

PUBLIC HEARING**Professional Conduct Committee
Initial Hearing****6th – 7th October 2025****Name:** TISSERA, David**Registration number:** 73925**Case number:** CAS-206809-K3S8M9

General Dental Council: Mr Tom Stevens, counsel
Instructed by Carly Smith, IHLPS**Registrant:** Present, unrepresented

Fitness to practise: Impaired by reason of misconduct**Outcome:** Reprimand

Committee members: Andrew Waite (Lay (Chair)
Alexandra Ward (DCP)
Vatsal Amin (Dentist)**Legal adviser:** Jenny Appleton**Committee Secretary:** Sarah Crewe

Charge (as amended):

1. You failed to provide an adequate standard of care to Patient A between 24 March 2007 and 27 October 2017 in that:
 - i. You failed to conduct sufficient pre-treatment investigations by not exposing periapical radiographs when required on or around:
 - a. 18 January 2012 (prior to preparing LL6 and LL7 inlays);
 - b. 11 July 2015 (prior to preparing LR6 for an onlay);
 - c. 5 April 2016 (prior to preparing LR7 for a Crown);
 - d. 9 May 2012 (prior to replacement restoration for UR4 and/or UR5);
 - e. 3 February 2012 (prior to replacement restoration for UL5 and/or UL6).
 - ii. You failed to expose bitewing radiographs in relation to Patient A on or around:
 - a. 24 March 2007;
 - b. 16 April 2008;
 - c. 09 December 2011;
 - d. 14 May 2013;
 - e. 24 March 2016
 - iii. You failed to sufficiently report on radiographs on the following occasions (or reasonably thereafter):
 - a. 17 April 2009;
 - b. 19 February 2010;
 - c. 8 March 2010;
 - d. 13 April 2016;
 - e. 29 August 2017;
 - f. 27 October 2017.
 - iv. You failed to provide an appropriate treatment plan in respect of Patient A's LR6 by not considering re-root treatment prior to providing restoration on or around the following occasions:
 - a. 6 May 2009;
 - b. 9 December 2011;
 - c. 18 March 2015;
 - d. 12 June 2015;
 - e. 11 July 2015;
 - f. 29 August 2017;
 - g. WITHDRAWN
 - v. You failed to identify the short obturation at LR6 on:
 - a. 17 April 2009;
 - b. 13 April 2016;
 - c. 29 August 2017.
 - vi. You failed to discuss the option of referring Patient A to a specialist in relation to the failed root canal treatment on or around:
 - a. 06 May 2009;
 - b. 09 December 2011;
 - c. 18 March 2015;
 - d. 12 June 2015;
 - e. 11 July 2015;
 - f. 29 August 2017;
 - g. WITHDRAWN

2. By virtue of your conduct at 1 (i)(a) and 1 (i)(b) and 1 (i)(c) you failed to obtain Patient A's informed consent for the proposed treatment conducted on or around:
 - a. 18 January 2012 (in respect of LL6 and LL7 inlays);
 - b. 11 July 2015 (in respect of LR6 onlay);
 - c. 5 April 2016 (in respect of LR7 Crown).
3. By virtue of your conduct at 1 (i)(d) and 1 (i)(e) you failed to obtain Patient A's informed consent for the proposed treatment conducted on or around:
 - a. 9 May 2012 (in respect of UR4 replacement restoration);
 - b. 9 May 2012 (in respect of UR5 replacement restoration);
 - c. 3 February 2012 (in respect of UL5 replacement restoration);
 - d. 3 February 2012 (in respect of UL6 replacement restoration).
4. By virtue of your conduct at 1 (iv)(a) and 1 (iv)(b) and 1(iv)(c) and 1(iv)(d) and 1(iv)(e) and 1(iv)(f) you failed to obtain Patient A's informed consent for the proposed treatment conducted on or around:
 - a. 6 May 2009;
 - b. 9 December 2011;
 - c. 18 March 2015;
 - d. 12 June 2015;
 - e. 11 July 2015;
 - f. 29 August 2017;
 - g. WITHDRAWNS

And that by reasons of the matters alleged above, your fitness to practise is impaired by reason of misconduct."

Mr Tissera,

1. This is a hearing before the Professional Conduct Committee (PCC). The hearing is being held remotely using Microsoft Teams.
2. You are present and unrepresented. Mr Tom Stevens, appears for the GDC.

