HEARING HELD IN PUBLIC

Professional Conduct Committee
Initial Hearing

8 to 15 June 2026

Name:	GUPTA, Nita Datta
Registration number:	74195
Case number:	CAS-210243-L5V9C3

General Dental Council:	Joe O'Leary, Counsel Instructed by Rosie Geddes, IHLPS
Registrant:	Present Represented by Christopher Geering, Counsel Instructed by Lucy Fell, MDDUS

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

Committee members:	Val Evans	(Chair, Lay Member)
	Donna Lightbody	(Dental Care Professional Member)
	Melissa Oura	(Dentist Member)
Legal Adviser:	Kenneth Hamer	
Committee Secretary:	Lola Bird	

Nita Datta GUPTA, a dentist, Statutory Exam 1998, FDS Royal College of Surgeons Of England 1995, BDS Calcutta 1985, Specialist List in Oral Surgery, is summoned to appear before the Professional Conduct Committee on 8 June 2026 for an inquiry into the following charge:

The charge:

"That being registered as a dentist Nita Gupta's (74195) fitness to practise is impaired in that:

1. *You failed to provide an adequate standard of care to Patient A, from 1 March 2023 to 24 October 2023 including by;*
   a) *Not carrying out sufficient treatment planning*
   b) *Exposing Patient A to avoidable ionising radiation*
   c) *By not discussing the full risks and benefits of the proposed treatment*
   d) *Not using a surgical guide, or alternative angulation controls*
2. *You failed to maintain an adequate standard of record keeping in respect of Patient A's appointments from 1 March 2023 to 24 October 2023.*
3. *You failed to maintain an adequate standard of record keeping in relation to radiographs, in respect of Patient A's appointments from 1 March 2023 to 24 October 2023.*
4. *You failed to obtain informed consent for the treatment provided to Patient A from 1 March 2023 to 24 October 2023.*
5. *You failed to act within your duty of candour between 07 September 2023 to 1 November 2023 in that:*
   a) *You did not properly inform Patient A that the cause of oral antral communication was due to the incorrect angulation of the dental implant.*

And, by reason of the matters set out above, your fitness to practise is impaired by reason of your misconduct."

Mrs Gupta,

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.

2. The hearing commenced on 8 June 2026 and is being conducted in person at the Dental Professionals Hearings Service.

3. You are represented at these proceedings by Mr Christopher Geering, Counsel. The Case Presenter for the GDC is Mr Joe O'Leary, Counsel.

Admissions to the charge – 8 June 2026

4. At the outset of the hearing, Mr Geering told the Committee that you admitted the following heads of charge: 1(a), 1(b), 1(d), 2 and 3. These are your admissions that you failed to provide an adequate standard of care to Patient A from 1 March 2023 to 24 October 2023 by not carrying out sufficient treatment planning, exposing the patient to avoidable ionizing radiation, and by not using a surgical guide, or alternative angulation controls. You also admitted that over the same period, you failed to maintain an adequate standard of record keeping in respect of Patient A's appointments and in relation to radiographs.

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

The Committee's decision on your admissions – 8 June 2026

6. The Committee was satisfied that your admissions were clear and unequivocal. In accordance with Rule 17(5) of the *GDC (Fitness to Practise) Rules Order of Council 2026*, the Chair of the Committee announced the admitted heads of charge 1(a), 1(b), 1(d), 2 and 3 as 'Found proved by way of admission'.

Summary of the GDC's opening submissions and case background

7. In opening the case for the GDC, Mr O'Leary stated that on 19 September 2023, the Council received a webform complaint from Patient A regarding a dental implant that you had provided to her.

8. Patient A stated in respect of her implant treatment that she had refused what she referred to as *"the new partial extraction therapy"* (PET), as she wanted what she called *"the 'tried and tested'* implant treatment. Patient A noted that PET was going to cost her an extra £350. However, she stated that on the day of treatment, you said that you would provide PET without extra charge, and PET was undertaken.

9. Patient A went on to state that when the numbness of the treatment wore off, she found it extremely difficult to drink, as air was coming into her mouth, stopping the water. She said that she returned to see you, and you told her that the implant had pierced her sinus but that it would heal and be fine. Patient A stated that the following morning, you sent her a message to ask her to come in and have the implant removed, which she did.

10. Mr O'Leary told the Committee that in support of her complaint, Patient A had provided the GDC with copies of emails, WhatsApp messages, a copy of her treatment plan, and handwritten notes that she had made. Patient A also provided the GDC with an update in relation to treatment she received at hospital, where you had referred her following the

incident. The GDC further obtained from you Patient A's clinical records, which show that the PET and implant treatment was provided to Patient A's UL3 on 5 September 2023.

11. Mr O'Leary stated that the GDC had sought expert opinion in relation to the matters in this case. In this regard, he referred the Committee to the report of Mr André Haigh, the expert witness instructed by the Council. With reference to the outstanding allegations at heads of charge 1(c), 4 and 5, Mr O'Leary took the Committee through the relevant parts of Mr Haigh's report.

The GDC's evidence

12. The documentary evidence received by the Committee from the GDC included:

- The expert report of Mr Haigh, dated 27 October 2025
- Patient A's clinical records as provided by you to the GDC
- The witness statement of a GDC Caseworker dated 22 October 2025. This was an agreed production statement, with which the Caseworker exhibits a number of documents received by the Council during its investigation of this case, including Patient A's communications and a letter dated 20 August 2024 written on your behalf to the GDC by your representatives, the MDDUS.

13. In addition, the Committee heard oral evidence from the GDC's expert witness, Mr Haigh.

Decision on submission of no case to answer – 10 June 2026

14. Following the conclusion of the factual case of the GDC, Mr Geering made a submission of no case to answer under Rule 19(3) of the *GDC (Fitness to Practise) Rules Order of Council 2006.* He made the submission in respect of all the outstanding allegations in this case, namely those at heads of charge 1(c), 4 and 5.

15. Head of charge 1(c) alleges that you did not discuss with Patient A the full risks and benefits of the proposed treatment. It was Mr Geering's submission that there is insufficient evidence to find this allegation proved. He submitted that Patient A does not allege, in any of her communications with the GDC, that you did not fully discuss risks and benefits with her, although she does make other complaints.

16. Mr Geering stated that Patient A has not been shy in raising her concerns. He submitted that the overwhelming likelihood is that, if the full risks and benefits of the proposed treatment had not been discussed with her, she would have raised this, either at a local level or with the GDC. Mr Geering submitted that this inference is reinforced by

Patient A's response to the letter dated 20 August 2024, which was sent on your behalf to the GDC by the MDDUS setting out your position in respect of the allegations. This included your denial of head of charge 1(c). It was stated that you recalled discussing with Patient A the risks and benefits of the procedure, *"though the full depth of the conversation was not recorded in the clinical records".* Mr Geering highlighted that in response to that letter, Patient A had challenged those parts of your account that she did not accept. He asked the Committee to take into account that Patient A did not challenge your recollection of the risks and benefits of the proposed treatment having been discussed with her.

