HEARING PART-HELD IN PRIVATE

Professional Conduct Committee
Initial Hearing

5 to 14 January 2026

Name:	FRANKL, Michael John
Registration number:	68691
Case number:	CAS-209252-R2X3V7

General Dental Council:	Christopher Saad, Counsel Instructed by Carla Marie Clough, IHLPS
Registrant:	Present Represented by Tom Day, Counsel Instructed by Laura Smith, Clyde and Co

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Fitness to practise:	Impaired by reason of misconduct
Outcome:	Suspended with immediate suspension (with a review)
Duration:	9 Months
Immediate order:	Immediate suspension order

Committee members:	Kerry McKevitt	(Chair, Lay Member)
	Clare Mcilwaine	(Dental Care Professional Member)
	Gillian Jones	(Dentist Member)
Legal Adviser:	Claire Robinson	
Committee Secretary:	Lola Bird	

FRANKL, Michael John, a dentist, BDS Lond 1993, is summoned to appear before the Professional Conduct Committee on 5 January 2026 for an inquiry into the following charge:

The charge (as amended)

"That being registered as a dentist:

On or around 31 July 2020

1. *You failed to provide an adequate standard of care to Patient A on or around 31 July 2020 in that you:*

i) *Did not discuss the treatment options to Patient A regarding UR7; and/or*

ii) *Did not discuss the risks and benefits of root canal treatment regarding UR7; and/or*

iii) *Did not undertake an adequate Basic Periodontal Examination of Patient A; and/or*

iv) *Did not take bitewing radiographs to screen for interproximal caries in all of the posterior teeth.*

2. *By virtue of your conduct at 1 (i) and/or 1 (ii), you did not obtain Patient A's informed consent to the root canal treatment at UR7.*

On or around 4 August 2020

3. *You failed to provide an adequate standard of care to Patient A on or around 4 August 2020 in that you:*

i) *Did not discuss the treatment options to Patient A regarding UR7; and/or*

ii) *Did not discuss the risks and benefits of root canal treatment regarding UR7; and/or*

iii) *Did not use a rubber dam while carrying out the root canal treatment at UR7; and/or*

iv) *WITHDRAWN.*

v) *Did not inform the Patient of the file fracture left in situ at UR7; and/or*

vi) *WITHDRAWN.*

vii) *Did not inform Patient A that only two canals in UR7 had been treated; and/or*

viii) *Replaced the crowns at UR3 and UL3 without clinical justification; and/or*

ix) *Did not adequately explain the limitations to any possible restoration at UR2 to UL2; and/or*

x) *Did not refer Patient A to a specialist in respect of the file fracture left in situ; and/or*

xi) *Did not refer Patient A to a specialist in respect of only treating two canals in UR7.*

4. *Your conduct in respect of 3 (v) and/or 3(vii) was:*

i) *Misleading; and/or*

ii) *Lacking in candour; and/or*

iii) Dishonest

5. *By virtue of your conduct at 3 (i) and/or 3 (ii), you did not obtain Patient A's informed consent to the root canal treatment at UR7.*

6. *By virtue of your conduct at 3 (ix), you did not obtain Patient A's informed consent to the bridge placed at UR2 to UL2.*

Record Keeping

7. *You failed to make adequate records in respect of Patient A in that you:*

i) Did not make any clinical records in respect of an appointment that occurred on 14 November 2019;

ii) Did not make any clinical records in respect of an appointment that occurred on 30 September 2020;

iii) Did not make any clinical records in respect of an appointment that occurred on 9 October 2020;

iv) Did not make any clinical records in respect of an appointment that occurred on 19 October 2020;

v) Did not make any clinical records in respect of an appointment that occurred on 13 November 2020;

vi) Did not make any clinical records in respect of an appointment that occurred on 17 November 2020;

vii) Did not make any clinical records in respect of an appointment that occurred on 9 December 2020;

viii) Did not make any clinical records in respect of an appointment that occurred on 26 January 2021;

Non-Cooperation

8. *"Between 1 June 2022 and 4 December 2024 you failed to cooperate with the GDC by not providing evidence of appropriate indemnity insurance;*

9. *From 1 June 2022 to date, you failed to cooperate with the GDC by not providing:*

i) Completed working arrangement form and / or

ii) WITHDRAWN.

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

Mr Frankl,

1. This is a Professional Conduct Committee hearing in respect of a case brought against you by the General Dental Council (GDC). The charge relates to your treatment of one patient, Patient A, and your alleged non-cooperation with the GDC's investigation into concerns raised by the patient about the treatment you provided.

2. The hearing commenced on 5 January 2026, with the evidence at the fact-finding stage (5 to 8 January) heard in person at the Dental Professionals Hearings Service. The remainder of the hearing is continuing remotely, with all participants attending via Microsoft Teams video-link.

3. You are represented at these proceedings by Mr Tom Day, Counsel. The Case Presenter for the GDC is Mr Christopher Saad, Counsel.

Preliminary Stage: admissions to the charge

4. At the outset of the hearing, Mr Day told the Committee that you admitted head of charge 7 in its entirety. These are the factual matters relating to your failings in record keeping. You admitted that you failed to make adequate records in respect of Patient A, in that you did not make clinical records in relation to eight of the patient's appointments between and including 14 November 2019 and 26 January 2021.

5. You denied all the other factual allegations within the charge.

6. Having heard your admissions, the Committee received advice from the Legal Adviser, who drew its attention to Rules 17(4) and 17(5) of the *GDC (Fitness to Practice) Rules 2006* ('the Rules'), in so far as those provisions relate to admissions made at the preliminary stage of a hearing. Rule 17(4) provides that in the first instance the Committee shall deal with any admissions and make determinations in respect of them before the commencement of the factual inquiry. Rule 17(5) states that the Chair of the Committee shall inform parties of the determinations made.

7. The Committee accepted the advice of the Legal Adviser. It confirmed that it was satisfied with your admissions, the effect being that head of charge 7, in its entirety, was determined to have been 'admitted and found proved'.

Summary of the GDC's opening submissions

8. Mr Saad submitted that this case relates to treatment that you provided to Patient A from July 2020 to Spring 2021, as well as your alleged failure to cooperate with an investigation conducted by the GDC into concerns raised by Patient A regarding that treatment.

9. The treatment you provided to Patient A was a cement retained implant bridge and root canal treatment. However, Mr Saad told the Committee that the clinical concerns within the charge relate primarily to the root canal treatment. He submitted that the factual allegations you face are wide-ranging, including alleged failings in the standard of care you provided to Patient A. Mr Saad highlighted that there is also an allegation of dishonesty relating to two aspects of the root canal treatment.

10. In relation to the non-cooperation allegations, Mr Saad submitted that when the GDC sought to investigate the concerns raised by Patient A, obtaining information from you was not easy.

11. By way of background to the alleged facts, Mr Saad told the Committee that following an internet search for dental services, Patient A attended to see you for an initial consultation at the dental practice where you worked ('the Practice'). Patient A's evidence, as set out in her witness statement prepared for this hearing, was that she noted that the pricing at the Practice was *"a bit expensive"* so she looked for alternatives. In this regard, Mr Saad outlined that soon after her initial consultation with you, Patient A attended another dental practice where she had two implants placed. However, that other dental practice stopped trading during the Covid-19 pandemic and so Patient A returned to see you.

12. Mr Saad referred to Patient A's evidence in her witness statement that she had initially found you to be respectful and did not have any problems. She went on to state, however, that during her last appointment, you were rude and hurried her out of the Practice. Mr Saad stated that although Patient A could not recall every detail of her appointments with you, her account of the events indicates that the professional relationship between you completely broke down. Patient A stated in her witness statement that she wrote to you on two occasions to express her unhappiness with her treatment, including to request a refund, which she said you refused. Mr Saad highlighted Patient A's evidence that she subsequently contacted the Citizens Advice Bureau regarding her dissatisfaction with you and was advised to send you a further letter requesting a refund. Patient A stated that when she did not receive any response to that further letter, she made a complaint to the GDC. Patient A's complaint was received by the GDC in July 2021.

13. Mr Saad told the Committee that the GDC was able to obtain Patient A's clinical records from the Practice. He stated that those clinical records, together with other documents gathered during the GDC's investigation, were reviewed by Mr Edward Bateman, the GDC's expert witness in this case. Mr Saad stated that Mr Bateman's expert opinion formed the basis of the clinical allegations set out in the charge.

14. Mr Saad drew the Committee's attention to the allegation of dishonesty, specifically in relation to your alleged failures to inform Patient A of a file fracture left in situ at UR7 and that only two of the three canals in that tooth had been treated. Mr Saad submitted that it was the GDC's case that not to inform Patient A about those matters was misleading, lacking in candour and dishonest.

15. With regard to your alleged non-cooperation with the GDC's investigation into Patient A's concerns, Mr Saad took the Committee through the chronology of correspondence sent to you by the GDC, which he said underpinned the relevant allegations. In doing so, Mr Saad reminded the Committee of your duty under the GDC's *'Standards for the Dental Team (September 2013)'* ('the GDC Standards') to comply and cooperate with any formal or informal inquiry conducted by the Council.

The GDC's evidence

16. The evidence adduced by the GDC was both documentary and oral. The documentary evidence provided to the Committee was as follows:

- The witness statement of Patient A dated 16 October 2025, along with associated exhibits.

