approach of Mr Andrew Thomas QC, sitting as a judge of the High Court in *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin). Spencer J stated:

'Mr Andrew Thomas QC considered the decision of the Court of Appeal in NMC v Ogbonna and also the decision in R (Bonhoeffer) v GMC [2012] IRLR 37 in which the Court of Appeal held that Ogbonna did not lay down a general rule that there always had to be good and cogent reasons for the absence of the witness; all such cases are fact-sensitive, and the test is the requirement of fairness. Important factors may be a history of animosity between the parties, a conflict of factual evidence, and the degree of impact which the evidence would have on the registrant's career. At [45] the judge continued:

" For the purposes of this appeal, the relevant principles which emerge from the authorities are these:

1.1. The admission of the statement of the absent witness should not be regarded as a routine matter. The FTP rules require the Panel to consider the issue of fairness before admitting the evidence.

1.2. The fact that the absence of the witness can be reflected in the weight to be attached to their evidence is a factor to weigh in balance, but it will not always be a sufficient answer to the objection to admissibility.

1.3. The existence or otherwise of a good and cogent reason for the non-attendance of the witness is an important factor. However, the absence of a good reason does not automatically result in the exclusion of the evidence.

1.4. Where such evidence is the sole or decisive evidence in relation to the charges, the decision whether or not to admit it requires the Panel to make a careful assessment, weighing up the competing factors. To do so, the Panel must consider the issues in the case, the other evidence which is to be called and the potential consequences of admitting the evidence. The Panel must be satisfied either that the evidence is demonstrably reliable, or alternatively there would be some means of testing its reliability. In my judgment, unless the Panel is given the necessary information to put the application in its proper context, it will be impossible to perform this balancing exercise."

12. The Committee first considered Ms Tahta's application to admit the entirety of the letter from NHS England to Dr Kontogiannis dated 15 January 2021. The Committee considered that the evidence is relevant, the two pages were omitted in error, had in any event been sent to the Registrant, who had not objected or challenged them.

PUBLIC

13. The Committee noted that the letter was served on Dr Kontogiannis as part of the GDC's evidence at an early stage. The Committee is satisfied that this is relevant to some of the heads of charge and should be included as part of the GDC's case. The Committee was satisfied in these circumstances that it would fair to admit the additional pages. It will in due course, decide what weight to attach to this.

14. The Committee then considered the application to admit two hearsay pieces of evidence.

15. The Committee considered the matter carefully, in particular the email correspondence between the GDC and the mother of Patient C which describes the problems she has been having and it accepts the clear and cogent reasons why she was unable to attend. The Committee notes that Dr Kontogiannis has not requested her or any other witnesses to give evidence. Whilst the Committee accepted her evidence, was the sole and decisive evidence in some of the heads of charge, it was satisfied that it was demonstrably reliable as it was consistent with her contemporaneous complaint to NHS England. Having weighed up the competing factors, the Committee was satisfied that it is fair to admit the parent of Patient C's evidence.

16. The Committee then considered the application to admit the evidence of Person X. The Committee noted distinctions between the parent of Patient C's situation and that of Person X. There is no witness statement from Person X. As to why Person X is not here, the Committee was told that she had not responded to GDC requests. Person X was the whistle blower. There was no good or cogent reason before the Committee for her non-attendance. However, this is not an automatic bar to the admission of her evidence. The Committee noted that whilst her evidence was not in a formal witness statement, it was contained in a formal investigative interview with NHS England. It was a verbatim record, contained in a transcript and not a summary.

17. Further, it was not the sole evidence in relation to the charges it concerned (save for head of charge 5(b)). The Committee also took into account that it had been served on Dr Kontogiannis, who had made no objection to it and no other response, despite being given the opportunity to do so. It was relevant and material evidence and despite the disadvantages of it being hearsay evidence, the Committee determined overall that it was fair to admit the interview evidence of Person X.

Application to admit additional exhibit – 4 November 2025

18. Ms Tahta next applied to admit part of Case Examiners bundle originally served on Dr Kontogiannis containing a copy of day sheets displaying patient appointments which were omitted in error from the evidence bundle. Ms Tahta submitted that there would be no undue prejudice or unfairness to include these documents as part of the GDC's case.

19. The Committee received and accepted the advice of the Legal Adviser, and determined that it would be fair to allow the admission of this document as it was part of Dr Kontogiannis own practice records.

Rule 18 application – 4 November 2025

20. Ma Tahta after giving her opening submissions to the Committee, then made an application to withdraw head of charge 7. She submitted having considered this with the GDC expert, his opinion had changed in respect of head of charge 7. Ms Tahta submitted that therefore there is no evidence to substantiate this head of charge and applied to withdraw head of charge 7. She submitted that no injustice would be made to either party.

PUBLIC

21. The Committee received and accepted legal advice from the Legal Adviser. It considers that that it was fair in the circumstances to allow the application by the GDC to withdraw head of charge 7.

Findings of fact – 11 November 2025

Background to the case and summary of allegations

22. The allegations giving rise to this hearing arise out of Dr Kontogiannis's care and treatment of a number of young patients in the Portsmouth area.

23. The General Dental Council ("the Council") first received information from NHS England in May 2019, notifying the Council that the conditions imposed on Dr Kontogiannis's inclusion on the National Performers List had been varied. In May 2020 the NHS conditions were reviewed and varied again with some suggestion of non-compliance. Subsequently further information was passed on to NHS England by Person X. This information resulted in the emergency suspension of Dr Kontogiannis from the National Performers List on 15 January 2021. Due to issues raised by Person X, a practice visit was arranged for 21 January 2021. The practice visit was conducted on 22 January 2021. The findings of this visit were reviewed by NHS England and the suspension was confirmed. On 26 January 2021 Dr Kontogiannis was notified by NHS England that on 25 January 2021 they had later suspended him from the dental performers' list with immediate effect for at least six months, due to concerns with patient safety and a serious risk to patient care, and the public.

Evidence

24. The Committee has been provided with documentary material in relation to the heads of charge that Dr Kontogiannis, faces. This material includes:
    - The witness statements and documentary exhibits of the following witnesses:
        - Witness 1, Professional Standards Manager for NHS England, dated 7 October 2024;
        - Witness 2, Senior Clinical Adviser, NHS England South East dated 24 October 2024 with Excel Spreadsheet;
        - Parent of Patient C dated 2 May 2024;
        - Parent of Patient B dated 29 August 2024;
        - Patient B dated 27 September 2024;
        - Parent of Patient D dated 10 January 2025;
        - Witness 3 GDC Case Worker dated 21 August 2024 and 8 January 2025;
        - Natalie Ayling, Capstick Senior Associate Solicitors dated 7 February 2025
    - The transcript interview between Witness 4, Clinical Dental Adviser and Person X dated 12 April 2021.
    - The expert reports of Nigel Hunt, the GDC expert witness in this case, dated 23 September 2024 and 29 January 2025;
    - A raw data spreadsheet from the NHS Scottish Dental Practice Board (SDPB) relating to the claims for payment.
    - Copies of day sheets.

25. The Committee heard oral evidence from the GDC expert witness.

PUBLIC

26. The Committee had no questions for all the other witnesses who the GDC were prepared to tender (save for the parent of Patient C). Dr Kontogiannis was invited to require the witnesses to give oral evidence or to indicate if he had questions for them, but did not do so. Accordingly, following GDC standard directions, their witness statements stood as their evidence in chief.

