

PUBLIC HEARING

Professional Conduct Committee Initial Hearing

1 to 4 December 2025

Name: FLATISCHLER, Günter Karl Rudolf

Registration number: 72439

Case number: CAS-208870

General Dental Council: Daniel Mansell, Counsel
Instructed by Clare Hastie, Kingsley Napley

Registrant: Not Present
Not represented

Fitness to practise: Impaired by reason of misconduct

Outcome: Erased with Immediate Suspension

Immediate order: Immediate suspension order

Committee members: Andrea Hammond (Chair, Dental Care Professional Member)
Peter Watson (Lay Member)
Susan Stevens (Dentist Member)

Legal Adviser: Alexander Coleman

Committee Secretary: Lola Bird

Günter Karl Rudolf Flatischler, a dentist, Tandläkare Karolinska Institutet 1996, is summoned to appear before the Professional Conduct Committee on 1 December 2025 for an inquiry into the following charge:

The Charge (as amended)

‘That, being registered as a Dentist:

1. *You failed to provide an adequate standard of care to Patient 1, in that you:*
 - a. *Between October 2020 and late 2021, did not see Patient 1 regularly as part of orthodontic treatment;*
 - b. *Between March 2021 and May 2021, did not respond to concerns raised by Patient 1’s mother in a timely manner;*
 - c. *Following an appointment in late 2021, did not provide a retainer and/or arrange for supervision of the retentive period, following the removal of the patient’s braces.*
2. *From 8 August 2019 to 30 October 2021, you failed to provide an adequate standard of care to Patient 3, in that you:*
 - a. *Did not carry out sufficient treatment planning in relation to Patient 3’s unerupted second molars;*
 - b. *Provided a poor standard of orthodontic treatment in that you did not fit a twin block functional appliance.*
3. *You failed to advise Patient 3 in a timely manner that you were unable to complete treatment as planned and the practice was closing.*
4. *From on or around 14 August 2021, you failed to cooperate with an investigation by the General Dental Council in that you:*
 - a. *Did not provide the General Dental Council with access to patient records;*
 - b. *Did not provide the General Dental Council with employment or indemnity information.*

And, by reason of the matters set out above, your fitness to practise as a Dentist is impaired by reason of your misconduct.’

1. This is a Professional Conduct Committee hearing in respect of a case brought by the General Dental Council (GDC) against Mr Flatischler. The charge relates to his treatment of two child patients (at the time of treatment), and his alleged failure to cooperate with an investigation by the GDC.

2. The hearing is being conducted remotely by Microsoft Teams video-link.

3. Mr Flatischler is not present at the hearing, and he is not represented in his absence. The Case Presenter for the GDC is Mr Daniel Mansell, Counsel.

Application to proceed with the hearing in the absence of the registrant – 1 December 2025

4. At the outset, Mr Mansell made an application pursuant to Rule 54 of the *GDC (Fitness to Practise) Rule 2006* ('the Rules'), to proceed with the hearing notwithstanding Mr Flatischler's absence.

5. Mr Mansell drew the Committee's attention to the relevant documents in respect of service. He also referred to the evidence of the attempts made by the GDC to contact Mr Flatischler following the referral of this case to the GDC's Case Examiners, and more recently regarding this hearing. Mr Mansell told the Committee that this had included the use of a tracing agent to try and locate Mr Flatischler. Mr Mansell stated that information was obtained by the GDC that Mr Flatischler was operating from an address in Austria; an email address and telephone number were also provided. Mr Mansell outlined the communications sent by the GDC to Mr Flatischler between November 2023 and October 2025, both to his UK address registered with the Council, and to the address in Austria.

6. It was Mr Mansell's submission that the GDC had gone above and beyond to engage Mr Flatischler with this hearing, and that his response had been minimal, amounting to a single voicemail left with the GDC on 1 October 2025. Mr Mansell referred to the evidence of the unsuccessful attempts made by the Council to contact Mr Flatischler following his voicemail message. Mr Mansell submitted that Mr Flatischler's absence is deliberate and voluntary, and that an adjournment would serve no useful purpose in the circumstances. He invited the Committee to proceed with the hearing in Mr Flatischler's absence.

7. The Committee took account of Mr Mansell's submissions and the supporting documentation provided. It accepted the advice of the Legal Adviser in relation to service and proceeding with a hearing in the absence of a registrant.

Decision on service – 1 December 2025

8. The Committee considered whether notice of the hearing had been served on Mr Flatischler in accordance with Rules 13 and 65. It had before it a copy of the Notice of Hearing dated 14 October 2025 ('the notice'), which was sent to Mr Flatischler's registered address held by the GDC, as is the requirement under section 50A of the *Dentist Act 1984 (as amended)* ('the Act'). The notice was sent by Special Delivery and First Class post. A copy was also sent to Mr Flatischler's registered email address.

9. The Committee took into account that the copy of the notice sent to Mr Flatischler's registered address was returned to the GDC by Royal Mail marked 'addressee gone away'. The Committee noted, however, that there is no requirement within the Rules for the GDC to prove receipt of the notice, only that it was sent. The Committee was satisfied on the evidence provided that the Council had met the requirement of sending. Whilst the Committee noted that further communications were sent by the GDC to the address in Austria, it took into account that the onus is on Mr Flatischler as a registrant to ensure that his contact details held by the Council are up to date.

10. The Committee was satisfied that the notice sent to Mr Flatischler complied with the 28-day notice period mandated by the Rules. It was further satisfied that the notice contained all the required particulars, including the date and time of the hearing, and that it was intended that the hearing would be conducted remotely via Microsoft Teams video-link. Mr Flatischler was also advised that the Committee had the power to proceed with the hearing in his absence.

11. On the basis of all the information provided, the Committee was satisfied that notice had been served on Mr Flatischler in accordance with the Rules and the Act.

Decision on whether to proceed with the hearing in the absence of the registrant – 1 December 2025

12. The Committee next considered whether to exercise its discretion under Rule 54 of the Rules to proceed with the hearing in the absence of Mr Flatischler. It approached this matter with the utmost care and caution. The Committee took account of the GDC's submissions in relation to the factors to be considered in reaching its decision, as set out in the case of *R v Jones* [2002] UKHL 5 and as affirmed in subsequent regulatory cases, including the case of *General Medical Council v Adeogba* [2016] EWCA Civ 162.

13. The Committee bore in mind that fairness to Mr Flatischler was an important consideration, but it also took into account the need to be fair to the GDC, and the public interest in the expeditious disposal of this case.

14. The Committee had regard to the communications drawn to its attention in relation to the GDC's efforts to contact Mr Flatischler, including in relation to this hearing. The Committee took into account that following the return of the notice of 14 October 2025, the GDC sent a letter dated 28 October 2025 to the address in Austria in a further attempt to reach him. Mr Flatischler has not responded to that letter. The last contact from him was the voicemail message he left for the GDC on 1 October 2025.