- A witness statement dated 15 October 2025, from the Interpreter who assisted Patient A in the making of her witness statement.

- The witness statement of Witness 1, a GDC Caseworker, dated 4 July 2025. Witness 1 exhibited with her witness statement the documentary evidence upon which the GDC relies in making the non-cooperation allegations.

- The clinical records of Patient A obtained from the Practice, as well as the patient's clinical records from two other subsequent dental practices.

- The expert report with appendices prepared by the GDC's expert witness, Mr Bateman, dated 7 July 2025, and an expert addendum bundle provided to the Committee during the hearing which contained a number of guidance documents referred to in evidence.

17. In addition, the Committee heard oral evidence from Patient A, who was assisted by an Interpreter. The Committee also heard oral evidence from Witness 1 and from Mr Bateman. All three witnesses appeared remotely via Microsoft Teams video-link.

Decision on application to amend the charge – 7 January 2026

18. Following the GDC's evidence and prior to the closing of the Council's case, Mr Saad made an application to amend the charge pursuant to Rule 18 of the Rules. He applied to withdraw the following factual allegations:

- **Head of charge 3(iv):**

  'You failed to provide an adequate standard of care to Patient A on or around 4 August 2020 in that you:

  Left a file fracture in situ after completing the root canal treatment at UR7; and/or'

- **Head of charge 3(vi):**

  'You failed to provide an adequate standard of care to Patient A on or around 4 August 2020 in that you:

  Did not treat more than two canals in UR7; and/or'

- **Head of charge 9(ii):**

'From 1 June 2022 to date, you failed to cooperate with the GDC by not providing:

Relevant patient records'.

19. In respect of head of charge 3(iv), Mr Saad submitted that there was indeed a file fracture left in situ at Patient A's UR7, and this is not disputed. He submitted that the criticism is in relation to whether you informed Patient A that the file fracture was left in situ, which is an issue covered separately at head of charge 3(v) and that head of charge will remain part of the GDC's case.

20. Mr Saad made the same submission in relation to head of charge 3(vi), in that it is not contested that you did not treat more than two canals in UR7. The criticism, Mr Saad submitted, is about whether you informed Patient A that you did not treat more than two canals, which is a matter covered separately at head of charge 3(vii) and that head of charge will remain part of the GDC's case.

21. With regard to head of charge 9(ii), which relates to the relevant patient records in this case, Mr Saad submitted that the GDC was able to obtain your records for Patient A after contacting the Practice and receiving them from the appointed 'data controller'. Mr Saad also highlighted the email produced on your behalf dated 29 September 2022, sent by the GDC to the Practice acknowledging receipt of the requested information and stating that *"If any further information is needed, we will contact you".* Mr Saad further highlighted the evidence of Witness1 that requests made by the GDC for patient records are typically addressed to the dental practice concerned as well as to the registrant in question. It was Mr Saad's submission that, in the circumstances, the GDC had taken the view that it would be unfair to continue to allege that you failed to cooperate with the GDC by not providing the relevant patient records.

22. Mr Day told the Committee that he agreed entirely with the GDC's application to amend the charge.

23. Having heard from both parties, the Committee accepted the advice of the Legal Adviser. The Legal Adviser advised that an application to withdraw allegations is treated as amending the charge under Rule 18, and that under this Rule the Committee had a discretion to amend the charge at any stage before making its findings of fact.

24. In acceding to the GDC's application in its entirety, the Committee had regard to the merits of the case and the fairness of the proceedings and was satisfied that the proposed withdrawals could be made without causing injustice.

25. The Committee noted the reasons given by the GDC for the withdrawal of heads of charge 3(iv) and 3(vi) and it was satisfied that those factual allegations did not add anything further to the GDC's case. The Committee agreed that the key areas for consideration would be what you discussed with Patient A about the leaving of the fractured file and not having treated more than two canals in UR7.

26. In relation to head of charge 9(ii), the Committee considered that it received clear evidence from Witness 1 that the relevant patient records did not necessarily have to be provided by you. The

Committee noted that correspondence requesting Patient A's clinical records were sent both to you and the Practice, and the Practice ultimately provided them to the GDC. In the circumstances, the Committee was satisfied that head of charge 9(ii) could be withdrawn.

27. The charge was amended accordingly.

The evidence in support of your case

28. The Committee received documentary and oral evidence presented on your behalf. In terms of documentary evidence, the Committee had before it:

- Your main witness statement dated 15 November 2025, and your addendum witness statement dated 6 January 2026, both with associated exhibits.
- A witness statement dated 5 November 2025, from Witness 2, a Dental Nurse who worked with you at the Practice.
- A witness statement dated 14 November 2025, from Witness 3, who worked at the Practice as a Receptionist and later as a Treatment Coordinator, including around the time of Patient A's treatment. As a Treatment Coordinator, Witness 2 was responsible for coordinator patient treatment plans and appointments.
- The expert report dated 24 October 2025, with appendices, prepared by Ms Sharon Caro, the expert witness called on your behalf.
- A bundle of testimonials and Continuing Professional Development (CPD) certificates.

29. The Committee heard oral evidence from you in person at this hearing. It also heard oral evidence from Witness 2, Witness 3 and Ms Caro, all of whom gave evidence remotely via video-link.

Other evidence

30. The Committee was also provided with a joint expert report signed and dated by Ms Caro on 24 November 2025 and Mr Bateman on 25 November 2025. In the joint expert report, the experts set out the aspects of this case on which they agreed and where they differed.

31. Additionally, the Committee received information in relation to your GDC referral history. This was in the form of an 'Admissions' statement agreed by both parties (you and the GDC). This statement sets out that you had been subject to three warnings issued by the GDC, namely two unpublished warnings, one in 2007 and the other in 2013, and a published warning in 2011. The Committee noted that the intention of the parties, in placing this information before it, was to ensure that it had a full and accurate picture of your referral history. It was not suggested by the GDC that your referral history demonstrated a propensity to act in the ways alleged.

The Committee's findings of fact – 12 January 2026

32. The Committee considered all the evidence presented to it. It took account of the closing submissions made orally, and then provided in writing, by Mr Saad on behalf of the GDC, as well as the oral and written submissions made by Mr Day on your behalf.

33. The Committee accepted the advice of the Legal Adviser in relation to the burden and standard of proof, the need to consider each of the outstanding allegations separately, including the wording of each of the charges, how it should approach the evidence received, the guidance and legal principles applicable to its decision-making at this stage and the need to give reasons for each decision made.

34. The Committee bore in mind that the burden of proof rests with the GDC, and that the standard of proof is the civil standard, that is, whether the allegations are proved on the balance of probabilities. The Committee has had to decide whether it is more likely than not that the alleged matters occurred.

35. The Committee noted the character evidence provided on your behalf in the form of a number testimonials. It also noted the agreed Admissions statement relating to your GDC referral history. It was the view of the Committee that these pieces of evidence had no relevance to the issues to be determined at this fact-finding stage, and therefore it placed no weight on them in reaching its decisions on the outstanding allegations.

36. The Committee findings are set out below. For completeness they include those matters that were admitted and found proved at the outset of the hearing:

On or around 31 July 2020	
1(i)	*You failed to provide an adequate standard of care to Patient A on or around 31 July 2020 in that you:* *Did not discuss the treatment options to Patient A regarding UR7; and/or* **Found proved.**
1(ii)	*You failed to provide an adequate standard of care to Patient A on or around 31 July 2020 in that you:* *Did not discuss the risks and benefits of root canal treatment regarding UR7; and/or* **Found proved.** The Committee considered heads of charge 1(i) and 1(ii) separately. It made the same finding in respect of each allegation based on the same evidence. The Committee took into account that the stem to these allegations (head of charge 1) refers to 'on or around 31 July 2020'. This is the date that Patient A first

	returned to see you at the Practice. You told the Committee in your oral evidence that this appointment with Patient A was a free consultation to discuss implant treatment. However, the cone beam computed tomography (CBCT) scan that you took of the patient at the appointment showed that two implants had already been placed in the upper anterior region. You stated that Patient A had also attended with pain in her UR7 and so there was a focus on relieving that pain. The Committee noted the itemised treatment and cost estimate dated 31 July 2020 in respect of the treatment you proposed for Patient A, which included root canal treatment at UR7. It was the agreed expert opinion that you should have discussed treatment options with Patient A regarding UR7. Mr Bateman's evidence was that valid options, besides the proposed root canal treatment, would have been to provide no treatment, although he acknowledged that patients in pain may not wish to accept this option, or to extract the tooth. Ms Caro cited referral to a specialist as a further possible treatment option. It was also the joint expert opinion that you should have discussed with Patient A the risks and benefits of root canal treatment. The Committee noted from Mr Bateman's evidence that the common risks are treatment failure, perforation of the root, instrument fracture and hypochlorite accidents. Both expert witnesses noted the absence of any records in your clinical notes for Patient A regarding discussions about treatment options and risks and benefits; they stated that it would be a matter for the Committee, having considered the evidence, whether such discussions took place. In relation to the timing of the required discussions, the Committee noted Mr Bateman's opinion that these should have taken place on 31 July 2020 and Ms Caro's opinion was that discussions about treatment options regarding UR7 and the risk and benefits of root canal treatment did not necessarily have to have occurred on 31 July 2020. It was her evidence that such discussions should have taken place prior to you starting Patient A's dental treatment. In light of Ms Caro's opinion and having noted that the alleged time period is 'on or around 31 July 2020' the Committee considered that, at the very latest, you should have discussed with Patient A treatment options regarding UR7 and the risks and benefits of root canal treatment prior to commencing the treatment. In considering whether you did have such discussions with the patient, the Committee took account of the evidence presented to it. You accepted that your record keeping at the material time was below the standard expected and, as such, there is no reference in the clinical records to a discussion with Patient A about treatment options for UR7 or the risks and benefits of root canal treatment. However, you stated in your witness statement regarding the appointment on 31 July 2020 that *"In accordance with my usual practice, I am confident that I would have discussed all treatment options with the patient".* You stated the same in relation to having discussed with Patient A the risks and benefits of root canal treatment. In your oral evidence, you told the Committee that while you did not recall every aspect of the consultation on 31 July 2020, you believed that you would have had these discussions with Patient A. Patient A's evidence was that you did not discuss with her treatment options for the UR7 or the risks and benefits of root canal treatment.

