PUBLIC HEARING

Professional Conduct Committee
Initial Hearing

3 – 5 August 2026

Name:	TOPALA, Dan Doru
Registration number:	264195
Case number:	CAS-209175-V9H0X5

General Dental Council:	Mr Ashley Hendron, counsel. Instructed by Andrew Richardson, IHLPS
Registrant:	Present Represented by Mr John Greany, counsel. Instructed by Julia Furley, JFH Law

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Fitness to practise:	Impaired by reason of misconduct
Outcome:	Fitness to Practise Impaired. Reprimand Issued

Committee members:	Adrian Smith (Lay member, Chair) Rose Thomas (Dentist member) Lynn Chalinder (Dental Care Professional member)
Legal adviser:	Nicola Gordelier
Committee Secretary:	Sarah Crewe

The Charge

That being registered as a dentist Dan Topala's (264195) fitness to practise is impaired by reason of misconduct. In that:

1. *You failed to provide an adequate standard of implant treatment to Patient A, from 07 December 2020 to 11 February 2021, in that you did not;*

   a) *discuss the risk of paraesthesia.*
   b) *take radiographs prior to the placement of the second implant at LL7.*
   c) *Take radiographs to assess the placement of the second implant at LL7.*

2. *By reason of your conduct at 1a. you failed to obtain informed consent for the implant treatment provided to Patient A from 07 December 2020 to 11 February 2021.*

3. *On 11 February 2021, you placed the second implant at LL7 without adequate support.*

4. *You failed to advise Patient A on or shortly after 12 February 2021 of the need for you to clinically assess the numbness.*

5. *5. You failed to urgently refer Patient A to a maxillofacial surgeon in light of the persistent numbness.*

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

Mr Topala,

1. This is a Professional Conduct Committee (PCC) hearing in respect of a case brought against you by the General Dental Council (GDC).

2. The hearing is being conducted remotely via TEAMs.

3. You are represented at these proceedings by Mr John Greany, Counsel. The Case Presenter for the GDC is Mr Ashley Hendron, Counsel.

Case background

4. This case concerns your treatment of Patient A on 11th February 2021. On that date, you performed a complex implant procedure at position 37/LL7. The procedure involved both the removal of a failed, loose implant and the surgical placement of a new implant. Significantly, you carried out this two-hour procedure entirely alone, without any support or assistance.
5. Following the procedure, Patient A experienced persistent numbness and pain affecting his jaw, lip, chin, gums, and teeth. Between 12th February and 2nd March 2021, Patient A corresponded with you regarding these symptoms. On 12th February, Patient A reported that his jaw was still frozen. You offered a clinic appointment, but Patient A did not respond at that time. On 21st February, you visited Patient A and provided B vitamins along with an examination. On 23 February Patient A emailed you to request that his dental records be sent to another dental

practice. On 2nd March, Patient A reported that his gums and chin were painful but anaesthetised. You suggested that implant removal might be necessary, but again Patient A did not respond.

6. On 12th March 2021, Patient A attended a different medical practice regarding his persisting numb lip. A CBCT scan was performed which revealed the full extent of the damage: the new implant placed by you at position 37 had been inserted entirely through the inferior dental nerve (IDN), resulting in complete severance of the nerve. The IDN is responsible for supplying sensation to the lower lip, gums, and teeth. As a consequence of this nerve damage, Patient A has suffered permanent numbness in these areas.
7. The expert evidence for the GDC distinguishes between the emergency removal of the failed implant and the non-emergency surgical placement of the new implant. The expert concludes that once Patient A reported persistent numbness following the procedure, you should have: (1) advised prompt examination of the patient; (2) referred Patient A to a maxillofacial surgeon as a matter of urgency for a specialist opinion on the nerve injury; and (3) sought an opinion on whether any remedial treatment was possible.
8. Patient A filed a formal complaint with the GDC on 28th August 2023. At the time of his witness statements in May and July 2025, Patient A was in his 80's and continued to suffer the effects of the nerve damage sustained on 11th February 2021.
9. You face five allegations arising from this treatment. Allegations 1-3 relate to the clinical care provided during the implant procedure on 11th February 2021 and matters of informed consent. You have made admissions in respect of these charges. Allegations 4-5 concern the aftercare provided between 12th February 2021 and 23rd February 2021, when Patient A moved to another practice. The case on these charges is not that you failed entirely to provide aftercare, but rather that what you did provide was insufficient given the severity of the reported numbness and the complete severance of the inferior dental nerve.