15. It was the view of the Committee that Mr Flatischler has had extensive opportunities to engage with this process over a number of years but has not done so. The Committee was satisfied on the evidence that he is aware of these proceedings and that he has decided to voluntarily absent himself. It noted that he did not request an adjournment, and there was no information before the Committee to suggest that deferring this hearing would secure his attendance on a future date. In the circumstances, the Committee concluded that an adjournment would serve no purpose other than to unnecessarily delay the hearing. The Committee took into account the GDC's submission that any adjournment would likely be for a significant period of time.

16. The Committee remained mindful of the potential inconvenience to witnesses of any delay and the impact on their memories, given that it has already been some time since the index events alleged in this case. The Committee further took into account its duty to act expeditiously in the public interest and to be fair to the GDC as the regulator.

17. Having taken the relevant factors into account, the Committee considered that without good reason for an adjournment, this hearing should go ahead as scheduled. It was satisfied that it was fair and in the public interest to proceed in the absence of Mr Flatischler.

Decision on application to amend the charge – 1 December 2025

18. Mr Mansell next made an application to amend the charge under Rule 18. In particular, he applied to amend head of charge 1(c), which originally read:

1. *You failed to provide an adequate standard of care to Patient 1, in that you:*
 - c. *Following an appointment in late 2021, did not provide a retainer following the removal of the patient's braces.*

19. Mr Mansell's request was to amend 1(c) to read as follows:

1. *You failed to provide an adequate standard of care to Patient 1, in that you:*
 - c. *Following an appointment in late 2021, did not provide a retainer and/or arrange for supervision of the retentive period, following the removal of the patient's braces.*

20. Mr Mansell submitted that this is a case in which no patient records have been provided by Mr Flatischler. He explained that head of charge 1(c), as originally drafted, was based on an inference drawn from the witness statement of Patient 1's mother (Witness 1), in which there is no mention of the provision of a retainer. However, Mr Mansell asked the Committee to note that in the documentation provided by Patient 3's mother (Witness 2), specifically her exchange of online messages with Witness 1 in late 2021, there is a suggestion that a retainer was provided to Patient 1.

21. Mr Mansell submitted that regardless of whether a retainer was provided to Patient 1, the GDC's expert witness in this case, Professor Nigel Hunt (Emeritus Professor of Orthodontics at UCL Eastman Dental Institute) remains critical in his report regarding the absence of supervision of the retentive period, following the removal of Patient 1's braces.

22. Mr Mansell submitted that proposed amendment to head of charge 1(c) could be made without causing any injustice. He submitted that Mr Flatischler had been provided with a copy of Professor Hunt's report as part of the GDC's case, and that the central issue in the allegation remains unchanged. Mr Mansell submitted that it would be unfair for a valid criticism to fall away simply because of technical wording within a head of charge.

23. In acceding to Mr Mansell's application, the Committee accepted the advice of the Legal Adviser in relation to its power under Rule 18 to amend the charge at any stage before making its findings of fact.

24. The Committee had regard to the merits of the case and the fairness of the proceedings, and it was satisfied that the proposed amendment to head of charge 1(c) could be made without injustice.

In reaching its decision, the Committee had regard to Professor Hunt's opinion on the allegation, as set out in his expert report. It considered it clear that his criticism related to the totality of what he observed from the evidence in relation to the removal of Patient 1's braces. The Committee took into account that Mr Flatischler had been sent a copy of the expert report containing all the criticisms in this case. In all the circumstances, the Committee concluded that it would not be unfair to allow the amendment. It considered that amending head of charge 1(c) in the way suggested would more accurately reflect the evidence.

25. Head of charge 1(c) was amended accordingly.

Summary of the GDC's opening submissions

26. In opening the case for the GDC, Mr Mansell provided the Committee with a written opening note and made submissions orally.

27. Mr Mansell outlined that Mr Flatischler is a registered dentist. At the relevant times in the charge, Mr Flatischler practised at a dental practice, which for the purposes of this determination is referred to as 'the Practice'. Mr Mansell stated that concerns were raised about Mr Flatischler's treatment of patients and this led to a referral made by the GDC's Case Examiners to the Professional Conduct Committee. The GDC's investigation of the concerns involved the instruction of Professor Hunt, the expert witness in these proceedings.

28. Mr Mansell stated that the charge against Mr Flatischler comprises three parts: allegations in respect of his treatment of Patient 1; allegations in respect of his treatment of Patient 3; and allegations in respect of his non-cooperation with the GDC's investigation. Mr Mansell addressed the individual allegations, and in doing so, he referred the Committee to the various pieces of evidence being relied upon by the GDC, including Professor Hunt's expert opinions.

29. In summary, Mr Mansell highlighted that it is alleged by the GDC that Mr Flatischler failed to provide an adequate standard of care to Patient 1 in the context of orthodontic treatment. Mr Mansell submitted that due to Mr Flatischler's failure to cooperate with the GDC's investigation, which is the subject of another allegation, Patient 1's clinical records are not available. Mr Mansell submitted that it would seem that Patient 1 had braces fitted in or around July 2018, when the patient would have been 12 years old.

30. Mr Mansell set out the alleged concerns regarding Patient 1's treatment with Mr Flatischler, including in relation to him not having seen the patient regularly for a period of time during the orthodontic treatment, and in relation to not supervising the patient during the retentive period following the removal of the braces. It is further alleged that Mr Flatischler did not respond to concerns raised by Witness 1 in a timely manner. Witness 1 made a complaint to the GDC about Mr Flatischler in May 2021.

31. In relation to Patient 3, the Committee heard that the allegations against Mr Flatischler also concerned an alleged failure to provide an adequate standard of care to the patient in the context of orthodontic treatment. Mr Mansell told the Committee that Mr Flatischler provided braces to Patient 3, with the initial consultation in respect of the treatment taking place in August 2019, when the

patient was 11 years old. Mr Mansell referred in his opening note to Witness 2 having provided a copy of Patient 3's treatment plan.

32. Mr Mansell highlighted that it is alleged in respect of Patient 3's treatment that Mr Flatischler did not carry out sufficient treatment planning in relation to the patient's unerupted second molars. It is also alleged that the standard of orthodontic treatment that Mr Flatischler did provide was poor. In addition, Mr Flatischler is alleged to have failed to advise Patient 3, in a timely manner, that he would be unable to complete the planned treatment and that the Practice was closing. Witness 2 made a complaint to the GDC regarding Mr Flatischler in October 2021.

33. With regard to the allegations of non-cooperation with the GDC's investigation, Mr Mansell drew the Committee's attention to the evidence provided by the GDC's Caseworker involved in this case. He asked the Committee to take into account the evidence of the attempts made by the Council from August 2021 to obtain the requested information from Mr Flatischler, which was access to his patient records and details of his employment and indemnity.

Evidence

34. The Committee received from the GDC both documentary and oral evidence. The Committee received the following documentary evidence:

- The witness statement of Witness 1, Patient 1's mother, dated 1 February 2025, along with associated exhibits.
- The witness statement of Witness 2, Patient 3's mother, dated 5 February 2025, along with associated exhibits.
- The witness statement of the GDC Caseworker involved in this case, dated 19 November 2024, along with associated exhibits.
- The expert report of Professor Hunt dated 6 March 2025.