17. Mr Geering further drew the Committee's attention to Patient A's most recent email to the GDC dated 8 June 2026. He asked the Committee to note that in this email, Patient A again itemises those aspects of your account that she considers to be inaccurate, and she repeats what she has said on previous occasions. It was Mr Geering's submission that, conspicuously, Patient A does not advance the point that she underwent the procedure not knowing the associated risks and benefits.

18. Mr Geering submitted that there is *"strong circumstantial evidence"* to suggest that you must have discussed the risks and benefits of the proposed treatment with Patient A. He submitted that the sole basis for the allegation at head of charge 1(c) is the absence of any record of such a discussion in the clinical notes. Mr Geering reminded the Committee of the evidence of the GDC's expert witness, Mr Haigh, that a lack of a record does not mean a discussion did not occur. Mr Geering also submitted that relying on the absence of a record to say that something did not happen is not a legal principle, and that proceeding on such a basis has been expressly criticised by the High Court.

19. Head of charge 4 is the allegation that you failed to obtain Patient A's informed consent for the treatment provided. Mr Geering stated that his understanding is that this allegation is being advanced by the GDC in light of Patient A's assertion that she was given no choice in the treatment provided to her. Mr Geering submitted that there are significant issues with head of charge 4, such that no Committee could find it proved. He asked the Committee to take into account that, despite maintaining that she had been subject to an experiment and that she had not wanted the Partial Extraction Therapy (PET), Patient A had nevertheless opened her mouth for that treatment to be provided.

20. Mr Geering asked the Committee to have regard to the reliability and credibility of Patient A's account. In doing so, he drew to the Committee's attention how Patient A's engagement with the GDC has fluctuated. Mr Geering submitted that there has been no medical evidence to justify why this has been the case. He further stated that whilst issues of health had been raised by Patient A in relation to her non-attendance at this hearing, there has been no explanation as to why she has not been able to provide a witness statement.

21. Mr Geering further asked the Committee to have regard to the accuracy of the information provided by Patient A, including her stating that she did not want to be a 'guinea pig'. It was Mr Geering's submission, however, that when one looks at the correspondence in this case as a whole, it makes plain that money was an operative factor in Patient A not initially opting for the PET, and not because she did not want that treatment. Mr Geering also invited the Committee to consider the details of the consent form signed by Patient A which, he said, was inconsistent with the PET being *"sprung on her".*

22. Lastly, Mr Geering addressed the Committee on head of charge 5, which is the allegation that you failed to act within your duty of candour. It is alleged that you did not properly inform Patient A that the cause of oral antral communication was due to the incorrect angulation of the dental implant. Mr Geering submitted that there is contemporaneous evidence from Patient A stating that she was told that the perforation of her sinus was because of the incorrect angulation of the implant. Therefore, Patient A was aware that the implant was the problem. Mr Geering also asked the Committee to note from the letter dated 20 August 2024, written on your behalf by the MDDUS, that you agreed *"that the cause of the oral antral communication was due to the incorrect angulation of the dental implant"* and that you recalled informing Patient A that this was the case. Mr Geering highlighted that in her response to that letter, Patient A did not challenge your account in this regard.

23. In all the circumstances, Mr Geering invited the Committee to conclude that there is no case to answer in relation to the three outstanding allegations at heads of charge 1(c), 4 and 5.

24. Mr O'Leary opposed the submission of no case to answer in its totality. In relation to head of charge 1(c), Mr O'Leary acknowledged Mr Haigh's evidence that the absence of a record does not mean that you did not discuss the risks and benefits of the proposed treatment with Patient A. However, Mr O'Leary submitted that the Committee could equally consider what has been written down when reaching its factual finding at the full time stage including, as highlighted by Mr Haigh, the generic nature of the consent form signed by Patient A for the PET and implant treatment.

25. Mr O'Leary submitted that the fact that Patient A does not raise the issue of risk and benefits in her correspondence should not undermine the allegation at 1(c). He submitted that Patient A did not have to respond to every single element of the case. Furthermore, that the Committee should bear in mind Mr Haigh's evidence that patients may not necessarily go into the intricacies of the treatment planning in their complaints and correspondence.

26. With regard to the issue of informed consent at head of charge 4, Mr O'Leary submitted that Patient A has stated on a number of occasions in her communications that she did not consent to the PET. Mr O'Leary stated that the arguments advanced on your

behalf in relation to this alleged matter were based on the reliability and credibility of Patient A's account. Mr O'Leary referred the Committee to paragraph 190 of the GDC's 'Guidance for the practice committees (January 2026)' which states that:

> *"Decision making at the half time stage should not be conflated with that at the full time stage. The question at half time is whether, on one possible view of the evidence, there is evidence upon which a reasonable PC (not all reasonable PCs) could find the matter proved when making the final decision at the end of the case. If the answer is yes, then there is a case to answer"*

27. It was Mr O'Leary's submission that the weight to be attached to Patient A's account would be a matter for the Committee at the conclusion of all the evidence. He submitted that at this half time stage, there is evidence to support the allegation that Patient A did not consent to the PET. He stated that this included the lack of information in the clinical records of any discussion with the patient about the risks and benefits of the treatment. Mr O'Leary stated that the submissions made on your behalf regarding the nature of Patient A's engagement with the GDC, conversations around the cost of the PET, and a possible financial motive for her complaint, did not render her account untrue.

28. In relation to your alleged failure to act within your duty of candour at head of charge 5, Mr O'Leary submitted that it is not disputed that the dental implant perforated Patient A's sinus. He stated that the question for the Committee is, what Patient A was told about what happened. Mr O'Leary submitted that there is evidence that you gave a number of accounts to the patient, as documented in the clinical records and in your emails to her. He submitted that, looking at those accounts, there is evidence to support the allegation that you breached your duty of candour, as they did not fully explain that the perforation was caused by the angulation of the implant. Mr O'Leary highlighted that this was a matter addressed by Mr Haigh in his evidence.

The Committee's decisions

29. In reaching its decisions, the Committee took account of the submissions made by Mr Geering on your behalf and those made by Mr O'Leary on behalf of the GDC.

30. The Committee accepted the advice of the Legal Adviser, who confirmed that the leading authority in relation to submissions of no case to answer is the case of *R v Galbraith* [1981] 1 WLR 1039. The Legal Adviser explained that whilst *Galbraith* is a criminal case, the legal principles from this authority are applied in regulatory proceedings in relation to half time submissions. In this regard, the Legal Adviser referred the Committee to the two limbs of the relevant test set out in Galbraith, which are as follows:

> *"(1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty - the judge will stop the case.*

(2) The difficulty arises where there is some evidence but it is of a tenuous character, for example, because of inherent weakness or vagueness or because it is inconsistent with other evidence. (a) Where the judge concludes that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict on it, it is his duty, on a submission being made, to stop the case. (b) Where however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witness's reliability, or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence on which the jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury."