27. The Committee notes that no patient records were provided for any of the patients stated below.

Committee's findings of fact

28. The Committee has taken into account all the evidence presented to it, both written and oral. It has borne in mind that as Dr Kontogiannis was neither present nor represented at this hearing, none of the witness evidence, including the expert witness was subject to the challenge of cross-examination. The Committee has considered the submissions made by Ms Tahta on behalf of the GDC and has had regard to the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016, updated December 2020).

29. The Committee has accepted the advice of the Legal Adviser concerning its powers and the principles to which it should have regard. The Committee is mindful that the burden of proof lies with the GDC, and has considered the heads of charge against the civil standard of proof, namely, the balance of probabilities. It reminded itself of Collins J's observations in Lawrance v GMC 2015 EWHC 581(Admin) to the effect that in cases of dishonesty cogent evidence was required to reach the civil standard of proof. The Committee heard that there had been no previous findings against Dr Kontogiannis and accepted that it was relevant to put his good character into the balance in his favour.

30. The Committee had in its papers the NHS report and reminded itself to disregard its conclusions and findings which were not probative of the allegations before it.

31. The Committee has considered each head of charge separately.

32. I will now announce the Committee's findings in relation to each head of charge:

	Referral 1
1.	*You failed to maintain an adequate standard of care between December 2016 and November 2018 in that you failed to:*
1.(a).	*Obtain a medical history from patient B and/or their parent on 21 December 2016;* **Proved** Patient B's parent stated in her written statement, "*Dr Kontogiannis did not ask about Patient B's medical history. Dr Kontogiannis did not explain the treatment plan and did not offer different treatment options".* The expert witness in his written and oral evidence stated that taking a patients medical history is absolutely vital, to identify any underlying problems. He stated that Dr Kontogianis failed to provide evidence that a medical history was taken in respect of Patient B on 21 December 2016. He stated that serious risk of patient harm could be caused if no medical history is taken.

PUBLIC

	The Committee noted that the expert witness agreed that there was an obligation on Dr Kontogiannis as the treating dentist, to ensure that a medical history was obtained from Patient B and/or their parent. The Committee noted that no records are available in respect of the treatment provided by Dr Kontogiannis to Patient B. There is no suggestion from Dr Kontogiannis to contradict Parent B's evidence, and in any event, the Committee found to be an accurate account. The Committee is satisfied that there is a duty to take a medical history, as stated in the GDC's standard, however, Dr Kontogiannis failed to do so. The Committee therefore finds this head of charge proved.
1.(b).	You provide full treatment options:
1(b).(i)	*to patient B and/or their parent, before commencing orthodontic treatment;* **Proved** Patient B's parent stated in her written statement, *"I first met Dr Kontogiannis at Patient B's initial appointment at the Practice, which was 21 December 2016. I had no choice as to which orthodontic practice Patient B was referred to. I also found out, as described below, that NHS England pay orthodontist up front for treatment, which meant you could not then move orthodontists after treatment had started. Throughout Patient B's treatment with Dr Kontogiannis our relationship with him was non-existent, in that he did not make any effort to get to know me or Patient B, he ignored our questions and did not ask us any questions".* "*Patient B had about six appointments with Dr Kontogiannis before I refused to return. I attended every appointment, other than the penultimate appointment, where my partner (Patient B''s dad) took her as I could not bear to go. When I did attend I would sit in the treatment room with them as Dr Kontogiannis worked. Patient B was 10 years old at the time of the first appointment and 11 years old by our last appointment with Dr Kontogiannis."* Patient B stated in her written statement *"At my first appointment with Dr Kontogiannis (I cannot recall the date of this appointment), I recall him examining my teeth by looking at them. I cannot recall any further details about his examination of my teeth. Dr Kontogiannis did not explain any different treatment options, nor did he explain to me the risks and benefits of the treatment he was providing at any of the appointments."* In his oral evidence the expert witness stated that Dr Kontogiannis had an obligation to discuss all treatment options with the patient/parent including the option of doing nothing, particularly where orthodontic treatment is being considered. The Committee noted that no records were provided by Dr Kontogiannis to confirm that any discussions of the treatment options took place. The Committee accepts the evidence of both Patient B and her parent and considers that Dr Kontogiannis had a duty of care to provide full treatment options as required in the GDC's standards. It concluded that there is no evidence to suggest otherwise and that on the balance of probabilities, Dr Kontogiannis failed to do so.

PUBLIC

	The Committee therefore finds this head of charge proved.
1.(b).(ii)	*to patient C and/or their parent, before commencing orthodontic treatment.* **Proved** Patient B stated in her written statement *"On one of the first appointments (I'm unsure what date this was) Dr Kontogiannis did not greet Patient C or me with any of the usual pleasantries (i.e asking us how we were). I agree Patient C was asked to sit in the treatment chair and Dr Kontogiannis told Patient C to open their mouth. I do not recall exactly what inspection, if any, Dr Kontogiannis carried out, but I recall Dr Kontogiannis quickly told us that Patient C needed braces. Dr Kontogiannis did not explain any other options nor did he explain why Patient C needed braces and how it would fix their overbite".* The parent of Patient C's evidence is clear and credible in that Dr Kontogiannis failed to provide treatment options. The Committee accepts the evidence of Patient C's mother who stated that no treatment options were discussed before commencing orthodontic treatment. The Committee considers that Dr Kontogiannis had a duty of care to provide full treatment options as required in the GDC's standards. However, Dr Kontogiannis failed to do so. The Committee therefore finds this head of charge proved.
2.	*You failed to obtain informed consent between December 2016 and January 2019 from:*
2.(a).	*patient B and/or their parent, before commencing orthodontic treatment;* **Proved.** Parent B's mother stated in her written statement *"Dr Kontogiannis did not ask about Patient B's' medical history. Dr Kontogiannis did not explain the treatment plan and did not offer different treatment options."* The Committee accepted the opinion evidence of the GDC expert that Dr Kontogiannis was under a professional duty to obtain informed consent from Patient B, as set out in the GDC's Standards. This was an integral aspect of providing care. He stated that it was a serious failing particularly when administering orthodontic treatment. The Committee is satisfied that having found proved that Dr Kontogiannis did not obtain Patient B's medical history and provide all treatment options, he could not have obtained Patient B or his mother's informed consent before commencing orthodontic treatment. The Committee therefore finds this head of charge proved.
2.(b)	*patient B, before administering local anaesthetic* **Proved.** Parent B's mother's evidence was that Dr Kontogiannis administered a local anesthetic without explaining either to Patient B or to her why he was doing so.