Evidence

10. The documentary evidence before the Committee included, but was not limited to, the following:
    - Statements from GDC witnesses and associated exhibits
    - Your witness statement
    - Patient A's dental records
    - Expert reports

Admissions

11. You made admissions to all of the heads of charge. 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 all proved on the basis of your admissions in accordance with Rule 17 (4) of the Rules.

Decision and reasons on fitness to practise (05 August 2026)

12. Having announced its decision on the facts, the Committee next moved forward to consider three matters: whether the facts found proved amount to misconduct; if so, whether your fitness to practise is currently impaired by reason of that misconduct; and, should impairment be found, what sanction, if any, to impose.
13. In accordance with Rule 20 of the Fitness to Practise Rules 2006, the Committee heard submissions from Mr Hendron on behalf of the GDC and from Mr Greany on your behalf in relation to the matters of misconduct, impairment and sanction.

Evidence

14. You gave oral evidence to the panel. You outlined your background and career history, including that you were permanently working full time in the UK from 2019. You told the panel that you had no adverse fitness to practise history in the UK or elsewhere. Further there have been no further issues raised about your practice since this incident.
15. You told the panel that you rushed the treatment of Patient A because he was keen to have it done as soon as possible.
16. Mr Greany took you through the documentation provided for stage 2 of these proceedings. You confirmed that the reflection was finalised yesterday. In respect of the audits contained within the documentation you accepted that there were minor things that had been raised, but nothing that was significant. You provided examples of your consent forms and confirmed that these are the ones that you currently use.
17. You accepted that you were wrong in your treatment of Patient A. You explained that you were very sorry, but that you had not had an opportunity to apologise directly to Patient A. You explained that you are still stressed about the whole thing, you accept what you did wrong and you hope that you will not make the same mistake again.
18. In response to panel questions you told the panel that you have not had any information about how Patient A is now or how the results of this has impacted on him. You explained that you understand there have been some consequences for him, but you do not know the specifics as you have not seen him to examine him since this incident.
19. In respect of the impact on the profession you explained that you have changed your consent forms and your processes around this and how this has impacted on your work and professionalism. You now ask patients to go home and read the consent forms to consider them before proceeding with treatment. You explained that you are now more careful about being compliant and you do not rush anything.
20. You explained that if the wider profession knew about this incident then they may learn from it and change their approach to implants. However, you stated that you do not know how much the profession knows about this incident.
21. You accepted that the public may lose confidence in the profession because of your actions.

Submissions

22. Mr Hendron addressed the Committee on misconduct, impairment, and sanction, referring to specific paragraphs in the guidance.
23. On misconduct, Mr Hendron reminded the Committee that it is a matter for the Committee's judgment. He invited the Committee to find that your actions breached the Standards and amounted to serious professional misconduct, referring to the Guidance for Practice Committees (2026).
24. Mr Hendron submitted that the facts found proved are serious and caused actual harm to Patient A.
25. On impairment, Mr Hendron submitted the question must be considered in current terms, not historically. He highlighted factors including insight, remorse, remediation and risk of repetition.
26. Mr Hendron submitted that a finding of current impairment is required to uphold professional standards and maintain public confidence. He also submitted that the panel must consider public protection.
27. On sanction, Mr Hendron submitted the appropriate and proportionate sanction would be a reprimand. However, if the panel considered that conditions would be appropriate then it should

consider conditions at the lower end of the scale, allowing you time to demonstrate full understanding and meaningful change while sending a clear message to the public and profession.

28. Mr Greany referred the panel to the guidance and submitted that it must first consider whether mere negligence amounts to misconduct. He submitted that this was a single patient and although it was accepted that your failures are serious and there was harm, he highlighted that there was no deliberate wrongdoing.