Case background

3. The charge against you relates to the treatment you provided to one patient, Patient A, over a prolonged period of time, between 2007 and 2017. In 2017 and into 2018, after being treated by you, Patient A received treatment from a subsequent dentist who raised concerns about your treatment. Patient A then made a complaint about the treatment provided. Following receipt of this complaint the GDC instructed an expert to review Patient A's records.
4. The charges relate to failures in record keeping, radiographs, and failing to discuss options with Patient A resulting in failing to obtain informed consent.

Evidence

5. The evidence received by the Committee is solely documentary.
6. The documentary evidence before the Committee included the following:
 - A witness statement from Patient A
 - Patient A's dental records
 - GDC Expert Report
 - A witness statement from you

Decision and reasons on application to amend charge (6 October 2025):

7. The Committee heard an application made by Mr Stevens, on behalf of the General Dental Council (GDC), under rule 18, to amend a number of particulars of the charge.
8. Mr Stevens provided a document for the Committee to consider, which highlighted the proposed amendments. Given the discussions that took place prior to the start of the hearing Mr Stevens proposed to outline the case in more detail than would otherwise be usual in these types of applications.
9. In relation to the date range Mr Stevens submitted that the date range is incorrect. He submitted that the start date error is likely to have resulted from a simple administrative error of transposing a 6 for a 9. He submitted that the start date should be 24 March 2007. The end date, in a similar manner has been incorrectly recorded and should be 27 October 2017. He submitted that there is no injustice in this proposed change given that the amendment reflects the dates that are included in the sub charges.
10. The second amendment being sought is to remove charges 1(i)(e) and (g) and include the words and/or UL5 to charge 1(i)(d) and and/or UL6 to charge 1(i)(f), which will then become 1(i)(e).
11. Mr Stevens next referred the Committee to charge 1(iii)(d) and submitted that this should read April and not June, this is reflected by the evidence. To ensure accuracy he submitted that this amendment should be made. Further, in order to simplify the charge and more accurately reflect the evidence, the term 'sufficiently report' covers all of the criticism and as such the words report and/or should be deleted.
12. The proposed amendment to charge 1(iv), based on the expert opinion, and following discussions with you prior to the hearing, is to delete the words 'and/or discussing'. It is accepted that if you did not consider re-root treatment you could not have discussed it with Patient A. Further it is applied to withdraw charge 1(iv)(g) following the patient records for this date having been reviewed, alongside the Patient's recollection of that appointment, there is some reference in the record of a discussion. Mr Stevens submitted that the logical follow on from withdrawing 1(iv)(g) is to remove the same date from 1(vi)(g) and 4.
13. In relation to charge 1(v)(a) the date currently being 2006 is clearly wrong and should read 2009. This is reflected in the evidence and no injustice would be caused by the amendment as it appears to be a simple administrative error. For the same reasons above Mr Stevens submitted that the words and/or record should be deleted from the charge as if you did not have the discussion you could not record the discussion.
14. Charge 1(vi)(c) currently refers to 8 March, however this should be 18 March. Again, this is submitted to be a simple clerical error in writing out the date. The evidence all refers to the 18th, and allowing this amendment would not cause any injustice, but more accurately

reflect the evidence. For the same reasons above Mr Stevens submitted that the words and/or record should be deleted from the charge as if you did not have the discussion, you could not record the discussion.

15. The last amendments being sought are to remove /or from charges 2, 3 and 4. Mr Stevens submitted that these amendments are sought to more accurately reflect the evidence before the Committee, and also to streamline the charges for a clearer understanding of what you have indicated that you will be admitting to.
16. You informed the Committee that you had discussed the proposed amendments prior to the commencement of the hearing, and that you are content with the suggested amendments and withdrawals.
17. The Committee accepted the advice of the Legal Adviser.
18. The Committee considered the application to withdraw charges and the reasoning provided by the GDC for this application. It was satisfied that given it is the GDC who brings this case against you, and in circumstances where the GDC does not seek to pursue these charges, it would be entirely appropriate to allow the application to withdraw the charges outlined by Mr Stevens.
19. The Committee considered that as there is no objection to the amendment of the dates in the charges and the removal of the wording from the stems of charges, having heard that the amendments are being sought following a review of the evidence, and a discussion with you, it would be both fair and appropriate to allow the amendments.
20. Given the above, the Committee accedes to the applications made by Mr Stevens on behalf of the GDC.