31. Bearing this test in mind, the Committee considered the evidence that has been adduced by the GDC and whether it is capable of proving the heads of charge in question.

32. The Committee made the following decisions:

Head 1(c)

The Committee does not accept the submission of no case to answer.

33. On the Committee's reading of the stem at head of charge 1, the allegation at 1(c) covers all of your appointments with Patient A from 1 March 2023 to 24 October 2023. However, taking into account how the evidence has proceeded so far in this case, including the evidence of the GDC's expert witness, Mr Haigh, the focus has been on your provision of the PET to Patient A. Notwithstanding this, the Committee considered that whatever the position may be, there is evidence to support the allegation that you did not fully discuss with Patient A the risks and benefits of the treatment you provided to her.

34. The Committee has been taken to the clinical records in respect of a number of your appointments with Patient A, where there are no notes at all regarding any discussions of the risks and benefits of proposed treatment. The Committee also heard evidence from Mr Haigh, as to what he would have expected to see detailed in the clinical records regarding such discussions. Mr Haigh also made reference to the generic nature of the consent form signed by Patient A in relation to the PET and implant treatment.

35. The Committee had regard to the submission made on your behalf about the absence of clinical records not being a basis to positively allege that a full discussion about risks and benefits did not happen. However, the Committee considered that it would be for it to determine what weight to place on the clinical records at the fact-finding stage, after it has considered all the evidence in this case.

36. It was the conclusion of the Committee that the evidence adduced by the GDC in support of head of charge 1(c), when taken at its highest, is such that a Committee could, on one view of the evidence, find the allegation proved.

Head 4

The Committee does not accept the submission of no case to answer.

37. Given the focus of this case so far, the Committee read *"the treatment"* referred to at head of charge 4 to mean the PET.

38. The Committee was satisfied that there is evidence in support of the matter alleged at head of charge 4. It took into account that none of your manuscript notes or computer records in relation to obtaining consent for the provision of the PET, refer to a discussion with Patient A about the risks and benefits of that treatment. The Committee heard from Mr Haigh that in his expert opinion, obtaining informed consent from a patient should include a discussion about risks and benefits.

39. Additionally, the Committee had regard to the GDC's 'Standards for the Dental Team (September 2013)' ('the GDC Standards'), in particular Standard 3.1.2, 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".*

40. It was the conclusion of the Committee, having considered the GDC's evidence along with the requirements of informed consent as set out in the GDC Standards, that there is sufficient information on which head of charge 4 could be found proved.

Head 5

The Committee does not accept the submission of no case to answer.

41. The Committee had regard to the submission made on your behalf that Patient A was aware that it was the implant that had perforated her sinus. However, it also noted the lack of any contemporaneous documentary evidence before it of you having informed Patient A that the oral antral communication was due to the incorrect angulation of the dental implant. The clinical records and your correspondence with Patient A around the time of the incident all refer to the long root at UL3 as being an issue.

42. The Committee noted Mr Haigh's expert evidence that whilst UL3 did have an unusually long root, in his opinion a long canine root alone would not have caused the implant to go "*off tilt*".

43. Taking into account Mr Haigh's evidence and that your contemporaneous documented explanations given to Patient A are inconsistent with informing her that it was the incorrect angulation of the implant that had perforated the sinus, the Committee concluded that on one view of the evidence, head of charge 5 could be found proved.

44. Accordingly, the Committee's determination is that heads of charge 1(c), 4 and 5 are maintained. These allegations will go forward to be considered as part of the Committee's findings on the alleged facts at the full time stage.

The evidence in respect of your case

45. The documentary evidence received by the Committee in respect of your case was:

- Your witness statement dated 24 May 2026
- A number of testimonials tendered on your behalf.

46. The Committee also heard oral evidence from you in relation to the outstanding factual matters alleged.

The Committee's findings of fact – 12 June 2026

47. The Committee considered all the evidence presented to it, both documentary and oral. It took account of the closing submissions made in respect of the outstanding allegations by Mr O'Leary on behalf of the GDC and by Mr Geering on your behalf.

48. In inviting the Committee to find the outstanding allegations proved, Mr O'Leary referred to the expert evidence of Mr Haigh, including in relation to the requirements of consent and the duty of candour. Mr O'Leary also referred to the account given by Patient A as contained in the documents exhibited by the GDC Caseworker. Whilst Mr O'Leary acknowledged that Patient A's account is hearsay evidence, given that she has not attended this hearing, he submitted that proper weight could be attached to its reliability.

49. Mr Geering invited the Committee to find the outstanding allegations not proved. In relation to head of charge 1(c), he submitted that the GDC had not come close to proving this allegation, given the absence of any criticism from Patient A regarding a discussion about risks and benefits of the treatment provided. With regard to the issue of consent at head of charge 4, Mr Geering asked the Committee to consider your *"straightforward account"* on the matter, which he said was indicative of common sense, as well as the supporting testimonials relating to your good practice. Addressing the Committee on the matter of duty of candour, Mr Geering submitted that there is evidence that Patient A was

told the implant had perforated her sinus. He also asked the Committee to consider the testimonial evidence of your good character and your compassion.

50. The Committee heard and accepted the advice of the Legal Adviser, who advised the Committee in relation to the burden and standard of proof, separate consideration of the allegations and their wording, and how to approach the evidence.

51. In accordance with the legal advice, the Committee considered each of the outstanding heads of charge separately, bearing in mind that the burden of proof rests with the GDC, and that the standard of proof is the civil standard, that is, the balance of probabilities. The Committee has had to determine whether it was more likely than not that the alleged matters occurred.

52. The Committee's findings are set out below. For completeness, they include the factual matters that were announced as 'Found proved by way of admission' at the outset of the hearing:

1(a)	*1. You failed to provide an adequate standard of care to Patient A, from 1 March 2023 to 24 October 2023 including by;* *a) Not carrying out sufficient treatment planning* **Found proved by way of admission.**
1(b)	*1. You failed to provide an adequate standard of care to Patient A, from 1 March 2023 to 24 October 2023 including by;* *b) Exposing Patient A to avoidable ionising radiation.* **Found proved by way of admission.**
1(c)	*1. You failed to provide an adequate standard of care to Patient A, from 1 March 2023 to 24 October 2023 including by;* *c) By not discussing the full risks and benefits of the proposed treatment* **Found proved.** The Committee took into account that although the stem of this allegation covers the period 1 March 2023 to 24 October 2023, the GDC's case in referring to *"the proposed treatment"* is specifically in relation to the PET. The clinical records show that you provided PET to Patient A's UL3 followed by the immediate placement of a dental implant on 5 September 2023. The clinical records and your email communications with Patient A prior to this