35. The Committee heard oral evidence from Witness 1, Witness 2 and Professor Hunt. The GDC Caseworker involved in this case was not called to give oral evidence, given that the primary purpose of her witness statement was to produce the various documents relied upon by the GDC in relation to Mr Flatischler's alleged non-cooperation with the Council's investigation.

The Committee's Findings of Fact – 3 December 2025

36. The Committee considered all the evidence presented to it, both oral and documentary. It took account of the closing submissions made by Mr Mansell on behalf of the GDC, in which he invited the Committee to find all the allegations proved based on the evidence adduced.

37. The Committee accepted the advice of the Legal Adviser in relation to the burden and standard of proof, how to approach the wording of the allegations, including the need to establish a duty where it is alleged that there had been a "failure" on Mr Flatischler's part, and the need to give clear and adequate reasons for its decisions.

38. The Committee bore in mind that the burden of proof at these proceedings rests with the GDC. It is not for Mr Flatischler to prove anything. The Committee took into account that the standard of proof is the civil standard, that is, whether the alleged matters are proved on the balance of probabilities. The Committee has had to decided whether it is more likely than not that what is alleged occurred.

39. The Committee considered each of the alleged matters separately and it made the following findings:

<p>1(a)</p>	<p>1. <i>You failed to provide an adequate standard of care to Patient 1, in that you:</i></p> <p style="padding-left: 40px;"><i>a. Between October 2020 and late 2021, did not see Patient 1 regularly as part of orthodontic treatment</i></p> <p>Found proved.</p> <p>It was the evidence of Witness 1, as set out in her witness statement, that following the fitting of Patient 1’s braces (which she remembered to be around 2019), Mr Flatischler saw Patient 1 regularly for a period of time. Witness 1 referred in her witness statement to Patient 1 having check-ups every six weeks. Witness 1 stated that <i>“I estimate that, for around 12 to 18 months, following Patient 1’s braces being fitted in 2019, there were no issues arranging check-up appointments”</i>.</p> <p>Witness 1 went on to state that appointments at the Practice were paused during the Covid-19 pandemic in 2020. She recalled Patient 1 next being seen by Mr Flatischler after this pause at an appointment in October 2020. Witness 1 recalled there being no-one else present at the practice during the entire time of that appointment.</p> <p>Witness 1 stated that she believed that Patient 1 did have a subsequent appointment arranged with Mr Flatischler following the October 2020 appointment but stated that <i>“...when I turned up to [the Practice], the building was locked and it did not seem that there was anyone inside...”</i>. It was Witness 1’s evidence that after that unsuccessful visit to the Practice, she was unable to arrange any appointments for Patient 1 with Mr Flatischler until late 2021, despite making significant attempts to do so. Witness 1 stated in her oral evidence that she had telephoned the Practice around 20 times and, as also stated in her witness statement, that she had visited the Practice on four separate occasions to see if she could get hold of anyone in the building, but each time she found the Practice locked and closed.</p> <p>Witness 1 also told the Committee that she sent multiple emails to the Practice and received some responses from Practice staff. This included the offer of an appointment in March 2021, after having mentioned in an email dated 17 March 2021 that it appeared that a wire had come away from the back of Patient 1’s braces. However, Witness 1 could not attend that appointment on account of having to self-isolate around that time.</p> <p>The Committee found Witness 1’s evidence on this issue to be credible and reliable. In considering her evidence, it took into account that she could not always</p>
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	<p>recall specific dates, which it did not find unreasonable given the passage of time. However, it considered that Witness 1’s recollection about the steps she took to try and contact Mr Flatischler was clear and consistent. Her recollection is also supported by the copies of her email correspondence to the Practice, which she exhibited with her witness statement. The Committee had before it multiple emails sent to the Practice, in which Witness 1 repeatedly asked about appointments for Patient 1. It noted that the one last minute appointment that Witness 1 was offered for Patient 1 could not be attended for reasons beyond Witness 1’s control, and no further appointments were offered. The Committee also noted Witness 1’s evidence that in around May 2021, after searching for Mr Flatischler’s name on the internet, she discovered that he had set up a practice in Austria and she left a complaint on his website.</p> <p>Having taken into account Witness 1’s evidence, both documentary and oral, the Committee was satisfied on the balance of probabilities that, between October 2020 and late 2021, Mr Flatischler did not see Patient 1 regularly as part of the patient’s orthodontic treatment. The evidence before the Committee was that there was a significant gap in Patient 1’s treatment from October 2020 until late 2021, when Witness 1 managed to arrange an appointment with Mr Flatischler and he cut the wire that had come loose from Patient 1’s braces.</p> <p>In considering whether there was a duty on Mr Flatischler to see Patient 1 regularly, as part of the orthodontic treatment being provided, the Committee had regard to the expert evidence of Professor Hunt. In doing so, it noted his extensive knowledge and experience in orthodontics.</p> <p>Professor Hunt stated in his report that “...it is important that orthodontic patients are seen at regular intervals throughout treatment (usually 6-8 weeks) to ensure that the tooth movements are proceeding as desired and that unwanted tooth movements are not occurring”.</p> <p>In relation to the impact of the Covid-19 pandemic on dental practices, Professor Hunt told the Committee in his oral evidence that in August 2020 the Chief Dental Officer had issued procedures for a transfer to no restrictions for non-aerosol generating procedures. Professor Hunt explained that most orthodontic procedures are non-aerosol generating procedures, and therefore Mr Flatischler should have continued to see Patient 1 every 6 to 8 weeks from August 2020. The Committee accepted Professor Hunt’s opinion that not to have done so, amounted to a failure by Mr Flatischler to provide an adequate standard of care.</p> <p>Accordingly, the Committee was satisfied that this head of charge is proved.</p>
<p>1b.</p>	<p>1. You failed to provide an adequate standard of care to Patient 1, in that you:</p> <p style="padding-left: 40px;">b. Between March 2021 and May 2021, did not respond to concerns raised by Patient 1’s mother in a timely manner</p> <p>Found proved.</p> <p>In her oral evidence, Witness 1 was taken through the various attempts she made to contact Mr Flatischler, including in relation to the numerous telephone calls she said she made to the Practice and her physical attendance at the Practice</p>