PUBLIC

	Patient B stated in their written statement *"On one occasion (I cannot recall what date this was), Dr Kontogiannis administered an injection of the numbing agent into my gums without explaining or warning me before-hand. I cannot recall what Dr Kontogiannis was doing prior to this and I recall Dr Kontogiannis did not say anything before injecting me. I started to panic and began crying, and so Dr Kontogiannis stopped what he was doing and the appointment ended early. I am not aware of why Dr Kontogiannis needed to use the numbing injection on me as he did not explain what treatment he was about to carry out."* The Committee accepted the evidence of Patient B and her mother. The Committee is satisfied that Dr Kontogiannis went ahead with a course of treatment without an explanation to either Patient B or her mother. He failed to inform Patient B or her mother that he was administering anaesthetic, which caused distress to both the patient and the mother. The Committee therefore finds this head of charge proved.
2.(c).	*patient C and/or their parent, before commencing orthodontic treatment.* **Proved.** The Committee accepted the written statement of the parent of Patient C where she states *"On one of the first appointments (I'm unsure what date this was) Dr Kontogiannis did not greet Patient C or me with any of the usual pleasantries (i.e asking us how we were). I agree Patient C was asked to sit in the treatment chair and Dr Kontogiannis told Patient C to open their mouth. I do not recall exactly what inspection, if any, Dr Kontogiannis carried out, but I recall Dr Kontogiannis quickly told us that Patient C needed braces. Dr Kontogiannis did not explain any other options nor did he explain why Patient C needed braces and how it would fix their overbite".* For the same reasons as provided in head of charge 2.(a), given that the Committee has found proved that Dr Kontogiannis did not obtain Patient C's medical history and provide full treatment options, he therefore could not have obtained Patient C or their mother's informed consent before commencing orthodontic treatment. The Committee therefore finds this head of charge proved.
3.	*Between December 2016 and November 2018 you failed to treat patients with kindness and compassion, in that you:*
3.(a).	*spoke rudely and/or abruptly to patient C, a child, on one or more occasions;* **Proved.** The Committee accepted the written statement of the parent of Patient C where she states" *During all the appointments I attended with Patient C, I had concerns with the way Dr Kontogiannis spoke to Patient C which I raised in my complaint to NHS England. As mentioned in my complaint Dr Kontogiannis barked orders at Patient C, for example, Dr Kontogiannis would shout instructions such as "open your mouth, wider, wider" at all appointments. Dr Kontogiannis did not explain what he was going to do during any of the appointments, nor did he explain what he was actually doing during the appointment.*

PUBLIC

PUBLIC

	In the appointment (I cannot recall the date) I recall Dr Kontogiannis stating angrily "you need to clean your teeth" and "how do you expect to have good teeth, if you don't open your mouth wider". I was concerned as Dr Kontogiannis came across as threatening and Dr Kontogiannis' tone was short and angry." The expert witness in his oral evidence stated that it is important to treat all patients with care and kindness, as failure to do so had the potential for patients and families to have a bad experience at a dental practice. The Committee is satisfied that Dr Kontogiannis had a duty to treat Patient C with kindness and compassion, as set out in the GDC's standards. This was agreed by the GDC expert witness. The parent of Patient C was clear in her written evidence that Dr Kontogiannis was rude and abrupt, and he came across as threatening towards her child. The Committee accepts the evidence of Parent C and is satisfied that Dr Kontogiannis failed to treat Patient C with care and kindness. The Committee is satisfied that Dr Kontogiannis failed in his duty as a dental practitioner, to treat Patient C with compassion and kindness by speaking rudely and/or abruptly to Patient C, a child. It noted this occurred more than once towards Patient C. It therefore finds this head of charge proved.
3.(b).	*spoke rudely and/or abruptly to patient B, a child, on one or more occasions;* **Proved.** Patient B's mother written statement stated that *" recall that Dr Kontogiannis was very abrupt. It was really hard to understand what Dr Kontogiannis said as he had a strong accent, would speak quickly and would not repeat anything. When Dr Kontogiannis spoke to me, they would continue working on my daughter's mouth and so would be looking down. This made it harder to understand Dr Kontogiannis.* Patient B stated in her written statement "*Generally Dr Kontogiannis did not explain what he was going to do during my appointments and he did not communicate with me about the treatment. Dr Kontogiannis did not treat me as a child, in that they were not gentle or kind, nor did he take steps to make me feel at ease."* The Committee accepts the evidence of both Patient B and her mother. It is satisfied that Patient B was visibly upset in front of her mother who was present. The Committee is satisfied that Dr Kontogiannis failed in his duty of care to treat the patient with kindness and compassion. There is clear evidence that Dr Kontogiannis spoke rudely and abruptly to Patient B on more than one occasion. It therefore finds this head of charge proved.
3.(c).	*told patient B, a child, when she was crying, to "stop making a fuss", or words to that effect, on 18 July 2017;* **Proved.**

PUBLIC

	Patient B's mother written statement stated that *"When we went into the appointment, Patient B spent most of the time in the chair screaming as Dr Kontogiannis was hurting her. Dr Kontogiannis told her to be quiet stating words to the effect of "stop making a fuss" and "stop crying, you have to have this done", but quite often he would just not react at all to her asking him to stop, he would just carry on and ignore her pleas. When my daughter tried to get up, he would force her back into the chair.* The Committee notes that Patient B was seen crying in front of her mother who was present. The Committee is satisfied that the written evidence of the parent of Patient B is cogent and reliable. Therefore, Dr Kontogiannis failed in his duty of care to treat the patient with kindness and compassion, by making these remarks to Patient B. It therefore finds this head of charge proved.
3.(d.)	*treated patient B, a child, roughly, by physically pushing her back into the chair when she tried to sit up on 18 July 2017* **Proved** Patient B's mother's written statement stated "*Patient B did not like Dr Kontogiannis as he was really rough with her. On some occasions, I recall Patient B would scream out in pain, or start crying and shaking during appointments. When Dr Kontogiannis put the pink moulding into my daughter's mouth, they did not pre-warn her. Dr Kontogiannis forced her mouth down and this made her gag. In general, Dr Kontogiannis was very physical with Patient B's and physically moved her around all the time, for example on numerous appointments he would push or pull Patient B to manipulate her positioning on the chair, and he would pull her backwards by the shoulders if Patient B tried to sit up or get out of the chair.* *When we went into the appointment, Patient B spent most of the time in the chair screaming as Dr Kontogiannis was hurting her. Dr Kontogiannis told her to be quiet stating words to the effect of "stop making a fuss" and "stop crying, you have to have this done", but quite often he would just not react at all to her asking him to stop, he would just carry on and ignore her pleas. When my daughter tried to get up, he would force her back into the chair."* The GDC expert was clear in his oral evidence that any physical contact and restraint by pushing a patient back in a dental chair is very serious. The Committee accepted the evidence of the parent of a Patient B. It considers the evidence of parent of Patient B to be consistent, plausible and reliable in her account. The Committee is satisfied that Dr Kontogiannis failed in his duty of care to treat Patient B with kindness and compassion by physically pushing her back into the chair. It therefore finds this head of charge proved.
4.	*Between January 2020 and 22 January 2021, you failed to ensure that appropriate cover was in place to cover emergency care whilst you were away from the practice.* **Proved.**

PUBLIC

<table>
<tr><td></td><td>The Committee specifically considered having admitted the evidence of Person X, what weight to attach to her evidence. It was mindful that her evidence was hearsay and to exercise caution when assessing such hearsay evidence, whilst noting that her evidence was not contested.

The Committee noted Person X's information was obtained in a formal investigation, in the form of a transcript of a recorded interview. There was no information before the Committee to suggest that Person X had fabricated her complaints, and the Committee was mindful that she was the whistle blower in this case. The Committee found that the formal circumstances of obtaining that evidence, and the fact that aspects of her account are corroborated by other evidence, meant that in the Committee's judgement it was appropriate to give considerable weight to the information from Person X, despite it being hearsay.

The Committee noted the written statement of TH, NHS Professional Standards Manager, and in particular "Whilst Dr Kontogiannis was away, Person X informed me that he did not arrange for a locum Orthodontist to cover the Practice. Instead the receptionist, who has no qualifications in dentistry or orthodontics, would triage patients who called the Practice. Person X stated that a locum Orthodontist would not be able to work at the Practice due to the state of it, stating that the equipment and drugs kit was out of date... She also stated that Dr Kontogiannis refused to bring in a locum Orthodontist because he feared they may blow the whistle on him."