	The Committee took into account that the events in this case occurred some years ago. It accepted that neither you nor Patient A could recall every detail of her appointments. However, it found that Patient A was cogent in her evidence about what she could recall, and, in the Committee's view, there was a consistency in the responses she gave during questioning. The Committee found that she was clear when she considered something to be 'correct' and in accordance with her recollection. She was also clear when she considered that something had not occurred during her appointments or had not been explained to her about her treatment. By contrast, the Committee found your oral evidence to be less clear. It found that your answers to many of the questions asked of you were limited and short, and when you provided longer responses, the Committee found that they sometimes lacked clarity and did not always answer the questions asked. The Committee noted that you stated on a number of occasions that you discussed treatment options and risks and benefits with Patient A, but offered little or no further information, including in relation to when and how this would have taken place at the time. The Committee also noted that you stated in your witness statement that the Practice's Treatment Coordinator, Witness 3, was trained to discuss treatment options with patients. The Committee heard from Witness 3, and from Witness 2, the Dental Nurse who assisted you with Patient A's appointments. Neither of them could recall whether you had discussions with Patient A about treatment options for UR7 and the risks and benefits of root canal treatment. Therefore, the Committee found that the evidence of Witness 2 and Witness 3 did not help in these regards. Furthermore, the Committee considered that there were issues with the reliability of some of the assertions they made. It noted that Witness 3 stated that she had recorded her discussions with Patient A about the proposed treatment plan in the patient's clinical records. This is not borne out in any of the documentation seen by the Committee. Witness 2 told the Committee that the standard of your record keeping at the material time was very good, again the Committee considered that this is not borne out in the evidence, which includes your admission that your record keeping was below standard at the time. In all the circumstances, the Committee preferred the evidence of Patient A. It was satisfied that it was more likely than not that you did not discuss the relevant treatment options and risks and benefits with her at the appointment on 31 July 2020. It was also satisfied that you did not have such discussions with her in a reasonable timeframe from 31 July 2020 which, at the very latest, should have been on 4 August 2020 before you began the root canal treatment. The opinion of both Mr Bateman and Ms Caro was that you should have had these discussions, and in not doing so, the Committee was satisfied that you failed to provide Patient A with an adequate standard of care.
1(iii)	*You failed to provide an adequate standard of care to Patient A on or around 31 July 2020 in that you:* *Did not undertake an adequate Basic Periodontal Examination of Patient A; and/or*

	Found proved. You admitted in your oral evidence that you did not undertake a Basic Periodontal Examination (BPE) in respect of Patient A. You stated that 31 July 2020 was a free consultation, which Patient A had originally attended for a discussion around implants. You stated that while you recognised there would need to be a full examination of the patient and a referral to the hygienist at some stage, at this first visit you were dealing with the patient's pain. You told the Committee that you had intended to undertake a BPE at a future appointment, although through oversight this did not happen. Mr Bateman's evidence was that you should have undertaken a BPE of Patient A prior to starting what was, in his opinion, complex treatment. He told the Committee that a BPE is an essential component of a dental examination used to screen for periodontal disease. He stated that if a BPE is not carried out, periodontal disease may go undetected and result in poor outcomes for the patient's health and for the treatment provided. Ms Caro's original position, as stated in the joint expert report, was that she was not critical that a BPE had not been undertaken at the appointment on 31 July 2020. She noted that it was a consultation for implant treatment and you had recorded in the clinical notes that the patient would need a full examination before treatment started. Ms Caro conceded in her oral evidence that a BPE should have been carried out prior to treatment being provided. The Committee was satisfied that this allegation is proved. It accepted the expert evidence that you should have undertaken a BPE of Patient A on or around 31 July 2020 which, at the very latest, should have been before treatment was commenced. The Committee was satisfied that not to have done so was a failure to provide the patient with an adequate standard of care.
1(iv)	*You failed to provide an adequate standard of care to Patient A on or around 31 July 2020 in that you:* *Did not take bitewing radiographs to screen for interproximal caries in all of the posterior teeth.* **Found proved.** You did not take bitewing radiographs of Patient A at the appointment on 31 July 2020. You told the Committee that you were planning to take bitewing radiographs later but first wanted to address the more urgent matters. You referred to an OPG radiograph taken of Patient A dated 14 November 2019 and also the CBCT scan. You stated that you could have seen caries from the OPG, although you accepted that bitewing radiographs would have been more precise. You also noted that the OPG radiograph was not taken for the purpose of diagnosing caries. It was Ms Caro's opinion that, although not the same quality as bitewing radiographs, the OPG radiograph and the CBCT scan were adequate. Mr Bateman's evidence was that bitewing radiographs should have been taken of Patient A to screen for interproximal caries in all the posterior teeth. Mr Bateman told the Committee that some of the posterior surfaces *"where the teeth touch"* cannot be seen on visual examination. He also stated that bitewing radiographs assist in assessing bone levels. His evidence was that if undetected, interproximal

	caries could worsen and lead to the destruction of tooth tissue and tooth loss. Mr Bateman's opinion was that neither the CBCT scan nor the OPG radiograph were sufficient for the purpose of diagnosing caries. In relation to CBCT scans, he referred the Committee to the 'Faculty of General Dental Practice (UK) Selection Criteria for Dental Radiography' in which it is stated that *"While three-dimensional imaging is of clinical significance in many fields, its use in caries diagnosis is not currently supported in a European guideline document. In practice, CBCT gives the advantage of three dimensions at the expense of a loss of resolution, when compared with intraoral radiography. There are significant problems with CBCT related to artefacts, principally from metallic restorations in the path of the x-ray beam. These artefacts introduce dark streaks that pass through the crowns of other teeth, leading to artefactual radiolucencies which can produce a caries-like appearance, or even mask real carious lesions."* The Committee preferred the evidence of Mr Bateman on this issue. It considered that he was clear and competent in giving his opinion, and it found his explanations logical and fair. The Committee considered that in the giving of her evidence, Ms Caro was trying to be helpful to you and in its view, this led to some circuitous answers from her in her oral evidence. The Committee noted that on a number of occasions, Ms Caro had to make concessions, as was the case in relation to the issue of BPE. It also noted in relation to this allegation at 1(iv), Ms Caro had to concede that the CBCT scan and OPG radiograph were not diagnostic in relation to caries. It was the finding of the Committee, having accepted the opinion of Mr Bateman, that you should have taken bitewing radiographs of Patient A on or around 31 July 2020 to screen for interproximal caries in her posterior teeth. The CBCT and OPG radiograph were not sufficient. The Committee noted that even if the OPG could have been used in some way, it was taken in November 2019, some nine months prior to the appointment on 31 July 2020, by which time interproximal caries might have developed. In the circumstances, the Committee was satisfied that you failed to provide Patient A with an adequate standard of care, and this head of charge is proved.
2	*By virtue of your conduct at 1 (i) and/or 1 (ii), you did not obtain Patient A's informed consent to the root canal treatment at UR7.* **Found proved.** The Committee's findings at heads of charge 1(i) and 1(ii) above were that it was more likely than not that, on or around 31 July 2020, you did not discuss with Patient A treatment options regarding the UR7 or the risks and benefits of root canal treatment. Both expert witnesses agreed that if the Committee found these matters proved, you could not have obtained informed consent from Patient A for the root canal treatment. Mr Bateman explained in his oral evidence that patients need to make informed decisions about their care, and discussions about treatment options and risks and benefits are required to ensure that they can make such decisions. The Committee also had regard to Standard 3.1.2 of the GDC Standards, which states that:

	"You should document the discussions you have with patients in the process of gaining consent. Although a signature on a form is important in verifying that a patient has given consent, it is the discussions that take place with the patient that determine whether the consent is valid. In addition, Standard 3.1.3 states that: *"You should find out what your patients want to know as well as what you think they need to know. Things that patients might want to know include:* *• options for treatment, the risks and the potential benefits;* *…"* In noting these GDC Standards, the Committee had regard to the lack of records relating to the discussions that you said you had with Patient A. While its findings at heads of charge 1(i) and 1(ii) are not solely based on the absence of records, it noted from the relevant standards that documenting discussions with patients is important to the consent process. This is in addition to any signed documentation that you may have obtained; the Committee noted your evidence regarding the presence of the signed treatment estimate dated 31 July 2020. With regard to the issue of record keeping, the Committee took account of your evidence that treating patients during the Covid-19 pandemic, which covered the time of Patient A's treatment, made keeping records more difficult. You told the Committee that around that time you were trying to ensure that your notes were made at the end of the day because of the restricted access to your computer due to covid fallow periods. It was the view of the Committee, having considered your evidence on this point, that the fact of the pandemic is not a legitimate excuse for failing to adhere to your duties as a dentist. The Committee acknowledged that it was a very challenging time for the country and for those working within the profession. However, there was guidance in place for dental professionals at the time. The Committee also considered that issues with access to the Practice's computer system would not have precluded you from maintaining complete and accurate records. To show that you were complying with your duty, you could have made and kept alternative forms of notes and updated the computer system when possible, at a later stage. Based on the evidence before it, including the absence of any records regarding the relevant discussions as part of the consent process, the Committee concluded that it was more likely than not, that you did not obtain Patient A's informed consent for treatment. The Committee noted in particular, your evidence that Patient A appeared unaware herself that she was having endodontic treatment. Accordingly, this allegation at head of charge 2 is proved.
On or around 4 August 2020	
3(i)	*You failed to provide an adequate standard of care to Patient A on or around 4 August 2020 in that you:* *Did not discuss the treatment options to Patient A regarding UR7; and/or* **Found proved.**

	For the same reasons given in respect of heads of charge 1(i) and 1(ii) above.
3(ii)	*You failed to provide an adequate standard of care to Patient A on or around 4 August 2020 in that you:* *Did not discuss the risks and benefits of root canal treatment regarding UR7; and/or* **Found proved.** For the same reasons given in respect of heads of charge 1(i) and 1(ii) above.
3(iii)	*You failed to provide an adequate standard of care to Patient A on or around 4 August 2020 in that you:* *Did not use a rubber dam while carrying out the root canal treatment at UR7; and/or* **Found proved.** The clinical records show that you carried out root canal treatment on Patient A's UR7 at the appointment on 4 August 2020. You did not use a rubber dam while carrying out the treatment but used Isolite as an alternative to a rubber dam. Ms Caro set out in her expert report that *"Isolite is a device that retracts the cheek and tongue, provides suction, and offers some level of light and aspiration control."* She also referred in her report to a number of papers regarding the use of Isolite in general dental practice. The Committee noted that while Ms Caro stated that she was not critical of you for using Isolite as an alternative, both expert witnesses agreed that the use of a rubber dam is standard practice for root canal treatment. They also noted that Isolite may not provide the same level of protection as a rubber dam. Ms Caro stated in her report that *"While it [Isolite] can be a useful adjunct, it does not provide the same level of isolation as a rubber dam. It doesn't seal off the gingiva from irrigants and medicaments."* However, it was Ms Caro's opinion that your use of Isolite met the minimum standards. It was Mr Bateman's opinion, as set out in his expert report, that *"the use of rubber dam is mandatory for root canal treatment for patient safety…".* In this regard, he referred the Committee to a number of relevant guidance documents. It was noted that some of the guidance highlighted by Mr Bateman post-dated Patient A's root canal treatment, such as that issued by the British Endodontic Society in September 2022. However, Mr Bateman stated that the use of rubber dam for root canal treatment has long been established. His evidence was that a rubber dam, which he described as a sheet of rubber which keeps the relevant tooth isolated, provides a complete barrier between the tooth and the rest of the mouth. Mr Bateman told the Committee that a rubber dam would guard against the accidental inhalation of the small files used for root canal treatment, help prevent hypochlorite injuries, which is a substance used during the treatment, and because of the barrier created, it would guard against bacterial contamination of the tooth. Mr Bateman questioned why the partial protection of Isolite would be preferred over the complete protection afforded by a rubber dam.

	You stated in your oral evidence that when you started using Isolite you did not see it as partial protection, although you accepted this now and you have stopped using it. You explained to the Committee that sometimes patients would find Isolite more comfortable than a rubber dam. You stated that it can be difficult fitting the clamp for a rubber dam all the way back in the mouth and then the patient having to keep their mouth open. It was the conclusion of the Committee, taking into account the evidence regarding the partial protection offered by Isolite, that you failed to provide Patient A with an adequate standard of care. The Committee accepted the expert evidence that the use of rubber dam during root canal treatment is standard practice. The Committee noted that Ms Caro relied on a number of published papers in giving her opinion that the use of Isolite met the minimum standard. However, it took into account Mr Bateman's evidence regarding the lack of peer review of some of those papers. It found his evidence regarding the long-established use and benefits of rubber dam to be clear and logical. The Committee also took into account the requirement under Standard 7.1.2 of the GDC Standards which states that: "*If you deviate from established practice and guidance, you should record the reasons why and be able to justify your decision".* While the Committee noted your general evidence about why some patients might prefer the use of Isolite in certain circumstances, it found nothing in the clinical records for Patient A to justify your use of Isolite for her root canal treatment on 4 August 2020. In all the circumstances, the Committee was satisfied that this allegation is proved.
3(iv)	WITHDRAWN.
3(v)	*You failed to provide an adequate standard of care to Patient A on or around 4 August 2020 in that you:* *Did not inform the Patient of the file fracture left in situ at UR7; and/or* **Found proved.** Both Mr Bateman and Ms Caro agreed that if there was a discussion with Patient A about the file fracture left in situ at UR7 they would not be critical. The Committee understood from the expert evidence that a fractured file was significant information that Patient A was entitled to know about, given the potential impact on any future treatment. In his oral evidence, Mr Bateman outlined the risks associated with a fractured file left situ, including that it would be a barrier to cleaning the canal and that there may be a flare up of problems in the future. He also stated that there are risks associated with trying to remove a fractured file, and that a specialist referral may be required. His evidence was that there should be a discussion with the patient for them to decide on an option. The Committee noted that there is nothing recorded in your clinical records for Patient A to indicate such a discussion. However, in reaching its decision, the Committee considered the other evidence presented to it regarding this issue. This included your evidence that you knew the file had fractured during the treatment. A post-operative radiograph dated 4 August 2020 shows the file fracture in situ at

	UR7. In terms of any discussion with Patient A, you told the Committee that you believed that you did discuss the fractured file with her. The Committee took into account that none of the other witnesses recalled a discussion about the file fracture, including Patient A. The evidence was that Patient A only became aware of the fractured file after it was highlighted by a subsequent treating dentist. The presence of the file fracture is recorded in the clinical records of the subsequent treating dentist. Furthermore, the Committee noted that Patient A attended a number of further appointments with you after her root canal treatment on 4 August 2020 and there is no indication, including in any of your subsequent clinical notes, that the patient was aware of the fractured file or that there had been any discussion regarding options. In considering this lack of information in the clinical records, the Committee again concluded that the prevailing circumstances of the pandemic would not have been an excuse to deviate from your record keeping duties. Having taken all the evidence into account, the finding of the Committee was that it was more likely than not that you did not discuss with Patient A the file fracture left in situ at UR7. The Committee was satisfied that this was a failure to provide an adequate standard of care.
3(vi)	WITHDRAWN.
3(vii)	*You failed to provide an adequate standard of care to Patient A on or around 4 August 2020 in that you:* *Did not inform Patient A that only two canals in UR7 had been treated; and/or* **Found proved.** For the same reasons given in respect of head of charge 3(v) above. Both experts agreed that Patient A should have been informed that you were only able to treat two of the three canals in her UR7. The Committee noted the evidence of Mr Bateman regarding the potential problems that could have arisen with the third canal left untreated. He mentioned the possibility of abscesses and ultimately loss of the tooth. The Committee noted that in this instance you did record in Patient A's clinical records *"DB blocked!!!"* as the reason that you were only able to fill two of the root canals in UR7. Notwithstanding this, the Committee concluded on the evidence presented, that it was more likely than not that you did not discuss the matter with Patient A, as you maintained you did. In reaching its decision, the Committee took into account that Patient A attended a number of subsequent appointments with you and there are no further records or documentation in relation to this matter which, as highlighted by Mr Bateman, could have had serious future consequences for the patient. The Committee was satisfied on the balance of probabilities that this allegation is proved, and that as a result, you failed to provide an adequate standard of care to Patient A.