	<p>premises on four separate occasions. The Committee also had before it email correspondence setting out the extensive history of Witness 1’s engagement with the Practice staff between March and May 2021. In those emails Witness 1 raised concerns about the lack of appointments for Patient 1, that the braces may have been on for too long, and in relation to the loose wire on the braces.</p> <p>The Committee found that Witness 1 was clear in both her oral evidence and in her witness statement about the great deal of effort she made to try and find Mr Flatischler after Patient 1’s appointment in October 2020. It accepted her evidence that no response was received from him during the period March to May 2021, although there were responses from the Practice staff. The Committee took account of Witness 1’s evidence that it was around May 2021, not having heard from Mr Flatischler, that she left a complaint on the website in relation to his Austrian practice. Witness 1 further stated in her witness statement that <i>“I asked [the Practice] for their complaint’s procedure; however, they did not respond to me”</i></p> <p>The Committee was satisfied on the balance of probabilities, that over the time period concerned in this allegation, Mr Flatischler did not respond to the concerns raised by Witness 1 in a timely manner. In finding that this amounted to a failure to provide an adequate standard of care to Patient 1, the Committee took into account Professor Hunt’s opinion on the issue. It noted that he made reference in his report to the following GDC ‘Standards for the Dental Team’ (September 2013) (‘the GDC Standards’):</p> <p><u>Standard 5.1.2</u></p> <p><i>You should make sure that everyone (dental professionals, other staff and patients) knows about the complaints procedure and understands how it works. If you are an employer, or you manage a team, you must ensure that all staff are trained in handling complaints.</i></p> <p><u>Standard 5.3</u></p> <p><i>You must give patients who complain a prompt and constructive response.</i></p> <p>Professor Hunt stated in his oral evidence that it was Mr Flatischler’s responsibility to ensure that staff at the Practice were aware of the complaints procedure and in a position to provide it to Witness 1. Further, it was Professor Hunt’s opinion that in his lack of response to Witness 1, Mr Flatischler did not adhere to Standard 5.3 and that this constituted a failure in the standard of care.</p> <p>Having taken all the evidence into account, the Committee was satisfied that this head of charge is proved.</p>
<p>1c.</p>	<p>1. <i>You failed to provide an adequate standard of care to Patient 1, in that you:</i></p> <p><i>c. Following an appointment in late 2021, did not provide a retainer and/or arrange for supervision of the retentive period, following the removal of the patient’s braces.</i></p>

Found proved (as amended) on the basis that supervision of the retentive period was not arranged following the removal of the patient's braces.

The Committee noted that it was initially inferred from Witness 1's witness statement that a retainer had not been provided to Patient 1. However, in an exchange of online messages between Witness 1 and Witness 2, who is Patient 3's mother, there is reference to a retainer having been provided to Patient 1. Witness 1 told the Committee that she and Witness 2 had been members of an online forum on which concerns had been raised regarding Mr Flatischler. When asked about the provision of a retainer, Witness 1 stated in her oral evidence that she believed one had been sent for Patient 1 through the post.

It was the conclusion of the Committee, having had regard to Witness 1's oral evidence, and having taken into account the contemporaneous online messages exchanged between Witness 1 and Witness 2, that it was more likely than not that a retainer was provided to Patient 1. Notwithstanding this, the Committee noted, as was confirmed in the GDC's closing submissions, that the focus of the Council's case is in relation to Mr Flatischler's alleged failure in supervision following the removal of Patient 1's braces.

Witness 1 recalled in her witness statement that following the appointment in late 2021, when Mr Flatischler cut the loose wire on Patient 1's braces there was a further appointment with him. Witness 1 stated that she remembered this because it was at that further appointment that Mr Flatischler removed Patient 1's braces. Witness 1 stated that *"He did not advise as to whether there would be any subsequent appointments following the removal of Patient 1's braces. We had an appointment booked after [Patient 1] had had them taken off by him, however, when we turned up at [the Practice], it was locked again and we could not access the building"*.

The Committee accepted Witness 1's evidence as clear and credible. It was satisfied from her account that it was more likely than not that there was no supervision following the removal of Patient 1's braces. The Committee further noted that there is no indication that Patient 1 was referred elsewhere for supervision.

The Committee took account of the expert opinion of Professor Hunt that retainers are necessary with almost all orthodontic treatment. He also stated that it is necessary to see a patient on provision of a retainer, to ensure an appropriate fit and to give the patient instructions on how to use it. Professor Hunt told the Committee that following the removal of braces and the provision of a retainer, supervision of a patient is required for up to one year. He stated that not supervising the retentive period is a failure of basic skills and could result in a relapse, undoing the orthodontic treatment provided.

The Committee was satisfied on all the evidence that this head of charge is proved on the basis that Mr Flatischler failed to provide an adequate standard of care to Patient 1, in that he did not arrange supervision of the retentive period following the removal of the patient's braces.

<p>2a.</p>	<p>2. <i>From 8 August 2019 to 30 October 2021, you failed to provide an adequate standard of care to Patient 3, in that you:</i></p> <p style="padding-left: 40px;"><i>a. Did not carry out sufficient treatment planning in relation to Patient 3's unerupted second molars</i></p> <p>Found proved.</p> <p>Professor Hunt stated in his report that “...<i>failure of eruption of the '12 year old' second molars should have necessitated further investigation during treatment. This would then have identified the impacted second molars whose management, ... should have been included in a revised overall plan</i>”</p> <p>The Committee noted that the clinical records of Mr Flatischler for Patient 3 were not obtained by the GDC. However, the Committee did have before it a copy of Mr Flatischler's treatment plan for Patient 3 and the clinical records of Patient 3's subsequent treating orthodontist, as exhibited by Witness 2 with her witness statement.</p> <p>Professor Hunt noted in his report that “<i>When the patient was seen by the orthodontist regarding continuing care once the Registrant's practice closed, it is noted that on a new OPG x-ray taken on 8 November 2022 (patient now aged 15.83 years)...the '12 year old' second molars had failed to erupt with LR7 horizontally impacted and LL7 vertically impacted</i>”</p> <p>It was Professor Hunt's opinion, having considered all the information presented to him, that Mr Flatischler “...<i>was deficient in the overall planning of treatment and allowed a situation to develop which could have caused harm to the patient's dentition</i>”.</p> <p>The Committee accepted Professor Hunt's opinion. In doing so, it noted that there was no evidence before it in relation to any revised treatment plan proposed by Mr Flatischler to take into account the fact that Patient 3's second molars did not erupt in the mouth as his orthodontic treatment progressed. The Committee further noted that Witness 2's expectations around Patient 3's treatment with Mr Flatischler remained focused on the proposals set out in the original treatment plan. Witness 2 did not refer to there being any revised treatment plan.</p> <p>Having considered all the evidence, the Committee was satisfied that it is proved on the balance of probabilities that Mr Flatischler failed to provide an adequate standard of care to Patient 3, as he did not carry out sufficient treatment planning in relation to Patient 3's unerupted second molars.</p>
<p>2b.</p>	<p>2. <i>From 8 August 2019 to 30 October 2021, you failed to provide an adequate standard of care to Patient 3, in that you:</i></p> <p style="padding-left: 40px;"><i>b. Provided a poor standard of orthodontic treatment in that you did not fit a twin block functional appliance</i></p> <p>Found proved.</p>

The Committee noted from the copy of the treatment plan provided by Witness 2, that Mr Flatischler had proposed “A [functional] appliance to expand the upper arch and to bring the lower jaw into a forward position to improve the facial profile (Twin Blocks...)”.

Professor Hunt explained in his report that “The twin block appliance works by holding the lower jaw in a downward and forward position. This encourages the patient’s natural growth to follow this direction so correcting deficiencies in the antero-posterior and vertical dimensions...and so correcting the overjet and deep or increased overbite.”. The Committee further noted Professor Hunt’s oral evidence that a twin block appliance needs to be fitted to coincide with the pubertal growth spurt, as the appliance relies largely on patient growth for its success.

The indication is that Mr Flatischler did not adhere to his treatment plan to provide the twin block appliance to Patient 3 but instead attempted to correct the antero-posterior and vertical discrepancies using elastic bands worn between the teeth in the upper and lower jaws.