The Committee also noted the written statement of HW, the inspector "I was concerned about the fact that Dr Kontogiannis was only at the Practice for around two weeks each month. While he had an arrangement in place for emergencies, there was no cover in place for routine appliance checks and this meant that treatment would be taking longer than it should. For example, as I identify in my statement, the last day he saw patients before Christmas was 8 December 2020 and I do not recall when the Practice opened following Christmas. This was a potentially log gap where patients were not able to get routine check -ups."…

When asked during the NHS interview if Dr Kontogiannis had ensured cover was provided in his absence, Person X replied "No. "G" up the road used to cover our emergency appointments but in later times over the past year he hasn't as I don't think he is practising anymore anyway, so we've had no cover since "G" stopped working".

The GDC expert witness stated his oral evidence that appropriate (including emergency) cover should always be in place to ensure patients are satisfactorily cared for. He stated that communication with a specialist practitioner is essential to ensure arrangement of appropriate level of competence cover to ensure continuation of targeted care and treatment.

The Committee accepted the evidence of Person X and also the evidence of Witness 2 as plausible and reliable. The Committee is satisfied that Dr Kontogiannis had failed to ensure appropriate cover was in place to cover emergency care whilst he was away from the practice. This was highlighted in the inspection report.

It therefore finds this head of charge proved.</td></tr>
<tr><td>5.</td><td>Between June 2020 and 22 January 2021, you failed to maintain adequate standards of cross infection control, in that you:</td></tr>
<tr><td>5.(a).</td><td>failed to provide safety glasses for patient use on or around 22 January 2021;</td></tr>
</table>

	Proved. Person X stated in the NHS interview: *"Oh yes, he rang me and asked me numerous times during that day of Witness 2's visit asking me where lots of different things were kept, like where are the patients' glasses. He never uses safety glasses…"* The Committee also notes the inspection report which identifies that no protective glasses were available upon request. The GDC expert witness stated in his oral evidence that stated failing to maintain appropriate standards of cross infection control, and in particular failure to provide a patient safety glasses, represents a real risk of harm particularly eye injury to patients in Dr Kontogiannis' care. The Committee accepted the evidence of Person X, and also Witness 2. It noted the inspection visit occurred during the Covid pandemic. Dr Kontogiannis upon request, was not able to provide safety glasses to Witness 2. Person X also stated during interview that he never wears safety glasses. The Committee therefore finds this head of charge proved.
5.(b).	*failed to wear a plastic apron between June 2020 and 22 January 2021;* **Proved.** Person X stated during the NHS interview when asked "*So how did you know what to wear for Covid?"* She replied "*Through my other employer. She was very good on it all. But going into that, obviously we were wearing aprons as well, he never wore an apron. He would walk in in his clothes and then he would treat patients in the same clothes, there was not changing of clothes when he came into the Practice. He would wear the same clothes for 3 days treating patients. He would never wear an apron*". The Committee accepts the evidence of Person X whose evidence is the sole evidence for this head of charge. It considers that he had a duty to wear an apron when treating patients. Person X's evidence is that she never saw him wear one at that material time. The Committee therefore considers, on the balance of probabilities, that it was more likely than not that Dr Kontogiannis had failed to wear a plastic apron between June 2000 and 22 January 2021. It therefore finds this head of charge proved.
5.(c).	*failed to allow sufficient time between patient appointments to ensure that an adequate decontamination of the surgery could be carried out on:*
5.(c).(i)	*16 September 2020;* **Proved.** The Committee noted the written statement of Witness 2 and in particular *"By not attending the Practice regularly, I considered Dr Kontogiannis was seeing more patients each day that I thought he should be. I cannot comment on the number of patients Dr Kontogiannis saw each day. As part of the inspection. I reviewed the appointment list and noticed that patients were being seen in 10 minute intervals. This was concerning for two main reasons:*

PUBLIC

<table>
<tr><td></td><td>
A) The frequency of appointments meant there would be several in the waiting room at any one time (as patients arrive early for the for appointments and it as not clear how the practice could maintain social distancing between them, given the reception area was not very big (please see photographs at HW3).
B) There would be insufficient time to see a patient, complete their notes and then decontaminate the room before the next patient arrived.
The GDC expert witness stated in his oral evidence that Dr Kontogiannis had seen a large number of patients over a two-week period. He opined that the large number, some being seen every 10 minutes left very little time to dental staff to allow them to carry out their duties in order to ensure the surgery was decontaminated. This included wiping down all contact surfaces.
The Committee noted the day list provided which clearly shows the dates and times which corresponds with the number of patients treated by Dr Kontogiannis. It is satisfied that Dr Kontogiannis has worked on these 4 days.
The Committee is satisfied there is a duty for Dr Kontogiannis to ensure the surgery was decontaminated between appointments. The Committee accepted the evidence from the GDC expert regarding his calculation of the number of patients seen, particularly during Covid period, which was so great, that there was insufficient time to decontaminate the surgery between patient appointments.
The Committee also accepts the evidence of Witness 2 who after his inspection at the practice, was concerned that attempting to treat so many patients in one day presented a real risk to patient safety, more particularly maintaining social distancing.
Therefore, the Committee is satisfied that the day list and times indicates that the time in between was insufficient to ensure the room was decontaminated, given the sheer number of patients booked.
The Committee is satisfied this amounts to a failure to maintain an adequate standard of infection control.
It therefore finds this head of charge proved in its entirety.
</td></tr>
<tr><td>5.(c).(ii).</td><td> 17 September 2020; Proved – for reasons provided above. </td></tr>
<tr><td>5.(c).(iii).</td><td> 18 January 2021. Proved - for reasons provided above. </td></tr>
<tr><td>5.(c).(iv).</td><td> 19 January 2021; Proved - for reasons provided above. </td></tr>
<tr><td>6.</td><td> Between February 2019 and 8 December 2020, you instructed an unqualified and unregistered person, your receptionist, to triage orthodontic patients over the telephone in your absence. Proved. </td></tr>
</table>

PUBLIC

	The Committee noted the written statement of Witness 1 who stated *"Whilst Dr Kontogiannis was away, Person X informed me that he did not arrange for a locum Orthodontist to cover the Practice. Instead the receptionist who has no qualifications in dentistry or orthodontics, would triage patients who called the Practice…"* Person X stated that the receptionist would ask them three basic questions, "*are you in any pain discomfort or bleeding?"*. If the answer was "*yes*", she would pass them to "G" or refer them to the NHS advice service. The Committee notes the GDC expert in his oral evidence referred to triaging in the sense of giving advice regarding orthodontic treatment. The evidence from Person X, was that the receptionist was asking basic questions only and the Committee is satisfied that the basic level of triaging was appropriate. There was no evidence that any advice was provided in this case. Whilst the wording used in head of charge 6 has been established, the Committee was satisfied that there was no wrongdoing or culpability made out and therefore the allegation at head of charge 11 did not put patient or staff safety at risk. It therefore finds this head of charge proved.
7.	***WITHDRAWN***
8.	*Between June 2020 and 22 January 2021, you failed to adhere to current laws and regulations in place in respect of:*
8.(a).	*decontamination, in that you carried out an inadequate number of autoclave cycles on 30 November 2020* **Proved.** The Committee noted the written statement of Witness 2 where he states *"I reviewed the autoclaves logs. The autoclave is the machine used to sterilize dental equipment. The autoclave used at Dolphin Orthodontics had an integral printer which printed a log of the details of each cycle (date, time, temperature, duration of cycle). Details of these were also manually entered onto log sheets. I took photographs of the logs that I reviewed from November 2020, and I produce a copy of these photos as Exhibit "HW3".* The GDC expert witness stated in his oral evidence that Dr Kontogiannis was attending to a large number of patients on that day. He stated the day sheets established that 26 patients were seen on that day, 8 of which required braces having to be removed. This involves a large use of the autoclave machine and large number of instruments to be cleaned. The GDC expert contended that the documentation indicated that a maximum 4 cycles was conducted, which would be an improper and insufficient use, given the number of patients seen that day. The Committee satisfied there is sufficient evidence to demonstrate that Dr Kontogiannis failed to adhere to current laws and regulations in place in respect decontamination, in that he carried out an inadequate number of autoclave cycles on 30 November 2020. It therefore finds this head of charge proved.
8.(b).	*medical emergencies, in that on or around the 22 January 2021, the:*
8.(b).(i).	*Automated External Defibrillator ("AED") pads expiry date was June 2019;*