29. Mr Greany submitted there whilst there were failures more than 5 years ago there is no suggestion you are a current risk to the public or that there is a risk of repetition. He asked the Committee to consider that English is not your first language when evaluating your evidence.

30. Mr Greany referred the panel to the documentation you provided and submitted that this is suggestive of full remediation. You have provided a number of testimonials from patients and demonstrated that you have learned from this process and changed your practice, putting measures in place to ensure that you will not make the same mistake again.

31. Mr Greany submitted that you have demonstrated insight and an understanding of the impact of your actions on the profession. He submitted that the public interest would be met by a finding of misconduct to mark the seriousness of the findings.

32. Mr Greany submitted that if the Committee reached the stage of sanction, the proportionate outcome is a reprimand. He highlighted factors outlined in the guidance to support his position that a reprimand would be appropriate.

33. The Committee heard and accepted the advice of the Legal Adviser.

Misconduct

34. The Committee, in reaching its decision, had regard to the public interest and accepted that there was no burden or standard of proof at this stage. The Committee exercised its own independent judgement in reaching its decision.

35. The Committee acknowledged that misconduct was defined in *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*."

36. The Committee considered the following principles from the Standards:

Standard 2.2.1
You must listen to patients and communicate effectively with them at a level they can understand. Before treatment starts you must:
explain the options (including those of delaying treatment or doing nothing) with the risks and benefits of each; and
give full information on the treatment you propose and the possible costs.
Standard 2.3
You must give patients the information they need, in a way they can understand, so that they can make informed decisions
Standard 3.1
You must obtain valid consent before starting treatment, explaining all the relevant options…
Standard 3.3
You must make sure that the patient's consent remains valid at each stage of investigation or treatment
Standard 6.2
You must be appropriately supported when treating patients

Standard 6.3
You must delegate and refer appropriately and effectively
Standard 7.1
You must provide good quality care based on current evidence and authoritative guidance
Standard 7.1.1
You must find out about current evidence and best practice which affect your work, premises, equipment and business and follow them.
Standard 7.1.2
If you deviate from established practice and guidance, you should record the reasons why and be able to justify your decision.

37. The Committee took into account that a breach of the relevant Standards does not automatically result in a finding of misconduct. However, it considered that failing to provide patient A with the information needed to make an informed decision is a serious matter. Further, working without appropriate support and failing to advise Patient A on or shortly after 12 February 2021 of the need for you to clinically assess the numbness, or refer him urgently, following his concern about numbness is significant and has resulted in permanent harm.

38. The Committee also had regard to the guidance and to the submissions that a single incident may not meet the requirements of misconduct. However, the panel considered that, while the harm caused was a mistake, the failure to communicate properly with Patient A, working without support and failing to provide appropriate follow up support, including a failure to refer Patient A, means that this incident is sufficiently serious to go beyond mere negligence and does amount to misconduct. Further, not taking a radiograph for a known risk in this treatment is a significant failure.

39. Therefore, the Committee determined that your conduct was a sufficiently serious departure from the Standards to amount to misconduct.

Impairment

40. The Committee accepted the advice of the Legal Adviser that it must assess current impairment of fitness to practise. It is not sufficient to find that your fitness to practise was impaired at the time the matters took place; rather, it must be found that your fitness to practise is impaired as of today.

41. The Committee therefore considered whether your conduct was likely to be repeated in the future; whether your misconduct is remediable; whether it had been remedied; and whether there is a risk of repetition.

42. The Committee considered that the misconduct in this case is capable of remediation. It considered the actions you have taken since the concerns came to light. It had regard to Mr Greany's submissions and the documentation you provided. It considered that you have demonstrated insight. It considered your genuine apology and remorse, albeit your understanding of the long lasting consequences into the significant impact on Patient A appeared to the panel to be limited. However, the panel did recognise that this could be a language issue rather than a genuine lack of insight and so did not consider that this was significant enough to mean that there is a risk to the public going forward.