	treatment show that there had been discussions about various treatment options from June 2023. The Committee noted that the period June to September 2023 is within the date range included in the stem of this allegation at 1(c). In his oral evidence, Mr Haigh told the Committee that PET involves leaving a small piece of the root of a tooth on the inside of the bone in the relevant area. He stated that the aim of PET is to maintain blood supply to preserve the bone for a better cosmetic outcome in implant treatment. Mr Haigh stated that at the time of Patient A's treatment in 2023, PET was not commonplace or standard treatment, but neither was it abnormal or experimental. He stated that there had been cases of PET documented in literature. It was alleged by the GDC that you did not discuss with Patient A the full risks and benefits of the PET. In bringing this allegation, the Council referred to the lack of any notes in the clinical records to show that such a discussion had occurred. Mr Haigh told the Committee in his oral evidence that he would have expected to see documented in the clinical records a discussion about the risks and benefits associated with any treatment provided to a patient. Moreover, he highlighted in relation to the PET provided to Patient A, that there were specific risks associated with that treatment, as the patient's UL3 had an unusually long root with close proximity to the sinus. Mr Haigh stated that such proximity of a canine root to the sinus was uncommon, and that it would have made Patient A's treatment more technically challenging, with an increased risk of an untoward event happening. He told the Committee that he would have expected these anatomical challenges to have been discussed with Patient A and to have been documented. Mr Haigh noted in his expert report the absence of any clinical records of a discussion with Patient A about the risks and benefits of PET. He also commented on the nature of the consent form provided to and signed by the patient. He stated that *"The consent form is generic and does not specifically mention the risks and benefits of PET…",* although he acknowledged the reference on the form to 'risk of sinus perforation for upper teeth'. In his oral evidence, Mr Haigh stated that he would have expected any documented information to be tailored to the patient. Notwithstanding this, Mr Haigh did state in both his written and oral evidence that because something is not written down this does not mean that it did not happen. Your evidence was that you did discuss with Patient A the full risks and benefits of PET, but you did not make a record of that discussion. The Committee noted that you admitted other allegations in this case regarding the inadequacy of your record keeping in respect of Patient A's treatment. In reaching its decision, the Committee took into account that it received no witness statement from Patient A. The only information from her is in the

exhibits provided by the GDC Caseworker, which the Committee acknowledged is hearsay evidence. The Committee recognised that Patient A made no complaint in any of those communications about not being told about the risks and benefits of PET. However, in approaching its consideration of this allegation at head of charge 1(c), the Committee focused more on what the clinical records showed and the evidence of Mr Haigh.

The Committee also had regard to the letter dated 20 August 2024, which was written on your behalf to the GDC by the MDDUS. In that letter under your response to head of charge 1(c), it is stated on two occasions that you explained the *"advantages"* or *"specific advantages"* of PET. However, at no point does the letter state that you explained the risks to Patient A.

The Committee considered the clinical notes of your appointments with Patient A from June 2023. In doing so, it found no record of any discussion with the patient about the risks and benefits of PET.

The Committee noted that at appointments from 15 to 19 June 2023, you had discussions with Patient A about various other treatment options, and that she had initially chosen to have a denture before changing her mind after impressions had been taken. According to the clinical records, as of 19 June 2023, the proposal was for Patient A to have standard implant treatment with no mention of PET. The Committee further noted that after the 19 June 2023 appointment a CBCT scan was taken of Patient A, but there is no record of any findings from the scan, although handwritten notes from an appointment on 27 June 2023 state *"review/TRIOS scan"*. The Committee took into account Mr Haigh's evidence in his report that the CBCT scan would have shown the close proximity of the UL3 root to the left maxillary sinus.

Your evidence, which is supported by the clinical records, was that the first time PET was raised as an option with Patient A was at an appointment on 27 June 2023. Your brief handwritten note of that appointment refers to *"PET therapy"*. However, there is no information in your note to indicate what you discussed with Patient A about PET.

The Committee took into account that Patient A signed a consent form on 5 September 2023, which was the date the PET and dental implant treatment was provided to her. However, the Committee accepted the opinion of Mr Haigh regarding the generic nature of that consent form, particularly in light of the specific anatomical challenges identified in Patient A's case.

The Committee recognised the lengthy nature of your appointments with Patient A on 19 June 2023 and 5 September 2023, the inference being that there would have been time for discussion. The Committee also took into account your admission regarding the poor nature of your record keeping in relation to Patient A's appointments. Notwithstanding that, the Committee

	noted that you documented many other aspects of Patient A's treatment, including that you discussed various other treatment options and that Patient A had refused a denture. By contrast, your references to PET are minimal. The Committee took into account the testimonial evidence tendered on your behalf, including from a number of patients regarding your discussions with them about risks and benefits. However, the Committee took into account that this was a somewhat unusual situation with Patient A and you told the Committee that this was only the third time that you had undertaken PET. As such, it behoved you to spell out the risks to Patient A, particularly in circumstances where she was seemingly initially reluctant for PET. In an email to you dated 17 August 2023, Patient A stated, *"I would like to proceed with the Implant per the treatment plan of the 19th June '23".* The Committee considered that the first time you outlined the risks in any detail was in your witness statement provided for this hearing, dated 24 May 2026, which is almost three years after the event. In the circumstances, the Committee was concerned about the impact on the passage of time on your recollection, particularly given the very limited nature of your clinical records in relation to the PET. It was the view of the Committee, taking into account all the information before it, that you were keen to provide PET to Patient A, as you considered that it would be beneficial for her. The Committee found that in these circumstances, it was more likely that your emphasis would have been on the advantages of PET as opposed to the risks. Having considered the evidence, the Committee was satisfied on the balance of probabilities that the GDC has satisfied it that you did not discuss with Patient A the full risks and benefits of the proposed treatment.
1(d)	*1. You failed to provide an adequate standard of care to Patient A, from 1 March 2023 to 24 October 2023 including by;* *d) Not using a surgical guide, or alternative angulation controls* **Found proved by way of admission.**
2	*You failed to maintain an adequate standard of record keeping in respect of Patient A's appointments from 1 March 2023 to 24 October 2023.* **Found proved by way of admission.**
3	*You failed to maintain an adequate standard of record keeping in relation to radiographs, in respect of Patient A's appointments from 1 March 2023 to 24 October 2023.*

	Found proved by way of admission.
4	*You failed to obtain informed consent for the treatment provided to Patient A from 1 March 2023 to 24 October 2023.* **Found proved.** The Committee again took into account the GDC's case that *"the treatment"* referred to in this allegation relates to the PET. The Committee noted that the basis for this allegation arises from the GDC's *'Standards for the Dental Team (September 2013)'*, which sets out the various requirements of consent, including: *<u>Standard 3.1.2</u>* *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.* *<u>Standard 3.1.3</u>* *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;* • *why you think a particular treatment is necessary and appropriate for them;* • *the consequences, risks and benefits of the treatment you propose;* • *the likely prognosis;* • *your recommended option;* • *the cost of the proposed treatment;* • *what might happen if the proposed treatment is not carried out; and* • *whether the treatment is guaranteed, how long it is guaranteed for and any exclusions that apply.* *<u>Standard 3.1.4</u>* *You must check and document that patients have understood the information you have given.* The Committee also took into account the expert opinion of Mr Haigh, who set out in his report that *"The basic requirements for obtaining valid consent are:*