PUBLIC

	Proved. The GDC expert witness stated in his oral evidence that an Automated External Defibrillator (AED) is essential to provide the patient a shock when required. He stated that the glue on the contact pads has a shelf life which was out of date. This therefore provides an insufficient shock, which presents a serious risk of harm to patients. In his report he states "*The photographs taken at the visit to the practice by the Dental Advisor (HW3) on 22 January 2021, show that the Automated External Defibrillator (AED) pads expiry date was June 2019. For accurate heart monitoring and analysis and the delivery of an effective shock, it is essential that the pads have excellent contact with the skin. The pads have an adhesive gel on the fitting surface to ensure good skin contact. Over time, the gel dries out and hardens preventing good skin contact and rendering the AED ineffective (Appendix 8a). In my opinion failure to monitor expiry dates and having pads that were out of date represents a standard far below that expected as patient, parent, staff safety were put at risk and could resulted in a fatality. It also contravenes the CQC mandatory requirements*." Witness 2 stated in his report that he found AED's at the practice during his visit to be out of date. He took photographs of these at the practice, confirming the AEDs were out of date. The Committee accepted the evidence of the GDC expert and also that of Witness 2. It also noted the photographic evidence provided by Witness 2 which he took during his inspection on 22 January 2021, which quite clearly shows the out-of-date AED pads at the practice. The Committee therefore finds this head of charge proved.
8.(b).(ii).	*oxygen cylinder expiry date was 25 October 2020;* **Proved** The GDC expert witness stated in his oral evidence that a oxygen cylinder is essential to provide the patient oxygen when required. The oxygen cylinder loses pressure over a period of time, which provides a serious risk of harm. Witness 2 stated in his written statement that he found an oxygen cylinder to be out of date at the practice. Again, he provided photographs which were taken during his inspection visit to confirm the cylinder was out of date. The Committee accepts the evidence of both Witness 2 and the GDC expert and finds this head of charge proved.
8.(b).(iii).	*size 2 oro-pharyngeal airway expiry date was 2010 and the size 3 was not present;* **Proved.** The GDC expert witness stated in his oral evidence that an oro-pharyngeal airway is placed in the patients mouth and needs a different size depending on the size of the patient's mouth, particularly young children. Failure to provide in date equipment is serious as it creates a serious risk of harm.

PUBLIC

	Witness 2 stated in his written statement that he found the size 2 oro-pharyngeal airway to be out of date, and the size 3 was not present at the practice. Again, he provided photographs which were taken during his inspection visit to confirm this. The Committee accepts the evidence of both Witness 2 and the GDC expert and finds this head of charge proved.
8.(c).	*medical emergencies, in that, between February 2020 and 22 January 2021, the emergency medical kit was incomplete and contained expired drugs;* **Proved.** The GDC expert witness stated in his oral evidence that having incomplete medical kits, containing out of date drugs, that are ineffectual, places patients at serious risk of harm. In his report he stated "…*photographs supplied by the practice nurse and sent to Witness 1 on 18 January 2021 show that several drugs were out of date: Medazolam in February 2020, Glucogel in May 2020, and Ventolin Inhaler December 2020*..." The Committee notes the photographs taken by Witness 2 during his inspection visit on 21 January 201 of the drugs packets stored at the practice. These quite clearly show them being out of date. The Committee is satisfied there is Contemporaneous evidence to support this head of charge. It therefore finds this head of charge proved.
8.(d).	*Covid-19 protocols, in that between June 2020 and January 2021, you:*
8.(d).(i).	*failed to conduct adequate risk assessments for staff;* **Proved.** The GDC expert witness stated in his oral evidence that conducting risk assessments for staff is essential to ensure anyone involved in the management of patients in a clinical setting is in a suitable and effective environment, for example to ensure patients and staff are safe from cross contamination. The concern is a failure by Dr Kontogiannis to conduct Covid risk assessments with staff. During the inspection conducted by Witness 2, no Covid risk assessments were provided. Two assessments dated 11 June 2020 were later provided by Dr Kontogiannis, but were not signed either by the staff or Dr Kontogiannis. The evidence from Person X was that Covid risk assessments were never conducted at the practice. The Committee was not persuaded that these Covid risk assessments were ever conducted. The GDC expert stated that these Covid risk assessments must be done in conjunction with a staff member, and that form should be signed by both him and the staff member and stored safely in the personal file of the staff member. The Committee considered on the balance of probabilities that Dr Kontogiannis failed to conduct adequate Covid-19 risk assessments.

PUBLIC

	It therefore finds this head of charge proved.
8.(d).(ii)	*caused or allowed too many patients to be booked for appointments on one or more occasion, thus being unable to adequately comply with social distancing regulations.* **Not proved.** The GDC expert witness stated in his oral evidence that there were four different dates identified where patients had to wait outside the building. He stated some patients were booked in for 10 minutes or less, which then presents an issue of a large number of patients in a small waiting room. This presents a risk of failure to adhere to social distancing contraventions. The Committee notes the photographs of the patient waiting room. The Committee took into account the size of the room, together with Person X's account that some patients were waiting outside in the street. However, the Committee found the GDC expert's conclusion was speculation. The Committee considers that there is a lack of evidence to demonstrate that there was insufficient space available in the practice to ensure social distancing was maintained given the evidence from Person X that patients waited outside. Accordingly, the Committee is satisfied that the GDC has failed to discharge its burden of proof. It was not persuaded that the GDC had shown that Dr Kontogiannis had too many patients inside the clinic which would result in him being unable to adequately comply with social distancing regulations. The Committee therefore finds this head of charge not proved.
9.	*Between February 2019 and 22 January 2021, you failed to protect patient confidentiality by not storing patient data securely, in that you instructed the staff to use their personal phones for the storage and/or transmission of patient data.* **Proved.** The GDC expert witness stated in his oral evidence that most patient data should be transmitted from a secure portal site. This secure portal was not being used on staff phones. This presents a risk of security breach and therefore the patients' data would not be secure. In his report he concluded" *In my opinion there is some evidence that the patient data was not kept or transmitted securely at all times and this is far below the standard required by the GDPR Principles, 2016. Data breaches could or may have occurred and contravenes GDC Guidance 4.5."* The Committee notes the transcript interview of 12 April 2021 of Person X who when asked, "*So, he was triaging patients whilst in Greece*?"..She replied "*Whilst he was in Greece, I would Viper him the problem and make contact with him over Viper and then he would contact them, or he would ring me back and tell me what to tell the patient. Then when he came back to England, he had me tell them to contact the Dolphin Ortho email and he would triage them via email". She was later asked "Did you ever exchange patient details via VIPER*?" She replied "*Yes, names, dates of birth and telephone numbers*".