The Committee found Witness 2 to be clear in her evidence when she said that a twin block appliance was never fitted for Patient 3. In accepting her account, the Committee recognised that a twin block is an unusual appliance that performs a specific function, and that this would have necessitated an explanation to both Patient 3 and Witness 2 about its purpose. The Committee noted that Witness 2 stated in her witness statement that as of 30 October 2021, more than two years after Patient 3’s treatment had commenced, Witness 2 was still expecting the twin block appliance to be fitted by Mr Flatischler. She stated regarding Patient 3’s orthodontic treatment at that time, “...He also still had the elastic bands attached. There had also been no mention of initiating the Twin Blocks treatment, as was previously advised in the treatment plan. I was still expecting this course of treatment to be needed, and had assumed that Günter Flatischler would action this...”

The Committee further took into account that there is no mention of Patient 3 having been fitted with a twin block appliance in the clinical records of the subsequent treating orthodontist. The Committee noted from those clinical records that it is stated in relation to an appointment Patient 3 attended on 8 November 2022 that the patient “...was due to have ctb but gunther said [could] treat with elastics and not treat with ctb...”

In finding that Mr Flatischler provided a poor standard of treatment to Patient 3 by not fitting a twin block appliance, it accepted the expert opinion of Professor Hunt, who referred to the photographs provided by the subsequent treating orthodontist. Professor Hunt stated that the photographs show that Patient 3 was left with a deep overbite, and that this could lead to periodontal problems. Professor Hunt further stated that, the mode of treatment actually supplied, namely the use of the elastic bands, “was incapable of achieving the treatment objectives and the patient’s dentition has been left in a potential harmful and unsatisfactory state”. In all the circumstances, the Committee was satisfied that Mr Flatischler failed to provide Patient 3 with an adequate standard of care in this regard, and therefore this head of charge is proved.

3.	<p>3. <i>You failed to advise Patient 3 in a timely manner that you were unable to complete treatment as planned and the practice was closing.</i></p> <p>Found proved.</p> <p>In considering this head of charge, the Committee noted that it heard some evidence relating to the issue of Patient 3’s referral to another orthodontist. However, the specific wording of the allegation relates to whether Patient 3 was advised in a timely manner that Mr Flatischler was unable to complete treatment as planned and the Practice was closing.</p> <p>Witness 2 stated in her witness statement that the last appointment Patient 3 had with Mr Flatischler was on 30 October 2021. Witness 2 stated that “ <i>At the time, I was not aware that this would be the last appointment. When I entered [the Practice], I could see that a lot of items were being packed up in boxes, and I thought that the building looked disorganised. I asked Günter Flatischler if he was moving premises and he advised that he was returning to Austria the following day. I was surprised to hear this and I asked him what would happen to Patient 3’s ongoing treatment. Günter Flatischler replied “I won’t forget you”. Günter Flatischler told me that he would arrange for another orthodontist to take over Patient 3’s treatment”.</i></p> <p>Witness 2 further stated that “<i>Günter Flatischler did not provide a continuation of treatment plan following this appointment, nor any other documentation. Further, until this appointment, he did not advise that he was leaving the country and closing [the Practice]”.</i></p> <p>The Committee accepted Witness 2’s evidence that the first time she became aware of this issue was at that appointment on 30 October 2021. It was satisfied that she accurately recalled what she knew and felt at the time, including her surprise in the way Mr Flatischler communicated the news to her. The Committee noted that Mr Flatischler did indeed leave the country and close the Practice.</p> <p>It was the opinion of Professor Hunt, which the Committee accepted, that this was an inappropriate way for Mr Flatischler to inform Patient 3 that treatment would not be continued and that the Practice was closing. The Committee considered that Patient 3 should have been informed well before the appointment on 30 October 2021. Furthermore, the Committee noted Mr Flatischler only offered the information in response to a question from Witness 2. It was the conclusion of the Committee that this amounted to a failure to provide Patient 3 with an adequate standard of care, and accordingly, this head of charge is proved.</p>
4a.	<p>4. <i>From on or around 14 August 2021, you failed to cooperate with an investigation by the General Dental Council in that you:</i></p> <p style="padding-left: 40px;"><i>a. Did not provide the General Dental Council with access to patient records</i></p> <p>Found proved.</p> <p>The Committee found this head of charge proved for the same reasons set out at in relation to head of charge 4b below.</p>

<p>4b.</p>	<p><i>4. From on or around 14 August 2021, you failed to cooperate with an investigation by the General Dental Council in that you:</i></p> <p style="padding-left: 40px;"><i>b. Did not provide the General Dental Council with employment or indemnity information.</i></p> <p>Found proved.</p> <p>The Committee considered heads of charge 4a and 4b separately but made the same findings in respect of both allegations based on the same evidence.</p> <p>The Committee had regard to the witness statement of the GDC Caseworker involved in this case, in which she stated that:</p> <p style="padding-left: 40px;"><i>“On 14 August 2021, Günter Flatischler was contacted by the GDC regarding an initial consideration of a concern that had been received in relation to Günter Flatischler’s conduct. In this letter, Günter Flatischler was asked to provide details regarding:</i></p> <p style="padding-left: 40px;"><i>a) his current and previous working arrangements;</i> <i>b) proof of indemnity;</i> <i>c) patient records.”</i></p> <p>Mr Flatischler was asked to provide the above information to the GDC by 30 August 2021, but he did not do so. The Committee was provided with copies of the GDC’s communication to him following its initial request made on 14 August 2021. It noted that some two years later, the GDC was still renewing its requests to Mr Flatischler for the information in question. It had regard to an email dated 24 August 2023, sent by the GDC Caseworker in which she stated <i>“We have written to you on several occasions, which include 14 August 2021, 13 July 2022, 25 August 2022...and 12 December 2022. We are still yet to receive a response. It is important that you respond to our requests for information...”</i>. Mr Flatischler was advised that the GDC’s investigation would proceed regardless of a lack of response from him.</p> <p>On 28 November 2023, the GDC wrote to Mr Flatischler to inform him that his case had been passed to the GDC’s Case Examiners.</p> <p>The Committee was satisfied on the evidence provided that Mr Flatischler failed to cooperate with the GDC’s investigation. He did not provide evidence of his working arrangements and indemnity as requested, nor did he provide any patient records, and as a result his clinical records have not been available for this hearing. The Committee noted that Mr Flatischler did respond to the GDC on one occasion between 14 August 2021 and 13 July 2022, when he sent an email to the Council enquiring about the possibility of Voluntary Removal, stating that his NHS contract had expired and that he had no intention to work. Further attempts to contact Mr Flatischler following that enquiry were unsuccessful. The evidence before the Committee is that he did not get in contact with the GDC again until the voicemail message he left on 1 October 2025, shortly before this hearing.</p>
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	In all the circumstances, the Committee was satisfied on the balance of probabilities that heads of charge 4a and 4b are proved.
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40. The hearing now moves to Stage Two.

Stage Two of the hearing – 3 to 4 December 2025

41. The Committee's tasks at this stage of the hearing were to consider whether the facts found proved against Mr Flatischler amount to misconduct, and if so, whether his fitness to practise is currently impaired by reason of that misconduct. The Committee took into account that if it found current impairment, it would need to consider what sanction, if any, to impose on Mr Flatischler's registration.