- *Obtain valid consent before starting treatment, explaining all the relevant options and the possible costs.*
- *The patient must be given sufficient information from which to form a balanced judgement. This means that the patient should be given reasonable and appropriate treatment options, along with their risks and benefits. This includes the option of having no treatment.*
- *The consent must be freely given, and can be withdrawn at any time.*
- *Patients should have enough time to ask questions and make a decision.*
- *Patient[s] expect to be listened to and have their preferences and concerns taken into account.*
- *Patients can withdraw their consent at any time, refuse treatment or ask for it to be stopped after it has started. The registrant must acknowledge the patient's right to do this and follow their wishes.*
- *Discussions with the patient in the process of confirming their ongoing consent should be documented"*

The Committee's finding at head of charge 1(c) is that you did not discuss with Patient A the full risks and benefits of the PET. Therefore, in its view, you could not have obtained informed consent for the treatment from her. Patient A would not have had all of the information she required to make a fully informed decision.

In reaching its conclusion in relation to head of charge 4, the Committee noted from the clinical records of 5 September 2023, the day the treatment was provided, that you had asked Patient A if she would agree to the PET if it was free of charge and you noted that *"Pt smiled and agreed".* You told the Committee in your oral evidence that you had taken this to be Patient A's consent to the treatment. However, the Committee noted the absence of any notes in the clinical records to indicate whether Patient A had been fully informed about the treatment she was agreeing to, including the full risks and benefits.

Furthermore, whilst the Committee bore in mind that it has not received a witness statement or heard evidence from Patient A, there is information before it in the form of her communications with you to indicate that up until 5 September 2023, when the treatment was carried out, her preference had not been for PET but for standard implant treatment.

The Committee was satisfied on the balance of probabilities that this head of charge is proved. It was satisfied from the GDC Standards and from Mr Haigh's evidence that you had a duty to obtain informed consent from Patient A for the PET, but that in all the circumstances, you failed to do so.

5(a)	*5. You failed to act within your duty of candour between 07 September 2023 to 1 November 2023* *in that:* *a) You did not properly inform Patient A that the cause of oral antral communication was due to the incorrect angulation of the dental implant.* **Found not proved.** The Committee had regard to the requirements of the professional duty of candour, as set out in the GDC's guidance of July 2016, and as included in Mr Haigh's report as follows: *"Duty of candour is the professional responsibility of healthcare professionals to be open and honest with patients when something goes wrong with their treatment or care.* *This means that healthcare professionals must:* • *tell the patient when something has gone wrong,* • *apologise to the patient,* • *offer an appropriate remedy or support to put matters right (if possible), and* • *explain fully to the patient the short- and long-term effects of what has happened".* The Committee noted that this allegation at head of charge 5 relates specifically to the aspect of the duty of candour which required you to tell Patient A that something had gone wrong, namely that "*the cause of oral antral communication was due to the incorrect angulation of the dental implant".* However, the Committee took into account the oral evidence of Mr Haigh, who stated during his cross-examination that, as part of your duty of candour, it would have been sufficient for you to have simply told Patient A that the implant perforated the sinus, without going into further detail about angulation. The Committee took into account that in the clinical records and in your emails to Patient A following the incident, you emphasised the unusually long root at UL3 as being a problem. However, it noted from the letter of 20 August 2024, written on your behalf by the MDDUS, when you addressed this allegation about duty of candour in more detail, you recalled telling Patient A that the perforation of her sinus was due to the incorrect angulation of the implant. The Committee also found that you were consistent in your evidence provided at this hearing that you told Patient A that it was the implant that had pierced the sinus. Whilst the Committee did not receive evidence directly from Patient A, it noted from the information

	before it that she was at least aware that the implant had pierced her sinus and that you told her this would heal. Having considered the evidence, the Committee was satisfied that your duty of candour was appropriately met. Whilst the Committee took into account that this allegation refers only to one aspect of that duty, it considered that you also fulfilled your duty in relation to the other requirements. In this regard, the Committee noted your explanation to Patient A that the perforation would heal, your offer and provision of a refund, and the efforts you made to ensure her follow-up care, including the referral to hospital when you acknowledged that the professional relationship between you had broken down. The Committee noted and accepted your evidence that you had wanted to apologise to Patient A for what she had experienced, but that you respected her wishes not to be contacted any further by you or by the practice.

53. The hearing now moves to Stage Two.

Stage Two of the Hearing – 12 and 15 June 2026

54. The facts found proved at the first stage of the hearing relate to your treatment of one patient, Patient A, from June to September 2023. Whilst the dates in the charge refer to a longer period, the focus of this case has been on your provision of PET and a dental implant to Patient A in September 2023, and the preceding appointments in June 2023.

55. You admitted, and the Committee found proved that, you failed to provide an adequate standard of care to Patient A in a number of respects. You admitted that you did not carry out sufficient treatment planning in respect of the treatment you provided to Patient A, that you exposed the patient to avoidable ionizing radiation by taking an additional panoramic radiograph (OPG) after having obtained a CBCT scan, and that you did not use a surgical guide, or alternative angulation controls when placing the dental implant.

56. In addition, the Committee found proved that you failed to provide Patient A with an adequate standard of care in that you did not discuss with her the full risks and benefits of the PET. Consequently, you failed to obtain informed consent from Patient A for the treatment, as she was not provided with all the necessary information she required to make an informed decision.

57. In respect of your record keeping, you admitted that you failed to maintain an adequate standard of record keeping in respect of Patient A's appointments and in relation to radiographs.

58. 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.

59. The Committee considered all the evidence presented to it, both at the first stage of the hearing and at this stage. The evidence received at this stage comprised a 'Stage 2 Bundle' submitted on your behalf, which included a copy of your Personal Development Plan (PDP), evidence of your Continuing Professional Development (CPD), a letter from your Mentor dated 13 April 2026 and further testimonial evidence. The Committee was also provided with your written reflections in respect of the matters in this case.

60. The evidence from the GDC at this second stage was a copy of a Case Examiners Decision sheet dated 15 October 2020, setting out advice that was given to you by the GDC's Case Examiners in relation to your treatment of a patient in 2017.

Summary of parties' submissions

61. Mr O'Leary provided his submissions in writing, and he made submissions orally. In accordance with Rule 20(1)(a) of the *GDC (Fitness to Practise) Rules Order of Council 2006*, he first addressed the Committee on your fitness to practise history. He referred to the advice you received from the GDC's Case Examiners in October 2020 which, he asked the Committee to note, was given in the context of an allegation in 2017 of insufficient treatment planning for implant treatment. Mr O'Leary highlighted that the Case Examiners did not make any findings of fact in relation to that matter.