PUBLIC

	The Committee accepts the evidence of the GDC expert and Person X. It is satisfied that there is evidence that Dr Kontogiannis allowed staff to send patient details through their personal mobile phones. Dr Kontogiannis failed to protect patient confidentiality by not storing patient data securely, in that he instructed the staff to use their personal phones for the storage and/or transmission of patient data. It therefore finds this head of charge proved.
10.	*Between 27 June 2022 and 29 July 2022, you failed to co-operate with an investigation conducted by the GDC, in that you failed to provide the GDC with:*
10.(a).	*evidence of your indemnity cover;* **Proved.** The Committee noted the written statement of HS who states *"On 27 June 2022 I contacted Dr Kontogiannis by letter informing him that we were considering concerns that had been raised by NHS England. In this letter, we requested the following information from Dr Kontogiannis; a. Information on his working arrangements, including details about where he currently works, and where he worked at the time the concerns relate to; b. Proof of his indemnity arrangements currently in place, and in place at the time the concerns relate to; and c. Patient records for the Patients listed in the enclosure with the letter.* *The letter at HS1 was as an attachment to an email, dated 27 June 2022, to Dr Kontogiannis's email address only... I can confirm that this letter was not sent by post. I can confirm that the GDC has no record of a response from Dr Kontogiannis, nor did we receive a download receipt from the email attachment.* *Therefore, on 13 July 2022 I sent a further letter to Dr Kontogiannis, via special July 2022. I produce the Royal Mail tracking information for this letter, which confirms the letter was signed for by "FLAT 5".* *Again, I can confirm that the GDC has no record of a response received from Dr Kontogiannis, and we did not receive a download receipt from Dr Kontogiannis. On 22 July 2022, I sent Dr Kontogiannis a final letter chasing for a response, by special delivery and by email. I produce the letter, and the email of the same date. I produce the Royal Mail tracking information for this letter. Although the letter was signed for, the letter was returned to the GDC marked "return to sender. No longer at this address" and I produce the returned envelope.* *I can confirm that the GDC does not have a record of receiving any response from Dr Kontogiannis to the above mentioned correspondence, nor did we receive a download receipt for the email attachments.* *Dr Kontogiannis has not responded to any of the GDC's correspondence regarding the investigation."* The GDC expert witness stated in his oral evidence that not to comply with the regulatory standards is a very serious matter. The Committee accepts the evidence of Witness 3. It is satisfied that he had a duty to cooperate with his regulator but failed to do so. The Committee considers that Witness 3's evidence clearly outlines the period where Dr

PUBLIC

	Kontogiannis, upon various requests, failed to cooperate with the GDC and provide evidence of indemnity cover. It therefore finds this head of charge proved.
10.(b).	*patient records.* **Proved -** For same reasons as above.
11.	*Your actions in respect of Heads of Charge 4, 5, 6, and/ or 8 put patient and/ or staff safety at risk.* **Proved in respect of heads of charge 4, 5, and 8 (excluding 8(d)(ii), and not proved in respect of head of charge 6** In respect of head of charge 4, the Committee accepted the evidence of the GDC expert, that in failing to provide access for emergency care risks delay to orthodontic treatment and its satisfactory progress. In respect of head of charge 5, the Committee accepted the evidence of the GDC expert in that failing to provide patients with eye protection, risks eye injury or even blindness. In respect of head of charge 8, the Committee accepted the evidence of the GDC expert, that inadequate infection control protocols, risks transmission of infectious disease, of particular concern during Covid-19, and that inadequate medical emergency equipment and drugs presented a safety if not fatal risk to patients should an emergency occur. In respect of head of charge 6, the Committee does not find head of charge 6 proved in relation to head of charge 11 for the reasons set out above in head of charge 6. It therefore find it proved in respect of heads of charge 4, 5 and 8 (excluding 8(d)(ii).
	<u>Referral 2</u>
12.	*Between 26 September 2018 and 2 March 2021 you failed to treat Patient D, a child, with kindness and compassion, in that you:*
12.(a)	*spoke aggressively and/ or rudely to Patient D on or around:*
12.(a)(i)	*27 September 2018;* **Proved.** Parent D's parent stated in her witness statement "*We had to go back to Dr Kontogiannis various times as Patient D's braces kept breaking. During these appointments, Dr Kontogiannis would shout at Patient D for breaking his braces. He would tell Patient off, stating, in an aggressive raised tone, "Patient D I've told you not to do this" or "Patient D, you've done that". He was trying to suggest that Patient D Was eating the wrong things, which he had told him not to do. I know that this was not the case, as Patient D is very good, and does everything properly. When Patient D was being told off, he would look at me horrified, but he did not reply to Dr Kontogiannis*".

PUBLIC

	The expert witness in his oral evidence stated that it is important to treat all patients with care and kindness, as failure to do so had the potential for patients and families to have a bad experience at a dental practice. The Committee accepts the evidence of the parent of Patient D. It is satisfied that Dr Kontogiannis was aggressive and failed to treat Patient D, a child, with kindness and compassion on these four dates. The Committee is satisfied that this presents similar behaviour from Dr Kontogiannis but from a different complainant. It therefore finds this head of charge proved.
12.(a).(ii)	*14 December 2018;* **Proved for the reasons above**
12.(a).(iii).	*22 February 2019;* **Proved for the reasons above**
12.(a).(iv)	*14 June 2019;* **Proved for the reasons above**
12.(b).	*treated Patient D roughly, by hitting his head to move it to one side on one or more occasion on or around:*
12.(b).(i).	*15 July 2019;* **Proved** Patient D's parent stated in her witness statement *" As Patient D was sitting in the same position for a long time, roughly 20 to 30 minutes, he was moving his head without thinking. her response, Dr Kontogiannis started hitting Patient D in the head, stating "move head". He used the palm of his hand to smack the side of Patient D's head. It was quite hard and aggressive hit, happening two or three times each appointment, before I intervened. It was noticeable that Dr Kontogiannis was becoming rough with Patient D, as he was frustrated that he could not get to the back of his mouth properly. Patient D did not say anything in response, as he has Dr Kontogiannis's hand in his mouth, but he was staring at me horrified*." The Committee is satisfied that Dr Kontogiannis on both occasions failed to treat Patient D with compassion and kindness. Dr Kontogiannis was seen by Patient D's mother hitting her son on the head on more than one occasion. The parent recorded her concerns in a diary and subsequently made a complaint. It therefore finds this head of charge proved.
12.(b).(ii).	*22 November 2019.* **Proved for the reasons given above.**
13.	*You failed to ensure that Patient D's parent was provided with a copy of a complaints procedure when she requested it on or around 7 December 2020.* **Proved.** Parent D's parent stated in her witness statement …"*In response to my request for the complaints procedure, Dr Kontogiannis advised that I ask the*

PUBLIC

PUBLIC

	receptionist for this. When doing so, the receptionist advised me there as no complaints procedure. ..” Person X during interview stated that no complaints procedure was available at the surgery. The Committee also notes the evidence of Witness 2, the inspector, who requested to see a complaints procedure during his inspection visit in April 2021, however, Dr Kontogiannis failed to provide a copy at that time. The Committee accepts the evidence of Patient D’s parent. Her evidence was clear and reliable. She asked for a copy of the complaints procedure but was not provided with one by Dr Kontogiannis. It notes there is no evidence before it of any complaint procedures in place at the material time. The Committee took into account the GDC’s standard 5.1, stating it is Dr Kontogiannis’ duty to ensure an effective complaint procedure is readily available. The Committee is satisfied that there is a duty for Dr Kontogiannis to ensure the complaints procedure is readily available upon request. There is credible evidence that he failed to do so. It therefore finds this head of charge proved.
14.	*You provided NHS treatment to Patient D on or around 2 March 2021, whilst you were suspended from the NHS Dental Performer’s List.* **Proved.** *Patient D’s mother stated in her written statement …”I know that he saw Patient D within the period he should not have, as the news article stated that Dr Kontogiannis had been suspended in January 2021, yet he treated Patient D in March 2021..”* The GDC expert witness stated in his oral evidence that if a practitioner is suspended, they must not treat patients. It presents a risk of harm to patients if they were to continue treating and a failure of duty. He stated that even if another dentist is present, it is irrelevant and inappropriate. The Committee took into account that Dr Kontogiannos, was suspended by NHS England in January 2021 and this appointment happened on 2 March 2021. Whilst the parent of Patient D accepts that another dentist was present, she was adamant that it was Dr Kontogiannis who treated her son. The Committee accepts the evidence of Patient D’s mother as credible and accurate. It also accepts the evidence from NHS England that he was suspended at that time. It is satisfied that Dr Kontogiannis had treated her son during these dates whilst he was suspended from the NHS Performers List. It therefore finds this head of charge proved.
15.	*Between 24 October 2022 and 29 November 2022, you failed to co-operate with an investigation conducted by the GDC, in that you failed to provide the GDC with:*
15.(a)	*evidence of your indemnity cover;* **Proved.**