3(viii)	*You failed to provide an adequate standard of care to Patient A on or around 4 August 2020 in that you:* *Replaced the crowns at UR3 and UL3 without clinical justification; and/or* **Found not proved.** The Committee took into account the joint expert opinion that if the replacement of the crowns at UR3 and UL3 was done for aesthetic reasons they would not be critical. In her oral evidence to the Committee, Patient A agreed with a question put to her in cross-examination that the crowns had been undertaken so that everything would *'look right'.* It was noted that there had been some gum shrinkage and without the crowns there would have been a large gap between the teeth in question and the proposed bridge. In the circumstances, notwithstanding the absence of any information in the clinical records regarding a clinical justification, the Committee was satisfied that Patient A clearly knew about the crowns and the reason they were proposed, namely for aesthetic reasons. The Committee noted that this was in accordance with her wishes. It was satisfied on the basis of the expert opinion that this was sufficient justification. Therefore, this alleged matter is not proved.
3(ix)	*You failed to provide an adequate standard of care to Patient A on or around 4 August 2020 in that you:* *Did not adequately explain the limitations to any possible restoration at UR2 to UL2; and/or* **Found proved.** The Committee understood from the expert evidence that patients should be made aware of what can be achieved with any treatment proposed. Both experts agreed that you should have adequately explained the limitations to any possible restoration at UR2 to UL2. You provided a cement retained implant bridge from UR2 to UL2, and it was noted by both experts that there were issues with the position and angulation of the implants (surgically placed by another dentist). Mr Bateman stated in his report that it would have been *"…very challenging to achieve a good aesthetic result."* Your evidence was that you explained the limitations of the restoration at UR2 to UL2 to Patient A which, you stated, included the option of removing the implants and repositioning them with the correct angulation following a bone graft. You stated that you explained to Patient A that this would be a long and expensive process. Patient A's evidence was that you only told her about the limitations of the bridge after the treatment had already started. The Committee preferred the evidence of Patient A. She was consistent in stating that there was no discussion around the limitations of the bridge prior to treatment commencing. The Committee found this aspect of her evidence to be particularly

	clear, given that the implant retained bridge was the treatment that she was most focused on. The Committee noted that Patient A twice questioned in her oral evidence why you did not mention anything to her prior to her treatment. The Committee also noted the absence of any records regarding any discussion with the patient. It was the view of the Committee that discussing such an important matter with Patient A after treatment had already begun was not adequate in all the circumstances and it represented a failure to provide an adequate standard of care. This head of charge is proved.
3(x)	*You failed to provide an adequate standard of care to Patient A on or around 4 August 2020 in that you:* *Did not refer Patient A to a specialist in respect of the file fracture left in situ; and/or* **Found not proved.** The Committee considered that the wording of this allegation assumes that there was a conversation with Patient A, during which she requested a specialist referral, and you did not act on it. The Committee received no evidence to suggest that this was the case. Patient A said that she could not recall a discussion about a specialist referral, although you maintained that you did discuss a referral with the patient, but she declined because of the cost. In the absence of any evidence that Patient A sought a referral and this was not actioned by you, the Committee concluded that it could not find this head of charge proved as constructed.
3(xi)	*You failed to provide an adequate standard of care to Patient A on or around 4 August 2020 in that you:* *Did not refer Patient A to a specialist in respect of only treating two canals in UR7.* **Found not proved.** For the same reason given in respect of head of charge 3(x) above.
4(i)	*Your conduct in respect of 3 (v) and/or 3(vii) was:* *Misleading; and/or* **Found proved.** In finding this allegation proved, the Committee considered the ordinary meaning of 'misleading'. It considered whether your conduct found proved at 3(v) and 3(vii), namely, not informing Patient A about the fractured file left in situ at UR7, and not informing her that only two canals in that tooth had been treated, gave the wrong idea or impression.

	The Committee was satisfied that your conduct in not informing Patient A of the matters in question was misleading. In its view, she was materially misled as to the status of the root canal treatment and its outcome.
4(ii)	*Your conduct in respect of 3 (v) and/or 3(vii) was:* *Lacking in candour; and/or* **Found proved.** The duty of candour relies on active disclosure and your responsibility to communicate issues of concern. The Committee heard from both expert witnesses that the left file fracture and your inability to treat the third canal at UR7 were matters that Patient A was entitled to know about because of the potential consequences and impact on any future treatment. The Committee was satisfied in its findings that you did not comment on either matter, and this was conduct that lacked candour and was contrary to the standard expected.
4(iii)	*Your conduct in respect of 3 (v) and/or 3(vii) was:* *Dishonest* **Found proved.** In reaching its decision, the Committee applied the test for dishonesty as set out in the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67.* In accordance with that test, the Committee first considered your actual state of knowledge at the material time. The Committee was satisfied that you knew that a file fracture had been left in situ at Patient A's UR7. You accepted in your oral evidence that you were aware of this at the time of treatment. The Committee was also satisfied that you knew that you had only treated two of the three canals in that tooth. You indicated in the clinical records that the third canal was blocked. The Committee next considered whether your conduct in not informing Patient A about either issue would be regarded as dishonest by the standards of ordinary decent people. In reaching its conclusion, the Committee took into account that there are no clinical records in respect of these matters. Further, that 4 August 2020, which was when the root canal treatment was undertaken, was not Patient A's last appointment with you. She returned to the Practice on a number of subsequent occasions, so there were several other opportunities for you to tell her about what had happened, but you did not. The Committee considered that to not tell a patient that you had broken an instrument in their tooth and that you had only been able to treat two of three root canals, would be regarded as dishonest by ordinary decent people. Accordingly, this allegation is found proved.
5	*By virtue of your conduct at 3 (i) and/or 3 (ii), you did not obtain Patient A's informed consent to the root canal treatment at UR7.* **Found proved.**

	For the same reasons given previously at head of charge 2 in respect of 1(i) and 1(ii).
6	*By virtue of your conduct at 3 (ix), you did not obtain Patient A's informed consent to the bridge placed at UR2 to UL2.* **Found proved.** As stated in its finding at head of charge 3(ix), the Committee preferred the evidence of Patient A, which it found compelling. She repeatedly questioned in her oral evidence why you had not told her from the beginning that there would be limitations with the bridge. Having considered Patient A's evidence, the Committee found, on balance, that she could not have been fully informed about the bridge placed at UR2 to UL2. The Committee also noted the evidence that there were consent forms available for use at the Practice, however such a form was not provided in respect of Patient A's treatment. This further indicated to the Committee that consent was lacking. It therefore found this allegation proved.
Record Keeping	
7(i)	*You failed to make adequate records in respect of Patient A in that you:* *Did not make any clinical records in respect of an appointment that occurred on 14 November 2019;* **Admitted and found proved.**
7(ii)	*You failed to make adequate records in respect of Patient A in that you:* *Did not make any clinical records in respect of an appointment that occurred on 30 September 2020;* **Admitted and found proved.**
7(iii)	*You failed to make adequate records in respect of Patient A in that you:* *Did not make any clinical records in respect of an appointment that occurred on 9 October 2020;* **Admitted and found proved.**
7(iv)	*You failed to make adequate records in respect of Patient A in that you:* *Did not make any clinical records in respect of an appointment that occurred on 19 October 2020;* **Admitted and found proved.**
7(v)	*You failed to make adequate records in respect of Patient A in that you:* *Did not make any clinical records in respect of an appointment that occurred on 13 November 2020;* **Admitted and found proved.**
7(vi)	*You failed to make adequate records in respect of Patient A in that you:*

	Did not make any clinical records in respect of an appointment that occurred on 17 November 2020; **Admitted and found proved.**
7(vii)	*You failed to make adequate records in respect of Patient A in that you:* *Did not make any clinical records in respect of an appointment that occurred on 9 December 2020;* **Admitted and found proved.**
7(viii)	*You failed to make adequate records in respect of Patient A in that you:* *Did not make any clinical records in respect of an appointment that occurred on 26 January 2021;* **Admitted and found proved.**
Non-Cooperation	
8	*Between 1 June 2022 and 4 December 2024 you failed to cooperate with the GDC by not providing evidence of appropriate indemnity insurance* **Found proved.** The Committee noted that the GDC had made a number of attempts to obtain evidence of your indemnity. In your evidence you stated that you had delegated the task of providing evidence of your indemnity to the GDC to the Practice Manager at the Practice. You told the Committee that she would have had access to that information. You told the Committee that the Practice Manager provided a zip file of information to the GDC, which you had assumed included evidence of your indemnity, but you subsequently found that you could not access the zip file to check. You eventually provided evidence of your indemnity to the GDC in December 2024 via your solicitors. While the Committee took into account your evidence, in its view, it was your sole responsibility, as the registrant concerned, to ensure that the GDC had received the evidence of your indemnity. Standard 9.4 of the GDC Standards states that "*You must co-operate with any relevant formal or informal inquiry and give full … information".* The Committee was satisfied on the balance of probabilities that by not checking with the GDC that evidence of your indemnity had been received you failed to cooperate with its investigation over the period in question. Therefore, this head of charge is proved.
9(i)	*From 1 June 2022 to date, you failed to cooperate with the GDC by not providing:* *Completed working arrangement form and / or* **Found proved.** The evidence was that you still have not provided a completed working arrangement form to the GDC as first requested in June 2022. You told the Committee that you had thought that the Practice Manager had submitted the form

	on your behalf at the time of the request. You also highlighted that you provided information regarding your working arrangements to the GDC every year, and you questioned why the Council would need these details again. The Committee considered that neither of your explanations given in evidence were satisfactory. In its view, this matter concerning the working arrangement form is covered by the same principle relating to the evidence of your indemnity. It was your sole responsibility to ensure that you provided the information requested by the GDC. The Committee was satisfied on the evidence that you received the requests for information. It noted that there was initially an issue with you receiving emails from the Council, but paper correspondence was also sent to you, and there were communications made on your behalf to the GDC regarding its requests for information. While the Committee noted that there was on one occasion a long gap in the GDC's communication, efforts were made to chase you for the information required. In all the circumstances, the Committee was satisfied that this head of charge is proved.
9(ii)	WITHDRAWN.

37. The hearing now moves to Stage Two.

Stage Two of the hearing – 13 to 14 January 2026

38. In accordance with Rule 53(2)(a) of the Rules, part of this second stage of the hearing was held in private. The Committee was satisfied that this was necessary for the protection of your private and family life while hearing information relating to your personal and family circumstances. The Legal Adviser confirmed the Committee's discretion under Rule 53 to hold part of the hearing in private.

39. The Committee's considerations at this second stage of the hearing were whether the facts found proved amount to misconduct, and if so, whether your 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 your registration.

