GENERAL DENTAL COUNCIL

AND

KHAN, Baber

[Registration number: 56620]

NOTICE OF INQUIRY

SUBSTANTIVE HEARING

Notice that an inquiry will be conducted by a Practice Committee of the General Dental Council commencing at **10:00am** on **02 February 2026.**

Please note that this hearing will be conducted remotely by video conference.

The heads of charge contained within this sheet are current at the date of publication. They are subject to amendments at any time before or during the hearing. For the final charge, findings of fact and determination against the registrant, please visit the Recent Decisions page at https://www.dentalhearings.org/hearings-and-decisions/decisions after this hearing has finished.

Committee members:	Clive Powell	Lay	Chair
	Gill Jones	Dentist	
	Victoria Hewson	DCP	
Legal Adviser:	Alex Coleman		

CHARGE

KHAN, Baber, a dentist, BDS University of Dundee 1982 is summoned to appear before the Professional Conduct Committee on 02 February 2026 for an inquiry into the following charge:

The Charge

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

"That being a registered dentist,

Patient 1

1. In advance of 21 March 2023, you failed to ensure that Patient 1 (identified in Schedule A [1]below) was provided with an adequate explanation of the decision taken:
   (a) to cancel her dental appointment for 21 March 2023;
   (b) to refuse to offer her any future dental appointments;
2. You failed to ensure that monthly payments received by Practice A (identified in Schedule A below) from Patient 1, were cancelled following the decision taken to cancel her treatment.

Patient 6

3. You failed to provide an adequate standard of care to Patient 6 (identified in Schedule A below) from 9 November 2022 to 14 December 2022, in that:
   (a) from 9 November to 14 December 2022, you did not diagnose and/or treat pathology found at the mesial aspect of Patient 6's UL4;
   (b) during an appointment on 17 November 2022, you provided a poor standard of root canal treatment to Patient 6's UL3, in that you failed to adequately fill the root canal of this tooth;
   (c) you did not redo the root canal treatment you provided at Patient 6's UL3, to ensure the root canal was adequately filled, before preparing this tooth for a crown;
   (d) during an appointment on 24 November 2022, you prepared Patient 6's teeth for bridgework and crowns, without adequately addressing Patient 6's periodontal condition and/or oral hygiene status first;
   (e) you did not take an adequate preoperative radiograph in advance of preparing Patient 6's:
      (i) UL1 for a crown, on 24 November 2022;
      (ii) UL2 for a crown, on 24 November 2022;
      (iii) UR1 as a bridge abutment, on 24 November 2022;

[1] Schedule A is a private document that cannot be disclosed

(iv) UR3 as a bridge abutment, on 24 November 2022.

4. By reason of your conduct in Charge 3(e)(i), you failed to obtain Patient 6's informed consent for the crown fitted at their UL1.

5. By reason of your conduct in Charge 3(e)(ii), you failed to obtain Patient 6's informed consent for the crown fitted at their UL2.

6. By reason of your conduct in Charge 3(e)(iii) and/ or 3(e)(iv), you failed to obtain Patient 6's informed consent for the bridge fitted at their UR1-UR3.

Patient 8

7. You failed to provide an adequate standard of care to Patient 8 (identified in Schedule A below) from 3 November 2022 to 18 January 2023, in that:

   (a) you took an OPG x-ray (*Orthopantomogram*) without adequate clinical justification, during an appointment on:

      (i) 16 November 2022;

      (ii) 18 January 2023.

8. You failed to maintain an adequate standard of record keeping in respect of Patient 8's appointment from 2 November 2022 to 18 January 2023, in that:

   (a) you did not make sufficiently clear who Patient's 8 treating dentist was, for an appointment held on 2 November 2022;

   (b) you did not record sufficient details of what discussion took place between yourself and Patient 8 during an appointment on 3 November 2022;

   (c) you did not make it sufficiently clear on what date Patient 8's lower incisors were extracted.

9. Following the forfeiture of Practice A's lease on 19 April 2023, you failed to ensure reasonable lines of communication were available to all patients resulting in:

   (a) Patient 11 (identified in Schedule A below) not being notified of Practice A's permanent closure in advance of 5 July 2023 and/or this information not being accessible to Patient 11 by other means;

   (b) Patient 11's request for her dental records (made on 5 July 2023) going unanswered;

   (c) Patient 10's (identified in Schedule A below) requests for his dental records (made on 5 and 7 June 2023) going unanswered;

   (d) Patient 10 not receiving sufficient contact details for a dentist purportedly providing temporary dental care (following a request for such details made on 3 May 2023);

   (e) Patient 12 (identified in Schedule A below) being unable to speak to anyone working for the Practice about her future dental care and/or the possibility of a refund, after 6 April 2023.

10. By 26 May 2023, you failed to ensure the voice message for Practice A's telephone numbers were updated to inform patients of Practice A's permanent closure.

11. Between 19 May 2023 and July 2023, you failed to ensure Practice A's website was updated to include details of Practice A's permanent closure.

12. You did not ensure Patient 9 (identified in Schedule A below) was provided with a refund for incomplete dental treatment, following a call with Patient 9's daughter, on or around 5 May 2024.

13. Your conduct in Charge 12 was:

    (a) inappropriate;

    (b) unprofessional;

    (c) financially motivated.

14. From 19 April 2023 to on or around 11 July 2023, you did not ensure all patient records, located at Practice A, were removed to a secure location or disposed of securely.

15. On or around 17 August 2023, whilst communicating with Witness A's (identified in Schedule A below) solicitors, you did not agree to cover the cost of removal of items (which included dental records) left at Practice A.

16. Prior to the retrieval of patient records from a public space by Witness B (identified in Schedule A below) on 3 July 2023, you did not ensure these records were removed from Practice A to a secure location, or disposed of securely.

17. Your conduct in Charge 14 and/or Charge 15 and/or Charge 16:

    (a) was inappropriate;

    (b) was unprofessional;

    (c) breached patient confidentiality.

18. From 19 April 2023 to 11 July 2023, you did not ensure study models located at Practice A were disposed of appropriately.

19. Your conduct in Charge 18 was:

    (a) inappropriate;

    (b) unprofessional.

20. You did not ensure that the contact telephone number listed for Practice A on its Google Business entry, was:

    (a) always correct between 19 April 2023 and 9 June 2023;

    (b) correct on:

        (i) 26 September 2023;

        (ii) 27 December 2023;

        (iii) 19 June 2024;

        (iv) 6 July 2024.

21. Your conduct in Charge 20(a) and/ or 20(b)(i) and/ or 20(b)(ii) and/ or 20(b)(iii) and/ or 20(b)(iv) was:

(a) inappropriate;

(b) unprofessional.

22. During a British Dental Association mediation that took place around September 2022, you said to Witness C (identified in Schedule A below): *"I have so much evidence against you, of you slandering the Practice, I could sue you for damages"*, or words to that effect.

23. Your conduct in Charge 22 was:

(a) inappropriate;

(b) unprofessional.

24. After an email was sent to you from Witness E (identified in Schedule A below) on 4 May 2023, in which he set out what he understood to be the reasons for Practice A's closure, you failed to respond to Witness E, to ensure he was not misled about why Practice A had been closed.

25. Your conduct in Charge 24:

(a) was misleading;

(b) lacked integrity;

(c) was dishonest, in that you knew Practice A had not been closed because of a water damage dispute that required remedial work to be undertaken, as Witness E had been led to believe.

AND that by reason of the matters alleged above your fitness to practise is impaired by reasons of Misconduct."