	Witness 3 stated in her written statement "*On 27 June 2022 I contacted Dr Kontogiannis by letter informing him that we were considering concerns that had been raised by NHS England. In this letter, we requested the following information from Dr Kontogiannis; a. Information on his working arrangements, including details about where he currently works, and where he worked at the time the concerns relate to; b. Proof of his indemnity arrangements currently in place, and in place at the time the concerns relate to; and c. Patient records for the Patients listed in the enclosure with the letter.* *The letter at HS1 was as an attachment to an email, dated 27 June 2022, to Dr Kontogiannis's email address only. I produce this email. I can confirm that this letter was not sent by post.* *I can confirm that the GDC has no record of a response from Dr Kontogiannis, nor did we receive a download receipt from the email attachment*". The Committee is satisfied that on this occasion Dr Kontogiannis has again failed to provide evidence of indemnity cover and patient records. It also took into account that he has failed to engage with his regulator for over 4 years. The GDC expert witness stated in his oral evidence that not to comply with the regulatory standards is a very serious matter. The Committee accepts the evidence of Witness 3. It is satisfied that he had a duty to cooperate with his regulator but failed to do so. The Committee considers that Witness 3's evidence clearly outlines the period where Dr Kontogiannis, upon various requests, failed to cooperate with the GDC and provide evidence of indemnity cover and patient records. It therefore finds this head of charge proved.
15.(b).	*Patient records.* **Proved for the same reason as above.**
16.	*From 27 June 2022 until at least 6 February 2025 you failed to provide the GDC with an up to date registered address.* **Proved.** The Committee noted the service bundle which contains documented efforts by the GDC to secure an up-to-date address from Dr Kontogiannis. They show his failure to respond to these requests. The GDC expert witness stated in his oral evidence that it is a duty for all dental practitioners to ensure their contact address is updated to ensure they can be contacted. The Committee is satisfied that the GDC has provided sufficient evidence to prove that Dr Kontogiannis failed to provide the GDC with an up-to-date registered address. It therefore finds this head of charge proved.
17.	*Your conduct in respect of Head of Charge 14 was:*

PUBLIC

17. (a)	*Misleading:* **Proved** Misleading for the purposes of this charge refers to the objective effect of the conduct, regardless of Dr Kontogiannis' intention. In respect of charge 14, the Committee was satisfied that Dr Kontogiannis' conduct in providing NHS treatment to Patient D whilst he was suspended from the NHS Dental Performer's List, is clearly misleading because any patient would expect the treating clinician not to be a suspended practitioner. It therefore finds this head of charge proved.
17. (b)	*Dishonest.* **Proved** In approaching this head of charge, the Committee applied the test set out in *Ivey v Genting Casinos (UK) Ltd. t/a Crockfords* [2017] UKSC 67. The test is that the Committee must decide subjectively the actual state of an individual's knowledge or belief as to the facts and must then apply the objective standards of ordinary and decent people to determine whether their conduct was dishonest by those standards. In accordance with the legal test set out above, the Committee first considered the actual state of Dr Kontogiannis' knowledge or belief as to the facts when he provided NHS treatment to a patient whilst he was suspended from the NHS Dental Performer's List. The Committee has accepted the evidence that Dr Kontogiannis was first informed by letter on 15 January 2021 that he was suspended from the NHS Performers List. He was further informed by telephone that he was suspended. Additionally, Witness 1 provided evidence that he was sent regular updates regarding his suspension by mail. Therefore, the Committee was satisfied that his state of knowledge was that he knew he was suspended from the NHS Performers List when he treated Patient D on 2 March 2021. In addition, the Committee notes that parent of Patient D was unaware at that time Dr Kontogiannis had been suspended by the NHS, and wasn't aware until some months later. It is satisfied that he deliberately withheld that information from her and her son. Having determined Dr Kontogiannis' actual knowledge at the relevant time, the Committee went on to determine whether his conduct was dishonest by reference to the objective standards of ordinary and decent people. The Committee considers that his conduct was dishonest by reference to those objective standards. The Committee considers that in treating Patient D, Dr Kontogiannis was deliberately misrepresenting to Patient D and his mother that he was able to treat patients without any restriction. The Committee finds that this is a blatant disregard of restrictions put in place to ensure patient safety and a clear breach of the trust Patient D and his mother had put in him. The Committee is satisfied that this conduct is clearly dishonest by the standards of ordinary and decent people.

PUBLIC

	For these reasons, the Committee finds the facts alleged at head of charge 17 proved.

33. We move to stage two.

Determination on misconduct, impairment and sanction – 12 November 2025

34. Following the handing down of the Committee's findings of fact on 11 November 2025, the hearing proceeded to stage two; that is to say, misconduct, impairment and sanction.

Proceedings at stage two

35. The Committee has considered all the evidence presented to it, both oral and documentary. It has taken into account the submissions made by Ms Tahta on behalf of the GDC. In its deliberations the Committee has had regard to the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016, updated December 2020). The Committee has accepted the advice of the Legal Adviser concerning its powers and the principles to which it should have regard.

Evidence at stage two

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

Summary of submissions

37. Ms Tahta on behalf of the GDC submitted that the facts that the Committee has found proved amount to misconduct. She submitted that Dr Kongtogiannis' fitness to practise is currently impaired by reason of that misconduct, and that a finding of impairment is also required for the protection of the public and is required the wider public interest. Ms Tahta invited the Committee to impose what she characterised as being the only appropriate sanction, namely erasure from the register.

Fitness to practise history

38. Ms Tahta addressed the Committee in accordance with Rule 20 (1) (a) of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules'). Ms Tahta stated that Dr Kongtogiannis, has no fitness to practise history with the GDC.

Misconduct

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

40. In its deliberations the Committee has had regard to the following paragraphs of the GDC's *Standards for the Dental Team* (September 2013) in place at the time of the incidents giving rise to the facts that the Committee has found proved. These paragraphs state that as a dentist:

1.2 you must treat every patient with dignity and respect at all times

1.3 You must be honest and act with integrity.

1.5 you must treat patients in a hygienic and safe environment.

PUBLIC

2.3 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

4.5 you must keep patients' information secure at all times

5.1 you must make sure that there is an effective complaint procedure readily available for patients to use

9.1 You must ensure that your conduct, both at work and in your personal life, justifies patients' trust in you and the public's trust in the dental profession.

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

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

42. The Committee has taken account the evidence of Professor Hunt, the GDC's expert witness and accepts his opinion that Dr Kongtogiannis's conduct was far below the standards expected of a dentist in respect of all of the heads of charge found proved.