62. In addressing this current case, Mr O'Leary submitted that, when considering the issue of misconduct and whether the facts found proved fell far below the standard expected, the Committee should have regard to the GDC's *'Standards for the Dental Team (September 2013'* ('the GDC Standards'). Mr O'Leary invited the Committee to take into account the opinion of Mr Haigh, the GDC's expert witness, who set out in his report that each of the alleged failings, if found proved, fell far below the standard expected, including your record keeping failings, which Mr Haigh regarded as cumulatively below standard.

63. Mr O'Leary submitted that both the public protection and public interest limbs of impairment are engaged in this case. He submitted that in determining the issue of current impairment, the Committee would need to consider whether your failings are remediable, whether they have in fact been remedied, and whether they are likely to be repeated. In submitting that there is a risk of repetition, Mr O'Leary referred to the advice you received from the GDC's Case Examiners in 2020. He submitted that despite that advice, in 2023 you demonstrated poor implant practice and poor record keeping. It was his submission that the

evidence of remediation you have provided in respect of the concerns relating to your treatment of Patient A does not fully dispose of the risk of repetition, which he said is high. Mr O'Leary invited the Committee to conclude that your fitness to practise is impaired on public protection grounds.

64. Mr O'Leary submitted that a finding of impairment is also required in the wider public interest, to maintain public confidence in the dental profession and to uphold proper professional standards. He stated that this is a case in which harm was caused to a patient. He highlighted Mr Haigh's evidence that, although the use of a surgical guide would not have eliminated the risk of perforating Patient A's sinus, it would have reduced the possibility. Mr O'Leary also referred to your inadequate record keeping and the impact record keeping failings have on communication between practitioners and the ability to establish what has gone wrong when mistakes are made. He also asked the Committee to take into account its finding that you provided treatment without the informed consent of the patient.

65. It was Mr O'Leary's submission that the appropriate and proportionate sanction in this case would be to impose conditions on your registration. He stated that whilst the matters found proved relate to one patient and you have expressed remorse for your failings, there are a number of aggravating factors. He stated that these factors were the harm caused to Patient A in the context of a lack of informed consent and the advice given to you by the GDC's Case Examiners in 2020 in respect of similar matters. Mr O'Leary submitted that a lesser sanction than a conditions of practice order would not meet the gravity of the Committee's findings. He invited the Committee to consider imposing conditions requiring the supervision of your practice and clinical audits.

66. Mr Geering told the Committee that he had no submissions to make in relation to the issue of misconduct.

67. In respect of the Case Examiner's advice given to you in October 2020, Mr Geering submitted that the Committee may think that this is of no relevance to its considerations at this hearing. He submitted that that matter did not concern the same issues, that the alleged facts in that case were disputed and that no findings were made. Furthermore, that even at its highest, that matter did not warrant referral to a hearing.

68. Mr Geering went on to address the matter of public protection. He stated that the question for the Committee would be whether there is risk of repetition such that a finding of impairment is required. He submitted that this is a case concerning one patient and one course of treatment within your lengthy career as a dentist. He highlighted that you have been practising without restriction since your treatment of Patient A, with no further issues raised during the intervening period. Mr Geering submitted that it would be difficult to conclude that there is a risk of repetition when considering these factors.

69. Mr Geering stated that you have been in practice for 33 years, and when looking at the period involved in this case; June to September 2023, a reasonable construction is that it was an isolated incident. He told the Committee that you are on the GDC's Specialist List for oral surgery. Mr Geering submitted that it has been three years since your treatment of Patient A and three years is the maximum period that conditions can be imposed on your registration. Therefore, that time has already passed.

70. It was Mr Geering's submission that there is positive evidence of your good practice in the testimonials tendered on your behalf by a number of patients. He asked the Committee to note that they speak highly of your treatment of them, including how you explain the associated risks and benefits. Mr Geering also drew the Committee's attention to the positive testimonials you have received from colleagues who have worked alongside you, as well as from colleagues to whom you have referred patients.

71. Mr Geering also asked the Committee to take into account the *"voluminous"* evidence of your insight and the *"tangible"* evidence of your remorse, both in your oral evidence and in your written reflections. He further asked the Committee to have regard to the prompt remedial action you took in relation to your treatment of Patient A, including the follow-up care you provided and the secondary referral you made when the patient disengaged with you.

72. Mr Geering submitted that the evidence of your insight was reinforced by your admissions made at the outset of these proceedings. He stated that the *"fulsome and tangible"* evidence of your insight had fed into the quality of your remediation. In this regard, he referred the Committee to the evidence of your CPD undertaken from 2024 to 2026 which, he highlighted, included CPD on the duty of candour, a matter that was not found proved in this case. Mr Geering also asked the Committee to note that you obtained the assistance of a mentor and engaged in peer review discussions as part of your remedial action.

73. It was Mr Geering's submission that, given the evidence of your insight, your learning and training, your reflection on your practice and the absence of any evidence of repetition, there was no need to find current impairment on public protection grounds. He stated that these proceedings have had a salutary impact on you and have reinforced lessons about the upholding of proper professional standards. Mr Geering submitted that the Committee could be confident that your failings are not likely to be repeated in future.

74. With regard to whether a finding of current impairment is required in the wider public interest, Mr Geering asked the Committee to consider the nature of this case. He submitted that the matters concern clinical allegations from 2023 with no attitudinal concerns. He stated that the public interest would be upheld by this regulatory process. Mr Geering

submitted that this is not the type of case that needs to be marked by a finding of impairment in the wider public interest.

The Committee's Decisions – 15 June 2026

75. The Committee considered all the evidence before it. It took account of the submissions made by Mr O'Leary on behalf of the GDC, both written and oral, as well as the submissions made orally by Mr Geering on your behalf. The Committee accepted the advice of the Legal Adviser as to the approach it should take to its decision-making and the applicable legal principles and guidance.

76. The Committee bore in mind that there is no burden or standard of proof at this stage of the proceedings, and that its decisions were for its independent judgement. It remained cognisant of the overarching statutory objective of the GDC which is: to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the dental professions, and to promote and maintain proper professional standards and conduct for members of those professions.

77. The Committee further took into account the *'Standards for the Dental Team (September 2013)* ('the GDC Standards') and the GDC's *'Guidance for the practice committees (Effective from 6 January 2026)'* ('the Guidance').

Decision on misconduct

78. The Committee considered whether the facts found proved amount to misconduct. It took into account that a finding of misconduct in the regulatory context requires a serious falling short of the standards expected of a registered dental professional. The Committee had regard to the GDC Standards, and it considered the following standards to be engaged in this case:

2.2.1 You must listen to patients and communicate effectively with them at a level they can understand. Before treatment starts you must:

- explain the options (including those of delaying treatment or doing nothing) with the risks and benefits of each; and
- give full information on the treatment you propose and the possible costs.