Summary of the facts found proved

42. The facts found proved in this case relate to Mr Flatischler's failure to provide an adequate standard of care to two child patients in the context of orthodontic treatment. It was also found proved that Mr Flatischler failed to cooperate with the GDC's investigation.

43. In relation to the first patient, Patient 1, who was 12 years old at the time treatment commenced, the Committee found proved that:

- Between October 2020 and late 2021, Mr Flatischler did not see Patient 1 regularly during the patient's orthodontic treatment. There was a gap of almost one year between the patient's appointment in October 2020 and the next time Mr Flatischler saw her in late 2021.
- Between March 2021 and May 2021, Mr Flatischler did not respond to concerns raised by Patient 1's mother (Witness 1) in a timely manner. Witness 1 sent repeated emails to the Practice regarding Patient 1's care, with no response from Mr Flatischler.
- Following an appointment in late 2021, Mr Flatischler did not arrange for supervision of the retentive period following the removal of Patient 1's braces. Supervision was required for up to a year after the removal of the braces, but Mr Flatischler did not arrange any supervision at all.

44. In relation to the second patient, Patient 3, who was 11 years old at the time treatment commenced, the Committee found proved that, from 8 August 2019 to 30 October 2021, Mr Flatischler:

- Did not carry out sufficient treatment planning in relation to Patient 3's unerupted second molars. When the second molars did not erupt as the patient's orthodontic treatment progressed, Mr Flatischler should have revised the original treatment plan to take into account the management of these unerupted teeth. However, he failed to do so.

- Provided a poor standard of orthodontic treatment to Patient 3, in that he did not fit a twin block functional appliance, which was part of the patient's treatment plan. Instead, Mr Flatischler attempted to correct the antero-posterior and vertical discrepancies using elastic bands worn between the teeth in the upper and lower jaws. The expert evidence, which the Committee accepted, was that the use of the elastic bands was incapable of achieving the treatment objectives and the patient's dentition was left in a potentially harmful and unsatisfactory state.

45. In addition to the failings in his treatment of Patient 3, Mr Flatischler failed to advise the patient in a timely manner that he was unable to complete the planned treatment and that the Practice was closing. Patient 3's mother (Witness 2), only became aware at an appointment on 30 October 2021, that Mr Flatischler would be closing the Practice and moving to Austria the next day.

46. With regard to Mr Flatischler's non-cooperation with the GDC's investigation, the Committee found proved that he failed to respond to the Council requests for information over a number of years. He was sent multiple communications by the GDC from 14 August 2021 onwards, with requests for his patient records and his employment and indemnity information. To date, Mr Flatischler has not provided the information sought.

Summary of the submissions made by the GDC

47. In accordance with Rule 20(1)(a) of the Rules, Mr Mansell first addressed the Committee on any fitness to practise history. He confirmed that Mr Flatischler has no fitness to practise history before the GDC.

48. In addressing the Committee on the issue of misconduct, Mr Mansell submitted that the courts have held that misconduct is a word of general effect, which often involves some act or omission which falls short of what would be proper in the circumstances. Further, it is conduct that fellow practitioners would regard as 'deplorable'.

49. Mr Mansell submitted that the expert evidence of Professor Hunt may assist the Committee in relation to the seriousness of the matters found proved. Mr Mansell drew the Committee's attention to Professor Hunt's opinion that each of its findings represented conduct that fell far below the standard expected. In this regard, Mr Mansell referred to Professor Hunt's report, in which he stated that:

"A standard of care far below that expected is based on one or more of the following: Whether actual harm or a risk of serious harm to a patient could have occurred; whether there was a gross or significant departure from the standard expected; whether there was a breach of the law or statutory requirements; a failure of basic skills, or cumulatively there has been a significant departure from the standard expected".

50. Mr Mansell submitted that the GDC Standards may also be of assistance to the Committee in relation to what is expected of registered dental professionals. He stated that in view of the Committee's findings, it may be considered that the following GDC Standards are relevant in this case: 1.4, 1.7, 2.1, 4.4, 5.1, 5.2 and 5.3.

51. Mr Mansell went on to outline the facts found proved. In doing so, he asked the Committee to take into account Mr Flatischler's failings in his treatment of both patients. This included that he did not see Patient 1 for almost a year during the course of her orthodontic treatment and that he failed to respond to Witness 1's repeated concerns about Patient 1's care. Further, that Witness 1's request for the Practice's complaints policy went unanswered. Mr Mansell also asked the Committee to have regard to the issues raised by Professor Hunt regarding the lack of supervision during the retentive period following the removal of Patient 1's braces. Mr Mansell submitted that this included Mr Flatischler sending a retainer to the patient in the post without a fit appointment and without assessing whether the patient's orthodontic treatment was progressing appropriately.

52. Mr Mansell highlighted in respect of Patient 3, that this patient has since had five teeth removed. Mr Mansell asked the Committee to take into account Professor Hunt's explanation that those extractions would have involved considerable bone loss. Mr Mansell drew the Committee's attention to the information received from Patient 3's subsequent treating orthodontist in relation to the remedial work required for the patient. In this regard, Mr Mansell submitted that Patient 3 no longer has the advantage of the pubertal growth spurt required for the twin block appliance to succeed and therefore the chance of success is reduced. Mr Mansell also referred to the evidence of Witness 2 that due to Patient 3's experience with Mr Flatischler, the patient is now not inclined to have any further orthodontic treatment.

53. In relation to Mr Flatischler's non-cooperation with the GDC's investigation, Mr Mansell highlighted that repeated requests for information were made to him by the Council. Mr Mansell submitted that the Committee may consider that it was hampered, to a degree, in its consideration of this case, given the lack of patient records.

54. Mr Mansell submitted that the Committee may agree that each of the matters found proved against Mr Flatischler fell far below the expected standard and would be regarded as deplorable by fellow practitioners. Mr Mansell invited the Committee to determine that the facts found proved amount to misconduct.

55. In relation to current impairment, Mr Mansell drew the Committee's attention to the relevant legal authorities. He submitted that the Committee should consider whether Mr Flatischler's failings are easily remediable, whether they have been remedied, and whether they are likely to be repeated.

56. It was Mr Mansell's submission that it may be considered that Mr Flatischler's clinical failings, which have been categorised by Professor Hunt, as failings in basic care, are not easily remediable. Mr Mansell further submitted that Mr Flatischler's failure to respond to the concerns of Witness 1, to tell Patient 3 that he would not be able to complete the planned treatment and that the Practice was closing, and the failure to cooperate with the GDC's investigation, may also be conduct that is not easily remediable.

57. Mr Mansell submitted that there is no evidence of remediation before the Committee in any event. He stated that Mr Flatischler has not provided anything, has not engaged with this process, and there is no evidence of insight. Accordingly, Mr Mansell submitted, the Committee may be of the view that the conduct found proved has not been remedied and that it is highly likely to be repeated.