Admissions

21. You made admissions to all of the heads of charge, as amended. The Committee, having assured itself that you had full and proper understanding of what you were making admissions to, and having accepted the advice of the Legal Adviser, determined and announced that the facts alleged at those heads and sub-heads of charge were proved on the basis of your admissions in accordance with Rule 17 (4) of the Rules.

Decision and reasons on fitness to practise

22. Having announced its decision on the facts, the Committee then moved on to consider whether the facts found proved amount to misconduct and, if so, whether your practice is currently impaired. Should the Committee find there is current impairment, it can then move on to consider what sanction, if any, to impose.
23. In accordance with Rule 20 of the Fitness to Practise Rules 2006, the Committee heard submissions from Mr Stevens on behalf of the GDC and from you in relation to the matters of misconduct, impairment and sanction.

Evidence

24. At the start of its considerations in relation to your fitness to practise, the Committee was provided with the following documents:
 - Reflective statement, dated 29 September 2025; and
 - Your Continuing Professional Development (CPD) bundle.

Submissions

25. Mr Stevens addressed the Committee on the matters of misconduct, impairment, and sanction. He informed the Committee that you have no previous FtP findings against you and submitted that this should be considered alongside the length of time since the concerns were raised and that you have continued to practice without repetition.
26. On the matter of misconduct, Mr Stevens reminded the Committee that there is no burden or standard when looking at misconduct, but rather it is for the judgment of the Committee. He referred the Committee to case law which gives a broad definition of misconduct and the matters for the Committee to consider when determining whether the facts found proved amount to misconduct.
27. Mr Stevens also invited the Committee to find that your actions had breached a number of the Standards, including 3.1 and 7.1. Furthermore, it is submitted that not obtaining consent, having not adequately explained to Patient A the treatment to be undertaken, or the risks involved, failing to take or report on radiographs, and failing to identify issues, and discuss a referral to another practitioner, would be comfortably cross the threshold for misconduct. He submitted that in particular the failure to obtain informed consent is serious and consent is a cornerstone of the profession and the trust that the public place in the profession. For those reasons, alongside the opinion of the GDC expert, Mr Stevens invited the Committee to conclude that the facts found proved do amount to misconduct.
28. On the matter of impairment, Mr Stevens invited the Committee to consider the risk to the public and to consider any evidence of remediation. In this regard, he submitted that in *Cohen v General Medical Council* [2008] EWHC 581 the questions that the Committee has to answer are: whether the misconduct is easily remediable, has been remedied and is highly unlikely to be repeated.
29. Mr Stevens submitted that, in relation to public protection, the GDC was neutral and does not positively seek to suggest that you currently present a risk to members the public. He submitted that the length of time since your failings must be taking into account, the most recent failing being almost 8 years ago, with no further complaints made about your treatment. Further, you have been allowed to continue to practice without restriction since.
30. Mr Stevens submitted that it is clear that you have demonstrated a degree of insight into the seriousness of the misconduct in this case through your full and unequivocal admissions, an acknowledgement of wrongdoing and a genuine apology. Furthermore, you have undertaken relevant courses to demonstrate remediation.
31. However, Mr Stevens submitted that the question of risk to the public is not the only consideration and there are public interest factors to be considered as well, as made clear by the observations of Cox J in *Council for Healthcare Regulatory Excellence v (1) NMC & (2) Grant* [2011] EWHC 927, in which reference is made to the four questions that a Committee must answer when considering impairment on public interest grounds.
32. In relation to public interest, Mr Stevens submitted that a finding of current impairment is required in the public interest, in order to declare and uphold proper professional standards and to maintain public confidence in the profession, by sending a clear message about the standard of care to be expected by patients, and that treatment being undertaken on a patient without their consent, will be taken seriously by the GDC as a regulatory body. Furthermore, Mr Stevens submitted that in a situation where treatment had been undertaken without informed consent and no finding of current impairment were made, that this would undermine public confidence in the profession and in the regulatory process.