2.3.5 You should make sure that patients have enough information and enough time to ask questions and make a decision.

2.3.6 You must give patients a written treatment plan, or plans, before their treatment starts and you should retain a copy in their notes. You should also ask patients to sign the treatment plan.

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;
- why you think a particular treatment is necessary and appropriate for them;
- the consequences, risks and benefits of the treatment you propose;
- the likely prognosis;
- your recommended option;
- the cost of the proposed treatment;
- what might happen if the proposed treatment is not carried out; and
- whether the treatment is guaranteed, how long it is guaranteed for and any exclusions that apply.

3.1.4 You must check and document that patients have understood the information you have given.

3.3.2 When carrying out an on-going course of treatment, you must make sure you have specific consent for what you are going to do during that appointment.

3.3.4 You must document the discussions you have with patients in the process of confirming their ongoing consent.

3.3.5 If you think that you need to change a patient's agreed treatment or the estimated cost, you must obtain your patient's consent to the changes and document that you have done so.

4.1.1 You must make and keep complete and accurate patient records, … each time that you treat patients.

Radiographs, consent forms, photographs, models, audio or visual recordings of consultations, laboratory prescriptions, statements of conformity and referral letters all form part of patients records where they are available.

4.1.2 You should record as much detail as possible about the discussions you have with your patients, including evidence that valid consent has been obtained. You should also include details of any particular patient's treatment needs where appropriate.

4.1.5 If you need to make any amendments to a patient's records you must make sure that the changes are clearly marked up and dated.

79. The Committee bore in mind that its findings relate to your treatment of one patient and one course of treatment. However, the treatment you provided to Patient A was complex dental treatment and there were a number of failures on your part, including in basic and fundamental areas of dentistry, such as treatment planning, radiography, consent and general record keeping. The Committee also took into account that you did not use a surgical guide or alternative angulation controls when placing the dental implant for Patient A, in a situation where the anatomical risk was high. The Committee noted Mr Haigh's opinion that *"…failing to use any method to ensure the correct angulation of the dental implant and avoid perforation of the anterior wall of the left sinus amounted to a significant departure from the standard expected"* and *"fell far below the standard expected of a reasonably competent registrant"*. It was Mr Haigh's evidence that all the failings found proved by the Committee fell far below the standard expected.

80. Having considered the evidence, including Mr Haigh's expert opinion, it was the view of the Committee that your conduct in the circumstances of Patient A's treatment represented a serious breach of the requirements set out in the relevant GDC Standards. Accordingly, the Committee determined that the facts found proved in this case amount to misconduct.

Decision on current impairment

81. The Committee was in no doubt that at the time of the events involving Patient A, your fitness to practise as a dentist was impaired. In considering the issue of 'current' impairment, the Committee took into account that it must determine whether your fitness to practise is impaired as at the time of this hearing.

82. In reaching its decision, the Committee had regard to the following test for impairment formulated by Dame Janet Smith in her fifth Shipman Report, as set out in the case of *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council and Grant* [2011] EWHC 927 (Admin):

> *"Do our findings of fact in respect of the [dentist's] misconduct … show that his/her fitness to practise is impaired in the sense that s/he:*
>
> *a. has in the past acted and/or is liable in the future to act so as to put a patient*

or patients at unwarranted risk of harm; and/or

b. *has in the past brought and/or is liable in the future to bring the [dental] profession into disrepute; and/or*

c. *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the [dental] profession; and/or*

d. *…*

83. The Committee considered the various aspects of your misconduct and it was satisfied that the factors referred to at (a) to (c) above are applicable. In its view, you have acted in the past so as to put a patient at unwarranted risk of harm, bring the dental profession into disrepute and breached fundamental tenets of the dental profession in your failure to adhere to several key GDC Standards, including in relation to informed consent.

84. The Committee also considered the questions arising from the case of *Cohen v General Medical Council* [2008] EWHC 581 (Admin), namely whether your misconduct is remediable, whether it has been remedied and whether it is likely to be repeated. The Committee further noted paragraph 233 of the Guidance, which states that:

"Factors which may be relevant to the assessment of whether a registrant's fitness to practise is currently impaired include:

a. Demonstration of insight and remorse (i.e. recognition of the issue by the registrant, and whether the registrant recognises that they should have behaved differently in the circumstances).

b. Any remedial action taken by the registrant (i.e. measures put in place to prevent a recurrence such as evidence of learning undertaken which addresses the impairment, reflective writing, formulating a personal development plan).

c. The risk of recurrence".

85. The Committee was satisfied that your failings in relation to Patient A's treatment, are capable of being remedied. It took into account that all of the issues of concern are clinical in nature and that these could be addressed with further learning and training.

86. In considering whether your failings have indeed been remedied, the Committee first considered whether there is any evidence before it of your insight into your shortcomings and any remorse. In doing so, the Committee had regard to your written reflections on the matters arising in this case. It noted from your reflections that you acknowledged the mistakes you made in respect of the Patient A's treatment, and you set out how you have

reviewed your performance in each of the areas of concern and made changes to your clinical practice.

87. For example, the Committee noted the information that you have since increased your appointment times, so you have the opportunity to write more detailed notes. In relation to radiography, you explained that you had sent Patient A to another practice for her CBCT scan, as you did not have the facility at your clinic at the time. You explained that the additional radiograph (OPG) that you took of Patient A on the day of her surgery was due to *"mismatched/ misplaced emails with appropriate password and I could not open the CBCT".* You stated in your written reflections that "*I have now invested in purchasing and installing our own CBCT machine so that a similar situation does not happen again."* Further that *"I now always make sure that on the day of treatment, all the relevant radiographic images are available and is accessible prior to the arrival of the patient"*. You refer to other steps you now take and to other equipment bought to safeguard patients from over-exposure to radiation.

88. The Committee also noted from your written reflections that you have undertaken CBCT – Level 2 training programmes. You stated that "*This gives me more knowledge and skill on how to navigate and make plans digitally. This gives us a better understanding of various structures and their relation to any proposed surgical intervention".*

89. The Committee noted that you specifically address where you went wrong with Patient A's treatment, stating that, *"In Patient A's case I veered off into the wrong angle and my mistake caused the perforation of the sinus. I feel extremely sad for the patient, and I feel very remorseful and I sincerely apologise to Patient A. My error has caused the patient pain and distress". You further stated that "The patient should receive the highest level of care and I accept that was not the case. I would like to say a sincere apology to the patient from the bottom of my heart."*

90. It was the view of the Committee that you have shown genuine remorse for what happened with Patient A, which has included your apology to her at this hearing. The Committee noted that you fully accepted the mistakes you made both in your written reflections and in the oral evidence that you gave at the first stage of these proceedings.