40. In reaching its decisions, the Committee took account of the evidence presented to it at the fact-finding stage and the further evidence provided at this stage. The evidence received on your behalf at this stage was a remediation bundle, which included a number of testimonials, a copy of your Personal Development Plan (PDP), a letter from your Mentor, dated 9 January 2026, invoices in relation to your record keeping software, evidence of your CPD, audits and other clinical documents. The Committee also received from you a reflective statement dated 12 January 2026, and a letter from your accountant dated 12 January 2026.

41. The evidence received from the GDC at this stage was in relation to your GDC referral history. The Council provided copies of the three warning letters you received from the Investigating Committee dated 25 October 2007 (unpublished warning), 9 May 2011 (published warning) and 24 July 2013 (unpublished warning).

Summary of the facts found proved

42. The facts found proved in this case relate to your care and treatment of one patient, Patient A, from July 2020 to Spring 2021. The treatment you provided involved root canal treatment and a cement retained implant bridge. Findings were also made in this case regarding your non-cooperation with the GDC's investigation into concerns raised by Patient A about her treatment.

43. The Committee found proved that across two appointments, which took place on 31 July 2020 and 4 August 2020 respectively, you failed to provide Patient A with an adequate standard of care. In summary, there were failings and concerns in relation to the following:

- The obtaining of informed consent for treatment.
- The lack of examination, BPE and bitewing radiographs prior to treatment commencing and not using sufficient isolation e.g. rubber dam for the root canal treatment.
- Lack of candour and dishonesty in that you did not inform Patient A that a file had fractured in her UR7 during the root canal treatment or that you had only been able to treat two of the three canals in the tooth.

44. Furthermore, there were failings in your record keeping spanning the period of the patient's treatment with you.

45. With regard to your non-cooperation with the GDC's investigation, the Committee found proved that between 1 June 2022 and 4 December 2024, you failed to provide evidence of appropriate indemnity insurance, despite a number of requests for this information. Also, that from 1 June 2022 to date, you failed to provide a working arrangement form, which was also the subject of repeated requests made to you by the GDC.

Summary of parties' submissions

46. In accordance with Rule 20(1)(a) of the Rules, Mr Saad first addressed the Committee in relation to your fitness to practise history. He stated that the Committee had already been directed to your GDC referral history at the first stage of these proceedings. At this second stage, the GDC provided copies of the three warning letters issued to you. Mr Saad outlined that in the first of those letters, dated 25 October 2007, you were issued with an unpublished warning regarding the accuracy of promotional material on your website. The second warning letter dated 9 May 2011 was published and related to an allegation that you were misleading the general public by claiming to be able to make decisions on treatment required by merely viewing a photograph of the patient's smile. It was highlighted that the third warning letter dated 24 July 2013, which was not published, concerned allegations relating to your cooperation with other members of the dental team, your record keeping and the obtaining of informed consent.

47. In making his submissions in respect of the case before this Committee, Mr Saad referred to a number of relevant paragraphs within the GDC's 'Guidance for the Practice Committees, including Indicative Sanctions Guidance (effective from October 2016; last revised in December 2020)' ('the

Guidance'). This included paragraph 4.1(iii), which states *that "Impairment can only be found on the basis of one or more of the statutory grounds, which include misconduct…".*

48. Mr Saad outlined the specific types of misconduct alleged by the GDC in this case. In relation to your failure to discuss treatment options, risks and benefits with Patient A, which led to your failures in obtaining informed consent, Mr Saad asked the Committee to consider the joint opinion of Mr Bateman and Ms Caro, the expert witnesses in this case, that this was conduct that fell far below the standard. Mr Saad also asked the Committee to take account of the relevant GDC Standards 1.1.1 and 3.1, which relate to the issue of informed consent. He further highlighted that English is not Patient A's first language and submitted that in the circumstances there was a greater need to ensure that she understood what was being said.

49. With regard to clinical matters found proved, including the absence of an examination, BPE and bitewing radiographs of Patient A and the issue of not using a sufficient isolation method e.g. rubber dam during the root canal treatment, Mr Saad referred the Committee to Mr Bateman's opinion about the matters he said fell far below the expected standard.

50. Mr Saad also addressed the Committee's findings in relation to your lack of candour and your dishonesty, your record keeping and your non-cooperation with the GDC's investigation. In doing so, he invited the Committee to consider the GDC Standards that he said were applicable including Standards 1.3 and 9.4. In relation to the issue of your poor record keeping, Mr Saad highlighted the joint opinion of the expert witnesses that your record keeping failings fell far below what was expected in the circumstances.

51. In addressing current impairment, Mr Saad submitted that the Committee would need to consider both the personal and the public components of impairment. In relation to the personal component, which concerns any ongoing risk posed to the public, Mr Saad referred to the evidence of your remediation. He also noted that the authors of the testimonials and your Mentor all speak highly of you. Mr Saad acknowledged that you had provided certificates which demonstrate that you have undertaken a number of relevant courses. He also submitted that the audits received show that there has been some improvement in your clinical practice, although he noted that the audits are quite recent. In view of this, Mr Saad questioned whether there had been an embedding of your remediation.

52. It was Mr Saad's submission that in all the circumstances of this case, the personal component of impairment is engaged. Therefore, the GDC's position was that there is an ongoing risk to the public. However, in making this submission, Mr Saad cautioned the Committee that in reaching its decision on the issue of current impairment, it should not conclude that you have a lack of insight because of your rejected defences at the fact-finding stage. In this regard, Mr Saad referred the Committee to the relevant legal authorities, including *Sayer v General Osteopathic Council* [2021] EWHC 370 (Admin).

53. In relation to the public component of impairment, namely the question of whether a finding of impairment is required in the wider public interest, Mr Saad submitted that it would be appropriate to find impairment on this basis alone, given the finding of dishonesty. He submitted that dishonesty in relation to complications occurring during treatment is precisely the conduct that undermines

public confidence in the dental profession. He also noted that informed consent is a cornerstone of the dental profession. Mr Saad submitted that when looking at the Committee's findings, individually and collectively, they are serious. He submitted that a finding of impairment is necessary in light of your failings.

54. With regard to sanction, Mr Saad invited the Committee to consider imposing a suspension order for a period of between 6 and 9 months, with a review, if the Committee determines that the personal component of impairment is engaged in this case.

55. Mr Day told the Committee that you acknowledged and respected its findings, and that you are taking the matters in this case very seriously, as stated in your reflective statement. Mr Day submitted that you are a reflective and insightful practitioner, and that you have sought to improve, including by making concrete changes to your clinical practice.

56. In relation to the issues of misconduct and current impairment, Mr Day submitted that these are admitted in the round. However, his submission was that a finding of impairment is only required to uphold standards and maintain public confidence in the dental profession. He submitted that there was no ongoing risk to the public in this case.

57. Mr Day submitted that the identified clinical failings have been remedied. He highlighted the time that has elapsed since your treatment of Patient A, during which you have remained in clinical practice. He submitted that this demonstrates that there is no continued risk, although it was accepted that your conduct must be met with a sanction. Mr Day disagreed with the submission of the GDC that a conditions of practice order was not conceptually appropriate in the case, but acknowledged the seriousness of the findings of the Committee and the likelihood of a suspension order.

58. Mr Day highlighted to the Committee that your conduct found proved is largely five years old and involves your treatment of a single patient. He submitted that this must be seen in the context of your almost 32 year career, during which your honesty had not been in question before, and you had not been referred to any Professional Conduct Committee. Mr Day submitted that your conduct, as highlighted in this case, is an aberration and not reflective of your whole character. He reiterated that this is a single patient case, and while the matters cannot strictly be characterised as an isolated event, he stated that the most serious issues, namely the lack of candour and the dishonesty, are isolated.

59. Mr Day drew the Committee to paragraph 5.17 of the Guidance, which deals with mitigation, and he outlined a number of mitigating factors for consideration, including the remedial action you have undertaken since the events in question. He invited the Committee to consider the evidence of your insight as demonstrated in your reflective statement, including your apology for having let down Patient A, your colleagues and the general public in the way that has been found proved.

60. In relation to your previous warnings received from the GDC, Mr Day asked the Committee to note that two of those warnings are unrelated to the matters under consideration. In respect of the third warning, which does include similar concerns, Mr Day invited the Committee to view that in the context of your long career.

61. In accepting that current impairment, Mr Day agreed with the GDC's submission regarding your rejected defences. He submitted that this is not a case where such an issue should impact on the assessment of insight. It was Mr Day's submission that your current practice does not pose a risk to patients going forward. He submitted that the best evidence before the Committee is that no further concerns have been raised in the five years since these issues arose, and nor were any raised in the previous 27 years before your treatment of Patient A. Mr Day submitted that you have shown insight, undertaken remediation and you have developed as a practitioner. He also asked the Committee to take into account the evidence of your engagement with your Mentor, which Mr Day said you found extremely helpful. Mr Day submitted that the clinical matters found proved in this case had been addressed and so they should not form part of the Committee's consideration on impairment. He accepted, however, that the findings of a lack of candour and dishonesty must be met with a finding of current impairment.

62. Mr Day reminded the Committee of its duty to act proportionately when considering sanction. In this regard, he addressed the Committee in private session in relation to current personal and family circumstances. He also emphasised the severe consequences for you and those in your employment should your registration be suspended. So while Mr Day acknowledged the likelihood of a suspension order, he submitted that the length of any order was open to the Committee's discretion, bearing in mind the principle of proportionality.