43. The Committee considered that the heads of charge found proved related to a broad area of dentistry including, inadequate care, clinical failings, failings to treat patients with kindness and compassion, failure to cooperate with his regulator and dishonestly treating a patient when he was suspended from the Dental Performers List. The Committee considered that each of them are serious. In particular, Dr Kontogiannis speaking to a young and vulnerable patient in a rude and aggressive manner and hitting his head side to side, which resulted in distress to both the patient and his mother. The Committee also noted there were serious and repeated failures by Dr Kontogiannis in not adhering to current laws and regulations in respect of decontamination, medical emergencies and Covid-19 protocols which put patient and/ or staff at risk of harm. In addition, Dr Kontogiannis' failure on more than one occasion to cooperate with his regulator is extremely serious as it has the potential to undermine its function to protect the public and maintain public confidence.

44. The Committee also considers that its findings relating to misleading and dishonest conduct, is very serious. The Committee is in no doubt as to the seriousness of Dr Kongtogiannis' misleading and dishonest conduct of treating a young patient whilst suspended from the NHS Performers List. The Committee considers that the need to act with honesty is a fundamental tenet of the profession. The Committee considers that Dr Kongtogiannis' conduct was liable to undermine the public's trust and confidence in the profession and in the regulatory process. Dr Kongtogiannis, put his own interests before the interests of patients. As a result, the public, including patients, were placed at risk of harm.

45. Furthermore, Dr Kongtogiannis's clinical failings all had the potential to place patients at serious risk of harm. This included failures to take medical histories, provide treatment options; failure to obtain patients informed consent, repeated failures in cross infection control and failures to ensure that appropriate cover when in place to cover emergency care when he was away for large periods time. In the Committee's judgement those clinical failings similarly constitute misconduct.

PUBLIC

46. The Committee is satisfied that taken together that the facts found proved demonstrates a pattern of serious misconduct and behaviour. Dr Kontogiannis' conduct poses a real risk to patient safety and breaches fundamental principles of honesty and integrity. In addition, the Committee finds that Dr Kongtogiannis' acts and omissions represent a serious and sustained departure from professional standards. His conduct, and particularly his misleading and dishonest conduct, fell far short of the standards reasonably to be expected of a registered dental professional, and his behaviour would be viewed as deplorable by his fellow practitioners.

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

Impairment

48. The Committee next considered whether Dr Kongtogiannis' fitness to practise is currently impaired by reason of the misconduct that it has found. In doing so, the Committee again exercised its own independent judgement.

49. Throughout its deliberations, the Committee has borne in mind that its overarching objective is to protect the public, which includes the protection of patients and the wider public, the maintenance of public confidence in the profession and in the regulatory process, and the declaring and upholding of proper standards of conduct and behaviour.

50. The Committee considers that the findings that it has made in relation to Dr Kongtogiannis' clinical misconduct is, in theory, capable of being remedied. Those findings relate to specific and identifiable aspects of his clinical practice as well as failures to cooperate with the GDC. The Committee considers, however, that the misconduct that it has found in relation to Dr Kongtogiannis, misleading and dishonest conduct is likely to be considerably more difficult to remediate than his clinical failings, as it is indicative of an attitudinal or behavioural failing.

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

52. Dr Kongtogiannis' dishonest conduct, is highly damaging to his fitness to practise, relating as it did to a blatant disregard for restrictions put in place on his practice to protect the public and was a deliberate departure from the fundamental tenet to act with honesty and integrity. The Committee took into account that Dr Kontogiannis has no previous fitness to practise history. However, it has also noted that the heads of charge it has found proved stretch over a significant period of time, are unremediated and placed patients and staff at significant risk of harm, and in some cases caused actual harm. The Committee has found that the lack of insight and remediation present in this case means that there is a high risk of repetition.

53. The Committee therefore finds that Dr Kongtogiannis' fitness to practise is currently impaired in respect of public protection.

54. The Committee considers that a finding of impairment is also, and undoubtedly, required to maintain public confidence in the profession and to declare and uphold proper professional standards of conduct and behaviour. In the Committee's judgement the public's trust and confidence in the profession, and in the regulatory process, would be significantly

PUBLIC

undermined if a finding of impairment was not made given the particularly serious nature of Dr Kongtogiannis' misconduct. Dr Kongtogiannis' actions were liable to have brought the reputation of the profession into considerable disrepute and relate to a breach of a fundamental tenet of the profession, namely the inherent requirement to act with honesty and integrity; provide safe and effective care; and uphold public safety and confidence in the profession.

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

Sanction

56. The Committee then determined what sanction, if any, is appropriate in light of the findings of facts, misconduct and impairment that it has made. The Committee recognises that the purpose of a sanction is not to be punitive, although it may have such an effect, but is instead imposed to protect patients and safeguard the wider public interests mentioned above.

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

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

59. In respect of the mitigating factors that are present, the Committee notes that Dr Kongtogiannis, has no fitness to practise history.

60. In terms of aggravating factors, the Committee notes that Dr Kongtogiannis, placed patients at the risk of harm. His conduct amounted to a breach of the trust that the patients and parents had placed in him and also to the dental profession. His conduct related to vulnerable patients which was sustained over a period of time. There was premeditated dishonest conduct. Dr Kontogiannis has not remediated at all or provide evidence of any insight into his misconduct. He has also displayed a blatant and harmful disregard towards his regulator and NHS England.

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

62. The Committee has considered the range of sanctions available to it, starting with the least restrictive. In the light of its findings, the Committee considers that taking no action, or issuing a reprimand, would be wholly insufficient in the particular circumstances of this case. In the Committee's judgement public trust and confidence in the profession and in the regulatory process would be significantly undermined if no action were taken, or if a reprimand were issued. The Committee also considers that taking no action or issuing a reprimand would not adequately protect the public and would not be sufficient to declare and uphold proper professional standards of conduct and behaviour.

63. The Committee also considers that a direction of conditional registration would not be sufficient to meet the public protection and public interest considerations engaged in this case. The Committee considers that conditions could not be formulated to deal with the risks that it has identified, and in particular those relating to Dr Kongtogiannis' misleading and dishonest conduct. Further, it was satisfied conditions would not be workable given Dr Kontogiannis' lack of engagement in this case. The Committee also considers that, even if conditions could be formulated, a direction of conditional registration would be entirely

PUBLIC

inadequate to declare and uphold proper professional standards of conduct and behaviour because of the serious nature of Dr Kongtogiannis' misconduct.

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

65. The Committee has found repeated and serious clinical failures, occurred over a prolonged period of time which was manifested in different aspects of Dr Kongtogiannis' practice. Further, by treating a young patient when he knew he was suspended by NHS England and then failing to engage with the GDC in subsequent investigations, the Committee has found that Dr Kontogiannis has a deep seated attitudinal problem towards his regulator and the safeguards put in place to protect the public. Dr Kontogiannis has demonstrated no insight or remediation in relation to his conduct and the Committee is satisfied Dr Kontogiannis poses an ongoing risk of significant harm to the public. The Committee considers that a period of suspended registration would not be sufficient to protect the public or the wider public interest considerations referred to above in the serious circumstances of this case.

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

67. The Committee hereby directs that Dr Kongtogiannis' name be erased from the register.

Interim order

68. In accordance with Rule 21 (3) of the Rules and section 27B (9) of the Act the interim order of suspension in place on Dr Kongtogiannis' registration is hereby revoked.

Determination on immediate order

69. Ms Tahta on behalf of the GDC submitted that an immediate order of suspension is necessary to protect the public and is otherwise in the public interest.

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

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

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

73. That concludes this case.

PUBLIC

PUBLIC