91. Furthermore, the Committee considered that you have demonstrated significant insight into your failings, why they occurred, and made considerable efforts to prevent recurrence. The Committee also noted the information you provided in your written reflections regarding your use of peer review groups which, you stated, prevents you from becoming professionally isolated. The Committee noted from your written reflections, your recognition of your failings on the reputation of the dental profession, including that *"I feel terrible that I have brought the reputation of the profession into disrepute. And I deeply regret my mistake."*

92. The Committee was of the view that the depth of your insight is evident in the quality of the remediation that you have undertaken. It noted that in addition to the practical changes that you have made to your clinical practice, you have completed a considerable amount of targeted CPD, and you have produced an ongoing PDP that is highly tailored to the issues in this case.

93. The Committee also took into account that your CPD commenced at a relatively early stage, with the evidence of your learning covering the period 2024 to 2026. It noted that you have undertaken courses on consent in implant dentistry, radiography, implant planning and placement and record keeping. The Committee also had regard to your detailed reflections on your learning and how you say this has informed your current clinical practice. The Committee took into account that you have also undertaken CPD in, and reflected on, the duty of candour, which was a matter not found proved by the Committee.

94. In addition, the Committee took into account your engagement of a mentor. It noted from his letter dated 13 April 2026, that he has known *you "in a professional capacity through a structured mentoring and advisory relationship focused on reviewing and strengthening her clinical systems, governance, and reflective practice"*. Your mentor stated in his letter that *"I have not had cause to doubt Dr Gupta's professionalism or her commitment to patient safety. In my experience, she approaches her responsibilities with seriousness and demonstrates a willingness to identify learning needs and address them appropriately through structured development."*

95. The Committee was satisfied, having taken account of all the evidence provided on your behalf at this stage, that there is ample evidence of you having embedded your learning in your clinical practice. The Committee also noted the up-to-date testimonial evidence from patients, colleagues and staff that speaks of your practice in commendable terms. In considering the risk of repetition, the Committee bore in mind that you have previously received advice from the GDC's Case Examiners in relation to a case with similar elements as this current one. However, the Committee noted that that previous matter did not lead to any findings against you. Moreover, that case related to an alleged incident nine years ago. Taking these factors into account, the Committee's view was that the presence of that issued advice does not significantly detract from the level of insight you have shown in relation to your failings in this case and the considerable and appropriate steps you have taken to ensure such failings do not recur.

96. In all the circumstances, the Committee concluded that the risk of repetition is minimal. In its view, based on everything that it has seen and heard, including the positive testimonials tendered on your behalf, it is unlikely that you are liable to act in the future to put patients at unwarranted risk of harm. Accordingly, the Committee determined that a finding of impairment is not necessary on the grounds of public protection.

97. The Committee went on to consider the wider public interest. It specifically had regard to your past actions in bringing the dental profession into disrepute and your breaching of fundamental tenets of the profession. The Committee noted that your conduct in this case does not fall into the categories of example given at paragraph 248 of the Guidance which deals with impairment of the grounds of public interest. It also took into account that the facts found proved relate to a single patient and one course of treatment. However, your misconduct involved a range of failings, over a number of months, during which time, aspects of your clinical practice fell far below what was expected.

98. The Committee remained mindful of the GDC's overarching statutory objective. It weighed the evidence of your insight, remorse, remedial action taken, and the minimal risk of repetition, against the public interest in maintaining public confidence in the dental profession and the upholding of proper professional standards. Notwithstanding that your practice has substantially improved since the events in 2023, it was the conclusion of the Committee, taking into account your failure to adhere to a number of basic and fundamental professional obligations, including your failure to discuss the full risks and benefits of PET and obtain informed consent for such treatment, that a finding of impairment is required on wider public interest grounds. The Committee considered that public confidence in the dental profession and the maintenance of proper professional standards would be undermined if a finding of impairment were not made in all the circumstances of this case.

99. The Committee therefore determined that your fitness to practise is impaired by reason of your misconduct on wider public interest grounds only.

Decision on sanction

100. Having found your fitness to practise to be impaired, the Committee considered 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. The Committee noted that in this case any sanction imposed must uphold the wider public interest. The Committee had regard to the Guidance. It applied the principle of proportionality, balancing the public interest with your own interests.

101. The Committee noted that it was open to it to conclude this case without taking any action in relation to your registration. However, it decided that in the circumstances of this case, such an outcome would not serve to maintain public confidence in the dental profession, nor would it promote proper professional standards.

102. In deciding on the appropriate sanction, the Committee considered the issue of mitigating and aggravating factors. It found the aggravating factors in this case to be that actual harm was caused to Patient A. The Committee also took into account your fitness to

practise history, in that you previously received advice from the GDC's Case Examiners, although it noted that no formal findings were made in relation to that matter.

103. The Committee identified the following factors in mitigation:

- That the events involved a single patient and one course of treatment.
- There was no financial gain on your part. The Committee noted that you provided Patient A with a refund.
- There is evidence of good conduct following the incident in question, which was three years ago.
- There is evidence of remorse, insight and apology.
- You have undertaken significant remedial action.

104. The Committee also had regard to the positive testimonial evidence tendered on your behalf, which it found to be recent and relevant. It also noted that the authors of the testimonials were aware of the concerns raised about your clinical practice.

105. Having taken into account these factors, the Committee considered the available sanctions. It started with the least restrictive as it is required to do. The Committee first considered whether it would be appropriate and proportionate to issue you with a reprimand. In reaching its decision, it had regard to paragraphs of the Guidance which deal with reprimand. Paragraph 262 states that:

> *A reprimand does not restrict a registrant's ability to practise, and may therefore be appropriate where the issues identified are at the lower end of the spectrum of seriousness, where a restrictive sanction is not required to protect the public or the public interest.*

106. Whilst the Committee took into account your breach of a number of GDC Standards, it considered that this was not a case at the high end of seriousness. It also took into account its conclusion that the ongoing risk to the public is minimal. In deciding whether a reprimand would sufficiently meet the wider public interest, the Committee had regard to paragraph 263 of the Guidance and was satisfied that a number of the factors applicable to the suitability of a reprimand are present in this case, namely:

- There is no evidence to suggest you pose any risk to the public.
- You have shown insight into your failings.
- The events involved a single patient and one course of treatment.
- Your behaviour was not deliberate.
- You have expressed genuine remorse.
- There is evidence that you have taken rehabilitative/corrective steps.

107. In deciding whether a reprimand is the most appropriate and proportionate sanction, the Committee considered the GDC's submissions regarding conditions. However, it concluded that imposing a conditions of practice order would be unnecessary and disproportionate. The Committee was satisfied that the evidence before it demonstrates that you have substantially improved your clinical practice since the events in 2023, such that there are no continuing public protection concerns. The Committee therefore decided that conditions would serve no meaningful purpose.

108. In all the circumstances, the Committee determined to issue you with a reprimand. The fact of this reprimand and a copy of this determination will appear alongside your name on the GDC Register for a period of 12 months. The reprimand will form part of your fitness to practise history and is disclosable to prospective employers and prospective registrars in other jurisdictions.

109. That concludes this determination.