58. Mr Mansell submitted that the Committee should also consider the wider public interest when determining the issue of impairment. In particular, whether proper professional standards and public confidence in the dental profession would be undermined if a finding of impairment were not made in the circumstances of this case. Mr Mansell submitted that this is a case involving a poor standard of care provided to two child patients by Mr Flatischler; both of whom were placed at the risk of harm and one suffering actual harm. Furthermore, Mr Flatischler failed to cooperate with the GDC's investigation despite his professional obligation to do so. Additionally, there has been no evidence of insight or remediation. Mr Mansell submitted that an informed member of the public would be perturbed if a finding of current impairment were not made. He invited the Committee to make such a finding in the wider public interest.

59. With regard to sanction, Mr Mansell submitted that the most appropriate and proportionate outcome in this case would be the imposition of a suspension order on Mr Flatischler's registration for a period of 12 months, with a review. Mr Mansell submitted that any lesser sanction would not be sufficient to protect the public and the wider public interest. He stated that the suspension of Mr Flatischler's registration would mark the seriousness of his conduct and provide him with an opportunity to reflect on his failings.

The Committee's decisions – 4 December 2025

60. In reaching its decisions, the Committee considered all the evidence provided to it at the fact-finding stage. It received no further evidence at this stage. The Committee took account of the submissions made by Mr Mansell on behalf of the GDC in relation to misconduct, impairment and sanction.

61. The Committee accepted the advice of the Legal Adviser in relation to the legal principles and guidance applicable at this stage, how it should approach its decision-making and the need to give clear and unequivocal reasons for each decision made. The Committee bore in mind that its decisions were for its independent judgement. There is no burden or standard of proof at this stage of the proceedings.

Decision on misconduct

62. The Committee considered whether the facts found proved amount to misconduct. It took into account that a finding of misconduct in the regulatory context requires a serious falling short of the professional standards expected of a registered dental professional.

63. The Committee had regard to its factual findings and was satisfied that the following GDC Standards are engaged in this case:

- 1.4 Take a holistic and preventative approach to patient care which is appropriate to the individual patient.
- 1.7 Put patients' interests before your own or those of any colleague, business or organisation.

- 2.1 Communicate effectively with patients – listen to them, give them time to consider information and take their individual views and communication needs into account.
- 4.4 Ensure that patients can have access to their records.
- 5.1 Make sure that there is an effective complaints procedure readily available for patients to use, and follow that procedure at all times.
- 5.2 Respect a patient’s right to complain.
- 5.3 Give patients who complain a prompt and constructive response.
- 9.1 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 Co-operate with any relevant formal or informal inquiry and give full and truthful information.

64. The Committee’s findings include Mr Flatischler’s failings in the provision of basic care to two child patients, Patient 1 and Patient 3, during orthodontic treatment. The Committee considered that through his actions and omissions, Mr Flatischler placed Patient 1 at risk of harm and caused actual harm to Patient 3. The Committee had regard to the expert opinion of Professor Hunt, who highlighted in his report that Patient 1 could have suffered harm as a consequence of unsupervised treatment intervals. In relation to Patient 3, the Committee took into account the evidence of the long-term effects that Mr Flatischler’s failings have had on this patient. It considered the evidence of Professor Hunt and the evidence of Witness 2, Patient 3’s mother, and noted that the harm suffered by Patient 3 has not only been in relation to ongoing issues with his dentition, but also in relation to his reluctance to have further orthodontic treatment on account of his experience with Mr Flatischler.

65. In addition to the identified clinical failings, the Committee found that there were considerable issues with Mr Flatischler’s communication with his patients and their parents regarding their treatment. He failed to respond over many months to numerous communications from Witness 1, in which she raised concerns about Patient’s 1 care. He also failed to inform Patient 3 in a timely manner that he would not be able to complete the patient’s planned treatment and that the Practice was closing. Mr Flatischler told Patient 3 and Witness 2 about this the day before he was due to move to Austria, and only because he was asked a related question by Witness 2.

66. The Committee also found proved in this case that Mr Flatischler failed to cooperate with the investigation conducted by the GDC. It is a basic and fundamental requirement of registration that dental professionals engage with their regulatory body. The GDC cannot effectively regulate and assess issues, such as fitness to practise, if registrants do not appropriately respond to communications sent to them, including requests for information.

67. The Committee accepted the expert opinion of Professor Hunt that each aspect of Mr Flatischler’s conduct, as demonstrated in this case, fell far below the expected standard. The

Committee was in no doubt that the facts found proved, both individually and cumulatively, represented a serious breach of Mr Flatischler's professional obligations under the GDC Standards, and amounted to misconduct.

Decision on current impairment

68. The Committee next considered whether Mr Flatischler's fitness to practise is currently impaired by reason of his misconduct. It had regard to the to the overarching objective of the GDC, which is: the protection, promotion and maintenance of the health, safety, and well-being of the public; the promotion and maintenance of public confidence in the dental profession; and the promotion and maintenance of proper professional standards and conduct for the members of the dental profession.

69. Mr Flatischler's clinical failings were serious and in basic aspects of care. His failings in communication were also significant and included failings that continued over a protracted period of time. The Committee further noted that his non-engagement with the GDC has persisted for a number of years. Taking these factors into account, it was the view of the Committee that Mr Flatischler's misconduct could not be regarded as easily remediable, although remediation would not be impossible.

70. However, the position is that Mr Flatischler has not engaged with this hearing in any way. Consequently, there is no evidence before the Committee to suggest that he has insight into his misconduct or that he has taken any steps to address the concerns that have been raised about him. The Committee therefore concluded that the risk of repetition is high. Accordingly, it determined that a finding of current impairment is necessary for the protection of the public.

71. The Committee also determined that such a finding is in the wider public interest. This is a case that involves Mr Flatischler's failure to provide an adequate standard of care to two children, who by definition were vulnerable patients. The Committee considered that members of the public would be shocked if a finding of current impairment were not made in the circumstances. The Committee also considered that the public would be very concerned about Mr Flatischler's failings in communication, and his continuing failure to engage with the GDC, such that there is no evidence at this hearing of any insight or remediation. The Committee was therefore satisfied that a finding of current impairment is required to maintain public confidence in the dental profession and to uphold proper professional standards.

Decision on sanction

72. The Committee went on to consider what sanction, if any, to impose on Mr Flatischler's registration. It took into account that the purpose of any sanction is not to be punitive, although it may have that effect, but to protect the public and the wider public interest. The Committee had regard to the GDC's *'Guidance for the Practice Committees, including Indicative Sanctions Guidance (October 2016; last revised in December 2020)'* ('the Guidance'). The Committee applied the principle of proportionality, balancing the public interest with Mr Flatischler's interests.

73. In deciding on the appropriate sanction, the Committee considered the issue of mitigating and aggravating factors. The only factor it identified in mitigation was Mr Flatischler's previous good character, in that he has no fitness to practise history before the GDC.