33. On the matter of sanction, Mr Stevens submitted that if the Committee were to find current impairment on public interest grounds only then a reprimand would be the appropriate and proportionate sanction to impose. He invited the Committee to consider the aggravating and mitigating factors when making any decision on sanction.
34. You told the Committee that you fully acknowledge that your standards fell below what was expected and you accept that the facts amount to misconduct. You stated that this experience has highlighted the standards that are expected of you and how important they are. You explained that you have taken the time to reflect on how this all came to be and recognised your failings and what you needed to do differently, which you have now implemented into your practice and taken steps to ensure that there is no repetition.
35. You outlined the courses that you have undertaken, including on radiographic practice, and the use of templates in your work. You asked the Committee to consider the documents that you provided for this stage of the hearing to demonstrate the changes that you have made in your record keeping.
36. You told the Committee that you accept the decision of the Committee and would comply with any direction that it might make. In reference to the public interest you stated that there are many positive public reviews given about you and the treatment that you have provided to patients. You said that, while this one case demonstrates what should not happen, you believe that you do not pose a risk and have taken steps to prevent it happening again. You asked the Committee to consider that you are not impaired on either ground, and will continue to work at a high standard.
37. In response to Committee questions you outlined the continuing professional development (CPD) courses that you have undertaken since the concerns came to light, in particular courses relating to radiographic practice. You explained that you have also undertaken your regular CPD that you have to complete as part of your registration. You explained that if the Committee considers that you should undertake other specific training you would be willing to comply with that.
38. Having heard the submission of both Mr Stevens and yourself, the Committee heard and accepted the advice of the Legal Adviser.

Misconduct

39. The Committee acknowledged that misconduct was defined, in the case of *Roylance (No. 2) v General Medical Council [2000] AC 311* as, "...a word of general effect, involving some act or omission, which falls short of what would be proper in the circumstances with the standard of propriety often being found by reference to the rules and standards ordinarily required to be followed by a [registrant] in the particular circumstances."
40. In considering whether any or all of the facts found proved amount to misconduct, the Committee considered the following principles from the Standards, in particular:

Standard 2.1

You must communicate effectively with patients – listen to them, give them time to consider information and take their individual views and communication needs into account

Standard 3.1

Obtain valid consent before starting treatment, explaining all the relevant options and the possible costs

Standard 7.1

You must provide good quality care based on current evidence and authoritative guidance

41. The Committee took into account that a breach, or breaches, of the relevant Standards does not automatically result in a finding of misconduct.
42. The Committee considered that a failure to obtain valid consent from Patient A amounted to an inadequate standard of care. The Committee was satisfied that without keeping Patient A fully informed, and thereby failing to obtain valid consent, your conduct reflected a standard far below that expected. The Committee noted that you admitted that you failed to identify aspects of concern on the radiographs and therefore you were unable to properly determine the treatment, including the risks associated with the treatment. The lack of radiographs leads to a potential risk of harm to the patient, and this falls far below the standards expected. The Committee considered that obtaining informed consent is a cornerstone of the trust that patients place in the profession. The Committee accepted the opinion of the GDC expert in this regard.
43. Therefore, the Committee determined that your conduct was a sufficiently serious departure from the Standards as a dental professional to amount to misconduct.

Impairment

44. In its consideration of impairment, the Committee bore in mind the advice of the Legal Adviser who reminded the Committee that it must find current impairment of fitness to practise. It took into account that it is not sufficient to find that your fitness to practise was impaired at the time that the matters found proved took place, but that it must be found that your fitness to practise is impaired as of today.
45. The Committee first considered whether your conduct was likely to be repeated in the future and was assisted by the questions outlined in *Cohen v GMC*, namely whether your misconduct is remediable; whether it had been remedied; and whether there is a risk of repetition. The Committee also had regard to the wider public interest, which includes the need to uphold and declare proper standards of conduct and behaviour to maintain public confidence in the profession and this regulatory process.
46. The Committee considered that the clinical failings in this case are capable of remediation, and it therefore considered what actions you have taken since the concerns came to. It had regard to your submissions and the documentation that you have provided for the Committee to consider. You have demonstrated insight to this Committee, through your reflection, your acceptance and acknowledgment of your failings, your apology and expression of remorse, and the steps that you have taken to ensure that the failings are not repeated.
47. The Committee concluded that you have remediated your misconduct and that you have demonstrated significant insight and genuine remorse. The Committee is of the view that, having considered all the information before it, there is an extremely low risk of repetition. Therefore, a finding of impairment is not appropriate on the ground of public protection.
48. In its consideration of the wider public interest, the Committee referred to the case of *CHRE v NMC and Grant* and whether public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.
49. The Committee bore in mind the failures related to a single patient. However, the treatment took place over a 10 year period and encompassed several appointments. The Committee considered that failing to get informed consent due to a lack of appropriate investigation, treatment planning and discussion is a significant matter in maintaining the trust of patients in the profession. The trust that a patient places in a dentist to be able to provide an

appropriate standard of care is fundamental and the failings identified in this case risk eroding that trust.

