GENERAL DENTAL COUNCIL

AND

HAUGHEY, John Patrick

[Registration number: 104042]

NOTICE OF INQUIRY

SUBSTANTIVE HEARING

Notice that an inquiry will be conducted by a Practice Committee of the General Dental Council, to be held at:

The General Dental Council
37 Wimpole Street
London
W1G 8DQ

Please note that some days of this hearing will take place in person at the Wimpole Street address listed above and some days will take place by remote video conference.

Monday 6 October 2025 will be held at Wimpole Street address listed above. Tuesday 7-Wednesday 15 October 2025 will be held remotely.

Commencing at **10am** on **6 October 2025.**

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:

Martin Isherwood	DCP	Chair
Gill Jones	Dentist	
Jayne Hidderley	Lay	

Legal Adviser:

Charles Apthorp	Legal Adviser

CHARGE

John Patrick HAUGHEY, a dentist, BDS Queen's University of Belfast 2006 is summoned to appear before the Professional Conduct Committee on 6 October 2025 for an inquiry into the following charge:

"Whilst being registered as a dentist you:

Standard of clinical care- diagnostic assessment and pre-treatment investigations

1. Between 30 August 2019 and 25 May 2022 you did not provide an adequate standard of care in that you did not carry out sufficient diagnostic assessments on:
    a. Patient 1
    b. Patient 2
    c. Patient 3
    d. Patient 4
    e. Patient 5
2. Between 30 August 2019 and 25 May 2022 you did not provide an adequate standard of care in that you did not carry out sufficient pre-treatment investigations on:
    a. Patient 1
    b. Patient 2
    c. Patient 3
    d. Patient 4
    e. Patient 5

Standard of clinical care- radiographic practise

3. Between 30 August 2019 and 25 May 2022 you did not provide an adequate standard of care in that your radiographic practise was not adequate in relation to:
    a. Patient 1
    b. Patient 2
    c. Patient 3
    d. Patient 4
    e. Patient 5

Standard of clinical care- treatment plan

4. Between 30 August 2019 and 25 May 2022 you did not provide an adequate standard of care in that you did not undertake sufficient treatment planning on:
    a. Patient 1
    b. Patient 2

c. Patient 3

d. Patient 4

e. Patient 5

Standard of clinical care- treatment options

5. Between 30 August 2019 and 25 May 2022 you did not provide an adequate standard of care in that you did not discuss all treatment options with:

    a. Patient 1

    b. Patient 2

    c. Patient 3

    d. Patient 4

    e. Patient 5

Standard of clinical care- discussion of risks and benefits

6. Between 30 August 2019 and 25 May 2022 you did not provide an adequate standard of care in that you did not discuss the full risks and benefits of the proposed treatment with:

    a. Patient 1

    b. Patient 2

    c. Patient 3

    d. Patient 4

    e. Patient 5

Informed consent

7. You failed to obtain informed consent for the treatment provided to:

    a. Patient 1 from 30 August 2019 to 03 February 2021

    b. Patient 2 from 03 February 2020 to 26 February 2021

    c. Patient 3 from 08 July 2020 to 27 July 2021

    d. Patient 4 from 07 September 2020 to 16 March 2022

    e. Patient 5 from 03 January 2020 to 25 May 2022.

Standard of clinical care- communicating treatment plan

8. Between 30 August 2019 and 25 May 2022 you did not provide an adequate standard of care in that you did not adequately communicate a treatment plan to:

    a. Patient 1

    b. Patient 2

    c. Patient 3

    d. Patient 4

    e. Patient 5

Poor standard of treatment

9. Between 30 August 2019 and 25 May 2022 you did not provide an adequate standard of care in that you provided a poor standard of aligner treatment or, caused and/or allowed a poor standard of aligner treatment to:
    a. Patient 1
    b. Patient 2
    c. Patient 3
    d. Patient 4
    e. Patient 5

Face-to-face contact

10. You approved treatment to patients without face-to-face patient contact and without ensuring they saw a dentist first, specifically:
    a. Patient 1
    b. Patient 2
    c. Patient 3
    d. Patient 4
    e. Patient 5

Record keeping

11. You failed to maintain an adequate standard of record keeping in respect of:
    a. Patient 1's appointments between 30 August 2019 to 03 February 2021
    b. Patient 2's appointments between 3 February 2020 to 26 February 2021
    c. Patient 3's appointments between 8 July 2020 to 27 July 2021
    d. Patient 4's appointments from 07 September 2020 to 16 March 2022
    e. Patient 5's appointments from 03 January 2020 to 25 May 2022.

Complaint handling

12. You failed to respond adequately to:
    a. Patient 1's complaint on 16 July 2020 about their dental treatment
    b. Patient 2's complaint on 11 September 2020 about their dental treatment
    c. Patient 3's complaint on 30 November 2020 about their dental treatment
    d. Patient 4's complaint on 27 November 2021 about their dental treatment.
13. You failed to provide an adequate standard of care to Patient 6 from 12 April 2022 to 01 March 2023 by:
    a. Failing to consider adequately or at all the GDC's guidance on direct-to-consumer/remote orthodontics.
    b. Not carrying out a full assessment of the patient's presenting dental condition in that:
        i. You did not take an adequate dental history;

ii. You did not adequately assess the occlusion of Patient 6's teeth specifically the overbite and overjet, specifically you did not correct the earlier assessment of the teeth as being Class II division 1 malocclusion;

iii. A comprehensive extra-oral assessment;

iv. A comprehensive intra-oral assessment, including noting the rotated teeth and the inclinations of the teeth.

c. Not carrying out sufficient pre-treatment investigations in that:

i. You did not conduct an adequate functional assessment of the patient's occlusion;

ii. You did not assess soft tissue harmony both at rest and in function;

iii. Consideration of the extent and impact of Patient 6's TMJD.

d. Not carrying out sufficient treatment planning in that:

i. You did not consider and advise Patient 6 of alternative orthodontic systems;

ii. You did not consider, advise or discuss with Patient 6 whether or not it was possible to obtain Patient 6's preferred outcome with Comany 1 system.

e. Providing a poor standard of orthodontic treatment, in that:

i. You failed to recognise that the digital images provided to you by Company 1 were not Patient 6's.

f. By not discussing the full risks and benefits of the proposed treatment specifically:

i. Its impact upon Patient 6's TMJD;

ii. An increased overbite;

iii. The risks associated with the proclination of the teeth;

iv. The inability of Company 1 aligner treatment to fully correct rotated teeth.

g. You failed to obtain informed consent for the treatment provided to Patient 6 from 12 April 2022 to 1 March 2023 in that you did not advise Patient 6 of:

i. alternative treatment options;

ii. patient-specific risks; and

iii. the limitations of treatment.

h. You failed to maintain an adequate standard of recording keeping in respect of Patient 6's appointments from 12 April 2022 to 01 March 2023.

i. You failed to respond adequately to Patient 6's complaints between 23 December 2022 and 16 August 2023.

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