43. The Committee noted you have acknowledged your failings following the findings of fact and offered an apology and expression of remorse. You have provided documentation for the panel that demonstrates the changes that you have made to your approach to consent, and informed the panel that you have engaged a mentor to assist you with your ongoing learning. There have also been audits into your practice, and while you recognise that these have highlighted minor issues, these are not significant enough to concern the panel. You have also provided copies of your CPD and patient testimonials and reviews.

44. The Committee concluded that the risk of repetition is sufficiently low so as to mean that a finding of impairment is not necessary on the ground of public protection.

45. In its consideration of the wider public interest, the Committee had regard to the test established in *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council and Grant* [2011] EWHC 927 (Admin) (the "Grant test"). This test requires the Committee to consider whether an informed member of the public, with knowledge of the regulatory objectives and the full circumstances of the case, would regard a finding of impairment as necessary to uphold those regulatory objectives.

46. The GDC's overarching regulatory objectives are threefold: to protect the public; to maintain and promote proper professional standards and conduct; and to maintain public confidence in the dental professions and the upholding of proper standards and conduct.

47. In applying the Grant test, the Committee considered what an informed member of the public would think, knowing that you failed to provide Patient A with relevant information prior to treatment; you failed to obtain informed consent; you provided treatment without appropriate support; and that your conduct caused actual permanent harm to Patient A.

48. Such a person would be troubled if no current impairment were found given the serious harm that was caused to Patient A under these circumstances; and that the profession might be brought into disrepute if such conduct were not met with a finding of impairment.

49. The Committee was satisfied that an informed member of the public would regard a finding of impairment as necessary to uphold the regulatory objectives. They would expect dental professionals to maintain the highest standards of professional conduct.

50. The Committee was mindful that this was an isolated incident, however the consequences of your failings were significant.

51. The Committee considered that the gravity of the misconduct is sufficiently serious to be capable of eroding public trust in dental professionals and the GDC as a regulator. An informed member of the public would expect registrants to uphold fundamental professional standards. Where those standards are breached in the manner found proved, a finding of impairment is necessary to maintain public confidence.

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 GDC's Guidance for the Practice Committees, including Indicative Sanctions Guidance (January 2026). The Committee reminded itself that any sanction imposed must be proportionate. The purpose of a sanction is not to punish for past misconduct. Although a sanction is not intended to be punitive, it may have that effect.

54. The Committee identified the following mitigating factors:

- Previous good character.
- That the incident in question was isolated and/or out of character.
- That there is evidence of good conduct following the incident in question
- Evidence of remorse, insight and/or apology.
- Remedial action taken.

55. The Committee also identified the following aggravating factor:

- Actual harm or risk of harm to a patient

56. The Committee considered each available sanction in ascending order of severity, applying the principle of proportionality throughout.

57. The Committee concluded immediately that taking no action would be wholly inappropriate given its findings of serious professional misconduct and current impairment. Taking no action would undermine confidence in the regulatory process.

58. The Committee next considered whether to issue a reprimand. It had careful regard to Mr Greany's submissions that the misconduct was not so serious as to warrant a higher sanction and that a reprimand would be suitable. It also considered the submissions made by Mr Hendron that the appropriate sanction is that of a reprimand.

59. 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.

60. The Committee found the following factors from the guidance to be applicable:

- The issues identified are at the lower end of the scale of seriousness.
- There is no evidence to suggest the dental professional poses any risk to the public.
- The dental professional has shown insight into their failings.
- The behaviour was an isolated incident.
- The behaviour was not deliberate.
- The dental professional has genuinely expressed remorse.
- There is evidence the dental professional has taken rehabilitative/corrective steps.
- The dental professional has no adverse fitness to practise history with the GDC.

61. 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, the remedial action taken, and the insight and remorse you have shown, which all mitigate the risk of recurrence.

62. 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.

63. 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.

64. 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.

65. The reprimand will form part of your fitness to practise history and may be disclosed to prospective employers or registration authorities in other jurisdictions.

66. You will receive written confirmation of this decision.

67. That concludes your case.