50. The Committee referred to the ISG and noted that it stated:

“The issue of informed or valid consent is a cornerstone of the public interest and must be paramount in a registrant’s mind prior to carrying out any treatment or investigation. Failure to obtain consent is a serious matter and, if the Committee is satisfied that it amounts to misconduct the PCC should consider whether a finding of impairment and the imposition of a sanction is appropriate in the public interest.”

51. The Committee concluded that, given the fundamental importance of obtaining valid consent, particularly where treatment is being undertaken on a patient over a significant period of time, and being able to recognise where there are clinical issues that will impact on the treatment of a patient, an informed member of the public would be surprised to learn that a finding of impairment was not made in this case.

52. Therefore, the Committee concluded that a finding of impairment is required on the ground of public interest.

Decision and reasons on sanction

53. In reaching its decision regarding sanction, the Committee carefully considered what action, if any, should be taken in relation to your registration. It had regard to the General Dental Council’s (GDC) document Guidance for the Practice Committees, including Indicative Sanctions Guidance 2016 (Revised December 2020) (“the ISG”). The Committee reminded itself that any sanction imposed must be proportionate and appropriate. While sanctions are not intended to be punitive, they may have that effect.

54. Having reviewed paragraph 5.17 of the ISG, the Committee identified the following mitigating factors in this case:

- Evidence of good conduct following the incident, including any remedial actions taken;
- A history of previous good character;
- Demonstrated remorse, insight, and an apology;
- Steps taken to prevent recurrence;
- The time elapsed since the incident.

55. In accordance with paragraph 5.18 of the ISG, the Committee also noted the following aggravating factors:

- Actual harm or risk of harm to a patient due to failure to obtain valid consent.
- Breach of trust;
- Misconduct sustained or repeated over a period of time

56. The Committee took into account its earlier findings on misconduct and impairment and considered each available sanction in ascending order of severity.

57. The Committee first considered taking no further action. However, given its finding of impairment on public interest grounds, it concluded that such an approach would not adequately reflect the seriousness of the misconduct. It determined that a sanction was

necessary to reinforce the importance of providing appropriate care and obtaining valid consent prior to treatment.

58. In considering whether to issue a reprimand, the Committee acknowledged that while the misconduct was serious, it was isolated in nature and at the lower end of the spectrum. The Committee was satisfied that you do not pose a risk to patients or the public and that no rehabilitation or restriction of practice is required.
59. The Committee found the following factors from the ISG to be applicable:
- No evidence suggesting a danger to the public;
 - Demonstrated insight into the failings;
 - Genuine expression of remorse;
 - Evidence of corrective or rehabilitative steps taken;
 - No prior fitness to practise concerns.
60. After careful deliberation, the Committee determined that a reprimand is the appropriate and proportionate sanction in this case. It recognised your good character, absence of previous concerns, and the insight and remorse you have shown, which mitigate the risk of recurrence.
61. The Committee considered imposing conditions on your registration but concluded that, given the absence of concerns regarding your current clinical practice, such a restriction would be disproportionate.
62. Accordingly, the Committee determined that a reprimand sufficiently reflects the seriousness of the misconduct. It is satisfied that this sanction addresses public interest considerations, maintains trust and confidence in the profession, and upholds proper professional standards. The Committee is confident that a well-informed member of the public would regard a reprimand as a suitable and proportionate response.
63. The reprimand will be publicly recorded as the outcome of this case and will appear alongside your name on the GDC register for a period of 12 months. The Committee considers this sufficient to mark the misconduct as a serious departure from expected professional standards, which must not be repeated.
64. The reprimand will form part of your fitness to practise history and may be disclosed to prospective employers or registration authorities in other jurisdictions.
65. You will receive written confirmation of this decision.
66. That concludes your case.