The Committee's decisions – 14 January 2026

63. The Committee considered all the evidence before it. It took account of the submissions made by Mr Saad on behalf of the GDC and those made by Mr Day on your behalf.

64. The Committee accepted the advice of the Legal Adviser in relation to the relevant considerations at this stage, how it should approach its decision-making and the need to have regard to the applicable legal principles and guidance. 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

65. The Committee considered whether the facts found proved against you 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. In considering what was expected in the circumstances of this case, the Committee had regard to the GDC Standards, and was satisfied that the following are engaged:

1.1.1 You must discuss treatment options with patients and listen carefully to what they say. Give them the opportunity to have a discussion and to ask questions.

1.3.1 You must justify the trust that patients, the public and your colleagues place in you by always acting honestly and fairly in your dealings with them. This applies to any

business or education activities in which you are involved as well as to your professional dealings.

1.3.2 You must make sure you do not bring the profession into disrepute.

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

3.1.2 You should document the discussions you have with patients in the process of gaining consent. Although a signature on a form is important in verifying that a patient has given consent, it is the discussions that take place with the patient that determine whether the consent is valid.

3.1.3 You should find out what your patients want to know as well as what you think they need to know. Things that patients might want to know include:

- options for treatment, the risks and the potential benefits;
- …;
- the consequences, risks and benefits of the treatment you propose;

…

4.1 Make and keep contemporaneous, complete and accurate patient records.

7.1.2 If you deviate from established practice and guidance, you should record the reasons why and be able to justify your decision.

9.4 Co-operate with any relevant formal or informal inquiry and give full … information.

66. The Committee considered the five areas covered by its findings, namely the issue of informed consent, the clinical matters including the lack of an examination, BPE and bitewing radiographs of Patient A, not using sufficient isolation during the root canal treatment, your lack of candour and dishonesty, your record keeping and your non-cooperation with the GDC's investigation.

67. In relation to informed consent, the Committee noted that your failures related to two different aspects of Patient A's treatment. You did not have discussions with her around the root canal treatment you provided, and you did not adequately explain the limitations of the cement retained implant bridge you fitted. The Committee noted that both expert witnesses agreed that a failure to obtain informed consent from a patient falls far below the expected standard. Informed consent is a cornerstone of the public interest and must be paramount in a registrant's mind prior to carrying out any treatment or investigation. The Committee was satisfied that your failure to obtain Patient A's informed consent for the treatments you provided represented a serious departure from your professional obligations and the appropriate standards.

68. The Committee next considered the lack of undertaking an examination of Patient A, particularly not undertaking a BPE and not taking bitewing radiographs before commencing treatment. It also took into account that you did not use sufficient isolation during the root canal treatment. The Committee accepted the opinion of the GDC's expert witness, Mr Bateman, that all of these matters fell far below the requisite standard. The Committee had regard to the identified risks to the patient, as outlined by Mr Bateman, such as periodontal disease potentially going undetected because of the lack of a BPE, which could have had poor outcomes for the patient's health and the treatment provided. Mr Bateman also raised the possibility that interproximal caries could have progressed due to the lack of bitewing radiographs and led to a destruction of tooth tissue and tooth loss. In relation to your failure to use a sufficient isolation method for Patient A's root canal treatment, Mr Bateman highlighted the risks of accidental inhalation of the small files used for the treatment, possible hypochlorite injury and the potential for bacterial contamination of the tooth. The Committee was satisfied on the evidence that the clinical matters found proved demonstrated a serious falling short of the standards.

69. When considering your lack of candour and your dishonesty, the Committee remained mindful that they related to a specific aspect of Patient A's treatment, this being the root canal treatment. It also took into account that there was no suggestion that you went out of your way to hide the fact of the file fracture or that you had only been able to treat two of the three canals in the tooth concerned. However, you were not open and honest with Patient A in relation to these matters, which she was entitled to know about. The Committee also took into account that, after the root canal treatment had been provided, Patient A returned to see you on a number of occasions, providing several opportunities for you to inform her of the fractured file and the fact that you had only been able to treat two of the three canals. Honesty and integrity are fundamental tenets of the dental profession, and the Committee considered that through your lack of candour and your dishonesty, you denied Patient A the opportunity to make an informed decision about her options. In the Committee's view, this was a serious failing.

70. The Committee went on to consider the issue of your record keeping. It bore in mind that your record keeping failings relate to the treatment of Patient A. However, there were eight separate appointments at which you did not make any records at all for Patient A. The Committee accepted the joint expert opinion that your failings in record keeping fell far below the standard expected of a reasonably competent practitioner.

71. Lastly, the Committee considered your non-cooperation with the GDC's investigation. In doing so, it noted that you have engaged with this hearing process, and you have provided reasons for why you did not respond to the GDC's requests for information in a timely manner. However, as set out in the Committee's findings, it was your responsibility to ensure that you adhered to the requests made by your regulator, which should have included following up to check that the required information had been received by the GDC. The evidence shows that you were chased for the information. Indemnity is a fundamental requirement of practice, and part of the GDC's regulatory function is to ensure that registrants are complying with this requirement for the protection of the public. Despite a number of requests from the GDC for your proof of indemnity dating back to 2022, you did not provide this information until December 2024. Furthermore, the Committee noted the evidence that, to date, you have not provided the GDC with the working arrangement form required. Whilst the Committee took into account the submissions made on your behalf about this, it remained

of the view that ultimate responsibility lies with you. It was highlighted in the submissions made by the GDC that it is rare for such matters to get to the stage of a hearing with information still outstanding. It was the judgement of the Committee, taking all the evidence into account, that the non-cooperation matters are serious enough to meet the threshold for a finding of misconduct.

72. Having considered the facts found proved, the Committee was satisfied that the matters in this case, both individually and cumulatively, are serious and amount to misconduct.

Decision on current impairment

73. The Committee next considered whether your fitness to practise is currently impaired by reason of your 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.

74. The Committee also had regard to the relevant guidance and legal principles brought to its attention. This included the case of *Council for Regulatory Healthcare Excellence v Nursing Midwifery Council and Grant* [2011] EWHC 927 (Admin), which sets out factors to be considered when determining the issue of current impairment. In accordance with *Grant,* the Committee considered whether its findings in respect of your misconduct show that your fitness to practise is impaired in the sense that you:

a. have in the past acted and/or are liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

b. have in the past brought and/or are liable in the future to bring the dental profession into disrepute; and/or

c. have in the past breached and/or are liable in the future to breach one of the fundamental tenets of the dental profession; and/or

d. have in the past acted dishonestly and/or are liable to act dishonestly in the future.

75. The Committee considered that all four factors at (a) to (d) are engaged in this case in terms of your past misconduct. The Committee went on to consider whether you are liable to act in these ways in the future.

76. It was the view of the Committee that your misconduct, albeit serious, is capable of being remedied. It took into account that the matters found proved include dishonesty, which is an attitudinal concern, and therefore more difficult to remedy than clinical failings. However, it is not an impossibility. The Committee therefore considered the evidence provided on your behalf at this stage and considered whether your misconduct has been remedied, and whether it is likely to be repeated.

77. The Committee had regard to the evidence of your CPD, showing that you have undertaken a considerable number of courses targeted to the areas of concern. This was acknowledged by the

GDC and was also outlined in the submissions made on your behalf. The Committee noted that you have undertaken courses on Record Keeping, Consent, Detecting Periodontal Disease, and Legal and Ethical issues. The Committee also took into account your completion of a full-day course in September 2025 on Probity and Ethics.

78. In addition, the Committee was provided with your reflective statement in which you address the concerns raised in relation to the standard of care you provided to Patient A, and your failure to cooperate with the GDC's investigation. You stated in respect of Patient A that *"I am very sorry for any distress or anxiety caused to the patient from this process and for having failed to reach the standards rightly expected of me".* You refer to the improvements you have made to your clinical practice and the systems and processes you now have in place to avoid repetition of the issues in this case.

79. The Committee considered from the material placed before it, which also included a number of audits and the letter from your Mentor, that there is evidence that you have started to review your clinical practice and where you went wrong in your care of Patient A. The Committee was satisfied that you recognise that you should have behaved differently in the circumstances of Patient A's treatment, and that you have put in place mechanisms to prevent recurrence of the matters found proved. In relation to your dishonesty, the Committee noted that you stated in your written reflections that *"This process has helped me to understand that acting without candour can undermine the integrity of the profession and lead to a breakdown of relationships. It has helped me to fully appreciate the importance of being transparent in all interactions and I am committed to ensuring that my conduct reflects openness and honesty at all times, even when mistakes inevitably occur or outcomes are not as expected. I have learnt that honesty is easy when nothing has gone wrong, it is of the most importance when things have not gone well…"*

80. You also acknowledge in your written reflections the importance of cooperating with the GDC. You stated that you recognise that your approach during the investigation could have been *"more proactive"*. You refer to the process you have implemented around following-up important correspondence that needs actioning.

81. The Committee welcomed the evidence of what you have done so far in terms of your remediation. However, it noted the recent nature of a large proportion of your learning, with a significant amount of your CPD undertaken in 2025, some five years after the events involving Patient A began, and three years since concerns were raised in 2022. The Committee also noted the submission of your Counsel that you began to use record keeping software from November 2025 onwards. The Committee further noted that the engagement of your Mentor has also been relatively recent, and while the audits provided show some improvements in your practice, they only cover the period September to November 2025. For all these reasons, the Committee was not confident that your remediation has been embedded into your practice.

