GENERAL DENTAL COUNCIL

AND

KONTOGIANNIS, Vassilis

[Registration number: 69201]

NOTICE OF INQUIRY

SUBSTANTIVE HEARING

Notice that an inquiry will be conducted by a Practice Committee of the General Dental Council, commencing at **10:00am** on **3 November 2025.**

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

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

Committee members:

Andy Waite	Lay	Chair
Nicola Jordan	Dentist	
Jenna Crookes	DCP	

Legal Adviser:

Alastair McFarlane

CHARGE

Vassilis KONTOGIANNIS, a dentist, DipDS Athens 1991 is summoned to appear before the Professional Conduct Committee on 3 November 2025 for an inquiry into the following charge:

"That, being registered as a dentist:

Referral 1

1. You failed to maintain an adequate standard of care between December 2016 and November 2018 in that you failed to:
   - *(a)* obtain a medical history from patient B and/or their parent on 21 December 2016;
   - *(b)* provide full treatment options:
     - *(i)* to patient B and/or their parent, before commencing orthodontic treatment;
     - *(ii)* to patient C and/or their parent, before commencing orthodontic treatment.
2. You failed to obtain informed consent between December 2016 and January 2019 from:
   - *(a)* patient B and/or their parent, before commencing orthodontic treatment;
   - *(b)* patient B, before administering local anaesthetic;
   - *(c)* patient C and/or their parent, before commencing orthodontic treatment.
3. Between December 2016 and November 2018 you failed to treat patients with kindness and compassion, in that you:
   - *(a)* spoke rudely and/or abruptly to patient C, a child, on one or more occasions;
   - *(b)* spoke rudely and/or abruptly to patient B, a child, on one or more occasions;
   - *(c)* told patient B, a child, when she was crying, to "stop making a fuss", or words to that effect, on 18 July 2017;
   - *(d)* treated patient B, a child, roughly, by physically pushing her back into the chair when she tried to sit up on 18 July 2017.
4. Between January 2020 and 22 January 2021, you failed to ensure that appropriate cover was in place to cover emergency care whilst you were away from the practice.
5. Between June 2020 and 22 January 2021, you failed to maintain adequate standards of cross infection control, in that you:
   - *(a)* failed to provide safety glasses for patient use on or around 22 January 2021;
   - *(b)* failed to wear a plastic apron between June 2020 and 22 January 2021;

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

(i) 16 September 2020;

(ii) 17 September 2020;

(iii) 18 January 2021;

(iv) 19 January 2021.

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

7. Between 8 December 2020 and 12 January 2021, you instructed an unqualified and unregistered person, a locum receptionist, to triage orthodontic patients for one week whilst your nurse was isolating.

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

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

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

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

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

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

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

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

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

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

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

10. Between 27 June 2022 and 29 July 2022, you failed to co-operate with an investigation conducted by the GDC, in that you failed to provide the GDC with:

(a) evidence of your indemnity cover;

(b) patient records.

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

Referral 2

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

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

(i) 27 September 2018;

(ii) 14 December 2018;

(iii) 22 February 2019;

(iv) 14 June 2019;

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

(i) 15 July 2019;

(ii) 22 November 2019.

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

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

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

(a) evidence of your indemnity cover;

(b) patient records.

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

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

(a) misleading;

(b) dishonest.

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