74. In terms of aggravating factors, the Committee considered the following:

- actual harm or risk of harm to a patient or another;
- premeditated misconduct in relation to the manner in which Mr Flatischler informed Patient 3 regarding the closure of the practice and that he would not be completing the planned treatment. The Committee also considered Mr Flatischler's prolonged non-engagement with the GDC.
- financial gain by the Registrant; the Committee noted the evidence of Witness 2 that she had paid in advance for Patient 3's orthodontic treatment with Mr Flatischler, which was not completed.
- breach of trust; the Committee was of the view that Mr Flatischler did breach the trust of Patient 1 and Patient 3, and their parents, in his position as the treating dentist.
- the involvement of vulnerable patients, given that Patient 1 and Patient 3 were child patients.
- misconduct sustained or repeated over a period of time.
- blatant or wilful disregard of the role of the GDC and the systems regulating the profession.
- lack of insight

75. Taking all the above factors into account, the Committee considered the available sanctions. It started with the least restrictive as it was required to do. The Committee took into account that it was open to it to conclude this case without taking any action in relation to Mr Flatischler's registration, however, it considered that this would be wholly inappropriate. The Committee has identified a high risk of repetition and wider public interest considerations. Taking no action in respect of Mr Flatischler's registration would not serve to protect the public, nor would it satisfy the wider public interest.

76. Accordingly, the Committee considered whether it would be appropriate and proportionate to issue Mr Flatischler with a reprimand. It had regard to paragraph 6.9 of the Guidance which sets out a list of factors which may make a reprimand suitable. The Committee noted that just one of the relevant factors applied in this case, namely that Mr Flatischler has no fitness to practise history. In the circumstances, the Committee decided that a reprimand would not be a sufficient or proportionate outcome.

77. The Committee considered whether to impose a conditions of practice order on Mr Flatischler's registration. It concluded, however, that given the serious nature of his misconduct, conditional registration would not be proportionate. The Committee also took into account that Mr Flatischler has not engaged with this process or expressed any willingness to comply with

conditions. It therefore considered that a conditions of practice order would not be workable, measurable or enforceable in any event.

78. The Committee next considered whether to suspend Mr Flatischler's registration for a specified period of up to 12 months, which is the maximum suspension period that can be imposed. It had regard to paragraph 6.28 of the Guidance, which states that "*Suspension is appropriate for more serious cases and may be appropriate when all or some of the following factors are present...*

- *there is evidence of repetition of the behaviour;*
- *the Registrant has not shown insight and/or poses a significant risk of repeating the behaviour;*
- *patients' interests would be insufficiently protected by a lesser sanction;*
- *public confidence in the profession would be insufficiently protected by a lesser sanction;*
- *there is no evidence of harmful deep-seated personality or professional attitudinal problems (which might make erasure the appropriate order)"*

79. The Committee was satisfied that the first four factors listed in paragraph 6.28 of the Guidance apply in this case. However, in view of the ongoing concerns in this case, it considered carefully the fifth factor, namely the absence of any evidence of "*harmful deep-seated personality or professional attitudinal problems*". Whilst the Committee recognised that there is no evidence before it to suggest that Mr Flatischler has a harmful deep-seated personality problem, it did consider that there is evidence indicating serious concerns with his professional attitude.

80. The Committee considered that its findings demonstrated concerns in respect of Mr Flatischler's professionalism from around October 2020, when the issues with Patient 1's treatment began. The Committee took into account that Mr Flatischler did see Patient 1 again in late 2021, after a long gap, but this was only following the complaint made by Witness 1 on the website for his Austrian practice. The Committee noted Witness 1's oral evidence that Mr Flatischler had asked her to take the complaint down.

81. The issues relating to Mr Flatischler's professional attitude continued and included his failure to respond to the communications he received from the GDC, which began in August 2021, and the manner in which he communicated to Patient 3 and Witness 2 that he would be closing the Practice, leaving for Austria and not completing the treatment he had planned for Patient 3.

82. The Committee noted from paragraph 6.28 of the Guidance that professional attitudinal problems may make erasure the appropriate sanction. It had regard to paragraph 6.34 of the Guidance which deals with erasure, and noted that following factors are relevant in this case:

- serious departure(s) from the relevant professional standards;
- serious harm to patients or other persons has occurred, either deliberately or through incompetence;
- a continuing risk of serious harm to patients or other persons is identified;
- an abuse of a position of trust or violation of the rights of patients, particularly if involving vulnerable persons, in this case child patients;

- a persistent lack of insight into the seriousness of actions or their consequences.

83. Given the presence of these factors from paragraph 6.34 of the Guidance, and its serious concerns about Mr Flatischler's professional attitude, the Committee concluded that the suspension of his registration would not be sufficient to uphold the public interest, even for the maximum period of 12 months. In the Committee's judgement, Mr Flatischler's behaviour, which has included the lack of any demonstration of insight and his continued non-engagement with the GDC, is fundamentally incompatible with being a dental professional. In the Committee's view, Mr Flatischler has shown complete disregard for the patients in this case, for his regulatory body and for the public's perception of the dental profession.

84. In all the circumstances, the Committee determined that the only appropriate and proportionate sanction in this case is one of erasure. In imposing this highest sanction, the Committee was satisfied that the need to protect the public interest outweighed Mr Flatischler's own interests.

85. Unless Mr Flatischler exercises his right of appeal, his name will be erased from the Dentists Register, 28 days from the date that notice of this Committee's determination is deemed to have been served upon him.

86. The Committee now invites submissions from Mr Mansell, as to whether an immediate order of suspension should be imposed on Mr Flatischler's registration to cover the appeal period, pending the taking effect of its substantive direction for erasure.

Decision on an immediate order – 4 December 2025

87. In considering whether to impose an immediate order of suspension on Mr Flatischler's registration, the Committee took account of Mr Mansell's application that such an order should be imposed. It was his submission that an immediate order is necessary for the protection of the public in view of the risk of repetition identified in the Committee's substantive determination. Mr Mansell also submitted that an immediate order is in the wider public interest, given the Committee's findings, to maintain confidence in the regulatory process.

88. The Committee accepted the advice of the Legal Adviser, who drew to its attention the statutory test for immediate orders.

89. In all the circumstances, the Committee determined that the imposition of an immediate order of suspension on Mr Flatischler's registration is necessary for the protection of the public and is otherwise in the public interest.

90. In its substantive determination, the Committee has identified a high risk of repetition, given the lack of any evidence of insight or remediation from Mr Flatischler. The Committee considered that it would be inconsistent not to impose an immediate order for the protection of the public. It took into account that in the absence of an immediate order, Mr Flatischler could, if he wished to do so, return to unrestricted practice during the appeal period, or for longer, in the event of an appeal against the substantive direction for erasure.

91. The Committee was also satisfied that an immediate order is required in the wider public interest, in view of the gravity of the matters found proved and Mr Flatischler's ongoing lack of engagement with the GDC. Having determined that Mr Flatischler's conduct is incompatible with continued registration, the Committee considered that immediate action is necessary in this case to maintain public confidence in the dental profession and the regulatory process, and to uphold proper professional standards of conduct and behaviour.

92. The effect of the foregoing substantive determination and this order is that Mr Flatischler's registration will be suspended to cover the appeal period. Unless he exercises his right of appeal, the substantive direction for erasure will take effect 28 days from the date of deemed service.

93. Should Mr Flatischler exercise his right of appeal, this immediate order will remain in place until the resolution of the appeal.

94. That concludes this determination.