82. The Committee's assessment of the evidence before it is that your insight is at the developing stage. You have demonstrated an understanding of your misconduct in relation to the GDC Standards, have begun reflecting on it, and have identified what changes you need to make. However, in the Committee's judgement, the processes of your remediation and your reflection are

still in the early stages. The Committee considered that your reflections are particularly limited in relation the impact of your failings on Patient A.

83. In reaching its conclusion, the Committee took into account that there is no evidence of any further concerns in the five years you have been practising since your treatment of Patient A. However, the Committee bore in mind your GDC referral history, which includes a warning you received in July 2013 for thematically similar issues. In view of this and given its concerns about the extent to which your recent learning has been embedded, the Committee was not reassured that the risk of repetition is low. The Committee remained concerned that you are liable to act in future in the ways identified by your misconduct. Accordingly, it determined that a finding of impairment is necessary in this case for the protection of the public.

84. The Committee next considered the wider public interest. It considered whether a finding of impairment is also required to maintain and promote public confidence in the dental profession and proper professional standards. This case concerns serious clinical and conduct concerns, including behaviour that breached fundamental tenets of the dental profession and put the safety and wellbeing of a patient at risk. The Committee considered that a well-informed member of the public would be shocked and dismayed if a finding of impairment were not made. It also considered that such a finding is required to uphold proper professional standards.

85. In all the circumstances, the Committee determined that your fitness to practise is impaired by reason of your misconduct.

Decision on sanction

86. The Committee went on to consider what sanction, if any, to impose on your 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 Guidance. It applied the principle of proportionality, balancing the public interest with your interests.

87. In deciding on the appropriate sanction, the Committee considered the issue of mitigating and aggravating factors. In mitigation, the Committee considered the following:

- evidence of good conduct following the incident in question, particularly any remedial action;
- evidence of remorse shown, developing insight, and apology given;
- evidence of steps taken to avoid repetition.

88. The Committee identified the following aggravating factors:

- risk of harm to a patient;
- dishonesty;
- breach of trust;
- blatant or wilful disregard of the role of the GDC and the systems regulating the profession;
- previous warnings.

89. Having had regard to the above factors, the Committee considered the available sanctions. It started with the least restrictive as it is 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 your registration, however, it considered that this would be wholly inappropriate, given the seriousness of its findings and the reasons for your impairment. Concluding this case with no action would not protect the public nor would it satisfy the wider public interest.

90. The Committee considered whether to issue you with a reprimand. It noted, however, that a reprimand would not impose any restriction on your registration. Paragraph 6.7 of the Guidance makes clear that a reprimand may be appropriate where the misconduct is at the lower end of the spectrum and in circumstances where no ongoing risk is posed to the public. This is not such a case. The Committee therefore concluded that a reprimand would not be appropriate or sufficient to protect the public and the wider public interest.

91. In considering whether a conditions of practice order would be an appropriate and proportionate sanction, the Committee had regard to paragraph 6.18 of the Guidance which sets out that conditions may be appropriate where there are discrete aspects of the registrant's practice that are problematic. The Committee did not consider this to be applicable in this case, given the range of clinical shortcomings that have been identified. It also took into account its serious findings in relation to your lack of candour, dishonesty and your non-cooperation with the GDC's investigation. The Committee was not satisfied that conditions would be able to address these attitudinal failings. Accordingly, it decided against the imposition of a conditions of practice order.

92. The Committee next considered whether to suspend your registration for a specified period, up to a maximum of 12 months. It took account of 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 (this list is not exhaustive):*
>
> - *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)".*

93. It was the view of the Committee that all of the above factors from paragraph 6.28 are applicable in this case. It took into account that your lack of candour, dishonesty and non-cooperation with the GDC's investigation all raise concerns about your attitude, but it was satisfied that there was no evidence before it to suggest that you have any deep-seated attitudinal problems.

94. However, the Committee did take into account that its findings indicate that there have been serious breaches of fundamental tenets of the profession. Therefore, in deciding whether the

sanction of suspension would be sufficient, appropriate and proportionate, the Committee considered paragraph 6.34 of the Guidance which deals with erasure.

95. The Committee noted that factors relevant to erasure include serious departures from relevant professional standards and also dishonesty. However, having considered the matters in this case in the round, the Committee did not regard your behaviour, as found proved, to be fundamentally incompatible with being a dental professional. It took into account that your dishonesty did not involve any deliberate act to conceal, but rather a failure to be open and honest about what had happened during treatment. The Committee also bore in mind that this is a single patient case, and although you failed to provide Patient A with an adequate standard of care in a number of ways, your failings were not such that they amounted to serious harm to the patient. In respect of your lack of cooperation with the GDC during its investigation, the Committee noted that you have engaged with this hearing. Additionally, the Committee took into account the evidence of your insight and your remediation, albeit both are in the early stages. The Committee concluded that, in all the circumstances, erasure would be disproportionate and punitive.

96. The Committee therefore determined that an order of suspension is an appropriate and proportionate sanction. It decided to direct the suspension of your registration for a period of 9 months. In deciding on this period, the Committee considered the need to protect the public and to uphold the wider public interest by marking the seriousness of your misconduct. It also took into account that your developing insight and the early stages of your remediation. It considered that a period of 9 months would give you the opportunity to further reflect on your misconduct and to provide evidence of your ongoing learning into your clinical practice.

97. In determining to suspend your registration and in its consideration of the period of time, the Committee took into account the potentially serious consequences for you, as outlined in the submissions made on your behalf regarding your personal circumstances and your professional life. However, the Committee was satisfied that the imposed sanction is necessary in light of its serious findings, the identified risk of repetition and the wider public interest considerations. It was satisfied that this is a case where the need to protect the public interest, including public confidence in the dental profession, outweighs your own interests.

98. The Committee directs that a review of the suspension order should be conducted at a resumed hearing to be held shortly before the expiry of the 9 month period. The Committee at the resumed hearing will consider what action to take in respect of your registration at that time.

99. This Committee considered that the reviewing Committee may be assisted by further reflections from you.

100. Unless you exercise your right of appeal, your registration will be suspended for a period of 9 months, starting 28 days from the date that notice of this Committee's direction is deemed to have been served upon you.

101. The Committee now invites submissions from Mr Saad and from Mr Day, as to whether an immediate order of suspension should be imposed on your registration to cover the 28-day appeal period, pending the taking effect of its substantive direction for suspension.

Decision on an immediate order – 14 January 2026

102. In considering whether to impose an immediate order of suspension on your registration, the Committee took account of the submissions made by both parties.

103. Mr Saad submitted that an immediate order is required in this case and he referred the Committee to the relevant paragraphs in the Guidance which deal with immediate orders. Mr Saad highlighted that the Committee has found current impairment on both the personal and public components and he submitted that an immediate order of suspension is required to cater for the risk identified.

104. Mr Day opposed the imposition of an immediate order of suspension. He submitted that the test for imposing an immediate order is a high one. He stated that an immediate order must be necessary, as its power has a dramatic effect and the impact is far reaching. He submitted that the finding of impairment on public protection grounds is not an answer to necessity. Mr Day submitted that in considering the issue of necessity, the Committee should look at the risk posed and the degree of that risk.

105. Mr Day submitted that it is relatively rare for a registrant to be subject to an immediate order on wider public interest grounds alone. He stated that this cannot be said to be a necessity in this case. In relation to the issue of public protection, Mr Day submitted that the most powerful evidence that there is no need for an immediate order is that you have remained in practice since the events in question with no further concerns raised. He asked the Committee to consider whether there would be a real risk to the public if you were not suspended immediately. Mr Day submitted that there were other factors that mitigate against the imposition of an immediate order, he cited the needs of your current patients and their ongoing care. Mr Day submitted that it would be appropriate and proportionate to permit you the 28 day appeal period to make arrangements for your business going forward.

106. Having heard from both parties, the Committee accepted the advice of the Legal Adviser, who drew its attention to the statutory test for immediate orders.

107. The Committee determined that the imposition of an immediate order of suspension on your registration is necessary for the protection of the public and is otherwise in the public interest.

108. The Committee has determined that your failings amounted to serious misconduct and in finding your fitness to practise to be impaired by reason of that misconduct, it has identified a risk of repetition on account of the early stages of your insight, reflection and remediation. In view of this identified risk, the Committee considered that it would be inconsistent not to impose an immediate order of suspension on your registration for the protection of the public. In reaching its decision, the Committee took into account that, in the absence of an immediate order and in the event of an appeal, you would be able to continue in unrestricted practice for a longer period of time, beyond the 28 day appeal period. The Committee considered that this would entirely undermine its substantive decision. In the circumstances, it was satisfied that an immediate order is necessary in this case.

109. The Committee was also satisfied that an immediate order is required in the wider public interest, in light of the gravity of the matters found proved. It considered that immediate action is necessary to maintain public confidence in the dental profession, the regulatory process, and to uphold proper professional standards.

110. The effect of the foregoing substantive determination and this order is that your registration will be suspended to cover the appeal period. Unless you exercise your right of appeal, the substantive direction for suspension for a period of 9 months will take effect 28 days from the date of deemed service.

111. Should you exercise your right of appeal, this immediate order will remain in place until the resolution of the appeal.

112. That concludes this determination.